Tab 1	**SB 18** by **Braynon**; (Similar to CS/H 06509) Relief of C.M.H. by the Department of Children and Families

Tab 2	**SB 42** by **Rodriguez**; (Similar to H 06505) Relief of Vonshelle Brothers by the Department of Health

Tab 3	**SB 44** by **Rodriguez**; (Similar to H 06501) Relief of Cristina Alvarez and George Patnode by the Department of Health

892122	A	S	RCS	AHS, Rodriguez	Delete L.46 - 62:	02/21 05:04 PM

Tab 4	**CS/SB 590** by **CF, Garcia (CO-INTRODUCERS) Campbell**; (Compare to CS/CS/H 01435) Child Welfare

497732	D	S	RCS	AHS, Garcia	Delete everything after	02/21 05:06 PM

Tab 5	**CS/SB 758** by **HP, Gibson (CO-INTRODUCERS) Torres**; (Similar to H 00561) Diabetes Educators

Tab 6	**CS/SB 1360** by **CF, Broxson**; (Compare to CS/CS/H 01079) Child Welfare

941496	D	S	RCS	AHS, Broxson	Delete everything after	02/21 05:09 PM

Tab 7	**CS/SB 1422** by **BI, Rouson**; (Similar to H 00955) Insurance Coverage Parity for Mental Health and Substance Use Disorders

370074	A	S	RCS	AHS, Rouson	btw L.307 - 308:	02/21 05:11 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Flores, Chair
Senator Stargel, Vice Chair

MEETING DATE: Wednesday, February 21, 2018
TIME: 4:00—6:00 p.m.
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Flores, Chair; Senator Stargel, Vice Chair; Senators Baxley, Book, Passidomo, Rader, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 18** Braynon (Similar CS/H 6509)	Relief of C.M.H. by the Department of Children and Families; Providing for the relief of C.M.H.; providing an appropriation to compensate C.M.H. for injuries and damages sustained as a result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services; requiring certain funds to be placed into an irrevocable trust, etc. SM JU 01/25/2018 Favorable AHS 02/21/2018 Favorable AP	Favorable Yeas 7 Nays 0
2	**SB 42** Rodriguez (Similar H 6505)	Relief of Vonshelle Brothers by the Department of Health; Providing for the relief of Vonshelle Brothers on behalf of her daughter Iyonna Hughey; providing an appropriation to compensate Iyonna Hughey for injuries and damages sustained as a result of the alleged negligence of the Brevard County Health Department, an agency of the Department of Health, etc. SM JU 01/25/2018 Favorable AHS 02/21/2018 Favorable AP	Favorable Yeas 7 Nays 0
3	**SB 44** Rodriguez (Similar H 6501)	Relief of Cristina Alvarez and George Patnode by the Department of Health; Providing for the relief of Cristina Alvarez and George Patnode; providing appropriations to compensate them for the death of their son, Nicholas Patnode, a minor, due to the negligence of the Department of Health, etc. SM JU 01/25/2018 Favorable AHS 02/21/2018 Fav/CS AP	Fav/CS Yeas 6 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 590** Children, Families, and Elder Affairs / Garcia (Compare CS/CS/H 1435)	Child Welfare; Requiring the Department of Children and Families, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, to develop a statewide family-finding program; requiring the court to request that parents consent to providing access to additional records; requiring the department to provide financial assistance to kinship caregivers who meet certain requirements; providing requirements and procedures for referring certain children to the Early Steps Program, etc. CF 12/04/2017 Fav/CS JU 02/06/2018 Favorable AHS 02/21/2018 Fav/CS AP	Fav/CS Yeas 6 Nays 0
5	**CS/SB 758** Health Policy / Gibson (Similar H 561)	Diabetes Educators; Redefining the term "health care practitioner" to include diabetes educators; creating part XVII of ch. 468, F.S., entitled "Diabetes Educators"; providing requirements for registration as a diabetes educator; prohibiting an unregistered person from certain activities relating to diabetes self-management training; authorizing the department to take disciplinary action against an applicant or registrant for specified violations, etc. HP 02/06/2018 Fav/CS AHS 02/21/2018 Favorable AP	Favorable Yeas 6 Nays 1
6	**CS/SB 1360** Children, Families, and Elder Affairs / Broxson (Compare CS/CS/H 1079, S 1514)	Child Welfare; Requiring the Department of Children and Families to establish rules for granting exemptions from criminal history and certain other records checks required for persons being considered for placement of a child; revising minimum requirements for child care personnel related to screening and fingerprinting; defining the term "severe disability" and providing an exemption from fingerprint requirements for adult household members with severe disabilities, etc. CF 02/06/2018 Fav/CS AHS 02/21/2018 Fav/CS AP	Fav/CS Yeas 6 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**CS/SB 1422** Banking and Insurance / Rouson (Similar H 955)	Insurance Coverage Parity for Mental Health and Substance Use Disorders; Requiring contracts between the Agency for Health Care Administration and certain managed care plans to require the plans to submit a specified annual report to the agency relating to parity between mental health and substance use disorder benefits and medical and surgical benefits; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders; repealing provisions relating to optional coverage required for substance abuse impaired persons, etc. BI 02/06/2018 Fav/CS AHS 02/21/2018 Fav/CS AP	Fav/CS Yeas 6 Nays 0

Other Related Meeting Documents

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

DATE	COMM	ACTION
1/22/18	SM	Favorable
01/23/18	JU	**Favorable**
2/20/18	AHS	Recommend: Favorable
	AP	

January 22, 2018

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 18** – Senator Oscar Braynon II
HB 6509 – Representative James Grant
Relief of C.M.H.

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $5,000,000 PREDICATED ON THE ENTRY OF A JURY AWARD IN FAVOR OF CHRISTOPHER HANN AND THERESA HANN, INDIVIDUALLY, AND AS NAUTRAL GUARDIANS OF C.M.H., A MINOR CHILD, DUE TO THE NEGLIGENCE OF THE DEPARTMENT OF CHILDREN AND FAMILIES.

FINDINGS OF FACT:

The Department of Children and Families, placed J.W., a 10 year old foster child with a history of violence and sexual assaults against younger children, in the home of Christopher and Theresa Hann. The Hanns had young children of their own, and because the Hanns were not trained to handle a child with J.W.'s propensity for violence, the department should not have placed J.W. in the Hann's home. Making matters worse, the department concealed J.W.'s violent past from the Hanns when it had a duty to disclose it. Ultimately, the department's placement of J.W. in the Hann's home led to the emotional, physical, and sexual abuse of C.M.H., the Hann's 8 year old son, by J.W.

The Department of Children and Families knew of J.W.'s propensity for violence toward other children.

J.W. was born January 23, 1992, in Florida, to a teenage mother who had a history of mental illness and homelessness. She did not receive prenatal care and attempted suicide during the third month of her pregnancy by inhaling butane. J.W.'s mother was living in a shelter for homeless and runaway youth at his birth. J.W.'s biological father had a history of drug abuse and played no major role in his life.

J.W. lived with his mother until the age of 4. During this time, he was subjected to extreme neglect, cruelty, and physical and sexual abuse by his mother, her boyfriends, and her extended family members. J.W., at age 1, was subjected to sexual abuse for approximately 2-3 years by males visiting his mother. He was severely beaten at age 2 while in the care of his mother's boyfriend.

As a result of his repeated abuse and neglect, J.W. began to exhibit symptoms of post-traumatic stress disorder. Due to aggressive behaviors, he was dismissed from two daycare centers. At age 3, he attempted suicide. He was subsequently diagnosed as having attention deficit hyperactivity disorder with psychotic behavior and suicidal tendencies and treated with anti-psychotic medication.

J.W. was returned to his mother's care at age 5. He was severely psychotic and began setting fires. In June 1997, J.W. was admitted to the Columbia Hospital Inpatient Psychiatric Program for a week due to self-mutilation, violent behavior, homicidal ideation, auditory hallucinations, and multiple suicide attempts. J.W. would continue receiving intensive outpatient psychiatric treatment for 7 months following his initial hospitalization.

After receiving a report that J.W. was again sexually molested by another of his mother's male friends, the department placed J.W. back into foster care where he resided on and off for approximately 5 years. He was involuntarily hospitalized at least two more times by age 9. One hospitalization was due to aggressive behavior, an attempt to stab his uncle and his babysitter with a knife. Later he was hospitalized for planning to bring a gun and knife to school to kill a teacher and himself. In 2002, J.W. was living with his mother who had married several years earlier and had given birth to a daughter with

her new husband. The department and the family entered into a voluntary case plan to address continuing allegations of abuse, neglect, and domestic violence in the home. During this time, J.W. began to exhibit sexually aggressive behavior towards other children. Multiple reports indicated that J.W. performed anal penetration on a neighborhood girl. He also continued to display severe psychotic behavior. On one occasion he attempted to cut his stepfather's throat while he slept.

On June 14, 2002, DCF family services counselor, Suzy Parchment, referred J.W. to Camelot Community Care, a DCF provider of child welfare and behavioral health services, for intensive therapeutic in-home services. Realizing the severity of J.W.'s behavior, in a communication with Camelot on June 24, Ms. Parchment noted that J.W. needed to be in a residential treatment facility as soon as possible.

As an emergency, temporary solution and noting that J.W. was a danger in the home, Camelot accepted the referral to provide mental health services to J.W. in his natural home while the department sought residential placement. Camelot noted on its admission form that J.W. was a sexual predator and engaged in sexually inappropriate behavior. It was also noted that J.W. suffered from non-specified psychosis, major depression with psychotic features, adjustment disorder and attention deficit hyperactivity disorder. The in-home counselor assigned to J.W.'s case did not have experience with sexual trauma, and Camelot's initial treatment plan did not include any specific goals or specialized treatment for sexual abuse.

J.W.'s mother informed Camelot and the department that J.W. was giving his 3 year old sister hickies, bouncing her on his lap in a sexual manner, and having her fondle his genitals. Camelot performed a child safety determination and found that based on J.W.'s history, a sibling was likely to be in immediate danger of moderate to severe harm if J.W. was not supervised. Camelot recommended that J.W.'s parents separate him from his younger sister at night and closely watch him when he interacts with his sister.

On or about August 2002, the department removed J.W. and his younger sister from their mother's care after she abandoned them at a friend's house. J.W. was sheltered in the home of a family friend, Luz Cruz, a non-relative

placement while his younger half-sister was placed with family members.

J.W. underwent a Comprehensive Behavioral Health Assessment on August 30, 2002, at the request of DCF. The assessment concluded that J.W. "should not have unsupervised access to [his younger sister], or to any younger, or smaller children wherever he resides." The Assessment also states: "***J.W.'s caregiver must be informed about these issues and must be able to demonstrate that they can provide adequate levels of supervision in order to prevent further victimization. These issues should be strongly considered in terms of making decisions about both temporary and long term care and supervision of J.W.***"

Based upon the findings and recommendations in the Assessment, J.W. was referred to Father Flanagan's Boys' Home d/b/s Girls and Boys Town, a DCF service provider, for case management services.

The Department of Children and Families knew that J.W., should not have been placed in a home with younger children.

Ms. Parchment removed J.W. from the Cruz home on September 6, 2002, due to allegations of sexual abuse by a member of the Cruz family; however, she did not report the abuse allegation as required by Florida law. It was also on September 6, 2002, that J.W. was placed with the Hanns.

Mr. and Mrs. Hann were former neighbors of J.W. and his natural family. The Hanns lived with their two children, a daughter, age 16, and a son, C.M.H., age 8. They were not licensed or trained foster parents. In the past, J.W. had often sought shelter in the Hann home when left alone by his mother. Theresa Hann had offered to care for J.W., and his mother lobbied Camelot and the department to have J.W. placed with the Hann family instead of Luz Cruz.

Ms. Parchment recalled her first impressions of the Hann family were of nice people who maintained a very organized and clean home. She believed Theresa Hann's main purpose was to care for J.W. and that she had no ulterior motives. However, despite the willingness of the Hanns to care for

J.W., the removal of J.W. from the Cruz home and placement in the Hann home violated DCF rules.

Under the department's rules, it is required to obtain prior court approval for all non-relative placements. This requirement eliminates non-relative placements for use in lieu of emergency shelter care. Ms. Parchment did not obtain the required court approval prior to placing J.W. in the Hann home. She also failed to notify the department's legal team, who is responsible for court filings, of the allegation of sexual abuse of J.W. in the Cruz home or his subsequent placement in the Hann home for two months.

Additionally, the placement directly conflicted with previous recommendations by department providers regarding placement for J.W. due to his sexually aggressive behaviors. J.W. was placed in a home with an 8 year old child even though 2 months earlier Camelot had warned that a sibling would be in danger in a home with J.W. One week prior to the placement, St. Mary's Medical Center had recommended that J.W. not have unsupervised access to younger children. The Hanns were not provided any information about J.W.'s ongoing inappropriate behavior with younger children and the Hanns allowed J.W. to share a bedroom with their son, C.M.H. Department rules expressly prohibit placing a sexually aggressive child in a bedroom with another child. Ms. Parchment knew of the planned sleeping arrangements prior to placing J.W. in the Hann home but did not tell them that the arrangement was prohibited under the department's rules.

