Health Care Appropriations Subcommittee

Tuesday, February 11, 2020
1:30 pm – 3:30 pm
Reed Hall (102 HOB)

MEETING PACKET

Jose R. Oliva
Speaker

MaryLynn Magar
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time:	Tuesday, February 11, 2020 01:30 pm
End Date and Time:	Tuesday, February 11, 2020 03:30 pm
Location:	Reed Hall (102 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

CS/HB 313 Voluntary Registration of Stem Cell Providers by Health Quality Subcommittee, Donalds
HB 467 Physical Therapy Practice by Stevenson
HB 687 Services for Veterans and Their Families by Zika, Hattersley
CS/HB 763 Patient Safety Culture Surveys by Health Market Reform Subcommittee, Grant, M.
CS/HB 1071 Substance Abuse and Mental Health by Children, Families & Seniors Subcommittee, Grant, M.
CS/HB 1081 Substance Abuse and Mental Health by Children, Families & Seniors Subcommittee, Stevenson
CS/HB 1143 Department of Health by Health Quality Subcommittee, Gregory
CS/HB 1163 Intermediate Care Facilities by Health Market Reform Subcommittee, Burton
HB 1217 Surrendered Newborn Infants by Beltran
CS/HB 1323 Economic Self-sufficiency by Oversight, Transparency & Public Management Subcommittee, Aloupis
HB 6029 Punitive Damages by Mariano
HB 7025 Guardianship by Children, Families & Seniors Subcommittee, Fetterhoff
HB 7053 Direct Care Workers by Health Market Reform Subcommittee, Tomkow

NOTICE FINALIZED on 02/07/2020 4:18PM by SPB

The Florida House of Representatives

Appropriations Committee

Health Care Appropriations Subcommittee

Jose Oliva
Speaker

MaryLynn Magar
Chair

AGENDA
Tuesday, February 04, 2020
12:00 PM – 3:00 PM
Sumner Hall (404 HOB)

I. **Call to Order/Roll Call**

II. **Opening Remarks by Chair Magar**

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

CS/HB 313 Voluntary Registration of Stem Cell Providers by Health Quality Subcommittee, Donalds
HB 467 Physical Therapy Practice by Stevenson
HB 687 Services for Veterans and Their Families by Zika, Hattersley
CS/HB 763 Patient Safety Culture Surveys by Health Market Reform Subcommittee, Grant, M.
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HB 6029 Punitive Damages by Mariano
HB 7025 Guardianship by Children, Families & Seniors Subcommittee, Fetterhoff
HB 7053 Direct Care Workers by Health Market Reform Subcommittee, Tomkow

IV. **Closing Remarks/Adjournment**

CS/HB 313

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 313 Voluntary Registration of Stem Cell Providers
SPONSOR(S): Health Quality Subcommittee, Donalds
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	12 Y, 0 N, As CS	Guzzo	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A stem cell is a cell that has the ability to develop into a specialized cell in the body. Stem cell therapy, also called regenerative medicine, is the use of stem cells to treat or prevent a disease or condition. The use of stem cells have shown potential in regenerative and reconstructive medicine. These practices are regulated by the United States Food and Drug Administration.

CS/HB 313 creates a voluntary registration program within the Department of Health (DOH) for stem cell providers. Physicians licensed under chapter 458 or chapter 459 who provide stem cell services may register with the program. Any physician who registers agrees to adhere to current good manufacturing practices established pursuant to the Federal Food, Drug, and Cosmetic Act. A manufacturer or distributor of stem cell products may also register with the program.

The bill requires DOH to establish and maintain an online registry on its website of all physicians, manufacturers, and distributors participating in the voluntary registration program. DOH is required to update this registry monthly.

The bill has an insignificant, negative fiscal impact on the DOH that can be absorbed with existing resources. The bill has no fiscal impact on local governments.

The bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Stem Cells

Stem cells are cells that have the ability to divide for indefinite periods in culture and to give rise to specialized cells.[1] Under certain physiologic or experimental conditions, stem cells can be induced to become tissue- or organ-specific cells with special functions.[2] Stem cells are referred to as "undifferentiated" because they have not yet committed to a developmental path for a specific tissue or organ.[3] Differentiation is the process of changing into a specific type of cell.[4] Stem cells have the potential to repair, restore, replace, and regenerate cells, and could possibly be used to treat a number of medical conditions.[5]

Scientists primarily work with two categories of stem cells: embryonic and adult.[6] Embryonic stem cells are derived from embryos, usually created by in vitro fertilization and donated for research with the informed consent of donors.[7] Embryonic stem cells may be used to generate every cell type found in the body because they are pluripotent.[8]

Adult stem cells (nonembryonic) are more specialized than embryonic stem cells and typically generate different cell types for the specific tissue or organ in which they live.[9] Adult stem cells have been found in organs that need to continuously replenish themselves, such as the blood, skin, and gut, but also are in other less generative organs such as the brain.[10]

In 2007, scientists identified conditions that would allow some specialized adult stem cells to be genetically reprogrammed or engineered to become pluripotent, i.e. behave like embryonic cells.[11] These reprogrammed cells are called induced pluripotent stem cells. It is not known if the induced pluripotent stem cells differ from embryonic stem cells in a clinically significant way.[12] However, induced pluripotent stem cells could replace the use of embryonic stem cells in research and clinics.[13]

Stem cell therapy is the treatment of a condition or illness with stem cells or cells that come from stem cells to replace or repair a patient's damaged cells or tissues.[14] Currently, the range of diseases for

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[1] National Institutes of Health, *Stem Cell Information: Glossary*, available at https://stemcells.nih.gov/glossary.htm (last visited January 31, 2020).
[2] National Institutes of Health, *Stem Cell Information: Stem Cell Basics I.*, available at https://stemcells.nih.gov/info/basics/1.htm (last visited January 31, 2020).
[3] National Institutes of Health, *Stem Cell Information: Stem cell Basics II.*, available at https://stemcells.nih.gov/info/basics/2.htm (last visited February 1, 2020).
[4] Id.
[5] U.S. Food and Drug Administration, *FDA Warns about Stem Cell Therapies*, (Nov. 16, 2017), available at https://www.fda.gov/ForConsumers/ConsumerUpdates/ucm286155.htm (last visited February 2, 2020).
[6] *Supra* note 2.
[7] National Institutes of Health, *Stem Cell Information: Stem Cell Basics III.*, available at https://stemcells.nih.gov/info/basics/3.htm (last visited February 1, 2020).
[8] Id. Pluripotent is the state of a single cell that is capable of differentiating into all tissues of an organism, but not alone capable of sustaining full organismal development (*supra* note 1).
[9] International Society for Stem Cell Research, *Stem Cell Facts*, available at https://www.closerlookatstemcells.org/wp-content/uploads/2018/10/stem-cell-facts.pdf (last visited February 1, 2020).
[10] Id.
[11] *Supra* note 9.
[12] National Institutes of Health, *Stem Cell Information: Stem Cell Basics VI.*, available at https://stemcells.nih.gov/info/basics/6.htm (last visited February 1, 2020).
[13] Vimal Singh, et al, *Induced Pluripotent Stem Cells: Applications in Regenerative Medicine, Disease Modeling, and Drug Discovery*,
[14] *Supra* note 9.

which there are proven treatments based on stem cell therapy is small.[15] However, treatments for disorders of the blood and immune systems and acquired loss of bone marrow, can in some cases be treated effectively with blood stem cells.[16] Tissue- and organ-specific treatments, such as those for skin and corneas, have proven successful.[17] However, other stem cell therapies are experimental, and may not yet be shown to be safe or effective.[18]

Stem Cell Regulation

The Center for Biologics Evaluation and Research (CBER), within the United States Food and Drug Administration (FDA), regulates biological products for human use, including gene therapy.[19] An establishment that manufactures human cells, tissues, and cellular and tissue-based products (HCT/Ps), must register with CBER, if the:[20]

- The HCT/P is minimally manipulated;
- The HCT/P is intended for homologous use only;
- The manufacture of the HCT/P does not involve the combination of cells or tissues with another article, except for water, crystalloids, or a sterilizing, preserving, or storage agent, provided that the addition of water, crystalloids, or the sterilizing, preserving, or storage agent does not raise new clinical safety concerns with respect to the HCT; and
- Either:
  - The HCT/P does not have a systemic effect and is not dependent upon the metabolic activity of living cells for its primary function; or
  - The HCT/P has a systemic effect or is dependent upon the metabolic activity of living cells for its primary function, and:
    - Is for autologous use;
    - Is for allogeneic use in a first-degree or second-degree blood relative; or
    - Is for reproductive use.

An establishment is not required to comply with registration and reporting requirements if the establishment:[21]

- Uses HCT/P's solely for nonclinical scientific or educational purposes;
- Removes HCT/P's from an individual and implants such HCT/P's into the same individual during the same surgical procedure;
- Is a carrier who accepts, receives, carries, or delivers HCT/P's in the usual course of business as a carrier;
- Does not recover, screen, test, process, label, package, or distribute, but only receives or stores HCT/P's solely for implantation, transplantation, infusion, or transfer within your facility;
- Only recovers reproductive cells or tissue and immediately transfers them into a sexually intimate partner of the cell or tissue donor; or
- Is an individual under contract, agreement, or other arrangement with a registered establishment and engaged solely in recovering cells or tissues and sending the recovered cells or tissues to the registered establishment; however, it must comply with all other applicable requirements.

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16 Id.

17 Id.

18 Id.

19 U.S. Food and Drug Administration, *About the Center for Biologics Evaluation and Research*, available at https://www.fda.gov/AboutFDA/CentersOffices/OfficeofMedicalProductsandTobacco/CBER/default.htm (last visited February 1, 2020).

20 21 C.F.R. s. 1271.10.

21 21 C.F.R. s. 1271.15.

The HCT/P is regulated as a drug, device, or biologic product under the Public Health Service Act and/or the Food, Drug, and Cosmetics Act, if it does not meet the above-referenced requirements or qualify for an exemption.[22]

In August 2017, the FDA announced plans to increase its regulation of clinics that use therapies involving biologic products that have not been approved by the FDA.[23] In November 2017, the FDA published its comprehensive regenerative medicine policy framework.[24] The only stem cell-based therapies that have been approved by the FDA for use in the United States consist of blood-forming stem cells derived from cord blood.[25]

Regulation of Physicians in Florida

The Board of Medicine and the Board of Osteopathic Medicine (collectively, Boards), within the Department of Health (DOH), have the authority to adopt rules to regulate the practice of medicine and osteopathic medicine, respectively. The Boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[26] Such standards may include education and training, medications including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[27]

In 2015, the Florida Board of Medicine warned physicians and consumers that they should be aware of the risks involved accessing stem cell therapies and regenerative medicine that has not approved by the FDA.[28] The Board of Medicine further warned that a physician providing stem cell treatment should have investigational new drug application (IND) or a single patient IND for Compassionate or Emergency Use.[29] Florida does not specifically regulate clinics that perform treatments using stem cells; however, the Board of Medicine and the Board of Osteopathic Medicine, have the authority to investigate and discipline physicians who fail to meet the standard of care for providing medical services. In 2013, the Board of Medicine revoked the licenses of two physicians in administrative cases involving stem cells for failing to meet the standard of care.[30]

Effect of Proposed Changes

CS/HB 313 creates a voluntary registration program within the Department of Health (DOH) for stem cell providers. Physicians licensed under chapter 458 or chapter 459 who provide stem cell services may register with the program. Any physician who registers agrees to adhere to current good manufacturing practices established pursuant to the Federal Food, Drug, and Cosmetic Act. A manufacturer or distributor of stem cell products may also register with the program.

The bill requires DOH to establish and maintain an online registry on its website of all physicians, manufacturers, and distributors participating in the voluntary registration program. DOH is required to update this registry monthly.

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[22] 21 C.F.R. s. 1270.20.
[23] *Statement from FDA Commissioner Scott Gottlieb, M.D. on the FDA's New Policy Steps and Enforcement Efforts to Ensure Proper Oversight of Stem Cell Therapies and Regenerative Medicine,* August 28, 2017, available at https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-fdas-new-policy-steps-and-enforcement-efforts-ensure (last visited February 1, 2020).
[24] *FDA Announces Comprehensive Regenerative Medicine Policy Framework*, November 15, 2017, available at https://www.fda.gov/news-events/press-announcements/fda-announces-comprehensive-regenerative-medicine-policy-framework (last visited February 1, 2020).
[25] *Supra* note 5.
[26] Sections 458.331(v) and 459.015(z), F.S.
[27] Id.
[28] Florida Board of Medicine, *Information on Stem Cell Clinics Offering Unapproved Therapies*, available at http://flboardofmedicine.gov/latest-news/october-2015-newsletter/ (last visited February 1, 2020).
[29] Id.
[30] Department of Health, *2018 Agency Analysis for House Bill 1185*, (Jan. 12, 2018), on file with the Health Quality Subcommittee.

The bill has an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.4017, F.S., voluntary registration of stem cell providers.
Section 2: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The DOH will incur costs to adopt rules for the voluntary registration of physicians, manufacturers, and distributors who provide stem cell services or products. This can be absorbed within existing resources.

   The DOH may experience additional workload relating to the voluntary registration and maintenance of the online registry. It is unknown how many registrants there will be but it is estimated these costs can be handled with existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides DOH sufficient rulemaking authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the voluntary registration of stem
3 cell providers; defining the term "stem cell";
4 authorizing a licensed physician who provides certain
5 stem cell services to register with the Department of
6 Health; requiring that such physician agree to adhere
7 to certain good manufacturing practices under
8 specified federal laws; authorizing manufacturers and
9 distributors of stem cells or products containing stem
10 cells to register with the department; requiring the
11 department to establish and maintain an online
12 registry identifying such physicians, manufacturers,
13 and distributors and documenting certain physician
14 agreements; requiring the department to update the
15 information contained in the registry at least
16 monthly; authorizing the department to adopt rules;
17 providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Section 381.4017, Florida Statutes, is created
22 to read:
23 381.4017 Voluntary registration of stem cell providers.—
24 (1) For purposes of this section, the term "stem cell"
25 means an allogenic or autologous cell that is altered or

26 processed to become undifferentiated, losing its original
27 structural function, so that it can become differentiated into a
28 specialized cell type. The term does not include cells that are
29 only rinsed, cleaned, or sized and remain differentiated.
30 (2) A physician licensed under chapter 458 or chapter 459
31 who advertises, uses, or purports to use stem cells or products
32 containing stem cells may register with the department. A
33 physician who registers under this section shall agree to adhere
34 to the current applicable good manufacturing practices for the
35 collection, removal, processing, implantation, and transfer of
36 stem cells, or products containing stem cells, pursuant to the
37 Federal Food, Drug, and Cosmetic Act, 21 U.S.C. ss. 301 et seq.;
38 52 Stat. 1040 et seq.; and 21 C.F.R. 1271, Human Cells, Tissues,
39 and Cellular and Tissue-Based Products, in the performance of
40 any procedure using or purporting to use stem cells or products
41 containing stem cells.
42 (3) A manufacturer or distributor of stem cells or
43 products containing stem cells who advertises, distributes, or
44 operates in this state may register with the department.
45 (4) The department shall establish and maintain an online
46 registry accessible on its website which identifies the
47 physicians, manufacturers, and distributors registered under
48 this section and which documents physician agreements to adhere
49 to the current applicable good manufacturing practices. The
50 department shall update the information contained in the

51 registry at least monthly.
52 (5) The department may adopt rules to implement this
53 section.
54 Section 2. This act shall take effect July 1, 2020.

HB 467

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 467 Physical Therapy Practice
SPONSOR(S): Stevenson
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 792

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	13 Y, 0 N	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke BM	Clark JC
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Physical therapy practice is the performance of physical therapy assessments and treatment, or prevention of any disability, injury, disease, or other health conditions and rehabilitation using various modalities. In Florida, the Board of Physical Therapy Practice, within the Department of Health (DOH), regulates physical therapists (PTs).

Current law prohibits PTs from using acupuncture if it punctures the skin. In some states, PTs may use a technique called dry needling, which requires a PT to insert an acupuncture needle to penetrate the skin and stimulate underlying myofascial trigger points, and muscular and connective tissues to manage pain and movement impairments.

HB 467 eliminates the prohibition on performing acupuncture that pierces the skin and authorizes the Board of Physical Therapy Practice to adopt rules related to the standards of practice for PTs to perform dry needling.

The bill also revises the scope of practice for PTs and terminology to reflect modern physical therapy practice.

The bill may have an insignificant, negative fiscal impact on the DOH, which can be absorbed within existing resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Physical therapists (PTs) are licensed in all 50 states. States utilize the National Physical Therapy Exam (NPTE), which was developed by the Federation of State Boards of Physical Therapy (FSBPT), to determine if a person has met competency standards for the safe provision of nationally accepted physical therapy procedural interventions.[1] Currently, all entry-level PT education programs in the U.S. only offer the Doctor of Physical Therapy (D.P.T.) degree.[2]

Model Practice Act

The FSBPT developed a model physical therapy practice act to revise and modernize state physical therapy laws.[3] The model practice act suggests statutory language that addresses the regulatory board's duties and powers, examination and licensure, and the regulation of physical therapy practice.[4] In the model practice act, the practice of physical therapy includes:[5]

- Examining, evaluating, and testing patients with mechanical, physiological, and developmental impairments, functional limitations, and disabilities or other health and movement-related conditions in order to determine a diagnosis, prognosis, and plan of treatment intervention, and to assess the ongoing effects of intervention.
- Alleviating impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions that may include, but are not limited to:
    - Therapeutic exercise;
    - Functional training in self-care and in-home, community or work integration or reintegration;
    - Manual therapy including soft tissue and joint mobilization/manipulation;
    - Therapeutic massage;
    - Prescription, application and, as appropriate, fabrication of assistive, adaptive, orthotic, prosthetic, protective and supportive devices and equipment;
    - Airway clearance techniques;
    - Integumentary protection and repair techniques;
    - Debridement and wound care;
    - Physical agents or modalities;
    - Mechanical and electrotherapeutic modalities, and
    - Patient-related instruction.
- Reducing the risk of injury, impairment, functional limitation, and disability, including the promotion and maintenance of fitness, health, and wellness.
- Engaging in administration, consultation, education, and research.

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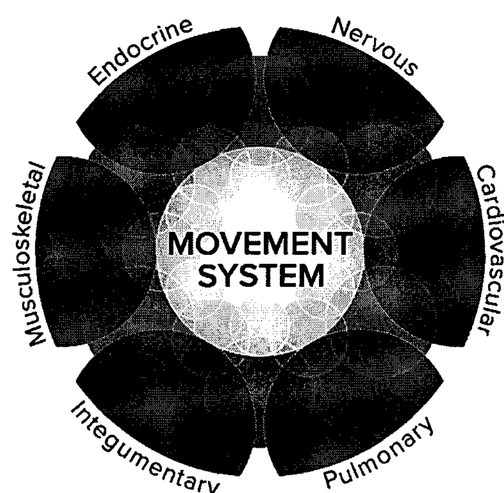
[1] American Physical Therapy Association, *About the National Physical Therapy Examination*, available at http://www.apta.org/Licensure/NPTE/ (last visited January 14, 2020).
[2] American Physical Therapy Association, *Physical Therapist (PT) Education Overview*, available at http://www.apta.org/For_Prospective_Students/PT_Education/Physical_Therapist_(PT)_Education_Overview.aspx (last visited March 4, 2016).
[3] Federation of State Boards of Physical Therapy, *Model Practice Act*, available at https://www.fsbpt.org/Free-Resources/Regulatory-Resources/Model-Practice-Act (last visited January 14, 2020).
[4] Federation of State Boards of Physical Therapy, *The Model Practice Act for Physical Therapy: A Tool for Public Protection and Legislative Change*, 6th Edition, (last rev. 2016), available at https://www.fsbpt.org/Portals/0/documents/free-resources/MPA_6thEdition2016.pdf?ver=2019-03-06-115216-323 (last visited January 14, 2020).
[5] Id.

Movement System

As a part of its guiding principles for the physical therapy profession, the American Physical Therapy Association (APTA), adopted a position that the movement system is at the core of physical therapy practice, education, and research.[6] The movement system is the integration of body systems that generate and maintain movement at all levels of bodily function.[7] The movement system incorporates several of the body's systems.[8]



APTA promotes that a PT must examine and evaluate the movement system, including diagnosis and prognosis, to provide a customized and integrated plan of care.[9] Uniform use of the term "movement system" will assist PTs in communicating effectively with communities internal and external to the profession.[10]

Physical Therapy Practice in Florida

PTs are regulated under ch. 486, F.S., the Physical Therapy Practice Act and the Board of Physical Therapy Practice (Board) within the Department of Health. In the 2018-2019 fiscal year, there were 19,324 licensed PTs in Florida.[11]

Licensure

To be licensed as a PT, an applicant must be at least 18 years old, be of good moral character, pass the Laws and Rules Examination offered by the FSBPT within 5 years before the date of application for licensure,[12] and meet one of the following requirements:[13]

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[6] American Physical Therapy Association, *Vision Statement for the Physical Therapy Profession and Guiding Principles to Achieve the Vision*, (last rev. Sept. 25, 2019), available at https://www.apta.org/Vision/ (last visited January 16, 2020).
[7] American Physical Therapy Association, *Movement System*, available at https://www.apta.org/MovementSystem/ (last visited January 16, 2020).
[8] American Physical Therapy Association, *Movement System Diagram*, available at https://www.apta.org/uploadedFiles/APTAorg/Practice_and_Patient_Care/Movement_System/MovementSystemDiagram.pdf (last visited January 16, 2020).
[9] American Physical Therapy Association, *Physical Therapist Practice and the Movement System*, (Aug. 2015), available at https://www.apta.org/MovementSystem/WhitePaper/ (last visited January 16, 2020).
[10] Id.
[11] Department of Health, *2020 Agency Legislative Bill Analysis for HB 467*, on file with the Health Quality Subcommittee.
[12] Rule 64B17-3.002, F.A.C.
[13] Sections 486.031, F.S., and 486.051, F.S.

- Have graduated from an accredited PT training program and have passed the National Physical Therapy Examination (NPTE) for PTs offered by the FSBPT within 5 years before the date of application for licensure;[14]
- Have graduated from a PT training program in a foreign country, have had his or her credentials deemed by the Foreign Credentialing Commission on Physical Therapy or other board-approved credentialing agency to be equivalent to those of U.S.-educated PTs and have passed the NPTE for PTs within 5 years before the date of application for licensure;[15] or
- Have passed a board-approved examination and hold an active license to practice physical therapy in another state or jurisdiction if the board determines that the standards for licensure in that state or jurisdiction are equivalent to those of Florida.[16]

A PT must complete 24 hours of continuing physical therapy education for each biennial licensure renewal.[17] At least 1 hour of education must be on HIV/AIDS, and 2 hours must be on medical error prevention.[18]

Scope of Practice

Physical therapy practice is the performance of physical therapy assessments and treatment, or prevention of any disability, injury, disease, or other health conditions and rehabilitation using various modalities, such as:[19]

- Electricity;
- Exercise;
- Massage;
- Radiant energy, including ultraviolet, visible, and infrared rays;
- Ultrasound;
- Water; and
- Physical, chemical, and other properties of air.

A PT may also test neuromuscular functions or perform electromyography[20] to diagnose and treat conditions. A PT may only perform acupuncture when no penetration of the skin occurs and in compliance with criteria established by the Board of Medicine.[21]

Acupuncture

The Board of Acupuncture, within the Department of Health, regulates the practice of acupuncture.[22] Acupuncture is a form of primary health care based on traditional Chinese medical concepts and modern oriental medicine techniques that employ acupuncture diagnosis and treatment, as well as adjunctive therapies and diagnostic techniques.[23] The practice of acupuncture includes, among other things, the insertion of acupuncture needles to specific areas of the human body.[24]

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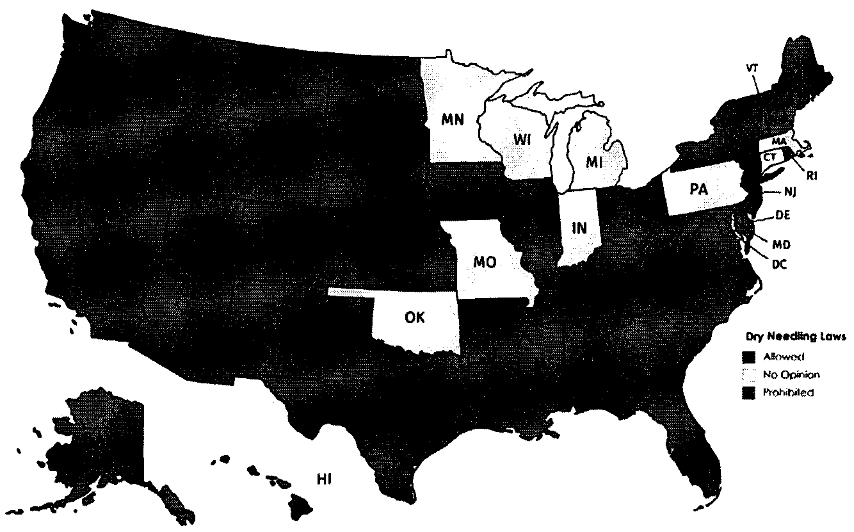
[14] *Id.*
[15] Rule 64B17-3.001, F.A.C.
[16] Rule 64B17-3.003, F.A.C.
[17] Rule 64B17-9.001, F.A.C.
[18] Id.
[19] Section 486.021(11), F.S.
[20] Rule 64B17-6.003, F.S., establishes the training, education, and supervised practice requirements a PT must meet to perform electromyography.
[21] *Supra* note 19.
[22] *See generally*, ch. 457, F.S.
[23] Section 457.102(1), F.S.
[24] Id.

Dry Needling

Dry needling[25] originated in the 1940s when practitioners discovered that pain could be relieved by simple hypodermic needling without injection of any substance.[26] At that time, the needles used were mainly hollow; however, beginning in the late 1970s, acupuncture or solid filiform needles became the instrument of choice.[27]

The modern practice primarily involves a PT using a thin filiform needle to penetrate the skin and stimulate underlying myofascial trigger points, muscular, and connective tissues to manage neuromusculoskeletal pain and movement impairments.[28] The goal of dry needling is to release or inactivate trigger points and relieve pain.[29]

Thirty-four states authorize PTs to perform dry needling, nine states are silent on the issue, and seven states, including Florida, prohibit PTs from performing dry needling.[30]



Dry Needling in Florida

At least two practitioners have filed Petitions for Declaratory Statement[31] seeking guidance from the Board on whether dry needling was within the scope of practice for PTs licensed in Florida. In June 2017, the Board found that a particular petitioner was uniquely qualified to perform dry needling and

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[25] Dry needling may also be referred to as "trigger point manual therapy" or "intramuscular manual therapy. *See* American Physical Therapy Association, *Physical Therapists &The Performance of Dry Needling: An Educational Resource Paper*, (Jan. 2012), available at http://www.apta.org/StateIssues/DryNeedling/ResourcePaper/ (last visited January 16, 2020).
[26] Heming Zhu, PhD, CMD, MD, MAcu, LicAcu, and Heidi Most, MAcu, LicAcu, *Dry Needling Is One Type of Acupuncture*, MEDICAL ACUPUNCTURE 28:4 (2016), available at https://pdfs.semanticscholar.org/1340/eb3836f644a3c38813a52ea3eb75a27bfbca.pdf?_ga=2.106070723.1123509245.1579131193-624244151.1579131193 (last visited January 15, 2020).
[27] *Supra* note 26.
[28] American Physical Therapy Association, *Physical Therapists &The Performance of Dry Needling: An Educational Resource Paper*, (Jan. 2012), available at http://www.apta.org/StateIssues/DryNeedling/ResourcePaper/ (last visited January 16, 2020).
[29] Id.
[30] American Physical Therapy Association, *State Laws and Regulations Governing Dry Needling Performed by Physical Therapists in the U.S.*, (2019), available at https://www.apta.org/uploadedFiles/APTAorg/Advocacy/State/Issues/Dry_Needling/APTADryNeedlingLawsByState.pdf (last visited January 16, 2020).
[31] Pursuant to s. 120.565, F.S., any substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision, or of any rule or order of the agency, as it applies to the petitioner's particular set of circumstances.

authorized the petitioner to do so without violating the practice act.[32] The Board denied a subsequent petition stating that dry needling was not prohibited and that the Board was moving forward with rulemaking to set the competencies required for a PT to practice dry needling.[33]

In February 2018, the Board published a proposed rule that established the minimum standards of practice for dry needling in physical therapy practice.[34] The proposed rule defined "dry needling" as a skilled technique based on western medical concepts performed by a PT using filiform needles to penetrate the skin and/or underlying tissue to affect change in body structures and functions for the evaluation and management of neuromusculoskeletal conditions, pain, movement impairments, and disability.[35] The proposed rule also established minimum education requirements and prohibited a PT from delegating dry needling to a physical therapy assistant, unlicensed personnel, or any other person who is not a PT.[36]

The Florida State Oriental Medical Association (FSOMA) challenged the rule, on the basis that the proposed rule was an invalid exercise of delegated legislative authority.[37] FSOMA argued that the proposed rule would allow PTs to perform acupuncture by inserting acupuncture needles into patients, in violation of the definition of the physical therapy scope of practice, which limits PTs' performance of acupuncture to noninvasive procedures. In January 2019, the Division of Administrative Hearings issued an administrative order finding that the proposed rule was invalid, as alleged. Specifically, the Administrative Law Judge found that the proposed rule exceeded the grant of rulemaking authority because it:

- Expands the scope of physical therapy practice;
- Enlarges, modifies, or contravenes the specific provisions of law implemented, s. 489.021(11), F.S., which states that PTs may perform acupuncture only upon compliance with the criteria set by the Board of Medicine, when no penetration of the skin occurs; and
- Is arbitrary because dry needling is not within the statutory scope of practice for PTs in this state.

The Board withdrew the proposed rule in March 2019.[38]

Effect of Proposed Changes

HB 467 eliminates the prohibition on performing acupuncture that pierces the skin and authorizes the Board of Physical Therapy Practice to adopt rules related to the standards of practice for PTs to perform dry needling.

The bill also revises the scope of practice for PTs by amending the definition of "practice of physical therapy" to more closely reflect the definition in the model practice act. The bill revises the description of the modalities used by PT to alleviate impairments, functional limitations, and disabilities by designing, implementing, and modifying treatment interventions that may include, but are not limited to:

- Therapeutic exercise;
- Functional training in self-care and in-home, community or work integration or reintegration;
- Manual therapy;

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[32] *In re the Petition for Declaratory Statement of Robert Stanborough,* Final Order No. DOH-17-1605-DS-MQA (Aug. 30, 2017), available at http://www.floridahealth.gov/licensing-and-regulation/declaratory/_documents/CLF-5501-14672DOH17-1605DS.pdf (last visited January 16, 2020).
[33] 44 Fla. Admin. Reg. 165 (Aug. 23, 2018).
[34] Proposed rule 64B17-6.008, F.A.C., published in 44 Fla. Admin. Reg. 38 (Feb. 23, 2018).
[35] Id.
[36] Id.
[37] *Florida State Oriental Medical Ass'n v. Dep't of Health and Florida Physical Therapy Ass'n, Inc.*, No. 18-2508RP (Fla. DOAH Jan. 28, 2019).
[38] 45 Fla. Admin. Reg. 47 (Mar. 8, 2019).

- Therapeutic massage;
- Airway clearance techniques;
- Maintaining and restoring the integumentary system and wound care;
- Physical agent or modality;
- Mechanical and electrotherapeutic modality, and
- Patient-related instruction.

The bill retains the authority of a PT to test neuromuscular functions or perform electromyography to diagnose and treat conditions.

The bill also expands the systems that a PT evaluates for a physical therapy assessment to the movement system, which encompasses more systems that the musculoskeletal and neuromuscular system currently in the definition. The bill also allows a PT to evaluate motor control as a part of the physical therapy assessment.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 486.021, F.S., relating to definitions.
Section 2: Amends s. 486.025, F.S., relating to powers and duties of the Board of Physical Therapy Practice.
Section 3: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have an insignificant, negative fiscal impact on the DOH if the Board chooses to adopt rules related to dry needling.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to implements its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to physical therapy practice; amending s. 486.021, F.S.; revising the definitions of the terms "physical therapy assessment" and "practice of physical therapy"; amending s. 486.025, F.S.; revising the powers and duties of the Board of Physical Therapy Practice; providing an effective date.

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

Section 1. Subsections (10) and (11) of section 486.021, Florida Statutes, are amended to read:

486.021 Definitions.—In this chapter, unless the context otherwise requires, the term:

(10) "Physical therapy assessment" means observational, verbal, or manual determinations of the function of the movement ~~musculoskeletal or neuromuscular~~ system relative to physical therapy, including, but not limited to, range of motion of a joint, motor power, motor control, posture ~~postural attitudes~~, biomechanical function, locomotion, or functional abilities, for the purpose of physical therapy ~~making recommendations for~~ treatment.

(11) "Practice of physical therapy" means the performance of physical therapy assessments and the treatment of any disability, injury, disease, or other health condition of human

26 beings, or the prevention of such disability, injury, disease,
27 or other health condition ~~of health~~, and the rehabilitation of
28 such disability, injury, disease, or other health condition ~~as~~
29 ~~related thereto~~ by alleviating impairments, functional
30 limitations, and disabilities by designing, implementing, and
31 modifying treatment interventions through therapeutic exercise;
32 functional training in self-care and in-home, community, or work
33 integration or reintegration; manual therapy; therapeutic
34 massage; airway clearance techniques; maintaining and restoring
35 the integumentary system and wound care; physical agent or
36 modality; mechanical or electrotherapeutic modality; patient-
37 related instruction ~~the use of the physical, chemical, and other~~
38 ~~properties of air; electricity; exercise; massage; the~~
39 ~~performance of acupuncture only upon compliance with the~~
40 ~~criteria set forth by the Board of Medicine, when no penetration~~
41 ~~of the skin occurs; the use of radiant energy, including~~
42 ~~ultraviolet, visible, and infrared rays; ultrasound; water~~; the
43 use of apparatus and equipment in the application of such
44 rehabilitation ~~the foregoing or related thereto~~; the performance
45 of tests of neuromuscular functions as an aid to the diagnosis
46 or treatment of any human condition; or the performance of
47 electromyography as an aid to the diagnosis of any human
48 condition only upon compliance with the criteria set forth by
49 the Board of Medicine.
50 (a) A physical therapist may implement a plan of treatment

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

51 developed by the physical therapist for a patient or provided
52 for a patient by a practitioner of record or by an advanced
53 practice registered nurse licensed under s. 464.012. The
54 physical therapist shall refer the patient to or consult with a
55 practitioner of record if the patient's condition is found to be
56 outside the scope of physical therapy. If physical therapy
57 treatment for a patient is required beyond 30 days for a
58 condition not previously assessed by a practitioner of record,
59 the physical therapist shall have a practitioner of record
60 review and sign the plan. The requirement that a physical
61 therapist have a practitioner of record review and sign a plan
62 of treatment does not apply when a patient has been physically
63 examined by a physician licensed in another state, the patient
64 has been diagnosed by the physician as having a condition for
65 which physical therapy is required, and the physical therapist
66 is treating the condition. For purposes of this paragraph, a
67 health care practitioner licensed under chapter 458, chapter
68 459, chapter 460, chapter 461, or chapter 466 and engaged in
69 active practice is eligible to serve as a practitioner of
70 record.
71 (b) The use of roentgen rays and radium for diagnostic and
72 therapeutic purposes and the use of electricity for surgical
73 purposes, including cauterization, are not "physical therapy"
74 for purposes of this chapter.
75 (c) The practice of physical therapy does not authorize a

76 physical therapy practitioner to practice chiropractic medicine
77 as defined in chapter 460, including specific spinal
78 manipulation. For the performance of specific chiropractic
79 spinal manipulation, a physical therapist shall refer the
80 patient to a health care practitioner licensed under chapter
81 460.
82 (d) This subsection does not authorize a physical
83 therapist to implement a plan of treatment for a patient
84 currently being treated in a facility licensed pursuant to
85 chapter 395.
86 Section 2. Section 486.025, Florida Statutes, is amended
87 to read:
88 486.025 Powers and duties of the Board of Physical Therapy
89 Practice.—The board may administer oaths, summon witnesses, take
90 testimony in all matters relating to its duties under this
91 chapter, establish or modify minimum standards of practice of
92 physical therapy as defined in s. 486.021, including, without
93 limitation, standards of practice for the performance of dry
94 needling by physical therapists, and adopt rules pursuant to ss.
95 120.536(1) and 120.54 to implement ~~the provisions of~~ this
96 chapter. The board may also review the standing and reputability
97 of any school or college offering courses in physical therapy
98 and whether the courses of such school or college in physical
99 therapy meet the standards established by the appropriate
100 accrediting agency referred to in s. 486.031(3)(a). In

101 determining the standing and reputability of any such school and
102 whether the school and courses meet such standards, the board
103 may investigate and <u>personally inspect the school and courses</u>
104 ~~make personal inspection of the same~~.
105 Section 3. This act shall take effect July 1, 2020.

HB 687

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 687 Services for Veterans and Their Families
SPONSOR(S): Zika
TIED BILLS: **IDEN./SIM. BILLS:** SB 104

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Local, Federal & Veterans Affairs Subcommittee	14 Y, 0 N	Renner	Miller
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) State Affairs Committee			

SUMMARY ANALYSIS

Veterans throughout the United States face mental health and substance abuse issues. Depression, post-traumatic stress disorder, and suicide affect between two and 17 percent of veterans returning from combat.

In 2014, the Legislature appropriated $150,000 to the Florida Department of Veterans Affairs (FDVA) to create a pilot program expanding existing Florida 211 Network (information and referral network) services to veterans in Hillsborough, Pasco, Pinellas, Polk, and Manatee Counties. Through the pilot project, veterans receive information on available services, referrals to federal Veterans Affairs (VA) funded and other community-based services, and care coordination to verify that referrals lead to successful service connection.

The bill creates the Florida Veterans' Care Coordination Program (Program), to provide veterans and their families dedicated behavioral health care referral services, primarily for mental health and substance abuse. Through the Program, a veteran may call a separate veteran-dedicated support line to receive assistance and support from a fellow veteran trained to respond to the calls for assistance.

The bill requires the FDVA to establish the Program and contract with a nonprofit entity that has statewide phone capacity to serve veterans, is accredited by the Council on Accreditation, and is fully accredited by the Alliance of Information and Referral Services. The contracting entity will enter into agreements with Florida 211 Network participants to provide services to veterans.

The bill models the Program after the pilot program. The bill specifies the goals, services, and follow-up requirements. The FDVA must compile data collected by the Florida 211 Network into a report for the Governor, President of the Senate, and Speaker of the House of Representatives by December 15, 2021.

The bill has no fiscal impact on the FDVA for Fiscal Year 2020-2021 and an indeterminate negative fiscal impact on the FDVA thereafter.

The bill has an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Veterans and Mental Health and/or Substance Abuse

Florida has the nation's third-largest veteran population with more than 1.5 million veterans.[1] Veterans face unique challenges and some struggle with mental health and substance abuse.

Posttraumatic Stress Disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event, including war or combat.[2] The National Center for PTSD, U.S. Department of Veterans Affairs (VA), lists the percentage of veterans with PTSD by service era:

- Between 11 and 20 percent of veterans who served in Operations Iraqi Freedom and Enduring Freedom were diagnosed with PTSD in a given year.
- About 12 percent of veterans who served in the Gulf War were diagnosed with PTSD in a given year.
- About 15 percent of veterans of the Vietnam War were diagnosed with PTSD at the time of the most recent study in the late 1980s. However, the National Center estimates that about 30 percent of veterans of the Vietnam War have had PTSD in their lifetimes.[3]

A strong association exists between PTSD and substance abuse disorders (SUD) among veterans. Statistics show:

- More than two in 10 veterans with PTSD also have SUD;
- Almost one in three veterans seeking treatment for SUD also have PTSD;
- About one in 10 veterans returning from the wars in Iraq and Afghanistan seen at the VA have problems with alcohol or other drugs.[4]

Suicide rates for veterans continue to be a cause of national concern. More than 6,000 veterans committed suicide each year from 2008 to 2016. In 2016, the suicide rate was 1.5 times greater for veterans than for non-veteran adults, after adjusting for age and gender. From 2005 to 2016, the increase in the suicide rate among veterans in Veterans Hospital Administration (VHA) care was lower than among veterans not in VHA care.[5]

Federal Veterans Crisis Line

The VA Veterans Crisis Line connects veterans and current service members in crisis and their families and friends with information from qualified responders through a confidential toll-free hotline, online chat, and text messaging service.[6]

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[1] Florida Department of Veterans' Affairs, *Our Veterans, Fast Facts,* http://floridavets.org/our-veterans/profilefast-facts/ (last visited Dec. 6, 2019).

[2] American Psychiatric Association, *What is Posttraumatic Stress Disorder?,* https://www.psychiatry.org/patients-families/ptsd/what-is-ptsd (last visited Dec. 9, 2019).

[3] National Center for PTSD, U.S. Department of Veterans Affairs, *How Common is PTSD in Veterans?,* https://www.ptsd.va.gov/understand/common/common_veterans.asp (last visited Dec. 9, 2019).

[4] National Center for PTSD, U. S. Department of Veterans Affairs, *PTSD and Substance Abuse in Veterans,* https://www.ptsd.va.gov/understand/related/substance_abuse_vet.asp (last visited Dec. 9, 2019).

[5] Office of Mental Health and Suicide Prevention, U.S. Department of Veterans Affairs, *VA National Suicide Data Report 2005-2016,* https://www.mentalhealth.va.gov/docs/data-sheets/OMHSP_National_Suicide_Data_Report_2005-2016_508.pdf (last visited Dec. 9, 2019).

[6] Veterans Crisis Line, *What to Expect,* https://www.veteranscrisisline.net/about/what-to-expect (last visited Dec. 13, 2019).

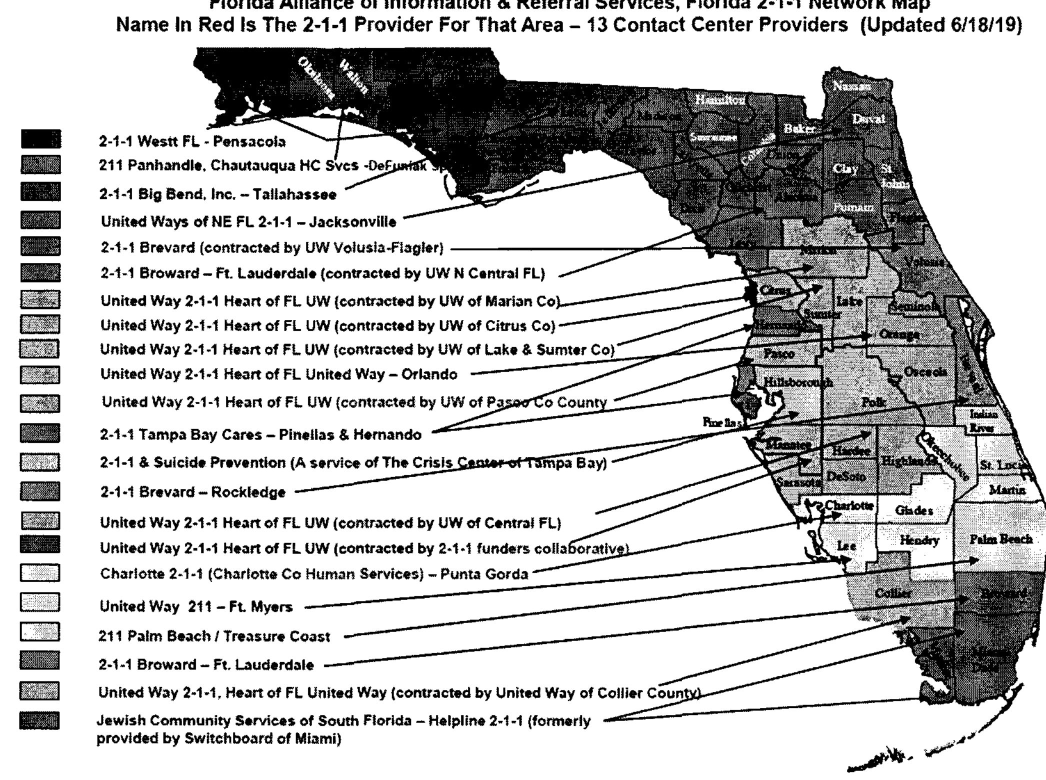
The Veterans Crisis Line launched in 2007. Over the course of the program, it has answered more than 4.4 million calls and initiated the dispatch of emergency services to callers in crisis more than 138,000 times. In 2009, an anonymous online chat service was added. In 2011, a text-messaging service was also added to provide another way for veterans to connect with confidential, round-the-clock support.[7]

Florida 211 Network

A 211 network is a telephone-based service offered by nonprofit and public agencies throughout the United States that provides free and confidential information and referral services 24 hours a day, 7 days a week. The network helps callers identify and connect with health and human service programs that can meet a variety of needs, including food, housing, employment, health care, crisis counseling, and more.[8]

The Florida Alliance of Information and Referral Services (FLAIRS) is the 211 collaborative organization for the state and is responsible for designing, studying, and implementing the Florida 211 Network.[9] The Florida 211 Network[10] operates as the single point of coordination for information and referral of health and human services.[11] These services are available statewide through any cell phone provider as well as through landlines in all 67 counties by dialing 2-1-1.[12] There are a total of thirteen Florida 211 Network certified providers, serving the areas shown below.[13]

Florida Alliance of Information & Referral Services, Florida 2-1-1 Network Map
Name In Red Is The 2-1-1 Provider For That Area – 13 Contact Center Providers (Updated 6/18/19)



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[7] Veterans Crisis Line, *What It is,* https://www.veteranscrisisline.net/about/what-is-vcl (last visited Dec. 13, 2019).
[8] Florida 2-1-1 Association, http://www.my211florida.org/ (last visited Dec. 9, 2019).
[9] S. 408.918(3), F.S.
[10] S. 408.918, F.S.
[11] S. 408.918(1), F.S.
[12] *Supra* note 6.
[13] Florida Alliance of Information and Referral Services, *Map of 2-1-1 Centers,* http://www.flairs.org/wp-content/uploads/sites/13/2019/09/FL-211-providers-and-coverage-areas-061819.pdf (last visited Dec. 9, 2019).

To participate in the Florida 211 Network, a 211 provider must be fully accredited by the National Alliance of Information and Referral Services or have received approval to operate, pending accreditation from its affiliate, the FLAIRS.[14]

Council on Accreditation

The Council on Accreditation (COA) is an international accrediting entity that accredits private and public organizations and programs that provide human services.[15] The COA specifically accredits entities providing child welfare, behavioral health, and community-based social services.[16]

Crisis Center of Tampa Bay Pilot Project

The 2014 Florida Legislature appropriated $150,000 to create a pilot project expanding existing 211 services to veterans in Hillsborough, Pasco, Pinellas, Polk, and Manatee counties.[17] In August 2014, the Crisis Center of Tampa Bay (CCTB), through the pilot project, expanded its services to veterans and launched the Florida Veterans Support Line (1-844-MYFLVET) in November 2014.[18] The expanded service is veteran-specific and peer-based. By calling the Florida Veterans Support Line, veterans in the Tampa Bay region are able to speak with a fellow veteran, called a Peer-to-Peer Coordinator, and offered:

- Comprehensive information and referral to VA-funded services and other community-based services;
- Assistance and support provided by a peer who has experienced the transition from military back to civilian life; and
- Care coordination services, including system navigation, advocacy, and ongoing support.[19]

During the Fiscal Year 2014-2015[20], the CCTB pilot project handled 1,135 total calls; of those, 925 calls were referred to care coordination services, as shown below.[21]

Call Origin:	Contact Made By:	Veteran Status:	Current Use of VA Services:	Presenting Need:	Type of Service Referred:
• Transfer from other 211 Line: 853 (75.2%) • Florida Veterans Support Line: 257 (22.6%) • Walk-In/ Event: 25 (2.2%)	• Self: 926 (81.6%) • Friend/ Relative: 168 (14.8%) • Organization : 38 (3.3%) • Other: 3 (0.3%)	• Veteran: 973 (85.7%) • Retired: 47 (4.1%) • Former Military (<180 Days): 20 (1.8%) • Active Duty: 20 (1.8%) • Reserve: 16 (1.4%)	• Yes: 530 (46.7%) • No: 316 (27.8%) • Unknown: 273 (24.1%) • Refused: 16 (1.4%)	• Financial Assistance: 292 (25.7%) • Substance Abuse Counseling: 221 (19.5%) • Shelter: 131 (11.5%) • Legal Services: 97 (8.5%) • Mental Health Counseling: 79 (7%) • Emotional Support: 66 (5.8%) • Suicide Related: 63 (5.6%)	• Care Coordination Services: 626 (55.2%) • Other Community Resources: 590 (52%) • VA Services: 294 (25.9%) • Community Mental Health Services: 270 (23.8%) • No referral made: 210 (18.5%)

During Fiscal Years 2015-2016 and 2016-2017, the CCTB pilot program handled 7,343 calls, as shown below.[22]

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[14] S. 408.918(2), F.S. The full accreditation process requires a remote database review, consultation component, on-site review, and demonstration of a call handling component, as well as payment of a membership fee. *See* https://www.airs.org/i4a/pages/index.cfm?pageid=3286 (last visited Dec. 9, 2019).

[15] Council on Accreditation, http://coanet.org/home/ (last visited Dec. 9, 2019).

[16] Council on Accreditation, *About COA,* http://coanet.org/about/whats-new/about-coa/ (last visited Dec. 9, 2019).

[17] Specific appropriation 595 of HB 5001, 2014-2015 General Appropriations Act.

[18] Crisis Center of Tampa Bay, *Overview of Current Funding.* (On file with Local, Federal & Veterans Affairs Subcommittee).

[19] Crisis Center of Tampa Bay, *Florida Veterans Support Line, What we offer,* https://www.myflvet.com/about-1 (last visited Dec. 10, 2019).

[20] The CCTB pilot program operates with an October-September fiscal year. Its first operating year began on October 28, 2014.

[21] Crisis Center of Tampa Bay, *Florida Veterans Support Line 1-844-MYFLVET: Fiscal Year 2015 Report* (On file with Local, Federal & Veterans Affairs Subcommittee).

[22] Crisis Center of Tampa Bay, *1-844-MYFLVET: Demographic Data FY 2016 and FY 2017* (On file with Local, Federal & Veterans Affairs Subcommittee).

Age	Gender	Branch	Relationship to Service Member:	Veteran Status:	Current Use of VA Services:	Greatest Needs:
• 25 and Under: 6% • 26-35: 16% • 36-45: 14% • 46-55: 22% • 56-65: 20% • Over 65: 15% • Refused: 8%	• Female: 32% • Male: 67% • Refused: 1%	• Air Force: 12% • Army: 45% • Coast Guard: 1% • Marines: 10% • Navy: 17% • Refused: 15%	• Self: 68% • Spouse: 13% • Child/ Dependent: 7% • Relative: 7%	• Veteran: 70% • Retired: 9% • Former Military (<180 Days): 6% • Active Duty: 3% • Reserve: 2% • National Guard: 1% • Refused: 8%	• Yes: 44% • No: 36% • Refused: 20%	• Behavioral Health: 59% (Suicide: 35%) • Financial Assistance: 40% • Employment: 1%

During Fiscal Years 2017-2018, there were 28,962 veterans served; 49,932 services referred; 396 suicide concerns; and 880 veterans served in Care Coordination.[23]

Expansion of the Florida Veterans Support Line

In 2017, the Florida Department of Veterans' Affairs (FDVA) provided the CCTB with one-time funding of $400,000 for a statewide expansion of the Florida Veterans Support Line. The CCTB used the funding to train 211 providers and to implement a marketing campaign to raise awareness for the support line. This funding was not used to expand the Peer-to-Peer Coordination component from the pilot project.[24]

In 2018, the VA provided partial funding for a statewide expansion of the Peer-to-Peer Coordination component of $1,000,000 for September 2018 through September 2019. This funding has a multi-year option at $1,000,000 per year for an additional three years until September 2021.[25] The VA activated the second-year option beginning September 28, 2019.[26] The third-year will be determined in June 2020. Additionally, the Department of Children and Families (DCF) provided $538,000 for operations from February 1, 2019 through June 30, 2019.[27] The DCF activated a second-year option beginning July 1, 2019, expiring June 30, 2020, for $1,000,000.[28]

Effect of the Bill

The bill creates the Florida Veterans' Care Coordination Program (Program) as a statewide program to provide veterans and their families dedicated behavioral health care referral services, primarily for mental health and substance abuse.

The bill requires the FDVA to establish the Program. The FDVA must contract with a nonprofit entity that has statewide phone capacity to serve veterans and is accredited by the Council on Accreditation and fully accredited by the National Alliance of Information and Referral Services. The entity will enter into agreements with Florida 211 Network participants to provide services to veterans.

The Program must be modeled after the pilot program established in 2014 by the CCTB and the FDVA in Hillsborough, Pasco, Pinellas, Polk, and Manatee Counties.

Goals of the program are to:

- Prevent suicide by veterans;
- Increase the use by veterans of programs and services provided by the VA; and

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[23] Crisis Center of Tampa Bay, *Overview of the 1-844-MYFLVET Support Line* (On file with Local, Federal & Veterans Affairs Subcommittee staff).
[24] *Id.*
[25] *Id.*
[26] Email from Sunny Hall, Vice President of Client Services, Crisis Center of Tampa Bay, RE: funding. (Dec. 10, 2019) (On file with Local, Federal & Veterans Affairs Subcommittee staff).
[27] *Supra* note 23.
[28] *Supra* note 26.

- Increase the number of veterans who use other available community-based programs and services.

Program services will include:
- Telephonic peer support, crisis intervention, and information on referral resources;
- Treatment coordination, including coordination of follow-up care;
- Assessment of suicide risk as part of an immediate needs assessment, including safety planning and support; and
- Resource coordination, including data analysis, to facilitate acceptance, enrollment, and attendance of veterans and their families in programs and services provided by the VA and other available community-based programs and services.

The bill requires Program teams to:
- Track the number of requests from veterans or family members;
- Follow up with callers to determine if they have pursued referrals and whether additional help is needed;
- Implement communication strategies to educate veterans and their families about programs and services provided by the VA and other community-based programs and services; and
- Document all calls and capture necessary data to improve outreach to veterans and their families and report such data to the contracted entity.

Florida 211 network participants must establish and maintain a database of services available locally. Both the FDVA and its contractor must work with managing entities to educate service providers about the Florida Veterans Support Line and the Program.

Florida 211 Network participants must provide all collected data to the FDVA. By December 15, 2021, the FDVA must submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives. The report must include:

- The nature, number, and outcome of each call received;
- Demographic information on each caller; and
- Follow-up by the Program team, including timeliness and positive outcomes, as well as the caller's level of satisfaction with Program services.

B. SECTION DIRECTORY:

Section 1	Creates s. 394.9087, F.S., relating to the establishment of the Florida Veterans' Care Coordination Program.
Section 2	Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   If the FDVA contracts with the Crisis Center of Tampa Bay to establish the Florida Veterans' Care Coordination Program no state funding for Fiscal Year 2020-2021 will be needed because the Crisis Center of Tampa Bay is currently operating with federal VA grant dollars.[29] The fiscal impact for Fiscal Year 2021-2022 and thereafter is indeterminate as it is not known what federal grant

[29] *Supra* note 23.

opportunities may be available at that time or what the cost to the state may be in the absence of grant dollars.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Veterans and their families may financially benefit from having greater access to treatments and services specifically designed for veterans with mental health or substance abuse issues.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill neither authorizes nor requires administrative rulemaking by executive branch agencies.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

None.

1 A bill to be entitled
2 An act relating to services for veterans and their
3 families; creating s. 394.9087, F.S.; requiring the
4 Department of Veterans' Affairs to establish the
5 Florida Veterans' Care Coordination Program to provide
6 for veterans and their families behavioral health care
7 referral and care coordination services; requiring the
8 department to contract with a certain nonprofit entity
9 to enter into agreements with Florida 211 Network
10 participants to provide such services; providing
11 program goals; providing for the statewide delivery of
12 specified services by program teams; requiring Florida
13 211 Network participants to collect program
14 implementation data and to submit such data to the
15 department; requiring the department to submit a
16 report to the Governor and Legislature by a specified
17 date; providing requirements for the report; providing
18 an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Section 394.9087, Florida Statutes, is created
23 to read:
24 394.9087 Florida Veterans' Care Coordination Program.—
25 (1) The Department of Veterans' Affairs shall establish

26 the Florida Veterans' Care Coordination Program. The Department
27 of Veterans' Affairs shall contract with a nonprofit entity that
28 is accredited by the Council on Accreditation, is fully
29 accredited by the National Alliance of Information and Referral
30 Services, and has statewide phone capacity to serve veterans, to
31 enter into agreements with Florida 211 Network participants to
32 provide veterans and their families in this state with dedicated
33 behavioral health care referral services, especially mental
34 health and substance abuse services. The Department of Veterans'
35 Affairs shall model the program after the proof-of-concept pilot
36 program established in 2014 by the Crisis Center of Tampa Bay
37 and the Department of Veterans' Affairs in Hillsborough, Pasco,
38 Pinellas, Polk, and Manatee Counties.
39 (2) The goals of the program are to:
40 (a) Prevent suicides by veterans.
41 (b) Increase veterans' use of programs and services
42 provided by the United States Department of Veterans Affairs.
43 (c) Increase the number of veterans who use other
44 available community-based programs and services.
45 (3) The program must be available statewide. Program
46 services must be provided by program teams operated by Florida
47 211 Network participants as authorized by s. 408.918. A Florida
48 211 Network participant may provide services in more than one
49 geographic area under a single contract.
50 (4) The program teams shall provide referral and care

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

51 coordination services to veterans and their families and expand
52 the existing Florida 211 Network to include the optimal range of
53 veterans' service organizations and programs. Florida 211
54 Network participants in the Florida Veterans' Care Coordination
55 Program must include all of the following:
56 (a) Telephonic peer support, crisis intervention, and the
57 communication of information on referral resources.
58 (b) Treatment coordination, including coordination of
59 followup care.
60 (c) Suicide risk assessment.
61 (d) Promotion of the safety and wellness of veterans and
62 their families, including continuous safety planning and
63 support.
64 (e) Resource coordination, including data analysis, to
65 facilitate acceptance, enrollment, and attendance of veterans
66 and their families in programs and services provided by the
67 United States Department of Veterans Affairs and other available
68 community-based programs and services.
69 (f) Immediate needs assessments, including safety planning
70 and support.
71 (5) To enhance program services, program teams shall:
72 (a) Track the number of requests from callers who are
73 veterans or members of a veteran's family.
74 (b) Follow up with callers who are veterans or members of
75 a veteran's family to determine whether they have acted on the

76 referrals or received the assistance needed and whether
77 additional referral or advocacy is needed.
78 (c) Develop and implement communication strategies, such
79 as media promotions, public service announcements, print and
80 Internet articles, and community presentations, to inform
81 veterans and their families about available programs and
82 services provided by the United States Department of Veterans
83 Affairs and other available community-based programs and
84 services.
85 (d) Document all calls and capture all necessary data to
86 improve outreach to veterans and their families and report such
87 data to the contracted entity.
88 (6) Florida 211 Network participants in the Florida
89 Veterans' Care Coordination Program shall maintain a database of
90 veteran-specific services available in the communities served by
91 the programs. The Department of Veterans' Affairs and its
92 selected contractor shall work with managing entities as defined
93 in s. 394.9082(2)(e) to educate service providers about the
94 Florida Veterans Support Line and the Florida Veterans' Care
95 Coordination Program.
96 (7) Florida 211 Network participants shall collect data on
97 the program and submit such data to the Department of Veterans'
98 Affairs in the format prescribed by the Department of Veterans'
99 Affairs. The Department of Veterans' Affairs shall use such data
100 to prepare a report for submittal to the Governor, the President

101 of the Senate, and the Speaker of the House of Representatives
102 by December 15, 2021. The report must include all of the
103 following:
104 (a) The number of calls received.
105 (b) Demographic information for each caller, including,
106 but not limited to, the caller's military affiliation, the
107 caller's veteran status, and whether the caller is receiving
108 services provided by the United States Department of Veterans
109 Affairs or other available community-based programs and
110 services.
111 (c) The nature of each call, including, but not limited
112 to, the concerns prompting the call and the services requested.
113 (d) The outcome of each call, including, but not limited
114 to, the services for which referrals were made and the
115 organizations to which the caller was referred.
116 (e) Services received as a result of each call.
117 (f) Information regarding followup by the program team,
118 including, but not limited to, the percentage of calls receiving
119 followup and the outcome of followup.
120 (g) Information regarding the program's impact on each
121 caller's quality of life and on the avoidance of negative
122 outcomes, including arrest and suicide.
123 (h) Each caller's level of satisfaction with program
124 services.
125 Section 2. This act shall take effect July 1, 2020.

Amendment No. 1

COMMITTEE/SUBCOMMITTEE ACTION

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

1 Committee/Subcommittee hearing bill: Health Care Appropriations
2 Subcommittee
3 Representative Zika offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 25-27 and insert:
7 (1) The Department of Veterans' Affairs may establish the
8 Florida Veterans' Care Coordination Program. If the department
9 establishes the program, it may contract with a nonprofit entity
10 that
11
12 ---
13 **T I T L E A M E N D M E N T**
14 Remove lines 3-7 and insert:
15 families; creating s. 394.9087, F.S.; authorizing the
16 Department of Veterans' Affairs to establish the Florida

17 Veterans' Care Coordination Program to provide for veterans
18 and their families behavioral health care referral and care
19 coordination services; authorizing the

CS/HB 763

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 763 Patient Safety Culture Surveys
SPONSOR(S): Health Market Reform Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:** SB 1370

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N, As CS	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Nobles	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, accurate information about the cost and quality of health care is necessary for consumers to make value-based selections.

Patient safety culture is the extent to which the beliefs, values, and norms shared by the staff of a health care organization support and promote patient safety. Patient safety culture surveys are used to measure patient safety culture by determining what is rewarded, supported, expected, and accepted in a health care organization as it relates to patient safety. They provide health care organizations with an understanding of the safety related perceptions and attitudes of its managers and staff and are used as diagnostic tools to identify areas for improvement. These can also be used to measure organizational conditions that can lead to adverse incidents and patient harm.

The bill requires hospitals and ambulatory surgical centers (ASCs) to use the Hospital Survey on Patient Safety Culture (SOPS) to conduct patient safety culture surveys of facility staff. The facility must conduct the survey biennially, and submit the data to AHCA, in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

The bill requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs. The bill requires AHCA to publish the survey results for each facility, in the aggregate, by composite measure, and by unit work areas. AHCA must designate the use of updated versions of the survey as they occur.

The bill requires AHCA to customize the survey to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and within the respondent's specific unit or department.

The bill also requires AHCA to customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital or ASC that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and $74,173 in recurring funds and $87,474 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Facility Regulation

Hospitals

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[1] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[2]

Ambulatory Surgical Centers (ASCs)

An ASC is a facility, which is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within 24 hours.[3] ASCs are licensed and regulated by the AHCA under the same regulatory framework as hospitals.[4]

Health Care Quality

The United States is experiencing significant changes in health care payment and delivery. Record numbers of newly-insured persons are enrolled in both public and private health insurance. Americans bear a greater share of health care costs, and more participate in high deductible health plans. Clear, factual information about the cost and quality of health care is necessary for consumers to select value-driven health care options and for consumers and providers to be involved in and accountable for decisions about health and health care services. To promote consumer involvement, health care pricing and other data should be free, timely, reliable, and reflect individual health care needs and insurance coverage.

Most Americans believe that the health care they receive is the best available, but the evidence shows otherwise.[5] Although the U.S. spends more than $3 trillion a year on health care,[6] 18 percent of the gross national product,[7] research shows that the quality of health care in America is, at best, imperfect, and, at worst, deeply flawed.[8] Issues with health care quality fall into three categories:

- Underuse. Many patients do not receive medically necessary care.
- Misuse. Each year, more than 100,000 Americans get the wrong care and are injured as a result. More than 1.5 million medication errors are made each year.
- Overuse. Many patients receive care that is not needed or for which there is an equally effective alternative that costs less money or causes fewer side effects.

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[1] S. 395.002(12), F.S.
[2] Id.
[3] S. 395.002(3), F.S.
[4] SS. 395.001-1065, F.S., and Part II, Chapter 408, F.S.
[5] National Committee for Quality Assurance, *The Essential Guide to Health Quality*, page 6, available at http://www.kdheks.gov/hcf/news/download/04172007_NCQA_Health_Quality.pdf (last viewed January 1, 2020).
[6] The Henry J. Kaiser Foundation, Peterson-Kaiser Health System Tracker, *Health Spending Explorer-U.S. Health Expenditures 1960-2017*, available at https://www.healthsystemtracker.org/interactive/?display=U.S.%2520%2524%2520Billions&service=&rangeType=range&years=1960%252C2017 (last viewed January 1, 2020).
[7] The World Bank, *Data-United States*, available at http://data.worldbank.org/country/united-states (last viewed January 1, 2020).
[8] Supra, FN 5.

Research indicates that quality of care in the U.S. is uneven. For example, Americans receive appropriate, evidence-based care when they need it only 55 percent of the time.[9] Similarly, more than 250,000 people die each year as a result of preventable hospital errors in the U.S.[10], and more than 72,000 people died in 2015 from an infection obtained while in the hospital.[11]

Quality Measures

There are hundreds of health care quality measures developed, maintained, and evaluated for relevancy and accuracy by many different organizations, including the federal Agency for Healthcare Research and Quality, the National Quality Forum, and the National Committee for Quality Assurance. In general, health quality measures can be sorted into four categories:[12]

- **Structure measures**- assess the aspects of the health care setting, including facility, personnel, and policies related to the delivery of care.
  - Example- What is the nurse-to-patient ratio in a neonatal intensive care unit?
- **Process measures**- determine if the services provided to patients are consistent with routine clinical care.
  - Example- Does a doctor recommend prostate-specific antigen testing for his male patients at average risk for prostate cancer beginning at age 50?
- **Outcome measures**- evaluate patient health as a result of care received.
  - Example- What is the infection rate of patients undergoing cardiac surgery at a hospital?
- **Patient experience measures**- provide feedback on patients' experiences with the care received.
  - Example- Do patients recommend their doctor to others following a procedure?

Standardized healthcare performance measures are used by a range of healthcare stakeholders for a variety of purposes. Measures help clinicians, hospitals, and other providers understand whether the care they provide their patients is optimal and appropriate, and if not, where to focus their efforts to improve. Public and private payers also use measures for feedback and benchmarking purposes, public reporting, and incentive-based payment. Lastly, measures are an essential part of making the cost and quality of healthcare more transparent to all, particularly for those who receive care or help make care decisions for loved ones. The Institute of Medicine's six domains of quality—safe, effective, patient-centered, timely, efficient, and equitable—are one way to organize the information.[13] Studies have found patients find effectiveness, safety, and patient-centeredness to be most meaningful in their consideration of health care options.[14]

As more and more health care consumers shop for their health care, value becomes more important than price alone. Determining value means comparing the cost of care with information on the quality or benefit of the service. Presenting health care price information without accompanying quality

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[9] McGlynn, E.A., Asch, S.M., et al., *The quality of health care delivered to adults in the United States*, New England Journal of Medicine, 348(26): 2635-45, June 2, 2003.
[10] John Hopkins Medicine, *Medical Error-The Third Leading Cause of Death in the U.S.,* available at https://www.bmj.com/content/353/bmj.i2139.full (last viewed January 1, 2020).
[11] Centers for Disease Control, *Healthcare-associated infections (HAI), Data and Statistics-HAI Prevalence Survey*, available at http://www.cdc.gov/HAI/surveillance/index.html (last viewed January 1, 2020).
[12] U.S. Government Accountability Office, *Health Care Transparency-Actions Needed to Improve Cost and Quality Information for Consumers*, October 2014, pgs. 6-7 (citing quality measure categories established by the U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality's National Quality Measures Clearinghouse, available at http://qualitymeasures.ahrq.gov/tutorial/varieties.aspx (last viewed January 1, 2020).
[13] Institute of Medicine, *Report: Crossing the Quality Chasm: A New Health System for the 21st Century*, March 1, 2001, available at http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2001/Crossing-the-Quality-Chasm/Quality%20Chasm%202001%20%20report%20brief.pdf (last viewed January 1, 2020).
[14] Hibbard, JH, Greene, J, Daniel D., *What is Quality Anyway? Performance Reports That Clearly Communicate to Consumers the Meaning of Quality Care*, Med. Care Res. Rev., 67(3): 275-293 (2010).

information leads consumers to assume that high-priced care is high quality care.[15] In fact, there is no evidence of a correlation between cost and quality in health care.[16]

Showing cost and quality information together helps consumers clearly see variation among providers.[17] Further, it helps consumers understand that high costs do not necessarily mean high quality—high-quality care is available without paying the highest price.[18] One way to accomplish this would be to present comparative quality and cost information on one, consumer-friendly website, using several specific measures or scores so multiple metrics can be compared at the same time.[19]

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (the Florida Center), within AHCA, provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data.

Current law requires every Florida licensed inpatient hospital, ambulatory surgery center (ASC), emergency department, and comprehensive rehabilitation hospital to report data to AHCA quarterly.[20] The Florida Center electronically collects this data validates it and maintains it in three major databases:

- The **hospital inpatient database** contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.
- The **ambulatory surgery database** contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.
- The **emergency department database** collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.

The Florida Center applies this data to standardized quality measures and price levels including total hospitalizations, high and low charges, infection rates, readmission rates and patient satisfaction among many other quality measures. The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public that allows access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida. The website also provides tools to researchers and

[15] Public Agenda and Robert Wood Johnson Foundation, *How Much Will It Cost? How Americans Use Prices in Health Care*, March 2015, page 5, available at http://www.publicagenda.org/files/HowMuchWillItCost_PublicAgenda_2015.pdf (last viewed January 1, 2020)
[16] Carman, KL, Maurer M., et al., *Evidence That Consumers Are Skeptical About Evidence-Based Health Care*, Health Affairs, 29(7): 1400-1406 (2010).
[17] American Institute of Research, The Robert Wood Johnson Foundation, *How to Report Cost Data to Promote High-Quality, Affordable Choices: Findings from Consumer Testing*, February 2014, available at https://www.rwjf.org/en/library/research/2014/02/how-to-report-cost-data-to-promote-high-quality--affordable-choi.html (last viewed January 1, 2020).
[18] Id.
[19] Id.
[20] S. 408.061, F.S.

professionals to allow specialized data queries, but requires users to have some knowledge of medical coding and terminology. Some of the features and data available on the website include a multimedia encyclopedia and symptoms navigator, hospital and ambulatory surgery centers performance data, data on mortality, complication, and infection rates for hospitals, and a facility/provider locator.

Patient Safety Culture Surveys[21]

Organizational culture refers to the beliefs, values, and norms shared by staff throughout the organization that influence their actions and behaviors. Patient safety culture is the extent to which these beliefs, values, and norms support and promote patient safety.[22] Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety.[23] In a safe culture, employees are guided by an organization-wide commitment to safety in which each member upholds their own safety norms and those of their co-workers. Safety culture is increasingly recognized as an important strategy to improving deficits in patient safety.[24] The question for health care facilities is how to measure the patient safety climate in the facility.

Agency for Healthcare Research and Quality Hospital and ASC Patient Safety Culture Survey

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture (SOPS 1.0), a staff survey designed to help hospitals assess the culture of safety in their institutions by measuring how their staff perceive various aspects of patient safety culture.[25] The survey occurs once every two years and has since been implemented in hundreds of hospitals across the United States, and in other countries.

In 2018, AHRQ began developing a new version of the survey, with the goal of shortening the survey.[26] A pilot test was conducted with 25 hospitals, the data of which was used to examine the survey's reliability. In 2019, AHRQ released a new version of the survey, the SOPS 2.0.[27]

Patient safety data collected from the survey results is not only provided in the aggregate, it can also be broken down to a more granular level. The first question on the survey allows the respondent to identify their position, title or area of expertise. The second question asks the respondent to identify the unit or department in which they work in the hospital. This allows survey data to be collected and categorized by staff position and by units or departments. As a result, a hospital can identify the specific positions and departments that may need improvement. The survey asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork
    - In this unit, we work together as an effective team.
    - During busy times, staff in this unit help each other.

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[21] Besides the two patient safety culture surveys highlighted is this section, other measures of safety climate include, but are not limited to, Zohar's (2000) assessment of unit safety climate; Zohar and Luria's (2005) measure of unit climate; Hofmann and Stetzer's (1996, 1998) measure of safety climate including safe practices, safety policies, and/or safety requirements; and Hofmann, Morgeson, and Gerras' (2003) measure of safety climate.

[22] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 3, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last viewed January 1, 2020).

[23] Id.

[24] Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations*. Qual Saf Health Care 2005;14:231–3;

[25] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, available at http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html (last viewed January 1, 2020). Besides hospitals, AHRQ developed patient safety culture surveys for nursing homes, ambulatory outpatient medical offices, community pharmacies, and ambulatory surgery centers.

[26] U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, *Pilot Test Results from the 2019 AHRQ Surveys on Patient Safety Culture (SOPS) Hospital Survey Version 2.0*, pg. 2, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hsops2-pilot-results-parti.pdf (last viewed January 1, 2020).

[27] The survey is available at http://www.ahrq.gov/sops/surveys/hospital/index.html (last viewed January 1, 2020).

  - There is a problem with disrespectful behavior by those working in this unit.
  - When one area in this unit gets really busy, others help out.
- Supervisor/Manager, or Clinical Leader Support for Patient Safety
  - My supervisor/manager, or clinical leader seriously considers staff suggestions for improving patient safety.
  - My supervisor/manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.
  - My supervisor/manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.
- Hospital Management Support for Patient Safety
  - Hospital management provides adequate resources to improve patient safety.
  - The actions of hospital management show that patient safety is a top priority.
  - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
  - In this unit, staff speak up if they see something that may negatively affect patient care.
  - When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.
  - In this unit, staff are afraid to ask questions when something does not seem right.
- Handoffs and Information Exchange
  - When transferring patients from one unit to another, important information is often left out.
  - During shift changes, important patient care information is often left out.
  - During shift changes, there is adequate time to exchange all key patient care information.
- Patient Safety Grade- Poor, Fair, Good, Very Good, Excellent
  - How would you rate your unit/work area on patient safety?[28]

AHRQ developed a tool kit and a user guide to provide instruction to hospitals on administering the SOPS survey.[29] The user guide includes instructions for modification and customization of the survey. The staff positions and departments on the survey can be modified to better match the names and titles used within a hospital. The survey may also be customized by adding questions.

The rate at which hospital staff have participated in the survey has never been high and has declined slightly in recent years, going from 55 percent in 2016[30] to 54 percent in 2018[31]. This may be the result of the prior survey being perceived as long or tedious.

AHRQ developed a comparative database on the survey, comprised of data from U.S. hospitals that administered the survey and voluntarily submitted the data.[32] The database allows hospitals to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.[33] AHRQ utilizes the database to publish a biennial report presenting non-identifiable statistics on the patient safety culture of all participating hospitals. In 2018, 630 hospitals

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[28] Id.

[29] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture Version 2.0 User's Guide,* available at https://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hospitalsurvey2-users-guide.pdf (last viewed January 1, 2020).

[30] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2016 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 8, available at http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/hospital/2016/2016_hospitalsops_report_pt1.pdf (last viewed January 1, 2020).

[31] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 5, available at http://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalopsreport_0.pdf (last viewed January 1, 2020).

[32] The database is available at http://www.ahrq.gov/sops/databases/hospital/index.html (last viewed January 1, 2020).

[33] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at pg. 1, available at https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalsopsreport.pdf (last viewed January 1, 2020).

submitted survey results to the database. However, only 306 of those hospitals submitted surveys in 2016. As a result, to identify trends, comparisons can only be drawn from the data submitted by those 306 hospitals.[34]

The 2018 biennial report includes a chapter on trending that presents results showing change over time for the 306 hospitals that administered the survey and submitted data in 2016 and 2018.[35] The trends and findings include:

- The average scores across the 12 patient safety culture composites increased by 1 percentage point.
- For hospitals that increased on Patient Safety Grade, scores for "Excellent" or "Very Good" increased on average by 6 percent.
- For hospitals that increased on the number of respondents who reported at least one event in the past 12 months, the average increase was 5 percent.

This seems to suggest that these hospitals improved their patient safety cultures after publication of the 2016 survey results.

AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ambulatory surgery centers (ASCs) in assessing patient safety culture in their facilities. This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.[36] In 2014, AHRQ conducted a pilot study on the use of the Patient Safety Culture survey in 59 ASCs.[37] The pilot study was intended to help ASCs assess the extent to which their culture emphasizes the importance of patient safety by viewing the patient safety culture survey results of the ASCs participating in the study.[38] The study was also used to prove the reliability and structure of the questions and items contained the in the survey. Based on the testing and input from AHRQ and a technical expert panel, the survey was determined to be reliable and it was made available for industry use.

University of Texas Safety Attitudes Questionnaire

Another patient safety culture survey widely used by hospitals and other facilities to measure patient safety culture is the Safety Attitudes Questionnaire (SAQ) developed by researchers at the University of Texas. The SAQ was adapted from two other safety surveys from the aviation industry- the Flight Management Attitudes Questionnaire and its predecessor, the Cockpit Management Attitudes Questionnaire, developed over 30 years ago. The aviation questionnaires were created after researchers found that most airline accidents were due to breakdowns in interpersonal aspects of crew performance such as teamwork, speaking up, leadership, communication, and collaborative decision making. The FMAQ measures crew member attitudes about these topics, and was found to be reliable, sensitive to change, and predictive of flight crew performance. Researchers also found that many of the items contained in the aviation questionnaires were useful in measuring attitudes about the same topics in a medical setting, so the SAQ was developed.

The SAQ was specifically designed to measure safety culture at both the individual and group level. Both the healthcare version (SAQ) and aviation version (FMAQ) of this survey instrument were shown to identify variability within and between hospitals and airlines[39]. The SAQ went through full derivation

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[34] Id. at pg. 29.
[35] Id.
[36] The survey is available at https://www.ahrq.gov/sops/surveys/asc/index.html.
[37] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Results From the 2014 AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture Pilot Study*, available at https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/asc_pilotstudy.pdf (last viewed January 1, 2020).
[38] Id. at pg. 1.
[39] Pronovost P, Sexton B. *Assessing safety culture: guidelines and recommendations.* Qual Saf Health Care 2005;14:231–3; see also Sexton JB, Thomas EJ. *Measurement: Assessing Safety Culture.* In: Leonard M, Frankel A, Simmonds T (eds). *Achieving Safe and*

and validation testing, and was determined to be both a valid and reliable measurement tool for determining patient safety culture.[40]

The SAQ is a one-page, 60 item survey instrument that assesses safety culture across six factors—perceptions of management, job satisfaction, working conditions, stress recognition, teamwork climate and safety climate.[41] The SAQ defines safety climate as perceptions of a strong and proactive organizational commitment to safety, as one aspect of overall safety culture. Each item is measured on a 5-point Likert scale, from disagree strongly to agree strongly, which is then converted to a 0–100 scale. The scaled scores correspond to the patient safety climate in a facility. The SAQ has been adapted for use in intensive care units, operating rooms, general inpatient settings, and ambulatory clinics.[42]

Research on Patient Safety Culture Surveys

Since 2000, a robust body of research has emerged to measure the effectiveness of patient safety culture surveys in identifying areas of improvement in hospitals, ASCs, and other health care settings. This research has found that facilities with a poor patient safety climate have poor or less desirable patient outcomes following treatment in those facilities. For example, in one study, the SAQ (operating version) was given to 60 hospitals in 16 states to administer to each hospital's operating room caregivers.[43] When the results of the surveys were compared with a chart showing surgical complication rates for each hospital participating in the study, the charts were nearly identical. The study showed that there was a correlation between patient safety culture in a hospital and patient outcomes.[44]

Another study examined the patient safety culture at 30 intensive care units (ICUs) across the country to determine if there was a correlation between safety culture and patient outcomes, specifically hospital mortality and length of stay.[45] Using the SAQ-ICU version, the study found that lower perceptions of management among ICU personnel were significantly associated with higher hospital mortality.[46] In fact, for every 10 percent decrease in an ICU's percentage of positive scores associated with perceptions of management, the odds of patient death in the ICU increased 1.24 times.[47] Also, the study found that lower safety climate, perceptions of management, and job satisfaction were significantly associated with increased lengths of stay in the hospital.[48] Other studies have also found a correlation between positive teamwork attitudes and patient outcomes in ICUs.[49]

Facilities whose frontline health care workers and managers score higher on patient safety climate surveys have been found to have lower rates of adverse patient safety indicators, such as postoperative sepsis, pressure ulcers, and inpatient falls resulting in a fractured hip.[50] Another study found a correlation between poor safety climate scores and high burnout rates among NICU nurses.[51]

Reliable Healthcare: Strategies and Solutions. Chicago, IL: Health Administration Press, 2004, pp. 115–27.
[40] Sexton JB, Helmreich RL, Neilands TB et al. *The Safety Attitudes Questionnaire: psychometric properties, benchmarking data, and emerging research*. BMC Health Serv Res 2006;6:44.
[41] Huang, D., Clermont, G. *Intensive care unit safety culture and outcomes: a U.S. multicenter study*. Intl. J. Quality in Health Care 2010;22:151-161.
[42] For each version of the SAQ, item content is the same, with minor modifications to reflect the clinical area.
[43] Makary M., Sexton B. *Patient safety in surgery*. Annals of Surgery 2006; 243:628-35.
[44] Makary, M. *Unaccountable: What Hospitals Won't Tell You and How Transparency Can Revolutionize Health Care* pgs. 90-92 (2012).
[45] Supra, FN 41.
[46] Id.
[47] Id.
[48] Id.
[49] Baggs J, Schmitt M, Mushlin A, Mitchell P, Eldredge D, Oakes D, Hutson AD: *Association between nurse-physician collaboration and patient outcomes in three intensive care units*. Crit Care Med 1999; 27:1991–8; Shortell S, Zimmerman J, Rousseau D, Gillies R, Wagner D, Draper E, Knaus W, Duffy J: *The performance of intensive care units: Does good management make a difference?* Med Care 1994; 32:508–25; Knaus W, Draper E, Zimmerman J: *An evaluation of outcome from intensive care in major medical centers*. Ann Intern Med 1986; 10:410–8.
[50] Singer S., Lin S. *Relationship of safety climate and safety performance in hospitals*. Health Serv Res 2009;44:399-421.
[51] Profit J., Sharek P. *Burnout in the NICU setting and its relation to safety culture*. BMJ Qual Saf 2014;23:806-813.

An additional study found that positive teamwork attitudes measured by patient safety culture survey tools are associated with better patient outcomes in pediatric surgery.[52]

Effect of Proposed Changes

The bill requires hospitals and ASCs to use the SOPS survey to conduct patient safety culture surveys of facility staff. The facilities must conduct the survey biennially, and submit the data to AHCA in a format specified by rule. The bill requires the facility to conduct the survey anonymously to encourage staff employed by or working in the facility to complete the survey. This will not only ensure a staff member's rights to privacy are protected, but it will lead to more reliable data by increasing the sample size of the survey. The bill authorizes a hospital or ASC to contract to administer the survey, and to develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA.

The bill requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs. The bill requires AHCA to publish the survey results for each facility, in the aggregate, by composite measure, and by unit work areas. AHCA must designate the use of updated versions of the survey as they occur.

The bill requires AHCA to customize the survey to include questions that will generate certain data, including, data on the likelihood of a respondent to seek care for the respondent, and for the respondent's family, at the surveying facility, both in general and within the respondent's specific unit or department.

The bill also requires AHCA to customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital or ASC that are not currently identifiable in the survey, including, a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.1012, F.S., relating to patient safety.
Section 2: Amends s. 395.1055, F.S., relating to rules and enforcement.
Section 3: Amends s. 408.05, F.S., relating to Florida Center for Health Information and Transparency.
Section 4: Amends s. 408.061, F.S., relating to data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.
Section 5: Provides for an appropriation.
Section 6: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

[52] de Leval M, Carthey J, Wright D, Farewell V, Reason J: *Human factors and cardiac surgery: A multicenter study.* J Thorac Cardiovasc Surg 2000;119:661–72.

2. Expenditures:

The AHCA has projected a need for one full-time equivalent position to oversee the project and $85,000 in contracted services to build the survey system to include associated programming and web-design costs. The bill authorizes one full-time equivalent position, with associated salary rate of 45,560, and $74,173 in recurring funds and $87,474 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Health care consumers will have access to patient safety culture survey results from hospitals and ASCs. Consumers may use the information to make informed decisions about where they receive health care services. Hospitals and ASCs with poor survey results may realize a reduction in patient volume, while hospitals and ASCs with positive survey results may realize an increase in patient volume.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:
None.

B. RULE-MAKING AUTHORITY:

Current law provides sufficient rule-making authority to AHCA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Health Market Reform Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Requires hospitals and ASCs to use the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality to conduct patient safety culture surveys of all facility staff;
- Requires hospitals and ASCs to conduct the survey biennially and anonymously;
- Requires hospitals and ASCs to submit the survey data and participation rate biennially to AHCA in a format specified by rule;
- Authorizes hospitals and ASCs to contract to administer the survey, and develop an internal action plan to identify survey measures to improve upon between surveys, which may be submitted to AHCA;
- Requires AHCA to collect, compile, and publish patient safety culture survey data submitted by hospitals and ASCs;
- Designate the use of updated versions of the survey as they occur;
- Customize the survey to include questions that will generate certain data;
- Customize the survey to allow a respondent to identify themselves as working in certain areas of a hospital that are not currently identifiable on the SOPS survey; and
- Publish the aggregate survey results for each facility by composite measure and unit work areas within the facility.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

1 A bill to be entitled
2 An act relating to patient safety culture surveys;
3 amending s. 395.1012, F.S.; requiring licensed
4 facilities to biennially conduct an anonymous patient
5 safety culture survey using a specified federal
6 publication; authorizing facilities to contract for
7 the administration of such survey; requiring
8 facilities to biennially submit patient safety culture
9 survey data to the Agency for Health Care
10 Administration; authorizing facilities to develop an
11 internal action plan for a specified purpose and
12 submit such plan to the agency; amending s. 395.1055,
13 F.S.; conforming a cross-reference; amending s.
14 408.05, F.S.; requiring the agency to collect,
15 compile, and publish patient safety culture survey
16 data submitted by facilities; amending s. 408.061,
17 F.S.; revising requirements for the submission of
18 health care data to the agency; providing
19 appropriations; providing an effective date.
20
21 Be It Enacted by the Legislature of the State of Florida:
22
23 Section 1. Subsection (4) is added to section 395.1012,
24 Florida Statutes, to read:
25 395.1012 Patient safety.—

26 (4) Each licensed facility must, at least biennially,
27 conduct a patient safety culture survey using the Hospital
28 Survey on Patient Safety Culture developed by the federal Agency
29 for Healthcare Research and Quality. Each facility shall conduct
30 the survey anonymously to encourage completion of the survey by
31 staff working in or employed by the facility. Each facility may
32 contract to administer the survey. Each facility shall
33 biennially submit the survey data to the agency in a format
34 specified by rule, which must include the survey participation
35 rate. Each facility may develop an internal action plan between
36 conducting surveys to identify measures to improve the survey
37 and submit the plan to the agency.
38 Section 2. Paragraph (d) of subsection (14) of section
39 395.1055, Florida Statutes, is amended to read:
40 395.1055 Rules and enforcement.—
41 (14)
42 (d) Each onsite inspection must include all of the
43 following:
44 1. An inspection of the program's physical facilities,
45 clinics, and laboratories.
46 2. Interviews with support staff and hospital
47 administrators.
48 3. A review of:
49 a. Randomly selected medical records and reports,
50 including, but not limited to, advanced cardiac imaging,

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

51 computed tomography, magnetic resonance imaging, cardiac
52 ultrasound, cardiac catheterization, and surgical operative
53 notes.
54 b. The program's clinical outcome data submitted to the
55 Society of Thoracic Surgeons and the American College of
56 Cardiology pursuant to s. 408.05(3)(l) ~~s. 408.05(3)(k)~~.
57 c. Mortality reports from cardiac-related deaths that
58 occurred in the previous year.
59 d. Program volume data from the preceding year for
60 interventional and electrophysiology catheterizations and
61 surgical procedures.
62 Section 3. Paragraphs (d) through (k) of subsection (3) of
63 section 408.05, Florida Statutes, are redesignated as paragraphs
64 (e) through (l), respectively, present paragraph (j) is amended,
65 and a new paragraph (d) is added to that subsection, to read:
66 408.05 Florida Center for Health Information and
67 Transparency.—
68 (3) HEALTH INFORMATION TRANSPARENCY.—In order to
69 disseminate and facilitate the availability of comparable and
70 uniform health information, the agency shall perform the
71 following functions:
72 (d)1. Collect, compile, and publish patient safety culture
73 survey data submitted by a facility pursuant to s. 395.1012.
74 2. Designate the use of updated versions of the survey as
75 they occur, and customize the survey to:

76 a. Generate data regarding the likelihood of a respondent
77 to seek care for the respondent and the respondent's family at
78 the surveying facility, both in general and within the
79 respondent's specific unit or work area; and
80 b. Revise the units or work areas identified in the survey
81 to include a pediatric cardiology patient care unit and a
82 pediatric cardiology surgical services unit.
83 3. Publish the survey results for each facility, in the
84 aggregate, by composite measure as defined in the survey and the
85 units or work areas within the facility.
86 (k)~~(j)~~ Conduct and make available the results of special
87 health surveys, including facility patient safety culture
88 surveys, health care research, and health care evaluations
89 conducted or supported under this section. Each year the center
90 shall select and analyze one or more research topics that can be
91 investigated using the data available pursuant to paragraph (c).
92 The selected topics must focus on producing actionable
93 information for improving quality of care and reducing costs.
94 The first topic selected by the center must address preventable
95 hospitalizations.
96 Section 4. Paragraph (a) of subsection (1) of section
97 408.061, Florida Statutes, is amended to read:
98 408.061 Data collection; uniform systems of financial
99 reporting; information relating to physician charges;
100 confidential information; immunity.—

101 (1) The agency shall require the submission by health care
102 facilities, health care providers, and health insurers of data
103 necessary to carry out the agency's duties and to facilitate
104 transparency in health care pricing data and quality measures.
105 Specifications for data to be collected under this section shall
106 be developed by the agency and applicable contract vendors, with
107 the assistance of technical advisory panels including
108 representatives of affected entities, consumers, purchasers, and
109 such other interested parties as may be determined by the
110 agency.
111 (a) Data submitted by health care facilities, including
112 the facilities as defined in chapter 395, shall include, but are
113 not limited to: case-mix data, patient admission and discharge
114 data, hospital emergency department data which shall include the
115 number of patients treated in the emergency department of a
116 licensed hospital reported by patient acuity level, data on
117 hospital-acquired infections as specified by rule, data on
118 complications as specified by rule, data on readmissions as
119 specified by rule, with patient and provider-specific
120 identifiers included, actual charge data by diagnostic groups or
121 other bundled groupings as specified by rule, facility patient
122 safety culture surveys, financial data, accounting data,
123 operating expenses, expenses incurred for rendering services to
124 patients who cannot or do not pay, interest charges,
125 depreciation expenses based on the expected useful life of the

126 property and equipment involved, and demographic data. The
127 agency shall adopt nationally recognized risk adjustment
128 methodologies or software consistent with the standards of the
129 Agency for Healthcare Research and Quality and as selected by
130 the agency for all data submitted as required by this section.
131 Data may be obtained from documents such as, but not limited to:
132 leases, contracts, debt instruments, itemized patient statements
133 or bills, medical record abstracts, and related diagnostic
134 information. Reported data elements shall be reported
135 electronically in accordance with rule 59E-7.012, Florida
136 Administrative Code. Data submitted shall be certified by the
137 chief executive officer or an appropriate and duly authorized
138 representative or employee of the licensed facility that the
139 information submitted is true and accurate.
140 Section 5. For the 2020-2021 fiscal year, one full-time
141 equivalent position with associated salary rate of 46,560 is
142 authorized, and the sums of $74,173 in recurring funds and
143 $87,474 in nonrecurring funds from the Health Care Trust Fund
144 are appropriated to the Agency for Health Care Administration,
145 for the purpose of implementing the requirements of this act.
146 Section 6. This act shall take effect July 1, 2020.

CS/HB 1071

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1071 Substance Abuse and Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Grant, M.
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark

SUMMARY ANALYSIS

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves).

CS/HB 1071 makes a variety of changes to laws relating to substance abuse and mental health services.

Specifically, the bill:

- Aligns the statutory definitions of "mental illness;"
- Adds two Community Action Treatment (CAT) teams;
- Revises statutes relating to the composition and duties of the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee;
- Revises the method of procurement for the school substance abuse prevention partnership grant;
- Requires continuing education every three years on specified topics for court-appointed forensic evaluators; and
- Repeals the requirement for DCF to develop a certification process for community substance abuse prevention coalitions.

The bill has a negative fiscal impact on DCF. See Fiscal Analysis & Economic Impact Statement.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Illness and Substance Abuse

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. One in five adults experiences mental illness in a given year, [4] and one in five children ages 13-18 have or will have a serious debilitating mental illness at some point during their life.[5] Half of all lifetime cases of mental illness begin by age 14, and scientists are discovering that changes in the body leading to mental illness may start much younger, before any symptoms appear.[6] Suicide is the third leading cause of death in youth age 10 to 24 and the tenth leading cause of death in adults, and research indicates that 90 percent of people who die by suicide have an underlying mental illness.[7]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[8] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[9] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[10] Brain imaging studies of

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[1] World Health Organization, *Mental Health: Strengthening Our Response,* https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Jan. 21, 2020).

[2] Centers for Disease Control and Prevention, *Learn About Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Jan. 21, 2020).

[3] Id.

[4] National Alliance on Mental Illness, *Mental Health Facts in America,* http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited Jan. 21, 2020).

[5] National Alliance on Mental Illness, *Mental Health Facts: Children & Teens*, http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited Jan. 21, 2020).

[6] National Institute of Mental Health, *Children and Mental Health*, https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited Jan. 21, 2020).

[7] *Supra,* note 5.

[8] *World Health Organization, Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited Jan. 21, 2020).

[9] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders,* http://www.samhsa.gov/disorders/substance-use (last visited Jan. 21, 2020).

[10] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited Jan. 21, 2020).

persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[11]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[12] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[13]

Mental illness and substance abuse commonly co-occur. Approximately 7.9 million adults have co-occurring disorders.[14] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[15] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[16] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[17] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[18]

<u>Mental Illness and Substance Abuse Treatment in Florida</u>

For the purpose of the public safety-net system of mental health treatment, s. 394.455(28), F.S., defines mental illness as “an impairment of the mental or emotional processes that exercise conscious control of one’s actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person’s ability to meet the ordinary demands of living.” The definition further excludes a developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse are excluded from this definition. This means that individuals with dementia or TBI (neither of which are a mental illness) who do not have a co-occurring mental illness can be subject to involuntary treatment under the Baker Act, disrupting them from their normal environment and possibly exacerbating their condition.

For the purpose of criminal procedure relating to mentally ill and intellectually disabled defendants, s. 916.106(14), F.S., defines mental illness as “an impairment of the emotional process that exercises conscious control of one’s actions, or of the ability to perceive or understand reality, which impairment substantially interferes with the defendant’s ability to meet the ordinary demands of living.” The statute specifically excludes an intellectual disability, autism, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment from being considered a mental illness. This means that defendants with dementia or TBI who lack a co-occurring mental illness continue to be committed to forensic facilities, even though a state mental health treatment facility is not an appropriate setting for such a population.

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state’s mental health commitment laws. [19] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[20]

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[11] Id.
[12] *Supra*, note 9.
[13] Id.
[14] National Institute on Mental Illness, *Dual Diagnosis*, https://www.nami.org/learn-more/mental-health-conditions/related-conditions/dual-diagnosis (last visited Jan. 21, 2020).
[15] Psychology Today, *Co-Occurring Disorders*, https://www.psychologytoday.com/conditions/co-occurring-disorders (last visited Jan. 21, 2020).
[16] *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf (last visited Jan. 21, 2020).
[17] Id.
[18] Id.
[19] Sections 394.451-394.47892, F.S.
[20] Section 394.459, F.S.

In the early 1970s, the federal government furnished grants for states to develop continuums of care for individuals and families affected by substance abuse.[21] The grants provided separate funding streams and requirements for alcoholism and drug abuse. In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[22] In 1993, legislation combined ch. 396 and ch. 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[23] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

DCF administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[24]

DCF contracts for behavioral health services through regional systems of care called managing entities. The 7 managing entities, in turn, contract with and oversee local service providers for the delivery of mental health and substance abuse services throughout the state.[25] Treatment for substance abuse through this community-based provider system includes detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence.[26]

- **Detoxification Services:** Medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[27]
- **Treatment Services:** Assessment, counseling, case management, and support that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment.[28]
- **Recovery Support:** Transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.[29]

Community Action Treatment Teams

According to the National Institute of Mental Health (NIMH), half of all lifetime cases of mental health disorders have begun by age 14 and three quarters have begun by age 24.[30] Successful transition between the children and adult systems is critical; many individuals with mental health disorders fall through the gaps between the children and adult mental health systems during a critical time in their

[21] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5. (on file with Children, Families, and Seniors Subcommittee staff).
[22] Id.
[23] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[24] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance, and children at risk for initiating drug use.
[25] Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited on Jan. 24, 2020).
[26] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/service-programs/samh/substance-abuse.shtml, (last visited Jan. 24, 2020).
[27] Id.
[28] Id. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.
[29] Id.
[30] Kessler, Berglund, Demler, Jin, Merikangas, and Walters, *Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication*, Archives of General Psychiatry. June 2005, https://www.ncbi.nlm.nih.gov/pubmed/15939837 (last visited Jan. 24, 2020).

lives.[31] In 2003, the New Freedom Commission on Mental Health released a report that identified further gaps in the mental health system and recommended transforming the mental health system through community-based services to help individuals with mental illnesses live successfully in their communities.[32] The CAT teams model is an example of a comprehensive service approach that allows young people with mental illnesses who are at risk or out-of-home placements to receive services and remain in their communities with their caregivers.[33]

CAT teams are intended to be a safe and effective alternative to out-of-home placement for children with a mental health condition and characteristics that impact their ability to function well in the community.[34] The goals of CAT teams are to:[35]

- Strengthen the family and support systems for youth and young adults to assist them to live successfully in the community;
- Improve school related outcomes such as attendance, grades and graduation rates;
- Decrease out-of-home placements;
- Improve family and youth functioning;
- Decrease substance use and abuse;
- Decrease psychiatric hospitalizations;
- Transition into age appropriate services; and
- Increase health and wellness.

To be eligible for services through a CAT team, the individual must be a child or young adult, up to 21 years old, with a mental health or co-occurring substance abuse diagnosis and specified accompanying characteristics, the requirements for which vary by age.[36] If the child is less than 11 years old he or she must meet two of the following accompanying characteristics; however, individuals aged 11-21 must only meet one of the following accompanying characteristics:[37]

- The individual is at-risk for out-of-home placement as demonstrated by repeated failures at less intensive levels of care;
- The individual has had two or more hospitalizations or repeated failures;
- The individual has had involvement with DJJ or multiple episodes involving law enforcement; or
- The individual has poor academic performance and/or suspensions.

The CAT model is an integrated service delivery approach that utilizes a team of individuals to comprehensively address the needs of the young person, and his or her family.[38] The CAT team includes a full-time team leader, mental health clinicians, a psychiatrist or advanced registered nurse practitioner (ARNP), a registered or licensed practical nurse, a case manager, therapeutic mentors, and support staff.[39] They work collaboratively to deliver the majority of behavioral health services, coordinate with other service providers when necessary, and assist the family in developing or strengthening its natural support system.[40]

[31] Maryann Davis and Bethany Hunt, *State efforts to expand transition supports for young adults receiving adult public mental health services*. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, 2005, https://pdfs.semanticscholar.org/40ae/063ae28b3273f498eb7c7b609677b1e5be92.pdf?_ga=2.44077420.995818869.1579903552-877004500.1579903552 (last visited Jan. 24, 2020).
[32] Letter from The President's New Freedom Commission on Mental Health to President George W. Bush, July 22, 2002, http://govinfo.library.unt.edu/mentalhealthcommission/reports/FinalReport/downloads/FinalReport.pdf (last visited Jan. 24, 2020).
[33] Department of Children and Families, *Community Action Team Evaluation Report*, February 1, 2014, p. 6, https://www.myflfamilies.com/service-programs/samh/publications/docs/CAT_Team_Evaluation_January_31_2014.pdf (last visited Jan. 24, 2020).
[34] Department of Children and Families, *Fiscal Year 2017-18 Managing Entity Templates, Guidance 32 – Community Action Treatment (CAT) Team*, Effective January 1, 2018, p. 1 (Guidance Document on file with Health and Human Services Committee).
[35] Id. at 1-2.
[36] Id. at 2.
[37] Id.
[38] Id.
[39] Id.
[40] Id.

CAT teams have greater flexibility than traditional mental health providers, which is intended to promote a "whatever it takes" approach to assisting young people with mental health or co-occurring substance use disorders and their families to achieve their goals.[41] One of the differences between CAT teams and traditional mental health services is that services are provided or coordinated by the multidisciplinary team; these services are individualized and often do not fit into the standard of medical necessity, and are typically not reimbursed by Medicaid or private insurance.[42] The number of sessions and the frequency at which they are provided is set through collaboration rather than service limits.[43] In addition, the family is treated as a unit, and the CAT team addresses all family members' needs.[44]

CAT teams provide services in the family's home or in other community locations that are convenient for the family being served. The mix of services and supports the CAT team provides to the individual and his or her family should be developmentally appropriate for the young person and serve to strengthen him or her and his or her family.[45] Examples of services provided by the CAT team are [46]

- **Crisis Intervention and 24/7 On-call Coverage:** Assists the family with crisis intervention, referrals, or supportive counseling;
- **Family Education:** Families are educated on topics related to their treatment goals, including effective parenting skills and behavior management; and
- **Therapy:** Provides and coordinates individual, group, and family therapy services. The type, frequency and location of therapy provided are based on their individual needs.

In addition to the services the CAT team provides, it also encourages the young person and his or her family to develop connections to natural supports[47] within their own network of associates, such as friends and neighbors; through connections with the community; through service and religious organizations; and through participation in clubs and other civic activities.[48]

Use of CAT Teams in Florida

In 2005, the Florida Legislature funded the first CAT team as a behavioral healthcare pilot project for children, adolescents, and young adults with significant mental health needs in Manatee County.[49] Manatee Glens, a non-profit behavioral health provider, implemented the first CAT team pilot project with the goal of diverting children and youth with significant behavioral health needs from residential mental health treatment, foster care, and juvenile detention facilities.[50]

In 2013, the Legislature funded ten pilot CAT teams through Specific Appropriation 352-A of the 2013–2014 GAA.[51] The Legislature directed DCF as part of the 352-A appropriation to develop a report that evaluates the effectiveness of CAT teams in meeting the goal of offering parents and caregivers of this target population a safe option for raising their child at home rather than utilizing more costly institutional placement, foster home care, or juvenile justice services.[52] Based on this directive, DCF published the Community Action Team Evaluation Report[53] on January 31, 2014. While the report was not able to provide an unequivocal conclusion as to the efficacy of the CAT team model, its assessment was positive and it found positive outcomes associated with the use of CAT teams, including diversion from out of home placement, functional improvement, improved school attendance, and an increased

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[41] *Supra,* note 33, at 8.
[42] Id.
[43] Id.
[44] Id. at 9.
[45] *Supra,* note 34, at 7.
[46] *Supra,* note 33, at 9.
[47] Natural supports ease the transition from formal services and provide ongoing support after discharge.
[48] *Supra,* note 34, at 6.
[49] *Supra,* note 34, at 1.
[50] Id.
[51] Fla. General Appropriation Act Fiscal Year 2013-2014, SB 1500 item 352-A, http://www.myfloridahouse.gov/filestores/Adhoc/Appropriations/GAA/2013-Senate/CR_SB_1500.pdf (last visited February 26, 2018).
[52] Id.
[53] *Supra,* note 33.

number of days spent in the community (i.e., not in a psychiatric hospital, juvenile detention center, residential treatment facility, or on runaway).[54]

Following the positive report on CAT teams, the Legislature allocated recurring funding and non-recurring funding expanding the number of CAT teams in Fiscal Years 2014-2015 to 2019-2020.[55]

As of July 1, 2019, recurring funding supports 23 CAT teams, and non-recurring funding supports 2 CAT teams (one team serving Charlotte County and one team serving Leon, Gadsden and Wakulla counties).[56]

In DCF's SAMH Annual Plan for Fiscal Years 2017-2019, it identified the need to increase intensive, in-home team interventions that are available 24 hours per day, 7 days per week as part of its strategic initiative to increase access to quality, recovery-oriented system of care, and enhance the community-based service array to shift from an acute care model to a recovery based model of care.[57] DCF identified increasing the number of CAT and mobile crisis teams as a way to meet this objective.[58]

Criminal Justice, Mental Health, and Substance Abuse Statewide Reinvestment Grant Program

In 2007, the Legislature created the Criminal Justice, Mental Health, and Substance Abuse Reinvestment Grant Program (Program). The purpose of the Program is to provide funding to counties to plan, implement, or expand initiatives that increase public safety, avert increased spending on criminal justice, and improve the accessibility and effectiveness of treatment services for adults and juveniles who have a mental illness, substance abuse disorder, or co-occurring mental health and substance abuse disorders and who are in, or at risk of entering, the criminal or juvenile justice systems.[59]

A county, non-profit community provider or managing entity designated by a county planning council or committee may apply for a one-year planning grant or a three-year implementation expansion grant under the Program.[60] The purpose of the grants is to demonstrate that investment in treatment efforts related to mental illness, substance abuse disorders, or co-occurring mental health and substance abuse disorders results in a reduced demand on the resources of the judicial, corrections, juvenile detention, and health and social services systems.[61]

The Program is currently funded at $9 million annually.[62] DCF manages 8 planning grants, 18 implementation or expansion grants, and 1 contract providing counties with technical assistance through the University of South Florida.

The Statewide Grant Review Committee (Committee) is composed of representatives from six state agencies, including DCF, and ten advocacy groups and professional and trade associations representing criminal justice professionals, behavioral health service providers, and local municipalities, each of which has varying degrees of involvement in county strategic planning and implementation of alternative service models addressing the Program's target populations. The Committee serves as an advisory body charged with reviewing policy and funding issues and advising DCF in selecting priorities for grants and investing awarded grant moneys. The Committee is also responsible for reviewing grant

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[54] Id. at 22-26.
[55] Fla. General Appropriation Act Fiscal Years 2014-2015, 2015-2016, 2016-2017, 2017-2018, 2018-2019, 2019-2020; HB 5001 item 349, SB 2500-A item 377G, HB 5001 item 382, SB 2500 item 361A, HB 5001 item 366, SB 2500 item 367, respectively.
[56] Fla. General Appropriation Act Fiscal Year 2019-2020, SB 2500 item 367.
[57] *Florida Substance Abuse and Mental Health Plan, Triennial State and Regional Master, Fiscal Years 2017-2019,* Department of Children and Families, Substance Abuse and Mental Health Program Office, January 31, 2016, pp. 8-9, https://www.myflfamilies.com/service-programs/samh/publications/docs/FL-SAMH-PlanFY17-19.pdf (last visited Jan. 24, 2020).
[58] Id. at 9.
[59] S. 394.656(1), F.S.
[60] S. 394.656(5), F.S.
[61] Id.
[62] Department of Children and Families, Agency Bill Analysis for 2020 HB 1071 (Jan. 14, 2020) (On file with Children, Families, and Seniors Subcommittee Staff).

applications and selecting the grant recipients, as well as notifying DCF in writing of the recipients' names before DCF can issue awards.

This statutory responsibility of the Committee creates significant challenges implementing the grant review functions due to the affiliations of the Committee members representing the participating ten advocacy groups and professional and trade associations. Specifically, conflict of interest standards routinely interfere with participation in annual grant reviews by the non-state agency members. Four organizations represent the actual grant applicants identified in statute and are automatically excluded from participation in all grant award decisions. The remaining six organizations may or may not be excluded from some grant reviews, depending on whether their members include an applicant, an applicant's proposed sub-recipient, or proposed source of local matching funds.

DCF has conducted three grant solicitations since this Committee's membership was expanded in 2016.[63] In each solicitation, four advocacy groups have been excluded for conflicts and an average of seven other organizations have been unable or unwilling to participate. Five organizations have consistently declined to participate in every solicitation. As a result, the conflicts of interest and non-participation generate considerable inconsistency in available grant review teams and increases DCF's risk of protests or appeals following each increasingly competitive solicitation cycle.

Purple Ribbon Task Force

Chapter 2012-172, Laws of Florida, created the Purple Ribbon Task Force. The task force was composed of 18 members with 6 members appointed by the Governor, 6 members appointed by the Speaker of the House of Representatives, and 6 members appointed by the President of the Senate.[64]

The law required the task force to conduct an interim study regarding Alzheimer's disease in the state.[65] This study required the task force to:[66]

- Assess the current and future impact of Alzheimer's disease on the state;
- Examine existing industries, services, and resources that address the needs of persons with Alzheimer's disease;
- Develop a strategy to mobilize a state response to Alzheimer's disease; and
- Gather information on state trends and policy regarding Alzheimer's disease.

Additionally, the law required the task force to submit a report in the form of an Alzheimer's disease state plan.[67] The 2013 completed report by the task force is the State Plan on Alzheimer's disease and Related Forms of Dementia.[68] The state report included the task force's findings and recommendations. Upon submission of this report, pursuant to law, the Purple Ribbon Task force terminated.

Included in the Task Force's recommendations was to exclude dementia, Alzheimer's disease, and traumatic brain injury (TBI) from the definition of mental illness, as none of these are mental illnesses.[69] This recommendation was made to keep such individuals from experiencing negative, life-impacting changes associated with being removed suddenly from a stable environment.[70]

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[63] Id.
[64] Ch. 2012-172, Laws of Fla.
[65] Id.
[66] Id.
[67] Id.
[68] Florida Department of Elder Affairs, *Purple Ribbon Task Force State Plan on Alzheimer's Disease and Related Forms of Dementia*, https://www.alz.org/media/Documents/florida-state-plan-august-2013.pdf (last visited Jan. 24, 2020).
[69] Id.
[70] Id.

Certification of Community Substance Abuse Prevention Coalitions

Prevention coalitions are local partnerships between multiple sectors of the community that respond to community conditions by developing and implementing comprehensive plans that lead to measurable, population-level reductions in drug use and related problems. Generally, prevention coalitions have community wide involvement including parents, youth, teachers, police, faith-based leaders and business partners.[71]

Section 397.321, F.S., requires DCF to license and regulate all substance abuse providers in the state. It also requires DCF to develop a certification process by rule for community substance abuse prevention coalitions (prevention coalitions). A rule has not been promulgated by DCF and as such, there is no process for state certification and no state certified providers.[72]

Prevention coalitions do not provide licensable substance abuse clinical treatment services, and certification is not a requirement for eligibility to receive federal or state substance abuse prevention funding. However, to receive funding from DCF, a coalition must follow a comprehensive process that includes a detailed needs assessment and plan for capacity building, development, implementation, and sustainability to ensure that data-driven, evidence–based practices are employed for addressing substance misuse for state-funded coalitions.

Some prevention coalitions choose to receive certification from nationally-recognized credentialing entities through an application process. Additionally, the Florida Certification Board, a non-profit professional credentialing entity, offers certifications for Certified Prevention Specialists and Certified Prevention Professionals, for those individuals who desire professional credentialing.

Florida is the only state that statutorily requires prevention coalitions to be certified.[73]

Forensic Evaluators

Forensic mental health evaluation is a form of evaluation performed by a mental health professional to provide relevant clinical and scientific data during civil or criminal proceedings. Florida's circuit courts are responsible for appointing mental health experts to conduct forensic evaluations of individuals with mental illnesses who are adjudicated incompetent to proceed of a felony offense or acquitted of a felony offense by reason of insanity.[74] DCF is required to provide one time training for psychiatrists, psychologists, and other mental health professionals on how to conduct evaluations for criminal courts.[75] The training program is a three day program offered through a course provided by the Louis de la Parte Florida Mental Health Institute at the University of South Florida which focuses on competence to stand trial and sanity evaluations.[76] Participants learn Florida laws and rules of criminal procedure relevant to forensic evaluation, general legal principles relevant to forensic evaluation, and assessment techniques and procedures used in competency to proceed and mental state at the time of the offense evaluations,[77] though no specific topics are required to be covered.

Because training for forensic evaluators is only a one time requirement, mental health professionals who have completed the training can remain on the list of DCF approved evaluators for years without

[71] Department of Children and Families, Agency Bill Analysis for 2018 HB 0721 (Nov. 30, 2017) (On file with Children, Families, and Seniors Subcommittee Staff).
[72] Email from John Paul Fiore, Legislative Specialist, Department of Children and Families, RE: HB 1071 Question, (Jan. 24, 2020) (on file with Children, Families, and Seniors Subcommittee staff).
[73] Only one other state, Ohio, has established a certification program for prevention coalitions, and it is voluntary.
[74] *Supra,* note 62.
[75] S. 916.111, F.S.
[76] Department of Children and Families, *Forensic Evaluator Training and the Importance of Appointing Approved Forensic Evaluators as Experts,* https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-evaluator-training-and-importance-appointing-approved-forensic-evaluators-experts.shtml (last visited Jan. 24, 2020).
[77] Id.

receiving continuing education, meaning that their initial training becomes outdated as statutes and practices change over time.[78]

Effect of Proposed Changes

Mental Illness

The bill amends s. 394.455(28), F.S., and s. 916.106(14), F.S., to exclude dementia and traumatic brain injury from the definition of "mental illness."

This proposed change aligns the definition of "mental illness" with current language in s. 394.467(6)(b), F.S., which prohibits individuals with dementia or TBI who lack a co-occurring mental illness form being involuntary admitted to a state mental health treatment facility. Additionally, this may also reduce the number of individuals with dementia or TBI who lack a co-occurring mental illness that are being inappropriately admitted for involuntary examination at Baker Act receiving facilities. However, the proposed change will not prohibit an individual who has dementia or TBI with a co-occurring mental illness who is experiencing a mental health crisis from being admitted to a Baker Act receiving facility for involuntary examination.

Community Action Treatment Teams

Legislative Joint Rule 2.2 states that budget items that are authorized in statute are not considered appropriations projects, and for those that do qualify as such, they may only receive nonrecurring funding.[79] The bill adds two CAT teams to the statutory list of geographic locations to be served by these teams: one serving Charlotte County and the other serving Leon, Gadsden, and Wakulla counties.

Criminal Justice, Mental Health, and Substance Abuse Statewide Reinvestment Grant Program

The bill allows county consortiums to apply for a 1-year planning or 3-year implementation or expansion grant. It allows a county planning council or committee to designate the county sheriff or local law enforcement agency to apply for a grant on behalf of the county.

The bill revises the duties of and renames the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Review Committee (committee) to the Criminal Justice, Mental Health, and Substance Abuse Statewide Grant Advisory Committee. The bill revises the membership of the committee to:

- Remove the administrator of an assisted living facility that holds a limited mental health license; and
- Add the Florida Behavioral Health Association, to reflect the merger of the Florida Alcohol and Drug Abuse Association with the Florida Council for Community Mental Health.

The bill removes the ability of the committee to participate in the development of criteria used to review grants and in the selection of grant recipients. Instead, DCF, in collaboration with the Department of Corrections, the Department of Juvenile Justice, the Department of Elder Affairs, the Office of the State Courts Administrator, and the Department of Veterans' Affairs must establish criteria used to review applications and select the county that will be awarded a 1-year planning grant or a 3-year implementation or expansion grant.

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[78] *Supra,* note 62.

[79] Joint Rule 2.3, Joint Rules of the Florida Legislature (2018-2020).

Repeal of Prevention Coalition Certification

The bill repeals the requirement that DCF develop a certification process by rule for community substance abuse prevention coalitions. Due to DCF having not establishing such process, this is no impact in rule.

School Substance Abuse Prevention Partnership Grants

The bill allows managing entities instead of DCF, to use a competitive solicitation process to review grant applications for the school substance abuse prevention partnership grant program.