The Department of Children and Families failed to inform the Hanns of J.W.'s background.

Christopher Hann specifically requested information about J.W., but the department failed to provide any information regarding J.W.'s troubled history of child-on-child sexual abuse or on his background generally. Florida law requires DCF to share psychological, psychiatric and behavioral histories, comprehensive behavioral assessments and other social assessments found in the child's resource record with caregivers. The department acknowledged during litigation that no evidence of a child resource record for J.W. was found. Additionally, for the purpose of preventing the reoccurrence of child-on-child sexual abuse, the department must provide caregivers of sexual abuse victims and aggressors with written, complete, and detailed information and strategies

related to such children, including the date of the sexual abuse incident(s), type of abuse, type of treatment received, and outcome of the treatment in order to "provide a safe living environment for **all** the children living in the home."

Not only did the department fail to comply with its own requirements, Ms. Parchment told Mr. Hann that she was not allowed to give him such information about J.W. because the placement was temporary. Nevertheless, J.W. remained in the Hann home for approximately 3 years during which his behavioral problems continued and quickly escalated.

The Department of Children and Families knew it should have removed J.W. from the Hann home as his violent behaviors increased.

Within a few weeks after J.W.'s placement in the Hann home, Mrs. Hann reported to Camelot that J.W. was playing with matches in the presence of C.M.H.; exhibited extreme anger and hostility towards C.M.H., including yelling, screaming "shut up" at the smallest aggravation or noise, and kicking C.M.H. Among J.W.'s behavioral problems, he stabbed himself with a straightened paper clip after being grounded for leaving the neighborhood without permission; threatened to jump out of a window after it was discovered he stole a roll of felt from school; and attacked Ms. Hann, biting and scratching her when she grounded him for cursing.

Camelot recommended to Ms. Parchment that the Hanns place a one way monitor in the bedroom shared by J.W. and C.M.H. While Ms. Parchment agreed to pass the recommendation on to the Hanns, there is no evidence that the information was shared or that the Hanns ever obtained the monitor.

J.W.'s behavior further deteriorated and on October 24, 2002, after a physical altercation with C.M.H., he pulled a knife on the younger child but was stopped from further assaulting him by Mr. Hann. Camelot was immediately informed of the incident by Mr. Hann, and J.W. was again involuntarily committed into Columbia Hospital for a mental health assessment. Camelot's notes indicate Ms. Parchment was informed of J.W.'s escalating behavior in the Hann home. Ms. Parchment later acknowledged that at this point she should have considered removing J.W. from the Hann home due to the danger he posed to himself, the Hanns and their son.

A week after the mental health assessment was performed, J.W. sexually assaulted a 4 year old girl who was visiting the Hann home. The children were watching a movie when J.W. exposed his genitals and began "humping" the young girl. Ms. Hann reported the incident to DCF. During the course of the investigation, the department learned the children were not under the direct supervision of any adult at the time of the incident – a failure that DCF providers warned would lead to harm of other children when left alone with J.W. Again, DCF was required to give immediate consideration to the safety of C.M.H. Despite, the inability of the Hanns, who both worked outside the home, to adequately supervise J.W. and his continuing access to young children, DCF did not remove J.W. from the Hann home.

Camelot began pressuring Ms. Parchment to schedule a psychosexual evaluation of J.W. which she was required to do months earlier pursuant to DCF's operating procedures. The evaluation had in fact been requested by Camelot when J.W. was placed with the Hanns and again just 2 days before he sexually assaulted the 4 year old girl visiting the Hann home. Camelot's notes indicate that it told Ms. Parchment that "[J.W.] needed specific sexual counseling by a specialist in this area." Ms. Parchment took no action so Camelot advised Mr. Hann that a new safety plan would be implemented which prohibited J.W. and C.M.H. from sharing a bedroom and requiring J.W. to be under close adult supervision when other children were present. Such recommendations had already been a complete failure at preventing J.W. from perpetuating sexual abuse on other children. Further, still without knowledge of J.W.'s extensive history of sexual abuse as a victim and aggressor, Mr. Hann informed Camelot that the family disagreed with and would not follow the safety plan.

The Department of Children and Families ignored repeated warnings from its service providers.

Beginning in November 2002, Girls and Boys Town began providing services to J.W. in conjunction with Camelot. The assessment of J.W.'s case and his current behaviors, which was performed by Girls and Boys Town, found that despite his escalating violence and suicidal and sexually aggressive actions, no additional interventions or therapies had been put in place.

Camelot again requested a psychosexual evaluation of J.W. on November 6, 2002.

Additionally, in November 2002, C.M.H. began to exhibit behavioral problems which Camelot directly attributed to J.W. being in the home. C.M.H.'s grade dropped. In one school year he went from being an "A", "B", or "C" student to failing grades and was ultimately retained in the fourth grade.

In December 2002, the Hanns, overwhelmed with the number of providers involved in J.W.'s care and the disruption to their family, canceled the services of Camelot. Camelot recommended in its discharge form, signed by Ms. Parchment, that J.W. be placed in a residential treatment facility; however, DCF did not initiate a change in placement.

In June 2003, J.W. began expressing sexually inappropriate behavior towards C.M.H., asking him if he wanted to "see what sperm looks like" before masturbating to completion in front of him and attempting to hand him the semen. Due to this new escalation of J.W.'s behavior now directed at C.M.H., the department finally secured the psychosexual evaluation of J.W. but still did not remove him from the Hann home.

The department received the results of the psychosexual evaluation of J.W. performed by The Chrysalis Center on September 18, 2003. The Center found that J.W. "fit the profile of a sexually aggressive child due to the fact that he continues to engage in extensive sexual behaviors with children younger than himself." Further, it was found that J.W. "[presented] a risk of potentially becoming increasing more aggressive" and "continuing sexually inappropriate behaviors." The Center warned that J.W. "may seek out victims who are children and coerce them to engage in sexual activity." And again the Center recommended specific counseling for J.W. and appropriate training for his caregivers, the Hanns.

Finally, in October 2003, the Hanns requested J.W. be placed in a therapeutic treatment facility as they did not feel equipped to provide him with services and interventions he needed. Therapeutic placement was authorized for J.W. and he was referred to Alternate Family Care in Jupiter, Florida. The Hanns were told that if J.W. was removed from their home they would not be permitted visitation privileges with him at the facility. The Hanns did not want to be the next in a series

of parental figures that abandoned J.W. so they ultimately made the decision to maintain him in their home with a request for additional services to treat his ongoing issues. At this time the Hanns begin training to become therapeutic foster parents.

C.M.H.'s problems due to J.W.'s presence in the home continued at school. Beginning in late 2003 to early 2004, C.M.H. began to act out and have more conflicts in school. He received a student discipline referral for ongoing behavioral problems in the classroom. Additionally, in early 2004 he began gaining weight and would subsequently gain about 40 pounds over the next two years.

The Department of Children and Families failed to remove a dangerous child it had placed in the Hann home when requested by the Hanns.

Mrs. Hann was diagnosed with terminal cancer on March 3, 2004. As a result, Mr. Hann contacted DCF within 48 hours of the diagnosis and requested the process of having J.W.'s placement with them as "long-term non-relative care" be stopped and asked that J.W. be placed elsewhere. Ms. Parchment visited the Hann home within 24 hours after the request and advised the family that "we'll get on it."

Nothing was done and contrary to the express request and wishes of the Hanns and without their knowledge, DCF had the Hanns declared as "long term non-relative caregivers" of J.W. The department subsequently closed the dependency case, leaving J.W. in the care of the Hanns.

The Department of Children and Family Services withdrew support for the Hann family when it was needed most.

The Hanns were not part of the foster care system so when DCF closed its dependency case, the Hann family lost approximately 50 percent of their services and counseling. Father Flanagan's suspended services to J.W. and the Hann family in April 2004. The Hanns would later directly attribute the resurgence in J.W.'s inappropriate sexual behavior to the loss of counseling services.

With almost no support from DCF, the Hanns grew more desperate as they tried to deal with Mrs. Hann's illness and J.W.'s escalating behavior.

C.M.H.'s troubles also continued. An April 2005 treatment plan from St. Mary's Child Development Center's Children's Provider Network noted that he began to have nightmares and was easily frustrated. The report also noted that his mother's diagnosis of terminal cancer and intensive chemotherapy treatments were contributing to C.M.H.'s increasing separation anxiety and grief issues. He was diagnosed with post-traumatic stress disorder.

In April 2005, Mr. Hann wrote DCF and the juvenile judge requesting help in placing J.W. in a residential placement. There was no response to his request, and J.W. remained in the Hann home.

A report from Child & Family Connections, the lead agency for community-based care in Palm Beach County, dated June 16, 2005, provided a description of J.W.'s personality and behavior, the high risk of sexual behavior problems and increasing aggression, his excessive masturbation, seeking out younger children, lies, and refusal to take responsibility for his actions. The report stated that the Hanns "[had] been told that it is not a matter of will J.W. perpetrate on their son again, but a matter of when the perpetration would occur. [J.W. was] in need of a more restrictive setting with intensive services specializing in sexual specific treatment." The report also noted that J.W.'s previous therapist, current therapist, and a psychosexual evaluation all recommended a full-time group home facility specializing in sexual specific treatment. The report concluded that J.W.'s condition was "so severe and the situation so urgent that treatment [could not] be safely attempted in the community."

Predictably, the numerous failures of the Department and its Family Services resulted in the sexual assault of another child.

On June 29, 2005, after a physical altercation between J.W. and Mrs. Hann, C.M.H., then 10 years old, told his parents that 2 years prior, J.W. had forced him to engage in oral sex while the boys were at a sleepover at this cousin's house. Mr. Hann called Girls & Boys Town and demanded that J.W. be removed from the home immediately. Later that same day, the department finally removed J.W. from the Hann home, and he was taken to an emergency shelter until a placement could be determined.

The court entered an order on August 11, 2005, authorizing the placement of J.W. into a residential treatment center. The court found that although a previous court order authorized placement in a specialized therapeutic group home, due to another incident that occurred while in emergency shelter, J.W. required a higher level of care.

Theresa Hann passed away the next year shortly after initiating litigation against DCF and its providers.

CLAIMANT'S POSITION:

The lawsuit was filed against the department, Camelot Community Care, Inc., Elaine Beckwith, Chrysalis Center, and Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida. The suit alleged the defendants were negligent and directly liable for the injuries suffered by C.M.H. as a result of the sexual abuse due to:

1. The initial placement of J.W. in the Hann home;
2. The failure of DCF to follow its own rules and operating procedures to provide the necessary treatment and services for J.W.;
3. The failure of DCF to provide the required information to the Hanns regarding J.W.'s history of sexual abuse and sexual aggressiveness, including the failure to formulate a safety plan for J.W. and all the children residing in the Hann home;
4. The failure of DCF to maintain the safety of J.W. and any children residing in the placement;
5. The failure of the DCF employee to report the allegations of sexual abuse of J.W. as mandated by s. 39.201, F.S.; and
6. DCF moving forward with having the court declare the Hanns "long-term non-relative caregivers," closing the case file, and leaving J.W. in the custody of the Hanns without notice to them and despite their request to stop the process.

RESPONDENT'S POSITION:

The Department of Children and Families defended the lawsuit. On November 18, 2013, after a 4-week jury trial, a judgment was entered in the amount of $10,000,000. DCF was found to be 50 percent liable ($5,000,000) and Mr. and Mrs. Hann were found to be 50 percent liable ($5,000,000). The jury attributed no liability to the remaining defendants.

CONCLUSIONS OF LAW:

Every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. With respect to this claim bill, which is based on a negligence claim, the claimant proved that the state had a duty to the claimant, the state breached that duty, and that the breach caused the claimant's damages.

Duty

The Department of Children and Families had a duty pursuant to exercise reasonable care when placing a child involved in child-on-child sexual abuse or sexual assault in substitute care; to provide caregivers of children with sexual aggression and sexual abuse with written, detailed and complete information of the child's history; to establish appropriate safeguards and strategies to protect all children living in the foster or temporary care; to ensure the foster family is properly trained and equipped to meet the serious needs of the foster child; and to exercise reasonable care under the circumstances.

Breach

A preponderance of the evidence establishes that DCF breached its duties by failing to follow its governing statutes, rules, and internal operating procedures by:

- Placing J.W., a known sexually aggressive, severely emotionally disturbed, and dangerous child in the Hann home without legal authority and in direct conflict with recommendations of DCF service providers that J.W. not have access to young children;
- Failing to ensure that Mr. and Mrs. Hann were duly licensed and trained as required by department rule, making them capable of safely caring for a child with J.W.'s extensive needs;
- Failing to fully and completely inform the Hanns of J.W.'s history, and the risk and danger he posed to C.M.H. as required by department rule; and
- Failing to remove J.W. from the Hann home when it became clear that the placement was inappropriate and dangerous to the Hanns and C.M.H. particularly.