Court-Appointed Forensic Evaluators

The bill requires court-appointed forensic evaluators to take continuing education on conducting forensic evaluations for the court every three years. At a minimum, the continuing education must provide current information on:

- Forensic statutory requirements;
- Recent changes to part II of ch. 916, F.S., relating to forensic services for persons who are mentally ill;
- Trends and concerns related to forensic commitments in the state;
- Alternatives to maximum security treatment facilities;
- Community forensic treatment providers;
- Evaluation requirements; and
- Forensic service array updates.

The bill makes technical and conforming changes.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.495, F.S., relating to child and adolescent mental health system of care: programs and services.
Section 3: Amends s. 394.656, F.S., relating to criminal justice, mental health, and substance abuse reinvestment grant program.
Section 4: Amends s. 394.657, F.S., relating to county planning councils or committees.
Section 5: Amends s. 394.658, F.S., relating to criminal justice, mental health, and substance abuse reinvestment grant program requirements.
Section 6: Amends s. 397.321, F.S., relating to duties of the department.
Section 7: Amends s. 397.99, F.S., relating to school substance abuse prevention partnership grants.
Section 8: Amends s. 916.111, F.S., relating to training of mental health experts.
Section 9: Amends s. 916.115, F.S., relating to appointment of experts.
Section 10: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill amends s. 394.495(6)(e)1, F.S., to include Charlotte, Leon, Gadsden, and Wakulla counties to the list of specified counties or regions required to be individually served by a CAT team. The Fiscal Year 2019-2020 General Appropriations Act provided $1,500,000 ($750,000 per team) in non-recurring General Revenue to fund two CAT teams in these counties.

The House proposed General Appropriations Act for Fiscal Year 2020-21 includes an additional, recurring $5,250,000 to expand the number of available CAT teams.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill permits a county consortium to apply for a Criminal Justice, Mental Health, and Substance Abuse Statewide Reinvestment Grant, and allows such to designate the sheriff or local law enforcement agency to apply for a grant on the county's behalf. To the extent that a county is more likely to apply for a grant if the local sheriff or law enforcement agency is the applicant, there will be an increase of applicants to a grant program that does not include an increase to the program's base appropriation.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to substance abuse and mental health;
3 amending s. 394.455, F.S.; revising the definition of
4 "mental illness;" amending s. 394.495, F.S.; revising
5 the counties that a community action treatment team
6 must serve; amending s. 394.656, F.S.; revising
7 membership and duties of the Criminal Justice, Mental
8 Health, and Substance Abuse Statewide Grant Advisory
9 Committee; authorizing additional entities that may
10 apply for a grant on behalf of a county; providing for
11 selection of grant recipients; amending s. 394.657,
12 F.S.; conforming provisions to changes made by the
13 act; amending s. 394.658, F.S.; revising requirements
14 of the Criminal Justice, Mental Health, and Substance
15 Abuse Reinvestment Grant Program; amending s. 397.321,
16 F.S.; removing the requirement that the department
17 develop a certification process for community
18 substance abuse prevention coalitions; amending s.
19 397.99, F.S.; requiring managing entities under
20 contract with the department to use a specified
21 process for school substance abuse prevention
22 partnership grants; amending s. 916.111, F.S.;
23 requiring the department to provide continuing
24 education for specified mental health professionals;
25 providing requirements for such education; amending s.

26 916.115, F.S.; revising requirements for the
27 appointment of experts to evaluate certain defendants;
28 providing an effective date.
29
30 Be It Enacted by the Legislature of the State of Florida:
31
32 Section 1. Subsection (28) of section 394.455, Florida
33 Statutes, is amended to read:
34 394.455 Definitions.—As used in this part, the term:
35 (28) "Mental illness" means an impairment of the mental or
36 emotional processes that exercise conscious control of one's
37 actions or of the ability to perceive or understand reality,
38 which impairment substantially interferes with the person's
39 ability to meet the ordinary demands of living. For the purposes
40 of this part, the term does not include a developmental
41 disability as defined in chapter 393, intoxication, or
42 conditions manifested only by antisocial behavior, dementia,
43 traumatic brain injury, or substance abuse.
44 Section 2. Paragraph (e) of subsection (6) of section
45 394.495, Florida Statutes, is amended to read:
46 394.495 Child and adolescent mental health system of care;
47 programs and services.—
48 (6) The department shall contract for community action
49 treatment teams throughout the state with the managing entities.
50 A community action treatment team shall:

51 (e)1. Subject to appropriations and at a minimum,
52 individually serve each of the following counties or regions:
53 a. Alachua.
54 b. Alachua, Columbia, Dixie, Hamilton, Lafayette, and
55 Suwannee.
56 c. Bay.
57 d. Brevard.
58 e. Charlotte.
59 f.~~e.~~ Collier.
60 g.~~f.~~ DeSoto and Sarasota.
61 h.~~g.~~ Duval.
62 i.~~h.~~ Escambia.
63 j.~~i.~~ Hardee, Highlands, and Polk.
64 k.~~j.~~ Hillsborough.
65 l.~~k.~~ Indian River, Martin, Okeechobee, and St. Lucie.
66 m.~~l.~~ Lake and Sumter.
67 n.~~m.~~ Lee.
68 o. Gadsden, Leon, and Wakulla.
69 p.~~n.~~ Manatee.
70 q.~~o.~~ Marion.
71 r.~~p.~~ Miami-Dade.
72 s.~~q.~~ Okaloosa.
73 t.~~r.~~ Orange.
74 u.~~s.~~ Palm Beach.
75 v.~~t.~~ Pasco.

76 w.~~u.~~ Pinellas.
77 x.~~v.~~ Walton.
78 2. Subject to appropriations, the department shall
79 contract for additional teams through the managing entities to
80 ensure the availability of community action treatment team
81 services in the remaining areas of the state.
82 Section 3. Section 394.656, Florida Statutes, is amended
83 to read:
84 394.656 Criminal Justice, Mental Health, and Substance
85 Abuse Reinvestment Grant Program.—
86 (1) There is created within the Department of Children and
87 Families the Criminal Justice, Mental Health, and Substance
88 Abuse Reinvestment Grant Program. The purpose of the program is
89 to provide funding to counties which they may use to plan,
90 implement, or expand initiatives that increase public safety,
91 avert increased spending on criminal justice, and improve the
92 accessibility and effectiveness of treatment services for adults
93 and juveniles who have a mental illness, substance use ~~abuse~~
94 disorder, or co-occurring mental health and substance use ~~abuse~~
95 disorders and who are in, or at risk of entering, the criminal
96 or juvenile justice systems.
97 (2) The department shall establish a Criminal Justice,
98 Mental Health, and Substance Abuse Statewide Grant Advisory
99 ~~Review~~ Committee. The committee shall include:
100 (a) One representative of the Department of Children and

101 Families.;
102 (b) One representative of the Department of Corrections.;
103 (c) One representative of the Department of Juvenile
104 Justice.;
105 (d) One representative of the Department of Elderly
106 Affairs.;
107 (e) One representative of the Office of the State Courts
108 Administrator.;
109 (f) One representative of the Department of Veterans'
110 Affairs.;
111 (g) One representative of the Florida Sheriffs
112 Association.;
113 (h) One representative of the Florida Police Chiefs
114 Association.;
115 (i) One representative of the Florida Association of
116 Counties.;
117 (j) One representative of the Florida Behavioral Health
118 Alcohol and Drug Abuse Association.;
119 (k) One representative of the Florida Association of
120 Managing Entities.;
121 (l) One representative of the Florida Council for
122 Community Mental Health;
123 (l)(m) One representative of the National Alliance of
124 Mental Illness.;
125 (m)(n) One representative of the Florida Prosecuting

126 Attorneys Association.;
127 (n)(o) One representative of the Florida Public Defender
128 Association; and
129 (p) One administrator of an assisted living facility that
130 holds a limited mental health license.
131 (3) The committee shall serve as the advisory body to
132 review policy and funding issues that help reduce the impact of
133 persons with mental illness and substance use abuse disorders on
134 communities, criminal justice agencies, and the court system.
135 The committee shall advise the department in selecting
136 priorities for grants and investing awarded grant moneys.
137 (4) The committee must have experience in substance use
138 and mental health disorders, community corrections, and law
139 enforcement. To the extent possible, the committee shall have
140 expertise in grant review and grant application scoring.
141 (5)(a) A county, a consortium of counties, or an a not-
142 for-profit community provider or managing entity designated by
143 the county planning council or committee, as described in s.
144 394.657, may apply for a 1-year planning grant or a 3-year
145 implementation or expansion grant. The purpose of the grants is
146 to demonstrate that investment in treatment efforts related to
147 mental illness, substance use abuse disorders, or co-occurring
148 mental health and substance use abuse disorders results in a
149 reduced demand on the resources of the judicial, corrections,
150 juvenile detention, and health and social services systems.

151 (b) To be eligible to receive a ~~1-year planning grant or a~~
152 ~~3-year implementation or expansion~~ grant:
153 1. An ~~A county~~ applicant must have a planning council or
154 committee that is in compliance with the membership requirements
155 set forth in this section.
156 2. A county planning council or committee may designate a
157 not-for-profit community provider, a ~~or~~ managing entity as
158 defined in s. 394.9082, the county sheriff or his or her
159 designee, or a local law enforcement agency to apply on behalf
160 of the county. The county planning council or committee must
161 provide ~~must be designated by the county planning council or~~
162 ~~committee and have written authorization to submit an~~
163 ~~application. A not-for-profit community provider or managing~~
164 ~~entity must have~~ written authorization for each designated
165 entity and each submitted application.
166 (c) The department may award a 3-year implementation or
167 expansion grant to an applicant who has not received a 1-year
168 planning grant.
169 (d) The department may require an applicant to conduct
170 sequential intercept mapping for a project. For purposes of this
171 paragraph, the term "sequential intercept mapping" means a
172 process for reviewing a local community's mental health,
173 substance abuse, criminal justice, and related systems and
174 identifying points of interceptions where interventions may be
175 made to prevent an individual with a substance use ~~abuse~~

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

176 disorder or mental illness from deeper involvement in the
177 criminal justice system.
178 (6) The department ~~grant review and selection committee~~
179 shall select the grant recipients in collaboration with the
180 Department of Corrections, the Department of Juvenile Justice,
181 the Department of Elderly Affairs, the Office of the State
182 Courts Administrator, and the Department of Veterans' Affairs
183 ~~and notify the department in writing of the recipients' names~~.
184 Contingent upon the availability of funds ~~and upon notification~~
185 ~~by the grant review and selection committee of those applicants~~
186 ~~approved to receive planning, implementation, or expansion~~
187 ~~grants~~, the department may transfer funds appropriated for the
188 grant program to a selected grant recipient.
189 Section 4. Subsection (1) of section 394.657, Florida
190 Statutes, is amended to read:
191 394.657 County planning councils or committees.—
192 (1) Each board of county commissioners shall designate the
193 county public safety coordinating council established under s.
194 951.26, or designate another criminal or juvenile justice mental
195 health and substance abuse council or committee, as the planning
196 council or committee. The public safety coordinating council or
197 other designated criminal or juvenile justice mental health and
198 substance abuse council or committee, in coordination with the
199 county offices of planning and budget, shall make a formal
200 recommendation to the board of county commissioners regarding

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

201 how the Criminal Justice, Mental Health, and Substance Abuse
202 Reinvestment Grant Program may best be implemented within a
203 community. The board of county commissioners may assign any
204 entity to prepare the application on behalf of the county
205 administration for submission to the Criminal Justice, Mental
206 Health, and Substance Abuse Statewide Grant Advisory ~~Review~~
207 Committee for review. A county may join with one or more
208 counties to form a consortium and use a regional public safety
209 coordinating council or another county-designated regional
210 criminal or juvenile justice mental health and substance abuse
211 planning council or committee for the geographic area
212 represented by the member counties.
213 Section 5. Section 394.658, Florida Statutes, is amended
214 to read:
215 394.658 Criminal Justice, Mental Health, and Substance
216 Abuse Reinvestment Grant Program requirements.—
217 (1) The ~~Criminal Justice, Mental Health, and Substance~~
218 ~~Abuse Statewide Grant Review Committee, in collaboration with~~
219 ~~the~~ department ~~of Children and Families~~, in collaboration with
220 the Department of Corrections, the Department of Juvenile
221 Justice, the Department of Elderly Affairs, the Department of
222 Veterans' Affairs, and the Office of the State Courts
223 Administrator, shall establish criteria to be used to review
224 submitted applications and to select a ~~the~~ county that will be
225 awarded a 1-year planning grant or a 3-year implementation or

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

226 expansion grant. A planning, implementation, or expansion grant
227 may not be awarded unless the application of the county meets
228 the established criteria.
229 (a) The application criteria for a 1-year planning grant
230 must include a requirement that the applicant ~~county or counties~~
231 have a strategic plan to initiate systemic change to identify
232 and treat individuals who have a mental illness, substance use
233 ~~abuse~~ disorder, or co-occurring mental health and substance use
234 ~~abuse~~ disorders who are in, or at risk of entering, the criminal
235 or juvenile justice systems. The 1-year planning grant must be
236 used to develop effective collaboration efforts among
237 participants in affected governmental agencies, including the
238 criminal, juvenile, and civil justice systems, mental health and
239 substance abuse treatment service providers, transportation
240 programs, and housing assistance programs. The collaboration
241 efforts shall be the basis for developing a problem-solving
242 model and strategic plan for treating individuals ~~adults and~~
243 ~~juveniles~~ who are in, or at risk of entering, the criminal or
244 juvenile justice system and doing so at the earliest point of
245 contact, taking into consideration public safety. The planning
246 grant shall include strategies to divert individuals from
247 judicial commitment to community-based service programs offered
248 by the department ~~of Children and Families~~ in accordance with
249 ss. 916.13 and 916.17.
250 (b) The application criteria for a 3-year implementation

251 or expansion grant must ~~shall~~ require the applicant to
252 demonstrate ~~information from a county that demonstrates~~ its
253 completion of a well-established collaboration plan that
254 includes public-private partnership models and the application
255 of evidence-based practices. The implementation or expansion
256 grants may support programs and diversion initiatives that
257 include, but need not be limited to:
258 1. Mental health courts.~~;~~
259 2. Diversion programs.~~;~~
260 3. Alternative prosecution and sentencing programs.~~;~~
261 4. Crisis intervention teams.~~;~~
262 5. Treatment accountability services.~~;~~
263 6. Specialized training for criminal justice, juvenile
264 justice, and treatment services professionals.~~;~~
265 7. Service delivery of collateral services such as
266 housing, transitional housing, and supported employment.~~; and~~
267 8. Reentry services to create or expand mental health and
268 substance abuse services and supports for affected persons.
269 (c) Each ~~county~~ application must include the following
270 information:
271 1. An analysis of the current population of the jail and
272 juvenile detention center in the county, which includes:
273 a. The screening and assessment process that the county
274 uses to identify an adult or juvenile who has a mental illness,
275 substance use ~~abuse~~ disorder, or co-occurring mental health and

276 substance <u>use</u> ~~abuse~~ disorders<u>.</u>~~;~~
277 b. The percentage of each category of <u>individuals</u> ~~persons~~
278 admitted to the jail and juvenile detention center that
279 represents people who have a mental illness, substance <u>use</u> ~~abuse~~
280 disorder, or co-occurring mental health and substance <u>use</u> ~~abuse~~
281 disorders<u>.</u>~~; and~~
282 c. An analysis of observed contributing factors that
283 affect population trends in the county jail and juvenile
284 detention center.
285 2. A description of the strategies the <u>applicant</u> ~~county~~
286 intends to use to serve one or more clearly defined subsets of
287 the population of the jail and juvenile detention center who
288 have a mental illness or to serve those at risk of arrest and
289 incarceration. The proposed strategies may include identifying
290 the population designated to receive the new interventions, a
291 description of the services and supervision methods to be
292 applied to that population, and the goals and measurable
293 objectives of the new interventions. <u>An applicant</u> ~~The~~
294 ~~interventions a county may use with the target population~~ may
295 <u>use</u> ~~include~~, but <u>is</u> ~~are~~ not limited to<u>, the following</u>
296 <u>interventions</u>:
297 a. Specialized responses by law enforcement agencies<u>.</u>~~;~~
298 b. Centralized receiving facilities for individuals
299 evidencing behavioral difficulties<u>.</u>~~;~~
300 c. Postbooking alternatives to incarceration<u>.</u>~~;~~

301 d. New court programs, including pretrial services and
302 specialized dockets.~~;~~
303 e. Specialized diversion programs.~~;~~
304 f. Intensified transition services that are directed to
305 the designated populations while they are in jail or juvenile
306 detention to facilitate their transition to the community.~~;~~
307 g. Specialized probation processes.~~;~~
308 h. Day-reporting centers.~~;~~
309 i. Linkages to community-based, evidence-based treatment
310 programs for adults and juveniles who have mental illness or
311 substance use ~~abuse~~ disorders.~~; and~~
312 j. Community services and programs designed to prevent
313 high-risk populations from becoming involved in the criminal or
314 juvenile justice system.
315 3. The projected effect the proposed initiatives will have
316 on the population and the budget of the jail and juvenile
317 detention center. The information must include:
318 a. An ~~The county's~~ estimate of how the initiative will
319 reduce the expenditures associated with the incarceration of
320 adults and the detention of juveniles who have a mental
321 illness.~~;~~
322 b. The methodology that will be used ~~the county intends to~~
323 ~~use~~ to measure the defined outcomes and the corresponding
324 savings or averted costs.~~;~~
325 c. An ~~The county's~~ estimate of how the cost savings or

326 averted costs will sustain or expand the mental health and
327 substance abuse treatment services and supports needed in the
328 community.~~; and~~
329 d. How the ~~county's~~ proposed initiative will reduce the
330 number of individuals judicially committed to a state mental
331 health treatment facility.
332 4. The proposed strategies ~~that the county intends to use~~
333 to preserve and enhance its community mental health and
334 substance abuse system, which serves as the local behavioral
335 health safety net for low-income and uninsured individuals.
336 5. The proposed strategies ~~that the county intends to use~~
337 to continue the implemented or expanded programs and initiatives
338 that have resulted from the grant funding.
339 (2)(a) As used in this subsection, the term "available
340 resources" includes in-kind contributions from participating
341 counties.
342 (b) A 1-year planning grant may not be awarded unless the
343 applicant ~~county~~ makes available resources in an amount equal to
344 the total amount of the grant. A planning grant may not be used
345 to supplant funding for existing programs. For fiscally
346 constrained counties, the available resources may be at 50
347 percent of the total amount of the grant.
348 (c) A 3-year implementation or expansion grant may not be
349 awarded unless the applicant ~~county or consortium of counties~~
350 makes available resources equal to the total amount of the

351 grant. For fiscally constrained counties, the available
352 resources may be at 50 percent of the total amount of the grant.
353 This match shall be used for expansion of services and may not
354 supplant existing funds for services. An implementation or
355 expansion grant must support the implementation of new services
356 or the expansion of services and may not be used to supplant
357 existing services.
358 (3) ~~Using the criteria adopted by rule, the county~~
359 ~~designated or established criminal justice, juvenile justice,~~
360 ~~mental health, and substance abuse planning council or committee~~
361 ~~shall prepare the county or counties' application for the 1-year~~
362 ~~planning or 3-year implementation or expansion grant.~~ The county
363 shall submit the completed application to the department
364 ~~statewide grant review committee~~.
365 Section 6. Subsections (16) of section 397.321, Florida
366 Statutes, is amended to read:
367 397.321 Duties of the department.—The department shall:
368 ~~(16) Develop a certification process by rule for community~~
369 ~~substance abuse prevention coalitions.~~
370 Section 7. Section 397.99, Florida Statutes, is amended to
371 read:
372 397.99 School substance abuse prevention partnership
373 grants.—
374 (1) GRANT PROGRAM.—
375 (a) In order to encourage the development of effective

376 substance abuse prevention and early intervention strategies for
377 school-age populations, the school substance abuse prevention
378 partnership grant program is established.
379 (b) The department shall administer the program in
380 cooperation with the Department of Education, ~~and~~ the Department
381 of Juvenile Justice, and the managing entities under contract
382 with the department under s. 394.9082.
383 (2) APPLICATION PROCEDURES; FUNDING REQUIREMENTS.—
384 (a) Schools, or community-based organizations in
385 partnership with schools, may submit a grant proposal for
386 funding or continued funding to the managing entity in its
387 geographic area ~~department~~ by March 1 of each year.
388 Notwithstanding s. 394.9082(5)(i), the managing entity shall use
389 a competitive solicitation process to review ~~The department~~
390 ~~shall establish~~ grant applications, ~~application procedures~~ which
391 ensures ~~ensure~~ that grant recipients implement programs and
392 practices that are effective. The managing entity ~~department~~
393 shall include the grant application document on its ~~an~~ Internet
394 website.
395 (b) Grants may fund programs to conduct prevention
396 activities serving students who are not involved in substance
397 use, intervention activities serving students who are
398 experimenting with substance use, or both prevention and
399 intervention activities, if a comprehensive approach is
400 indicated as a result of a needs assessment.

401 (c) Grants may target youth, parents, and teachers and
402 other school staff, coaches, social workers, case managers, and
403 other prevention stakeholders.
404 (d) Performance measures for grant program activities
405 shall measure improvements in student attitudes or behaviors as
406 determined by the managing entity ~~department~~.
407 (e) At least 50 percent of the grant funds available for
408 local projects must be allocated to support the replication of
409 prevention programs and practices that are based on research and
410 have been evaluated and proven effective. The managing entity
411 ~~department~~ shall develop related qualifying criteria.
412 (f) In order to be considered for funding, the grant
413 application shall include the following assurances and
414 information:
415 1. A letter from the administrators of the programs
416 collaborating on the project, such as the school principal,
417 community-based organization executive director, or recreation
418 department director, confirming that the grant application has
419 been reviewed and that each partner is committed to supporting
420 implementation of the activities described in the grant
421 proposal.
422 2. A rationale and description of the program and the
423 services to be provided, including:
424 a. An analysis of prevention issues related to the
425 substance abuse prevention profile of the target population.

426 b. A description of other primary substance use and
427 related risk factors.
428 c. Goals and objectives based on the findings of the needs
429 assessment.
430 d. The selection of programs or strategies that have been
431 shown to be effective in addressing the findings of the needs
432 assessment.
433 e. A method of identifying the target group for universal
434 prevention strategies, and a method for identifying the
435 individual student participants in selected and indicated
436 prevention strategies.
437 f. A description of how students will be targeted.
438 g. Provisions for the participation of parents and
439 guardians in the program.
440 h. An evaluation component to measure the effectiveness of
441 the program in accordance with performance-based program
442 budgeting effectiveness measures.
443 i. A program budget, which includes the amount and sources
444 of local cash and in-kind resources committed to the budget and
445 which establishes, to the satisfaction of the managing entity
446 ~~department~~, that the grant applicant ~~entity~~ will make a cash or
447 in-kind contribution to the program of a value that is at least
448 25 percent of the amount of the grant.
449 (g) The managing entity ~~department~~ shall consider the
450 following in awarding such grants:

451 1. The number of youths that will be targeted.
452 2. The validity of the program design to achieve project
453 goals and objectives that are clearly related to performance-
454 based program budgeting effectiveness measures.
455 3. The desirability of funding at least one approved
456 project in each of the department's substate entities.
457 (3) The managing entity must ~~department shall~~ coordinate
458 the review of grant applications with local representatives of
459 the Department of Education and the Department of Juvenile
460 Justice and shall make award determinations no later than June
461 30 of each year. All applicants shall be notified by the
462 managing entity ~~department~~ of its final action.
463 (4) Each entity that is awarded a grant as provided for in
464 this section shall submit performance and output information as
465 determined by the managing entity ~~department~~.
466 Section 8. Subsection (1) of section 916.111, Florida
467 Statutes, is amended to read:
468 916.111 Training of mental health experts.—The evaluation
469 of defendants for competency to proceed or for sanity at the
470 time of the commission of the offense shall be conducted in such
471 a way as to ensure uniform application of the criteria
472 enumerated in Rules 3.210 and 3.216, Florida Rules of Criminal
473 Procedure. The department shall develop, and may contract with
474 accredited institutions:
475 (1) To provide:

476 (a) A plan for training mental health professionals to
477 perform forensic evaluations and to standardize the criteria and
478 procedures to be used in these evaluations.~~;~~
479 (b) Clinical protocols and procedures based upon the
480 criteria of Rules 3.210 and 3.216, Florida Rules of Criminal
481 Procedure.~~; and~~
482 (c) Training for mental health professionals in the
483 application of these protocols and procedures in performing
484 forensic evaluations and providing reports to the courts.~~; and~~
485 (d) Continuing education for mental health professionals
486 who have completed the training required by paragraph (c) and s.
487 916.115(1). At a minimum, the continuing education must include
488 current information on:
489 1. Forensic statutory requirements.
490 2. Recent changes to part II of this chapter.
491 3. Trends and concerns related to forensic commitments in
492 the state.
493 4. Alternatives to maximum security treatment facilities.
494 5. Community forensic treatment providers.
495 6. Evaluation requirements.
496 7. Forensic service array updates.
497 Section 9. Subsection (1) of section 916.115, Florida
498 Statutes, is amended to read:
499 916.115 Appointment of experts.—
500 (1) The court shall appoint no more than three experts to

501 determine the mental condition of a defendant in a criminal
502 case, including competency to proceed, insanity, involuntary
503 placement, and treatment. The experts may evaluate the defendant
504 in jail or in another appropriate local facility or in a
505 facility of the Department of Corrections.
506 (a) ~~To the extent possible,~~ The appointed experts must
507 ~~shall~~ have completed forensic evaluator training approved by the
508 department under s. 916.111(1)(c), and, to the extent possible,
509 each shall be a psychiatrist, licensed psychologist, or
510 physician. Appointed experts who have completed the training
511 under s. 916.111(1)(c) must complete continuing education under
512 s. 916.111(1)(d) every 3 years.
513 (b) The department shall maintain and annually provide the
514 courts with a list of available mental health professionals who
515 have completed the approved training under ss. 916.111(1)(c) and
516 (d) ~~as experts~~.
517 Section 10. This act shall take effect July 1, 2020.

CS/HB 1081

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1081 Substance Abuse and Mental Health
SPONSOR(S): Children, Families & Seniors Subcommittee, Stevenson
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	11 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark

SUMMARY ANALYSIS

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves).

- The bill makes a variety of changes to laws relating to substance abuse and mental health services.
- The bill amends s. 394.455(28), F.S., and s. 916.106(14), F.S., to exclude dementia and traumatic brain injury from the definition of "mental illness."
- The bill maintains the exemption, from licensing, for organizations and individuals that provide healthcare services and are already licensed under another section of law.
- The bill repeals s. 397.311(26)(a)3., F.S., which removes day or night treatment as one of the licensable service components of clinical treatment services under chapter 397, F.S.
- The bill requires that county jails continue to administer the psychotropic medications prescribed by DCF when a forensic client is discharged and return to the county jail, unless the jail physician documents the need to change or discontinue such medication. The treating physician must consult with the jail physician and consider prescribing medication included in the jail's drug formulary. Additionally, the bill requires county jails to send all medical information for individuals in their custody who will be admitted to state mental health treatment facilities. DCF must request this information immediately upon receipt of a completed commitment packet. Upon receipt of such a request, the county jail must provide the requested information within three business days.
- The bill does not have a fiscal impact on state government, but may have an indeterminate impact on counties and upon the private sector.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Illness and Substance Abuse

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.[1] The primary indicators used to evaluate an individual's mental health are:[2]

- **Emotional well-being**- Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being**- Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being**- Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.[3] Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. One in five adults experiences mental illness in a given year,[4] and one in five children ages 13-18 have or will have a serious debilitating mental illness at some point during their life.[5] Half of all lifetime cases of mental illness begin by age 14, and scientists are discovering that changes in the body leading to mental illness may start much younger, before any symptoms appear.[6] Suicide is the third leading cause of death in youth age 10 to 24 and the tenth leading cause of death in adults, and research indicates that 90 percent of people who die by suicide have an underlying mental illness.[7]

Substance abuse also affects millions of people in the United States each year. Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[8] Substance abuse disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[9] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance abuse disorder.[10] Brain imaging studies of

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[1] World Health Organization, *Mental Health: Strengthening Our Response*, https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response (last visited Jan. 21, 2020).
[2] Centers for Disease Control and Prevention, *Learn About Mental Health*, http://www.cdc.gov/mentalhealth/basics.htm (last visited Jan. 21, 2020).
[3] Id.
[4] National Alliance on Mental Illness, *Mental Health Facts in America*, http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited Jan. 21, 2020).
[5] National Alliance on Mental Illness *Mental Health Facts: Children & Teens*, http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited Jan. 21, 2020).
[6] National Institute of Mental Health, *Children and Mental Health*, https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited Jan. 21, 2020).
[7] Supra note 5.
[8] *World Health Organization, Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited Jan. 21, 2020).
[9] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders*, http://www.samhsa.gov/disorders/substance-use (last visited Jan. 21, 2020).
[10] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last visited Jan. 21, 2020).

persons with substance abuse disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[11]

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance abuse disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.[12] The most common substance abuse disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.[13]

Mental illness and substance abuse commonly co-occur. Approximately 7.9 million adults have co-occurring disorders.[14] In fact, more than half of all adults with severe mental illness are further impaired by substance use disorders (abuse or dependence related to alcohol or other drugs).[15] Drug abuse can cause individuals to experience one or more symptoms of another mental illness.[16] Additionally, individuals with mental illness may abuse drugs as a form of self-medication.[17] Examples of co-occurring disorders include the combinations of major depression with cocaine addiction, alcohol addiction with panic disorder, alcoholism and drug addiction with schizophrenia, and borderline personality disorder with episodic drug abuse.[18]

Mental Illness and Substance Abuse Treatment in Florida

For the purpose of the public safety-net system of mental health treatment, s. 394.455(28), F.S., defines mental illness as "an impairment of the mental or emotional processes that exercise conscious control of one's actions or of the ability to perceive or understand reality, which impairment substantially interferes with the person's ability to meet the ordinary demands of living." The definition further excludes a developmental disability, intoxication, or conditions manifested only by antisocial behavior or substance abuse are excluded from this definition. This means that individuals with dementia or traumatic brain injury (neither of which are truly mental illnesses) who do not have a co-occurring mental illness can be subject to involuntary treatment under the Baker Act, disrupting them from their normal environment and possibly exacerbating their condition.

For the purpose of criminal procedure relating to mentally ill and intellectually disabled defendants, s. 916.106(14), F.S., defines mental illness as "an impairment of the emotional process that exercises conscious control of one's actions, or of the ability to perceive or understand reality, which impairment substantially interferes with the defendant's ability to meet the ordinary demands of living." The statute specifically excludes an intellectual disability, autism, intoxication, or conditions manifested only by antisocial behavior or substance abuse impairment from being considered a mental illness. This means that defendants with dementia or TBI who lack a co-occurring mental illness continue to be committed to forensic facilities, even though a state mental health treatment facility is not an appropriate setting for those populations.

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [19] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[20]

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[11] Id.
[12] Supra, note 9.
[13] Id.
[14] National Institute on Mental Illness, *Dual Diagnosis*, https://www.nami.org/learn-more/mental-health-conditions/related-conditions/dual-diagnosis (last visited Jan. 21, 2020).
[15] Psychology Today, *Co-Occurring Disorders*, https://www.psychologytoday.com/conditions/co-occurring-disorders (last visited Jan. 21, 2020).
[16] *Comorbidity: Addiction and Other Mental Illnesses*, National Institute on Drug Abuse, NIH Publication Number 10-5771, September 2010. https://www.drugabuse.gov/sites/default/files/rrcomorbidity.pdf (last visited Jan. 21, 2020).
[17] Id.
[18] Id.
[19] Sections 394.451-394.47892, F.S.
[20] Section 394.459, F.S.

In the early 1970s, the federal government furnished grants for states to develop continuums of care for individuals and families affected by substance abuse.[21] The grants provided separate funding streams and requirements for alcoholism and drug abuse. In response, the Florida Legislature enacted ch. 396, F.S., (alcohol) and ch. 397, F.S. (drug abuse).[22] In 1993, legislation combined ch. 396 and ch. 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").[23] The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.[24]

DCF contracts for behavioral health services through regional systems of care called managing entities. The 7 managing entities, in turn, contract with and oversee local service providers for the delivery of mental health and substance abuse services throughout the state.[25] Treatment for substance abuse through this community-based provider system includes detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence.[26]

- **Detoxification Services:** Medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.[27]
- **Treatment Services:** Assessment, counseling, case management, and support that are designed to help individuals who have lost their abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment. [28]
- **Recovery Support:** Transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.[29]

DCF regulates substance abuse treatment by licensing individual treatment components under ch. 397, F.S., and rule 65D-30, F.A.C. All private and publicly-funded entities providing substance abuse services must be licensed for each service component they provide.[30] However, current law exempts certain entities from licensure:[31]

- A hospital or hospital-based component;
- A nursing home facility;

[21] Department of Children and Families, *Baker Act and Marchman Act Project Team Report for Fiscal Year 2016-2017*, p. 4-5.
[22] Id.
[23] Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.
[24] These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance, and children at risk for initiating drug use.
[25] Department of Children and Families, *Managing Entities*, http://www.dcf.state.fl.us/service-programs/samh/managing-entities/index.shtml (last visited on Jan. 21, 2020).
[26] Department of Children and Families, *Treatment for Substance Abuse*, https://www.myflfamilies.com/service-programs/samh/substance-abuse.shtml, (last visited Jan. 21, 2020).
[27] Id.
[28] Id. Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.
[29] Id.
[30] S. 397.403, F.S.
[31] S. 397.4012, F.S.

- A substance abuse education program established under the public school system;
- A facility or institution operated by the Federal Government;
- An allopathic or osteopathic physician or physician assistant;
- A psychologist;
- A social worker;
- A marriage and family therapist;
- A mental health counselor;
- A church or nonprofit religious organization or denomination that provides services which are solely religious, spiritual, or ecclesiastical in nature;
- A facility licensed by the Agency for Persons with Disabilities;
- DUI education and screening services under the Florida Uniform Traffic Control Law; and
- A crisis stabilization unit.

This exemption from licensure does not apply if the entity provides state-funded services through the DCF managing entity system or provides services under a government-operated substance abuse program.[32]

Licensed service components include a continuum of substance abuse prevention,[33] intervention,[34] and clinical treatment services.[35] Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle.[36] "Clinical treatment services" include, but are not limited to, the following licensable service components: [37]

- Addictions receiving facility;
- Day or night treatment;
- Day or night treatment with community housing;
- Detoxification;
- Intensive inpatient treatment;
- Intensive outpatient treatment;
- Medication-assisted treatment for opiate addiction;
- Outpatient treatment; and
- Residential treatment.

Day-or-Night Treatment Facilities

Day or night treatment is one of the licensable service components of clinical treatment services under ch. 397, F.S. This service is provided in a nonresidential environment with a structured schedule of treatment and rehabilitative services.[38] Some day or night treatment facilities have a community housing component, which is a program intended for individuals who can benefit from living independently in peer community housing while participating in treatment services at a day or night treatment facility for a minimum of 5 hours a day for a minimum of 25 hours per week.[39] There are 102

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[32] S. 397.4012, F.S.
[33] S. 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles. *See also,* Department of Children and Families, *Substance Abuse: Prevention,* https://www.myflfamilies.com/service-programs/samh/prevention/ (last visited Jan. 21, 2020). Substance abuse prevention is best accomplished through the use of ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices. These prevention programs are focused primarily on youth, and, recent years, have shifted to the local level, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. This community focus allows prevention strategies to have a greater impact on behavioral change by shifting social, cultural and community environments.
[34] S. 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.
[35] S. 397.311(25), F.S.
[36] Id.
[37] S. 397.311(25)(a), F.S.
[38] S. 397.311(26)(a)2., F.S.
[39] S. 397.311(26)(a)3., F.S.

providers who hold a total of 108 licenses for day or night treatment with community housing, 85 of which are located in Broward, Palm Beach, and the Treasure Coast.[40]

These community housing components operate similarly to a recovery residence, as defined in statute, by providing a peer-supported, alcohol- and drug-free living environment. However, unlike recovery residences which operate independently and do not provide treatment to or otherwise have treatment requirements for their residents, community housing components operate directly under a licensed day or night treatment facility and are intended to house individuals while they are receiving treatment at the day or night treatment facility. As such, licensed day or night treatment facilities with group housing components are not required to obtain recovery residence certification to operate their group housing components.

DCF confirmed this in an order, finding that a day or night treatment center with a community housing component is distinct from a recovery residence as defined in statute.[41] In its opinion, DCF states that unlike a recovery residence, a day or night treatment facility with a community housing component is a licensable service component monitored by DCF and is a program which requires its residents to participate in minimum treatment hours each week at the day or night treatment facility.

State Forensic System – Mental Health Treatment for Criminal Defendants

The Due Process Clause of the 14th Amendment prohibits the states from trying and convicting defendants who are incompetent to stand trial.[42] The states must have procedures in place that adequately protect the defendant's right to a fair trial, which includes his or her participation in all material stages of the process.[43] Defendants must be able to appreciate the range and nature of the charges and penalties that may be imposed, understand the adversarial nature of the legal process, and disclose to counsel facts pertinent to the proceedings. Defendants also must manifest appropriate courtroom behavior and be able to testify relevantly.[44]

If a defendant is suspected of being incompetent, the court, counsel for the defendant, or the state may file a motion for examination to have the defendant's cognitive state assessed.[45] If the motion is well-founded the court will appoint experts to evaluate the defendant's cognitive state. The defendant's competency is then determined by the judge in a subsequent hearing.[46] If the defendant is found to be competent, the criminal proceeding resumes.[47] If the defendant is found to be incompetent to proceed, the proceeding may not resume unless competency is restored.[48]

Chapter 916, F.S., governs the state forensic system, which is a network of state facilities and community services for persons who have mental health issues, an intellectual disability, or autism and who are involved with the criminal justice system. Offenders who are charged with a felony and adjudicated incompetent to proceed[49] and offenders who are adjudicated not guilty by reason of

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[40] Department of Children and Families, Agency Bill Analysis for 2020 House Bill 1081, (Jan. 14, 2020) (On file with Children, Families, and Seniors Subcommittee Staff).
[41] *In the Matter of: Amethyst Recovery Center, LLC, Order on Petition for Declaratory Statement* (Case No. 18-064CF; Rendition No. DCF-18-196-DS, Aug. 21, 2018)(on file with the Children, Families, and Seniors Subcommittee staff). In June 2018, the facility filed a petition for declaratory judgment asking DCF to clarify whether a community housing component of a day or night treatment facility is required to obtain certification as a recovery residence in order for the day or night treatment facility to provide clinical services to its residents. DCF found that a licensed day or not treatment facility with a community housing component was not subject to the voluntary certification requirements for recovery residences.
[42] *Pate v. Robinson*, 383 U.S. 375, 86 S.Ct. 836, 15 L.Ed. 815 (1966); *Bishop v. U.S.*, 350 U.S.961, 76 S.Ct. 440, 100 L.Ed. 835 (1956); *Jones v. State*, 740 So.2d 520 (Fla. 1999).
[43] Id. See also Rule 3.210(a)(1), Fla.R.Crim.P.
[44] Id. See also s. 916.12, 916.3012, and 985.19, F.S.
[45] Rule 3.210, Fla.R.Crim.P.
[46] Id.
[47] Rule 3.212, Fla.R.Crim.P.
[48] Id.
[49] "Incompetent to proceed" means "the defendant does not have sufficient present ability to consult with her or his lawyer with a reasonable degree of rational understanding" or "the defendant has no rational, as well as factual, understanding of the proceedings against her or him." s. 916.12(1), F.S.

insanity may be involuntarily committed to state civil[50] and forensic[51] treatment facilities by the circuit court,[52] or in lieu of such commitment, may be released on conditional release[53] by the circuit court if the person is not serving a prison sentence.[54] Conditional release is release into the community accompanied by outpatient care and treatment. The committing court retains jurisdiction over the defendant while the defendant is under involuntary commitment or conditional release.[55]

Sections 916.13 and 916.15, F.S., set forth the criteria under which a court may involuntarily commit a defendant charged with a felony who has been adjudicated incompetent to proceed, or who has been found not guilty by reason of insanity. If a person is committed pursuant to either statute, the administrator at the commitment facility must submit a report to the court:

- No later than 6 months after a defendant's admission date and at the end of any period of extended commitment; or
- At any time the administrator has determined that the defendant has regained competency or no longer meets the criteria for involuntary commitment.[56]

State Treatment Facilities

State treatment facilities are the most restrictive settings for forensic services. DCF oversees two state-operated forensic facilities, Florida State Hospital[57] and North Florida Evaluation and Treatment Center,[58] and two privately-operated, maximum security forensic treatment facilities.[59] The forensic facilities provide assessment, evaluation, and treatment to the individuals who have mental health issues and who are involved with the criminal justice system.[60] In addition to general psychiatric treatment approaches and environment, specialized services include:

- Psychosocial rehabilitation;
- Education;
- Treatment modules such as competency, anger management, mental health awareness, medication and relapse prevention;
- Sexually transmitted disease education and prevention;
- Substance abuse awareness and prevention;
- Vocational training;
- Occupational therapies; and
- Full range of medical and dental services.[61]

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[50] A "civil facility" is: a mental health facility established within the Department of Children and Families (DCF) or by contract with DCF to serve individuals committed pursuant to chapter 394, F.S., and defendants pursuant to chapter 916, F.S., who do not require the security provided in a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting designated by the Agency for Persons with Disabilities (APD) to serve defendants who do not require the security provided in a forensic facility. Section 916.106(4), F.S. DCF oversees two state-operated forensic facilities, Florida State Hospital and North Florida Evaluation and Treatment Center, and two privately-operated, maximum security forensic treatment facilities, South Florida Evaluation and Treatment Center and Treasure Coast Treatment Center.

[51] A "forensic facility" is a separate and secure facility established within DCF or APD to service forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed pursuant to chapter 916, F.S., from non-forensic residents. Section 916.106(10), F.S.

[52] Sections 916.13, 916.15, and 916.302, F.S.

[53] Conditional release is release into the community accompanied by outpatient care and treatment. Section 916.17, F.S.

[54] Section 916.17(1), F.S.

[55] Section 916.16(1), F.S.

[56] Section 916.13(2), F.S.; section 916.15(3), F.S.

[57] Florida State Hospital has capacity for 959 individuals, of which 469 may receive forensic services. Up to an additional 245 individuals with forensic commitments (but do not require the security of a forensic setting) may occupy the hospital's civil beds. *See* Department of Children and Families, *Forensic Facilities*, https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-facilities.shtml (last visited Jan. 21, 2020).

[58] Id. The North Florida Evaluation and Treatment Center has 193 beds.

[59] Id. South Florida Evaluation and Treatment Center has a capacity to serve 238 individuals, and Treasure Coast Treatment Center has a contracted capacity of 208 beds.

[60] Florida Department of Children and Families, *About Adult Forensic Mental Health (AFMH)*, https://www.myflfamilies.com/service-programs/samh/adult-forensic-mental-health/forensic-facilities.shtml (last visited Jan. 21, 2020).

[61] Id.

In Fiscal Year 2014-2015, there were 1,573 forensic commitments.[62] This number was 1,587 and 1,680 in Fiscal Years 2015-2016 and 2016-2017, respectively.[63] The increasing number of forensic commitments has made it difficult for DCF to admit individuals to state forensic facilities within the statutorily mandated 15 days.[64] Between July 1, 2016 and June 30, 2017, it took an average of 10 days to admit forensic individuals into state mental health treatment facilities.[65]

Medical Information Sharing Between County Jails and DCF

Forensic clients committed to DCF's state mental health treatment facilities are transferred to the facilities directly from the county jails, and some may have medical conditions that require on-going or immediate medical treatment.[66] Current law requires jail physicians to provide a current psychotropic medication[67] order at the time a forensic client is transferred to the state mental health treatment facility or upon request of the admitting physician after the client is evaluated.[68] However, there is no statutory timeframe within which a jail physician must respond to a request by DCF for such information, nor is there any requirement for jail physicians to provide other medical information about individuals being transferred to DCF. While DCF currently requests medical information from the county jails when a commitment packet is received from the courts, there is no statutory time requirement within which DCF must make the request. According to DCF, lack of continuity of care and lack of information on the individual's medical status can result in life-threatening situations.[69]

Continuation of Psychotropic Medications

When forensic clients are restored to competency and released from state mental health treatment facilities, most are returned to the county jail of the committing jurisdiction to await resolution of their court cases. Some individuals are maintained by county jails on the same psychiatric medication regimen prescribed and administered at the state mental health treatment facility, while others individuals are not.

Continuation of a forensic client's psychotropic medication treatment upon transfer from a state mental health treatment facility to a county jail may prevent negative health outcomes, including loss of competency.[70] If an individual loses competency, then the jail must return him or her to a secure forensic facility, as he or she once again becomes unable to stand trial or proceed with resolution of his or her court case.[71]

DCF defines a recidivist as an individual who is recommended as competent to the court, returned to the jail from the forensic facility, and then readmitted to the forensic facility as incompetent to proceed on the same charge for which he or she was originally found competent.[72] Over the last three years, an average of 12% of those deemed competent to proceed were readmitted to the forensic facility.[73] DCF does not collect information on the reason for the recidivism, so DCF cannot identify how often such

[62] Department of Children and Families, *Exhibit D-3A, Expenditures by Issue and Appropriation Category, Budget Period 2019-2020*, p. 351.
[63] Id.
[64] Id. *See also* s. 916.107(1)(a), F.S.
[65] Id.
[66] Supra, note 40.
[67] Psychotropic medication is a broad term referring to medications that affect mental function, behavior, and experience; these medications include anxiolytic/hypnotic medications, such as benzodiazepines, antidepressant medications, such as selective serotonin reuptake inhibitors (SSRIs), and antipsychotic medications. Pamela L. Lindsey, *Psychotropic Medication Use among Older Adults: What All Nurses Need to Know*, J. Gerontol Nurs., (Sept. 2009), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3128509/ (last visited Jan. 21, 2020).
[68] S. 916.107(3)(a)2.a., F.S.
[69] Supra, note 66.
[70] Id.
[71] Id.
[72] Email from Lindsey Zander, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Recidivist Data, (Dec. 17, 2017) (on file with Children, Families, and Seniors Subcommittee staff).
[73] Email from John Paul Fiore, Legislative Specialist, Department of Children and Families, RE: HB 1071 and 1081 Information, (Jan. 21, 2020) (on file with Children, Families, and Seniors Subcommittee staff).

recidivism is caused by the jail's failure to maintain the forensic client's psychotropic medication as determined by the state mental health treatment facility.

Purple Ribbon Task Force

Chapter 2012-172, Laws of Florida, created the Purple Ribbon Task Force. The task force was composed of 18 members with 6 members appointed by the Governor, 6 members appointed by the Speaker of the House of Representatives, and 6 members appointed by the President of the Senate.[74]

The law required the task force to conduct an interim study regarding Alzheimer's disease in the state.[75] This study required the task force to:[76]

- Assess the current and future impact of Alzheimer's disease on the state;
- Examine existing industries, services, and resources that address the needs of persons with Alzheimer's disease;
- Develop a strategy to mobilize a state response to Alzheimer's disease; and
- Gather information on state trends and policy regarding Alzheimer's disease.

Additionally, the law required the task force to submit a report in the form of an Alzheimer's disease state plan.[77] The 2013 completed report by the task force is the State Plan on Alzheimer's Disease and Related Forms of Dementia.[78] The state report included the task force's findings and recommendations. Upon submission of this report, pursuant to law, the Purple Ribbon Task Force terminated.

Included in the task force's recommendations was to exclude dementia, Alzheimer's disease, and traumatic brain injury (TBI) from the definition of mental illness, none of which are mental illnesses.[79] This recommendation was made to keep such individuals from experiencing negative, life-impacting changes associated with being removed suddenly from a stable environment.[80]

Effect of the Bill

Definition of Mental Illness

The bill amends s. 394.455(28), F.S., and s. 916.106(14), F.S., to exclude dementia and traumatic brain injury from the definition of "mental illness."

This aligns the definition of "mental illness" with the current provision in s. 394.467(6)(b), F.S., which prohibits individuals with dementia or TBI who lack a co-occurring mental illness from being involuntarily admitted to a state mental health treatment facility. Additionally, this will also reduce the number of individuals with dementia or TBI who lack a co-occurring mental illness that are being inappropriately admitted for involuntary examination at Baker Act receiving facilities. However, the revisions will not prohibit an individual who has dementia or TBI with a co-occurring mental illness who is experiencing a mental health crisis from being admitted to a Baker Act receiving facility for involuntary examination.

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[74] Ch. 2012-172, Laws of Fla.
[75] Id.
[76] Id.
[77] Id.
[78] Florida Department of Elder Affairs, *Purple Ribbon Task Force State Plan on Alzheimer 's disease and Related Forms of Dementia*, https://www.alz.org/media/Documents/florida-state-plan-august-2013.pdf (last visited Jan. 21, 2020).
[79] Id.
[80] Id.

Licensure Requirements for Substance Abuse Service Providers

The bill allows the following types of entities to contract with DCF and MEs without needing DCF licensure:

- A hospital or hospital-based component;
- A nursing home facility;
- An allopathic or osteopathic physician or physician assistant;
- A psychologist;
- A social worker;
- A marriage and family therapist;
- A mental health counselor; and
- A crisis stabilization unit.

This will expand the number of organizations with which DCF and MEs could contract to improve access to services for individuals with substance use disorders. Maintaining the exemption for these organizations will also remove the impediment to organizations of needing to be licensed by two different agencies.

The bill also exempts an inmate substance abuse program under the Department of Corrections from the accreditation requirements for licensure under the substance abuse chapter. While still subject to licensure, these programs are exempt from certain licensure requirements, such as background screening requirements for substance abuse provider personnel.[81]

Day-or-Night Treatment Facilities

The bill repeals s. 397.311(26)(a)3., F.S., which removes day or night treatment with community housing (DNTCH) as one of the licensable service components of clinical treatment services under ch. 397, F.S. The treatment services of this component will continue to be regulated through the existing licensable component day or night treatment. In addition, the housing component of this service meets the statutory definition for a recovery residence under s. 397.311(37), F.S.
Current providers of DNTCH would be provided with the following options:

- If they choose to continue to not provide any services in the housing portion, they may change their license to a day or night treatment license pursuant to s. 397.311(26)(a)2., F.S., and treat the housing as a recovery residence; or
- Change their DNTCH license to a day or night treatment license pursuant to s. 397.311(26)(a)2., F.S., and choose to turn the housing portion into residential treatment and obtain such a license.

Psychotropic Medication Treatment

The bill requires the treating physician to consult with the jail physician on the jail's drug formulary and consider prescribing the same psychotropic medications included in the jail's drug formulary. The bill requires county jails to administer the same psychotropic medications to a defendant as prescribed by the treating physician upon discharge by a mental health treatment facility, unless the jail physician determines there is a compelling medical reason to change or discontinue the medication for the health and safety of the defendant. If the jail physician changes or discontinues the medication and the defendant is later determined to be incompetent to stand trial and is recommitted to DCF, the bill requires the jail physician to refrain from changing or discontinuing the defendant's prescribed psychotropic medication upon the next discharge from a treatment facility.

The bill also requires county jails to send all medical information for individuals in their custody who will be admitted to state mental health treatment facilities. The bill requires DCF to request this information immediately upon receipt of a completed commitment packet which is provided by the court. Upon

[81] Ss. 397.4073(a)1 and (e), F.S.

receipt of such a request, the county jail must provide the requested information within 3 business days or at the time the defendant enters the physical custody of DCF, whichever is earlier. This proposed change will provide staff at the state mental health treatment facility the required information to provide continued or necessary medical care and treatment.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 3: Amends s. 397.311, F.S., relating to definitions.
Section 4: Amends s. 397.4012, F.S., relating to exemptions from licensure.
Section 5: Amends s. 916.106, F.S., relating to definitions.
Section 6: Amends s. 916.13, F.S., relating to involuntary commitment of defendant adjudicated incompetent.
Section 7: Amends s. 916.15, F.S., relating to involuntary commitment of defendant adjudicated not guilty by reason of insanity.
Section 8: Provides an effective date of July 1, 2020.

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:

   The bill may have an indeterminate, but likely insignificant, negative fiscal impact on county jails that are required to administer specific psychotropic medications that would not have otherwise been administered. The number of instances in which this occurs is unknown.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Providers of day or night treatment with community housing may experience both negative and positive economic impacts depending on the ability to transition operations to a different licensure category, or by establishing the community housing as a recovery residence. The number of providers who elect to make these changes is unknown.