Causation

The sexual, physical and emotional abuse suffered by C.M.H. was the direct and proximate result of DCF's failure to fulfill its duties regarding the foster placement of a known sexually aggressive child.

Damages

At the conclusion of a 2-week trial, the jury found DCF and Mr. and Mrs. Hann each 50 percent responsible for the negligence that resulted in the injuries suffered by C.M.H. The jury awarded C.M.H. $6 million for past pain and suffering, $3.5 million for future pain and suffering, $250,000.00 for future treatment and services and $250,000.00 for future loss of earning capacity for a total award of $10 million. The department and Mr. and Mrs. Hann were each responsible for $5 million. The jury did not assess any liability for negligence against the remaining 6 defendants.

C.M.H. was initially diagnosed with post-traumatic stress disorder in 2005. Thomas N. Dikel, Ph.D., reaffirmed the diagnosis in 2010, finding that C.M.H.'s severe PTSD was cause by his "experiences of child-on-child sexual abuse, exacerbated and magnified by his mother's diagnosis of stage 4, metastatic colon cancer."

He was re-evaluated by Dr. Stephen Alexander in October 2014. Dr. Alexander found C.M.H. to continue to suffer from PTSD and major depression, but had become even more dysfunctional since his initial evaluation due to lack of services. Dr. Alexander attributed the majority of C.M.H.'s psychological trauma to this mother's illness and death; however, he did note that due to J.W.'s presence in the home during her illness, the two events have become inextricably intertwined in this psyche.

Comprehensive Rehabilitation Consultants, Inc., created a life plan for C.M.H. to determine the funds necessary to provide the support needed by C.M.H. as a direct consequence of the sexual abuse he experienced. It was determined the cost for medical, psycho-therapies, educational and support services as well as ancillary services of transportation, housing and personal items would be $2.23 million over C.M.H.'s life.

As a result of the judgment entered by the court against DCF, the state paid $100,000 (the maximum allowed under the state's sovereign immunity waiver) with the remaining $4.9 million to be paid if this claim bill is passed by the Legislature and signed into law by the Governor.

COLLATERAL SOURCES OF RECOVERY:

Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida (Father Flanagan) was a named defendant in the lawsuit. Father Flanagan executed a settlement agreement with Claimants on July 30, 2013, in the amount of $340,000. However, in October 2013, the jury found that Father Flanagan was not negligent for any loss, injury or damage to C.M.H.

ATTORNEYS FEES:

Claimant's attorneys have acknowledged in writing that nothing in excess of 25 percent of the gross recovery will be withheld or paid as attorneys' fees.

RECOMMENDATIONS:

The negligence of the department and the Hanns were the legal proximate cause of the damages suffered by C.M.H. However, the jury award of $9.5 million for non-economic damages or pain and suffering is not supported by the weight of the evidence. According to Dr. Alexander's October 2014 report, C.M.H. continues to suffer from PTSD but attributes a majority of C.M.H.'s psychological trauma to the illness and death of his mother. The department should not be held financially liable for C.M.H.'s psychological trauma that occurred due to the illness and death of his mother.

Damages awarded by the jury in the amount of $500,000 for future treatment and services and lost wages due to the sexual abuse are reasonable under the circumstances and are fully supported by the weight of the evidence. C.M.H. requires intensive and long-term psychotherapy, psychiatric evaluation and treatment and possible psychotropic mediations to assist him in dealing with his PTSD.

It should be noted that since receiving the settlement from Father Flanagan's in 2013, C.M.H. has only sought psychiatric treatment one time.

Accordingly, I recommend that SB 18 be reported FAVORABLY, with the amount to be paid amended to $2.5 million. The jury awarded $9.5 million ($4.75 million assessed to DCF) for past and future pain and suffering. Based on a lack of objective evidence in the record, a 50 percent reduction of DCF's obligation or $2.375 million may be a more appropriate amount to be paid for the non-economic damages. A corresponding reduction of 50 percent of DCF's share of the economic damages ($125,000) would be appropriate.

I further recommend that the funds be paid into a trust established for C.M.H. in equal installments over 10 years to pay for expenses related to education, psycho-therapies and living expenses. Any funds remaining in the trust after 10 years should be distributed in full to C.M.H.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Secretary of the Senate

By Senator Braynon

35-00102-18 201818__

A bill to be entitled

An act for the relief of C.M.H.; providing an appropriation to compensate C.M.H. for injuries and damages sustained as a result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services; requiring certain funds to be placed into an irrevocable trust; providing a limitation on attorney fees; providing an effective date.

WHEREAS, beginning at a very young age, J.W. was subjected to incidents of physical and sexual abuse, which caused him to become sexually aggressive, and

WHEREAS, on September 5, 2002, J.W., then in the custody of the Department of Children and Families (DCF), formerly known as the Department of Children and Family Services, was placed into the home of C.M.H., whose parents volunteered to have J.W. live in their home, and

WHEREAS, before the placement of J.W. with the family, DCF obtained a comprehensive behavioral health assessment that stated that J.W. was sexually aggressive and that recommended specific precautions and training for potential foster parents, which C.M.H.'s parents did not receive, and

WHEREAS, the testimony of the DCF caseworker confirmed that DCF was aware that then-10-year-old J.W. and then-8-year-old C.M.H. were sharing a bedroom, and

WHEREAS, on October 31, 2002, J.W. sexually assaulted a 4-year-old child who was visiting C.M.H.'s home, and

WHEREAS, although DCF knew that J.W. was sexually

35-00102-18 201818__

aggressive, the agency did not remove him from the home, and

WHEREAS, after November 2002, J.W.'s behavioral problems escalated, and he deliberately squeezed C.M.H.'s pet mouse to death in front of C.M.H. and made physical threats toward C.M.H., and

WHEREAS, C.M.H.'s parents began to discuss adopting J.W., whom they considered a part of their family, and

WHEREAS, in January 2004, the family began taking therapeutic parenting classes to better meet J.W.'s needs, and

WHEREAS, in March 2004, after C.M.H.'s mother was diagnosed with stage 4 terminal metastatic colon cancer, which had spread to her liver, C.M.H.'s father requested that DCF stop the process of having the family designated as "long-term nonrelative caregivers," and

WHEREAS, in April 2004, DCF closed out J.W.'s dependency file, leaving J.W. in the custody of the family, and

WHEREAS, in April 2005, C.M.H.'s father wrote DCF and the juvenile judge assigned to the case to request help in placing J.W. in a residential treatment facility, and

WHEREAS, on July 28, 2005, after a physical altercation between J.W. and C.M.H., C.M.H. disclosed to his parents that J.W. had sexually assaulted him, and J.W. was immediately removed from the home, and

WHEREAS, C.M.H. sustained severe and permanent psychiatric injuries, including posttraumatic stress disorder, as a result of the sexual and emotional abuse perpetrated by J.W., and

WHEREAS, the sexual assault of C.M.H. by J.W. was predictable and preventable, and

WHEREAS, on April 14, 2006, a lawsuit, Case No. 2006 CA

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

003727, was filed in the 15th Judicial Circuit in and for Palm Beach County on behalf of C.M.H., by and through his parents, alleging negligence on the part of DCF and its providers, which allowed the perpetration of sexual abuse against and the victimization of C.M.H. by J.W., and

WHEREAS, a mutually agreeable settlement could not be reached, and a jury trial was held in Palm Beach County, and

WHEREAS, on January 2, 2014, after a jury trial and verdict, the court entered a judgment against DCF for $5,176,543.08, including costs, and

WHEREAS, the Division of Risk Management of the Department of Financial Services paid the family of C.M.H. $100,000, the statutory limit at that time under s. 768.28, Florida Statutes, and

WHEREAS, C.M.H., now a young adult, is at a vulnerable stage in his life and urgently needs to recover the balance of the judgment awarded him so that his psychiatric injuries may be addressed and he may lead a normal life, and

WHEREAS, the balance of the judgment is to be paid into an irrevocable trust through the passage of this claim bill in the amount of $5,076,543.08, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. There is appropriated from the General Revenue Fund to the Department of Children and Families the sum of $5,076,543.08 for the relief of C.M.H. for the personal injuries

and damages he sustained. After payment of attorney fees and costs, lobbying fees, and other similar expenses relating to this claim, the remaining funds shall be placed into an irrevocable trust created for C.M.H. for his exclusive use and benefit.

Section 3. The Chief Financial Officer is directed to draw a warrant in favor of C.M.H. in the sum of $5,076,543.08 upon funds of the Department of Children and Families in the State Treasury, and the Chief Financial Officer is directed to pay the same out of such funds in the State Treasury not otherwise appropriated.

Section 4. The amount paid by the Department of Children and Families pursuant to s. 768.28, Florida Statutes, and the amount awarded under this act are intended to provide the sole compensation for all present and future claims arising out of the factual situation described in the preamble to this act which resulted in the personal injuries and damages to C.M.H. The total amount of attorney fees relating to this claim may not exceed 25 percent of the amount awarded under this act.

Section 5. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

DATE	COMM	ACTION
1/22/18	SM	Unfavorable
1/23/18	JU	**Favorable**
2/20/18	AHS	Recommend: Favorable
	AP	

January 22, 2018

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 42** – Senator Jose Rodriguez
HB 6505 – Representative Jenne
Relief of Vonshelle Brothers, Individually, and as the Natural Parent and Guardian of Iyonna Hughey

SPECIAL MASTER'S FINAL REPORT

THIS IS A SETTLED EXCESS JUDGMENT CLAIM FOR $1 MILLION. THE CLAIM SEEKS COMPENSATION FROM THE GENERAL REVENUE FUND FOR THE ALLEGED MEDICAL MALPRACTICE COMMITTED BY THE BREVARD COUNTY HEALTH DEPARTMENT DURING THE PRENATAL CARE OF VONSHELLE BROTHERS AND THE RESULTING DAMAGES TO HER DAUGHTER, IYONNA HUGHEY.

CASE SUMMARY:

Iyonna Hughey is a 7-year-old child who developed meningoencephalitis[1] soon after birth. The disease was both an infection of the meninges, the tissue covering the brain, and an infection of the brain tissue itself. The disease was caused by herpes simplex virus type 2. As a result, Iyonna is severely brain damaged and has profound developmental delays.

Vonshelle Brothers, the Claimant, is Iyonna's mother. Vonshelle alleges that the infection and resulting damage

[1] Iyonna's condition is referred to throughout the depositions as being meningoencephalitis, herpetic encephalopathy, and alternatively, herpetic encephalitis.

were caused by the failure of the Brevard County Health Department to sufficiently test her, the mother, for herpes. Adequate testing, the Claimant argued, would have led to Vonshelle's treatment with an anti-viral drug that would have prevented her from passing the virus to Iyonna. However, the evidence submitted through deposition testimony and medical records demonstrated that Vonshelle Brothers did not have the herpes simplex virus type 2. As a result, Iyonna must have contracted the herpes virus by contact with another person who had the infection. Because the Department did not cause the injuries to Iyonna, I recommend this claim unfavorably.

BACKGROUND INFORMATION: As a foundational matter, it is helpful to understand how Iyonna may have contracted the herpes virus. The herpes simplex viruses exist in two forms: herpes simplex virus type 1, which is oral herpes and abbreviated as HSV-1, and herpes simplex virus type 2, which is genital herpes and abbreviated as HSV-2.

HSV-1 generally causes sores near the mouth and lips, which are referred to as cold sores or fever blisters. HSV-1 is usually transmitted by oral-to-oral contact through oral secretions or sores on the skin and can be spread through sharing eating utensils and toothbrushes or kissing. With HSV-2, sores generally occur around the genitals or rectum. Genital herpes may be caused by HSV-1 or HSV-2, but most cases are caused by HSV-2 and are spread during sexual contact with someone who has a genital herpes type 2 infection. HSV-2 is highly contagious.

Many people infected with genital herpes do not display symptoms or have mild symptoms that are not noticed. When symptoms are noticed, they present as blisters, open ulcers, scabs, fever, muscle aches, or swollen lymph nodes. Both HSV-1 and HSV-2 remain in a person's body for life, even when no signs of infection are present. While it is rare, HSV-2 may be transmitted from a mother to her baby during

the delivery process.[2] The incubation period for HSV-1 or HSV-2 ranges anywhere from 2 to 12 days.[3]

FINDINGS OF FACT:

Initial Pre-Natal Visit

On March 16, 2010, Vonshelle Brothers visited the Brevard County Health Department to determine if she was pregnant.

Regina Pappagallo, a registered nurse, performed the initial intake interview and obtained a Patient History from Vonshelle.

To complete the Prenatal History form, Nurse Pappagallo asked Vonshelle two pages of extensive questions about her previous pregnancies, medical history, genetic screening, and infection history. The nurse recorded Vonshelle's response to each question. Under the "infection history" portion of the screening, Vonshelle responded "no" when asked if she or her partner had a history of genital herpes.[4]

Elena Cruz-Hunter, a certified nurse mid-wife and advanced registered nurse practitioner, then reviewed the patient history taken by Nurse Pappagallo, performed a vaginal exam, and conducted a Pap test to screen for the presence of pre-cancerous cells on the cervix.[5]

In conducting the initial physical examination, Ms. Cruz-Hunter was required to examine and note whether 17 specific areas of Vonshelle's body were normal or abnormal. The notations from the physical exam recorded no lesions, discharge, or inflammation in the areas of the vulva, vagina,

---

[2] WebMD, *Herpes Simplex: Herpes Type 1 and 2,* http://www.webmd.com/genital-herpes/pain-management-herpes#1; Center for Disease Control and Prevention, *2015 Sexually Transmitted Diseases Treatment Guidelines, Genital HSV Infections*, available at https://www.cdc.gov/std/tg2015/herpes.htm; World Health Organization, *Herpes simplex virus*, available at http://www.who.int/mediacentre/factsheets/fs400/en/; Mayo Clinic, *Genital herpes*, available at http://www.mayoclinic.org/diseases-conditions/genital-herpes/basics/complications/con-20020893; Johns Hopkins Medicine, *Herpes Meningoencephalitis*, available at http://www.hopkinsmedicine.org/healthlibrary/conditions/adult/nervous_system_disorders/herpes_meningoencephalitis_134,27/.

[3] The American College of Obstetricians and Gynecologists, ACOG Practice Bulletin, Clinical Management Guidelines for Obstetrician-Gynecologists, *Management of Herpes in Pregnancy*, Number 82, June 2007.

[4] The Prenatal History indicates that Vonshelle acknowledged smoking 4 cigarettes per day for about 2 years and noted "daily" drug use/abuse for about 3 years, and drinking socially for about 1 year, but stated that she did not participate with tobacco, drugs, or alcohol when pregnant.

[5] The Pap test, or Pap smear, is a screening, not a diagnostic test, in which cells are scraped from the cervix and sent to a lab for testing to determine if abnormal cells are present that could lead to cancer. Deposition testimony from medical professionals in the case and The American College of Obstetricians and Gynecologists, *Frequently Asked Questions*, available at http://www.acog.org/Patients/FAQs/Cervical-Cancer-Screening#cervical.

or cervix. She checked that each of the specific areas was normal. In her deposition, Ms. Cruz-Hunter testified that she did not see any indication of any lesions or any signs or symptoms that suggested the presence of the herpes simplex virus. The urine test performed on Vonshelle that day was negative and showed that her urine was "perfectly normal." She noted that Vonshelle's uterus size indicated that she was 8-10 weeks pregnant. The Pap test used to screen for precancers was sent to Quest Diagnostics for interpretation.

Pap Test Results from Quest Diagnostics

On March 22, 2010, Quest Diagnostics reported that the patient was 9 weeks pregnant[6] and that the Pap test culture was satisfactory for evaluation. In the category titled "Interpretation/Result" the report stated:

"Negative for intraepithelial lesion or malignancy.
Cellular changes consistent with Herpes simplex virus
Shift in vaginal flora suggestive of bacterial vaginosis."

Under the comment section, the following cryptic and ambiguous phrase was noted: "Queued for Alerts call." No deposition testimony of any Quest pathologist was submitted to clarify what Quest meant by this ambiguous notation or if Quest made a call to the Brevard County Health Department alerting them to this observation. Accordingly, it is unclear if this phrase meant that Quest was indicating that someone in its office would call the clinician to alert them to this additional observation, given that someone at Quest was commenting on an issue outside the scope of the initial test for precancer or pre-malignancy.

Brevard County Health Department's Lab Slip Tracking Policy

The Claimant attached, as an exhibit to Nurse Regina Pappagallo's deposition, the cover page for the Brevard County Health Department Tracking Policy, dated 07-10-06, which did not contain the terms of the policy. The Claimant also attached the Brevard County Health Department Tracking [Policy for] Lab Slips and Missed Appointments, dated 7/15/10,[7] which contained the policy's contents. This

[6] This was Vonshelle's third pregnancy, which would be followed by two additional pregnancies. None of the other four pregnancies involved herpes simplex virus issues or injuries.
[7] The date of "7/15/10" is almost 4 months after Vonshelle visited the Brevard County Health Department. It is unclear if this policy was also in place when she visited the Department for her initial pregnancy exam.

policy explains what the staff members are to do when they receive the result of lab tests, like the results of Vonshelle's Pap test.

The policy for reviewing lab slips was a two-step process, and how the second step was to be completed depended on whether the lab test results were positive or negative. The first step in the policy required that a nurse review and initial the incoming lab slip. The second step required the medical staff to file the slip in the client's medical record if the results were negative, or pull the slip and give it to a nurse/clinician for additional orders if the results were positive. Under the policy, all abnormal slips needed to be signed by a clinician. The nurse would then determine how the client was to be contacted about the positive results–whether by the health support technician or nurse and whether by a letter or phone call. Someone was then required to make three documented attempts to reach the client. The Sr. CHN Supervisor[8] or designee was to determine if there were a need to send a certified letter. The policy also established the procedure for notating when a client failed to make an appointment.

The Quest Diagnostic lab report for Vonshelle was initialed by Nurse Pappagallo in the upper right hand corner, as required. A checkmark was placed at the end of the phrase "Negative for intraepithelial lesion of malignancy" indicating that the diagnosis was reviewed. Accordingly, the Pap test lab slip was negative for a malignancy, so it was placed in Vonshelle's medical records, in compliance with the policy. The purpose of the test was to determine the existence of precancerous cells, not herpes or another sexually transmitted disease. Among Vonshelle's additional medical records, labeled "Laboratory Results" and the category of Pap Test, it is recorded "3/16/10" and the word "normal" is circled. If the results had been abnormal, or positive for a malignancy, the records should have been pulled by the medical records staff and given to the nurse/clinician for possible orders and the nurse would have determined the type of contact with the patient that was appropriate.

What is confusing in this case but important to the issue of liability is the meaning of the unusual and added verbiage stating, "Cellular changes consistent with Herpes simplex

[8] It is unclear what this designation means.

virus." This is apparently an unusual notation to be placed on a Pap test result. According to the deposition testimony of Nurse Pappagallo, she had never seen this writing on another Pap smear; it was the first time she had ever seen this notation. Dr. Mark Sargent, the Brevard County Health Department physician who was Vonshelle's obstetrician, testified that he had "never even heard of this result on a pap smear . . . it's not even supposed to be on a pap smear and I've never seen it on a pap smear." He said that he did not know if the nurse was confused by the remark, because it was so unusual, but if he had seen the notation he would have certainly pursued it.

Additionally, there is no evidence in the record to demonstrate that Quest Diagnostic contacted the Clinic as suggested by the phrase "Queued for Alerts call." Further, Quest's lab results did not state whether herpes simplex virus type 1 or type 2 might be indicated.

No additional tests were performed by the Brevard County Health Department during the pregnancy to determine whether Vonshelle was infected with the herpes virus. Additionally, there is no documentation in the medical records that Vonshelle complained to the medical staff or requested prescriptions to alleviate the common symptoms of the herpes simplex virus.

The Pregnancy

According to the medical records, the pregnancy was not without complications and Vonshelle did not consistently comply with medical advice. Vonshelle had low amniotic fluid, which can be dangerous for the baby. She was admitted to the hospital for a 3-day stay in September to monitor pre-term contractions and preterm labor at 31 weeks. She was advised to stay 3 days and increase her fluids. Vonshelle left the hospital 1 day early, against the doctor's recommendation. She was given multiple sonograms throughout the pregnancy to monitor the level of amniotic fluid.

Because she had given birth prematurely in two earlier pregnancies, Vonshelle was given a prescription of progesterone to help reduce the risk of early labor.[9] The

[9] In his deposition, Dr. Mark Sargent testified that he gave the nurse a progesterone prescription for Vonshelle on August 12, but Vonshelle later denied ever having it. He wrote another prescription for progesterone on August 26, and handed the prescription to Vonshelle. Dr. Sargent had someone call Vonshelle on August 30 to follow up

medical notes indicate that she smoked cigarettes and declined Quitline[10] at her initial visit and stated that she could quit smoking on her own.[11]

Delivery

On October 14, 2010, an ultrasound and non-stress test were performed on Vonshelle. Because of the stress test results and decreased fetal movement, she was admitted to the labor and delivery unit at Wuesthoff Memorial Hospital in Melbourne and labor was induced. Vonshelle gave birth by vaginal delivery to Iyonna Hughey that night at 36 weeks and 4 days gestation.

On October 16, 2010, Vonshelle and Iyonna were discharged 2 days later, both in good condition. In her deposition testimony, Vonshelle stated that at the time of Iyonna's delivery she did not have any lesions or sores on her vagina or elsewhere on her body. This was confirmed by Dr. Mark Sargent, the delivering doctor, who stated that Vonshelle never indicated any lesions either pre-pregnancy, early pregnancy, or during the labor and delivery process. He noted that other than the "spurious finding on the pap smear, there is no indication that she ever had herpes."

Vonshelle returned with Iyonna to her home where her two older daughters were living and another woman, Cynthia Retland. It is unclear if Cynthia Retland's sons were also living in the home at that time.

Emergency Room Visit

On October 31, 2010, at about 11:00 p.m., Vonshelle took Iyonna to the emergency room at Wuesthoff because Iyonna had a fever, was lethargic and pale, was not eating, and was sleeping a lot. She stated in her deposition that the fever may have been present for a couple of days. Vonshelle stated that

---

to make certain that the prescription was filled, but Vonshelle said she was unable to fill the prescription. Vonshelle did not show for her next appointment, and it is unclear when she actually began taking the progesterone.

[10] Quitline is a tobacco cessation service that supplies nicotine replacement therapy at no cost to the participants. http://c.ymcdn.com/sites/www.naquitline.org/resource/resmgr/ppp/fl_bureau_of_tobacco_prevent.pdf.

[11] Smoking during pregnancy can cause problems with the placenta and reduce a baby's food and oxygen. Smoking is known to increase the risk that a baby will be born prematurely or have a low birth weight. This increases the likelihood that the baby will be sick and require a longer hospitalization. See Centers for Disease Control and Prevention, Reproductive Health, *Tobacco Use and Pregnancy*, available at https://www.cdc.gov/reproductivehealth/maternalinfanthealth/tobaccousepregnancy/index.htm.

her mother kept saying that night that something was not right with Iyonna, and she was pale.

Vonshelle's deposition states that she signed in and spoke with a nurse in the front area of the waiting room. She estimates that she was in the waiting room for a total of about 30 minutes during which she spoke with a nurse for about 10 minutes. Vonshelle said that the nurse told her that the way Iyonna was behaving was "what newborns do, they sleep." Vonshelle stated that the nurse told her to take a cold rag and rub it over Iyonna's body and see if that would wake her. Vonshelle stated that the nurse told her to go home and come back in the morning if something was not right. Vonshelle left the emergency room and did not wait for her name to be called to see medical personnel. She stated that she thought, "maybe we are just overreacting. So, we left."

Vonshelle stated that she did not tell the nurse that Iyonna was lethargic or had a fever. Vonshelle added that she really thought nothing was wrong. She took Iyonna home, and both slept through the night from about midnight until 7:00 a.m.

Wuesthoff Memorial Hospital
On November 1, the next morning, when Vonshelle woke, she noticed that Iyonna was not responsive, her eyes were rolling back in her head, her lips were dark, she would not eat, and her breathing was shallow. Vonshelle called her mother who came and drove them to the Wuesthoff Hospital. She did not call 911.

Transfer to Arnold Palmer Hospital
The staff at Wuesthoff performed a lumbar puncture on Iyonna and drew spinal fluid. She was transferred to Arnold Palmer Hospital for Children in Orlando for further evaluation and care. The lumbar puncture was repeated and the results came back positive for herpes simplex virus type 2. Iyonna was diagnosed with herpes meningoencephalitis, meaning that her brain tissue was infected. She remained at Arnold Palmer for 36 days, from November 1, 2010 until her discharge on December 6, 2010. While at the hospital, Iyonna was treated intravenously with acyclovir for 21 days, to stop the viral growth, followed by oral acyclovir for suppressive therapy. She was fed through a gastric tube and was on a ventilator.

Iyonna's Injuries and Disabilities

The viral infection caused severe brain damage and neurological disabilities that impair Iyonna's ability to develop and function as a normal child. This was caused by the herpes simplex virus type 2. At the time of the special master hearing Iyonna spoke only about 20 words, could feed herself, but could not walk independently or bathe herself, and wore diapers each day. She was in kindergarten in a special needs program at Palm Bay Elementary. Iyonna rode a special needs school bus to and from school each day. She had a walker and wheelchair at school for mobility. She enjoyed playing games on a tablet, coloring, and watching television. The professionals who have observed Iyonna believe that she is going to need continuous care throughout her lifetime and will never be able to live or function independently due to the brain damage she received from the herpes meningoencephalitis.