There may be an increase of available behavioral health service providers, as the bill permits certain existing licensures to obtain DCF licensure. An increase of providers will expand the costs upon a fixed, available revenue for these services.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   The county/municipality mandates provision of Art. VII, section 18, of the Florida Constitution may apply because this bill may require county jails to spend funds to continue psychotropic medications under limited conditions; however, an exemption applies because the bill amends criminal procedures and may have an insignificant fiscal impact.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to substance abuse and mental health;
3 amending s. 394.455, F.S.; revising the definition of
4 the term "mental illness" to exclude conditions
5 manifested by dementia or traumatic brain injury;
6 amending s. 394.9085, F.S.; conforming a cross-
7 reference; amending s. 397.311, F.S.; revising
8 definitions; amending s. 397.4012, F.S.; revising
9 entities that are exempt from certain licensing
10 requirements; amending s. 916.106, F.S.; revising the
11 definition of the term "mental illness;" amending ss.
12 916.13 and 916.15, F.S.; authorizing jails to share
13 medical information pertaining to specified defendants
14 to the Department of Children and Families; requiring
15 the maintenance of psychotropic medications to
16 specified defendants under certain circumstances;
17 providing an exception; providing an effective date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Subsection (28) of section 394.455, Florida
22 Statutes, is amended to read:
23 394.455 Definitions.—As used in this part, the term:
24 (28) "Mental illness" means an impairment of the mental or
25 emotional processes that exercise conscious control of one's

26 actions or of the ability to perceive or understand reality,
27 which impairment substantially interferes with the person's
28 ability to meet the ordinary demands of living. For the purposes
29 of this part, the term does not include a developmental
30 disability as defined in chapter 393, intoxication, or
31 conditions manifested only by dementia, traumatic brain injury,
32 antisocial behavior, or substance abuse.
33 Section 2. Subsection (6) of section 394.9085, Florida
34 Statutes, is amended to read:
35 394.9085 Behavioral provider liability.—
36 (6) For purposes of this section, the terms
37 "detoxification services," "addictions receiving facility," and
38 "receiving facility" have the same meanings as those provided in
39 ss. 397.311(26)(a)3. ~~ss. 397.311(26)(a)4.~~, 397.311(26)(a)1., and
40 394.455(39), respectively.
41 Section 3. Paragraph (a) of subsection (26) of section
42 397.311, Florida Statutes, is amended to read:
43 397.311 Definitions.—As used in this chapter, except part
44 VIII, the term:
45 (26) Licensed service components include a comprehensive
46 continuum of accessible and quality substance abuse prevention,
47 intervention, and clinical treatment services, including the
48 following services:
49 (a) "Clinical treatment" means a professionally directed,
50 deliberate, and planned regimen of services and interventions

51 that are designed to reduce or eliminate the misuse of drugs and
52 alcohol and promote a healthy, drug-free lifestyle. As defined
53 by rule, "clinical treatment services" include, but are not
54 limited to, the following licensable service components:
55 1. "Addictions receiving facility" is a secure, acute care
56 facility that provides, at a minimum, detoxification and
57 stabilization services; is operated 24 hours per day, 7 days per
58 week; and is designated by the department to serve individuals
59 found to be substance use impaired as described in s. 397.675
60 who meet the placement criteria for this component.
61 2. "Day or night treatment" is a service provided in a
62 nonresidential environment, with a structured schedule of
63 treatment and rehabilitative services.
64 ~~3. "Day or night treatment with community housing" means a~~
65 ~~program intended for individuals who can benefit from living~~
66 ~~independently in peer community housing while participating in~~
67 ~~treatment services for a minimum of 5 hours a day for a minimum~~
68 ~~of 25 hours per week.~~
69 <u>3.</u>~~4.~~ "Detoxification" is a service involving subacute care
70 that is provided on an inpatient or an outpatient basis to
71 assist individuals to withdraw from the physiological and
72 psychological effects of substance abuse and who meet the
73 placement criteria for this component.
74 <u>4.</u>~~5.~~ "Intensive inpatient treatment" includes a planned
75 regimen of evaluation, observation, medical monitoring, and

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

76 clinical protocols delivered through an interdisciplinary team
77 approach provided 24 hours per day, 7 days per week, in a highly
78 structured, live-in environment.
79 5.~~6.~~ "Intensive outpatient treatment" is a service that
80 provides individual or group counseling in a more structured
81 environment, is of higher intensity and duration than outpatient
82 treatment, and is provided to individuals who meet the placement
83 criteria for this component.
84 6.~~7.~~ "Medication-assisted treatment for opioid use
85 disorders ~~opiate addiction~~" is a service that uses methadone or
86 other medication as authorized by state and federal law, in
87 combination with medical, rehabilitative, supportive, and
88 counseling services in the treatment of individuals who are
89 dependent on opioid drugs.
90 7.~~8.~~ "Outpatient treatment" is a service that provides
91 individual, group, or family counseling by appointment during
92 scheduled operating hours for individuals who meet the placement
93 criteria for this component.
94 8.~~9.~~ "Residential treatment" is a service provided in a
95 structured live-in environment within a nonhospital setting on a
96 24-hours-per-day, 7-days-per-week basis, and is intended for
97 individuals who meet the placement criteria for this component.
98 Section 4. Section 397.4012, Florida Statutes, is amended
99 to read:
100 397.4012 Exemptions from licensure.—The following are

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

101 exempt from the licensing provisions of this chapter:
102 (1) A hospital or hospital-based component licensed under
103 chapter 395.
104 (2) A nursing home facility as defined in s. 400.021.
105 (3) A substance abuse education program established
106 pursuant to s. 1003.42.
107 (4) A facility or institution operated by the Federal
108 Government.
109 (5) A physician or physician assistant licensed under
110 chapter 458 or chapter 459.
111 (6) A psychologist licensed under chapter 490.
112 (7) A social worker, marriage and family therapist, or
113 mental health counselor licensed under chapter 491.
114 (8) A legally cognizable church or nonprofit religious
115 organization or denomination providing substance abuse services,
116 including prevention services, which are solely religious,
117 spiritual, or ecclesiastical in nature. A church or nonprofit
118 religious organization or denomination providing any of the
119 licensed service components itemized under s. 397.311(26) is not
120 exempt from substance abuse licensure but retains its exemption
121 with respect to all services which are solely religious,
122 spiritual, or ecclesiastical in nature.
123 (9) Facilities licensed under chapter 393 which, in
124 addition to providing services to persons with developmental
125 disabilities, also provide services to persons developmentally

126 at risk as a consequence of exposure to alcohol or other legal
127 or illegal drugs while in utero.
128 (10) DUI education and screening services provided
129 pursuant to ss. 316.192, 316.193, 322.095, 322.271, and 322.291.
130 Persons or entities providing treatment services must be
131 licensed under this chapter unless exempted from licensing as
132 provided in this section.
133 (11) A facility licensed under s. 394.875 as a crisis
134 stabilization unit.
135
136 The exemptions from licensure in subsections (3), (4), (8), (9),
137 and (10) ~~this section~~ do not apply to any service provider that
138 receives an appropriation, grant, or contract from the state to
139 operate as a service provider as defined in this chapter or to
140 any substance abuse program regulated under ~~pursuant to~~ s.
141 397.4014. Furthermore, this chapter may not be construed to
142 limit the practice of a physician or physician assistant
143 licensed under chapter 458 or chapter 459, a psychologist
144 licensed under chapter 490, a psychotherapist licensed under
145 chapter 491, or an advanced practice registered nurse licensed
146 under part I of chapter 464, who provides substance abuse
147 treatment, so long as the physician, physician assistant,
148 psychologist, psychotherapist, or advanced practice registered
149 nurse does not represent to the public that he or she is a
150 licensed service provider and does not provide services to

151 individuals under ~~pursuant to~~ part V of this chapter. Failure to
152 comply with any requirement necessary to maintain an exempt
153 status under this section is a misdemeanor of the first degree,
154 punishable as provided in s. 775.082 or s. 775.083.
155 Section 5. Subsection (14) of section 916.106, Florida
156 Statutes, is amended to read:
157 916.106 Definitions.—For the purposes of this chapter, the
158 term:
159 (14) "Mental illness" means an impairment of the emotional
160 processes that exercise conscious control of one's actions, or
161 of the ability to perceive or understand reality, which
162 impairment substantially interferes with the defendant's ability
163 to meet the ordinary demands of living. For the purposes of this
164 chapter, the term does not apply to defendants who have only an
165 intellectual disability or autism or a defendant with traumatic
166 brain injury or dementia who lacks a co-occurring mental
167 illness, and does not include intoxication or conditions
168 manifested only by antisocial behavior or substance abuse
169 impairment.
170 Section 6. Subsection (2) of section 916.13, Florida
171 Statutes, is amended to read:
172 916.13 Involuntary commitment of defendant adjudicated
173 incompetent.—
174 (2) A defendant who has been charged with a felony and who
175 has been adjudicated incompetent to proceed due to mental

176 illness, and who meets the criteria for involuntary commitment
177 under this chapter, may be committed to the department, and the
178 department shall retain and treat the defendant.
179 (a) Immediately after receipt of a completed copy of the
180 court commitment order containing all documentation required by
181 the applicable Florida Rules of Criminal Procedure, the
182 department shall request all medical information relating to the
183 defendant from the jail. The jail shall provide the department
184 with all medical information relating to the defendant within 3
185 business days after receipt of the department's request or at
186 the time the defendant enters the physical custody of the
187 department, whichever is earlier.
188 (b)1. To ensure continuity of care when a defendant
189 returns to jail, the facility physician shall consult with the
190 jail physician regarding the jail's drug formulary and consider
191 prescribing medication included in the jail's drug formulary
192 when the facility physician prescribes psychotropic medications
193 to the defendant.
194 2. Each defendant returning to a jail shall continue to
195 receive the same psychotropic medications as prescribed by the
196 facility physician at the time of discharge from a forensic or
197 civil facility, unless the jail physician determines there is a
198 compelling medical reason to change or discontinue the
199 medication. If the jail physician changes or discontinues the
200 medication and the defendant is later determined at the

201 competency hearing to be incompetent to stand trial and is
202 recommitted to the department, the jail physician may not change
203 or discontinue the defendant's prescribed psychotropic
204 medication upon the defendant's next discharge from the forensic
205 or civil facility.
206 (c) ~~(a)~~ Within 6 months after the date of admission and at
207 the end of any period of extended commitment, or at any time the
208 administrator or designee determines that the defendant has
209 regained competency to proceed or no longer meets the criteria
210 for continued commitment, the administrator or designee shall
211 file a report with the court pursuant to the applicable Florida
212 Rules of Criminal Procedure.
213 (d) ~~(b)~~ A competency hearing shall be held within 30 days
214 after the court receives notification that the defendant is
215 competent to proceed or no longer meets the criteria for
216 continued commitment. The defendant must be transported to the
217 committing court's jurisdiction for the hearing.
218 Section 7. Subsection (3) of section 916.15, Florida
219 Statutes, is amended to read:
220 916.15 Involuntary commitment of defendant adjudicated not
221 guilty by reason of insanity.—
222 (3)(a) Every defendant acquitted of criminal charges by
223 reason of insanity and found to meet the criteria for
224 involuntary commitment may be committed and treated in
225 accordance with the provisions of this section and the

226 applicable Florida Rules of Criminal Procedure.
227 (b) Immediately after receipt of a completed copy of the
228 court commitment order containing all documentation required by
229 the applicable Florida Rules of Criminal Procedure, the
230 department shall request all medical information relating to the
231 defendant from the jail. The jail shall provide the department
232 with all medical information relating to the defendant within 3
233 business days after receipt of the department's request or at
234 the time the defendant enters the physical custody of the
235 department, whichever is earlier.
236 (c)1. The department shall admit a defendant so
237 adjudicated to an appropriate facility or program for treatment
238 and shall retain and treat such defendant. To ensure continuity
239 of care when a defendant returns to jail, the facility physician
240 shall consult with the jail physician regarding the jail's drug
241 formulary and consider prescribing medication included in the
242 jail's drug formulary when the facility physician prescribes
243 psychotropic medications to the defendant.
244 2. Each defendant returning to a jail shall continue to
245 receive the same psychotropic medications as prescribed by the
246 facility physician at the time of discharge from a forensic or
247 civil facility, unless the jail physician determines there is a
248 compelling medical reason to change or discontinue the
249 medication. If the jail physician changes or discontinues the
250 medication and the defendant is later determined at the

251 competency hearing to be incompetent to stand trial and is
252 recommitted to the department, the jail physician may not change
253 or discontinue the defendant's prescribed psychotropic
254 medication upon the defendant's next discharge from the forensic
255 or civil facility.
256 (d) No later than 6 months after the date of admission,
257 before ~~prior to~~ the end of any period of extended commitment, or
258 at any time the administrator or designee determines ~~shall have~~
259 ~~determined~~ that the defendant no longer meets the criteria for
260 continued commitment placement, the administrator or designee
261 shall file a report with the court pursuant to the applicable
262 Florida Rules of Criminal Procedure.
263 Section 8. This act shall take effect July 1, 2020.

CS/HB 1143

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1143 Department of Health
SPONSOR(S): Health Quality Subcommittee, Gregory
TIED BILLS: HB 1269 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	11 Y, 0 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

CS/HB 1143 makes numerous changes to health care professions regulated by Medical Quality Assurance within the Department of Health (DOH).

The Interstate Medical Licensure Compact (IMLC) is a multi-state agreement that creates an expedited path to licensure by setting qualifications for licensure and outlining a process for physicians to apply and receive licenses in states where they are not currently licensed. The IMLC is not a mutual recognition agreement. A physician must obtain a license from each state in which the physician plans to practice. Twenty-nine states, the District of Columbia, and the Territory of Guam have adopted the IMLC. The bill authorizes Florida to enter into the IMLC.

The bill allows a physician who is licensed through the IMLC and whose license is suspended or revoked through the IMLC as a result of disciplinary action taken against the physician's license in another state, to have a formal hearing before the Florida Division of Administrative Hearings (DOAH).

The IMLC Commission oversees the operations of the IMLC, and is responsible for, among other things, adopting rules, issuing advisory opinions, and enforcing compliance. Each member state designates two individuals to serve as commissioners. The bill requires the Florida-appointed IMLC commissioners to ensure the commission complies with the state's laws on public records and open meetings.

The Florida Center for Nursing (Center) examines the supply and demand of nurses in the state, including issues of recruitment, retention, and utilization of nurse workforce resources. A 16-member board of directors oversees the work of the Center and implements its major functions. The bill revises the requirements for appointment to the Florida Center for Nursing Board of Directors.

DOH has the authority to certify master social workers. However, there is no statutory definition of the scope of practice for a certified master social worker. The bill establishes a scope of practice for the certified master social worker and aligns the application process with the process used for other licensed mental health professionals.

The bill also authorizes the Board of Clinical Social Work, Marriage and Family Therapists, and Mental Health Counseling to approve a one-time exception to the 60-month limit on an internship registration and revises the licensure requirements for Licensed Clinical Social Workers, Marriage and Family Therapists, and Licensed Mental Health Counselors.

The bill has various positive and negative fiscal impacts on the DOH, which can be absorbed with existing resources. Additionally, there may be an indeterminate, negative fiscal impact on the DOAH. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Physician Licensure in Florida

The regulation of the practices of medicine and osteopathic medicine falls under chapters 458 and 459, F.S., respectively. The practice acts for both professions establish the regulatory boards, a variety of licenses, the application process with eligibility requirements, and financial responsibilities for the practicing physicians. The boards have the authority to establish, by rule, standards of practice and standards of care for particular settings.[1] Such standards may include education and training, medication including anesthetics, assistance of and delegation to other personnel, sterilization, performance of complex or multiple procedures, records, informed consent, and policy and procedures manuals.[2]

Licensure by Examination

The general requirements for licensure under both practice acts are very similar with the obvious differences found in the educational backgrounds of the applicants. Where the practice acts share the most similarities are the qualifications for licensure. Both the Board of Medicine and the Board of Osteopathic Medicine require their respective applicants to meet these minimum qualifications:[3]

- Complete an application form as designated by the appropriate regulatory board.
- Be at least 21 years of age.
- Be of good moral character.
- Have completed at least two years (medical) or three years (osteopathic) of pre-professional post-secondary education.
- Have not previously committed any act that would constitute a violation of this chapter or lead to regulatory discipline.
- Have not had an application for a license to practice medicine or osteopathic medicine denied or a license revoked, suspended or otherwise acted upon in another jurisdiction by another licensing authority.
- Must submit a set of fingerprints to DOH for a criminal background check.
- Demonstrate that he or she is a graduate of a medical college recognized and approved by the applicant's respective professional association.
- Demonstrate that she or he has successfully completed a resident internship (osteopathic medicine) or supervised clinical training (medical) of not less than 12 months in a hospital approved for this purpose by the applicant's respective professional association.
- Demonstrate that he or she has obtained a passing score, as established by the applicant's appropriate regulatory board, on all parts of the designated professional examination conducted by the regulatory board's approved medical examiners no more than five years before making application to this state; or, if holding a valid active license in another state, that the initial licensure in the other state occurred no more than five years after the applicant obtained a passing score on the required examination.

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[1] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[2] Id.
[3] Sections 458.311 and 459.0055, F.S.

The current licensure application fee for a medical doctor is $350 and is non-refundable.[4] Applications must be completed within one year. If a license is approved, the initial license fee is $355. The entire process may take from two to six months from the time the application is received.[5]

For osteopathic physicians, the current application fee is non-refundable $200, and if approved, the initial licensure fee is $305.[6] The same application validity provision of one year applies and the processing time of two to six months is the range of time that applicants should anticipate for a decision.[7]

Licensure by Endorsement

In Florida, to practice medicine an individual must become a licensed medical doctor through licensure by examination[8] or licensure by endorsement.[9] Florida does not recognize another state's medical license or provide licensure reciprocity.[10] To qualify for licensure by endorsement a physician must:[11]

- Meet one of the following education and training requirements:
  - Be a graduate of an allopathic U.S. medical school recognized and approved by the U.S. Office of Education and completed at least one year of residency training;
  - Be a graduate of an allopathic international medical school and have a valid Educational Commission for Foreign Medical Graduates (ECFMG) certificate and completed an approved residency of at least two years in one specialty area; or
  - Be a graduate who has completed the formal requirements of an international medical school except the internship or social service requirements, passed parts I and II of the National Board of Medical Examiners (NBME) or ECFMG equivalent examination, and completed an academic year of supervised clinical training (5th pathway) and completed an approved residency of at least two years in one specialty area.
- Have passed all parts of a national examination (the NBME; the Federation Licensing Examination offered by the Federation of State Medical Boards of the United States, Inc.; or the United States Medical Licensing Exam); and
- Have actively practiced medicine in another jurisdiction for at least two of the immediately preceding four years; or passed a board-approved clinical competency examination within the year preceding filing of the application or; successfully completed a board approved postgraduate training program within two years preceding filing of the application.

There is no specific statutory authority for osteopathic medicine licensure by endorsement. However, if an applicant is licensed in another state, the applicant may request that Florida "endorse" those exam scores and demonstrate that the license was issued based on those exam scores. The applicant must also show that the exam was substantially similar to any exam that Florida allows for licensure.[12]

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[4] Florida Board of Medicine, *Medical Doctor - Fees,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (Last visited January 31, 2020).
[5] Florida Board of Medicine, *Medical Doctor Unrestricted – Process,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 31, 2020).
[6] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Fees,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 31, 2020).
[7] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure - Process,* available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited January 31, 2020)
[8] Section 458.311, F.S.
[9] Section 458.313, F.S.
[10] Notwithstanding this lack of reciprocity, physicians and other health care practitioners licensed out-of-state who meet certain requirements may register with DOH under s. 456.47(4), F.S., and provide services to patients within Florida via telehealth.
[11] Section 458.313 F.S. *See also* Florida Board of Medicine, *Medical Doctor-Unrestricted; Licensure by Endorsement,* available at https://flboardofmedicine.gov/licensing/medical-doctor-unrestricted/ (last visited January 31, 2020).
[12] Florida Board of Osteopathic Medicine, *Osteopathic Medicine Full Licensure – Requirements*, available at https://floridasosteopathicmedicine.gov/licensing/osteopathic-medicine-full-licensure/ (last visited January 31, 2020).

Financial Responsibility

Florida-licensed allopathic and osteopathic physicians are required to maintain professional liability insurance or other financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.[13] Physicians who perform surgeries in a certain setting or have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim.[14] Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim.[15] Certain physicians who are exempted from the requirement to carry professional liability insurance or other financial responsibility must provide notice to their patients.[16] With specified exceptions, DOH must suspend, on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.[17]

Licensure Discipline

Chapter 456, F.S., contains the general regulatory provisions for health care professions and occupations under the Division of Medical Quality Assurance (MQA) in DOH. Section 456.072, F.S., specifies acts that constitute grounds for which disciplinary actions may be taken against a health care practitioner. Section 458.331, F.S., identifies acts that constitute grounds for which disciplinary actions may be taken against an allopathic physician and s. 459.015, F.S., identifies acts specific to an osteopathic physician. Some portions of the licensure discipline process are public and some are confidential.[18]

MQA reviews complaints against licensees to determine if the complaint is legally sufficient.[19] A determination of legal sufficiency is made if the ultimate facts show that a violation has occurred.[20] The complaint is forwarded for investigation if it is found to be legally sufficient. MQA notifies the complainant by letter to advise whether the complaint will be investigated, additional information is needed, or the complaint is being closed because it is not legally sufficient.[21] Complaints that involve an immediate threat to public safety are given the highest priority.

A probable cause panel of the appropriate board reviews all evidence and information gathered during the investigation and determine whether the case should be escalated to a formal administrative complaint, closed with a letter of guidance, or dismissed.[22] If a formal administrative complaint is filed, the case may be heard before an administrative law judge (ALJ) if it involves disputed issues of material fact and the ALJ will issue a recommended order.[23] The issue of whether a licensee has violated the laws and rules regulating the profession, including determining the reasonable standard of

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[13] Section 458.320, F.S.
[14] Section 458.320(2), F.S.
[15] Section 458.320(1), F.S.
[16] Section 458.320(5)(f) and (g), F.S.
[17] Sections 458.320(8) and 459.0085(9), F.S.
[18] Fla. Department of Health, Division of Medical Quality Assurance, *Enforcement Process,* (last rev. Nov. 2019), available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/_documents/enforcement-process-chart.pdf (last visited January 31, 2020).
[19] Section 456.073, F.S.
[20] Fla. Department of Health, *Consumer Services – Administrative Complaint Process,* available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/consumer-services.html (last visited January 31, 2020).
[21] Id.
[22] Fla. Department of Health, Medical Quality Assurance, *A Quick Guide to the MQA Disciplinary Process Probable Cause Panels*, available at http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process.pdf (last visited January 31, 2020).
[23] Section 456.073(5), F.S.

care, is a conclusion of law determined by the board.[24] The appropriate board will issue a final order in each disciplinary case.[25]

Authorization for the discipline of allopathic and osteopathic physicians can be found in state law and administrative rule.[26] If held liable for one of the offenses, the fines and sanctions by category and by offense are based on whether it is the physician's first, second, or third offense.[27] The boards may issue a written notice of noncompliance for the first occurrence of a single minor violation.[28] The amount of fines assessed can vary depending on the severity of the situation, such as improper use of a substance to concealment of a material fact. A penalty may come in the form of a reprimand, a licensure suspension, or revocation followed by some designated period of probation if there is an opportunity for licensure reinstatement. Other sanctions may include supplemental continuing education requirements and require proof of completion before the license can be reinstated.

Interstate Compacts

An interstate compact is an agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[29] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other. Case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[30] There are currently more than 200 compacts between the states, including 50 national compacts of which six are for health professions.[31,32]

Interstate Medical Licensure Compact

In 2013-2014, a group of state medical board executives, administrators, and attorneys created the model language of Interstate Medical Licensure Compact (IMLC).[33] The IMLC creates an expedited path to licensure by setting qualifications for licensure and outlining a process for physicians to apply and receive licenses in states where they are not currently licensed.[34] Twenty-nine states, the District of Columbia, and the Territory of Guam have adopted the IMLC.[35]

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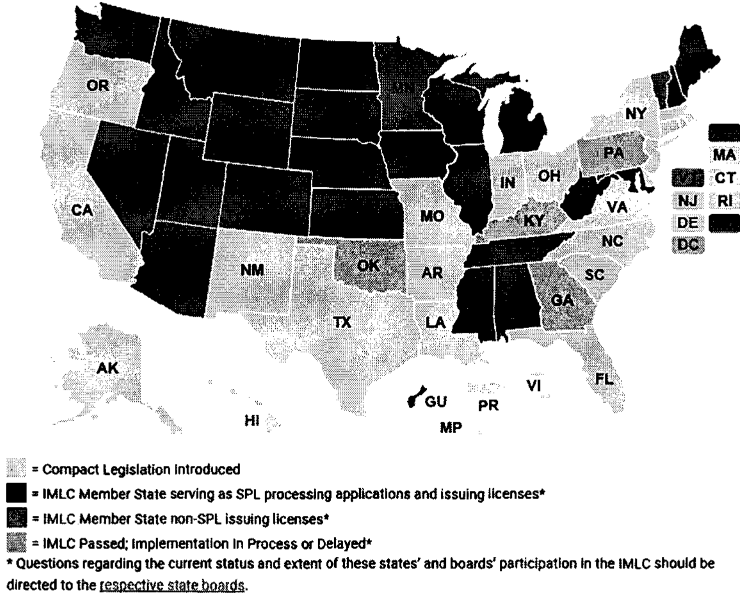
[24] Id.
[25] Section 456.073(6), F.S.
[26] *See* ss. 458.307 and 459.004, F.S., for the regulatory boards, and rules 64B8-8 and 64B15-19, F.A.C., for administrative rules relating to disciplinary procedures.
[27] Id.
[28] Rules 64B8-8.011 and 64B15-19.0065, F.A.C. A minor violation is deemed to not endanger the public health, safety, and welfare and does not demonstrate a serious inability to practice.
[29] Council of State Governments, Capitol Research, *Special Edition – Interstate Compacts*, available at http://knowledgecenter.csg.org/kc/content/interstate-compacts-background-and-history (last visited January 31, 2020).
[30] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[31] Ann O'M. Bowman and Neal D. Woods, *Why States Join Interstate Compacts,* The Council of State Governments (March 2017) p. 19 and 20, available at http://knowledgecenter.csg.org/kc/system/files/Bowman%202017.pdf, (last visited January 31, 2020).
[32] Federal Trade Commission, *Policy Perspectives: Options to Enhance Occupational License Portability* (September 2018), p. 9, available at https://www.ftc.gov/system/files/documents/reports/options-enhance-occupational-license-portability/license_portability_policy_paper.pdf (last visited January 31, 2020). The six health professions are nurses, medical, emergency medical services, physical therapy, psychology, and advanced registered nurse practitioners. The only two compacts currently operational are the Enhanced Nurse Compact and the physicians compacts as the others are awaiting the completion of an administrative structure.
[33] Interstate Medical Licensure Compact, *The Interstate Medical Licensure Compact: Frequently Asked Questions*, available at https://imlcc.org/faqs/ (last visited January 31, 2020).
[34] Id.
[35] Interstate Medical Licensure Compact, *The IMLC*, available at https://imlcc.org/ (last visited January 31, 2020).



The model language of the IMLC provides the framework under which party states must operate. The Compact has 24 sections that establish the Compact's administration and components and prescribe how the Interstate Medical Licensure Compact Commission will oversee the Compact and conduct its business. The table below describes, by Compact section, the components of the Compact.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
1	Purpose *Establishes prevailing standard of care*	The purpose of the Interstate Medical Licensure Compact (Compact) is to provide a streamlined, comprehensive process that allows physicians to become licensed in multiple states. It allows physicians to become licensed without changing a state's Medical Practice Act(s). The Compact adopts the prevailing standard of care based on where the patient is located at the time of the patient-provider encounter. Jurisdiction for disciplinary action or any other adverse actions against a physician's license is retained in the jurisdiction where the license is issued to the physician.
2	Definitions *Establishes standard definitions for operation of the Compact and the Commission.*	Definitions are provided for: - Bylaws: means those Bylaws established by the Commission pursuant to Section 11 for governance, direction, and control of its action and conduct. - Commissioner: means the voting representative appointed by each member board pursuant to Section 11 whereby each member state appoints two members to the Commission. If the member state has two medical boards, the two representatives should entry between the two boards. - Conviction: means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the offender. A conviction also means evidence of an entry of a conviction of a criminal offense by the court shall be considered final for the purposes of disciplinary action by a member board. - Expedited license: means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the Compact.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		- Interstate Commission: means the interstate commission created pursuant to Section 11. - License: means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization. - Medical Practice Act: means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state. (In Florida, the Medical Practice Act for allopathic medicine is under ch. 458, F.S., and for osteopathic medicine, under ch. 459, F.S.) - Member Board: means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government. (The Florida Board of Medicine and the Florida Board of Osteopathic Medicine are responsible for the licensure, regulation, and education of physicians in Florida.) - Member State: means a state that has enacted the Compact. - Practice of medicine: means the diagnosis, treatment, prevention, cure, or relieving of a human disease, ailment, defect, complaint, or other physical, or mental condition, by attendance, advise, device, diagnostic test, or other means, or offering, undertaking, attempting to do, or holding oneself out as able to do, any of these acts. - Physician means: any persons who is a graduate of medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent; passed each component of the USMLE or the COMPLEX-USA within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes; successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association; holds specialty certification or time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Board of Osteopathic Specialties; however, the times unlimited specialty certificate does not have to be maintained once the physician is initially determined through the expedited Compact process; possess a full and unrestricted license to engage in the practice of medicine issued by a member board; has never been convicted received adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction; has never held a license authorizing the practice of medicine subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license; has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		jurisdiction. - Offense means: A felony, high court misdemeanor, or crime of moral turpitude. - Rule means: A written statement by the Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Commission, and has the force and effect of statutory law in a member state, if the rule is not inconsistent with the laws of the member state. The term includes the amendment, repeal, or suspension of an existing rule. - State means: Any state, commonwealth, district, or territory of the United States. - State of Principal License means: A member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.
3	Eligibility *Provides minimum requirements to receive an expedited license*	To be eligible to participate and receive an expedited license, a physician must meet the requirements of Section 2 (definition of physician). A physician who does not meet the requirements of Section 2 may obtain a license to practice medicine in a member state outside of the Compact if the individual complies with all of the laws and requirements to practice medicine in that state.
4	State of Principal License (SPL) *Defines a SPL*	The Compact requires participating physicians to designate a State of Principal License (SPL) for purposes of registration for expedited licensure if the physician possesses a full and unrestricted license to practice medicine in that state. The SPL must be a state where: - The physician has his/her primary residence, or - The physician has at least 25 percent of his/her practice, or - The state where the physician's employer is located. If no state qualifies for one of the above options, then the state of residence as designated on the physician's federal income taxes is the SPL. A SPL may be re-designated at any time as long as the physician possesses a full and unrestricted license to practice medicine in that state. The Commission is authorized to develop rules to facilitate the re-designation process.
5	Application and Issuance of Expedited Licensure *Qualifications*	Section 5 of the Compact establishes the process for the issuance of the expedited license. A physician must file an application with the member of the state selected as the SPL. The SPL will evaluate the application to determine whether the physician is eligible for the expedited licensure process and issue a letter of qualification, either verifying or denying eligibility, to the Commission. - Static Qualifications: Include verification of medical education, graduate medical education, results of any medical or licensing examinations and any other qualifications set by the Commission through rule.

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
		- Performance of Criminal Background Checks by the member board through FBI, with the exception of federal employees who have suitability determined in accordance with U.S. 5 CFR section 731.202. - Appeals on eligibility determinations are handled through the member state. - Upon completion of eligibility verification process with member state, applicants suitable for an expedited license are directed to complete the registration process with the Commission, including the payment of any fees. - After receipt of registration and payment of fees, the physician receives his/her expedited license. The license authorizes the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state. - An expedited license must be valid for a period consistent with the member state licensure period and in the same manner as required for other physicians holding a full and unrestricted license. - An expedited license obtained through the Compact must be terminated if a physician fails to monitor a license in the SPL for a non-disciplinary reason, without re-designation of a new SPL.
	Commission rulemaking provisions	The Commission is authorized to develop rules relating to the application process, including fees and issuing the expedited license.
6	Fees for Expedited Licensure	A member state is authorized to charge a fee for an expedited license that is issued or renewed through the Compact. The individual state fees currently vary from a low of $75.00 in Alabama to a high of $700 in Maine.[36]
	Rulemaking authority	The Commission is authorized is develop rules relating to fees for expedited licenses. The rules are not permitted to limit the authority of the member states, the regulating authority of the member states, or to impose and determine the amount of the fee charged by the member states.
7	Renewal and Continued Participation *Renewal license process created*	A physician with an expedited license in a member state must complete a renewal process with the Commission if the physician: - Maintains a full and unrestricted license in a SPL. - Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction. - Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action relating to non-payment of fees related to a license. - Has not had a controlled substance license or permit suspended or revoked by a state or the United State Drug Enforcement Administration.
	Continuing education	Physicians are required to comply with all continuing education and

[36] Interstate Medical Licensure Compact, *What Does It Cost?* https://imlcc.org/what-does-it-cost/ (last visited Mar. 8, 2019).

Provisions of the Interstate Medical Licensure Compact		
Section	**Title**	**Description**
	required for renewal with member state	professional development requirements for renewal of a license issued by a member state.
	Fees collected, if any, by member state.	The Commission must collect any renewal fees charged for the renewal of a license and distribute the fees to the appropriate member board. Upon payment of fees, a physician's license may be renewed. Any information collected during the renewal process shall also be shared with all member boards.
	Rulemaking authority.	The Commission is authorized to develop rules to address the renewal of licenses.
8	Coordinated Information Systems *Authorized to create database of all applicants*	The Commission is required to establish a database of all licensed physicians who have applied for licensure. Member boards are required to report disciplinary or investigatory actions as required by Commission rule. Member boards may also report any non-public complaint, disciplinary, or investigatory information not required to be reported to the Commission.
	By request, may share data	Upon request, member boards may share complaint or disciplinary information about physicians to another member board. All information provided to the Commission or distributed by the member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.
	Rulemaking authority	The Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.
9	Joint Investigations *Permits joint investigations between the state and the member boards*	Licensure and disciplinary records of physicians are deemed investigative. A member board may participate with other member boards in joint investigations of physicians licensed by the member boards in addition to the authority granted by the member board and its respective Medical Practice Act or other respective state law. Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact. Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.
10	Disciplinary Actions	Any disciplinary action taken by any member board against a physician licensed through the Compact is be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that State.
	Licensure actions specific actions to reinstate	If the physician's license is revoked, surrendered, or relinquished in lieu of discipline in the SPL, or suspended, then all licenses issued to that physician by member boards are automatically placed, without any further action necessary by any member board, on the

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		same status. If the SPL subsequently reinstates the physician's license, a license issued to the physician by any other member board remains encumbered until that respective board takes action to specifically reinstate the license in a manner consistent with the Medical Practice Act in that state.
	Discipline by a member state has reciprocal actions	If a disciplinary action is taken against the physician in a member state that is the physician's SPL, any other member state may deem the action conclusive as to matter of law and fact decided, and: - Impose the same or lesser sanction or sanctions against the physician so long as such sanctions are consistent with the Medical Practice Act of that state; or - Pursue separate disciplinary action against the physician under the Medical Practice Act, regardless of the action taken in other member states. If a license granted to a physician by a member board is revoked, surrendered, or relinquished in lieu of discipline, or suspended, then any license issued to the physician by any other member board or boards is be suspended, automatically, and without further action necessary by the other board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.
11	Interstate Medical Licensure Compact Commission	The member states create the Interstate Medical Licensure Compact Commission as a joint agency of the member states and administration of the Compact. The Commission has all the duties, powers, and responsibilities set forth in the Compact, plus any other powers conferred upon it by the member states through the Compact.
	Recognizes creation of Commission and state's representative with 2 Commissioners, one from each regulatory board	Each member state has two (2) two voting representatives appointed by each member state to serve as Commissioners. For states with separate regulatory boards for allopathic and osteopathic regulatory boards, the member appoints one representative from each member board. A Commissioner must be: - An allopathic or osteopathic physician appointed to a member board. - Executive director, executive secretary, or similar executive or a member board, or - Member of the public appointed to a member board.
	Availability of Commission meetings, except for certain topics	The Commission must meet at least once per calendar year and at least a portion of the meeting shall be a business meeting which shall include the election of officers. The Chair may call additional meeting and shall call for all meeting upon the request of a majority of the member states.

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		Meetings are permitted via telecommunication according to the Bylaws. Each Commissioner is entitled to one vote. A majority of Commissioners constitutes a quorum, unless a larger quorum is required by the Bylaws of the Commission. A Commissioner may not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who meets the requirements of being a Commissioner.
	Public notice required	The Commission must provide public notice of all meetings and all meetings shall be open to the public. A meeting may be closed to the public, in full or in portion, when it determines by a 2/3 vote of the Commissioners present, that an issue or matter would likely to: - Relate solely to the internal personnel practices and procedures of the Interstate Commission. - Discuss matters specifically exempted from disclosure by federal statute; - Discuss trade secrets, commercial, or financial information that is privileged or confidential; - Involve accusing a person of a crime, or formally censuring a person; - Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy; - Discuss investigative records compiled for law enforcement purposes; or - Specifically relate to the participation in a civil action or other legal proceeding.
	Availability of public data from the Commission	The Commission must make its information and official records, to the extent, not otherwise designated in the Compact or by its rules, available to the public for inspection.
	Creates an executive committee to act on behalf of the Commission	An executive committee is established which has the authority to act on behalf of the Commission, with the exception of rulemaking, when the Commission is not in session. The executive committee oversees the administration of the Compact, including enforcement and compliance with the Compact, its bylaws and rules, and other such duties as necessary. The Commission may establish other committees for governance and administration of the Compact.
12	Powers and Duties of the Interstate Commission *Recognizes creation of the Commission*	The Commission has the duties and the powers to: - Oversee and administer the Compact. - Promulgate rules which are binding. - Issue advisory opinions upon the request of member states concerning the meaning or interpretation of the Compact or its bylaws, rules, and actions. - Enforce compliance with the Compact, provisions, the rules, and the bylaws.

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		- Establish and appoint committees, including the executive committee, which has the power to act on behalf of the Interstate Commission. - Pay, or provide for the payment of Commission expenses. - Establish and maintain one or more offices. - Borrow, accept, hire, or contract for services of personnel. - Purchase and maintain insurance and bonds. - Employ an executive director with power to employ, select, or appoint employees, agents, or consultants, determine their duties, and fix their compensation. - Establish personnel policies and programs. - Accept donations and grants of money, equipment, supplies, materials, and services, and to receive, utilize and dispose of it consistent with conflict of interest policies as established by the Commission. - Lease, purchase, accept contributions, or donation of, or otherwise own, hold, improve or use, any property, real, personal, or mixed. - Establish a budget and make expenditures. - Adopt a seal and bylaws governing the management and operation of the Commission. - Report annually to the legislatures and governors of the members concerning the activities of the Commission during the preceding year, including reports of financial audits and any recommendations that may have been adopted by the Commission. - Coordinate education, training, and public awareness regarding the Compact, its implementation and operation. - Maintain records in accordance with bylaws. - Seek and obtain trademarks, copyrights, and patents. - Perform such functions as may be necessary or appropriate to achieve the purpose of the Compact.
13	Finance Powers *Provides for annual assessment* *Requires rule for any assessment* *No pledging credit without authorization* *Yearly audits*	The Compact authorizes an annual assessment levied on each member state to cover the costs of operations and activities of the Commission and its staff. The assessment must be sufficient to cover the amount not provided by other sources and needed to cover the annual budget approved each year by the Commission. The Compact requires that the assessment be memorialized by rule binding all the member states. The Commission is not authorized to pledge the credit of any of the member states, except by, and with the authority of, the member states. The Compact requires yearly financial audits conducted by a certified or licensed public accountant and the report is to be included in the Commission's annual report.
14	Organization and Operation of the	The Compact creates a requirement for the Commission to adopt bylaws by a two-thirds (2/3) vote within twelve months of the first

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	Interstate Commission	meeting which has already occurred. The first Bylaws were adopted in October 2015.[37]
	Annual officer election	A Chair, Vice Chair, and Treasurer are be elected or appointed each year by the Commission.
	No officer remuneration	Officers serve without remuneration. Officers and employees are immune from suit and liability, either personally or in their professional capacity, for a claim for damage to or loss of property or personal injury or other civil liability cause or arising out of, or relating to, an actual or alleged act, error or omission that occurred with the scope of Commission employment, duties, or responsibilities, provided such person should not be protected from suit or liability for damage or loss, injury or liability caused by the intentional or willful and wanton conduct of such a person.
	Liability protection for actions within scope of duties and responsibilities only for officers, employees, and agents	The liability of the executive director and Commission employees or representatives of the Commission, acting within the scope of their employment, may not exceed the limits set forth under the state's Constitution and laws for state officials, employees, and agents. The Compact provides that the Commission is considered an instrumentality of the state for this purpose. The Compact provides that the Commission must defend the executive director, its employees, and subject to the approval of the state's attorney general or other appropriate legal counsel, must defend in any civil action seeking to impose liability within scope of duties. The Compact provides that employees and representatives of the Commission shall be held harmless in the amount of any settlement or fees, including attorney fees and costs that occurred within the scope of employment or responsibilities and not a result of willful or wanton misconduct.
15	Rulemaking Functions of the Interstate Commission *Promulgate reasonable rules*	The Commission is required to promulgate reasonable rules in order to implement and operate the Compact and the Commission. The Compact adds that any attempt to exercise rulemaking beyond the scope of the Compact renders the action invalid. The rules should substantially conform to the "Model State Administrative Procedures Act" of 2010 and subsequent amendments thereto.
	Judicial review at U.S. Federal District Court	The Compact allows for judicial review of any promulgated rule. A petition may be filed thirty (30) days after a rule has been promulgated in the U.S. District Court in Washington, D.C., or the federal court where the Commission is located.[38] The Compact requests deference to the Commission's action consistent with state law.

[37] Interstate Medical Licensure Compact, *Annual Report 2017,* https://imlcc.org/wp-content/uploads/2018/03/IMLCC-Annual-Report-2017-1.pdf (last visited Mar. 11, 2019).
[38] The Interstate Medical Licensure Compact Commission is currently headquartered in Littleton, Colorado. *See* Interstate Medical License Commission, Frequently Asked Questions (FAQS), https://imlcc.org/faqs/

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Section	**Title**	**Description**
16	Oversight of Interstate Contract *Enforcement* *Service of process*	The Compact is the responsibility of each state's own executive, legislative, and judicial branch to oversee and enforce. All courts are to take judicial notice of the Compact and any adopted administrative rules in a proceeding involving Compact subject matter. The Compact provides that the Commission is entitled to receive service of process in any proceeding and have standing in any proceeding. Failure to serve the Commission renders a judgment null and void as to the Commission, the Compact, or promulgated rule.
17	Enforcement of Interstate Contract	The Compact provides the Commission reasonable discretion to enforce the provisions and rules of the Compact, including when and where to initiate legal action. The Commission is permitted to seek a range of remedies.
18	Default Procedures	The Compact provides a number of reasons a member state may default on the Compact, including failure to perform required duties and responsibilities and the options available to the Commission. The Compact requires the Commission to promulgate rules to address how physician licenses are affected by the termination of a member state from the Compact. The rules must also ensure that a member state does not bear any costs when a state has been found to be in default. The Compact provides an appeal process for the terminating state and procedures for attorney's fees and costs.
19	Dispute Resolution	The Compact authorizes the Commission to use dispute resolution tools to resolve disputes between states, such as mediation and binding dispute resolution. The Commission must promulgate rules for the dispute resolution process.
20	Member States, Effective Date and Amendment	The Compact allows any state to become a member state and that the Compact is binding upon the legislative enactment of the Compact by no less than seven (7) states.[39]
21	Withdrawal	A member state may withdraw from the Compact through repeal of this section of law which inserted the Compact into state statute. Any repeal of the Compact through repeal of the state law cannot take effect until one (1) year after the effective date of such an action and written notice has been given by the withdrawing state to the governor of each other member state. The Compact provision also requires that upon introduction of any repeal legislation, that the withdrawing state immediately notify the Chairperson of the Commission of the legislation. The Compact provides that it is the Commission's responsibility to notify the other member states within 60 (sixty) days of its receipt of information about legislation that would repeal that state's participation in the Compact. The withdrawing state would be responsible for any dues, obligations, or liabilities incurred through

[39] The Compact is in force now. The Commission was seated for the first time in October 2015 and issued its first letters of qualification to physicians in April 2017. *See* Interstate Medical Licensure Compact, https://imlcc.org/faqs/ (last Mar. 11, 2019).

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		the date of withdrawal. Reinstatement is an option under the Compact. The Compact authorizes the Commission to develop rules to address the impact of the withdrawal of a member state on licenses.
22	Dissolution	When the membership of the Compact is reduced to one, the Compact shall be dissolved. Once dissolved, the Compact is null and void. Once concluded, any surplus funds of the Commission shall be distributed in accordance with the bylaws.
23	Severability and Construction	If any part of this Compact is not enforceable, the remaining provisions are still enforceable. The provisions of the Compact are to be liberally construed, and nothing is to be construed so as to prohibit the applicability of other interstate compacts to which states might be members.
24	Binding Effect of Compact and Other Laws	This Compact does not prohibit the enforcement of other laws which are not in conflict with this Compact. All laws which are in a member state which are inconsistent with this Compact are superseded to the point of the contact. The actions of the Commission are binding on the member states, including all promulgated rules and the adopted bylaws of the Commission. All agreements between the Commission and the member state are binding in accordance with their terms. In the event that any provision of this Compact exceeds Florida's constitutional limits imposed on the legislature of any member state, such provision is ineffective to the extent that the conflict of the constitutional provision in question in that member state.

OPPAGA Review of the IMLC

Chapter 2019-138, Laws of Florida, directed the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze the IMLC and develop recommendations addressing Florida's prospective entry into the Compact. On October 1, 2019, OPPAGA published its report.[40] To avoid legal conflict, OPPAGA recommended that the Legislature:

- Repeal Florida's initial licensure provisions that fall outside of the Compact's licensure provisions. Florida does not license persons who are listed on the United States Department of Health and Human Services Office of Inspector General's List of Excluded Individuals and Entities.[41] The Compact has no comparable requirement.
- Enact statutory language providing physicians who practice in Florida whose licenses were revoked in their State of Principal License (SPL) an opportunity to challenge the reason for the revocation or suspension in Florida.

[40] Office of Program Policy Analysis and Gov't Accountability, Florida Legislature, *Florida's Participation in the Interstate Medical Licensure Compact Would Require Statutory Changes to Avoid Legal Conflicts*, Report No. 19-07, (Oct. 1, 2019) available at http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1907rpt.pdf (last visited January 31, 2020).
[41] Section 456.0635, F.S.

- Enact statutory language clarifying that the Compact pays claims or judgments arising from the Commission's employment-related actions in the state.
- Provide an exception from public meeting requirements to allow closed meetings of the Commission.
- Provide an exception from public records requirements to exempt application records received by the Commission from disclosure.
- Set a Compact implementation date to ensure that the DOH would have adequate time to make required changes to rule, forms, and technological infrastructure in order to process licenses through the Compact.

OPPAGA also found that the average time to receive a license through the IMLC is 55 days, while the average time to receive a license from the state of Florida is 10-15 days.[42] The average time to receive a license through the IMLC is 19 days if the time for obtaining the Letter of Qualification is excluded.

While The Average Time to Receive a License Via the Compact Is Higher Than the Average Time to Receive a Florida License, Physicians May Receive Multiple Licenses Under the Compact Process

Licensure Process	Average Number of Days to Receive an LOQ	Average Number of Days to Receive a License	Total Time (In Average Number of Days) to Receive a License	Type of License Received
Florida Licensure	N/A	10-15 days[1,2]	10-15 days[1,2]	Florida License
Compact Licensure	36 days	19 days	55 days	One or more licenses in compact state(s) of physician's choice

[1] The average number of days for licensure was 10 days for osteopathic physicians and 15 days for medical doctors.
[2] This is the average time to receive a license under circumstances where there are no complications or missing information from the applications.
Source: OPPAGA analysis of Florida Department of Health data and commission data.

Sovereign Immunity

Sovereign immunity generally bars lawsuits against the state or its political subdivisions for torts committed by an officer, employee, or agent of such governments unless the immunity is expressly waived. The Florida Constitution recognizes that the concept of sovereign immunity applies to the state, although the state may waive its immunity through the enactment of general law. [43]

In 1973, the Legislature enacted s. 768.28, F.S., a partial waiver of sovereign immunity, allowing individuals to sue state government and its subdivisions.[44] According to subsection (1), individuals may sue the government under circumstances where a private person "would be liable to the claimant, in accordance with the general laws of [the] state . . ." Section 768.28(5), F.S., imposes a $200,000 limit on the government's liability to a single person, and a $300,000 total limit on liability for claims arising out of a single incident.

Florida Center for Nursing

The Legislature established the Florida Center for Nursing (Center) to address the supply and demand of nurses in the state, including issues of recruitment, retention, and utilization of nurse workforce resources.[45] The primary goals of the Center are to:

- Develop a strategic statewide plan for nursing manpower in this state by:
    - Establishing and maintaining a database on nursing supply and demand in the state, to include current supply and demand;
    - Analyzing the current supply and demand in the state and making future projections of such; and
    - Selecting priorities to be addressed.
- Convene various groups representative of nurses, other health care providers, business and industry, consumers, legislators, and educators to:
    - Review and comment on data analysis prepared for the center;

[42] *Supra* note 40.
[43] FLA. CONST. art. X, s. 13.
[44] Chapter 73-313, L.O.F., codified at s. 768.28, F.S.
[45] Section 464.0195, F.S.

  - Recommend systemic changes, including strategies for implementation of recommended changes; and
  - Evaluate and report the results of these efforts to the Legislature and others.
- Enhance and promote recognition, reward, and renewal activities for nurses in the state by:
  - Promoting nursing excellence programs such as magnet recognition by the American Nurses Credentialing Center;
  - Proposing and creating additional reward, recognition, and renewal activities for nurses; and
  - Promoting media and positive image-building efforts for nursing.

The Center is governed by a 16-member board of directors, which includes:

- Four members recommended by the President of the Senate, at least one of whom shall be a registered nurse recommended by the Florida Organization of Nurse Executives and at least one other representative of the hospital industry recommended by the Florida Hospital Association;
- Four members recommended by the Speaker of the House of Representatives, at least one of whom shall be a registered nurse recommended by the Florida Nurses Association and at least one other representative of the long-term care industry;
- Four members recommended by the Governor, two of whom shall be registered nurses;
- One nurse educator recommended by the Board of Governors who is a dean of a College of Nursing at a state university; and
- Three nurse educators recommended by the State Board of Education, one of whom must be a director of a nursing program at a Florida College System institution.

The powers and duties of the board of directors include:

- Employing an executive director;
- Determining operational policy;
- Electing a chair and officers, to serve 2-year terms;
- Establishing committees of the board;
- Appoint a multidisciplinary advisory council for input and advice on policy matters;
- Implementing the major functions of the center as established in the goals; and
- Seeking and accepting non-state funds for sustaining the center and carrying out center policy.

Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling

Intern Registration

To be licensed as a clinical social worker, marriage and family therapist, or mental health counselor, an applicant must meet educational requirements, complete at least 2 years of postgraduate or postmaster's clinical practice supervised by a licensed practitioner, and pass a theory and practice examination.[46] During the time in which an applicant is completing the required supervised clinical experience or internship, he or she must register with the DOH as an intern.[47] The supervised clinical experience may be met by providing at least 1,500 hours of face-to-face psychotherapy with clients, which may not be accrued in less than 100 weeks.[48]

An applicant seeking registration as an intern must:[49]

- Submit a completed application form and the nonrefundable fee to the DOH;

[46] Section 491.005, F.S. A procedure for licensure by endorsement is provided in s. 491.006, F.S.
[47] Section 491.0045, F.S.
[48] Rule 64B4-2.001, F.A.C.
[49] Section 491.0045(2), F.S.

- Complete education requirements;
- Submit an acceptable supervision plan for meeting the practicum, internship, or field work required for licensure that was not satisfied by graduate studies; and
- Identify a qualified supervisor.

An intern registration expires 60 months after the date of issue and may only be renewed if the candidate has passed the theory and practice examination required for full licensure.[50] DOH has no authority to extend an intern registration beyond the 60 months if there are extenuating circumstances.

Certified Master Social Workers

Currently, an individual may be designated as a certified master social worker if the individual applies to DOH and submits an application fee of $50 and an initial certification fee of $150.[51] To qualify for certification, an applicant must:

- Possess a master's or doctoral degree from an accredited program; and
- Have at least three years' experience in clinical service or administrative activities, two of which must be at the post-master's level.

There is no defined scope of practice for certified master's social workers in statute or rule. However, statute expressly prohibits certified master social workers from providing clinical services.[52]

Licensed Clinical Social Workers

Licensed clinical social work uses scientific and applied knowledge, theories, and methods for the purpose of describing, preventing, evaluating, and treating individual, couple, marital, family, or group behavior, based on the person-in-situation perspective of psychosocial development, normal and abnormal behavior, psychopathology, unconscious motivation, interpersonal relationships, environmental stress, differential assessment, differential planning, and data gathering to prevent and treat undesired behavior and enhance of mental health.[53] An applicant seeking licensure as a clinical social worker must:[54]

- Possess a master's or doctoral degree from an accredited program;
- Have a least two years' experience in clinical social work;
- Pass a theory and practice examination approved by DOH; and
- Demonstrate knowledge of laws and rules governing the practice.

Licensed Clinical Social Workers must pass an examination offered by the American Association of State Social Worker Boards.[55] In 1999, the American Association of State Social Worker Boards changed its name to the Association of Social Work Boards.[56]

Marriage and Family Therapists

Marriage and family therapy incorporates marriage and family therapy, psychotherapy, hypnotherapy, sex therapy, counseling, behavior modification, consultation, client-centered advocacy, crisis

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[50] Section 491.0045(6), F.S.
[51] Rule 64B25-28.002, F.A.C. Section 491.0145, F.S., authorizes an application fee of up to $250 and an examination fee of up to $250.
[52] Section 491.0145(6), F.S.
[53] Section 491.003(7), F.S.
[54] Section 491.005(1), F.S.
[55] Id.
[56] Association of Social Work Boards, *History*, available at https://www.aswb.org/about/history/ (last visited January 31, 2020).

intervention, and the provision of needed information and education to clients.[57] An applicant seeking licensure as a mental health counselor must:[58]

- Possess a master's degree from an accredited program;
- Complete 36 semester hours of graduate coursework that includes a minimum of 3 semester hours of graduate-level coursework in:
  - The dynamics of marriage and family systems;
  - Marriage therapy and counseling theory;
  - Family therapy and counseling theory and techniques;
  - Individual human development theories throughout the life cycle;
  - Personality or general counseling theory and techniques;
  - Psychosocial theory; and
  - Substance abuse theory and counseling techniques.
- Complete at least one graduate-level course of 3 semester hours in legal, ethical, and professional standards;
- Complete as least one graduate-level course of 3 semester hours in diagnosis, appraisal, assessment, and testing for individual or interpersonal disorder or dysfunction;
- Complete at least one graduate-level course of 3 semester hours in behavioral research;
- Complete at least one supervised clinical practicum, internship, or field experience in a marriage and family counseling setting, during which the student provided 180 direct client contact hours of marriage and family therapy services;
- Complete two years of post-master's supervised experience under the supervision of a licensed marriage and family therapist with five years of experience or the equivalent who is a qualified supervisor as determined by the board;
- Pass a board-approved examination; and
- Demonstrate knowledge of laws and rules governing the practice.

DOH must verify that an applicant's education matches the specified courses and hours as outlined in statute. However, there are organizations that accredit marriage and family therapy education programs, including the Commission on Accreditation for Marriage and Family Therapy Education and the Council for the Accreditation of Counseling and Related Educational Programs that establish the minimum standards to meet the requirements to practice the profession.[59]

Mental Health Counselors

A mental health counselor is an individual who uses scientific and applied behavioral science theories, methods, and techniques to describe, prevent, and treat undesired behavior and enhance mental health and human development and is based on research and theory in personality, family, group, and organizational dynamics and development, career planning, cultural diversity, human growth and development, human sexuality, normal and abnormal behavior, psychopathology, psychotherapy, and rehabilitation.[60] To qualify for licensure as a mental health counselor, an individual must:[61]

- Have a master's degree from a mental health counseling program accredited by the Council of the Accreditation of Counseling and Related Educational Programs, or a program related to the

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[57] Id.

[58] Section 491.005(3), F.S. An individual may qualify for a dual license in marriage and family therapy if he or she passes an examination in marriage and family therapy and has held an active license for at least three years as a psychologist, clinical social worker, mental health counselor, or advanced registered nurse practitioner who is determined by the Board of Nursing to be a specialist in psychiatric mental health (s. 491.0057, F.S.)

[59] *See* Commission on Accreditation for Marriage and Family Therapy Education, *What Are the Benefits of COAMFTE Accreditation*, available at https://www.coamfte.org/COAMFTE/Accreditation/About_Accreditation.aspx (last visited December 2, 2019), and Council for the Accreditation of Counseling and Related Educational Programs, *About CACREP*, available at https://www.cacrep.org/about-cacrep/ (last visited December 2, 2019).

[60] Sections 491.003(6) and (9), F.S.

[61] Section 491.005(4), F.S.

practice of mental health counseling that includes coursework and a 1,000-hour practicum, internship, or fieldwork of at least 60 semester hours that meet certain requirements;

- Have at least two years of post-master's supervised clinical experience in mental health counseling;
- Pass an examination from the Professional Examination Service for the National Academy of Certified Clinical Mental Health Counselors; and
- Pass an eight-hour course on Florida laws and rules approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.[62]

Currently, an applicant for a mental health counselor license must, by rule, pass the National Clinical Mental Health Counseling Examination. Current law refers to an outdated mental health counseling examination.

Effect of Proposed Changes

Interstate Medical Licensure Compact

CS/HB 1143 enacts the Interstate Medical Licensure Compact (see a description of the compact provisions in the Present Situation section), and authorizes Florida to enter into the IMLC with all other jurisdictions that have legally joined the IMLC. The bill authorizes DOH to adopt rules to implement the IMLC. Under the bill, any physician licensed to practice medicine or osteopathic medicine under the IMLC is deemed to be licensed under chapter 458 F.S., or chapter 459, F.S., respectively.

The bill provides Florida-licensed physicians or those licensed under the IMLC whose licensure is disciplined by another state access to the administrative review process under Florida law.

Commissioners

The bill requires the appointed commissioners to ensure that the IMLC Commission complies with Florida laws on public records and open meetings. The bill also provides that commissioners and any administrator, officer, executive director, employee, or representative of the IMLC Commission, when acting within the scope of their employment or responsibilities in this state are considered agents of the state. The bill requires the IMLC Commission to pay any claims or judgments that arise and authorizes the IMLC Commission to maintain insurance coverage to any such claims or judgments.

Florida Center for Nursing Board of Directors

The bill revises the requirements for appointment to the Florida Center for Nursing Board of Directors. The bill retains the number of members that the Governor, President of the Senate, Speaker of the House of Representatives, the Board of Governors, and the State Board of Education must appoint, but removes the specifications for such appointments.

Mental Health Professions

Certified Master Social Workers

The bill requires DOH to license, as a certified master social worker (CMSW), an individual who applies to DOH and:

- Remits the appropriate fee as established by the Board;[63]
- Submits proof of receipt of a doctoral degree in social work or a master's degree to the Board;

[62] Section 491.005(4), F.S., and r. 64B4-3.0035, F.A.C.
[63] Under current law, DOH is authorized to charge a nonrefundable application fee of up to $250, as established by DOH rule.

- Submits proof of two years' experience providing clinical services or performing administrative activities to the Board; and
- Passes the Board-designated licensure examination.

The bill defines the scope of practice for a certified master social worker as the application of social work theory, knowledge, methods, and ethics, and the professional use of the self to restore or enhance social, psychosocial, or biopsychosocial functioning of individuals, couples, families, groups, organizations, or communities. This also includes the application of specialized knowledge and advanced practice skills in non-diagnostic assessment, treatment planning, implementation and evaluation, case management, information and referral, supervision, consultation, education, research, advocacy, community organization, and the development, implementation, and administration of policies, programs, and activities.

The bill requires CMSWs to use the title "certified master social worker" and the acronym "CMSW" on all promotional materials, including cards, brochures, stationery, advertisements, social media and signs on which the CMSW is named.

Mental Health Interns

The bill authorizes the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling to make a one-time exception to the 60-month limit on an internship registration. Such exceptions may only be granted in an emergency or hardship case, as defined by rule. The bill deletes obsolete language related to biennial renewals of intern registrations.

Licensed Clinical Social Workers

The bill updates the name of the organization that administers the licensure examination for clinical social work licensure applicants to the Association of Social Work Boards, which was previously known as the American Association of State Social Work Boards.[64] The bill requires the Board, rather than DOH, to designate the theory and practice examination for licensure.

The bill also eliminates the specified coursework required for licensure that is currently enumerated in statute, and authorizes the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling adopt rules on the specific course requirements. This will simplify the education review process and expedite licensure.[65]

Marriage and Family Therapists

The bill requires that an applicant for licensure hold a master's degree with an emphasis in marriage and family therapy from a program accredited by the Commission of Accreditation for Marriage and Family Therapy Education or a Florida university program accredited by the Council for Accreditation of Counseling and Related Educational Programs. An applicant may also qualify for licensure if he or she holds a master's degree in a closely related field and has completed graduate courses approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling. The bill eliminates specified coursework and clinical experience required for licensure that is currently enumerated in statute.

To be licensed as a marriage and family therapist, s. 491.005(3), F.S., requires an applicant to complete two years of clinical experience. However, later in the same paragraph, it states the clinical experience required is three years. The bill corrects the scrivener's error in the paragraph to clarify that

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[64] *See* Association of Social Work Boards, *History*, available at https://www.aswb.org/about/history/ (last visited January 30, 2020).
[65] Fla. Department of Health, *2020 Agency Legislative Bill Analysis for HB 1143*, (Jan. 21, 2020), on filed with the Health Quality Subcommittee.

two years of clinical experience is required for licensure. The bill requires the Board, rather than DOH, to designate the theory and practice examination for licensure.

Licensed Mental Health Counselors

The bill updates the name of the organization that administers the licensure examination for mental health counseling licensure applicants to the National Board for Certified Counselors or its successor. The bill revises the content areas that must be included in educational programs used to qualify for licensure to include substance abuse; legal, ethical, and professional standards issues in the practice of mental health counseling; and diagnostic process.

The bill reduces the number of hours required for the clinical practicum or internship from 1,000 hours to 700 hours to conform the number of hours to the accreditation standards established by the Council for Accreditation of Counseling and Related Educational Programs. The bill requires the clinical practicum or internship to include at least 280 hours of direct client services. The bill requires the Board, rather than DOH, to designate the theory and practice examination for licensure.

The bill requires that applicants who apply for licensure after July 1, 2026, hold a master's degree from a program accredited by the Council for Accreditation of Counseling and Related Educational Programs.

Licensure by Endorsement

The bill repeals educational requirements for applicants for licensure by endorsement. Such applicant qualifies for licensure if he or she holds a valid, active license to practice in another state for three of the five years preceding the date of application, passes an equivalent licensure examination, and is not under investigation for and has not been found to have committed any act that would constitute a licensure violation in Florida.

The bill clarifies that DOH may deny or impose penalties on the license of a certified master social worker who violates the practice act or ch. 456, F.S., the general regulatory statute by deleting an inaccurate reference to psychologists. This will alleviate confusion regarding the authority of DOH to impose such discipline or deny a license.

The bill also adds social media to the list of promotional materials required to include the professional titles of all licensees, certificate holders, provisional licensees and interns in professions of clinical social work, marriage and family therapy, and mental health counseling.