Subsequent Herpes Tests

Vonshelle returned to the Brevard County Health Department for a subsequent pregnancy test in 2014, almost 4 years after Iyonna's birth. She did not alert the Health Department that she might be carrying the herpes virus, which allegedly caused the severe brain damage to Iyonna. If Vonshelle believed she had herpes, one would have expected her to disclose this information to the Department in order to protect her next child from the virus and the potential for brain damage. However, the Department recognized Vonshelle's name because of the ongoing litigation and tested her for herpes to determine if an anti-viral medication needed to be prescribed to prevent the fetus from getting the disease.

Blood was drawn from Vonshelle on August 1, 2014, for two separate HerpeSelect tests[12] and sent to different labs. The first blood sample was collected on August 1, 2014, and tested by Health Management System. The second blood sample was collected a few minutes later and tested by Quest Diagnostics. Both tests were negative for HSV-1 and HSV-2.[13]

[12] According to a website, the HerpeSelect test "is the most commonly used HSV antibody test in the U.S." The test can detect antibodies and differentiate between HSV-1 and HSV-2. It generally takes about 3-6 weeks for someone to develop a detectable amount of antibodies to the herpes simplex virus. Most everyone will have detectable antibodies 16 weeks after exposure. http://www.healthassist.net/medical/herpes-test.shtml

[13] There is a third DOH hsv test result in the records, apart from the two tests discussed above, which shows that more blood was drawn from Vonshelle on August 4, 2014, and sent to Quest Diagnostics. This was also initiated

On November 20, 2014, Vonshelle's attorneys initiated a third, and different type, of herpes test on Vonshelle. Blood was collected in Florida for an HSV Western Blot test[14] and sent overnight to the University of Washington Medical Center in Washington state. That test found that Vonshelle had been exposed to HSV-1, but was "indeterminate" for antibodies to HSV-2. No additional Western Blot tests were performed to clarify the results. The Claimant's attorneys did not reveal this test to the Brevard County Health Department during discovery claiming it was protected under the Claimant's work product privilege. Because the attorneys for the Department were unaware of the test's existence, they did not question any experts on the Western Blot's credibility or reliability.

Not one of the three blood tests performed on Vonshelle has demonstrated that she was exposed to herpes simplex virus, type 2.

LITIGATION HISTORY:

Litigation
Vonshelle Brothers filed a medical malpractice suit, individually and on behalf of her daughter, Iyonna Hughey, a minor, against the Brevard County Health Department on October 9, 2012. The suit was filed in the Circuit Court of the Eighteenth Judicial Circuit in and for Brevard County. The Brevard County Health Department is a division of the Florida Department of Health, an agency of the State of Florida. An extensive period of discovery ensued, and depositions were taken in 2014, 2015, and 2016.

Mediation
The parties attempted to mediate the case on February 10, 2015, but were not able to reach a settlement.

Settlement
The trial was scheduled to begin April 25, 2016. Approximately 1 week before the trial, the parties reached their first of two settlement agreements. The Department of

by DOH. The results were again negative for HSV type-1 and HSV type-2. The expert witness depositions seem to discuss only two tests initiated by the Department of Health, so the presence of this third hsv test, although present in the submitted records, does not appear to be mentioned in the depositions. Because the Department of Health did not present a case at the claim bill hearing, this third DOH test, nor any of their theories, were argued at the hearing.

[14] In the last paragraph of the HSV Western Blot test results two sentences are printed: "This test was developed and its performance characteristics determined by UW Medicine, Department of Laboratory Medicine. *It has not been cleared or approved by the U.S. Food and Drug Administration*." (Emphasis added.)

Health agreed to pay the statutory cap of $200,000, and the Claimant would pursue a claim bill for the excess amount of $3 million. However, the Department maintained the right to contest the claim bill during the legislative process.

The Department then paid the $200,000, the maximum amount that may be paid without legislative authority which was disbursed as follows:

$101,841.41	Litigation Expenses Paid to Plaintiff's Law Firm
$7,560.58	Payment of Medical Liens
$50,000.00	Purchase of Annuity for Iyonna Hughey[15]
$40,698.01	Disbursement to Vonshelle Brothers
$200,000.00	

As of the date of the special master hearing, the Claimant's law firm had not received any fees for its legal work, only reimbursements for costs. An additional $71.19 is due the firm for interest accrued.

The Claimant's attorneys later offered to reduce the claim to $1 million if the Department would not contest the claim bill. The Department accepted this offer and has agreed to maintain a neutral position on the claim bill, but it has not admitted liability.

Claim Bill Hearing

On February 24, 2017, a lengthy, almost day-long hearing was held before the House and Senate special masters. Ronald Gilbert and Jonathan Gilbert appeared with their clients, Vonshelle Brothers and Iyonna Hughey. Patrick Reynolds, Chief Legal Counsel for the Department, Michael J. Williams, Assistant General Counsel, and Maria Stahl, Health Officer for Brevard County, appeared for the Department of Health. Because the Department agreed that it would not oppose the claim bill, it did not present any theories, arguments, or evidence on the Department's behalf. However, the Department did provide documentation in response to specific requests by the special masters. The Department did not admit fault in this claim.

[15] The annuity will begin making payments to Iyonna Hughey when she is 18 years old. As the annuity is structured, Iyonna will receive annual income of $2,500 per year for 5 years when she turns 18, $3,500 per year for 5 years when she turns 23, $4,500 per year for 5 years when she turns 28, $5,500 per year for 5 years when she turns 33, and lump sum annual disbursements of $6,500 payable at ages 38, 39, and 40, then $3,825.85 when she is 41, for a total lifetime yield of $103,325.85.

CLAIMANT'S POSITION: Vonshelle Brothers' position is that the Brevard County Health Department was negligent and did not meet the standard of care when reviewing her Pap test. Her argument then follows that, if the lab slip had been properly reviewed, additional testing would have revealed that Vonshelle carried the herpes virus. A proper course of treatment could have then prevented Iyonna from contracting the herpes virus, suffering herpetic encephalitis, and sustaining substantial brain damage.

RESPONDENT'S POSITION: While the Respondent did not present a case at the special master hearing, a review of the depositions taken over the course of discovery in this case reveals what its arguments might have been. Based upon the depositions of expert witnesses, the Department was likely preparing to argue that Vonshelle did not have the herpes virus and therefore, could not have transmitted the virus to Iyonna during the pregnancy or delivery.

An alternative theory might have been that Vonshelle contributed to Iyonna's damage by transmitting the herpes virus to her. Additionally, it might have been argued, that Vonshelle did not seek timely medical attention when severe symptoms were apparent on the night that she left the emergency room without seeing a doctor, thereby delaying treatment for Iyonna by 7 or 8 hours. Prompt treatment for Iyonna might have prevented or mitigated her brain damage.

A case might also have been built on missed opportunities by Vonshelle. She missed many obstetrical appointments and apparently did not fill an initial progesterone prescription to prevent early labor, which required that a second prescription be written for her, thus causing the medicine to be taken later. Iyonna missed many appointments for speech therapy, physical therapy, occupational therapy, and Vonshelle chose not to acquire a wheelchair that was prescribed for Iyonna because she did not want people to see Iyonna in a wheelchair. It was questioned whether she made a diligent effort to enroll Iyonna in school as early as she could have.

CONCLUSIONS OF LAW: The Brevard County Health Department, a department of the Florida Department of Health, is an agency of the State of Florida. Under the legal doctrine of *respondeat superior*, the Department is liable for its employees' wrongful acts, or medical negligence, committed within the scope of their employment.

When a plaintiff seeks to recover damages for a personal injury and alleges that the injury resulted from the negligence of a health care provider, the plaintiff bears the legal burden of proving, by the greater weight of the evidence, that the alleged actions of the health care provider were a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care is defined in statute as "that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers."[16] The standard of care is established at trial by providing expert testimony from professionals in that field.

To establish liability in a medical malpractice action, the plaintiff must prove:
(1) A duty of care owed by the healthcare provider to the injured party;
(2) A breach of that duty;
(3) Causation--that the breach of the duty caused the plaintiff's injury;[17] and
(4) Damages.

In this case, the Department's liability turns on whether the Department breached a duty and whether it caused Iyonna's damages. To express these legal principles in the factual context of this case, the issues are whether the Department should have tested Vonshelle Brothers for the herpes simplex virus, and whether that testing would have led to treatment that could have prevented Iyonna Hughey from acquiring meningoencephalitis, which caused her brain damage.

These elements as outlined below are based upon depositions, testimony, and other information provided before and during the special master hearing. Medical malpractice cases generally "involve a battle of expert witnesses."[18] This claim is no exception. The parties deposed medical experts in several cities in Florida, Atlanta, New York City, and Michigan to support their cases.

[16] Section 766.102(1), F.S.
[17] *Saunders v. Dickens*, 151 So. 3d 434, 441 (Fla. 2014).
[18] *Id.*

Duty
As discussed above, a health care facility and its employees have a duty to provide a professional standard of care to its patients that is recognized as acceptable and appropriate by reasonably prudent similar health care providers.[19] The issue of whether the Brevard County Health Department owed a duty to Vonshelle Brothers is not contested in this case. The duty was owed.

Breach of Duty
If this case had proceeded to trial, it would likely have been disputed whether the duty of care owed to Vonshelle Brothers and Iyonna Hughey was breached. Three areas of a potential breach were identified:

(1) Whether the Department breached the standard of care when it received and filed the Pap test lab results in Vonshelle's medical records and did not have a clinician review the results or pursue additional testing to determine if she carried the herpes virus.

(2) Whether the Health Department breached its duty by not starting Vonshelle on a regimen of anti-viral medicines that would have suppressed the alleged hsv in her body, thereby preventing her from passing the disease to Iyonna during the birth process.

(3) Whether an anti-viral medicine should have been given to Vonshelle and when it should have been given because of her history of delivering two earlier babies before full-term gestation at 40 weeks.[20]

Based upon the deposition testimony of medical experts, each side would have had arguments to support its case before a jury.

The Claimant's Arguments
The Claimant provided experts who testified in depositions that the Brevard County Health Department breached the duty of care owed to Vonshelle.

[19] Section 766.102(1), F.S.
[20] Authoritative medical literature and expert witness medical testimony suggest waiting until the 36th week of pregnancy to begin an anti-viral medicine for the mother.

Dr. Berto Lopez

Dr. Berto Lopez, a medical doctor practicing in obstetrics and gynecology, testified as a standard of care expert. He stated that he personally reads the results of all Pap smears that he orders and that Dr. Mark Sargent, Vonshelle's obstetrician at the Brevard County Health Department, should have read the results himself rather than allowing a subordinate on staff to read the results. In his opinion, this was a breach of the standard of care. Regarding the issues of initiating an anti-viral medicine and when the anti-viral should be initiated, he stated that he generally starts women on an anti-viral drug early in the pregnancy. To prevent the passage of the disease to the baby at birth, he does not wait until 36 weeks to begin suppression therapy.

Nurse Sharon Hall

Sharon Hall[21] testified in her deposition about the nursing standard of care at the Brevard County Health Department. Nurse Hall is an obstetrical nurse who formerly practiced in high-risk labor and delivery. She stated that it was a deviation from the standard of care when the Department nurse did not report to Dr. Sargent the changes that were observed in the Pap smear report.

The Respondent's Arguments

Perhaps the Respondent's theory would have been that the added phrase "Cellular changes consistent with Herpes simplex virus" was so out of place on a Pap test report that it did not actually alert the nurse to notify a clinician. Because the test was negative for precancers, she technically complied with the policy for handling negative lab slips.

Dr. Mark Sargent

Dr. Mark Sargent, Vonshelle's treating obstetrician, stated in his deposition that he felt the findings should have been reported to him, but that he had "never even heard of this result on a Pap smear. It's not even – it's not even supposed to be on a pap smear and I've never seen it on a pap smear….I would have expected, had I seen it, I would have certainly pursued it." Dr. Sargent said that he would have expected the nurse to bring this report to someone's attention.

[21] Sharon Hall is an obstetrical nurse with approximately 30 years of experience. She earned a bachelor's degree in nursing and a master's degree and is certified in inpatient obstetric care and electronic fetal monitoring.

Dr. David Colombo

Dr. David Colombo was also deposed as a defense expert witness for the Department. He is a practicing physician in obstetrics and gynecology and maternal fetal medicine.[22] He stated in his deposition that he believed that Dr. Sargent deviated from the standard of care by not personally reviewing the Pap test results. However, as will be discussed later, he did not believe that this deviation caused any damage.