The bill makes conforming changes and deletes obsolete provisions.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Creates s. 456.4501, F.S., relating to Interstate Medical Licensure Compact.
Section 2: Creates s. 456.4502, F.S., relating to Interstate Medical Licensure Compact; disciplinary proceedings.
Section 3: Creates s. 456.4503, F.S., relating to Interstate Medical Licensure Compact Commissioners.
Section 4: Creates s. 456.4504, F.S., relating to Interstate Medical Licensure Compact rules.
Section 5: Creates s. 458.3129, F.S., relating to Interstate Medical Licensure Compact.
Section 6: Creates s. 459.074, F.S., relating to Interstate Medical Licensure Compact.
Section 7: Amends s. 464.0196, F.S., relating to Florida Center for Nursing; board of directors.
Section 8: Amends s. 491.003, F.S., relating to definitions.
Section 9: Amends s. 491.004, F.S., relating to Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling.

Section 10: Amends s. 491.0045, F.S., relating to intern registration, requirements.
Section 11: Amends s. 491.005, F.S., relating to licensure by examination.
Section 12: Amends s. 491.0057, F.S., relating to dual licensure as a marriage and family therapist.
Section 13: Amends s. 491.006, F.S., relating to licensure or certification by endorsement.
Section 14: Amends s. 491.007, F.S., relating to renewal of license, registration, or certificate.
Section 15: Amends s. 491.009, F.S., relating to discipline.
Section 16: Amends s. 491.012, F.S., relating to violations; penalty; injunction.
Section 17: Amends s. 491.0145, F.S., relating to certified master social workers.
Section 18: Amends s. 491.0149, F.S., relating to display of license; use of professional title on promotional materials.
Section 19: Repeals s. 491.015, F.S., relating to duties of the department as to certified master social workers.
Section 20: Amends s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; risk management programs.
Section 21: Amends s. 414.065, F.S., relating to noncompliance with work requirements.
Section 22: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   DOH may experience a recurring increase in revenue associated with the application and initial and renewal licensure fees under the IMLC.[66] It is unknown how many physicians may apply.

2. Expenditures:

   DOH will incur rulemaking costs associated with the IMLC, Certified Master Social Workers, Mental Health Interns, Licensed Clinical Social Workers, Marriage and Family Therapists, and Licensed Mental Health Counselors, which current resources are adequate to absorb.[67]

   DOH may experience additional workload related to a possible increase in the number of physicians licensed in Florida under the IMLC and the preparation of letters of qualification for Florida licensees.[68] With an increase in licensees, costs associated with regulation and complaints and investigations will increase.[69] It is estimated the additional licensure fee revenue will offset these costs.

   DOH will incur costs to update the LEIDS licensing system with IMLC information and to create a process for sharing information with the IMLC commission. This cost is currently unknown, however, it is estimated current resources are adequate to absorb.[70]

   Additionally, there may be a negative fiscal impact on the Division of Administrative Hearings if physicians who are disciplined request a formal hearing. It is not known how many hearings there may be so the impact is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

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[66] Id at p. 9.
[67] Id.
[68] Id.
[69] Id.
[70] Id.

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The IMLC may lead to more physicians practicing in Florida, which may increase access for patients and create additional competition for existing physicians.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Delegation of Legislative Authority

The bill delegates authority to the commission to adopt rules that facilitate and coordinate the implementation and administration of the IMLC.

If enacted into law, the state will effectively bind itself to rules not yet adopted by the commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative power to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[71,72] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely address this issue in the context of interstate compacts.

The most recent opportunity Florida courts have had to address this issue appears to be in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[73] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this

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[71] *Freimuth v. State*, 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel. Orange State Oil Co.*, 155 Fla. 772 (1945).

[72] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State*, 723 So.2d 199 (Fla. 1998).

[73] 801 So.2d 1047 (Fla. 1st DCA 2001).

compact."[74] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[75] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.,* 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[76]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[77]

Public Records and Open Meetings

Provisions in the compact conflict with Florida's public records and open meeting requirements. All or portions of an IMLC Commission meeting may be closed if the topic of the meeting is likely to involve certain matter, such as personnel matters or investigative records. Recordings, minutes, and records generated in such matter are also not publicly available.

Article I, s. 24(a) of the State 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) of the State Constitution sets forth the state's public policy regarding access to government meetings. The section requires that all meetings of any collegial public body of the executive branch of state government or of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, be open and noticed to the public.

The Legislature may provide by general law for the exemption of records and meetings from the requirements of Article I, s. 24(a) and (b) of the State Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.[78]

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[74] *Id* at 1052.
[75] *Id.*
[76] *Id.*
[77] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).
[78] Art. I, s. 24(c), Fla. Const.

B. RULE-MAKING AUTHORITY:

The bill authorizes the IMLC Commission to adopt rules to facilitate and coordinate the implementation and administration of the compact. The IMLC specifies that the rules have the force and effect of law and are binding in all party states. If a party state fails to meet its obligations under the IMLC or the promulgated rules, the state may be subject to remedial training, alternative dispute resolution, suspension, termination, or legal action.

The compact details the rule-making process that must be followed including, notice, an opportunity for public participation, and hearings. The compact also provides a procedure for emergency rule-making in cases of imminent danger to public health, safety, or welfare, to prevent financial loss to the state's or commission, or to comply with federal laws or regulations. All rules and amendments are binding on a party state as of the effective date specified.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to the Department of Health; creating
3 s. 456.4501, F.S.; implementing the Interstate Medical
4 Licensure Compact in this state; providing for an
5 interstate medical licensure process; providing
6 requirements for multistate practice; creating s.
7 456.4502, F.S.; establishing that a formal hearing
8 before the Division of Administrative Hearings must be
9 held if there are any disputed issues of material fact
10 when the licenses of certain physicians and
11 osteopathic physicians are suspended or revoked by
12 this state under the compact; requiring the department
13 to notify the division of a petition for a formal
14 hearing within a specified timeframe; requiring the
15 administrative law judge to issue a recommended order;
16 requiring the Board of Medicine or the Board of
17 Osteopathic Medicine, as applicable, to determine and
18 issue final orders in certain cases; providing the
19 department with standing to seek judicial review of
20 any final order of the boards; creating s. 456.4503,
21 F.S.; requiring the Interstate Medical Licensure
22 Compact Commissioners to ensure that the Interstate
23 Medical Licensure Compact Commission complies with
24 specified public records and public meetings laws;
25 creating s. 456.4504, F.S.; authorizing the department

26 to adopt rules; creating s. 458.3129, F.S.;
27 establishing that a physician licensed under the
28 Interstate Medical Licensure Compact is deemed to be
29 licensed as a physician under chapter 458, F.S.;
30 creating s. 459.074, F.S.; establishing that an
31 osteopathic physician licensed under the Interstate
32 Medical Licensure Compact is deemed to be licensed as
33 an osteopathic physician under chapter 459, F.S.;
34 amending s. 464.0196, F.S.; revising the membership of
35 the board of directors of the Florida Center for
36 Nursing; deleting obsolete provisions; amending s.
37 491.003, F.S.; providing definitions; amending s.
38 491.004, F.S.; deleting an obsolete provision;
39 amending s. 491.0045, F.S.; authorizing the Board of
40 Clinical Social Work, Marriage and Family Therapy, and
41 Mental Health Counseling to make a one-time exception
42 to intern registration requirements under certain
43 circumstances; amending s. 491.005, F.S.; revising the
44 licensure requirements for clinical social workers,
45 marriage and family therapists, and mental health
46 counselors; amending s. 491.0057, F.S.; requiring that
47 an applicant for dual licensure as a marriage and
48 family therapist pass an examination designated by the
49 Board of Clinical Social Work, Marriage and Family
50 Therapy, and Mental Health Counseling; amending s.

51 491.006, F.S.; revising requirements for licensure or
52 certification by endorsement for certain professions;
53 amending s. 491.007, F.S.; deleting a provision
54 providing certified master social workers an exemption
55 from continuing education requirements; deleting a
56 provision requiring the board to establish a procedure
57 for the biennial renewal of intern registrations;
58 amending s. 491.009, F.S.; revising who may enter an
59 order denying licensure or imposing penalties against
60 an applicant for licensure under certain
61 circumstances; amending s. 491.012, F.S.; providing
62 that using the title "certified master social worker"
63 without a valid, active license is unlawful; amending
64 s. 491.0145, F.S.; requiring the department to license
65 an applicant for designation as a certified master
66 social worker under certain circumstances; providing
67 that applicants for designation as a certified master
68 social worker submit their application to the board;
69 deleting a provision relating to the nonrefundable fee
70 for examination set by department rule; authorizing
71 the board to adopt rules; amending s. 491.0149, F.S.;
72 requiring the use of applicable professional titles by
73 specified licensees and registrants on social media
74 and other specified materials; repealing s. 491.015,
75 F.S., relating to duties of the department as to

76 certified master social workers; amending s. 768.28,
77 F.S.; designating the state commissioners of the
78 Interstate Medical Licensure Compact Commission and
79 other members or employees of the commission as state
80 agents for the purpose of applying sovereign immunity
81 and waivers of sovereign immunity; requiring the
82 commission to pay certain claims or judgments;
83 authorizing the commission to maintain insurance
84 coverage to pay such claims or judgments; amending s.
85 414.065, F.S.; conforming a cross-reference; providing
86 an effective date.
87
88 Be It Enacted by the Legislature of the State of Florida:
89
90 Section 1. Section 456.4501, Florida Statutes, is created
91 to read:
92 456.4501 Interstate Medical Licensure Compact.—The
93 Interstate Medical Licensure Compact is hereby enacted into law
94 and entered into by this state with all other jurisdictions
95 legally joining therein in the form substantially as follows:
96
97 SECTION 1
98 PURPOSE
99
100 In order to strengthen access to health care, and in

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

101 recognition of the advances in the delivery of health care, the
102 member states of the Interstate Medical Licensure Compact have
103 allied in common purpose to develop a comprehensive process that
104 complements the existing licensing and regulatory authority of
105 state medical boards, provides a streamlined process that allows
106 physicians to become licensed in multiple states, thereby
107 enhancing the portability of a medical license and ensuring the
108 safety of patients. The Compact creates another pathway for
109 licensure and does not otherwise change a state's existing
110 Medical Practice Act. The Compact also adopts the prevailing
111 standard for licensure and affirms that the practice of medicine
112 occurs where the patient is located at the time of the
113 physician-patient encounter, and therefore, requires the
114 physician to be under the jurisdiction of the state medical
115 board where the patient is located. State medical boards that
116 participate in the Compact retain the jurisdiction to impose an
117 adverse action against a license to practice medicine in that
118 state issued to a physician through the procedures in the
119 Compact.
120
121 SECTION 2
122 DEFINITIONS
123
124 In this Compact:
125 (1) "Bylaws" means those bylaws established by the

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126 Interstate Commission pursuant to section 11 for its governance,
127 or for directing and controlling its actions and conduct.
128 (2) "Commissioner" means the voting representative
129 appointed by each member board pursuant to section 11.
130 (3) "Conviction" means a finding by a court that an
131 individual is guilty of a criminal offense through adjudication,
132 or entry of a plea of guilt or no contest to the charge by the
133 offender. Evidence of an entry of a conviction of a criminal
134 offense by the court shall be considered final for purposes of
135 disciplinary action by a member board.
136 (4) "Expedited license" means a full and unrestricted
137 medical license granted by a member state to an eligible
138 physician through the process set forth in the Compact.
139 (5) "Interstate Commission" means the Interstate Medical
140 Licensure Compact Commission created pursuant to section 11.
141 (6) "License" means authorization by a state for a
142 physician to engage in the practice of medicine, which would be
143 unlawful without the authorization.
144 (7) "Medical Practice Act" means laws and regulations
145 governing the practice of allopathic and osteopathic medicine
146 within a member state.
147 (8) "Member board" means a state agency in a member state
148 that acts in the sovereign interests of the state by protecting
149 the public through licensure, regulation, and education of
150 physicians as directed by the state government.

151 (9) "Member state" means a state that has enacted the
152 Compact.
153 (10) "Practice of medicine" means the diagnosis,
154 treatment, prevention, cure, or relieving of a human disease,
155 ailment, defect, complaint, or other physical or mental
156 condition, by attendance, advice, device, diagnostic test, or
157 other means, or offering, undertaking, attempting to do, or
158 holding oneself out as able to do, any of these acts.
159 (11) "Physician" means any person who:
160 (a) Is a graduate of a medical school accredited by the
161 Liaison Committee on Medical Education, the Commission on
162 Osteopathic College Accreditation, or a medical school listed in
163 the International Medical Education Directory or its equivalent;
164 (b) Passed each component of the United States Medical
165 Licensing Examination (USMLE) or the Comprehensive Osteopathic
166 Medical Licensing Examination (COMLEX-USA) within three
167 attempts, or any of its predecessor examinations accepted by a
168 state medical board as an equivalent examination for licensure
169 purposes;
170 (c) Successfully completed graduate medical education
171 approved by the Accreditation Council for Graduate Medical
172 Education or the American Osteopathic Association;
173 (d) Holds specialty certification or a time-unlimited
174 specialty certificate recognized by the American Board of
175 Medical Specialties or the American Osteopathic Association's

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176 Bureau of Osteopathic Specialists; however, the specialty
177 certification or a time-unlimited specialty certificate does not
178 have to be maintained once a physician is initially determined
179 to be eligible for expedited licensure through the Compact;
180 (e) Possesses a full and unrestricted license to engage in
181 the practice of medicine issued by a member board;
182 (f) Has never been convicted, received adjudication,
183 deferred adjudication, community supervision, or deferred
184 disposition for any offense by a court of appropriate
185 jurisdiction;
186 (g) Has never held a license authorizing the practice of
187 medicine subjected to discipline by a licensing agency in any
188 state, federal, or foreign jurisdiction, excluding any action
189 related to non-payment of fees related to a license;
190 (h) Has never had a controlled substance license or permit
191 suspended or revoked by a state or the United States Drug
192 Enforcement Administration; and
193 (i) Is not under active investigation by a licensing
194 agency or law enforcement authority in any state, federal, or
195 foreign jurisdiction.
196 (12) "Offense" means a felony, high court misdemeanor, or
197 crime of moral turpitude.
198 (13) "Rule" means a written statement by the Interstate
199 Commission promulgated pursuant to section 12 of the Compact
200 that is of general applicability, implements, interprets, or

201 prescribes a policy or provision of the Compact, or an
202 organizational, procedural, or practice requirement of the
203 Interstate Commission, and has the force and effect of statutory
204 law in a member state, if the rule is not inconsistent with the
205 laws of the member state. The term includes the amendment,
206 repeal, or suspension of an existing rule.
207 (14) "State" means any state, commonwealth, district, or
208 territory of the United States.
209 (15) "State of principal license" means a member state
210 where a physician holds a license to practice medicine and which
211 has been designated as such by the physician for purposes of
212 registration and participation in the Compact.
213
214 SECTION 3
215 ELIGIBILITY
216
217 (1) A physician must meet the eligibility requirements as
218 defined in subsection (11) of section 2 to receive an expedited
219 license under the terms and provisions of the Compact.
220 (2) A physician who does not meet the requirements of
221 subsection (11) of section 2 may obtain a license to practice
222 medicine in a member state if the individual complies with all
223 laws and requirements, other than the Compact, relating to the
224 issuance of a license to practice medicine in that state.
225

226 SECTION 4

227 DESIGNATION OF STATE OF PRINCIPAL LICENSE

228

229 (1) A physician shall designate a member state as the
230 state of principal license for purposes of registration for
231 expedited licensure through the Compact if the physician
232 possesses a full and unrestricted license to practice medicine
233 in that state, and the state is:
234 (a) The state of primary residence for the physician, or
235 (b) The state where at least 25% of the practice of
236 medicine occurs, or
237 (c) The location of the physician's employer, or
238 (d) If no state qualifies under paragraph (a), paragraph
239 (b), or paragraph (c), the state designated as state of
240 residence for purpose of federal income tax.
241 (2) A physician may redesignate a member state as state of
242 principal license at any time, as long as the state meets the
243 requirements in subsection (1).
244 (3) The Interstate Commission is authorized to develop
245 rules to facilitate redesignation of another member state as the
246 state of principal license.

247

248 SECTION 5

249 APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

250

251 (1) A physician seeking licensure through the Compact
252 shall file an application for an expedited license with the
253 member board of the state selected by the physician as the state
254 of principal license.
255 (2) Upon receipt of an application for an expedited
256 license, the member board within the state selected as the state
257 of principal license shall evaluate whether the physician is
258 eligible for expedited licensure and issue a letter of
259 qualification, verifying or denying the physician's eligibility,
260 to the Interstate Commission.
261 (a) Static qualifications, which include verification of
262 medical education, graduate medical education, results of any
263 medical or licensing examination, and other qualifications as
264 determined by the Interstate Commission through rule, shall not
265 be subject to additional primary source verification where
266 already primary source verified by the state of principal
267 license.
268 (b) The member board within the state selected as the
269 state of principal license shall, in the course of verifying
270 eligibility, perform a criminal background check of an
271 applicant, including the use of the results of fingerprint or
272 other biometric data checks compliant with the requirements of
273 the Federal Bureau of Investigation, with the exception of
274 federal employees who have suitability determination in
275 accordance with U.S. 5 C.F.R. s. 731.202.

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276 (c) Appeal on the determination of eligibility shall be
277 made to the member state where the application was filed and
278 shall be subject to the law of that state.
279 (3) Upon verification in subsection (2), physicians
280 eligible for an expedited license shall complete the
281 registration process established by the Interstate Commission to
282 receive a license in a member state selected pursuant to
283 subsection (1), including the payment of any applicable fees.
284 (4) After receiving verification of eligibility under
285 subsection (2) and any fees under subsection (3), a member board
286 shall issue an expedited license to the physician. This license
287 shall authorize the physician to practice medicine in the
288 issuing state consistent with the Medical Practice Act and all
289 applicable laws and regulations of the issuing member board and
290 member state.
291 (5) An expedited license shall be valid for a period
292 consistent with the licensure period in the member state and in
293 the same manner as required for other physicians holding a full
294 and unrestricted license within the member state.
295 (6) An expedited license obtained through the Compact
296 shall be terminated if a physician fails to maintain a license
297 in the state of principal licensure for a non-disciplinary
298 reason, without redesignation of a new state of principal
299 licensure.
300 (7) The Interstate Commission is authorized to develop

301 rules regarding the application process, including payment of
302 any applicable fees, and the issuance of an expedited license.
303
304 SECTION 6
305 FEES FOR EXPEDITED LICENSURE
306
307 (1) A member state issuing an expedited license
308 authorizing the practice of medicine in that state, or the
309 regulating authority of the member state, may impose a fee for a
310 license issued or renewed through the Compact.
311 (2) The Interstate Commission is authorized to develop
312 rules regarding fees for expedited licenses. However, those
313 rules shall not limit the authority of a member state, or the
314 regulating authority of the member state, to impose and
315 determine the amount of a fee under subsection (1).
316
317 SECTION 7
318 RENEWAL AND CONTINUED PARTICIPATION
319
320 (1) A physician seeking to renew an expedited license
321 granted in a member state shall complete a renewal process with
322 the Interstate Commission if the physician:
323 (a) Maintains a full and unrestricted license in a state
324 of principal license;
325 (b) Has not been convicted, received adjudication,

326 deferred adjudication, community supervision, or deferred
327 disposition for any offense by a court of appropriate
328 jurisdiction;
329 (c) Has not had a license authorizing the practice of
330 medicine subject to discipline by a licensing agency in any
331 state, federal, or foreign jurisdiction, excluding any action
332 related to non-payment of fees related to a license; and
333 (d) Has not had a controlled substance license or permit
334 suspended or revoked by a state or the United States Drug
335 Enforcement Administration.
336 (2) Physicians shall comply with all continuing
337 professional development or continuing medical education
338 requirements for renewal of a license issued by a member state.
339 (3) The Interstate Commission shall collect any renewal
340 fees charged for the renewal of a license and distribute the
341 fees to the applicable member board.
342 (4) Upon receipt of any renewal fees collected in
343 subsection (3), a member board shall renew the physician's
344 license.
345 (5) Physician information collected by the Interstate
346 Commission during the renewal process will be distributed to all
347 member boards.
348 (6) The Interstate Commission is authorized to develop
349 rules to address renewal of licenses obtained through the
350 Compact.

351
352 SECTION 8
353 COORDINATED INFORMATION SYSTEM
354
355 (1) The Interstate Commission shall establish a database
356 of all physicians licensed, or who have applied for licensure,
357 under section 5.
358 (2) Notwithstanding any other provision of law, member
359 boards shall report to the Interstate Commission any public
360 action or complaints against a licensed physician who has
361 applied or received an expedited license through the Compact.
362 (3) Member boards shall report disciplinary or
363 investigatory information determined as necessary and proper by
364 rule of the Interstate Commission.
365 (4) Member boards may report any non-public complaint,
366 disciplinary, or investigatory information not required by
367 subsection (3) to the Interstate Commission.
368 (5) Member boards shall share complaint or disciplinary
369 information about a physician upon request of another member
370 board.
371 (6) All information provided to the Interstate Commission
372 or distributed by member boards shall be confidential, filed
373 under seal, and used only for investigatory or disciplinary
374 matters.
375 (7) The Interstate Commission is authorized to develop

376 rules for mandated or discretionary sharing of information by
377 member boards.
378
379 SECTION 9
380 JOINT INVESTIGATIONS
381
382 (1) Licensure and disciplinary records of physicians are
383 deemed investigative.
384 (2) In addition to the authority granted to a member board
385 by its respective Medical Practice Act or other applicable state
386 law, a member board may participate with other member boards in
387 joint investigations of physicians licensed by the member
388 boards.
389 (3) A subpoena issued by a member state shall be
390 enforceable in other member states.
391 (4) Member boards may share any investigative, litigation,
392 or compliance materials in furtherance of any joint or
393 individual investigation initiated under the Compact.
394 (5) Any member state may investigate actual or alleged
395 violations of the statutes authorizing the practice of medicine
396 in any other member state in which a physician holds a license
397 to practice medicine.
398
399 SECTION 10
400 DISCIPLINARY ACTIONS

401
402 (1) Any disciplinary action taken by any member board
403 against a physician licensed through the Compact shall be deemed
404 unprofessional conduct which may be subject to discipline by
405 other member boards, in addition to any violation of the Medical
406 Practice Act or regulations in that state.
407 (2) If a license granted to a physician by the member
408 board in the state of principal license is revoked, surrendered
409 or relinquished in lieu of discipline, or suspended, then all
410 licenses issued to the physician by member boards shall
411 automatically be placed, without further action necessary by any
412 member board, on the same status. If the member board in the
413 state of principal license subsequently reinstates the
414 physician's license, a license issued to the physician by any
415 other member board shall remain encumbered until that respective
416 member board takes action to reinstate the license in a manner
417 consistent with the Medical Practice Act of that state.
418 (3) If disciplinary action is taken against a physician by
419 a member board not in the state of principal license, any other
420 member board may deem the action conclusive as to matter of law
421 and fact decided, and:
422 (a) Impose the same or lesser sanction(s) against the
423 physician so long as such sanctions are consistent with the
424 Medical Practice Act of that state; or
425 (b) Pursue separate disciplinary action against the

426 physician under its respective Medical Practice Act, regardless
427 of the action taken in other member states.
428 (4) If a license granted to a physician by a member board
429 is revoked, surrendered or relinquished in lieu of discipline,
430 or suspended, then any license(s) issued to the physician by any
431 other member board(s) shall be suspended, automatically and
432 immediately without further action necessary by the other member
433 board(s), for ninety (90) days upon entry of the order by the
434 disciplining board, to permit the member board(s) to investigate
435 the basis for the action under the Medical Practice Act of that
436 state. A member board may terminate the automatic suspension of
437 the license it issued prior to the completion of the ninety (90)
438 day suspension period in a manner consistent with the Medical
439 Practice Act of that state.
440
441 SECTION 11
442 INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION
443
444 (1) The member states hereby create the "Interstate
445 Medical Licensure Compact Commission."
446 (2) The purpose of the Interstate Commission is the
447 administration of the Interstate Medical Licensure Compact,
448 which is a discretionary state function.
449 (3) The Interstate Commission shall be a body corporate
450 and joint agency of the member states and shall have all the

451 responsibilities, powers, and duties set forth in the Compact,
452 and such additional powers as may be conferred upon it by a
453 subsequent concurrent action of the respective legislatures of
454 the member states in accordance with the terms of the Compact.
455 (4) The Interstate Commission shall consist of two voting
456 representatives appointed by each member state who shall serve
457 as Commissioners. In states where allopathic and osteopathic
458 physicians are regulated by separate member boards, or if the
459 licensing and disciplinary authority is split between multiple
460 member boards within a member state, the member state shall
461 appoint one representative from each member board. A
462 Commissioner shall be a(n):
463 (a) Allopathic or osteopathic physician appointed to a
464 member board;
465 (b) Executive director, executive secretary, or similar
466 executive of a member board; or
467 (c) Member of the public appointed to a member board.
468 (5) The Interstate Commission shall meet at least once
469 each calendar year. A portion of this meeting shall be a
470 business meeting to address such matters as may properly come
471 before the Commission, including the election of officers. The
472 chairperson may call additional meetings and shall call for a
473 meeting upon the request of a majority of the member states.
474 (6) The bylaws may provide for meetings of the Interstate
475 Commission to be conducted by telecommunication or electronic

476 communication.
477 (7) Each Commissioner participating at a meeting of the
478 Interstate Commission is entitled to one vote. A majority of
479 Commissioners shall constitute a quorum for the transaction of
480 business, unless a larger quorum is required by the bylaws of
481 the Interstate Commission. A Commissioner shall not delegate a
482 vote to another Commissioner. In the absence of its
483 Commissioner, a member state may delegate voting authority for a
484 specified meeting to another person from that state who shall
485 meet the requirements of subsection (4).
486 (8) The Interstate Commission shall provide public notice
487 of all meetings and all meetings shall be open to the public.
488 The Interstate Commission may close a meeting, in full or in
489 portion, where it determines by a two-thirds vote of the
490 Commissioners present that an open meeting would be likely to:
491 (a) Relate solely to the internal personnel practices and
492 procedures of the Interstate Commission;
493 (b) Discuss matters specifically exempted from disclosure
494 by federal statute;
495 (c) Discuss trade secrets, commercial, or financial
496 information that is privileged or confidential;
497 (d) Involve accusing a person of a crime, or formally
498 censuring a person;
499 (e) Discuss information of a personal nature where
500 disclosure would constitute a clearly unwarranted invasion of

501 personal privacy;
502 (f) Discuss investigative records compiled for law
503 enforcement purposes; or
504 (g) Specifically relate to the participation in a civil
505 action or other legal proceeding.
506 (9) The Interstate Commission shall keep minutes which
507 shall fully describe all matters discussed in a meeting and
508 shall provide a full and accurate summary of actions taken,
509 including record of any roll call votes.
510 (10) The Interstate Commission shall make its information
511 and official records, to the extent not otherwise designated in
512 the Compact or by its rules, available to the public for
513 inspection.
514 (11) The Interstate Commission shall establish an
515 executive committee, which shall include officers, members, and
516 others as determined by the bylaws. The executive committee
517 shall have the power to act on behalf of the Interstate
518 Commission, with the exception of rulemaking, during periods
519 when the Interstate Commission is not in session. When acting on
520 behalf of the Interstate Commission, the executive committee
521 shall oversee the administration of the Compact including
522 enforcement and compliance with the provisions of the Compact,
523 its bylaws and rules, and other such duties as necessary.
524 (12) The Interstate Commission may establish other
525 committees for governance and administration of the Compact.

526
527 SECTION 12
528 POWERS AND DUTIES OF THE INTERSTATE COMMISSION
529
530 The Interstate Commission shall have the duty and power to:
531 (1) Oversee and maintain the administration of the
532 Compact;
533 (2) Promulgate rules which shall be binding to the extent
534 and in the manner provided for in the Compact;
535 (3) Issue, upon the request of a member state or member
536 board, advisory opinions concerning the meaning or
537 interpretation of the Compact, its bylaws, rules, and actions;
538 (4) Enforce compliance with Compact provisions, the rules
539 promulgated by the Interstate Commission, and the bylaws, using
540 all necessary and proper means, including but not limited to the
541 use of judicial process;
542 (5) Establish and appoint committees including, but not
543 limited to, an executive committee as required by section 11,
544 which shall have the power to act on behalf of the Interstate
545 Commission in carrying out its powers and duties;
546 (6) Pay, or provide for the payment of the expenses
547 related to the establishment, organization, and ongoing
548 activities of the Interstate Commission;
549 (7) Establish and maintain one or more offices;
550 (8) Borrow, accept, hire, or contract for services of

551 personnel;
552 (9) Purchase and maintain insurance and bonds;
553 (10) Employ an executive director who shall have such
554 powers to employ, select or appoint employees, agents, or
555 consultants, and to determine their qualifications, define their
556 duties, and fix their compensation;
557 (11) Establish personnel policies and programs relating to
558 conflicts of interest, rates of compensation, and qualifications
559 of personnel;
560 (12) Accept donations and grants of money, equipment,
561 supplies, materials and services, and to receive, utilize, and
562 dispose of it in a manner consistent with the conflict of
563 interest policies established by the Interstate Commission;
564 (13) Lease, purchase, accept contributions or donations
565 of, or otherwise to own, hold, improve or use, any property,
566 real, personal, or mixed;
567 (14) Sell, convey, mortgage, pledge, lease, exchange,
568 abandon, or otherwise dispose of any property, real, personal,
569 or mixed;
570 (15) Establish a budget and make expenditures;
571 (16) Adopt a seal and bylaws governing the management and
572 operation of the Interstate Commission;
573 (17) Report annually to the legislatures and governors of
574 the member states concerning the activities of the Interstate
575 Commission during the preceding year. Such reports shall also

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576 include reports of financial audits and any recommendations that
577 may have been adopted by the Interstate Commission;
578 (18) Coordinate education, training, and public awareness
579 regarding the Compact, its implementation, and its operation;
580 (19) Maintain records in accordance with the bylaws;
581 (20) Seek and obtain trademarks, copyrights, and patents;
582 and
583 (21) Perform such functions as may be necessary or
584 appropriate to achieve the purposes of the Compact.
585
586 SECTION 13
587 FINANCE POWERS
588
589 (1) The Interstate Commission may levy on and collect an
590 annual assessment from each member state to cover the cost of
591 the operations and activities of the Interstate Commission and
592 its staff. The total assessment, subject to appropriation, must
593 be sufficient to cover the annual budget approved each year for
594 which revenue is not provided by other sources. The aggregate
595 annual assessment amount shall be allocated upon a formula to be
596 determined by the Interstate Commission, which shall promulgate
597 a rule binding upon all member states.
598 (2) The Interstate Commission shall not incur obligations
599 of any kind prior to securing the funds adequate to meet the
600 same.

601 (3) The Interstate Commission shall not pledge the credit
602 of any of the member states, except by, and with the authority
603 of, the member state.
604 (4) The Interstate Commission shall be subject to a yearly
605 financial audit conducted by a certified or licensed public
606 accountant and the report of the audit shall be included in the
607 annual report of the Interstate Commission.
608
609 SECTION 14
610 ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION
611
612 (1) The Interstate Commission shall, by a majority of
613 Commissioners present and voting, adopt bylaws to govern its
614 conduct as may be necessary or appropriate to carry out the
615 purposes of the Compact within twelve (12) months of the first
616 Interstate Commission meeting.
617 (2) The Interstate Commission shall elect or appoint
618 annually from among its Commissioners a chairperson, a vice-
619 chairperson, and a treasurer, each of whom shall have such
620 authority and duties as may be specified in the bylaws. The
621 chairperson, or in the chairperson's absence or disability, the
622 vice-chairperson, shall preside at all meetings of the
623 Interstate Commission.
624 (3) Officers selected in subsection (2) shall serve
625 without remuneration from the Interstate Commission.

626 (4) The officers and employees of the Interstate
627 Commission shall be immune from suit and liability, either
628 personally or in their official capacity, for a claim for damage
629 to or loss of property or personal injury or other civil
630 liability caused or arising out of, or relating to, an actual or
631 alleged act, error, or omission that occurred, or that such
632 person had a reasonable basis for believing occurred, within the
633 scope of Interstate Commission employment, duties, or
634 responsibilities; provided that such person shall not be
635 protected from suit or liability for damage, loss, injury, or
636 liability caused by the intentional or willful and wanton
637 misconduct of such person.
638 (a) The liability of the executive director and employees
639 of the Interstate Commission or representatives of the
640 Interstate Commission, acting within the scope of such person's
641 employment or duties for acts, errors, or omissions occurring
642 within such person's state, may not exceed the limits of
643 liability set forth under the constitution and laws of that
644 state for state officials, employees, and agents. The Interstate
645 Commission is considered to be an instrumentality of the states
646 for the purposes of any such action. Nothing in this subsection
647 shall be construed to protect such person from suit or liability
648 for damage, loss, injury, or liability caused by the intentional
649 or willful and wanton misconduct of such person.
650 (b) The Interstate Commission shall defend the executive

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651 director, its employees, and subject to the approval of the
652 attorney general or other appropriate legal counsel of the
653 member state represented by an Interstate Commission
654 representative, shall defend such Interstate Commission
655 representative in any civil action seeking to impose liability
656 arising out of an actual or alleged act, error or omission that
657 occurred within the scope of Interstate Commission employment,
658 duties or responsibilities, or that the defendant had a
659 reasonable basis for believing occurred within the scope of
660 Interstate Commission employment, duties, or responsibilities,
661 provided that the actual or alleged act, error, or omission did
662 not result from intentional or willful and wanton misconduct on
663 the part of such person.
664 (c) To the extent not covered by the state involved,
665 member state, or the Interstate Commission, the representatives
666 or employees of the Interstate Commission shall be held harmless
667 in the amount of a settlement or judgment, including attorney's
668 fees and costs, obtained against such persons arising out of an
669 actual or alleged act, error, or omission that occurred within
670 the scope of Interstate Commission employment, duties, or
671 responsibilities, or that such persons had a reasonable basis
672 for believing occurred within the scope of Interstate Commission
673 employment, duties, or responsibilities, provided that the
674 actual or alleged act, error, or omission did not result from
675 intentional or willful and wanton misconduct on the part of such

676 persons.
677
678 SECTION 15
679 RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION
680
681 (1) The Interstate Commission shall promulgate reasonable
682 rules in order to effectively and efficiently achieve the
683 purposes of the Compact. Notwithstanding the foregoing, in the
684 event the Interstate Commission exercises its rulemaking
685 authority in a manner that is beyond the scope of the purposes
686 of the Compact, or the powers granted hereunder, then such an
687 action by the Interstate Commission shall be invalid and have no
688 force or effect.
689 (2) Rules deemed appropriate for the operations of the
690 Interstate Commission shall be made pursuant to a rulemaking
691 process that substantially conforms to the "Model State
692 Administrative Procedure Act" of 2010, and subsequent amendments
693 thereto.
694 (3) Not later than thirty (30) days after a rule is
695 promulgated, any person may file a petition for judicial review
696 of the rule in the United States District Court for the District
697 of Columbia or the federal district where the Interstate
698 Commission has its principal offices, provided that the filing
699 of such a petition shall not stay or otherwise prevent the rule
700 from becoming effective unless the court finds that the

701 petitioner has a substantial likelihood of success. The court
702 shall give deference to the actions of the Interstate Commission
703 consistent with applicable law and shall not find the rule to be
704 unlawful if the rule represents a reasonable exercise of the
705 authority granted to the Interstate Commission.
706
707 SECTION 16
708 OVERSIGHT OF INTERSTATE COMPACT
709
710 (1) The executive, legislative, and judicial branches of
711 state government in each member state shall enforce the Compact
712 and shall take all actions necessary and appropriate to
713 effectuate the Compact's purposes and intent. The provisions of
714 the Compact and the rules promulgated hereunder shall have
715 standing as statutory law but shall not override existing state
716 authority to regulate the practice of medicine.
717 (2) All courts shall take judicial notice of the Compact
718 and the rules in any judicial or administrative proceeding in a
719 member state pertaining to the subject matter of the Compact
720 which may affect the powers, responsibilities or actions of the
721 Interstate Commission.
722 (3) The Interstate Commission shall be entitled to receive
723 all service of process in any such proceeding, and shall have
724 standing to intervene in the proceeding for all purposes.
725 Failure to provide service of process to the Interstate

726 Commission shall render a judgment or order void as to the
727 Interstate Commission, the Compact, or promulgated rules.
728
729 SECTION 17
730 ENFORCEMENT OF INTERSTATE COMPACT
731
732 (1) The Interstate Commission, in the reasonable exercise
733 of its discretion, shall enforce the provisions and rules of the
734 Compact.
735 (2) The Interstate Commission may, by majority vote of the
736 Commissioners, initiate legal action in the United States
737 District Court for the District of Columbia, or, at the
738 discretion of the Interstate Commission, in the federal district
739 where the Interstate Commission has its principal offices, to
740 enforce compliance with the provisions of the Compact, and its
741 promulgated rules and bylaws, against a member state in default.
742 The relief sought may include both injunctive relief and
743 damages. In the event judicial enforcement is necessary, the
744 prevailing party shall be awarded all costs of such litigation
745 including reasonable attorney's fees.
746 (3) The remedies herein shall not be the exclusive
747 remedies of the Interstate Commission. The Interstate Commission
748 may avail itself of any other remedies available under state law
749 or the regulation of a profession.
750

751 SECTION 18
752 DEFAULT PROCEDURES
753
754 (1) The grounds for default include, but are not limited
755 to, failure of a member state to perform such obligations or
756 responsibilities imposed upon it by the Compact, or the rules
757 and bylaws of the Interstate Commission promulgated under the
758 Compact.
759 (2) If the Interstate Commission determines that a member
760 state has defaulted in the performance of its obligations or
761 responsibilities under the Compact, or the bylaws or promulgated
762 rules, the Interstate Commission shall:
763 (a) Provide written notice to the defaulting state and
764 other member states, of the nature of the default, the means of
765 curing the default, and any action taken by the Interstate
766 Commission. The Interstate Commission shall specify the
767 conditions by which the defaulting state must cure its default;
768 and
769 (b) Provide remedial training and specific technical
770 assistance regarding the default.
771 (3) If the defaulting state fails to cure the default, the
772 defaulting state shall be terminated from the Compact upon an
773 affirmative vote of a majority of the Commissioners and all
774 rights, privileges, and benefits conferred by the Compact shall
775 terminate on the effective date of termination. A cure of the

776 default does not relieve the offending state of obligations or
777 liabilities incurred during the period of the default.
778 (4) Termination of membership in the Compact shall be
779 imposed only after all other means of securing compliance have
780 been exhausted. Notice of intent to terminate shall be given by
781 the Interstate Commission to the governor, the majority and
782 minority leaders of the defaulting state's legislature, and each
783 of the member states.
784 (5) The Interstate Commission shall establish rules and
785 procedures to address licenses and physicians that are
786 materially impacted by the termination of a member state, or the
787 withdrawal of a member state.
788 (6) The member state which has been terminated is
789 responsible for all dues, obligations, and liabilities incurred
790 through the effective date of termination including obligations,
791 the performance of which extends beyond the effective date of
792 termination.
793 (7) The Interstate Commission shall not bear any costs
794 relating to any state that has been found to be in default or
795 which has been terminated from the Compact, unless otherwise
796 mutually agreed upon in writing between the Interstate
797 Commission and the defaulting state.
798 (8) The defaulting state may appeal the action of the
799 Interstate Commission by petitioning the United States District
800 Court for the District of Columbia or the federal district where

801 the Interstate Commission has its principal offices. The
802 prevailing party shall be awarded all costs of such litigation
803 including reasonable attorney's fees.
804
805 SECTION 19
806 DISPUTE RESOLUTION
807
808 (1) The Interstate Commission shall attempt, upon the
809 request of a member state, to resolve disputes which are subject
810 to the Compact and which may arise among member states or member
811 boards.
812 (2) The Interstate Commission shall promulgate rules
813 providing for both mediation and binding dispute resolution as
814 appropriate.
815
816 SECTION 20
817 MEMBER STATES, EFFECTIVE DATE AND AMENDMENT
818
819 (1) Any state is eligible to become a member state of the
820 Compact.
821 (2) The Compact shall become effective and binding upon
822 legislative enactment of the Compact into law by no less than
823 seven (7) states. Thereafter, it shall become effective and
824 binding on a state upon enactment of the Compact into law by
825 that state.

826 (3) The governors of non-member states, or their
827 designees, shall be invited to participate in the activities of
828 the Interstate Commission on a non-voting basis prior to
829 adoption of the Compact by all states.
830 (4) The Interstate Commission may propose amendments to
831 the Compact for enactment by the member states. No amendment
832 shall become effective and binding upon the Interstate
833 Commission and the member states unless and until it is enacted
834 into law by unanimous consent of the member states.
835
836 SECTION 21
837 WITHDRAWAL
838
839 (1) Once effective, the Compact shall continue in force
840 and remain binding upon each and every member state; provided
841 that a member state may withdraw from the Compact by
842 specifically repealing the statute which enacted the Compact
843 into law.
844 (2) Withdrawal from the Compact shall be by the enactment
845 of a statute repealing the same, but shall not take effect until
846 one (1) year after the effective date of such statute and until
847 written notice of the withdrawal has been given by the
848 withdrawing state to the governor of each other member state.
849 (3) The withdrawing state shall immediately notify the
850 chairperson of the Interstate Commission in writing upon the

851 introduction of legislation repealing the Compact in the
852 withdrawing state.
853 (4) The Interstate Commission shall notify the other
854 member states of the withdrawing state's intent to withdraw
855 within sixty (60) days of its receipt of notice provided under
856 subsection (3).
857 (5) The withdrawing state is responsible for all dues,
858 obligations and liabilities incurred through the effective date
859 of withdrawal, including obligations, the performance of which
860 extend beyond the effective date of withdrawal.
861 (6) Reinstatement following withdrawal of a member state
862 shall occur upon the withdrawing state reenacting the Compact or
863 upon such later date as determined by the Interstate Commission.
864 (7) The Interstate Commission is authorized to develop
865 rules to address the impact of the withdrawal of a member state
866 on licenses granted in other member states to physicians who
867 designated the withdrawing member state as the state of
868 principal license.
869
870 SECTION 22
871 DISSOLUTION
872
873 (1) The Compact shall dissolve effective upon the date of
874 the withdrawal or default of the member state which reduces the
875 membership in the Compact to one (1) member state.

876 (2) Upon the dissolution of the Compact, the Compact
877 becomes null and void and shall be of no further force or
878 effect, and the business and affairs of the Interstate
879 Commission shall be concluded and surplus funds shall be
880 distributed in accordance with the bylaws.
881
882 SECTION 23
883 SEVERABILITY AND CONSTRUCTION
884
885 (1) The provisions of the Compact shall be severable, and
886 if any phrase, clause, sentence, or provision is deemed
887 unenforceable, the remaining provisions of the Compact shall be
888 enforceable.
889 (2) The provisions of the Compact shall be liberally
890 construed to effectuate its purposes.
891 (3) Nothing in the Compact shall be construed to prohibit
892 the applicability of other interstate compacts to which the
893 states are members.
894
895 SECTION 24
896 BINDING EFFECT OF COMPACT AND OTHER LAWS
897
898 (1) Nothing herein prevents the enforcement of any other
899 law of a member state that is not inconsistent with the Compact.
900 (2) All laws in a member state in conflict with the

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901 Compact are superseded to the extent of the conflict.
902 (3) All lawful actions of the Interstate Commission,
903 including all rules and bylaws promulgated by the Commission,
904 are binding upon the member states.
905 (4) All agreements between the Interstate Commission and
906 the member states are binding in accordance with their terms.
907 (5) In the event any provision of the Compact exceeds the
908 constitutional limits imposed on the legislature of any member
909 state, such provision shall be ineffective to the extent of the
910 conflict with the constitutional provision in question in that
911 member state.
912 Section 2. Section 456.4502, Florida Statutes, is created
913 to read:
914 456.4502 Interstate Medical Licensure Compact;
915 disciplinary proceedings.—A physician licensed pursuant to
916 chapter 458, chapter 459, or s. 456.4501 whose license is
917 suspended or revoked by this state pursuant to the Interstate
918 Medical Licensure Compact as a result of disciplinary action
919 taken against the physician's license in another state shall be
920 granted a formal hearing before an administrative law judge from
921 the Division of Administrative Hearings held pursuant to chapter
922 120 if there are any disputed issues of material fact. In such
923 proceedings:
924 (1) Notwithstanding s. 120.569(2), the department shall
925 notify the division within 45 days after receipt of a petition

926 or request for a formal hearing.
927 (2) The determination of whether the physician has
928 violated the laws and rules regulating the practice of medicine
929 or osteopathic medicine, as applicable, including a
930 determination of the reasonable standard of care, is a
931 conclusion of law that is to be determined by appropriate board,
932 and is not a finding of fact to be determined by an
933 administrative law judge.
934 (3) The administrative law judge shall issue a recommended
935 order pursuant to chapter 120.
936 (4) The Board of Medicine or the Board of Osteopathic
937 Medicine, as applicable, shall determine and issue the final
938 order in each disciplinary case. Such order shall constitute
939 final agency action.
940 (5) Any consent order or agreed-upon settlement is subject
941 to the approval of the department.
942 (6) The department shall have standing to seek judicial
943 review of any final order of the board, pursuant to s. 120.68.
944 Section 3. Section 456.4503, Florida Statutes, is created
945 to read:
946 456.4503 Interstate Medical Licensure Compact
947 Commissioners.—The duly appointed commissioners to the
948 Interstate Medical Licensure Compact Commission under s.
949 456.4501 shall ensure that the Interstate Medical Licensure
950 Compact Commission complies with the requirements of chapter 119

951 and s. 24, Art. I of the State Constitution.
952 Section 4. Section 456.4504, Florida Statutes, is created
953 to read:
954 456.4504 Interstate Medical Licensure Compact Rules.—The
955 department may adopt rules to implement the Interstate Medical
956 Licensure Compact.
957 Section 5. Section 458.3129, Florida Statutes, is created
958 to read:
959 458.3129 Interstate Medical Licensure Compact.—A physician
960 licensed to practice medicine under s. 456.4501 is deemed to be
961 licensed as a physician under this chapter.
962 Section 6. Section 459.074, Florida Statutes, is created
963 to read:
964 459.074 Interstate Medical Licensure Compact.—A physician
965 licensed to practice osteopathic medicine under s. 456.4501 is
966 deemed to be licensed as an osteopathic physician under this
967 chapter.
968 Section 7. Subsections (1) and (2) of section 464.0196,
969 Florida Statutes, are amended to read:
970 464.0196 Florida Center for Nursing; board of directors.—
971 (1) The Florida Center for Nursing shall be governed by a
972 policy-setting board of directors. The board shall consist of 16
973 members, with a simple majority of the board being nurses
974 representative of various practice areas. Other members shall
975 include representatives of other health care professions,

976 business and industry, health care providers, and consumers. The
977 members of the board shall be appointed by the Governor as
978 follows:
979 (a) Four members recommended by the President of the
980 Senate~~, at least one of whom shall be a registered nurse~~
981 ~~recommended by the Florida Organization of Nurse Executives and~~
982 ~~at least one other representative of the hospital industry~~
983 ~~recommended by the Florida Hospital Association~~;
984 (b) Four members recommended by the Speaker of the House
985 of Representatives~~, at least one of whom shall be a registered~~
986 ~~nurse recommended by the Florida Nurses Association and at least~~
987 ~~one other representative of the long-term care industry~~;
988 (c) Four members recommended by the Governor~~, two of whom~~
989 ~~shall be registered nurses~~;
990 (d) One nurse educator recommended by the Board of
991 Governors ~~who is a dean of a College of Nursing at a state~~
992 ~~university~~; and
993 (e) Three nurse educators recommended by the State Board
994 of Education~~, one of whom must be a director of a nursing~~
995 ~~program at a Florida College System institution~~.
996 (2) ~~The initial terms of the members shall be as follows:~~
997 ~~(a) Of the members appointed pursuant to paragraph (1)(a),~~
998 ~~two shall be appointed for terms expiring June 30, 2005, one for~~
999 ~~a term expiring June 30, 2004, and one for a term expiring June~~
1000 ~~30, 2003.~~

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1001 ~~(b) Of the members appointed pursuant to paragraph (1)(b),~~
1002 ~~one shall be appointed for a term expiring June 30, 2005, two~~
1003 ~~for terms expiring June 30, 2004, and one for a term expiring~~
1004 ~~June 20, 2003.~~
1005 ~~(c) Of the members appointed pursuant to paragraph (1)(c),~~
1006 ~~one shall be appointed for a term expiring June 30, 2005, one~~
1007 ~~for a term expiring June 30, 2004, and two for terms expiring~~
1008 ~~June 30, 2003.~~
1009 ~~(d) Of the members appointed pursuant to paragraph (1)(d),~~
1010 ~~the terms of two members recommended by the State Board of~~
1011 ~~Education shall expire June 30, 2005; the term of the member who~~
1012 ~~is a dean of a College of Nursing at a state university shall~~
1013 ~~expire June 30, 2004; and the term of the member who is a~~
1014 ~~director of a state community college nursing program shall~~
1015 ~~expire June 30, 2003.~~
1016
1017 ~~After the initial appointments expire,~~ The terms of all the
1018 members shall be for 3 years, with no member serving more than
1019 two consecutive terms.
1020 Section 8. Subsections (2) through (7) of section 491.003,
1021 Florida Statutes, are renumbered as subsections (3) through (8),
1022 respectively, present subsections (8) through (17) are
1023 renumbered as subsections (10) through (19), respectively, and
1024 new subsections (2) and (9) are added to that section to read:
1025 491.003 Definitions.—As used in this chapter:

1026 (2) "Certified master social worker" means a person
1027 licensed under this chapter to practice generalist social work.
1028 (9) "Practice of generalist social work" means the
1029 application of social work theory, knowledge, methods, and
1030 ethics, and the professional use of self to restore or enhance
1031 social, psychosocial, or biopsychosocial functioning of
1032 individuals, couples, families, groups, organizations, and
1033 communities. The term includes the application of specialized
1034 knowledge and advanced practice skills in nondiagnostic
1035 assessment, treatment planning, implementation and evaluation,
1036 case management, information and referral, supervision,
1037 consultation, education, research, advocacy, community
1038 organization, and the development, implementation, and
1039 administration of policies, programs, and activities.
1040 Section 9. Subsections (4) through (7) of section 491.004,
1041 Florida Statutes, are renumbered as subsections (3) through (6),
1042 respectively, and present subsections (3) and (4) of that
1043 section are amended to read:
1044 491.004 Board of Clinical Social Work, Marriage and Family
1045 Therapy, and Mental Health Counseling.—
1046 ~~(3) No later than January 1, 1988, the Governor shall~~
1047 ~~appoint nine members of the board as follows:~~
1048 ~~(a) Three members for terms of 2 years each.~~
1049 ~~(b) Three members for terms of 3 years each.~~
1050 ~~(c) Three members for terms of 4 years each.~~

1051 (3) ~~(4)~~ As the terms of the ~~initial~~ members expire, the
1052 Governor shall appoint successors for terms of 4 years; and
1053 those members shall serve until their successors are appointed.
1054 Section 10. Subsection (6) of section 491.0045, Florida
1055 Statutes, is amended to read:
1056 491.0045 Intern registration; requirements.—
1057 (6) A registration issued on or before March 31, 2017,
1058 expires March 31, 2022, and may not be renewed or reissued. Any
1059 registration issued after March 31, 2017, expires 60 months
1060 after the date it is issued. The board may make a one-time
1061 exception from the requirements of this section in emergency or
1062 hardship cases, as defined by board rule, if ~~A subsequent intern~~
1063 ~~registration may not be issued unless~~ the candidate has passed
1064 the theory and practice examination described in s.
1065 491.005(1)(d), (3)(d), and (4)(d).
1066 Section 11. Subsection (1), paragraph (b) of subsection
1067 (2), and subsections (3) and (4) of section 491.005, Florida
1068 Statutes, are amended to read:
1069 491.005 Licensure by examination.—
1070 (1) CLINICAL SOCIAL WORK.—Upon verification of
1071 documentation and payment of a fee not to exceed $200, as set by
1072 board rule, plus the actual per applicant cost ~~to the department~~
1073 for purchase of the examination from the ~~American~~ Association of
1074 ~~State~~ Social Work ~~Worker's~~ Boards or its successor ~~a similar~~
1075 ~~national organization~~, the department shall issue a license as a

1076 clinical social worker to an applicant who the board certifies:
1077 (a) Has submitted an application and paid the appropriate
1078 fee.
1079 (b)1. Has received a doctoral degree in social work from a
1080 graduate school of social work which at the time the applicant
1081 graduated was accredited by an accrediting agency recognized by
1082 the United States Department of Education or has received a
1083 master's degree in social work from a graduate school of social
1084 work which at the time the applicant graduated:
1085 a. Was accredited by the Council on Social Work Education;
1086 b. Was accredited by the Canadian Association of Schools
1087 of Social Work; or
1088 c. Has been determined to have been a program equivalent
1089 to programs approved by the Council on Social Work Education by
1090 the Foreign Equivalency Determination Service of the Council on
1091 Social Work Education. An applicant who graduated from a program
1092 at a university or college outside of the United States or
1093 Canada must present documentation of the equivalency
1094 determination from the council in order to qualify.
1095 2. The applicant's graduate program must have emphasized
1096 direct clinical patient or client health care services,
1097 including, but not limited to, coursework in clinical social
1098 work, psychiatric social work, medical social work, social
1099 casework, psychotherapy, or group therapy. The applicant's
1100 graduate program must have included all of the following

1101 coursework:
1102 a. A supervised field placement which was part of the
1103 applicant's advanced concentration in direct practice, during
1104 which the applicant provided clinical services directly to
1105 clients.
1106 b. Completion of 24 semester hours or 32 quarter hours in
1107 courses approved by board rule ~~theory of human behavior and~~
1108 ~~practice methods as courses in clinically oriented services,~~
1109 ~~including a minimum of one course in psychopathology, and no~~
1110 ~~more than one course in research, taken in a school of social~~
1111 ~~work accredited or approved pursuant to subparagraph 1~~.
1112 ~~3. If the course title which appears on the applicant's~~
1113 ~~transcript does not clearly identify the content of the~~
1114 ~~coursework, the applicant shall be required to provide~~
1115 ~~additional documentation, including, but not limited to, a~~
1116 ~~syllabus or catalog description published for the course.~~
1117 (c) Has had at least 2 years of clinical social work
1118 experience, which took place subsequent to completion of a
1119 graduate degree in social work at an institution meeting the
1120 accreditation requirements of this section, under the
1121 supervision of a licensed clinical social worker or the
1122 equivalent who is a qualified supervisor as determined by the
1123 board. An individual who intends to practice in Florida to
1124 satisfy clinical experience requirements must register pursuant
1125 to s. 491.0045 before commencing practice. If the applicant's

1126 graduate program was not a program which emphasized direct
1127 clinical patient or client health care services as described in
1128 subparagraph (b)2., the supervised experience requirement must
1129 take place after the applicant has completed a minimum of 15
1130 semester hours or 22 quarter hours of the coursework required. A
1131 doctoral internship may be applied toward the clinical social
1132 work experience requirement. A licensed mental health
1133 professional must be on the premises when clinical services are
1134 provided by a registered intern in a private practice setting.
1135 (d) Has passed a theory and practice examination
1136 designated ~~provided~~ by the board ~~department for this purpose~~.
1137 (e) Has demonstrated, in a manner designated by board rule
1138 ~~of the board~~, knowledge of the laws and rules governing the
1139 practice of clinical social work, marriage and family therapy,
1140 and mental health counseling.
1141 (2) CLINICAL SOCIAL WORK.—
1142 (b) An applicant from a master's or doctoral program in
1143 social work which did not emphasize direct patient or client
1144 services may complete the clinical curriculum content
1145 requirement by returning to a graduate program accredited by the
1146 Council on Social Work Education or the Canadian Association for
1147 Social Work Education ~~of Schools of Social Work~~, or to a
1148 clinical social work graduate program with comparable standards,
1149 in order to complete the education requirements for examination.
1150 However, a maximum of 6 semester or 9 quarter hours of the

1151 clinical curriculum content requirement may be completed by
1152 credit awarded for independent study coursework as defined by
1153 board rule.
1154 (3) MARRIAGE AND FAMILY THERAPY.—Upon verification of
1155 documentation and payment of a fee not to exceed $200, as set by
1156 board rule, plus the actual cost ~~to the department~~ for the
1157 purchase of the examination from the Association of Marital and
1158 Family Therapy Regulatory Boards ~~Board~~, or its successor ~~similar~~
1159 ~~national~~ organization, the department shall issue a license as a
1160 marriage and family therapist to an applicant who the board
1161 certifies:
1162 (a) Has submitted an application and paid the appropriate
1163 fee.
1164 (b)~~1.~~ Has a minimum of a master's degree with major
1165 emphasis in marriage and family therapy from a program
1166 accredited by the Commission on Accreditation for Marriage and
1167 Family Therapy Education or from a state university program
1168 accredited by the Council for Accreditation of Counseling and
1169 Related Educational Programs, or a closely related field, and
1170 graduate courses approved by the Board of Clinical Social Work,
1171 Marriage and Family Therapy, and Mental Health Counseling. ~~has~~
1172 ~~completed all of the following requirements:~~
1173 ~~a. Thirty-six semester hours or 48 quarter hours of~~
1174 ~~graduate coursework, which must include a minimum of 3 semester~~
1175 ~~hours or 4 quarter hours of graduate-level course credits in~~

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1176 ~~each of the following nine areas: dynamics of marriage and~~
1177 ~~family systems; marriage therapy and counseling theory and~~
1178 ~~techniques; family therapy and counseling theory and techniques;~~
1179 ~~individual human development theories throughout the life cycle;~~
1180 ~~personality theory or general counseling theory and techniques;~~
1181 ~~psychopathology; human sexuality theory and counseling~~
1182 ~~techniques; psychosocial theory; and substance abuse theory and~~
1183 ~~counseling techniques. Courses in research, evaluation,~~
1184 ~~appraisal, assessment, or testing theories and procedures;~~
1185 ~~thesis or dissertation work; or practicums, internships, or~~
1186 ~~fieldwork may not be applied toward this requirement.~~
1187 ~~b. A minimum of one graduate-level course of 3 semester~~
1188 ~~hours or 4 quarter hours in legal, ethical, and professional~~
1189 ~~standards issues in the practice of marriage and family therapy~~
1190 ~~or a course determined by the board to be equivalent.~~
1191 ~~c. A minimum of one graduate-level course of 3 semester~~
1192 ~~hours or 4 quarter hours in diagnosis, appraisal, assessment,~~
1193 ~~and testing for individual or interpersonal disorder or~~
1194 ~~dysfunction; and a minimum of one 3-semester-hour or 4-quarter-~~
1195 ~~hour graduate-level course in behavioral research which focuses~~
1196 ~~on the interpretation and application of research data as it~~
1197 ~~applies to clinical practice. Credit for thesis or dissertation~~
1198 ~~work, practicums, internships, or fieldwork may not be applied~~
1199 ~~toward this requirement.~~
1200 ~~d. A minimum of one supervised clinical practicum,~~

1201 ~~internship, or field experience in a marriage and family~~
1202 ~~counseling setting, during which the student provided 180 direct~~
1203 ~~client contact hours of marriage and family therapy services~~
1204 ~~under the supervision of an individual who met the requirements~~
1205 ~~for supervision under paragraph (c). This requirement may be met~~
1206 ~~by a supervised practice experience which took place outside the~~
1207 ~~academic arena, but which is certified as equivalent to a~~
1208 ~~graduate-level practicum or internship program which required a~~
1209 ~~minimum of 180 direct client contact hours of marriage and~~
1210 ~~family therapy services currently offered within an academic~~
1211 ~~program of a college or university accredited by an accrediting~~
1212 ~~agency approved by the United States Department of Education, or~~
1213 ~~an institution which is publicly recognized as a member in good~~
1214 ~~standing with the Association of Universities and Colleges of~~
1215 ~~Canada or a training institution accredited by the Commission on~~
1216 ~~Accreditation for Marriage and Family Therapy Education~~
1217 ~~recognized by the United States Department of Education.~~
1218 ~~Certification shall be required from an official of such~~
1219 ~~college, university, or training institution.~~
1220 ~~2. If the course title which appears on the applicant's~~
1221 ~~transcript does not clearly identify the content of the~~
1222 ~~coursework, the applicant shall be required to provide~~
1223 ~~additional documentation, including, but not limited to, a~~
1224 ~~syllabus or catalog description published for the course.~~
1225

1226 The required master's degree must have been received in an
1227 institution of higher education which at the time the applicant
1228 graduated was: fully accredited by a regional accrediting body
1229 recognized by the Council for Higher Education Accreditation
1230 ~~Commission on Recognition of Postsecondary Accreditation~~;
1231 publicly recognized as a member in good standing with ~~the~~
1232 ~~Association of~~ Universities ~~and Colleges of~~ Canada; or an
1233 institution of higher education located outside the United
1234 States and Canada~~,~~ which at the time the applicant was enrolled
1235 and at the time the applicant graduated maintained a standard of
1236 training substantially equivalent to the standards of training
1237 of those institutions in the United States which are accredited
1238 by a regional accrediting body recognized by the Council for
1239 Higher Education Accreditation ~~Commission on Recognition of~~
1240 ~~Postsecondary Accreditation~~. Such foreign education and training
1241 must have been received in an institution or program of higher
1242 education officially recognized by the government of the country
1243 in which it is located as an institution or program to train
1244 students to practice as professional marriage and family
1245 therapists or psychotherapists. The burden of establishing that
1246 the requirements of this provision have been met shall be upon
1247 the applicant, and the board shall require documentation, such
1248 as, but not limited to, an evaluation by a foreign equivalency
1249 determination service, as evidence that the applicant's graduate
1250 degree program and education were equivalent to an accredited

1251 program in this country. An applicant with a master's degree
1252 from a program which did not emphasize marriage and family
1253 therapy may complete the coursework requirement in a training
1254 institution fully accredited by the Commission on Accreditation
1255 for Marriage and Family Therapy Education recognized by the
1256 United States Department of Education.
1257 (c) Has had at least 2 years of clinical experience during
1258 which 50 percent of the applicant's clients were receiving
1259 marriage and family therapy services, which must be at the post-
1260 master's level under the supervision of a licensed marriage and
1261 family therapist with at least 5 years of experience, or the
1262 equivalent, who is a qualified supervisor as determined by the
1263 board. An individual who intends to practice in Florida to
1264 satisfy the clinical experience requirements must register
1265 pursuant to s. 491.0045 before commencing practice. If a
1266 graduate has a master's degree with a major emphasis in marriage
1267 and family therapy or a closely related field that did not
1268 include all the coursework required under paragraph (b) sub-
1269 subparagraphs (b)1.a.-c., credit for the post-master's level
1270 clinical experience shall not commence until the applicant has
1271 completed a minimum of 10 of the courses required under
1272 paragraph (b) sub-subparagraphs (b)1.a.-c., as determined by the
1273 board, and at least 6 semester hours or 9 quarter hours of the
1274 course credits must have been completed in the area of marriage
1275 and family systems, theories, or techniques. Within the 2 3

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1276 years of required experience, the applicant shall provide direct
1277 individual, group, or family therapy and counseling, to include
1278 the following categories of cases: unmarried dyads, married
1279 couples, separating and divorcing couples, and family groups
1280 including children. A doctoral internship may be applied toward
1281 the clinical experience requirement. A licensed mental health
1282 professional must be on the premises when clinical services are
1283 provided by a registered intern in a private practice setting.
1284 (d) Has passed a theory and practice examination
1285 designated ~~provided~~ by the board ~~department~~ for this purpose.
1286 (e) Has demonstrated, in a manner designated by board rule
1287 ~~of the board~~, knowledge of the laws and rules governing the
1288 practice of clinical social work, marriage and family therapy,
1289 and mental health counseling.
1290 (f) For the purposes of dual licensure, the department
1291 shall license as a marriage and family therapist any person who
1292 meets the requirements of s. 491.0057. Fees for dual licensure
1293 shall not exceed those stated in this subsection.
1294 (4) MENTAL HEALTH COUNSELING.—Upon verification of
1295 documentation and payment of a fee not to exceed $200, as set by
1296 board rule, plus the actual per applicant cost ~~to the department~~
1297 for purchase of the examination from the National Board for
1298 Certified Counselors or its successor ~~Professional Examination~~
1299 ~~Service for the National Academy of Certified Clinical Mental~~
1300 ~~Health Counselors or a similar national organization~~, the

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1301 department shall issue a license as a mental health counselor to
1302 an applicant who the board certifies:
1303 (a) Has submitted an application and paid the appropriate
1304 fee.
1305 (b)1. Has a minimum of an earned master's degree from a
1306 mental health counseling program accredited by the Council for
1307 the Accreditation of Counseling and Related Educational Programs
1308 that consists of at least 60 semester hours or 80 quarter hours
1309 of clinical and didactic instruction~~, including a course in~~
1310 ~~human sexuality and a course in substance abuse~~. If the master's
1311 degree is earned from a program related to the practice of
1312 mental health counseling that is not accredited by the Council
1313 for the Accreditation of Counseling and Related Educational
1314 Programs, then the coursework and practicum, internship, or
1315 fieldwork must consist of at least 60 semester hours or 80
1316 quarter hours and meet the following requirements:
1317 a. Thirty-three semester hours or 44 quarter hours of
1318 graduate coursework, which must include a minimum of 3 semester
1319 hours or 4 quarter hours of graduate-level coursework in each of
1320 the following 11 content areas: counseling theories and
1321 practice; human growth and development; diagnosis and treatment
1322 of psychopathology; human sexuality; group theories and
1323 practice; individual evaluation and assessment; career and
1324 lifestyle assessment; research and program evaluation; social
1325 and cultural foundations; <u>substance abuse; and legal, ethical,</u>

1326 and professional standards issues in the practice of mental
1327 health counseling ~~in community settings; and substance abuse~~.
1328 Courses in research, thesis or dissertation work, practicums,
1329 internships, or fieldwork may not be applied toward this
1330 requirement.
1331 b. A minimum of 3 semester hours or 4 quarter hours of
1332 graduate-level coursework addressing diagnostic processes,
1333 including differential diagnosis and the use of the current
1334 diagnostic tools, such as the current edition of the American
1335 Psychiatric Association's Diagnostic and Statistical Manual of
1336 Mental Disorders. The graduate program must have emphasized the
1337 common core curricular experience ~~in legal, ethical, and~~
1338 ~~professional standards issues in the practice of mental health~~
1339 ~~counseling, which includes goals, objectives, and practices of~~
1340 ~~professional counseling organizations, codes of ethics, legal~~
1341 ~~considerations, standards of preparation, certifications and~~
1342 ~~licensing, and the role identity and professional obligations of~~
1343 ~~mental health counselors. Courses in research, thesis or~~
1344 ~~dissertation work, practicums, internships, or fieldwork may not~~
1345 ~~be applied toward this requirement~~.
1346 c. The equivalent, as determined by the board, of at least
1347 700 ~~1,000~~ hours of university-sponsored supervised clinical
1348 practicum, internship, or field experience that includes at
1349 least 280 hours of direct client services, as required in the
1350 accrediting standards of the Council for Accreditation of

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1351 Counseling and Related Educational Programs for mental health
1352 counseling programs. This experience may not be used to satisfy
1353 the post-master's clinical experience requirement.
1354 2. If the course title which appears on the applicant's
1355 transcript does not clearly identify the content of the
1356 coursework, the applicant shall be required to provide
1357 additional documentation, including, but not limited to, a
1358 syllabus or catalog description published for the course.
1359
1360 Education and training in mental health counseling must have
1361 been received in an institution of higher education which at the
1362 time the applicant graduated was: fully accredited by a regional
1363 accrediting body recognized by the Council for Higher Education
1364 Accreditation or its successor ~~Commission on Recognition of~~
1365 ~~Postsecondary Accreditation~~; publicly recognized as a member in
1366 good standing with ~~the Association of~~ Universities ~~and Colleges~~
1367 ~~of~~ Canada; or an institution of higher education located outside
1368 the United States and Canada, which at the time the applicant
1369 was enrolled and at the time the applicant graduated maintained
1370 a standard of training substantially equivalent to the standards
1371 of training of those institutions in the United States which are
1372 accredited by a regional accrediting body recognized by the
1373 Council for Higher Education Accreditation or its successor
1374 ~~Commission on Recognition of Postsecondary Accreditation~~. Such
1375 foreign education and training must have been received in an

1376 institution or program of higher education officially recognized
1377 by the government of the country in which it is located as an
1378 institution or program to train students to practice as mental
1379 health counselors. The burden of establishing that the
1380 requirements of this provision have been met shall be upon the
1381 applicant, and the board shall require documentation, such as,
1382 but not limited to, an evaluation by a foreign equivalency
1383 determination service, as evidence that the applicant's graduate
1384 degree program and education were equivalent to an accredited
1385 program in this country. Beginning July 1, 2026, an applicant
1386 must have a master's degree in a program that is accredited by
1387 the Council for Accreditation of Counseling and Related
1388 Educational Programs which consists of at least 60 semester
1389 hours or 80 quarter hours to apply for licensure under this
1390 paragraph.
1391 (c) Has had at least 2 years of clinical experience in
1392 mental health counseling~~,~~ which must be at the post-master's
1393 level under the supervision of a licensed mental health
1394 counselor or the equivalent who is a qualified supervisor as
1395 determined by the board. An individual who intends to practice
1396 in Florida to satisfy the clinical experience requirements must
1397 register pursuant to s. 491.0045 before commencing practice. If
1398 a graduate has a master's degree with a major related to the
1399 practice of mental health counseling that did not include all
1400 the coursework required under sub-subparagraphs (b)1.a.-b.,

1401 credit for the post-master's level clinical experience shall not
1402 commence until the applicant has completed a minimum of seven of
1403 the courses required under sub-subparagraphs (b)1.a.-b., as
1404 determined by the board, one of which must be a course in
1405 psychopathology or abnormal psychology. A doctoral internship
1406 may be applied toward the clinical experience requirement. A
1407 licensed mental health professional must be on the premises when
1408 clinical services are provided by a registered intern in a
1409 private practice setting.
1410 (d) Has passed a theory and practice examination
1411 designated ~~provided~~ by the board ~~department~~ for this purpose.
1412 (e) Has demonstrated, in a manner designated by board rule
1413 ~~of the board~~, knowledge of the laws and rules governing the
1414 practice of clinical social work, marriage and family therapy,
1415 and mental health counseling.
1416 Section 12. Subsection (3) of section 491.0057, Florida
1417 Statutes, is amended to read:
1418 491.0057 Dual licensure as a marriage and family
1419 therapist.—The department shall license as a marriage and family
1420 therapist any person who demonstrates to the board that he or
1421 she:
1422 (3) Has passed the examination designated ~~provided~~ by the
1423 board ~~department~~ for marriage and family therapy.
1424 Section 13. Paragraph (b) of subsection (1) of section
1425 491.006, Florida Statutes, is amended to read:

1426 491.006 Licensure or certification by endorsement.—
1427 (1) The department shall license or grant a certificate to
1428 a person in a profession regulated by this chapter who, upon
1429 applying to the department and remitting the appropriate fee,
1430 demonstrates to the board that he or she:
1431 (b)1. Holds an active valid license to practice and has
1432 actively practiced the profession for which licensure is applied
1433 in another state for 3 of the last 5 years immediately preceding
1434 licensure.
1435 ~~2. Meets the education requirements of this chapter for~~
1436 ~~the profession for which licensure is applied.~~
1437 2.~~3.~~ Has passed a substantially equivalent licensing
1438 examination in another state or has passed the licensure
1439 examination in this state in the profession for which the
1440 applicant seeks licensure.
1441 3.~~4.~~ Holds a license in good standing, is not under
1442 investigation for an act that would constitute a violation of
1443 this chapter, and has not been found to have committed any act
1444 that would constitute a violation of this chapter. ~~The fees paid~~
1445 ~~by any applicant for certification as a master social worker~~
1446 ~~under this section are nonrefundable.~~
1447 Section 14. Subsections (2) and (3) of section 491.007,
1448 Florida Statutes, are amended to read:
1449 491.007 Renewal of license, registration, or certificate.—
1450 (2) Each applicant for renewal shall present satisfactory

1451 evidence that, in the period since the license or certificate
1452 was issued, the applicant has completed continuing education
1453 requirements set by rule of the board or department. Not more
1454 than 25 classroom hours of continuing education per year shall
1455 be required. ~~A certified master social worker is exempt from the~~
1456 ~~continuing education requirements for the first renewal of the~~
1457 ~~certificate.~~
1458 ~~(3) The board or department shall prescribe by rule a~~
1459 ~~method for the biennial renewal of an intern registration at a~~
1460 ~~fee set by rule, not to exceed $100.~~
1461 Section 15. Subsection (2) of section 491.009, Florida
1462 Statutes, is amended to read:
1463 491.009 Discipline.—
1464 (2) The ~~department, or, in the case of psychologists, the~~
1465 board~~,~~ may enter an order denying licensure or imposing any of
1466 the penalties in s. 456.072(2) against any applicant for
1467 licensure or licensee who is found guilty of violating any
1468 provision of subsection (1) of this section or who is found
1469 guilty of violating any provision of s. 456.072(1).
1470 Section 16. Paragraph (a) of subsection (1) of section
1471 491.012, Florida Statutes, is amended to read:
1472 491.012 Violations; penalty; injunction.—
1473 (1) It is unlawful and a violation of this chapter for any
1474 person to:
1475 (a) Use the following titles or any combination thereof,

1476 unless she or he holds a valid, active license as a clinical
1477 social worker issued pursuant to this chapter:
1478 1. "Licensed clinical social worker."
1479 2. "Clinical social worker."
1480 3. "Licensed social worker."
1481 4. "Psychiatric social worker."
1482 5. "Psychosocial worker."
1483 6. "Certified master social worker."
1484 Section 17. Section 491.0145, Florida Statutes, is amended
1485 to read:
1486 491.0145 Certified master social worker.—
1487 (1) The department shall license ~~may certify~~ an applicant
1488 for a designation as a certified master social worker who, upon
1489 applying to the department and remitting the appropriate fee,
1490 demonstrates to the board that he or she has met the following
1491 conditions:
1492 (a)~~(1)~~ The applicant has submitted ~~completes~~ an
1493 application and has paid ~~to be provided by the department and~~
1494 ~~pays~~ a nonrefundable fee not to exceed $250 to be established by
1495 rule of the board ~~department~~. ~~The completed application must be~~
1496 ~~received by the department at least 60 days before the date of~~
1497 ~~the examination in order for the applicant to qualify to take~~
1498 ~~the scheduled exam.~~
1499 (b)~~(2)~~ The applicant submits proof satisfactory to the
1500 board ~~department~~ that the applicant has received a doctoral

1501 degree in social work, or a master's degree in social work with
1502 a major emphasis or specialty in ~~clinical practice or~~
1503 ~~administration, including, but not limited to, agency~~
1504 administration and supervision, program planning and evaluation,
1505 staff development, research, community organization, community
1506 services, social planning, and human service advocacy. Doctoral
1507 degrees must have been received from a graduate school of social
1508 work which at the time the applicant was enrolled and graduated
1509 was accredited by an accrediting agency approved by the United
1510 States Department of Education. Master's degrees must have been
1511 received from a graduate school of social work which at the time
1512 the applicant was enrolled and graduated was accredited by the
1513 Council on Social Work Education or the Canadian Association of
1514 Schools for ~~of~~ Social Work Education or by one that meets
1515 comparable standards.
1516 (c) ~~(3)~~ The applicant has had at least 2 ~~3~~ years'
1517 experience, as defined by rule of the board, including, but not
1518 limited to, ~~clinical services or~~ administrative activities as
1519 described in paragraph (b) ~~defined in subsection (2)~~, 2 years of
1520 which must be at the post-master's level under the supervision
1521 of a person who meets the education and experience requirements
1522 for certification as a certified master social worker, as
1523 defined by rule of the board, or licensure as a clinical social
1524 worker under this chapter. A doctoral internship may be applied
1525 toward the supervision requirement.

1526 <u>(d)</u>~~(4)~~ Any person who holds a master's degree in social
1527 work from institutions outside the United States may apply to
1528 the <u>board</u> ~~department~~ for certification if the academic training
1529 in social work has been evaluated as equivalent to a degree from
1530 a school accredited by the Council on Social Work Education. Any
1531 such person shall submit a copy of the academic training from
1532 the Foreign Equivalency Determination Service of the Council on
1533 Social Work Education.
1534 <u>(e)</u>~~(5)~~ The applicant has passed an examination required by
1535 the <u>board</u> ~~department~~ for this purpose. ~~The nonrefundable fee for~~
1536 ~~such examination may not exceed $250 as set by department rule.~~
1537 <u>(2)</u>~~(6)~~ Nothing in this chapter shall be construed to
1538 authorize a certified master social worker to provide clinical
1539 social work services.
1540 <u>(3) The board may adopt rules to implement this section.</u>
1541 Section 18. Section 491.0149, Florida Statutes, is amended
1542 to read:
1543 491.0149 Display of license; use of professional title on
1544 promotional materials.—
1545 (1)(a) A person licensed under this chapter as a clinical
1546 social worker, marriage and family therapist, or mental health
1547 counselor, or certified as a master social worker shall
1548 conspicuously display the valid license issued by the department
1549 or a true copy thereof at each location at which the licensee
1550 practices his or her profession.

1551 (b)1. A licensed clinical social worker shall include the
1552 words "licensed clinical social worker" or the letters "LCSW" on
1553 all promotional materials, including cards, brochures,
1554 stationery, advertisements, social media, and signs, naming the
1555 licensee.
1556 2. A licensed marriage and family therapist shall include
1557 the words "licensed marriage and family therapist" or the
1558 letters "LMFT" on all promotional materials, including cards,
1559 brochures, stationery, advertisements, social media, and signs,
1560 naming the licensee.
1561 3. A licensed mental health counselor shall include the
1562 words "licensed mental health counselor" or the letters "LMHC"
1563 on all promotional materials, including cards, brochures,
1564 stationery, advertisements, social media, and signs, naming the
1565 licensee.
1566 (c) A generalist social worker shall include the words
1567 "certified master social worker" or the letters "CMSW" on all
1568 promotional materials, including cards, brochures, stationery,
1569 advertisements, social media, and signs, naming the licensee.
1570 (2)(a) A person registered under this chapter as a
1571 clinical social worker intern, marriage and family therapist
1572 intern, or mental health counselor intern shall conspicuously
1573 display the valid registration issued by the department or a
1574 true copy thereof at each location at which the registered
1575 intern is completing the experience requirements.

1576 (b) A registered clinical social worker intern shall
1577 include the words "registered clinical social worker intern," a
1578 registered marriage and family therapist intern shall include
1579 the words "registered marriage and family therapist intern," and
1580 a registered mental health counselor intern shall include the
1581 words "registered mental health counselor intern" on all
1582 promotional materials, including cards, brochures, stationery,
1583 advertisements, social media, and signs, naming the registered
1584 intern.
1585 (3)(a) A person provisionally licensed under this chapter
1586 as a provisional clinical social worker licensee, provisional
1587 marriage and family therapist licensee, or provisional mental
1588 health counselor licensee shall conspicuously display the valid
1589 provisional license issued by the department or a true copy
1590 thereof at each location at which the provisional licensee is
1591 providing services.
1592 (b) A provisional clinical social worker licensee shall
1593 include the words "provisional clinical social worker licensee,"
1594 a provisional marriage and family therapist licensee shall
1595 include the words "provisional marriage and family therapist
1596 licensee," and a provisional mental health counselor licensee
1597 shall include the words "provisional mental health counselor
1598 licensee" on all promotional materials, including cards,
1599 brochures, stationery, advertisements, social media, and signs,
1600 naming the provisional licensee.

1601 Section 19. Section 491.015, Florida Statutes, is
1602 repealed.
1603 Section 20. Paragraph (h) is added to subsection (10) of
1604 section 768.28, Florida Statutes, to read:
1605 768.28 Waiver of sovereign immunity in tort actions;
1606 recovery limits; limitation on attorney fees; statute of
1607 limitations; exclusions; indemnification; risk management
1608 programs.—
1609 (10)
1610 (h) For the purposes of this section, the representative
1611 appointed from the Board of Medicine and the representative
1612 appointed from the Board of Osteopathic Medicine, when serving
1613 as commissioners of the Interstate Medical Licensure Compact
1614 Commission pursuant to s. 456.4501, and any administrator,
1615 officer, executive director, employee, or representative of the
1616 Interstate Medical Licensure Compact Commission, when acting
1617 within the scope of their employment, duties, or
1618 responsibilities in this state, are considered agents of the
1619 state. The commission shall pay any claims or judgments pursuant
1620 to this section and may maintain insurance coverage to pay any
1621 such claims or judgments.
1622 Section 21. Paragraph (c) of subsection (4) of section
1623 414.065, Florida Statutes, is amended to read:
1624 414.065 Noncompliance with work requirements.—
1625 (4) EXCEPTIONS TO NONCOMPLIANCE PENALTIES.—Unless

1626 otherwise provided, the situations listed in this subsection
1627 shall constitute exceptions to the penalties for noncompliance
1628 with participation requirements, except that these situations do
1629 not constitute exceptions to the applicable time limit for
1630 receipt of temporary cash assistance:
1631 (c) Noncompliance related to treatment or remediation of
1632 past effects of domestic violence.—An individual who is
1633 determined to be unable to comply with the work requirements
1634 under this section due to mental or physical impairment related
1635 to past incidents of domestic violence may be exempt from work
1636 requirements, except that such individual shall comply with a
1637 plan that specifies alternative requirements that prepare the
1638 individual for self-sufficiency while providing for the safety
1639 of the individual and the individual's dependents. A participant
1640 who is determined to be out of compliance with the alternative
1641 requirement plan shall be subject to the penalties under
1642 subsection (1). The plan must include counseling or a course of
1643 treatment necessary for the individual to resume participation.
1644 The need for treatment and the expected duration of such
1645 treatment must be verified by a physician licensed under chapter
1646 458 or chapter 459; a psychologist licensed under s. 490.005(1),
1647 s. 490.006, or the provision identified as s. 490.013(2) in s.
1648 1, chapter 81-235, Laws of Florida; a therapist as defined in <u>s.</u>
1649 <u>491.003(3) or (7)</u> ~~s. 491.003(2) or (6)~~; or a treatment
1650 professional who is registered under s. 39.905(1)(g), is

1651 authorized to maintain confidentiality under s. 90.5036(1)(d),
1652 and has a minimum of 2 years' ~~years~~ experience at a certified
1653 domestic violence center. An exception granted under this
1654 paragraph does not automatically constitute an exception from
1655 the time limitations on benefits specified under s. 414.105.
1656 Section 22. This act shall take effect July 1, 2020.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1163 Intermediate Care Facilities
SPONSOR(S): Health Market Reform Subcommittee, Burton
TIED BILLS: **IDEN./SIM. BILLS:** SB 1344

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	13 Y, 0 N, As CS	Guzzo	Calamas
2) Health Care Appropriations Subcommittee		Nobles JRN	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

An intermediate care facility for the developmentally disabled (ICFDD) provides intensive care and rehabilitative services in a residential setting to individuals with developmental disabilities.

Medicaid is the only payer, so current law requires a need assessment and a certificate of need (CON) from the Agency for Health Care Administration (AHCA), to build a new ICFDD or add beds to an existing ICFDD. HB 1163 creates a CON exemption for a new ICFDD that meets specific criteria. It must have a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. To obtain an exemption, an applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in Florida.

The bill prohibits AHCA from granting an additional CON exemption to an applicant that has been granted an exemption under these provisions unless the facility has been licensed and operational for a period of at least two years.

The bill also establishes certain continued licensure requirements for an ICFDD that has been granted the CON exemption created by the bill.

The bill may have a significant, but indeterminate, negative fiscal impact on AHCA. The bill has no fiscal impact on local governments. The bill specifies that the exemption does not require a specific appropriation.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Intermediate Care Facilities for the Developmentally Disabled

An intermediate care facility for the developmentally disabled (ICFDD) provides care and residence for individuals with developmental disabilities. A developmental disability is a disorder or syndrome that is attributable to intellectual disability, cerebral palsy, autism, spina bifida, Down syndrome, Phelan-McDermid syndrome, or Prader-Willi syndrome; that manifests before the age of 18; and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely.[1]

ICFDDs are licensed and regulated under Part VIII of ch. 400, F.S., and Chapter 59A-26, F.A.C. ICFDDs provide the following services: nursing services, activity services, dental services, dietary services, pharmacy services, physician services, rehabilitative care services, room/bed and maintenance services and social services.[2] ICFDD services are only covered by the Medicaid program. Individuals who have a developmental disability and who meet Medicaid eligibility requirements may receive services in an ICFDD.

While the majority of individuals who have a developmental disability live in the community, a small number live in ICFDDs. Currently, there are 88 privately owned ICF/DD facilities in Florida. As of January 2020, the ICFDDs were 95.7 percent occupied, with 1,971 individuals in 2,060 possible beds.[3] There are also 11 ICFDDs that are operated by the state.

Prior to obtaining a license, the applicant must obtain certificate of need (CON) approval from the Agency for Health Care Administration (AHCA). Since Medicaid is the only payer, the CON requirement is used to manage the Medicaid provider network of ICFDD services.

ICFDDs are considered institutional placements and are reimbursed for two levels of care, which are based on the client's mobility:

- ICF Level of Reimbursement One- for recipients who are ambulatory or self-mobile using mechanical devices and are able to transfer themselves without human assistance, but may require assistance and oversight to ensure safe evacuation; and
- ICF Level of Reimbursement Two- for recipients who are capable of mobility only with human assistance or require human assistance to transfer to or from a mobility device or require continuous medical and nursing supervision. [4]

ICFDD providers in Florida have reported an increase in the number of recipients with severe maladaptive behaviors that require significant resources to provide appropriate care beyond what is

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[1] *See* s. 393.063(12), F.S.
[2] Agency for Health Care Administration, *Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/DD) Services,* available at: https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/Intermediate_Care.shtml (last visited February 2, 2020).
[3] Florida Medicaid ICF/IID Rate Study Report, prepared by Navigant for the Florida Agency for Health Care Administration, January 27,2020 (on file with Health Market Reform Subcommittee staff).
[4] S. 408.038, F.S.

currently provided through the level one and level two-reimbursement methodology.[5] Maladaptive behaviors are those behaviors that are disruptive, destructive, aggressive, or significantly repetitive.[6]

The Agency for Persons with Disabilities (APD) developed a Global Behavioral Service Need Matrix (Matrix) to classify the severity of a person's maladaptive behavior for purposes of its home and community based waiver services, or iBudget, program, which is the Medicaid waiver program for persons with developmental disabilities.[7] The Matrix categorizes symptoms of maladaptive behaviors such as behavior frequency, behavioral impact, physical aggression to others, police involvement, property destruction, and elopement/wandering, among others. Each symptom is ranked on a scale of one to six, with one being the least severe and six being the most severe. If a symptom is not present, it is ranked as a zero. Based on a person's behavior score, the person will be evaluated for services. The initial evaluation period is 12 months and then the frequency of evaluations afterwards depends on the severity of the person's score, with a need level of six being evaluated more frequently than a need level of one.[8]

According to APD, 661 people within its iBudget program have higher level Matrix scores of 4, 5 or 6. The table below shows the average annual cost for individuals at these levels within the APD home-and-community-based services program.[9]

Global Behavioral Service Need Matrix Level	Average Annual APD Cost
4	$132,777.73
5	$138,476.51
6	$158,823.46

Certificates of Need (CON)

Florida's CON program has existed since 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 ("the Act"), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[10] Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.

In Florida, a CON is a written statement issued by AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service. The Florida CON program has three levels of review: full, expedited, and exempt.[11]

A CON is predicated on a determination of need. The future need for services and projects is known as the "fixed need pool"[12], which AHCA publishes for each batching cycle. A batching cycle is a means of grouping of, for comparative review, CON applications submitted for beds, services or programs having

[5] Supra note 3.
[6] Fulton, Elizabeth et al. "Reducing maladaptive behaviors in preschool-aged children with autism spectrum disorder using the early start denver model." Frontiers in pediatrics vol. 2 40. available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023017/ (last visited February 2, 2020).
[7] Available at http://apdcares.org/news/news/2011/ib-matrix-instructions.pdf (last visited February 2, 2020).
[8] *Id.*
[9] Agency for Persons with Disabilities, email from Jeff Ivey, Legislative Affairs Director, Feb. 3, 2020 (on file with staff of the Health Market Reform Subcommittee).
[10] Pub. L. No. 93-641, 42 U.S.C. §§ 300k et seq.
[11] S. 408.036, F.S.
[12] Rule 59C-1.002(19), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.

a like CON need methodology, or licensing category in the same planning horizon and the same applicable district or sub-district.[13]

Upon determining that a need exists, AHCA accepts applications for CON based on batching cycles for each district. Section 408.032(5), F.S., establishes the 11 district service areas in Florida.[14]

The CON review process consists of two batching cycles each year for ICFDDs, nursing homes, hospice programs, and hospice inpatient facilities.

At least 30 days prior to the application deadline for a batch cycle, an applicant must file a letter of intent with AHCA.[15] A letter of intent must describe the proposal, specify the number of beds sought, and identify the services to be provided and the location of the project.[16] Applications for CON review must be submitted by the specified deadline for the particular batch cycle.[17] AHCA must review the application within 15 days of the filing deadline and, if necessary, request additional information for an incomplete application.[18] The applicant then has 21 days to complete the application or it is deemed withdrawn from consideration.[19]

Within 60 days of receipt of the completed applications for that batch, AHCA must issue a State Agency Action Report and Notice of Intent to Award a CON for a project in its entirety, to award a CON for identifiable portions of a project, or to deny a CON for a project.[20] AHCA must then publish the decision, within 14 days, in the Florida Administrative Weekly.[21] If no administrative hearing is requested within 21 days of the publication, the State Agency Action Report and the Notice of Intent to Award the CON become a final order of AHCA.[22]

An applicant for CON review must pay a fee to AHCA when the application is submitted. The minimum CON application filing fee is $10,000.[23] In addition to the base fee, an applicant must pay a fee of 1.5 percent of each dollar of the proposed expenditure; however, the total fee may not exceed $50,000.[24] A request for a CON exemption must be accompanied by a $250 fee payable to AHCA.[25]

CON for ICFDDs

In 2019, the legislature eliminated CON review for general hospitals, complex medical rehabilitation beds and tertiary hospital services.[26] CON is still required for new ICFDDs, and for adding beds to existing ICFDDs.[27]

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[13] Rule 59C-1.002(5), F.A.C.
[14] District 1.—Escambia, Santa Rosa, Okaloosa, and Walton Counties; District 2.—Holmes, Washington, Bay, Jackson, Franklin, Gulf, Gadsden, Liberty, Calhoun, Leon, Wakulla, Jefferson, Madison, and Taylor Counties; District 3.—Hamilton, Suwannee, Lafayette, Dixie, Columbia, Gilchrist, Levy, Union, Bradford, Putnam, Alachua, Marion, Citrus, Hernando, Sumter, and Lake Counties; District 4.—Baker, Nassau, Duval, Clay, St. Johns, Flagler, and Volusia Counties;
District 5.—Pasco and Pinellas Counties; District 6.—Hillsborough, Manatee, Polk, Hardee, and Highlands Counties;
District 7.—Seminole, Orange, Osceola, and Brevard Counties; District 8.—Sarasota, DeSoto, Charlotte, Lee, Glades, Hendry, and Collier Counties; District 9.—Indian River, Okeechobee, St. Lucie, Martin, and Palm Beach Counties.
District 10.—Broward County; District 11.—Miami-Dade and Monroe Counties.
[15] S. 408.039(2)(a), F.S.
[16] S. 408.039(2)(c), F.S.
[17] Rule 59C-1.008(1)(g), F.A.C.
[18] S. 408.039(3)(a), F.S.
[19] Id.
[20] S. 408.039(4)(b), F.S.
[21] S. 408.039(4)(c), F.S.
[22] S. 408.039(4)(d), F.S.
[23] S. 408.038, F.S.
[24] Id.
[25] S. 408.036(4), F.S., and Rule 59C-1.005(2)(g), F.A.C.
[26] Ch. 2019-136, Laws of Fla.
[27] S. 408.036(1)(a), F.S.

Rule 59C-1.034, F.A.C., requires the proposal of a CON applicant for a new ICFDD to:

- Be justified in context with current legislative Medicaid appropriations for ICFDD placements;
- Be determined by AHCA to be justified in context with the applicable review criteria; and
- Have not more than 60 beds divided into living units of not more than 15 beds.

Since 2010, there have been six ICFDD CON applications, of which, five were to replace an existing facility. The one CON application for a new ICFDD project was submitted by Sunrise Community, Inc., to establish a new 24-bed facility in Hardee County. AHCA denied the application, finding:[28]

- The applicant failed to demonstrate the new ICFDD project would work in harmony with APD's efforts to meet the needs of APD's clients;
- The applicant failed to demonstrate the stated need could be met by the proposed new ICFDD beds on the timeline of the stated need; and
- Funding for the new ICFDD is doubtful and awarding a CON cannot be justified in the context of legislative appropriations.

Effect of the Bill

The bill amends s. 408.036, F.S., to create a CON exemption for a new ICFDD which has a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight.

To obtain the exemption, the applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in this state. It is unknown how many providers would meet these two criteria, and be eligible to apply for a CON exemption under the bill. The bill prohibits AHCA from granting an additional exemption to an applicant that has been granted an exemption under these provisions unless the facility has been licensed and operational for a period of at least two years. This prevents multiple concurrent, or subsequent applications from a single provider.

The bill also amends s. 400.962, F.S., to establish additional licensure and application requirements for an ICFDD that has been granted the CON exemption, including:

- The total number of beds per home within the facility may not exceed eight, with each resident having his or her own bedroom and bathroom. Each eight-bed home must be co-located on the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.
- A minimum of 16 beds within the facility must be designated for individuals with severe maladaptive behaviors who have been assessed using the Matrix with a score of at least Level 4 through Level 6, or assessed using criteria deemed appropriate by the AHCA regarding the need for a specialized placement in an ICFDD.
- The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.
- The applicant must make available medical and nursing services 24 hours per day, 7 days per week.
- The applicant must demonstrate a history of using interventions that are least restrictive and that follow a behavioral hierarchy.
- The applicant must maintain a policy prohibiting the use of mechanical restraints.

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[28] AHCA, State Agency Action Report on Application for Certificate of Need, Sunrise Community, Inc./CON #10541, available at https://ahca.myflorida.com/MCHQ/CON_FA/Batching/pdf/10541.pdf (last visited February 2, 2020).

The bill specifies that the exemption does not require a specific appropriation. This overrides the AHCA rule requirement that a CON for an ICFDD be issued only if AHCA can justify the new CON in light of legislative Medicaid appropriations for ICFDD services; that is, a determination that Medicaid has the funds to cover services in the new ICFDD beds.

Finally, the bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.962, F.S., relating to license required; license application.
Section 2: Amends s. 408.036, F.S., relating to projects subject to review; exemptions.
Section 3: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill may have a significant, but indeterminate, negative fiscal impact on AHCA. It is unknown how many providers will apply for the CON exemption, or how many CONs will be issued. Up to 661 people in the current APD iBudget program would qualify for placement in the new ICFDDs under the bill. Medicaid ICFDD services cost more than home and community based services. Assuming new ICFDD facilities and beds will be utilized by APD iBudget clients currently living in the community, the Medicaid program will experience costs for their care, rather than APD, and will experience greater costs than APD currently incurs. The bill specifies that the exemption does not require a specific appropriation.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority in existent law to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Health Market Reform Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Change the APD maladaptive behavior Global Behavioral Service Need Matrix score threshold for the minimum designated beds required by the bill for new CON recipients, from 3 to 6, to 4 through 6; and
- Replace the term "facility" with the term "applicant" as it relates to qualifying criteria established for the CON exemption.

The analysis is drafted to the committee substitute as passed by the Health Market Reform Subcommittee.

1 A bill to be entitled
2 An act relating to intermediate care facilities;
3 amending s. 400.962, F.S.; requiring certain
4 facilities that have been granted a certificate-of-
5 need exemption to demonstrate and maintain compliance
6 with specified criteria; amending s. 408.036, F.S.;
7 providing an exemption from a certificate-of-need
8 requirement for certain intermediate care facilities;
9 prohibiting the Agency of Health Care Administration
10 from granting an exemption to an applicant unless a
11 certain condition is met; providing that a specific
12 legislative appropriation is not required for such
13 exemption; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Subsection (6) is added to section 400.962,
18 Florida Statutes, to read:
19 400.962 License required; license application.—
20 (6) An applicant that has been granted a certificate-of-
21 need exemption under s. 408.036(3)(o) must also demonstrate and
22 maintain compliance with the following criteria:
23 (a) The total number of beds per home within the facility
24 may not exceed eight, with each resident having his or her own
25 bedroom and bathroom. Each eight-bed home must be colocated on

26 the same property with two other eight-bed homes and must serve
27 individuals with severe maladaptive behaviors and co-occurring
28 psychiatric diagnoses.
29 (b) A minimum of 16 beds within the facility must be
30 designated for individuals with severe maladaptive behaviors who
31 have been assessed using the Agency for Persons with
32 Disabilities' Global Behavioral Service Need Matrix with a score
33 of Level 4 through Level 6, or assessed using the criteria
34 deemed appropriate by the Agency for Health Care Administration
35 regarding the need for a specialized placement in an
36 intermediate care facility for the developmentally disabled.
37 (c) The applicant has not had a facility license denied,
38 revoked, or suspended within the 36 months preceding the request
39 for exemption.
40 (d) The applicant must have at least 10 years of
41 experience serving individuals with severe maladaptive behaviors
42 in the state.
43 (e) The applicant must implement a state-approved staff
44 training curriculum and monitoring requirements specific to the
45 individuals whose behaviors require higher intensity, frequency,
46 and duration of services.
47 (f) The applicant must make available medical and nursing
48 services 24 hours per day, 7 days per week.
49 (g) The applicant must demonstrate a history of using
50 interventions that are least restrictive following a behavioral

51 hierarchy.
52 (h) The applicant must maintain a policy prohibiting the
53 use of mechanical restraints.
54 Section 2. Paragraph (o) is added to subsection (3) of
55 section 408.036, Florida Statutes, to read:
56 408.036 Projects subject to review; exemptions.—
57 (3) EXEMPTIONS.—Upon request, the following projects are
58 subject to exemption from subsection (1):
59 (o) For a new intermediate care facility for the
60 developmentally disabled that has a total of 24 beds, comprised
61 of three eight-bed homes, for use by individuals exhibiting
62 severe maladaptive behaviors and co-occurring psychiatric
63 diagnoses requiring increased levels of behavioral, medical, and
64 therapeutic oversight. The applicant must not have had a license
65 denied, revoked, or suspended within the 36 months preceding the
66 request for exemption and must have at least 10 years of
67 experience serving individuals with severe maladaptive behaviors
68 in this state. The agency may not grant an exemption to an
69 applicant that has been granted an exemption under this
70 paragraph unless the facility, awarded by exemption, has been
71 licensed and operational for a period of at least 2 years. The
72 exemption under this paragraph does not require a specific
73 legislative appropriation.
74 Section 3. This act shall take effect July 1, 2020.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1217 Surrendered Newborn Infants
SPONSOR(S): Beltran and others
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 864

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Market Reform Subcommittee	12 Y, 0 N	Cunningham	Calamas
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida law allows parents who are unwilling or unable to care for their infants to safely relinquish them at hospitals, fire stations, and emergency medical services stations. This 'safe haven law' allows parents to anonymously surrender infants up to seven days old and grants the parents immunity from criminal prosecution unless there is actual or suspected child abuse or neglect.

A newborn safety device, or baby box, provides a place for a mother in crisis to safely, securely, and anonymously surrender her unwanted newborn. The concept of a baby box has existed for centuries throughout Europe, and over 20 countries still utilize some form of a baby box today.

HB 1217 increases the age that an infant may be surrendered from seven days old to 30 days old. The bill authorizes hospitals, emergency medical service stations, and fire stations that are staffed 24 hours a day to opt to utilize newborn safety devices, and specifies the requirements for such devices.

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

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Safe Haven Laws

Safe haven laws allow parents or agents of the parents to safely relinquish babies at designated locations while remaining anonymous, and confer immunity from criminal liability and prosecution for child endangerment, abandonment, or neglect.[1] The purpose of safe haven laws is to ensure that abandoned infants are left with those who can provide immediate care necessary for the children's safety and wellbeing.[2]

In 1999, Texas was the first State to enact safe haven legislation.[3] Now each of the 50 states, the District of Columbia, and Puerto Rico all have variations of safe haven laws.[4] In 11 states and Puerto Rico, only infants who are up to 72 hours old may be relinquished to a designated site, and in 19 states infants are accepted up to one month old.[5] Additionally, 16 states and Puerto Rico require parents to surrender their infants only to a hospital, emergency medical services provider, or healthcare facility.[6] In 27 states, fire stations are also designated as safe haven providers.[7] Personnel at police stations or other law enforcement agencies may accept infants in 25 states.[8]

Since the initial enactment of safe haven legislation in 1999, there have been an estimated 4,015 surrenders at safe havens and 1,465 illegal abandonments across the United States.[9]

Florida Safe Haven Law

Florida enacted safe haven legislation in 2000 in response to tragedies of newborn abandonment at unsafe locations, such as public restrooms or trash receptacles.[10] The law authorizes parents to surrender a newborn infant up to seven days old at a hospital, fire station or emergency medical service station. It creates a presumption that the parents consent to the termination of their parental rights[11], and for the transport and medical treatment for the child[12]. The law expressly grants the parents a right to anonymity and to not be pursued, and requires hospital registrars to complete the infant's birth certificate without naming the mother, if she requests it and expresses an intent to leave without the infant and not return. The law also grants the parents immunity from criminal prosecution unless there is actual or suspected abuse or neglect of the infant.[13]

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[1] *Infant Safe Haven Laws*, CHILD WELFARE INFORMATION GATEWAY (Dec. 2016), https://www.childwelfare.gov/pubPDFs/safehaven.pdf
[2] *Id.*
[3] NY LEGISLATIVE COUNSEL BUREAU, *A Study of Infant Abandonment Legislation*, https://www.leg.state.nv.us/Division/Research/Publications/Bkground/BP01-03.pdf (last visited Jan. 22, 2020).
[4] *Id.*
[5] *Id.*
[6] *Supra* note 1.
[7] *Id.*
[8] *Id.*
[9] A SAFE HAVEN FOR NEWBORNS, *Safe Haven Statistics*, https://asafehavenfornewborns.com/what-we-do/safe-haven-statistics/ (last visited Jan. 29, 2020).
[10] S. 383.50, F.S.; *see* ch. 2000-188, Laws of Fla.
[11] S. 63.0423, F.S.
[12] S. 383.50, F.S.
[13] *Id.*

The Florida safe haven law requires hospitals, fire stations, and emergency medical services stations that are staffed with full-time firefighters or emergency medical technicians to accept any newborn infant left with a firefighter or emergency medical technician. The law grants emergency medical technicians, paramedics and fire department staff immunity from criminal and civil liability when acting in good faith for a surrendered infant.[14]

Since 2000, approximately 310 newborns have been surrendered at a safe haven in Florida. In that time, 64 infants are known to have been unsafely abandoned, of which 34 died.[15]

Newborn Safety Devices

For centuries, mothers throughout Europe have surrendered their babies in hatches or crib structures, commonly referred to as "foundling wheels" or "baby boxes," at the entrance of a place of worship, a charity organization, or hospital.[16] The modern-day newborn safety device was created in South Africa in 1999, in which mothers placed their child in a hatch in a church wall and the door automatically locked, sending a signal to care workers inside.[17]

Over 20 countries currently have some form of baby boxes, including Austria, Germany, Italy, Poland, Portugal, and Slovakia.[18] Approximately 200 baby boxes have been installed across Europe in the past decade.[19] There are about 30 baby boxes located throughout the United States.[20]

Indiana's Baby Boxes

Indiana's safe haven law authorizes the use of newborn safety devices, called Safe Haven Boxes.[21] Indiana has utilized the Safe Haven Baby Box since 2016, and there are currently 19 baby boxes in use throughout the state.[22]

The box is installed on the exterior wall of a designated safe haven, with an interior access door attached.[23] Once a parent has placed the baby in the padded box, the door will automatically lock and an alarm is triggered alerting personnel that a baby needs to be picked up.[24] The boxes are similar to incubators, with heating and cooling functions to keep the baby safe until help arrives.[25] The boxes cost between $10,000 and $15,000.[26]

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[14] *Id.*
[15] *Supra* note 9.
[16] Atsushi Asai, *Should We Maintain Baby Hatches in Our Society?*, BMC MED. ETHICS (Feb. 22, 2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3586365/#B1
[17] *Baby Boxes Allow Mothers to Drop-off Unwanted Children*, APOLITICAL (Aug. 22, 2019), https://apolitical.co/solution_article/baby-boxes-allow-mothers-to-drop-off-unwanted-children
[18] EUROPEAN COMMISSION, *Child Abandonment and Its Prevention,* http://ec.europa.eu/justice/grants/results/daphne-toolkit/content/child-abandonment-and-its-prevention_en (last visited Jan. 22, 2020).
[19] Amber Hildebrandt, *The Revival of 'Baby Boxes' for Unwanted Infants*, CBC NEWS (May 07, 2013), https://www.cbc.ca/news/canada/the-revival-of-baby-boxes-for-unwanted-infants-1.1357615
[20] A SAFE HAVEN FOR NEWBORNS, *Baby Box Locations,* https://shbb.org/locations (last visited Jan. 22, 2020).
[21] Associated Press, *Northwest Indiana to Get More Baby Boxes for Abandoned Newborns,* WGN9 (Nov. 9, 2019), https://wgntv.com/2019/11/09/northwest-indiana-to-get-more-baby-boxes-for-abandoned-newborns/
[22] *Indiana Nears 20 Baby Boxes for Surrendering Newborns,* WBIW (Jan. 2, 2020), http://www.wbiw.com/2020/01/02/indiana-nears-20-baby-boxes-for-surrendering-newborns/
[23] A SAFE HAVEN FOR NEWBORNS, *What is a Safe Haven Baby Box?,* https://shbb.org/ (last visited Jan. 22, 2020).
[24] *Id.*; *See also* https://www.usatoday.com/story/life/parenting/2019/09/13/safe-haven-laws-things-you-didnt-know-surrendering-newborn/2031516001/
[25] Jennie Runevitch, *Safe Haven Baby Boxes: Here's How They Work*, WTHR-TV CHANNEL 13 (Oct. 18, 2019), https://www.wthr.com/article/safe-haven-baby-boxes-heres-how-they-work
[26] *Supra* note 14.

Effect of Proposed Changes

HB 1217 amends Florida's safe haven law to increase the infant age limit from seven days old to 30 days old. This gives parents more time to make this decision, possibly preventing the unsafe abandonment of infants older than seven days.

The bill also authorizes the use of newborn safety devices, or baby boxes, at the designated safe haven sites, if they are staffed 24 hours a day.

The boxes must be physically part of the hospital, fire station or emergency medical services station, and installed in an exterior wall. The boxes must have an exterior point of access that locks. The box must have an interior point of access in an area that is conspicuous and visible to facility employees. Placing an infant inside the box must automatically trigger an alarm inside the building has to alert individuals inside the building to safely retrieve the newborn infant.

The bill requires facilities that use a newborn safety device to check the device at least twice a day and test the device at least once a week to ensure that the alarm system is in working order.

The bill makes all the provisions in the current safe haven law applicable to surrendering an infant using a baby box, including parental consent for the child's transport and medical treatment, consent to termination of parental rights, the right to anonymity and non-pursuit, and the immunities for both the parents and the receiving facility's staff.

B. SECTION DIRECTORY:

Section 1: Amends s. 383.50, F.S., relating to the treatment of a surrendered newborn infant.
Section 2: Amends s. 63.0423, F.S., to incorporate a conforming cross-reference revision.
Section 3: Provides an 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:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private sector facilities that opt to use a newborn safety device as a means for the relinquishment of a newborn will incur the cost of acquisition and installation of the new device.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

Rulemaking is not authorized by the bill and is not necessary to implement it.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to surrendered newborn infants;
3 amending s. 383.50, F.S.; revising the definition of
4 the term "newborn infant"; defining the term "newborn
5 safety device"; authorizing hospitals, emergency
6 medical services stations, and fire stations to use
7 newborn safety devices to accept surrendered newborn
8 infants under certain circumstances; requiring such
9 hospital, emergency medical services station, or fire
10 station to visually check and test the device within
11 specified timeframes; conforming provisions to changes
12 made by the act; providing additional locations under
13 which the prohibition on the initiation of criminal
14 investigations based solely on the surrendering of a
15 newborn infant applies; amending s. 63.0423, F.S.;
16 conforming a cross-reference; providing an effective
17 date.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Present subsections (2) through (10) of section
22 383.50, Florida Statutes, are redesignated as subsections (3)
23 through (11), respectively, a new subsection (2) is added to
24 that section, and present subsections (1), (3), (5), and (10) of
25 that section are amended, to read:

26 383.50 Treatment of surrendered newborn infant.—
27 (1) As used in this section, the term:
28 (a) "Newborn infant" means a child who a licensed
29 physician reasonably believes is approximately 30 ~~7~~ days old or
30 younger at the time the child is left at a hospital, an
31 emergency medical services station, or a fire station.
32 (b) "Newborn safety device" means a fixture installed in
33 an exterior wall of a building which has an exterior point of
34 access that locks and automatically triggers an alarm inside the
35 building upon placement of a newborn infant inside and which has
36 an interior point of access that allows individuals inside the
37 building to safely retrieve the newborn infant.
38 (2)(a) A hospital, an emergency medical services station,
39 or a fire station that is staffed 24 hours per day may use a
40 newborn safety device to accept surrendered newborn infants
41 under this section if the device is:
42 1. Physically part of the hospital, emergency medical
43 services station, or fire station;
44 2. Located in such a way that the interior point of access
45 is in an area that is conspicuous and visible to the employees
46 of the hospital, emergency medical services station, or fire
47 station; and
48 3. Equipped with a dual alarm system connected to the
49 physical location of the device.
50 (b) A hospital, an emergency medical services station, or

51 a fire station that uses a newborn safety device to accept
52 surrendered newborn infants must visually check the device at
53 least twice a day and must test the device at least once a week
54 to ensure the alarm system is in working order.
55 (4)~~(3)~~ Each emergency medical services station or fire
56 station staffed with ~~full-time~~ firefighters, emergency medical
57 technicians, or paramedics 24 hours per day shall accept any
58 newborn infant left with a firefighter, an emergency medical
59 technician, or a paramedic, or in a newborn safety device that
60 is physically part of the emergency medical services station or
61 fire station. The firefighter, emergency medical technician, or
62 paramedic shall consider these actions as implied consent to and
63 shall:
64 (a) Provide emergency medical services to the newborn
65 infant to the extent he or she is trained to provide those
66 services, and
67 (b) Arrange for the immediate transportation of the
68 newborn infant to the nearest hospital having emergency
69 services.
70
71 A licensee as defined in s. 401.23, a fire department, or an
72 employee or agent of a licensee or fire department may treat and
73 transport a newborn infant pursuant to this section. If a
74 newborn infant is placed in the physical custody of an employee
75 or agent of a licensee or fire department, or in a newborn

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

76 <u>safety device that is physically part of an emergency medical</u>
77 <u>services station or a fire station,</u> such placement shall be
78 considered implied consent for treatment and transport. A
79 licensee, a fire department, or an employee or agent of a
80 licensee or fire department is immune from criminal or civil
81 liability for acting in good faith pursuant to this section.
82 Nothing in this subsection limits liability for negligence.
83 <u>(6)</u>~~(5)~~ Except when there is actual or suspected child
84 abuse or neglect, any parent who leaves a newborn infant <u>in a</u>
85 <u>newborn safety device or</u> with a firefighter, <u>an</u> emergency
86 medical technician, or <u>a</u> paramedic at a fire station or
87 emergency medical services station, <u>leaves a newborn infant in a</u>
88 <u>newborn safety device at a hospital,</u> or brings a newborn infant
89 to an emergency room of a hospital and expresses an intent to
90 leave the newborn infant and not return, has the absolute right
91 to remain anonymous and to leave at any time and may not be
92 pursued or followed unless the parent seeks to reclaim the
93 newborn infant. When an infant is born in a hospital and the
94 mother expresses intent to leave the infant and not return, upon
95 the mother's request, the hospital or registrar shall complete
96 the infant's birth certificate without naming the mother
97 thereon.
98 <u>(11)</u>~~(10)~~ A criminal investigation shall not be initiated
99 solely because a newborn infant is left at a hospital<u>, an</u>
100 <u>emergency medical services station, or a fire station</u> under this

101 section unless there is actual or suspected child abuse or
102 neglect.
103 Section 2. Subsection (4) of section 63.0423, Florida
104 Statutes, is amended to read:
105 63.0423 Procedures with respect to surrendered infants.—
106 (4) The parent who surrenders the infant in accordance
107 with s. 383.50 is presumed to have consented to termination of
108 parental rights, and express consent is not required. Except
109 when there is actual or suspected child abuse or neglect, the
110 licensed child-placing agency shall not attempt to pursue,
111 search for, or notify that parent as provided in s. 63.088 and
112 chapter 49. For purposes of s. 383.50 and this section, an
113 infant who tests positive for illegal drugs, narcotic
114 prescription drugs, alcohol, or other substances, but shows no
115 other signs of child abuse or neglect, shall be placed in the
116 custody of a licensed child-placing agency. Such a placement
117 does not eliminate the reporting requirement under s. 383.50(8)
118 ~~s. 383.50(7)~~. When the department is contacted regarding an
119 infant properly surrendered under this section and s. 383.50,
120 the department shall provide instruction to contact a licensed
121 child-placing agency and may not take custody of the infant
122 unless reasonable efforts to contact a licensed child-placing
123 agency to accept the infant have not been successful.
124 Section 3. This act shall take effect July 1, 2020.

CS/HB 1323

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1323 Economic Self-sufficiency
SPONSOR(S): Oversight, Transparency & Public Management Subcommittee; Aloupis
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1624

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Oversight, Transparency & Public Management Subcommittee	15 Y, 0 N, As CS	Toliver	Smith
2) Health Care Appropriations Subcommittee		Fontaine WGF	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The bill requires the Department of Children and Families (DCF) to contract for an evaluation on the effectiveness of the following programs:

- Medicaid;
- Temporary cash assistance program;
- School Readiness program;
- Supplemental Nutrition Assistance Program; and
- Housing Choice Voucher Program

The evaluations must include a review of the following aspects of those programs:

- History and description of the programs;
- Analysis of the impacts and effectiveness of the programs;
- Eligibility, including:
  - Criteria for eligibility;
  - Frequency of eligibility determinations;
  - Clarity in written, electronic, and verbal communication in which eligibility requirements are conveyed to current and potential program subscribers; and
  - The process used to establish and document eligibility;
- The changes in levels of economic self-sufficiency among Floridians over the life of the program;
- The degree to which the program is responsible for any positive changes in economic self-sufficiency;
- The strengths and weaknesses in the methods of assistance used by the program;
- Opportunities for improving service efficiency and efficacy; and
- Potential innovations in, alternatives to, or improvements in the program to increase achievement of economic self-sufficiency.

The bill requires DCF to establish a working group to develop criteria for selecting an entity to conduct the program evaluations, evaluate the bid responses, and select the entity to conduct the evaluations. The working group will consist of two representatives from each of the following agencies: DCF, the Agency for Health Care Administration, the Department of Economic Opportunity, the Department of Education, and the Florida Housing Finance Corporation.

The program evaluations must be compiled into a final report by February 1, 2021, which must then be sent to various persons, including the Governor, the President of the Senate, and the Speaker of the House of Representatives.

The bill has an indeterminate negative fiscal impact on DCF, which can likely be absorbed with existing resources.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Florida Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), which makes eligibility determinations.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.[1] Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include physician services, hospital services, home health services, and family planning.[2] States can add benefits, with federal approval. Florida has added many optional benefits, including prescription drugs, ambulatory surgical center services, and dialysis.[3]

The Florida Medicaid program covers approximately 3.8 million low-income individuals.[4] Medicaid is the second largest single program in the state, behind public education, representing approximately one-third of the total FY 2019-2020 state budget.[5]

Temporary Aid for Needy Families

Under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996,[6] the Temporary Aid for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program. The law ended federal entitlement to assistance and instead created TANF as a block grant that provides federal funds to states, territories, and tribes each year. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized by the Deficit Reduction Act of 2005. States receive block grants to operate their individual programs and to accomplish the goals of the TANF program.