Conclusion

Accordingly, I find that the Brevard County Health Department deviated from the acceptable standard of care owed to Vonshelle Brothers by not having a clinician review the results of the Pap test that was ordered by a nurse midwife.[23]

Causation

If this case had proceeded to trial, it would likely have been disputed whether the damage to Iyonna was actually caused by the negligence of the employees of the Brevard County Health Department. The Claimant argues that the failure of the Brevard County Health Department to discover whether Vonshelle had herpes, and its subsequent failure to provide her with anti-viral medication that would have prevented her from passing the herpes virus to Iyonna at birth, is the cause of Iyonna's injuries. It is undisputed that Iyonna contracted HSV-2, which caused her brain damage. Whether she contracted the disease from her mother at birth is not so clear.

The Claimant's Arguments

Dr. Berto Lopez

Dr. Berto Lopez, an expert witness for the claimant, testified that, upon receiving and reviewing Vonshelle's Pap smear lab slip, he would have given her extra tests to determine whether she had herpes. He would have given her anti-viral medication early in the pregnancy and would not have waited until she was 36 weeks pregnant. He believed that there was

[22] Dr. Colombo is a former clinical assistant professor of maternal fetal medicine at the Ohio State University hospitals and associate professor of obstetrics and gynecology and maternal fetal medicine at Michigan State University.

[23] The Brevard County Health Department instituted a new policy for reviewing lab slips, on or around August 2015, according to an affidavit submitted by Maria Stahl, the Administrator for the Brevard County Health Department. The ordering clinician must review and acknowledge the laboratory results, in addition to the review performed by the assigned nursing staff. The laboratory review process is reviewed at all new employee orientations for the Brevard County Health Department.

no harm in giving the anti-viral medication to Vonshelle early, but that there could be tremendous harm to the baby if the medication were not given.

Dr. Fred Gonzalez

Dr. Fred Gonzalez, a board certified perinatologist[24] or maternal fetal medicine specialist, practicing in New York City, was another expert witness for the claimant. He also testified that when he has a pregnant patient with a recurrent herpes infection and she has not had an outbreak in the last year, he puts her on an anti-viral drug for suppression therapy at 36 weeks. He then lets the pediatrician or neonatologist know that the mother has a history of herpes. According to Dr. Gonzalez, the mother's primary outbreak is the most dangerous to the baby. When asked if he recommended beginning anti-viral therapy earlier than 36 weeks for someone with previous pre-term births at 35 or 36 weeks, he said he did not. If a mother has herpes symptoms or a lesion at the time of delivery, the treatment is to do a Caesarean section.

Dr. Catherine Lamprecht

Dr. Catherine Lamprecht, a pediatric infectious disease specialist for the claimant, treated Iyonna at Arnold Palmer Hospital for Children. She testified that she could say with medical certainty that Iyonna was exposed to hsv and suffered meningoencephalitis as a result. Dr. Lamprecht was asked in her deposition if she was an expert in the prenatal care of a mother with herpes who was about to give birth. She stated that she did not consider herself an expert in that area. Dr. Lamprecht said that she could not give a medical expert opinion as to whether Vonshelle had herpes.

Respondent's Arguments

Dr. Mark Sargent

Diagnosing Herpes In Pregnant Women

Dr. Mark Sargent, Vonshelle's treating obstetrician, testified in his deposition that he had dealt with approximately 10,000 patients in his obstetrical career of which "a couple hundred" were pregnant women having confirmed cases of herpes simplex virus.

[24] Perinatology is a subspecialty within the field of obstetrics and gynecology. It focuses on high-risk, complicated pregnancies. Perinatology is also referred to as maternal-fetal medicine. http://www.perinatologist.net/

When asked how he confirms that a pregnant woman has herpes, Dr. Sargent responded that, if the woman has been diagnosed with herpes or told of it and treated for it, that is the first way. If the patient tells him that she has a lesion in the vaginal area or vulva, he cultures the lesion, sends it to a lab, and if it comes back positive, that is definitive. A third way, which is less definitive, is a blood test to determine the presence of herpes antibodies, because it means that a patient has been exposed to herpes.

Sores or Boils

Later in the deposition, Dr. Sargent discussed Vonshelle's claim that she had boils. Vonshelle stated that she had a sore under her arm and in the area of the crease in her leg near the vaginal area during the pregnancy. She described the sores to be boils about the size of a penny. When asked if this could be characteristic of a herpes lesion, Dr. Sargent said "No" and that boils are not cratered lesions characteristic of herpes. Moreover, Dr. Sargent testified that there was nothing in the medical records that indicated that Vonshelle had any boils during her pregnancy. He said that he would have examined those areas and the information would have been in Vonshelle's medical records if he had been notified, but there was nothing in her records about boils.

Standard of Care and Suppression Therapy

When asked what Dr. Sargent would have done if the Quest Pap test lab report had been brought to his attention, he replied that he would have gotten a second opinion about starting an anti-viral medicine on a baby in the first trimester. He does not order acyclovir, an anti-viral prescription that suppresses herpes, in the first trimester, but waits until the last trimester, at approximately 34 or 36 weeks, if the mother has a history of herpes. He stated that it is too late to treat a mother with acyclovir during the birthing process because it would not be helpful to her, the mother. Additionally, a Caesarean section was never recommended for Vonshelle because they were not aware that she had herpes.

Dr. Sargent testified that treating the mother at 34 to 36 weeks with acyclovir does not protect the baby and because Vonshelle delivered Iyonna at 36 weeks, the medicine would not have been in Vonshelle's system long enough to help the baby. He stated that the medical recommendation is that the

drug needs to be administered for 4 to 6 weeks before it is helpful.

When asked if Iyonna likely contracted herpes during the birthing process, Dr. Sargent responded, "No." He said that he really did not know when the transmission of the disease likely occurred, and commented that the case was very odd.[25]

Dr. Keith Van Dyke

Herpes Testing

Dr. Keith Van Dyke was also deposed as a defense expert witness. At the time of his deposition, he was a practicing gynecologist who had worked in high risk obstetrics. He stated that he had never had a patient who tested positive for hsv on a Pap test.

Whether Vonshelle Had the Herpes Simplex Virus

Dr. Van Dyke stated that Vonshelle "has never had herpes based on her lab test from 2014." He noted that Vonshelle took a blood serum test and the results test were negative.

Dr. Van Dyke was asked to comment on conclusions made by Dr. Lamprecht, the infectious disease specialist practicing at Arnold Palmer Hospital for Children. Dr. Lamprecht concluded that Iyonna contracted hsv during the vaginal birth. Dr. Van Dyke stated that Dr. Lamprecht was wrong to conclude that Iyonna was exposed to hsv during the vaginal delivery. He based this on the fact that Vonshelle tested negative for herpes.

When asked if false-negatives could occur, he responded that it is possible if the herpes test is performed on someone soon after the virus is transmitted to them. This is because the particular anti-body had not been around long enough in the body to register. However, Dr. Van Dyke said that he was not aware of any false negative tests in the literature he reviewed. When asked if Vonshelle could have had a false negative for the hsv test, Dr. Van Dyke stated, "I would think not."

Iyonna's Acquisition of Herpes

When asked his opinion of how Iyonna acquired the herpes simplex virus, Dr. Van Dyke stated, "I can only suppose that

[25] At the time of Dr. Sargent's deposition on March 13, 2014, Vonshelle had not been tested for herpes. The multiple HerpeSelect tests were not taken until almost 5 months later, in August 2014. It was then that people became aware that she did not have the herpes type 2 virus.

the baby acquired it after delivery." The follow up question was asked if there were any possibility that the baby would have acquired the virus before labor and delivery and he responded, "No."

Herpes Incubation Period
During Dr. Van Dyke's deposition, the issue was raised about the length of an incubation period for the herpes simplex virus. Dr. Van Dyke stated that generally, the incubation period before lesions appear is 2 to 12 days or so after exposure.

Validity of HSV Test
Dr. Van Dyke placed more validity on the negative hsv test than on the Pap test report which stated "cellular change consistent with herpes simplex virus." He explained his reasoning as being that the blood serology test, or the test that was performed on Vonshelle in 2014 after Iyonna's birth in 2010, is an antibody test, and if someone has been exposed to the herpes virus, the person will remain positive for antibodies for his or her lifetime. He said that this holds true if it was a blood sample test, regardless of the location of where the blood was drawn or the amount of blood that was drawn.

Dr. Van Dyke stated that, in his opinion, other than when the test was performed during the early stage of an initial or primary herpes outbreak, a negative result would be 100 percent confirmation that the patient had never had herpes.

Suppression Therapy
Dr. Van Dyke relies on the American Congress of Obstetrics and Gynecology's publication, the Herpes Management in Pregnancy document, published in 2007 and reaffirmed in 2014. It states that suppression therapy for herpes should begin at 36 weeks. He found the bulletin to be authoritative and follows its guidelines for suppression therapy.

Dr. Van Dyke was asked about suppression therapy for hsv and using a daily therapy drug such as acyclovir or Valtrex to prevent recurrences of herpes outbreaks, and whether that would affect the results of an antibody hsv test. He stated suppression therapy would not affect those test results because "antibodies" are for life and that "They don't go away."

When asked if he would have begun a regimen of suppression therapy based upon the Pap test results, he responded that it would not have been appropriate to initiate suppression therapy without a diagnosis of hsv with a serum blood test. He stated, once again, that Vonshelle did not have a diagnosis of herpes simplex, and in his opinion, because Vonshelle never had herpes, it would not matter. He noted that it is not good practice to give medicine for no reason. Dr. Van Dyke expounded that suppression therapy is a treatment for a known disease. He stated that suppression will decrease outbreaks, but some of his patients on daily suppression still get outbreaks of herpes. Unless it is a primary outbreak during pregnancy, suppression is used for recurrences at 36 weeks and up.

Standard of Care

When asked whether the handling of Vonshelle's Pap test met the standard of care, Dr. Van Dyke responded that he did not think there was a standard of care on this particular Pap test because it was so unusual. He said, "It's got to be rare because I've never seen one. I wouldn't know that there would be a standard." He noted that the Pap test result did not say "diagnostic of" herpes, and suggested that there are other possibilities that might not always be true, such as other infections. He concluded that the Pap test results did not need to be communicated to Vonshelle because the results were negative for what it was tested for, cervical disease, dysplasia, and malignancy.

Dr. Van Dyke also stated that the pathologist's notation about cellular changes did not make any distinction between herpes-1 and herpes-2. He stated, once again, that note on the Pap smear lab slip is odd and extremely rare and he could not say what the standard of care would be for it.

He further stated that a Pap test is not diagnostic of herpes.

Transmission from Mother to Baby

When asked his theories of how a baby could acquire HSV-2 after birth, Dr. Van Dyke said that if someone had lesions in his or her mouth, he or she could shed the virus through saliva. If someone has active herpes or lesions on their genitals and they touch themselves and then touch the baby, that is a possible way to transmit the virus as well. "So, kissing, touching."

In summary, when Dr. Van Dyke was asked if it was his opinion that the baby absolutely did not acquire hsv from the mother during vaginal birth but rather was exposed to the herpes simplex virus after birth by someone other than the mother, he replied, "Correct."

Dr. David Columbo

Dr. David Columbo was also deposed as a defense expert witness. He is board certified in obstetrics and gynecology and maternal fetal medicine.[26] He regularly addresses the prevention of neonatal herpes in his maternal fetal medicine practice.

Impact of Previous Pre-term Births on this Pregnancy

When asked if Vonshelle's two earlier pre-term births were important to the issues in this case, Dr. Columbo stated, "No." He said that he would not have done anything differently than what Dr. Sargent did in treating Vonshelle in 2010.

He agreed with the American Congress of Obstetrics and Gynecology's guidelines for maternal fetal medicine. Those guidelines recommend beginning an anti-viral medicine at 36 weeks, and he found those guidelines to be reliable and well thought out. This opinion is in direct conflict with the testimony offered by the Claimant's medical expert, Dr. Berto Lopez.

Whether Vonshelle had the Herpes Simplex Virus

Dr. Colombo commented on the testimony of Dr. Lamprecht, the pediatric infectious disease specialist. He stated that her testimony was actually very good but her conclusion was wrong when she was asked about the pathology results showing cellular changes consistent with herpes. He also said that Dr. Lamprecht was wrong to conclude that Vonshelle had hsv during her pregnancy. When asked to elaborate, he said that Vonshelle Brothers did not have hsv during her pregnancy. He based that opinion upon the 2014 test results of the antibody screen for HSV-1 and HSV-2, after the 2010 pregnancy. Those test results show that it was impossible for her to have had hsv during her pregnancy.

[26] Dr. Colombo served as a clinical assistant professor of maternal fetal medicine at the Ohio State University hospital system and at the time of the deposition was an associate professor at Michigan State University in obstetrics and gynecology and maternal fetal medicine.