Florida's Temporary Cash Assistance Program

Florida's temporary cash assistance (TCA) program is one of several programs funded with TANF block grant funds. The purpose of the TCA program is to help families with children become self-

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[1] 42 U.S.C. §§ 1396-1396w-5; 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

[2] Section 409.905, F.S.

[3] Section 409.906, F.S.

[4] Agency for Health Care Administration, *Florida Statewide Medicaid Monthly Enrollment Report*, September 2019, https://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Jan. 31, 2020).

[5] Chapter 2019-115, L.O.F.; *see also Fiscal Analysis in Brief: 2019 Legislative Session*, http://flsenate.gov/UserContent/Committees/Publications/FiscalAnalysisInBrief/2019_Fiscal_Analysis_In_Brief.pdf (last visited Jan. 31, 2020).

[6] P.L. 104-193.

supporting while allowing children to remain in their own homes. It provides cash assistance to families that meet the technical, income, and asset requirements.[7]

Various state agencies and entities work together through a series of contracts or memoranda of understanding to administer the TCA program. DCF receives the federal TANF block grant and administers the TCA program, monitoring eligibility and dispersing benefits. The Department of Economic Opportunity (DEO) is responsible for financial and performance reporting to ensure compliance with federal and state measures, and for providing training and technical assistance to Local Workforce Development Boards (LWDBs). LWDBs provide information about available jobs, on-the-job training, and education and training services within their respective areas and contract with one-stop career centers.[8] CareerSource Florida has planning and oversight responsibilities for all workforce-related programs.

School Readiness Program
Established in 1999,[9] the School Readiness Program provides subsidies for child care services and early childhood education for children of low-income families; children in protective services who are at risk of abuse, neglect, abandonment, or homelessness; foster children; and children with disabilities.[10] The School Readiness Program offers financial assistance for child care to these families while supporting children in the development of skills for success in school. Additionally, the program provides developmental screening and referrals to health and education specialists where needed. These services are provided in conjunction with other programs for young children such as Head Start, Early Head Start, Migrant Head Start, Child Care Resource and Referral and the Voluntary Prekindergarten Education Program.[11]

The School Readiness Program is a state-federal partnership between Florida's Office of Early Learning (OEL)[12] and the Office of Child Care of the United States Department of Health and Human Services.[13] It is administered by early learning coalitions (ELC) at the county or regional level.[14] Florida's OEL administers the program at the state level, including statewide coordination of ELCs.[15]

The Florida DCF's Office of Child Care Regulation, as the agency responsible for the state's child care provider licensing program, inspects all child care providers that provide the School Readiness Program for specified health and safety standards.[16] The law authorizes a county to designate a local licensing agency to license providers if its licensing standards meet or exceed DCF's standards. Five counties have done this – Broward, Hillsborough, Palm Beach, Pinellas, and Sarasota. Thus, in these

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[7] Children must be under the age of 18, or under age 19 if they are full time secondary school students. Parents, children and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[8] CareerSource Florida, Inc., *Workforce Investment Act – Workforce Innovation and Opportunity Act Annual Report for 2015-2016 Program Year*, https://careersourceflorida.com/wp-content/uploads/2016/10/161003_AnnualReport.pdf (last visited Jan. 31, 2020).
[9] Section 1, ch. 99-357, L.O.F.
[10] Sections 1002.81 and 1002.87, F.S.
[11] Florida Office of Early Learning, *School Readiness Program,* http://www.floridaearlylearning.com/family-resources/financial-assistance (last visited Feb. 2, 2020).
[12] In 2013, the Legislature established the Office of Early Learning in the Office of Independent Education and Parental Choice within the Department of Education. The office is administered by an executive director and is fully accountable to the Commissioner of Education but shall independently exercise all powers, duties, and functions prescribed by law, as well as adopt rules for the establishment and operation of the School Readiness Program and the VPK Program. Section 1, ch. 2013-252, L.O.F., *codified at* s. 1001.213, F.S.
[13] *See* U.S. Department of Health and Human Services, *Office of Child Care Fact Sheet*, http://www.acf.hhs.gov/programs/occ/fact-sheet-occ(last visited Feb. 2, 2020).
[14] Section 1002.83, F.S.
[15] Section 1001.213(3), F.S.
[16] *See* ss. 402.301-402.319 and 1002.88, F.S.

five counties the local licensing agency, not DCF, inspects child care providers that provide the School Readiness Program[17] for health and safety standards.

Supplemental Nutrition Assistance Program (SNAP)
The Food and Nutrition Service (FNS), under the U.S. Department of Agriculture (USDA), administers the Supplemental Nutrition Assistance Program (SNAP).[18] SNAP offers nutrition assistance to millions of eligible, low-income individuals and families, in the form of funds to purchase "eligible food,"[19] and provides economic benefits to communities by reducing poverty and food insecurity.[20]

The federal government funds 100% of the benefit amount. However, FNS and states share the administrative costs of the program. Federal laws, regulations, and waivers provide states with various policy options to better target benefits to those most in need, streamline program administration and field operations, and coordinate SNAP activities with those of other programs.[21]

The amount of benefits, or allotment, for which a households qualifies depends on the number of individuals in the household and the household's net income. To calculate a household's allotment, 30% of its net income is subtracted from the maximum allotment for that household size.[22] This is because SNAP households are expected to spend about 30% of their own resources on food.[23]

Housing Choice Voucher Program
The Housing Choice Voucher Program (HCVP) "is the federal government's major program for assisting very low-income families, the elderly, and the disabled to afford decent, safe, and sanitary housing in the private market."[24] There are two different types of assistance under the HCVP: tenant-based and project-based.[25] Tenant-based assistance is an arrangement where the unit is selected by the family, wherever they wish to live, and the PHA pays the landlord a subsidy and the family pays the difference between the rent price and subsidy. In project-based assistance, "rental assistance is paid for families living in specific housing developments or units."[26]

The U.S. Department of Housing and Urban Development (HUD) oversees the HCVP,[27] but the program "is generally administered by State or local governmental entities called public housing agencies (PHAs)."[28] HUD provides funding to the PHAs, who then contract with a landlord to subsidized rent on behalf of the program participant.[29] Housing units receiving HCVP funding must meet and maintain certain housing quality standards.[30] To be eligible for HCVP the applicant must be a

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[17] Section 402.306(1), F.S.
[18] U.S. Department of Agriculture, Food and Nutrition, *A Short History of SNAP*, https://www.fns.usda.gov/snap/short-history-snap (last visited December 7, 2017).
[19] The Food and Nutrition Act of 2008 defines eligible food as any food or food product intended for human consumption except alcoholic beverages, tobacco, hot foods and hot food products prepared for immediate consumption, with some exceptions. 7 USC § 2012(k).
[20] For a detailed overview of SNAP, *see* Randy Alison Aussenberg, *Supplemental Nutrition Assistance Program (SNAP): A Primer on Eligibility and Benefits*, CONGRESSIONAL RESEARCH SERVICE, Dec. 29, 2014, *available at* https://www.fas.org/sgp/crs/misc/R42505.pdf (last visited Feb. 2, 2020).
[21] U.S. Department of Agriculture, Food and Nutrition, *State Options Report: Supplemental Nutrition Assistance Program* , (11th ed.), Sept. 2013, *available at* http://www.fns.usda.gov/sites/default/files/snap/11-State_Options.pdf (last visited Feb. 2, 2020).
[22] U.S. Department of Agriculture Food and Nutrition Service, *SNAP Eligibility*, https://www.fns.usda.gov/snap/recipient/eligibility (last visited Feb. 2, 2020).
[23] *Id.*
[24] *Housing Choice Vouchers Fact Sheet*, U.S. Department of Housing and Urban Development, https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet (last visited Jan. 31, 2020).
[25] 24 C.F.R. § 982.201.
[26] *Id.*
[27] *See* 42 U.S.C. s. 1437.
[28] 24 C.F.R. § 982.1.
[29] *Id.*
[30] *See* 24 C.F.R. § 982.401.

low income family[31] with "the family's income not exceeding 50% of the median income for the county or metropolitan area."[32]

Effect of the Bill

The bill requires the Department of Children and Families (DCF) to contract for an evaluation on the effectiveness of the following programs:

- Medicaid;
- The Temporary cash assistance program;
- The School Readiness program;
- The Supplemental Nutrition Assistance Program; and
- The Housing Choice Voucher Program

The evaluations must include a review of the following aspects of those programs:

- History and description of the programs;
- Analysis of the impacts and effectiveness of the programs;
- Eligibility, including:
    - Criteria for eligibility;
    - Frequency of eligibility determinations;
    - Clarity in written, electronic, and verbal communication in which eligibility requirements are conveyed to current and potential program subscribers; and
    - The process used to establish and document eligibility.
- The changes in levels of economic self-sufficiency among Floridians over the life of the program;
- The degree to which the program is responsible for any positive changes in economic self-sufficiency;
- The strengths and weaknesses in the methods of assistance used by the program;
- Opportunities for improving service efficiency and efficacy; and
- Potential innovations in, alternatives to, or improvements in the program to increase achievement of economic self-sufficiency.

The bill requires DCF to establish a working group to develop criteria for selecting an entity to conduct the program evaluations, evaluate the bid responses, and select the entity to conduct the evaluations. The working group will consist of two representatives from each of the following agencies: DCF, the Agency for Health Care Administration, the Department of Economic Opportunity, the Department of Education, and the Florida Housing Finance Corporation. One of the two representatives from DCF will serve as chair. The criteria used to select the entity must identify datasets necessary to evaluate the effectiveness of the programs and determine the qualifications necessary in order to bid on the contract.

The program evaluations must be compiled into a final report by February 1, 2021. DCF must submit the report to the following public officers:

- The Governor,
- The President of the Senate,
- The Speaker of the House of Representatives;
- The Secretary of the Agency for Health Care Administration;
- The Director of the Department of Economic Opportunity;
- The Commissioner of Education; and
- The Board of Directors of the Florida Housing Finance Corporation.

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[31] 24 C.F.R. § 982.201.

[32] U.S. Department of Housing and Urban Development, *Housing Choice Vouchers Fact Sheet,* https://www.hud.gov/program_offices/public_indian_housing/programs/hcv/about/fact_sheet (last visited Jan. 31, 2020).

B. SECTION DIRECTORY:

Section 1 creates an unnumbered section of a law related to the evaluation of certain programs.

Section 2 provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate negative fiscal impact on state government expenditures as it requires DCF to contract with a third party to evaluate five government programs. A review of historical budget reversions demonstrates the likely ability to absorb the cost with existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill does not confer rulemaking authority nor require the promulgation of rules.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 4, 2020, the Oversight, Transparency & Public Management Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Removed the requirement that the auditor general audit each of the programs at least triennially;
- Removed the provision of the bill deleting certain definition from s. 1002.81, F.S.;
- Removed a provision of the bill requiring parents who have an intensive services account or an individual training account be given priority for participation in the School Readiness program equal to parents receiving TCA benefits
- Requires DCF to contract with a third party for an evaluation on the effectiveness of the programs;
- Provides requirements for aspects of the program to be reviewed in the evaluations;
- Requires the establishment of a working group to aid in the procurement of the third party;
- Requires DCF to provide a final report on the program evaluations by February 1, 2021.

The analysis is drafted to the committee substitute as approved by the Oversight, Transparency & Public Management Subcommittee.

1 A bill to be entitled
2 An act relating to economic self-sufficiency;
3 requiring the Department of Children and Families to
4 contract for an evaluation of the effectiveness of
5 certain programs; creating an interagency working
6 group for specified purposes; providing membership and
7 duties of the working group; providing requirements
8 for specified evaluations; requiring a report be
9 submitted to specified entities by a certain date;
10 providing for future expiration; providing an
11 effective date.
12
13 Be It Enacted by the Legislature of the State of Florida:
14
15 Section 1. (1) The Department of Children and Families
16 shall contract for an evaluation of and a report on the
17 effectiveness of the following programs in this state:
18 (a) The Supplemental Nutrition Assistance Program
19 established under 7 U.S.C. ss. 2011 et seq.
20 (b) The temporary cash assistance program under s.
21 414.095, Florida Statutes.
22 (c) The Medicaid program under s. 409.963, Florida
23 Statutes.
24 (d) The school readiness program under Part VI of chapter
25 1002, Florida Statutes.

26 (e) The housing choice voucher program established under
27 42 U.S.C. s. 1437.
28 (2) The Department of Children and Families, in
29 coordination with the Agency for Health Care Administration, the
30 Department of Economic Opportunity, the Department of Education,
31 and the Florida Housing Finance Corporation, shall establish a
32 working group comprised of two representatives from each agency
33 with a representative from the Department of Children and
34 Families serving as chair. The working group shall:
35 (a) Develop criteria for selecting an entity to conduct an
36 evaluation of the effectiveness of the programs described in
37 subsection (1). The criteria must, at a minimum, identify
38 datasets necessary to evaluate the effectiveness of the programs
39 and determine the qualifications necessary in order to bid on
40 the contract.
41 (b) Evaluate the bid responses and select an entity to
42 conduct the program evaluations.
43 (3) The program evaluations must include a history of the
44 program; a description of the program, including its objectives,
45 methods of assistance, and ongoing accountability activities; an
46 analysis of the impacts and effectiveness of the program; a
47 review of the eligibility criteria for the program; the process
48 used to establish and document eligibility; the frequency of
49 eligibility determinations; the clarity in written, verbal, and
50 electronic communication in which eligibility requirements are

51 conveyed to current and potential program subscribers; and the
52 opportunities for improving service efficiency and efficacy. In
53 addition, to the degree possible for each program, the program
54 evaluation must quantify the changes in levels of economic self-
55 sufficiency among Floridians over the life of the program;
56 assess the degree to which the program is responsible for any
57 positive changes in economic self-sufficiency and identify any
58 contributing factors; identify the strengths and weaknesses in
59 the methods of assistance used by the program; and identify
60 potential innovations in, alternatives to, or improvements in
61 the program that may increase achievement of economic self-
62 sufficiency.
63 (4) Program evaluations must be compiled into a final
64 report. The Department of Children and Families must submit the
65 final report by February 1, 2021, to the Governor, the President
66 of the Senate, and the Speaker of the House of Representatives.
67 In addition, the department must provide copies of the report to
68 the Secretary of the Agency for Health Care Administration, the
69 Director of the Department of Economic Opportunity, the
70 Commissioner of Education, and the Board of Directors of the
71 Florida Housing Finance Corporation.
72 (5) This section expires July 1, 2021.
73 Section 2. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 6029 Punitive Damages
SPONSOR(S): Mariano
TIED BILLS: **IDEN./SIM. BILLS:** SB 1226

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	12 Y, 1 N	Frost	Luczynski
2) Health Care Appropriations Subcommittee		Nobles JRN	Clark
3) Judiciary Committee			

SUMMARY ANALYSIS

In Florida, a nursing home or and assisted living facility (ALF) resident has specific legal rights, including the right to receive adequate and appropriate health care and protective and support services. A nursing home or ALF resident whose rights are violated has a cause of action against the nursing home. Florida law provides a comprehensive framework for litigation and recovery against a nursing home or ALF, including provisions for presuit notice, mediation, availability of records, and punitive damages.

Punitive damages are not compensation for an injury. Instead, they are private fines imposed by civil juries to punish reprehensible conduct and to deter its future occurrence. A nursing home or an ALF may be liable for punitive damages if a judge or jury finds, by clear and convincing evidence, that the nursing home or ALF actively and knowingly participated in intentional misconduct or engaged in conduct that constituted gross negligence, and contributed to the loss, damages, or injury suffered by the claimant.

The Quality of Long-Term Care Facility Improvement Trust Fund (Trust Fund) was created in 2001, within the Agency of Health Care Administration, to support activities and programs directly related to the care of nursing home and ALF residents. Punitive damages awarded in a claim against a nursing home or ALF must be split equally between the claimant and the Trust Fund. However, since 2008, only two awards for punitive damages have resulted in deposits into the Trust Fund, and no direct assisted living projects have been funded from those monies.

HB 6029 removes the requirement that punitive damages awarded in a claim against a nursing home or an ALF be split equally between the claimant and the Trust Fund. The bill makes conforming changes to s. 400.0239, F.S., to remove, as a source of funding for the Trust Fund, the proceeds generated from punitive damages awards.

The bill will eliminate a revenue source for the Trust Fund, but it does not appear that removing this source will have a meaningful impact on the Trust Fund.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

In Florida, long-term care facilities include nursing home facilities and assisted living facilities (ALFs). A nursing home is a residential facility where a person lives or where a person can stay temporarily. A temporary nursing home stay may be for respite care or recuperation after being in a hospital.[1] An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services[2] for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[3] Florida provides every resident of an ALF a number of specific rights

Litigation against Nursing Homes and ALFs

Section 400.022, F.S., provides the legal rights of nursing home residents and s. 429.28, F.S., provides the rights of ALF resident. Included in those rights is the right to receive "adequate and appropriate health care and protective and support services." A resident whose rights are violated by a nursing home or an ALF[4] has a cause of action against the nursing home or the ALF.[5] Florida law provides a comprehensive framework for litigation and recovery against a nursing home or an ALF, including provisions for presuit notice, mediation, availability of records, and punitive damages.[6]

Before filing a claim for a violation of a nursing home or ALF resident's rights resulting in death or injury, the claimant must notify each prospective defendant by certified mail.[7]

Named Defendants in Nursing Home Cases

If a cause of action for violation of a nursing home resident's rights alleges direct or vicarious liability for the nursing home resident's personal injury or death, the claim may only be brought against:[8]
- The licensee;
- The licensee's management or consulting company;
- The licensee's management employees; and
- Any direct caregivers, whether employees or contractors.

However, a cause of action cannot be brought against a passive investor.[9]

For the purpose of civil enforcement of a violation of a nursing home resident's rights:
- "Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the Agency, and that is legally responsible for all aspects of the operation of the nursing home facility.[10]

[1] State of Florida Department of Elder Affairs, *Nursing Homes*, http://elderaffairs.state.fl.us/doea/nh.php (last visited Feb. 5, 2020).
[2] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication. Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks. Ss. 429.02(1) and 429.02(16), F.S.
[3] S. 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[4] Ss. 400.02 and 429.29, F.S.,
[5] The action may be brought by the resident or his or her guardian, by a person or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of the deceased resident regardless of the cause of death. Ss. 400.023(1) and 429.29, F.S.
[6] Ss. 400.023–400.0238 and 429.29–429.298, F.S.
[7] Ss. 400.0233(2) and 429.293(2), F.S.
[8] S. 400.023(1), F.S.
[9] *Id.*
[10] S. 400.023(2)(a), F.S.

- "Management or consulting company" means an individual or entity who contracts with, or receives a fee from a licensee to provide any of the following services for a nursing home facility:
    - Hiring or firing of the administrator or director of nursing;
    - Controlling or having control over the staffing levels at the facility;
    - Having control over the budget of the facility; or
    - Implementing and enforcing the policies and procedures of the facility.[11]
- "Passive investor" means an individual or entity that has an interest in a facility but does not participate in the decision making or operations of the facility.[12]

Before a person other than the licensee, the licensee's management or consulting company, the licensee's managing employees, or a direct caregiver employee may be named as a defendant in a lawsuit alleging violation of a nursing home resident's rights, the court or arbitration panel must find that sufficient evidence exists to show that the:

- Individual or entity owed a duty of reasonable care to the resident;
- Individual or entity breached that duty; and
- Breach of duty was a legal cause of loss, injury, or damage to, or death of, the resident.[13]

Once the court or arbitration panel makes this finding, and a proposed amended pleading asserts that the cause of action arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the proposed amendment is considered to relate back to the original pleading.[14]

If a violation of rights resulted in a nursing home or ALF resident's death, the resident's estate must choose either survival damages under s. 46.021, F.S., or wrongful death damages under s. 768.21, F.S. This choice must be made after the verdict and before the judgment is entered.[15]

Punitive Damages and Limitations

Punitive damages are not compensation for an injury. Instead, they are private fines imposed by civil juries to punish reprehensible conduct and to deter its future occurrence.[16] A nursing home or ALF may be liable for punitive damages only if the judge or jury finds, by clear and convincing evidence, that a nursing home actively and knowingly participated in intentional misconduct[17] or engaged in conduct that constituted gross negligence,[18] and contributed to the loss, damages, or injury suffered by the claimant.[19]

Punitive damages are generally limited to three times the amount of compensatory damages or $1 million, whichever is greater.[20] However, a jury may award punitive damages not exceeding the greater of four times the amount of compensatory damages or $4 million, if it finds that the:[21]

- Conduct was motivated primarily by unreasonable financial gain; and

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[11] S. 400.023(2)(b), F.S.
[12] S. 400.023(2)(c), F.S.
[13] S. 400.023(4), F.S.
[14] An amended pleading that relates back is considered to have been filed when the original lawsuit was filed for purposes of determining compliance with the statute of limitations. S. 400.023(3)(b), F.S.
[15] Ss. 400.023(1)(b) and 429.29(1), F.S.
[16] *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 350 (1974).
[17] Intentional misconduct means that the nursing home had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage. Ss. 400.0237(2)(a) and 429.297(2)(b), F.S.
[18] Gross negligence means that a nursing home's or ALF's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct. Ss. 400.0237(2)(b) and 429.297(2)(b)F.S.
[19] Ss. 400.0237(2) and 429.297(2), F.S.
[20] Ss. 400.0238(1)(a) and 429.298(1)(a), F.S.
[21] Ss. 400.0238(4)(b) and 429.298(1)(b), F.S.

- Unreasonably dangerous nature of the conduct, together with the high likelihood of injury resulting from the conduct, was actually known by the managing agent, director, officer, or other person responsible for making policy decisions on behalf of the defendant.

However, there is no cap on punitive damages if a jury determines that the:
- Defendant acted with specific intent to harm the claimant; and
- Defendant's conduct did in fact harm the claimant.[22]

Quality of Long-Term Care Facility Improvement Trust Fund

Section 400.0239, F.S., created the Quality of Long-Term Care Facility Improvement Trust Fund (Trust Fund) within the Agency for Health Care Administration (AHCA).[23] The Trust Fund was created in 2001[24] to support activities and programs directly related to the care of nursing home and assisted living facility residents.[25] Expenditures from the Trust Fund can be made for direct support of the following:[26]
- Development and operation of a mentoring program for increasing the competence, professionalism, and career preparation of long-term care facility direct care staff, including nurses, nursing assistances, and social service and dietary personnel.
- Development and implementation of specialized training programs for long-term care facility personnel who provide direct care of residents with Alzheimer's Disease and other dementias, residents at risk of developing pressure sores, and residents with special nutrition and hydration needs.
- Provision of economic and other incentives to enhance the stability and career development of the nursing home direct care workforce, including paid sabbaticals for exemplary direct care career staff to visit facilities throughout the state to train and motivate younger workers to commit to careers in long-term care.
- Promotion and support for the formation and active involvement of resident and family councils in the improvement of nursing home care.

The Trust Fund receives money through a combination of:
- General revenues;
- The Civil Money Penalty Fund; and
- Fifty-percent of any punitive damages awarded as part of lawsuit against a nursing home or related healthcare facility.[27]

Punitive Damages

Sections 400.0238, F.S., and 429.298, F.S., both require the amount of punitive damages awarded in a claim against a nursing home and assisted living facility, respectively, to be split equally between the claimant and the Trust Fund.

Civil Money Penalty Funds

Civil Money Penalties (CMP) are monetary penalties imposed by the Centers for Medicare and Medicaid Services against nursing facilities that have failed to maintain compliance with federal requirements. A portion of these funds are returned to states and may be used for projects supporting

[22] Ss. 400.0238(4)(c) and 429.298(1)(c), F.S.
[23] S. 400.0239(1), F.S.
[24] Ch. 2001-205, L.O.F.
[25] Office of the Assistant Secretary for Planning and Evaluation, *State Nursing Home Quality Improvement Programs*, https://aspe.hhs.gov/report/state-nursing-home-quality-improvement-programs-site-visit-and-synthesis-report/funding-quality-long-term-care-facility-improvement-trust-fund (last visited Feb. 5, 2018).
[26] S. 400.0239(2), F.S.
[27] S. 400.0238(4), F.S.

activities that benefit nursing facility residents or that protect and improve their quality of life or care. CMP funds may be used for, but not limited to the following: [28]

- Training;
- Transition preparation;
- Culture change/quality of life;
- Projects that support resident and family councils; and
- Resident transition due to facility closure or downsizing.

AHCA began this project in 2005 in an effort to use federal CMP funds (fines) to support innovative ideas that directly impact quality of care or quality of life of nursing home residents beyond minimum standards. The ideas proposed must be innovative to the facility, the state or to long-term care.[29]

Trust Fund Balance

As of December 31, 2019, the total balance in the Trust Fund was $29,965,929.58.[30] This amount includes $473,475.19 deposited from two punitive damages awards and $29,492,454.39 deposited from Civil Money Penalty Funds.[31] The total spent from the Trust Fund in FY 2018-2019 was $157,228.97.[32] Since its creation, AHCA estimates that approximately $1,040,990.53 has been spent from the Trust Fund.[33]

Since 2008, only $473,475.19 has been deposited in the Trust Fund from two punitive damages awards.[34] To date, no funds from punitive damages have been spent from the Trust Fund.[35] The majority of proceeds in the Trust Fund are deposited from nursing home federal civil monetary penalties, but these funds may only be used for resident-related projects in nursing homes, while funds from punitive damages may be used for assisted living facility-related projects.[36, 37] While current law directs the Clerk of Court to send certified copies of punitive damages jury verdicts to the Chief Financial Officer of the Department of Financial Services, AHCA is unware of any actions taken to monitor the verdicts to ensure a portion of the punitive damages go into the Trust Fund.[38]

Effect of Proposed Changes

HB 6029 removes the requirement that punitive damages awarded in a claim against a nursing home or an assisted living facility be split equally between the claimant and the Trust Fund. The bill makes conforming changes to s. 400.0239, F.S., to remove, as a source of funding for the Trust Fund, the proceeds generated pursuant to punitive damages.

The bill provides an effective date of July 1, 2020.

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[28] Agency for Health Care Administration, *Nursing Home Civil Money Penalty (CMP) Reinvestment Projects*, https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/CMP.shtml (last visited Feb. 5, 2020)
[29] *Id.*
[30] Email from James Kotas, Deputy Chief of Staff/Legislative Affairs Director, Agency for Health Care Administration, received January 10, 2020.
[31] *Id.*
[32] *Id.*
[33] Florida Agency for Health Care Administration, Agency Analysis of 2020 House Bill 6029, p. 2 (Jan 8, 2020).
[34] *Supra*, note 30.
[35] *Id.*.
[36] *Supra*, note 30, p. 2
[37] According to AHCA, no direct assisted living projects have been funded to date, but there is interest in expanding programs developed for nursing home staff to include assisted living staff. *Supra*, note 30, p. 3.
[38] *Id.*

B. SECTION DIRECTORY:

Section 1: Amends s. 400.0238, F.S., relating to punitive damages; limitation.
Section 2: Amends s. 400.0239, F.S., relating to Quality of Long-Term Care Facility Improvement Trust Fund.
Section 3: Amends s. 429.298, F.S., relating to punitive damages; limitation.
Section 4: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

While AHCA indicates the bill will eliminate a revenue source for the Trust Fund, it does not appear that removing this source will have any meaningful impact on the Trust Fund, given that only two deposits from punitive damages awards have been made in the last 12 years.[39]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   None.

2. Other:

   None.

[39] *Supra*, notes 27, 30, and 31.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to punitive damages; amending ss.
3 400.0238, 400.0239, and 429.298, F.S.; removing
4 provisions requiring that a portion of the punitive
5 damages awarded for claims brought under part II of
6 ch. 400, F.S., relating to nursing homes, and part I
7 of ch. 429, F.S., relating to assisted living
8 facilities, be deposited into the Quality of Long-Term
9 Care Facility Improvement Trust Fund; providing an
10 effective date.
11
12 Be It Enacted by the Legislature of the State of Florida:
13
14 Section 1. Subsection (4) of section 400.0238, Florida
15 Statutes, is amended to read:
16 400.0238 Punitive damages; limitation.—
17 ~~(4) Notwithstanding any other law to the contrary, the~~
18 ~~amount of punitive damages awarded pursuant to this section~~
19 ~~shall be equally divided between the claimant and the Quality of~~
20 ~~Long-Term Care Facility Improvement Trust Fund, in accordance~~
21 ~~with the following provisions:~~
22 ~~(a) The clerk of the court shall transmit a copy of the~~
23 ~~jury verdict to the Chief Financial Officer by certified mail.~~
24 ~~In the final judgment, the court shall order the percentages of~~
25 ~~the award, payable as provided herein.~~

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

26 ~~(b) A settlement agreement entered into between the~~
27 ~~original parties to the action after a verdict has been returned~~
28 ~~must provide a proportionate share payable to the Quality of~~
29 ~~Long-Term Care Facility Improvement Trust Fund specified herein.~~
30 ~~For purposes of this paragraph, a proportionate share is a 50-~~
31 ~~percent share of that percentage of the settlement amount which~~
32 ~~the punitive damages portion of the verdict bore to the total of~~
33 ~~the compensatory and punitive damages in the verdict.~~
34 ~~(c) The Department of Financial Services shall collect or~~
35 ~~cause to be collected all payments due the state under this~~
36 ~~section. Such payments are made to the Chief Financial Officer~~
37 ~~and deposited in the appropriate fund specified in this~~
38 ~~subsection.~~
39 ~~(d) If the full amount of punitive damages awarded cannot~~
40 ~~be collected, the claimant and the other recipient designated~~
41 ~~pursuant to this subsection are each entitled to a proportionate~~
42 ~~share of the punitive damages collected.~~
43 Section 2. Subsection (1) of section 400.0239, Florida
44 Statutes, is amended to read:
45 400.0239 Quality of Long-Term Care Facility Improvement
46 Trust Fund.—
47 (1) There is created within the Agency for Health Care
48 Administration a Quality of Long-Term Care Facility Improvement
49 Trust Fund to support activities and programs directly related
50 to improvement of the care of nursing home and assisted living

51 facility residents. The trust fund shall be funded ~~through~~
52 ~~proceeds generated pursuant to ss. 400.0238 and 429.298,~~ through
53 funds specifically appropriated by the Legislature, through
54 gifts, endowments, and other charitable contributions allowed
55 under federal and state law, and through federal nursing home
56 civil monetary penalties collected by the Centers for Medicare
57 and Medicaid Services and returned to the state. These funds
58 must be utilized in accordance with federal requirements.
59 Section 3. Subsection (4) of section 429.298, Florida
60 Statutes, is amended to read:
61 429.298 Punitive damages; limitation.—
62 ~~(4) Notwithstanding any other law to the contrary, the~~
63 ~~amount of punitive damages awarded pursuant to this section~~
64 ~~shall be equally divided between the claimant and the Quality of~~
65 ~~Long-Term Care Facility Improvement Trust Fund, in accordance~~
66 ~~with the following provisions:~~
67 ~~(a) The clerk of the court shall transmit a copy of the~~
68 ~~jury verdict to the Chief Financial Officer by certified mail.~~
69 ~~In the final judgment, the court shall order the percentages of~~
70 ~~the award, payable as provided herein.~~
71 ~~(b) A settlement agreement entered into between the~~
72 ~~original parties to the action after a verdict has been returned~~
73 ~~must provide a proportionate share payable to the Quality of~~
74 ~~Long-Term Care Facility Improvement Trust Fund specified herein.~~
75 ~~For purposes of this paragraph, a proportionate share is a 50-~~

76 ~~percent share of that percentage of the settlement amount which~~
77 ~~the punitive damages portion of the verdict bore to the total of~~
78 ~~the compensatory and punitive damages in the verdict.~~
79 ~~(c) The Department of Financial Services shall collect or~~
80 ~~cause to be collected all payments due the state under this~~
81 ~~section. Such payments are made to the Chief Financial Officer~~
82 ~~and deposited in the appropriate fund specified in this~~
83 ~~subsection.~~
84 ~~(d) If the full amount of punitive damages awarded cannot~~
85 ~~be collected, the claimant and the other recipient designated~~
86 ~~pursuant to this subsection are each entitled to a proportionate~~
87 ~~share of the punitive damages collected.~~
88 Section 4. This act shall take effect July 1, 2020.

HB 7025

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7025 PCB CFS 20-01 Guardianship
SPONSOR(S): Children, Families & Seniors Subcommittee, Fetterhoff
TIED BILLS: **IDEN./SIM. BILLS:** SB 1762

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Children, Families & Seniors Subcommittee	15 Y, 0 N	Morris	Brazzell
1) Health Care Appropriations Subcommittee		Nobles	Clark

SUMMARY ANALYSIS

Guardianship is a concept whereby a "guardian" acts on behalf of a "ward" whom the law regards as incapable of managing his or her own person or property, or both, due to age or incapacity. A court may appoint a public or private guardian if there is no family member or friend, other person, bank, or corporation willing and qualified to serve as guardian of that ward. Before a guardian may be appointed to act for the ward, a court must determine that the ward is incapable of handling his or her affairs.

HB 7025 amends sections of law relating to guardianship. Specifically, the bill:

- Removes the requirement that the executive director of the Office of Public and Professional Guardians (OPPG) within the Department of Elder Affairs (DOEA) be a member of the Florida Bar;
- Revises the duties of the executive director of the OPPG to include offering and making certain information about guardianship available for dissemination by the Area Agencies on Aging and Aging Resource Centers in this state;
- Requires professional guardians to submit and maintain information with the OPPG relating to their employees and counties in which they are appointed to a ward;
- Revises the continuing education requirements of professional guardians;
- Revises the process by which the OPPG investigates complaints and notifies guardians and complainants of the investigation process; and
- Requires the Clerks of the Circuit Court (Clerks) to report sanctions imposed by the court on a professional guardian to the OPPG.

The bill has no fiscal impact on state and local governments; see fiscal comments.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Guardianship

When an individual is unable to make legal decisions regarding his or her person or property, a guardian may be appointed to act on his or her behalf. A guardian is someone who is appointed by the court to act on behalf of a ward (an individual who has been adjudicated incapacitated) regarding his or her person or property or both.[1] Adjudicating a person totally incapacitated and in need of a guardian deprives a person of his or her civil and legal rights.[2] The Legislature has recognized that the least restrictive form of guardianship should be used to ensure the most appropriate level of care and the protection of that person's rights.[3]

The process to determine an individual's incapacity and the subsequent appointment of a guardian begins with a verified petition detailing the factual information supporting the reasons the petitioner believes the individual to be incapacitated, including the rights the alleged incapacitated person is incapable of exercising.[4] Once a person has been adjudicated incapacitated (termed a "ward"), the court appoints a guardian, and the letters of guardianship are issued.[5] The order appointing a guardian must be consistent with the ward's welfare and safety, must be the least restrictive appropriate alternative, and must reserve to the ward the right to make decisions in all matters commensurate with his or her ability to do so.[6]

Who Can Be Appointed Guardian

The following may be appointed guardian of a ward:

- Any resident of Florida who is 18 years of age or older and has full legal rights and capacity;
- A nonresident if he or she is related to the ward by blood, marriage, or adoption;
- A trust company, a state banking corporation, or state savings association authorized and qualified to exercise fiduciary powers in this state, or a national banking association or federal savings and loan association authorized and qualified to exercise fiduciary powers in Florida;
- A nonprofit corporation organized for religious or charitable purposes and existing under the laws of Florida;
- A judge who is related to the ward by blood, marriage, or adoption, or has a close relationship with the ward or the ward's family, and serves without compensation;
- A provider of health care services to the ward, whether direct or indirect, when the court specifically finds that there is no conflict of interest with the ward's best interests; or
- A for-profit corporation that meets certain qualifications, including being wholly owned by the person who is the circuit's public guardian in the circuit where the corporate guardian is appointed.[7]

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[1] S. 744.102(9), F.S.
[2] S. 744.101(1), F.S.
[3] S. 744.101(2), F.S
[4] S. 744.3201, F.S.
[5] ss. 744.3371-744.345, F.S.
[6] S. 744.2005, F.S.
[7] S. 744.309, F.S.

Guardians[8] are required to complete 8 hours of instruction and training through a course approved by the chief judge of the circuit court and taught by a court-approved organization within 4 months after being appointed to a ward.[9] The instruction and training must cover:[10]

- The legal duties and responsibilities of the guardian;
- The rights of the ward;
- The availability of local resources to aid the ward; and
- The preparation of habilitation plans and annual guardianship reports, including financial accounting for the ward's property.

Office of Public and Professional Guardians

In 1999 the Legislature created the "Public Guardianship Act" and established the Statewide Public Guardianship Office (SPGO) within the Department of Elder Affairs (DOEA).[11] By December 2013, the SPGO had expanded public guardianship services to cover all 67 counties.[12] In 2016, the Legislature renamed the Statewide Public Guardianship Office within the DOEA as the Office of Public and Professional Guardians (OPPG), required OPPG to regulate professional guardians and investigate complaints, and added 6 full-time equivalent positions to the OPPG, including an attorney and investigators.[13]

The OPPG appoints local public guardian offices to provide guardianship services to people who have neither adequate income nor assets to afford a private guardian, nor any willing family or friend to serve.[14]

There are 17 public guardian offices that serve all 67 counties.[15] In fiscal year 2017-2018, the public guardian offices served 3,846 wards.[16] Currently, there are 515 professional guardians registered with the Office of Public and Professional Guardians within the Department of Elder Affairs.[17] The total number of wards served by registered professional guardians in this state is unknown by DOEA.[18]

Executive Director

The executive director of the OPPG is responsible for the oversight of all public and professional guardians.[19] The Secretary of the DOEA appoints the executive director as the head of the OPPG. The executive director must:[20]

- Be a member of the Florida Bar;
- Be knowledgeable of guardianship law and of the social services available to meet the needs of incapacitated persons;
- Serve on a full-time basis; and
- Personally, or through a representative of the OPPG, carry out the purposes and functions of the OPPG in accordance with state and federal law.

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[8] Other than a parent who is the guardian of the property of a minor child.
[9] S. 744.3145, F.S.
[10] Id.
[11] S. 744.701, F.S. (1999).
[12] Florida Department of Elder Affairs, Summary of Programs and Services, February, 2014, *available at* http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2014/2014%20SOPS_complete.pdf (last visited Jan. 13, 2020).
[13] Ch. 2016-40, Laws of Florida.
[14] Department of Elder Affairs, *Office of Public and Professional Guardians*, available at http://elderaffairs.state.fl.us/doea/spgo.php (last visited Jan. 13, 2020).
[15] Office of Public and Professional Guardians, *2018 Annual Report,* available at http://elderaffairs.state.fl.us/doea/SPGO/pubs/OPPG_AR_2018.pdf (last visited Jan. 13, 2020).
[16] Id.
[17] Email from Derek Miller, Legislative Analyst, Department of Elder Affairs, RE: HB 709 Analysis, (Dec. 9, 2019).
[18] Id.
[19] S. 744.2001(2)(a), F.S.
[20] S. 744.2001, F.S.

The executive director's oversight responsibilities for professional guardians include but are not limited to:

- Establishing standards of practice for public and professional guardians;
- Reviewing and approving the standards and criteria for the education, registration, and certification of public and professional guardians;
- Developing a guardianship training program curriculum that may be offered to all guardians;
- Developing and implementing a monitoring tool to use for periodic monitoring activities of professional guardians; however, this monitoring tool may not include a financial audit as required to be performed by the clerk of the circuit court under s. 744.368, F.S.;
- Developing procedures for the review of an allegation that a professional guardian has violated an applicable statute, fiduciary duty, standard of practice, rule, regulation, or other requirement governing the conduct of professional guardians; and
- Establishing disciplinary proceedings, conducting hearings, and taking administrative action under ch. 120, F.S.

Complaint Investigations by the OPPG

Any person may submit a complaint against a professional guardian to the OPPG. Once the OPPG receives a complaint, it is required to:

- Review and, if determined legally sufficient,[21] investigate complaints against professional guardians;
- Initiate an investigation no later than 10 business days after OPPG receives a complaint;
- Complete and provide initial investigative findings and recommendations, if any, to the professional guardian and person filing the complaint within 60 days;
- Obtain supporting information, including interviewing the ward, family member, or interested party, or documentation to determine the legal sufficiency of a complaint;
- Dismiss any complaint that is not legally sufficient; and
- Coordinate with the clerks of the court to avoid duplication of duties.

Professional Guardians

A professional guardian is a guardian who has at any time rendered services to three or more wards as their guardian; however, a person serving as a guardian for two or more relatives is not considered a professional guardian. A public guardian is considered a professional guardian for purposes of regulation, education, and registration.[22]

Registration

A professional guardian must register with the OPPG annually.[23] As part of the registration, the professional guardian must:[24]

- Provide sufficient information to identify the professional guardian;
- Complete a minimum of 40 hours of instruction and training through a course approved or offered by the OPPG (may not be paid with the assets of the ward);
- Successfully pass an examination approved by DOEA[25] to demonstrate competency to act as a professional guardian;
- Undergo a criminal background check by the Federal Bureau of Investigation and the Florida Department of Law Enforcement;

[21] S. 744.2004(1), F.S., states that a complaint is legally sufficient if it contains ultimate facts that show a violation of a standard of practice by a professional guardian has occurred.
[22] S. 744.102(17), F.S
[23] S. 744.2002, F.S.
[24] S. 744.2002(3), F.S.; S. 744.2003, F.S.; S. 744.3135, F.S.
[25] The examination is currently administered by the University of South Florida's College of Education. University of South Florida, *Florida Professional Guardian Examination*, http://guardianship.usf.edu/index.html (last visited Jan. 13, 2020).

- Submit to a credit history check; and
- Maintain a current blanket bond.

Guardians registered with the OPPG must complete a minimum of 16 hours of continuing education every 2 calendar years after the year in which the initial 40-hour educational requirement is met and may not be paid with the assets of the ward.[26]

Guardians seeking appointment by the court and all employees of a professional guardian who have a fiduciary responsibility to the ward must submit to a credit history check and undergo a level 2 background screening.[27] The DOEA must ensure the clerks of the court and the chief judge of each judicial circuit receive information about each registered professional guardian.[28]

The executive director of the OPPG may deny registration to a professional guardian if the executive director determines that the guardian's proposed registration, including the guardian's credit or criminal investigations, indicates that registering the professional guardian would violate any provision of ch. 744, F.S.[29] However, the court is the only entity that can remove a guardian from a case to which he or she has been appointed.

<u>Responsibilities of the Clerk of the Circuit Court</u>

In addition to the duty to serve as the custodian of the guardianship files, the clerk must review each initial and annual guardianship report to ensure that it contains required information about the ward.[30] The clerk is required to:[31]

- Within 30 days after the date of filing of the initial or annual report of the guardian of the person, complete his or her review of the report;
- Within 90 days after the filing of the verified inventory and accountings by a guardian of the property, the clerk shall audit the verified inventory and the accountings and advise the court of the results of the audit; and
- Report to the court when a report is not timely filed.

If the clerk has reason to believe further review is appropriate, the clerk may request and review records and documents that reasonably impact guardianship assets, including, but not limited to, the beginning inventory balance and any fees charged to the guardianship.[32]

If a guardian fails to produce records and documents to the clerk upon request, the clerk may request the court to enter an order s. 744.3685(2), F.S., by filing an affidavit that identifies the records and documents requested and shows good cause as to why the documents and records requested are needed to complete the audit.[33] The judge may also impose sanctions on the guardian, which may include contempt, removal of the guardian, and fines.[34]

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[26] S. 744.2003(3), F.S.
[27] S. 744.3135(1), F.S.
[28] S. 744.2002(9), F.S.
[29] S. 744.2002, F.S.
[30] S. 744.368, F.S.
[31] Id.
[32] Id.
[33] Id.
[34] S. 744.3685(3) and S. 744.367(5), F.S.

Guardian Investigations

In July 2019, Steven Stryker, a ward appointed to professional guardian Rebecca Fierle,[35] died in a Tampa hospital after choking on food.[36] Hospital staff could not perform lifesaving procedures on him due to a do-not-resuscitate order (DNRO) executed by Fierle.[37]

It was also reported that Fierle had billed AdventHealth, an Orlando area hospital, approximately $4 million for services rendered to wards[38] and developed conflicts of interest with members of appointed examining committees used to determine incapacity of a person.[39]

The Clerk of the Circuit Court and Comptroller of Okaloosa County (Clerk)[40] investigated complaints filed against Fierle with the OPPG. The Clerk found Fierle had executed a DNRO against Stryker's wishes, violating the standards of practice established by the OPPG.[41] The Clerk reported that Fierle kept a DNRO in place after a psychiatrist examined Stryker while he was admitted to St. Joseph's hospital and determined Stryker had the ability to decide that he wanted to live and stated that Stryker wanted to be resuscitated.

The Orange County Comptroller also investigated Fierle's guardianships.[42] The Comptroller found Fierle had submitted over 6,000 invoices and charges of at least $3.9M to AdventHealth for payments between January 2009 and June 2019.[43] The payments were made on behalf of 682 patients. The Comptroller also found that in some cases Fierle had billed both AdventHealth and the wards for identical fees and services. Additionally, the Comptroller identified conflicts of interest, including several situations in which Fierle had previous relationships with wards to whom she was appointed guardian and did not disclose these relationships in the petitions for appointment of a guardian.

An Orange County judge removed Fierle from nearly 100 cases to which she had been appointed.[44] Fierle has appealed the judge's decision.[45] In a letter to the OPPG, Fierle resigned from all appointed guardianship cases (approximately 450 in 13 counties) in July, 2019.[46] As of November 2019, Fierle is under criminal investigation by the Florida Department of Law Enforcement.[47]

In January 2017, the Clerk and Comptroller for Lake County conducted an investigation into a complaint filed against Fierle.[48] The complaint made several allegations against Fierle, including that

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[35] The Orlando Sentinel, *Florida's Troubled Guardian Program,* https://www.orlandosentinel.com/news/florida/guardians/ (last visited Dec. 6, 2019).
[36] Adrianna Iwasinski, *Orange commissioners approve new position to help monitor guardianship cases,* Click Orlando (Oct. 22, 2019), https://www.clickorlando.com/news/2019/10/23/orange-commissioners-approve-new-position-to-help-monitor-guardianship-cases/ (last visited Jan. 13, 2020).
[37] Id.
[38] *Supra* note 35.
[39] Monivette Cordeiro, *Florida's troubled guardianship system riddled with conflicts of interest, critics claim | Special Report,* Orlando Sentinel (Aug. 14, 2019), https://www.orlandosentinel.com/news/florida/guardians/os-ne-guardianship-examining-committee-conflicts-20190814-osbekpwlnfezneolyxttvzmrhy-story.html (last visited Jan. 13, 2020).
[40] J.D. Peacock II, Clerk of the Circuit Court and Comptroller Okaloosa County, Florida, *OPPG Investigation Case Number 19-064* (July 9, 2019), https://www.scribd.com/document/417992870/Fierle-State-Report (last visited Jan. 13, 2020).
[41] Id.
[42] Orange County Comptroller, *Report No. 479 – Investigation of Payments Made to Professional Guardian – Rebecca Fierle by AdventHealth,* https://www.occompt.com/download/Audit%20Reports/rpt479.pdf (last visited Jan. 13, 2020).
[43] Id.
[44] *Supra* note 35.
[45] Id.
[46] Greg Angel, *Embattled Guardian Resigns From Cases Statewide; Criminal Investigation Continues,* Spectrum News 13 (July 29, 2019), https://www.mynews13.com/fl/orlando/crime/2019/07/29/embattled-guardian-resigns-from-cases-statewide (last visited Jan. 13, 2020).
[47] Greg Angel, *Watchdog: Judge Dismisses Embattled Guardian's Appeal to Reverse Court Order,* Spectrum News 13 (Nov. 19, 2019) https://www.mynews13.com/fl/orlando/news/2019/11/19/watchdog-fierle-appeal-to-reverse-court-order-dismissed (last visited Jan. 13, 2020).
[48] Neil Kelly, Clerk of Circuit Court, Lake County Florida, *Investigation Report Case Number 2016-002,* (Jan. 9, 2017) (on file with Children, Families, and Seniors Subcommittee staff).

Fierle was "not following statutes." The investigation report noted information they came across in their investigation into Fierle, including noting that Fierle employed staff whose responsibilities included "visiting wards, reviewing the charts of wards and participating in their care plans, inspecting the physical health of the wards, and ensuring their needs were being met and they are getting the proper care." The investigation report stated that there is no clear requirement to disclose the names and information of a guardian's employees to the OPPG or to the courts and that employees with direct, unsupervised access to wards are not held to the same requirements of a credit history check and level 2 background check which is required for employees who have a fiduciary responsibility to the ward. The investigation report concludes that the OPPG should consider "the need for appropriate legislation and/or rules to better protect wards in these circumstances."

These investigations led to changes in OPPG's staff and internal operations. Seven staff members resigned, including the executive director of the OPPG.[49] The Secretary of DOEA, with the assistance of the General Counsel, assumed oversight of the OPPG following the resignations.[50] In a presentation to the Children, Families, and Seniors Subcommittee on November 7, 2019, the Secretary of DOEA noted a backlog of complaints that had gone uninvestigated.[51] Almost 300 complaints have been received by the OPPG since 2017. As of October 12, 2019, 193 backlogged investigations were completed, leading to 13 registration revocation letters, 1 administrative complaint, 6 reprimand letters, and 42 letters of concern.[52]

The OPPG underwent operational improvements, including:[53]

- Revising its investigation referral process;
- Implementing new processes to improve transparency and responsiveness to complainants and affected guardians following the completion of investigations; and
- Continuing efforts with the Clerks to improve complaint intake and referral procedures.

Effect of Proposed Changes

Office of Public and Professional Guardians

HB 7025 revises the requirements and responsibilities of the executive director of the OPPG. Specifically, the bill removes the requirement that the executive director of the OPPG be a member of the Florida Bar. It requires the executive director to, within available resources, to:

- Offer and make available online an education course for use by guardians who are required to complete the 8 hour education course pursuant to s. 744.3145, F.S.; and
- Produce and make available information about alternatives to guardianship and types of guardianship for dissemination by Area Agencies on Aging and Aging Resource Centers.

Professional Guardians

HB 7025 revises the continuing education requirements of professional guardians by increasing the hours of continuing education required to be taken by a professional guardian from 16 hours to 20 hours every two years and be completed through a course approved or offered by the OPPG. The bill specifically requires that continuing education include at least:

- 2 hours on fiduciary responsibilities;
- 2 hours on professional ethics;

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[49] Adam Walser, *State confirms mass resignations at Florida watchdog office overseeing guardianship abuse,* ABC Action News (Aug. 9, 2019) https://www.abcactionnews.com/news/local-news/i-team-investigates/the-price-of-protection/major-shakeup-at-florida-watchdog-office-that-oversees-guardianship-abuse (last visited Jan. 14, 2020).

[50] Id.

[51] Presentation to the Children, Families, and Seniors Subcommittee by the Florida Department of Elder Affairs, https://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3019&Session=2020&DocumentType=Meeting%20Packets&FileName=cfs%2011-7-19.pdf (Nov. 7, 2019).

[52] Id.

[53] Id.

- 1 hour on advance directives;
- 3 hours on abuse, neglect, and exploitation; and
- 4 hours on guardianship law.

The bill requires professional guardians to submit and maintain the names and titles of their employees and the counties in which they are appointed to a ward with the OPPG.

Complaint Investigations by the OPPG

HB 7025 revises the process by which the OPPG is required to investigate complaints made against a professional guardian and details timelines for providing information to the complainant and the professional guardian who is subject to the complaint. Specifically, the bill requires the OPPG to:

- Notify the complainant no later than 10 business days after the OPPG determines a complaint is not legally sufficient;
- Within 45 business days after receipt of a complaint by the OPPG, complete and provide initial investigative findings and recommendations, if any, to the professional guardian and the complainant; and
- Within 10 business days after completing an investigation, provide the complainant and the professional guardian with a written statement specifying any finding of a violation of a standard of practice by a professional guardian and any actions taken or specifying that no such violation was found.

Guardian Education Requirements

HB 7025 allows a guardian appointed by the court who must complete the required 8 hours of instruction pursuant to s. 744.3145, F.S., to satisfy this requirement through a course offered by the OPPG in addition to the course approved by the chief judge of the circuit court and taught by a court-approved organization.

The bill removes the ability of the court, in its discretion, to waive some or all of the education requirements of a guardian under s. 744.3145, F.S..

Responsibilities of the Clerk of the Circuit Court

HB 7025 adds the reporting of any sanctions imposed by the court on a professional guardian, including, but not limited to, contempt of court or removal of the professional guardian, to the responsibilities of the clerk of the circuit court. The clerk must submit such information to the OPPG within 10 business days after the court imposes any sanctions.

HB 7025 makes technical and conforming changes.

HB 7025 provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 744.2201, F.S., relating to Office of Public and Professional Guardians.
Section 2: Amends s. 744.2003, F.S., relating to regulation of professional guardians; application; bond required; educational requirements.
Section 3: Amends s. 744.2004, F.S., relating to complaints, disciplinary proceedings, penalties, enforcement.
Section 4: Amends s. 744.3145, relating to guardian education requirements.
Section 5: Amends s. 744.368, F.S., relating to responsibilities of the clerk of the circuit court.
Section 6: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   HB 7025 requires the OPPG to offer and place online, an education course to satisfy the education requirement under s. 744.3145, F.S. and to provide information on guardianship for the Area Agencies on Aging and the Aging and Disability Resource Centers to disseminate. OPPG must also implement new procedural changes. Per the DOEA, these changes have no fiscal impact on DOEA.

   OPPG must also collect additional information from guardians. Per the DOEA, these changes have no fiscal impact on DOEA.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The expenses incurred by the guardian to satisfy the required training under s. 744.3145, F.S., may be paid from the ward's estate, unless the court directs that such expenses be paid by the guardian individually.

The increase in the required continuing education hours for professional guardians may result in a negative fiscal impact on the professional guardians as a ward's assets may not be used to fund this continuing education.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to guardianship; amending s. 744.2001,
3 F.S.; deleting the requirement that the executive
4 director of the Office of Public and Professional
5 Guardians be a member of The Florida Bar; requiring
6 the executive director to offer and make certain
7 education courses available online; requiring the
8 executive director to produce and make available
9 information about alternatives to and types of
10 guardianship for dissemination by certain entities;
11 deleting obsolete language; amending s. 744.2003,
12 F.S.; revising continuing education requirements for
13 guardians; requiring professional guardians to submit
14 to and maintain with the office specified information;
15 amending s. 744.2004, F.S.; deleting obsolete
16 language; revising the office's disciplinary
17 procedures; requiring the office to notify parties to
18 the complaint of certain information within specified
19 timeframes; amending s. 744.3145, F.S.; authorizing
20 guardians to satisfy certain education requirements
21 through courses offered by the office; removing the
22 court's ability to waive education requirements for
23 guardians; amending s. 744.368, F.S.; requiring the
24 clerks of court to notify the office of any sanctions
25 imposed on professional guardians, within a specified

26 timeframe; providing an effective date.
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28 Be It Enacted by the Legislature of the State of Florida:
29
30 Section 1. Subsections (1), (2), and (3) of section
31 744.2001, Florida Statutes, are amended to read:
32 744.2001 Office of Public and Professional Guardians.—
33 There is created the Office of Public and Professional Guardians
34 within the Department of Elderly Affairs.
35 (1) The Secretary of Elderly Affairs shall appoint the
36 executive director, who shall be the head of the Office of
37 Public and Professional Guardians. The executive director must
38 be ~~a member of The Florida Bar,~~ knowledgeable of guardianship
39 law and of the social services available to meet the needs of
40 incapacitated persons, shall serve on a full-time basis, and
41 shall personally, or through a representative of the office,
42 carry out the purposes and functions of the Office of Public and
43 Professional Guardians in accordance with state and federal law.
44 The executive director shall serve at the pleasure of and report
45 to the secretary.
46 (2) The executive director shall, within available
47 resources:
48 (a) Have oversight responsibilities for all public and
49 professional guardians.
50 (b) Establish standards of practice for public and

51 professional guardians by rule, in consultation with
52 professional guardianship associations and other interested
53 stakeholders~~, no later than October 1, 2016. The executive~~
54 ~~director shall provide a draft of the standards to the Governor,~~
55 ~~the Legislature, and the secretary for review by August 1, 2016~~.
56 (c) Review and approve the standards and criteria for the
57 education, registration, and certification of public and
58 professional guardians in Florida.
59 (d) Offer and make available online an education course to
60 satisfy the requirements of s. 744.3145(2).
61 (e) Produce and make available information about
62 alternatives to and types of guardianship for dissemination by
63 area agencies on aging as defined in s. 430.203 and aging
64 resource centers as described in s. 430.2053.
65 (3) The executive director's oversight responsibilities of
66 professional guardians ~~must be finalized by October 1, 2016, and~~
67 shall include, but are not limited to:
68 (a) Developing and implementing a monitoring tool to
69 ensure compliance of professional guardians with the standards
70 of practice established by the Office of Public and Professional
71 Guardians. This monitoring tool may not include a financial
72 audit as required by the clerk of the circuit court under s.
73 744.368.
74 (b) Developing procedures, in consultation with
75 professional guardianship associations and other interested

76 stakeholders, for the review of an allegation that a
77 professional guardian has violated the standards of practice
78 established by the Office of Public and Professional Guardians
79 governing the conduct of professional guardians.
80 (c) Establishing disciplinary proceedings, conducting
81 hearings, and taking administrative action pursuant to chapter
82 120.
83 Section 2. Subsection (10) of section 744.2003, Florida
84 Statutes, is renumbered as subsection (11), subsection (3) is
85 amended, and a new subsection (10) is added to that section, to
86 read:
87 744.2003 Regulation of professional guardians;
88 application; bond required; educational requirements.—
89 (3)(a) Each professional guardian as defined in s.
90 744.102(17) and public guardian must receive a minimum of 40
91 hours of instruction and training. Each professional guardian
92 must receive a minimum of 20 ~~16~~ hours of continuing education
93 every 2 calendar years after the year in which the initial 40-
94 hour educational requirement is met, which must include at least
95 2 hours each on fiduciary responsibilities and professional
96 ethics, respectively; 1 hour on advance directives; 3 hours on
97 abuse, neglect, and exploitation; and 4 hours on guardianship
98 law.
99 (b) The instruction, training, and education required
100 under paragraph (a) must be completed through a course approved

101 or offered by the Office of Public and Professional Guardians.
102 The expenses incurred to satisfy the educational requirements
103 prescribed in this section may not be paid with the assets of
104 any ward.
105 (c) This subsection does not apply to any attorney who is
106 licensed to practice law in this state or an institution acting
107 as guardian under s. 744.2002(7).
108 (10) Each professional guardian shall submit to and
109 maintain with the Office of Public and Professional Guardians
110 all of the following information:
111 (a) The names and position titles of all employees of the
112 professional guardian.
113 (b) The counties in which the professional guardian is
114 appointed to any ward.
115 Section 3. Subsections (1) and (6) of section 744.2004,
116 Florida Statutes, are amended to read:
117 744.2004 Complaints; disciplinary proceedings; penalties;
118 enforcement.—
119 (1) ~~By October 1, 2016,~~ The Office of Public and
120 Professional Guardians shall establish procedures to:
121 (a) Review and, if determined legally sufficient, initiate
122 an investigation of ~~investigate~~ any complaint that a
123 professional guardian has violated the standards of practice
124 established by the Office of Public and Professional Guardians
125 governing the conduct of professional guardians within 10

126 business days after receipt of the complaint. A complaint is
127 legally sufficient if it contains ultimate facts that show a
128 violation of a standard of practice by a professional guardian
129 has occurred.
130 (b) Notify the complainant no later than 10 business days
131 after the Office of Public and Professional Guardians determines
132 that a complaint is not legally sufficient ~~Initiate an~~
133 ~~investigation no later than 10 business days after the Office of~~
134 ~~Public and Professional Guardians receives a complaint~~.
135 (c) Complete and provide initial investigative findings
136 and recommendations, if any, to the professional guardian and
137 the person who filed the complaint within 45 business ~~60~~ days
138 after receipt of a complaint.
139 (d) Obtain supporting information or documentation to
140 determine the legal sufficiency of a complaint.
141 (e) Interview a ward, family member, or interested party
142 to determine the legal sufficiency of a complaint.
143 (f) Dismiss any complaint if, at any time after legal
144 sufficiency is determined, it is found there is insufficient
145 evidence to support the allegations contained in the complaint.
146 (g) Within 10 business days after completing an
147 investigation, provide to the complainant and the professional
148 guardian a written statement specifying any finding of a
149 violation of a standard of practice by a professional guardian
150 and any actions taken or specifying that no such violation was

151 found.
152 (h) ~~(g)~~ Coordinate, to the greatest extent possible, with
153 the clerks of court to avoid duplication of duties with regard
154 to the financial audits prepared by the clerks pursuant to s.
155 744.368.
156 (6) ~~By October 1, 2016,~~ The Department of Elderly Affairs
157 shall adopt rules to implement ~~the provisions of~~ this section.
158 Section 4. Subsection (7) of section 744.3145, Florida
159 Statutes, is renumbered as subsection (6), and subsection (4)
160 and present subsection (6) of that section are amended, to read:
161 744.3145 Guardian education requirements.—
162 (4) Each person appointed by the court to be a guardian
163 must complete the required number of hours of instruction and
164 education within 4 months after his or her appointment as
165 guardian. The instruction and education must be completed
166 through a course approved by the chief judge of the circuit
167 court and taught by a court-approved organization or through a
168 course offered by the Office of Public and Professional
169 Guardians under s. 744.2001. Court-approved organizations may
170 include, but are not limited to, community or junior colleges,
171 guardianship organizations, and the local bar association or The
172 Florida Bar.
173 ~~(6) The court may, in its discretion, waive some or all of~~
174 ~~the requirements of this section or impose additional~~
175 ~~requirements. The court shall make its decision on a case-by-~~

176 ~~case basis and, in making its decision, shall consider the~~
177 ~~experience and education of the guardian, the duties assigned to~~
178 ~~the guardian, and the needs of the ward.~~
179 Section 5. Subsection (8) is added to section 744.368,
180 Florida Statutes, to read:
181 744.368 Responsibilities of the clerk of the circuit
182 court.—
183 <u>(8) Within 10 business days after the court imposes any</u>
184 <u>sanctions on a professional guardian, including, but not limited</u>
185 <u>to, contempt of the court or removal of the professional</u>
186 <u>guardian, the clerk shall report such actions to the Office of</u>
187 <u>Public and Professional Guardians.</u>
188 Section 6. This act shall take effect July 1, 2020.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 7053 PCB HMR 20-03 Direct Care Workers
SPONSOR(S): Health Market Reform Subcommittee, Tomkow
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 1676

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health Market Reform Subcommittee	10 Y, 5 N	Siples	Calamas
1) Health Care Appropriations Subcommittee		Nobles	Clark

SUMMARY ANALYSIS

Direct care workers, such as certified nursing assistants (CNAs), home health aides (HHAs), and personal care assistants (PCAs), provide hands-on assistance to older adults and disabled individuals. They assist with bathing, eating, dressing, and housekeeping. Florida, with its large aging population, is facing a shortage of direct care workers. However, employers find it difficult to retain individuals in these positions due to a lack of full-time employment and upward mobility.

HB 7053 increases opportunity for advancement for direct care workers by expanding the authority of registered nurses to delegate certain tasks to a certified nursing assistant or a home health aide. A registered nurse may delegate any task to a CNA or HHA that the nurse determines that the CNA or HHA can safely perform. The bill also authorizes CNAs and HHAs to administer certain medications if the CNA or HHA has completed training required by the bill, and a physician or registered nurse has validated the CNA's or HHA's competency to perform medication administration.

The bill also expands the scope of practice for CNAs in nursing home facilities by authorizing CNAs to assist with preventative skin care and basic wound care when assisting with the application of topical medications and to assist with intermittent positive pressure breathing treatments and nebulizer treatments. The bill also authorizes a nursing home facility to use dining room assistants to meet minimum staffing requirements.

The bill requires the Agency for Health Care Administration (AHCA) to create and maintain a direct care worker registry. Direct care workers, as well as licensed entities providing such services, may list themselves in the registry, along with their contact information, qualifications, background screening information, and photograph.

Currently, there is no reliable state-based data on the Florida direct care workforce. The bill requires all licensed nursing home facilities, home health agencies, hospices, nurse registries, and homemaker and companion services providers to complete a workforce survey at each biennial licensure renewal.

The bill creates an Excellence in Home Health Program that awards a designation to home health agencies that meet certain criteria. The home health agency may use the designation in marketing materials until such time that the home health agency no longer holds the designation or no longer qualifies for the designation.

The bill has a significant, negative fiscal impact on AHCA. The bill has no impact on local government.

The bill provides an effective date of July 1, 2020.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

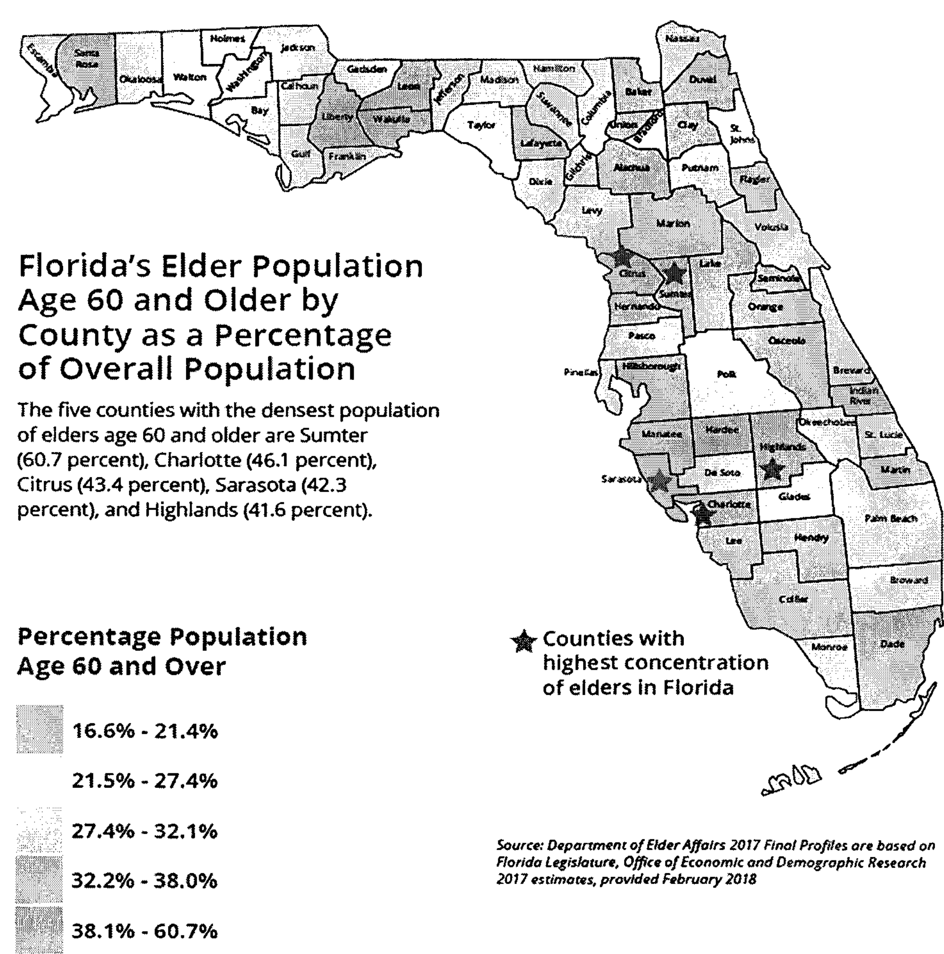
A. EFFECT OF PROPOSED CHANGES:

Present Situation

Florida's Aging Population

In the U.S. in 2015, nearly 19 million people under the age of 65 and nearly 14 million people over the age of 65 reported that they had difficulty taking care of themselves or living independently.[1]

Florida ranks first in the nation in the percentage of residents who are age 65 or older.[2] It is estimated that 20.5 percent of the state's population is over the age of 65.[3] Florida ranks fourth in the nation in the percentage of residents who are 60 and older,[4] and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.[5]



[1] Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).
[2] Department of Elder Affairs, *2019 Summary of Programs and Services*, (Jan. 2019), available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited January 10, 2020).
[3] U.S. Census Bureau, *Quick Facts: Florida*, (July 1, 2019), available at https://www.census.gov/quickfacts/FL (last visited January 10, 2020). Florida's population is estimated to be 21,477,737.
[4] *Supra* note 1 at p. 8.
[5] Id.

Someone turning 65 today has almost a 70 percent chance of needing some type of long term care services and supports in their remaining years.[6] As Florida grays, individuals with disabilities who need assistance with activities of daily living, such as eating, grooming, and making meals, may also lose their caretakers. Direct care workers may provide such care and enable these individuals to remain in the community.

Direct Care Workers

Direct care workers assist older individuals and those with disabilities with daily tasks, such as dressing, bathing, and eating.[7] They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.[8] Direct care workers account for 70 to 80 percent of all paid hands-on long-term care and personal assistance for the elderly or disabled.[9]

Florida Direct Care Workers

Nursing Assistants or Nursing Aides

Nursing assistants or nursing aides generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals.[10] The Florida Board of Nursing, within the Department of Health, certifies nursing assistants (CNAs) who must, among other things, hold a high school diploma or equivalent, complete a 120-hour board-approved training program, and pass a nursing assistant competency exam, which includes written and practical portions.[11] A CNA must biennially complete 24 hours of inservice training to maintain certification.[12]

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision[13] of a registered nurse or licensed practical nurse.[14] A CNA may perform the following services:[15]

- Personal care services, such as bathing, dressing grooming, and light housekeeping;
- Tasks associated with maintaining mobility, such as ambulating, transferring, positioning, lifting, and performing range of motion exercises;
- Nutrition and hydration tasks, such a feeding or assisting with eating and drinking;
- Tasks associated with elimination, such as toileting, providing catheter care, and emptying or changing ostomy bags;
- Tasks associated with using assistive devices;
- Maintaining the environment and resident safety;
- Taking measurements and gathering data, i.e. pulse, blood, pressure, height, and weight;

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[6] U.S. Department of Health and Human Services, *How Much Care Will You Need?*, (last rev. Oct. 2017), available at https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (last visited January 20, 2020).
[7] Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at https://phinational.org/policy-research/key-facts-faq/ (last visited November 8, 2019).
[8] Paraprofessional Healthcare Institute, *Direct Care Workforce 2018 Year in Review*, https://phinational.org/resource/the-direct-care-workforce-year-in-review-2018/ (last visited November 12, 2019) and Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?* https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[9] Id.
[10] Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?*, (Feb. 2011), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[11] Section 464.203, F.S., and r. 64B9-15.006, F.A.C. Eighty hours must be classroom instruction and 40 hours must be clinical instruction, 20 of which must be in long term care clinical instruction in a licensed nursing home. 42 C.F.R. § 483.95 requires 75 hours of training; Florida training requirements exceed the federal minimum training requirements.
[12] Section 464.203(7), F.S.
[13] Under general supervision, the registered nurse or licensed practical nurse does not need to be present but must be available for consultation and advice, either in person or by a communication device. Rule 64B9-15.001(5), F.A.C
[14] Rule 64B9-15.002, F.A.C.
[15] *Supra* note 14.

- Reporting abnormal resident findings, signs, and symptoms;
- Post mortem care;
- Tasks associated with end of life care;
- Tasks associated with resident socialization, leisure activities, reality orientation, and validation techniques;
- Performing basic first aid, CPR, and emergency care; and
- Documentation of CNA services provided to the resident.

A CNA may not work independently and may not may not perform any tasks that requires specialized nursing knowledge, judgement, or skills.[16]

Home Health Aides

Home health aides (HHA) provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or a physical, speech, occupational, or respiratory therapist.[17] In Florida, HHAs are not licensed or certified. However, the Agency for Health Care Administration (AHCA) licenses home health agencies and establishes training requirements for HHAs employed by home health agencies. A HHA must complete at least 75 hours of training and/or successfully pass a competency evaluation by the home health agency.[18] HHAs who work for a home health agency that is not certified by Medicare or Medicaid or who work for a nurse registry must complete 40 hours of training or pass an AHCA-developed competency examination.[19]

AHCA establishes the scope of practice for HHAs performing services under a licensed home health agency. A HHA performs services delegated by and under the supervision of a registered nurse, which include:[20]

- Assisting the patient or client with personal hygiene, ambulation, eating, dressing, shaving, physical transfer, and other personal care activities;
- Maintaining a clean, safe, and healthy environment, including light housekeeping;
- Activities taught by a licensed health professional for a specific patient or client and restricted to:
    - Toileting;
    - Assisting with tasks related to elimination;
    - Assisting with the use of devices for aid to daily living, such as a wheelchair;
    - Assisting with prescribed range of motion exercises;
    - Assisting with prescribed ice cap or collar;
    - Doing simple urine tests for sugar, acetone, or albumin;
    - Measuring and preparing special diets; and
- Assisting with self-administration of medication.

A HHA may not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, or any other services that has not been included in the patient's plan of care.[21]

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[16] *Supra* note 14.
[17] *Supra* note 10. If the only service the home health agency provides, is physical, speech, or occupational therapy, in additional to the home health aide or CNA services, the licensed therapist may provide supervision.RUle
[18] Agency for Health Care Administration, *Home Health Aides,* available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml (last visited January 20, 2020).
[19] Rules 59A-8.0095(5)
[20] Id., and 64B9-15.002, F.A.C.
[21] Rule 59A-8.0095(5)(p), F.A.C.

Personal Care Assistants

Personal care assistants (PCAs) work in either private or group homes.[22] They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.[23] (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living, they also help individuals go to work and remain engaged in their communities.[24] A growing number of these workers are employed and supervised directly by consumers.

There are no minimum training requirements for PCAs, and there is no agency that directly regulates them. PCAs may be employed by or provide services through a home health agency or homemaker/companion agency, although some PCAs work independently and are directly supervised by the employing family or individual.

A PCA does not have a clearly defined scope of practice because it is not a regulated profession. However, the Florida Medicaid program defines personal care services as medically necessary assistance with activities of daily living to enable an individual to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.[25] Florida Medicaid authorizes the following personal care services:[26]

- Bathing or assistance with bathing;
- Assistance with dressing, including application of prosthetic devices or therapeutic stockings;
- Grooming and skin care;
- Positioning;
- Transfers;
- Toileting and maintaining continence;
- Assistance with eating; and
- Non-skilled medical task delegated by a registered nurse, and may include assisting with pre-measured medications, monitoring vital signs, and measuring intake and output.

Medication Administration and Assistance with Self-Administration

Medication Administration

Medication administration means to obtain and provide a single dose of a medication to a patient for his or her consumption.[27] Currently, neither CNAs nor HHAs may administer medication to a patient. However, Florida law authorizes unlicensed direct care personnel who complete a 6-hour training course to administer medication under the developmental disabilities program.[28] Many other states authorize HHAs or CNAs who complete additional training to administer medication.[29] For example, Texas authorizes home health medication aides.[30] Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.[31] Connecticut has a stand-alone medication administration technician profession.[32]

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[22] *Supra* note 10.
[23] Id.
[24] Id.
[25] Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.
[26] Id.
[27] Section 465.003, F.S.
[28] Section 393.506, F.S.
[29] Some states specifically certify or license medication aides.
[30] *See* TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.
[31] *See* ARIZ. REV. STAT. §32-1650, GA. CODE. ANN. 31-7-12.2, 225 ILL. COMP. STAT. 65 (pilot program), MINN. R. 4658.1360, N.C. GEN. STAT. § 131E-114.2, respectively.
[32] *See* CONN. GEN. STAT. §17a-210-1, et. seq.

Assistance with Self-Administration

Some patients are capable of administering their own medication,but need assistance to ensure that they are taking the correct medication, at the proper dosage, and at the correct time. Under current law, HHAs may assist with self-administration after completion of prescribed training.

HHAs must complete two hours of training to assist with self-administration of medication.[33] The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.[34] This 2-hour training may be included in the primary 75-hour or 40-hour HHA training.

Assistance with self-administration of medication includes:[35]

- Taking the medication, in its properly labeled container, from where it is stored to the patient;
- In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container;
- Placing an oral dose in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth;
- Applying topical medications;
- Returning the medication container to proper storage; and
- Keeping a record of when a patient receives assistance.

A HHA with the authority to assist with self-administration of medication may not:[36]

- Mix, compound, convert, or calculate medication doses;
- Prepare syringes for injection or the administration of medications by any injectable route;
- Administer medications through intermittent positive pressure breathing machines or a nebulizer;
- Administer medications by way of a tube inserted in a cavity of the body;
- Administer parenteral preparations;
- Irrigate or use debriding agents to treat a skin condition;
- Prepare rectal, urethral, or vaginal medications.
- Administer medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the HHA, and at the request of a competent patient;
- Administer medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

CNAs who are not working for a home health agency may not assist with medication administration.

Challenges of the Direct Care Workforce

The federal Bureau of Labor Statistics estimate that home health aides and personal care assistants are in the top five occupations with the fastest job growth in the U.S. economy.[37] The demand for home

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[33] *Supra* note 19.
[34] Id.
[35] Section 400.488(3), F.S.
[36] Section 400.488(4), F.S.
[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*,

health aides and nursing assistants is expected to increase by 34 percent by 2025.[38] However, the turnover rate in long term care is estimated to be between 45 to 66 percent.[39]

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.[40] Direct care workers also often have substantial family caregiving obligations, which adds to the stress of the job and contribute to the days missed from work.[41]

High turnover rates have a negative impact on both employers and patients. Turnover may have a negative impact on patient care and employers must incur costs for continuous recruitment and training of new employees.[42] Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.[43] Employers must pay costs related to filling vacancies and training new employees. It is estimated that turnover costs direct care employers approximately $4.1 billion per year.[44] Turnover can cause a break in continuity of care and a reduction in the quality of care, which may ultimately affect the patient's quality of life.[45]

Approximately two-thirds of HHAs and PCAs work part time.[46] This may be due to personal needs; however, many home care workers receive several assignments to work in a day the total of which does not amount to a full work day. For example, a HHA may be scheduled to see two separate clients for three hours each, but due to the time to travel between patients, the HHA is unable to achieve a full 8-hour work day. Many direct workers also face other obstacles to remaining in their jobs, including challenges with transportation, family commitments, or health care.[47] Some states or regions have launched matching service registries to make it easier for workers to find clients and build schedules to suit individual needs and commitments.[48]

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.[49] Many direct care workers chose the career because they wanted to help people, and this motivation also plays a role in retaining workers in direct care.[50] However, many direct care workers leave the career field for other entry-level jobs in the food and hospitality industry that pay similarly, are less mentally and physically strenuous, and provide opportunities for advancement.[51] In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.[52]

(March 2018), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltts-direct-care-worker-report.pdf (last visited January 14, 2020).

[38] Id.

[39] Kezia Scales, PhD, *Staffing in Long-Term Care is a National Crisis*, (June 8, 2018), available at https://phinational.org/recruitment-retention-long-term-care-national-perspective/ (last visited January 14, 2020).

[40] *Supra* note 1, at pp. 27-37.

[41] U.S. Department of Health and Human Services, *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs – Certified Nursing Assistants and Home Health Aides*, (March 2011), available at https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf (last visited January 20, 2020).

[42] Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, *Retooling for an Aging America: Building the Health Care Workforce*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf (last visited January 14, 2020).

[43] Dorie Seavey, Better Jobs Better Care, *The Cost of Frontline Turnover in Long-Term Care*, (Oct. 2004), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/TOCostReport.pdf (last visited January 25, 2020).

[44] *Supra* note 42.

[45] Id.

[46] Paraprofessional Healthcare Institute, *U.S. Home Care Workers: Key Facts*, available at https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf (last visited January 14, 2020).

[47] Paraprofessional Healthcare Institute, *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, available at https://phinational.org/wp-content/uploads/2018/05/RRGuide-PHI-2018.pdf (last visited January 20, 2020).

[48] Allison Cook, Paraprofessional Healthcare Institute, *Issue Brief: Localized Strategies For Addressing the Workforce Crisis in Home Care*, (Oct. 2019), available at https://phinational.org/wp-content/uploads/2019/11/Localized-Strategies-2019-PHI.pdf (last visited January 20, 2020).

[49] *Supra* note 41.

[50] *Supra* note 41, at p. 48.

[51] *Supra* note 42.

[52] Id.

Direct care workers are also at an increased risk of work-related injuries.[53] Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.[54] By contrast, the injury rate across all occupations is 100 per 10,000 workers.[55]

In order to meet the future demand for direct care worker, employers will need to consider options such as offering better compensation, full-time hours, better training and advancement opportunities, and improved working conditions.[56]

Direct Care Workforce Data

In 2009, the federal Centers for Medicare and Medicaid Services (CMS) issued a report acknowledging that there was a lack of ongoing, reliable state-based information about the direct care workforce.[57] This lack of information has hampered the ability to develop policy to ensure that a stable and quality direct care workforce is available to meet the increasing demand for long term care services.[58]

CMS proposed that states collect a minimum data set of information on direct care workers, including the:

- Number umber of direct care workers (full time and part time);
- Stability of the direct care workforce (turnover and vacancies); and
- Average compensation of workers (wages and benefits).

Collecting this minimum data on the direct care workforce enables states to, among other things:[59]

- Create a baseline against which the progress of workforce initiatives can be measured;
- Inform policy formulation regarding workforce initiatives;
- Help identify and set long-term priorities for long-term care reform and system changes; and
- Promote integrated planning and coordinated approaches for long-term care and comparability of data across programs to assist in the assessment and evaluation of adopted policy initiatives.

This information will also enable states to determine the most useful deployment of state resources, anticipate increased demand for services, and assess trends in workforce turnover and related costs.[60]

In addition to direct care workers who are employed by entities, like home health agencies and nursing home facilities, there is a growing "gray market" comprised of independent providers. These independent providers are directly employed by the individuals to whom they provide care[61] and some may be employed by individuals through government-funded programs, such as Medicaid.[62] However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

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[53] *Supra* note 41.
[54] Stephen Campbell, Paraprofessional Healthcare Institute, *Issue Brief: Workplace Injuries and the Direct Care Workforce*, (April 2018), available at https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf (last visited January 20, 2020).
[55] Id.
[56] *Supra* note 46, at p. 8.
[57] Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, *The Need for Monitoring Long-Term Direct Service Workforce and Recommendations for Data Collection*, (Feb. 2009), available at https://www.medicaid.gov/sites/default/files/2019-12/monitoring-dsw.pdf (last visited January 8, 2020).
[58] Id.
[59] Id at p. 8.
[60] Id.
[61] *Supra* note 1 at 18.
[62] For example, see *supra* note 25.

Regulation of Long Term Care Providers

The Division of Health Quality Assurance (HQA) within AHCA licenses, certifies, and regulates 40 different types of health care providers. Regulated providers include, among others, these providers of long-term care services:

- Nursing home facilities under part II of ch. 400, F.S.
- Assisted living facilities under part I of ch. 429, F.S.
- Home health agencies under part III of ch. 400, F.S.
- Companion or homemaker services providers under part III of ch. 400, F.S.
- Nurse registries under part III of ch. 400, F.S.
- Hospices under part IV of ch. 400, F.S.

In addition to provider-specific requirements listed in the authorizing statutes for each provider type listed above, the Health Care Licensing Procedures Act (Act), in part II of ch. 408, F.S., establishes uniform licensing procedures and statutes for 29 provider types regulated by HQA. The Act authorizes HQA to inspect facilities, verify compliance with licensure requirements, identify deficiencies or violations, and impose fines and penalties for noncompliance.

Nursing Home Staffing

Section 400.23(3), F.S., establishes minimum staffing requirements for nursing home facilities:

- A minimum weekly[63] average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants and licensed nursing staff.
- A minimum of 2.5 hours of direct care per resident per day provided by certified nursing assistant staff. A facility may not staff at a ratio of less than one certified nursing assistant per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.

When computing the staffing ratio for certified nursing assistants, nursing home facilities are allowed to use uncertified nursing assistants under certain conditions to satisfy the staffing ratio requirements so long as their job duties only include nursing assistant-related duties.[64] If approved by AHCA, licensed nurses may also be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.[65] Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.[66]

Background Screening

Certain licensees, including CNAs, and certain individuals who provide services to vulnerable populations[67] must pass a background screening to be approved for certification or employment. Chapter 435, F.S., outlines the screening requirements.

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[63] A week is defined as Sunday through Saturday.
[64] Sections 400.23(3)(a)2. and 400.211(2), F.S. Nursing facilities may employ uncertified nursing assistants for up to 4 months if they are enrolled in, or have completed, a state-approving nursing assistant program, have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state, or have preliminarily passed the state's certification exam.
[65] Section 400.23(3)(a)4., F.S., and r. 59A-4.108(7), F.A.C. The hours of a licensed nurse with dual job responsibilities may not be counted twice.
[66] Sections 400.23(3)(b), F.S..
[67] "Vulnerable person" means a minor or a person over the age of 18 whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, developmental disability or dysfunction, or brain damage, or the infirmities of aging.

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[68] A level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[69] and may include criminal records checks through local law enforcement agencies. A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[70]

For both level 1 and 2 screenings, the employer must submit the information necessary for screening to FDLE within five working days after receiving it.[71] The FDLE notifies the employer or agency whether a screening has revealed any disqualifying information.[72]

The Care Provider Background Screening Clearinghouse (Clearinghouse), housed within AHCA, warehouses criminal history checks of individuals who have direct contact with vulnerable persons and are required to be screened by AHCA, Department of Health, Department of Children and Families, Agency for Persons with Disabilities, Division of Vocational Rehabilitation, Department of Elder Affairs, Department of Juvenile Justice, and local child care licensing agencies.[73] The Clearinghouse allows the background screening results to be shared among these agencies, so that the employee or licensee does not have to undergo multiple background screenings when changing employers.[74] Employers register with the Clearinghouse and maintain the employment status of its employees listed in the Clearinghouse by timely reporting changes in employment.[75]

Effect of Proposed Bill

Nurse Delegation

HB 7053 authorizes a registered nurse to delegate any task, including medication administration, to a CNA or HHA, as long as the registered nurse determines that the CNA or HHA is competent to perform the tasks, the task is delegable under federal law, and the task:

- Is within the nurse's scope of practice;
- Frequently recurs in the routine care of a patient or group of patients;
- Is performed according to an established sequence of steps;
- Involved little or no modification from one patient to another;
- May be performed with a predictable outcome;
- Does not inherently involve ongoing assessment, interpretation, or clinical judgement; and
- Does not endanger a patient's life or well-being.

Medication Administration

Currently, HHAs can only assist a patient with medication but not actually provide it to the patient; CNAs can neither provide medication nor assist a patient with medication. The bill authorizes a registered nurse to delegate administration of oral, transdermal, ophthalmic, otic, rectal, inhaled,

[68] Section 435.05(1)(a), F.S.
[69] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 20, 2020).
[70] Section 435.04, F.S.
[71] Section 435.05(1)(b)-(c), F.S.
[72] Section 435.05(1)(c), F.S.
[73] Section 435.12, F.S.
[74] Section 435.12(1), F.S.
[75] Section 435.12(20, F.S.

enteral, or topical prescription medications to a CNA or HHA. Once delegated the authority, the CNA or HHA can provide a dose of a prescribed or over-the-counter medication to a patient in the manner indicated by the prescribing health care practitioner. A nurse may delegate medication administration to the CNA or HHA if the CNA or HHA:

- Has completed a 6-hour training course approved by the Board of Nursing or AHCA, respectively; and
- Has been found competent to administer medication to a patient in a safe and sanitary manner.

A registered nurse or physician must conduct the training and determine whether the CNA or HHA can competently administer medication, and annually validate such competency. A CNA or HHA who has qualified to administer medications must annually complete 2 hours of inservice training in medication administration and medication error prevention. This inservice training is in addition to the training that CNAs and HHAs must currently complete. The bill places an affirmative duty on a nursing facility or home health agency to ensure that CNAs or HHAs performing medication administration meet these requirements.

The bill requires the Board of Nursing and AHCA to adopt rules, in consultation with each other, on the standards and procedures that a CNA or HHA must follow for medication administration. Such rules must address qualifications for trainers, medication label requirements, documentation and recordkeeping, storage and disposal of medication, instructions for safe medication administration, informed consent, training curriculum, and validation procedures.

The bill specifically prohibits a registered nurse from delegating the administration of medications listed as Schedule II, Schedule III, or Schedule IV controlled substances. However, a CNA or HHA may administer Schedule V controlled substances.

The bill authorizes the Board of Nursing to adopt rules, in consultation with AHCA, on delegation of duties. The bill also creates a grounds for discipline against a registered nurse's license if the nurse delegates responsibilities to an individual that the nurse knows or has reason to know that such individual is not qualified to perform.

This authority will align Florida with other states that allow CNAs or HHAs to administer medication.

Direct Care Worker Survey

Beginning January 1, 2021, the bill requires each licensed nursing home facility, assisted living facility, home health agency, nurse registry, or companion or homemaker services provider to complete a survey on the direct care workforce at each license renewal. AHCA must adopt a survey form by rule, which requests the following information of each licensee:

- Number of direct care workers employed by the licensee;
- Turnover and vacancy rates of direct care workers and contributing factors;
- Average employee wage for each category of direct care worker;
- Employment benefits for direct care workers and average cost to the employer and employee; and
- Type and availability of training for direct care workers.

AHCA may not issue a license renewal until the licensee submits a completed survey. The administrator or designee must complete the survey and attest to the accuracy of the information provided, to the best of his or her knowledge.

AHCA must review and analyze the data received at least monthly and publish the results of the analysis on its website. The analysis should address:

- The number of direct care workers in the state, both full-time and part-time;
- Turnover rate and causes of turnover;
- Vacancy rate;
- Average hourly wage;
- Benefits offered; and
- Availability of post-employment training.

Direct Care Worker Registry

The bill directs AHCA to create and maintain a voluntary registry of home care workers,[76] accessible by the general public. A link to the registry must be available on the home page of its website. The registry must include:

- The full name, date of birth, social security number,[77] and a full face, passport-type color photograph of the home care worker;
- Contact information for the home care worker, including his or her city, county and phone number, or contact information for the employing home health agency;
- Name of the state-approved training program the home care worker completed and the date on which the training was completed;
- The number of years the home care worker has provided home health care services for compensation;
- Any disciplinary action taken or pending against a certification by the Department of Health, if the home care worker is a CNA; and
- Whether the home care worker provides services to special populations.

The bill authorizes AHCA to automatically populate work history information based on information in its records. The bill also authorizes AHCA to enter into an agreement with the Department of Health to obtain disciplinary history. A home care worker must meet the same background screening requirements to be included in the registry if the home care worker is not a CNA or currently employed by a home health agency.

The bill requires AHCA to post a disclaimer on each page of the home care worker registry website in bold, 14-point font stating that AHCA does not guarantee the accuracy of the information entered by a third party and does not endorse any individual listed in the registry.

Excellence in Home Health Award Program

The bill creates a gold seal program to designate home health agencies that meet certain criteria. The home health agency must have been actively licensed and operating for at least 24 months and have had no licensure denials revocations, or serious deficiencies during the preceding 24 months to be considered for the award

AHCA must adopt rules establishing standards for the award, including those relating to:

- Patient satisfaction;
- Patients requiring emergency care for wound infections;

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[76] The bill defines "home care worker" as a certified nursing assistant certified under Part II of ch. 464, F.S., or a home health aide as defined in s. 400.462, F.S., which is a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation exercises, or assists in administering medication as permitted in rule and for which the person has received training established by AHCA.

[77] The bill expressly prohibits AHCA from displaying the social security number on its website.

- Patients admitted or re-admitted to an acute care hospital;
- Patient improvement in the activities of daily living;
- Employee satisfaction;
- Quality of employee training; and
- Employee retention rates.

The bill authorizes an award recipient to use the designation in advertising and marketing. However, a home health agency may not use the designation if the agency:

- Has not been awarded the designation;
- Fails to review the award upon expiration of an award designation;
- Has undergone a change in ownership;
- Has been notified that it no longer meets the criteria for the award upon re-application after expiration of the award designation.

The award designation is not transferrable. The award designation is not subject to chapter 120, F.S.

Self-Administration of Medication

The bill authorizes a CNA to provide assistance with preventative skin care and basic wound care by assisting with the application of topical medications. The bill also authorizes a CNA to assist with intermittent positive pressure breathing treatments and nebulizer treatments to include:

- Assisting with devices set up and cleaning in the presence of the resident;
- Confirming that the medication is intended for the resident;
- Orally advising the resident of the medication name and purpose;
- Removing the prescribed amount for a single treatment from a properly labeled container; and
- Assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

The bill requires a CNA assisting with self-administration to confirm that the medication is intended for the resident taking the medication. The CNA must also verbally advise the resident of the name and the purpose of the medication.

The bill authorizes a nursing home facility to count non-nursing staff who assist residents with eating to meet minimum staffing requirements.

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
Section 2: Creates s. 400.212, F.S., relating to nurse delegated tasks.
Section 3: Amends s. 400.23, F.S., relating to rules; evaluation and deficiencies; licensure status.
Section 4: Amends s. 400.462, F.S., relating to definitions.
Section 5: Amends s. 400. 464, F.S., relating to home health agencies to be licensed; expiration of license; unlawful acts; penalties.
Section 6: Amends s. 400.488, F.S., relating to assistance with self-administration of medication.
Section 7: Creates s. 400.489, F.S., relating to administration of medication; staff training; requirements.
Section 8: Creates s. 400.490, F.S., relating to nurse delegated tasks.
Section 9: Creates s. 400.52, F.S., relating to Excellence in Home Health program.
Section10: Creates s. 408.064, F.S., relating to registry of home care workers.
Section 11: Creates s. 408.822, F.S., relating to direct care workforce survey.
Section 12: Creates s. 464.0156, F.S., relating to delegation of duties.

Section 13: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 14: Creates s. 464.2035, F.S., relating to administration of medication.
Section 15: Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill will incur a negative fiscal impact of $1.2 million in the initial year with $955,000 used to build the Home Care Registry system and execute the Direct Care Provider Survey. AHCA would need an additional 4.0 FTE to oversee these programs. Recurring expenditures would be $650,000 with $400,000 going to maintenance, updates, and upgrades to the systems.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Home health agencies and nursing facilities may incur costs associated with providing medication administration training to CNAs and HHAs.

Consumers will have access to a centralized database of home care workers and may reduce costs associated with researching and hiring such individuals. Home care workers may acquire work, or more consistent work, using the registry.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to the Agency for Health Care Administration and the Board of Nursing to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to direct care workers; amending s.
3 400.141, F.S.; requiring a nursing home facility that
4 authorizes a registered nurse to delegate tasks to a
5 certified nursing assistant to ensure that certain
6 requirements are met; creating s. 400.212, F.S.;
7 authorizing a certified nursing assistant to perform
8 tasks delegated by a registered nurse; amending s.
9 400.23, F.S.; authorizing certain nonnursing staff to
10 count toward compliance with staffing standards;
11 amending s. 400.462, F.S.; revising the definition of
12 "home health aide"; amending s. 400.464, F.S.;
13 requiring a licensed home health agency that
14 authorizes a registered nurse to delegate tasks to a
15 certified nursing assistant to ensure that certain
16 requirements are met; amending s. 400.488, F.S.;
17 authorizing an unlicensed person to assist with self-
18 administration of certain treatments; revising the
19 requirements for such assistance; creating s. 400.489,
20 F.S.; authorizing a home health aide to administer
21 certain prescription medications under certain
22 conditions; requiring the home health aide to meet
23 certain training and competency requirements;
24 requiring that the training, determination of
25 competency, and annual validations be performed by a

26 registered nurse or a physician; requiring a home
27 health aide to complete annual inservice training in
28 medication administration and medication error
29 prevention in addition to existing annual inservice
30 training requirements; requiring the Agency for Health
31 Care Administration, in consultation with the Board of
32 Nursing, to adopt rules for medication administration;
33 creating s. 400.490, F.S.; authorizing a certified
34 nursing assistant or home health aide to perform tasks
35 delegated by a registered nurse; creating s. 400.52,
36 F.S.; creating the Excellence in Home Health Program
37 within the agency; requiring the agency to adopt rules
38 establishing program criteria; requiring the agency to
39 annually evaluate certain home health agencies that
40 apply for a program award; providing eligibility
41 requirements; requiring an agency to reapply
42 biennially for the award designation; authorizing an
43 award recipient to use the designation in advertising
44 and marketing; prohibiting a home health agency from
45 using the award designation in any advertising or
46 marketing under certain circumstances; providing that
47 an application for an award designation under the
48 program is not an application for licensure and such
49 designation does not constitute final agency action
50 subject to certain administrative procedures; creating

51 s. 408.064, F.S.; providing definitions; requiring the
52 agency to develop and maintain a voluntary registry of
53 home care workers; providing requirements for the
54 registry; requiring a home care worker to apply to be
55 included in the registry; requiring the agency to
56 develop a process by which a home health services
57 provider may include its employees on the registry;
58 requiring certain home care workers to undergo
59 background screening and training; requiring each page
60 of the registry website to contain a specified notice;
61 requiring the agency to adopt rules; creating s.
62 408.822, F.S.; defining the term "direct care worker";
63 requiring certain licensees to provide specified
64 information about employees in a survey beginning on a
65 specified date; requiring that the survey be completed
66 on a form with a specified attestation adopted by the
67 agency in rule; requiring a licensee to submit such
68 survey before the agency renews its license; requiring
69 the agency to analyze the results of such survey and
70 publish its results on the agency's website; requiring
71 the agency to update such information monthly;
72 requiring the agency's analysis to include specified
73 information; creating s. 464.0156, F.S.; authorizing a
74 registered nurse to delegate tasks to a certified
75 nursing assistant or home health aide under certain

76 conditions; providing the criteria that a registered
77 nurse must consider in determining if a task may be
78 delegated; authorizing a registered nurse to delegate
79 medication administration to a certified nursing
80 assistant or home health aide if certain requirements
81 are met; requiring the Board of Nursing, in
82 consultation with the agency, to adopt rules; amending
83 s. 464.018, F.S.; providing that a registered nurse
84 who delegates certain tasks to a person the registered
85 nurse knows or has reason to know is unqualified is
86 grounds for licensure denial or disciplinary action;
87 creating s. 464.2035, F.S.; authorizing a certified
88 nursing assistant to administer certain prescription
89 medications under certain conditions; requiring the
90 certified nursing assistant to meet certain training
91 and competency requirements; requiring the training,
92 determination of competency, and annual validations to
93 be performed by a registered nurse or a physician;
94 requiring a certified nursing assistant to complete
95 annual inservice training in medication administration
96 and medication error prevention in addition to
97 existing annual inservice training requirements;
98 requiring the board, in consultation with the agency,
99 to adopt rules; providing an effective date.
100

101 Be It Enacted by the Legislature of the State of Florida:
102
103 Section 1. Paragraph (v) is added to subsection (1) of
104 section 400.141, Florida Statutes, to read:
105 400.141 Administration and management of nursing home
106 facilities.—
107 (1) Every licensed facility shall comply with all
108 applicable standards and rules of the agency and shall:
109 (v) Ensure that a certified nursing assistant meets the
110 requirements of chapter 464 and the rules adopted thereunder, if
111 the facility authorizes a registered nurse to delegate tasks,
112 including medication administration, to the certified nursing
113 assistant.
114 Section 2. Section 400.212, Florida Statutes, is created
115 to read:
116 400.212 Nurse delegated tasks.—A certified nursing
117 assistant may perform any task delegated to him or her by a
118 registered nurse as provided in chapter 464, including, but not
119 limited to, medication administration.
120 Section 3. Paragraph (b) of subsection (3) of section
121 400.23, Florida Statutes, is amended to read:
122 400.23 Rules; evaluation and deficiencies; licensure
123 status.—
124 (3)
125 (b) Nonnursing staff providing eating assistance to

126 residents <u>may</u> ~~shall not~~ count toward compliance with minimum
127 staffing standards.
128 Section 4. Subsection (15) of section 400.462, Florida
129 Statutes, is amended to read:
130 400.462 Definitions.—As used in this part, the term:
131 (15) "Home health aide" means a person who is trained or
132 qualified, as provided by rule, and who provides hands-on
133 personal care, performs simple procedures as an extension of
134 therapy or nursing services, assists in ambulation or exercises,
135 or assists in administering medications as permitted in rule and
136 for which the person has received training established by the
137 agency under <u>this part or performs tasks delegated to him or her</u>
138 <u>pursuant to chapter 464</u> ~~s. 400.497(1)~~.
139 Section 5. Subsections (5) and (6) of section 400.464,
140 Florida Statutes, are renumbered as subsections (6) and (7),
141 respectively, present subsection (6) is amended, and a new
142 subsection (5) is added to that section, to read:
143 400.464 Home health agencies to be licensed; expiration of
144 license; exemptions; unlawful acts; penalties.—
145 <u>(5) If a licensed home health agency authorizes a</u>
146 <u>registered nurse to delegate tasks, including medication</u>
147 <u>administration, to a certified nursing assistant pursuant to</u>
148 <u>chapter 464 or a home health aide pursuant to s. 400.490, the</u>
149 <u>licensed home health agency must ensure that such delegation</u>
150 <u>meets the requirements of this chapter, chapter 464, and the</u>

151 rules adopted thereunder.
152 (7) ~~(6)~~ Any person, entity, or organization providing home
153 health services which is exempt from licensure under subsection
154 (6) ~~(5)~~ may voluntarily apply for a certificate of exemption
155 from licensure under its exempt status with the agency on a form
156 that specifies its name or names and addresses, a statement of
157 the reasons why it is exempt from licensure as a home health
158 agency, and other information deemed necessary by the agency. A
159 certificate of exemption is valid for a period of not more than
160 2 years and is not transferable. The agency may charge an
161 applicant $100 for a certificate of exemption or charge the
162 actual cost of processing the certificate.
163 Section 6. Subsections (2) and (3) of section 400.488,
164 Florida Statutes, are amended to read:
165 400.488 Assistance with self-administration of
166 medication.—
167 (2) Patients who are capable of self-administering their
168 own medications without assistance shall be encouraged and
169 allowed to do so. However, an unlicensed person may, consistent
170 with a dispensed prescription's label or the package directions
171 of an over-the-counter medication, assist a patient whose
172 condition is medically stable with the self-administration of
173 routine, regularly scheduled medications that are intended to be
174 self-administered. Assistance with self-medication by an
175 unlicensed person may occur only upon a documented request by,

176 and the written informed consent of, a patient or the patient's
177 surrogate, guardian, or attorney in fact. For purposes of this
178 section, self-administered medications include both legend and
179 over-the-counter oral dosage forms, topical dosage forms, and
180 topical ophthalmic, otic, and nasal dosage forms, including
181 solutions, suspensions, sprays, ~~and~~ inhalers, intermittent
182 positive pressure breathing treatments, and nebulizer
183 treatments.
184 (3) Assistance with self-administration of medication
185 includes:
186 (a) Taking the medication, in its previously dispensed,
187 properly labeled container, from where it is stored and bringing
188 it to the patient.
189 (b) In the presence of the patient, confirming that the
190 medication is intended for that patient, orally advising the
191 patient of the medication name and purpose ~~reading the label~~,
192 opening the container, removing a prescribed amount of
193 medication from the container, and closing the container.
194 (c) Placing an oral dosage in the patient's hand or
195 placing the dosage in another container and helping the patient
196 by lifting the container to his or her mouth.
197 (d) Applying topical medications, including routine
198 preventative skin care and basic wound care.
199 (e) Returning the medication container to proper storage.
200 (f) For intermittent positive pressure breathing

201 treatments or nebulizer treatments, assisting with setting up
202 and cleaning the device in the presence of the patient,
203 confirming that the medication is intended for that patient,
204 orally advising the patient of the medication name and purpose,
205 opening the container, removing the prescribed amount for a
206 single treatment dose from a properly labeled container, and
207 assisting the patient with placing the dose into the medicine
208 receptacle or mouthpiece.
209 (g) ~~(f)~~ Keeping a record of when a patient receives
210 assistance with self-administration under this section.
211 Section 7. Section 400.489, Florida Statutes, is created
212 to read:
213 400.489 Administration of medication by a home health
214 aide; staff training requirements.—
215 (1) A home health aide may administer oral, transdermal,
216 ophthalmic, otic, rectal, inhaled, enteral, or topical
217 prescription medications if the home health aide has been
218 delegated such task by a registered nurse licensed under chapter
219 464; has satisfactorily completed an initial 6-hour training
220 course approved by the agency; and has been found competent to
221 administer medication to a patient in a safe and sanitary
222 manner. The training, determination of competency, and initial
223 and annual validations required in this section shall be
224 conducted by a registered nurse licensed under chapter 464 or a
225 physician licensed under chapter 458 or chapter 459.

226 (2) A home health aide must annually and satisfactorily
227 complete a 2-hour inservice training course in medication
228 administration and medication error prevention approved by the
229 agency. The inservice training course shall be in addition to
230 the annual inservice training hours required by agency rules.
231 (3) The agency, in consultation with the Board of Nursing,
232 shall establish by rule standards and procedures that a home
233 health aide must follow when administering medication to a
234 patient. Such rules must, at a minimum, address qualification
235 requirements for trainers, requirements for labeling medication,
236 documentation and recordkeeping, the storage and disposal of
237 medication, instructions concerning the safe administration of
238 medication, informed-consent requirements and records, and the
239 training curriculum and validation procedures.
240 Section 8. Section 400.490, Florida Statutes, is created
241 to read:
242 400.490 Nurse delegated tasks.—A certified nursing
243 assistant or home health aide may perform any task delegated by
244 a registered nurse as provided in chapter 464, including, but
245 not limited to, medication administration.
246 Section 9. Section 400.52, Florida Statutes, is created to
247 read:
248 400.52 Excellence in Home Health Program.—
249 (1) There is created within the agency the Excellence in
250 Home Health Program for the purpose of awarding home health

251 agencies that meet the criteria specified in this section.
252 (2)(a) The agency shall adopt rules establishing criteria
253 for the program which must include, at a minimum, meeting
254 standards relating to:
255 1. Patient satisfaction.
256 2. Patients requiring emergency care for wound infections.
257 3. Patients admitted or readmitted to an acute care
258 hospital.
259 4. Patient improvement in the activities of daily living.
260 5. Employee satisfaction.
261 6. Quality of employee training.
262 7. Employee retention rates.
263 (b) The agency must annually evaluate home health agencies
264 seeking the award to apply on a form and in the manner
265 designated by rule.
266 (3) The home health agency must:
267 (a) Be actively licensed and operating for at least 24
268 months to be eligible to apply for a program award. An award
269 under the program is not transferrable to another license,
270 except when the existing home health agency is being relicensed
271 in the name of an entity related to the current licenseholder by
272 common control or ownership, and there will be no change in the
273 management, operation, or programs of the home health agency as
274 a result of the relicensure.
275 (b) Have had no licensure denials, revocations, or any

276 Class I, Class II, or uncorrected Class III deficiencies within
277 the 24 months preceding the application for the program award.
278 (4) The award designation shall expire on the same date as
279 the home health agency's license. A home health agency must
280 reapply and be approved for the award designation to continue
281 using the award designation in the manner authorized under
282 subsection (5).
283 (5) A home health agency that is awarded under the program
284 may use the designation in advertising and marketing. A home
285 health agency may not use the award designation in any
286 advertising or marketing if the home health agency:
287 (a) Has not been awarded the designation;
288 (b) Fails to renew the award upon expiration of the award
289 designation;
290 (c) Has undergone a change in ownership that does not
291 qualify for an exception under paragraph (3)(a); or
292 (d) Has been notified that it no longer meets the criteria
293 for the award upon reapplication after expiration of the award
294 designation.
295 (6) An application for an award designation under the
296 program is not an application for licensure. A designation
297 awarded by the agency under this section does not constitute
298 final agency action subject to chapter 120.
299 Section 10. Section 408.064, Florida Statutes, is created
300 to read:

301 408.064 Home Care Services Registry.—
302 (1) As used in this section, the term:
303 (a) "Home care services provider" means a home health
304 agency licensed under part III of chapter 400 or a nurse
305 registry licensed under part III of chapter 400.
306 (b) "Home care worker" means a home health aide as defined
307 in s. 400.462 or a certified nursing assistant certified under
308 part II of chapter 464.
309 (2) The agency shall develop and maintain a voluntary
310 registry of home care workers. The agency shall display a link
311 to the registry on its website homepage.
312 (3) The registry shall include, at a minimum:
313 (a) Each home care worker's full name, date of birth,
314 social security number, and a full face, passport-type, color
315 photograph of the home care worker. The home care worker's date
316 of birth and social security number may not be publicly
317 displayed on the website.
318 (b) Each home care worker's contact information, including
319 but not limited to, his or her city, county, and phone number.
320 If employed by a home care services provider, the home care
321 worker may use the provider's contact information.
322 (c) Any other identifying information of the home care
323 worker, as determined by the agency.
324 (d) The name of the state-approved training program
325 successfully completed by the home care worker and the date on

326 which such training was completed.
327 (e) The number of years the home care worker has provided
328 home health care services for compensation. The agency may
329 automatically populate employment history as provided by current
330 and previous employers of the home care worker. The agency must
331 provide a method for a home care worker to correct inaccuracies
332 and supplement the automatically populated employment history.
333 (f) For a certified nursing assistant, any disciplinary
334 action taken or pending against the nursing assistant's
335 certification by the Department of Health. The agency may enter
336 into an agreement with the Department of Health to obtain
337 disciplinary history.
338 (g) Whether the home care worker provides services to
339 special populations and the identities of such populations.
340 (4) A health care worker must submit an application on a
341 form adopted by the agency to be included in the registry. The
342 agency shall develop a process by which a home health services
343 provider may include its employees in the registry by providing
344 the information listed in subsection (3).
345 (5) A home care worker who is not employed by a home care
346 services provider must meet the background screening
347 requirements under s. 408.809 and chapter 435 and the training
348 requirements of part III of chapter 400 or part II of chapter
349 464, as applicable, which must be included in the registry.
350 (6) Each page of the registry website shall contain the

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351 following notice in at least 14-point boldfaced type:
352
353 NOTICE
354
355 The Home Care Services Registry provides limited
356 information about home care workers. Information
357 contained in the registry is provided by third
358 parties. The Agency for Health Care Administration
359 does not guarantee the accuracy of such third-party
360 information and does not endorse any individual listed
361 in the registry. In particular, the information in the
362 registry may be outdated or the individuals listed in
363 the registry may have lapsed certifications or may
364 have been denied employment approval due to the
365 results of a background screening. It is the
366 responsibility of those accessing this registry to
367 verify the credentials, suitability, and competency of
368 any individual listed in the registry.
369
370 (7) The agency shall develop rules necessary to implement
371 the requirements of this section.
372 Section 11. Section 408.822, Florida Statutes, is created
373 to read:
374 408.822 Direct care workforce survey.—
375 (1) For purposes of this section, the term "direct care

376 worker" means a certified nursing assistant, home health aide,
377 personal care assistant, companion services or homemaker
378 services provider, or other individuals who provide personal
379 care as defined in s. 400.462 to individuals who are elderly,
380 developmentally disabled, or chronically ill.
381 (2) Beginning January 1, 2021, each licensee that applies
382 for licensure renewal as a nursing home facility licensed under
383 part II of chapter 400; an assisted living facility licensed
384 under part I of chapter 429; or a home health agency, nurse
385 registry, or a companion services or homemaker services provider
386 licensed under part III of chapter 400 must furnish the
387 following information to the agency in a survey on the direct
388 care workforce:
389 (a) The number of direct care workers employed by the
390 licensee.
391 (b) The turnover and vacancy rates of direct care workers
392 and contributing factors to the rates.
393 (c) Average employee wage for each category of direct care
394 workers.
395 (d) Employment benefits for direct care workers and
396 average cost to the employer and employee.
397 (e) Type and availability of training for direct care
398 workers.
399 (3) An administrator or designee shall include the
400 information required in subsection (2) on a survey form

401 developed by the agency in rule which must contain an
402 attestation that the information provided is true and accurate
403 to the best of his or her knowledge.
404 (4) The licensee must submit the completed survey prior to
405 the agency issuing the license renewal.
406 (5) The agency shall continually analyze the results of
407 the survey and publish the results on its website. The agency
408 must update the information published on its website monthly.
409 The analysis must include the:
410 (a) Number of direct workers in the state, including the
411 number of full-time workers and the number of part-time workers.
412 (b) Turnover rate and causes of turnover.
413 (c) Vacancy rate.
414 (d) Average hourly wage.
415 (e) Benefits offered.
416 (f) Availability of post-employment training.
417 Section 12. Section 464.0156, Florida Statutes, is created
418 to read:
419 464.0156 Delegation of duties.—
420 (1) A registered nurse may delegate a task to a certified
421 nursing assistant certified under part II of this chapter or a
422 home health aide as defined in s. 400.462, if the registered
423 nurse determines that the certified nursing assistant or home
424 health aide is competent to perform the task, the task is
425 delegable under federal law, and the task:

426 (a) Is within the nurse's scope of practice.
427 (b) Frequently recurs in the routine care of a patient or
428 group of patients.
429 (c) Is performed according to an established sequence of
430 steps.
431 (d) Involves little or no modification from one patient to
432 another.
433 (e) May be performed with a predictable outcome.
434 (f) Does not inherently involve ongoing assessment,
435 interpretation, or clinical judgement.
436 (g) Does not endanger a patient's life or well-being.
437 (2) A registered nurse may delegate to a certified nursing
438 assistant or a home health aide the administration of medication
439 of oral, transdermal, ophthalmic, otic, rectal, inhaled,
440 enteral, or topical prescription medications if the certified
441 nursing assistant or home health aide meets the requirements of
442 s. 464.2035 or s. 400.489, respectively. A registered nurse may
443 not delegate the administration of any controlled substance
444 listed in Schedule II, Schedule III, or Schedule IV of s. 893.03
445 or 21 U.S.C. s. 812.
446 (3) The board, in consultation with the Agency for Health
447 Care Administration, may adopt rules to implement this section.
448 Section 13. Paragraph (r) is added to subsection (1) of
449 section 464.018, Florida Statutes, to read:
450 464.018 Disciplinary actions.—

451 (1) The following acts constitute grounds for denial of a
452 license or disciplinary action, as specified in ss. 456.072(2)
453 and 464.0095:
454 (r) Delegating professional responsibilities to a person
455 when the nurse delegating such responsibilities knows or has
456 reason to know that such person is not qualified by training,
457 experience, certification, or licensure to perform them.
458 Section 14. Section 464.2035, Florida Statutes, is created
459 to read:
460 464.2035 Administration of medication.—
461 (1) A certified nursing assistant may administer oral,
462 transdermal, ophthalmic, otic, rectal, inhaled, enteral, or
463 topical prescription medication to a resident of a nursing home
464 or a patient of a home health agency if the certified nursing
465 assistant has been delegated such task by a registered nurse
466 licensed under part I of this chapter, has satisfactorily
467 completed an initial 6-hour training course approved by the
468 board, and has been found competent to administer medication to
469 a resident or patient in a safe and sanitary manner. The
470 training, determination of competency, and initial and annual
471 validations required in this section shall be conducted by a
472 registered nurse licensed under this chapter or a physician
473 licensed under chapter 458 or chapter 459.
474 (2) A certified nursing assistant must annually and
475 satisfactorily complete 2 hours of inservice training in

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476 medication administration and medication error prevention
477 approved by the board, in consultation with the Agency for
478 Health Care Administration. The inservice training is in
479 addition to the annual inservice training hours required under
480 this part.
481 (3) The board, in consultation with the Agency for Health
482 Care Administration, shall establish by rule standards and
483 procedures that a certified nursing assistant must follow when
484 administering medication to a resident or patient. Such rules
485 must, at a minimum, address qualification requirements for
486 trainers, requirements for labeling medication, documentation
487 and recordkeeping, the storage and disposal of medication,
488 instructions concerning the safe administration of medication,
489 informed-consent requirements and records, and the training
490 curriculum and validation procedures.
491 Section 15. This act shall take effect upon becoming a
492 law.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health Care Appropriations
2 Subcommittee
3 Representative Tomkow offered the following:
4
5 **Amendment (with title amendment)**
6 Between lines 490 and 491, insert:
7 Section 15. For the 2020-2021 fiscal year, 4.0 full-time
8 equivalent positions, with associated salary rate of 166,992,
9 are authorized and the sums of $643,659 in recurring and
10 $555,200 in nonrecurring funds from the Health Care Trust Fund
11 are appropriated to the Agency for Health Care Administration
12 for the purpose of implementing this act.
13
14 ---
15 **T I T L E A M E N D M E N T**
16 Remove lines 99-100 and insert:

17 to adopt rules; providing an appropriation; providing an

18 effective date.