Dr. Colombo expounded on the pathology notation about changes consistent with herpes. He said that the pathologist saw a multinucleated giant cell with inclusions in the nucleus that were not specific for herpes. At that point, he felt that it was the obstetrician's job to do an antibody screen to see if Vonshelle actually had herpes or if it were due to another cause. The fact that the obstetrician did not follow up then was not an issue because the fact that the tests were negative years later meant that the results would have been negative at the time that the Pap smear was done in 2010.

He felt that the pathologist was correct to say that he saw those type of cells, but those types of cells could also be human papilloma virus, chronic inflammation, or a lot of things that can give that appearance. He felt that the pathologist was unable to distinguish between herpes simplex virus and other viruses or infections at that point. Dr. Colombo felt that the pathologist made an incorrect assumption that the cells were herpes simplex virus.

The Method of Transmission to Iyonna
Dr. Colombo believed that Dr. Lamprecht actually gave the method of Iyonna's transmission in her deposition when she related the story of someone with a cold sore kissing a baby. He concluded that what happened to Iyonna was either "in the nursery or a family member, somebody with herpes contacted this child shortly after delivery and transmitted the herpes virus then." He stated, "But the mom didn't have it. So it had to be that other two percent where somebody else gave it to the kid shortly after delivery."

Standard of Care
Dr. Colombo felt that Dr. Sargent deviated from the standard of care by failing to review the lab report. However, because the mistake did not result in any damage, the mistake is less relevant. He found no causal connection between the deviation in the standard of care and the resulting damages.

Suppression Therapy
If he had received a positive antibody screen on Vonshelle, he would have offered acyclovir at 36 weeks. He would not have started it any sooner even though she had two pregnancies that delivered at 32 and 36 weeks.

Dr. Colombo stated that, if a mother has antibodies and a recurrent infection, the risk of transmitting herpes to the baby is about 1 in 4,000. Some people have a reaction or side effects to acyclovir or Valtrex which could be catastrophic, even fatal. He did not think that giving the medicines in a timely manner would prevent herpetic meningoencephalitis, but would decrease the risk of herpetic meningoencephalitis.

Dr. Colombo said that the HSV-2 antibody test used in 2014 for determining whether Vonshelle had herpes is a very good test.

Source of Transmission of HSV to Iyonna
Dr. Colombo testified that the virus likely came from a well-meaning relative who was excited for the baby, who came in with a cold sore and kissed the child. He noted that it could have been a nurse or tech in the newborn nursery who picked the child up without gloves and had a herpes lesion on her or his hand. He said that this method is consistent with the incubation period because it happened shortly after delivery.

Dr. Colombo expressed once again that Iyonna's exposure to the virus was not during labor and delivery and he based that upon the fact that Vonshelle tested negative for herpes in a subsequent pregnancy. He also noted that if Vonshelle were exposed to herpes, she would have antibodies in her blood for life. He stated that because she twice tested negative for herpes means that she was never exposed to the virus

Incubation Period
Dr. Colombo testified that herpes incubation periods generally occur with a general range of time. The shortest incubation period he has seen was 7 days and the longest was 21 days.

<u>Conclusion</u>
In light of the negative HerpeSelect tests[27] and expert witness testimony, as well as the Western Blot test, I find that Vonshelle did not have HSV-2 while pregnant with Iyonna. She was, therefore, incapable of transmitting the virus to Iyonna during the birth process and causing her neurological

[27] According to a website, the HerpeSelect test "is the most commonly used HSV antibody test in the U.S." The test can detect antibodies and differentiate between HSV-1 and HSV-2. It generally takes about 3-6 weeks for someone to develop a detectable amount of antibodies to the herpes simplex virus. Most everyone will have detectable antibodies 16 weeks after exposure. http://www.healthassist.net/medical/herpes-test.shtml

damage. Iyonna's infection must have originated from coming into contact with another person who had the infection.

Damages

The parties agreed to settle this claim for:

(1) The $200,000 statutory cap, which was previously paid to the Claimant and her attorneys; and
(2) The right to pursue a claim bill for no more than $1 million that would not be contested by the Department of Health.

As discussed on page 11, the attorneys have been reimbursed $101,841.41 for their costs, but have not received any compensation for their legal services. Vonshelle has received $40,698.01. An annuity costing $50,000 has been purchased for Iyonna.

Vonshelle has incurred no out-of-pocket medical expenses because she and Iyonna are covered by Medicaid. According to Vonshelle's deposition testimony in 2014, she received $720 per month in Social Security disability payments for Iyonna.

FINAL CONCLUSION IN LIGHT OF THE EVIDENCE:

I do not find that the Claimant has proven, by the greater weight of the evidence, that the Brevard County Health Department is responsible for Iyonna's neurological injuries.

The Department's breach of the standard of care when Dr. Sargent did not review the entire results of Vonshelle's Pap test did not cause Iyonna's injuries. Vonshelle has never tested positive for HSV-2, in separate tests submitted to the special masters, and therefore, she did not have the virus and was not capable of passing the virus to Iyonna. Any further testing by the Department for hsv after the lab slip noted the cellular changes consistent with the herpes virus would not have yielded a positive test result. Therefore, the Department is not liable for any damages.

ATTORNEY FEES:

Section 768.28, F.S, limits the claimant's attorney fees to 25 percent of the claimant's total recovery by way of any judgment or settlement obtained pursuant to s. 768.28, F.S. The claimant's attorney has agreed to limit attorney fees to 15 percent of the claim bill award.

RECOMMENDATIONS: Based upon the foregoing, the undersigned recommends that Senate Bill 42 be reported UNFAVORABLY.

Respectfully submitted,

Eva M. Davis
Senate Special Master

cc: Secretary of the Senate

By Senator Rodriguez

37-00065-18 201842__

A bill to be entitled

An act for the relief of Vonshelle Brothers on behalf of her daughter Iyonna Hughey; providing an appropriation to compensate Iyonna Hughey for injuries and damages sustained as a result of the alleged negligence of the Brevard County Health Department, an agency of the Department of Health; providing that certain payments and the appropriation satisfy all present and future claims related to the alleged negligent acts; providing a limitation on the payment of fees and costs; providing an effective date.

WHEREAS, on March 16, 2010, Vonshelle Brothers visited a location of the Brevard County Health Department for her initial prenatal visit, during which a complete obstetrical and gynecological exam was conducted, including a Pap smear, and

WHEREAS, the lab results of the exam were reported to be within normal limits with the exception of the Pap smear, which had tested negative for intraepithelial lesion or malignancy, but showed cellular changes consistent with herpes simplex virus and bacterial vaginosis, and

WHEREAS, despite the results of the Pap smear, the Brevard County Health Department did not report the results to Vonshelle Brothers, and

WHEREAS, Vonshelle Brothers continued to receive treatment from the Brevard County Health Department through the duration of her pregnancy until the birth of her daughter, Iyonna Hughey, on October 14, 2010, at the Wuesthoff Medical Center, and both were discharged from the hospital 2 days later in good

37-00065-18 201842__

condition, and

WHEREAS, on November 1, 2010, Vonshelle Brothers brought Iyonna to the emergency room at Wuesthoff Medical Center, citing Iyonna's lack of eating, weak condition, and fever, and

WHEREAS, a lumbar puncture was performed and cerebral spinal fluid was collected which initially suggested that Iyonna had meningitis, which prompted her transfer to the Arnold Palmer Hospital for Children for further evaluation and management, and

WHEREAS, on November 3, 2010, the final results of the cerebral spinal fluid collection were reported, and the fluid had tested positive for herpes simplex type 2, and

WHEREAS, as a result of her diagnosis, Iyonna continues to experience significant developmental delay and neurologic impairment related to the herpes meningoencephalitis and has required continued treatment, including physical therapy, occupational and speech therapy, and neurologic and ophthalmologic care, and

WHEREAS, Iyonna's condition requires her to be under the constant care and supervision of Vonshelle Brothers, and

WHEREAS, the Brevard County Health Department had a duty to provide a reasonable level of care to Vonshelle Brothers and Iyonna, but that duty was allegedly breached by the department's failure to disclose the presence of the herpes simplex virus in Vonshelle Brothers and to order proper treatment of the virus, which eventually resulted in Iyonna's medical condition, and

WHEREAS, in June 2016, a final order was entered approving a settlement in the sum of $3.2 million between Vonshelle Brothers, individually and as parent and legal guardian of Iyonna, and the Brevard County Health Department to settle all

claims arising out of the factual situation described in this act, and

WHEREAS, the Department of Health has paid $200,000 to Vonshelle Brothers under the statutory limits of liability set forth in s. 768.28, Florida Statutes, and the parties have agreed to a reduced settlement in the amount of $1 million, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of $1 million is appropriated from the General Revenue Fund to the Department of Health for the Supplemental Care Trust for the Benefit of Iyonna Hughey or other special needs trust for the exclusive use and benefit of Iyonna Hughey.

Section 3. The Chief Financial Officer is directed to draw a warrant in favor of the Supplemental Care Trust for the Benefit of Iyonna Hughey or other special needs trust for the exclusive use and benefit of Iyonna Hughey in the sum of $1 million upon funds of the Department of Health in the State Treasury and to pay the same out of such funds in the State Treasury.

Section 4. The amount paid by the Department of Health pursuant to s. 768.28, Florida Statutes, and the amount awarded under this act are intended to provide the sole compensation for all present and future claims arising out of the factual situation described in this act which resulted in injuries and

damages to Vonshelle Brothers and Iyonna Hughey. Of the amount awarded under this act, the total amount paid for attorney fees may not exceed $100,000, the total amount paid for lobbying fees may not exceed $50,000, and the total amount paid for costs and other similar expenses relating to this claim may not exceed $2,214.

Section 5. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

SB 42
Bill Number (if applicable)

Topic Relief of Brothers (Claims Bill)

Amendment Barcode (if applicable)

Name Jonathan Gilbert

Job Title Attorney for Brothers / Hughey

Address _____ Phone _____
Street

Orlando
City *State* *Zip*

Email _____

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Brothers Family and Colling Gilbert Wright & Carter

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
515 Knott Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5198

DATE	COMM	ACTION
1/22/18	SM	Favorable
1/23/18	JU	Favorable
2/23/18	AHS	Recommend: Fav/CS
	AP	

January 22, 2018

The Honorable Joe Negron
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **PCS/SB 44 (366626)** – Appropriations Subcommittee on Health and Human Services and Senator Jose Rodriguez
HB 6501 – Representative Jackie Toledo
Relief of Christina Alvarez and George Patnode by the Department of Health

SPECIAL MASTER'S FINAL REPORT

THIS IS A CONTESTED EXCESS JUDGMENT CLAIM FOR $2.4 MILLION AGAINST THE DEPARTMENT OF HEALTH FOR THE NEGLIGENT MEDICAL CARE PROVIDED TO NICHOLAS PATNODE IN 1998 AT THE COUNTY HEALTH DEPARTMENT/PUBLIC HEALTH CLINIC OPERATED BY THE DEPARTMENT IN MARTIN COUNTY.

CURRENT STATUS:

This claim bill was previously filed with the Legislature for the 2004 through 2010 Legislative Sessions. At some point, it was heard by T. Kent Wetherell, an administrative law judge from the Division of Administrative Hearings, serving as a Senate Special Master. After the hearing, the judge issued a report containing findings of fact and conclusions of law and recommended that the bill be reported FAVORABLY. Judge Wetherell's special master report from SB 46 (2007), the latest report available, is attached.

According to counsel for the parties, no changes have occurred since the hearing which might have altered the findings and recommendations in the report. Additionally, the

prior claim bills on which the attached special master report is based, is effectively identical to claim bill filed for the 2018 Legislative Session. Therefore, the undersigned recommends that Senate Bill 44 be reported FAVORABLY.

Respectfully submitted,

Thomas C. Cibula
Senate Special Master

cc: Secretary of the Senate

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
402 Senate Office Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
1/17/07	SM	Favorable

January 17, 2007

The Honorable Ken Pruitt
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 46 (2007)** – Senator Dave Aronberg
Relief of Nicholas Patnode

SPECIAL MASTER'S FINAL REPORT

THIS IS A CONTESTED EXCESS JUDGMENT CLAIM FOR $2.4 MILLION AGAINST THE DEPARTMENT OF HEALTH FOR THE NEGLIGENT MEDICAL CARE PROVIDED TO NICHOLAS PATNODE IN 1998 AT THE COUNTY HEALTH DEPARTMENT/PUBLIC HEALTH CLINIC OPERATED BY THE DEPARTMENT IN MARTIN COUNTY.

FINDINGS OF FACT:

On December 26, 1997, 5-month-old Nicholas Patnode was taken to the Martin County Health Department - Indiantown Clinic (hereafter "the Clinic") by his mother, Christina Alvarez, because of a fever. Nicholas received his primary care through the Clinic, as did the claimants' other two children. Nicholas' regular pediatrician was Dr. Stephen Williams.

Dr. Williams diagnosed Nicholas with an ear infection. He prescribed an antibiotic, and told Ms. Alvarez to bring Nicholas back in 10 days. Nicholas completed the antibiotic, and went in for the follow-up appointment on January 6, 1998. At the follow-up appointment, Dr. Williams found that Nicholas had recovered from the ear infection.

Two days later, on Thursday, January 8, 1998, Nicholas again ran a fever causing his mother to bring him back to the Clinic. Dr. Williams saw Nicholas and measured his fever at 103.7

degrees. The fever was "without focus," meaning that there was no apparent cause for the fever. In order to rule out a dangerous bacterial infection, Dr. Williams properly ordered a complete blood count (CBC) and urine test.

The Clinic did not have lab facilities. Lab work, such as the CBC ordered by Dr. Williams, was sent to the lab at Martin Memorial Hospital for analysis. The lab faxed the results of the tests back to the Clinic physician who ordered the tests.

In addition to ordering the CBC, Dr. Williams prescribed Tylenol and Motrin for Nicholas, told his mother to keep cool clothes on him, and to watch him for a rash. He also told her that if there was a rash or if the fever persisted or got worse, she should take Nicholas immediately to the emergency room.

The next day, January 9, 1998, Ms. Alvarez stated that she checked Nicholas' temperature every 4 hours, and that his temperature was "normal" (i.e., 98.6 degrees) throughout the day. At about 4:30 p.m., Nicholas felt hot and had a fever of 100 degrees. Ms. Alvarez gave Nicholas a dose of Tylenol, and when she checked his temperature again an hour later, his fever was up to 101 degrees. At about the same time, Nicholas' father, George Patnode, arrived home from working on a friend's car.

Mr. Patnode and Ms. Alvarez proceeded directly to the Martin Memorial Hospital emergency room with Nicholas. They arrived at the hospital at approximately 6:50 p.m. Ms. Alvarez did not mention during the admission process that Nicholas had been seen by Dr. Williams on the prior day or that he had ordered a CBC test.

The emergency room physician ordered another CBC test, which showed an abnormal white blood cell count. While waiting for test results, Cristina noticed that Nicholas was getting limp and whining, and was starting to get blotches on his lips. A lumbar puncture (i.e., spinal tap) indicated that Nicholas had pneumoccoccal meningitis. Nicholas was given intravenous antibiotics, and transferred by ambulance to St. Mary Hospital's pediatric intensive care unit.

Nicholas arrived at St. Mary's at 1:57 a.m., on January 10, 1998. By that time, Nicholas had gone into septic shock. He was removed from life support and died later that morning.

Dr. Williams' Background

Dr. Williams obtained his medical degree in Nigeria in the 1980's. He came to the United States in 1991 after completing an internship in a Nigerian hospital and working for a year in a public health clinic in Nigeria. It took Dr. Williams two tries to pass the exams required for him to practice medicine in the United States. He did a residency program in pediatrics in New York before coming to the Clinic in July 1996. According the Department's website, Dr. Williams was licensed to practice medicine in Florida on July 1, 1996, and his license number is ME70792.

Dr. Williams was granted permanent resident status in the United States in 1996. He worked for the Clinic pursuant to an F-1 visa that required him to provide services in an underserved area for three years. It took Dr. Williams three tries to pass the exam for Board certification in pediatrics. He was Board certified at some point in 1998 after the incident involving Nicholas.

Negligent Medical Care Provided by Dr. Williams

Dr. Williams did not order a rush or "stat" CBC; he ordered a routine CBC. Had Dr. Williams ordered the CBC "stat," the results would have been ready by 5:30 p.m., the day that they were ordered, i.e., January 8, 1998. The more credible expert testimony establishes that, in order to meet standard of care, Dr. Williams should have ordered the CBC "stat" because the test involved a five-month old child who had a fever without a focus.

The tests were completed by the lab at 11:30 p.m., on January 8, 1998. The results were faxed to the Clinic at 12:17 p.m., on January 9, 1998.

The lab results showed that Nicholas had a white blood cell count of 24,900. The normal range for a child of Nicholas' age was between 6,000 to 15,000. Nicholas' elevated white blood cell count was an indication that he might have a serious bacterial infection which, in turn, might develop into bacterial meningitis. In such cases, the standard of care requires immediate treatment with antibiotics.

The Clinic policy in effect at the time required abnormal lab results to be followed-up on with the patient within 24 hours of receipt. Dr. Williams did not review Nicolas' lab results until January 14, 1998, four days after he passed away. His failure to do so violated the clinic policy, and more importantly, fell below the standard of care.

The Clinic had a policy that required the lab to call the physician immediately if the lab results exceeded "panic values" set by the Clinic. The "panic value" set for white blood cell counts was 25,000, which was 100 higher than Nicholas' white blood cell count. The claimants' expert testified that the "panic value" should have been 15,000, which was the reference range published by the American Academy of Pediatrics.

The claimants' expert ultimately opined that had the CBC test been ordered "stat," or if the regular and actual results that were received by the Clinic at 12:17 p.m. on January 9, 1998, had been promptly reviewed and acted upon by Dr. Williams, then a course of intravenous antibiotics could have been administered in time to save Nicholas' life. The Clinic's expert, while not agreeing that a "stat" CBC was required, agreed that had Nicholas been started on antibiotics at any point up until 4:30 p.m. or so on January 9, 1998, he most likely would not have died.

The Clinic

The Clinic a county health department/public health clinic operated by the Department, with funding support from Martin County. See generally ss. 154.001-.067, F.S. Employees of the Clinic are employees of the Department. s. 154.04(2), F.S.

The Clinic serves Medicaid recipients and other low income patients who do not otherwise have access to health care. It is one of only three facilities in Martin County serving that patient population. In fiscal year 2005-06, the Clinic served more than 19,000 patients and had a budget of $7.8 million. It now has 137 employees.

The Clinic was only one of only three county health departments in the state that provides prenatal care from pregnancy to birth. The Clinic delivers approximately one-

third of the babies born in Martin County. Pediatric care is provided to many of these children after birth, as was the case with Nicholas and his siblings.

The Clinic is funded with a mix of federal, state, and county funds. It receives approximately $3.5 million in state funds and $920,000 (or 12 percent of its budget) from Martin County. As of November 30, 2006, the Clinic had a cash reserve of $1.3 million and a cash-to-budget ratio of 17.85 percent, which exceeds the 8.5 percent operating reserve required by s. 154.02(5)(a), F.S.

The Claimants

Nicholas' parents, Cristina Alvarez and George Patnode had two children prior to Nicolas. One of the other children is emotionally handicapped, has ADHD, and has pervasive developmental disorder. The other child has ADHD.

Ms. Alvarez and Ms. Patnode had been married for 10 years at the time of Nicholas' death. They separated four days after Nicolas' death, and they divorced in 2000. Both have remarried, and they each have had additional children since Nicholas' death.

George Patnode is 45-years-old. He does not work. He is a disabled veteran, who receives $724 per month in Social Security disability benefits and $115 per month from the Veterans Administration. He has been on Social Security disability since 1998. He has been working on an Associate in Arts degree at Indian River Community College for several years. He expects to complete that degree soon and then he intends to pursue a Bachelor's degree at Florida Atlantic University.

Mr. Patnode pays a total of $1,200 per month in child support, $600 of which is paid to Ms. Alvarez. He is current on his child support obligations. He is a "recovering alcoholic." He has been sober for 8 years, except for a "brief relapse in 2004," and he is active in Alcoholics Anonymous. He had two criminal offenses in 2002. The offenses were misdemeanor domestic batteries to which he pled no contest and served 30 days in jail.

Ms. Alvarez does not work outside the home. She receives $982 per month in government benefits for the two children

fathered by Mr. Patnode who are disabled, in addition to the $600 per month in child support that she receives from Mr. Patnode. She has no history of drug or alcohol abuse.

Relevant Subsequent Events

Dr. Williams no longer works for the Clinic. He left the Clinic in June 1999, after the end of the 3-year term required by his visa. Dr. Williams is now in private practice in the Tampa area.

Dr. Williams was not disciplined by the Clinic as a result of the incident. No disciplinary action was taken against his medical license.

The only policy change that came about at the Clinic as a result of Nicholas' death was the that the white blood cell count "panic value" of 25,000 was changed. Now, the "panic value" for that and other tests depends upon the range established by the lab for the specific test. No Department-wide policy changes were made as a result of the incident.

Source of Funds to Pay this Claim Bill

The bill authorizes and directs payment of this claim out of General Revenue, not the funds of the Department or the Clinic. The Department argues that neither it nor the Clinic has funds available to pay this claim and that payment of the claim from funds earmarked for the Clinic would be contrary to state law and would seriously hamper the Clinic's ability to serve its patients.

The Clinic and other county health departments receive a majority of their state funding from the County Health Department Trust Fund (CHDTF). In the 2006-07 General Appropriations Act, for example, a total of approximately $980 million of state funds were appropriated for the operation of the 67 county health departments, with $192 million (19.6%), coming from General Revenue and $780 million (79.4%) coming from the CHDTF, and the remainder (1%) coming from other sources.

Section 154.02(2), F.S., provides that funds in the CHDTF "shall be expended by the Department of Health solely for the purposes of carrying out the intent and purposes of [Part I of Chapter 154, F.S.]." Nothing in Part I of Chapter 154.02, F.S., addresses payment of claims against county health

departments. Moreover, s. 154.02(3), F.S., provides very specific language regarding the use of funds in the CHDTF; limitations on the transfer of the funds; and specific accounting requirements for those funds. Thus, it does not appear that that funds from the CHDTF could be used to pay this claim, and, under the circumstances, it is appropriate to pay the claim from General Revenue.

If the claim is paid from General Revenue, the Legislature will have to make a policy decision as to whether to concomitantly increase the appropriation of General Revenue to the Department to offset the payment of the claim. Failure to do so will provide a measure of accountability to the Department, whose employee's negligence was the basis of the claim, but it will mean that the other 66 county health departments are effectively subsidizing the payment of this claim since they will receive proportionally less General Revenue than they otherwise would have received.

In my view, it is unlikely that a proportional reduction in General Revenue would have a material negative impact on the operation of the county health departments since the amount of the claim ($2.4 million) amounts to less than 1.3 percent of the General Revenue ($192 million) and only 0.25 percent of the total state funds ($980 million) appropriated to the county health departments in fiscal year 2006-07. Thus, I recommend that the bill be amended to require payment of the claim out of the General Revenue funds appropriated to the Department for the county health departments and not from a separate and additional appropriation of General Revenue to the Department specifically for the payment of this claim.

LITIGATION HISTORY:

In 2000, the claimants filed suit against the Clinic, Dr. Williams, Martin Memorial Hospital, and others involved in the care and treatment of Nicholas from January 8 through 10, 1998. The suit was filed in circuit court in Martin County.

The claimants offered to settle with the Clinic for $200,000 prior to trial, but the Clinic rejected the offer. Martin Memorial Hospital settled with the claimants for $35,000. The claims against the other defendants were dismissed, and the case proceeded to trial against the Clinic only.

A jury trial was held in February 2002. The trial judge granted a directed verdict in favor of Mr. Patnode on the issue of his comparative negligence, but the jury had the opportunity to apportion negligence to Ms. Alvarez. The jury returned a $2.6 million verdict in favor of the claimants, finding the Clinic 100 percent responsible for Nicholas' death. The damages award was for past and future pain and suffering; no economic damages were sought or awarded. The jury apportioned 61.5 percent of the damages ($1.6 million) to Ms. Alvarez and 38.5 percent ($1 million) to Mr. Patnode.

The Department's post-trial motions were denied, and a final judgment consistent with the jury verdict was entered on March 26, 2002. The Fourth District Court of Appeal affirmed the final judgment without an opinion on April 30, 2003. The Clinic paid $200,000 in partial satisfaction of the judgment pursuant to s. 768.28, F.S., in September 2003.

The final judgment reserved jurisdiction to tax costs and attorney's fees, but no subsequent order was entered. The claimant's attorney has advised that no costs are being sought as part of the claim bill.

CLAIMANTS' POSITION:

- The claim is based on a jury verdict that was affirmed on appeal, and the jury verdict should be given full effect because it is supported by the evidence.
- Government entities should be held to the same level of accountability as the private sector, especially in the area of health care.
- The Department had an opportunity to settle this case for $200,000, but it failed to do so and, therefore, it should be required to pay the full amount awarded by the jury.

DEPARTMENT'S POSITION:

- Nicholas' mother, Ms. Patnode, should be found comparatively negligent for not taking Nicolas to the emergency room sooner, and for not telling the emergency room nurse about seeing Dr. Williams the day before.
- Payment of the claim would hinder the Clinic's ability to provide services to its patients.

- Payment of the claim should come from a separate appropriation of General Revenue because the Clinic and the Department do not have the funds to pay the claim.

CONCLUSIONS OF LAW:

Dr. Williams was an employee of the Department acting within the course and scope of his employment at the time of the incidents giving rise to this claim. As a result, the Department is vicariously liable for his negligence.

Dr. Williams owed a duty to Nicholas and his parents to properly diagnose and treat his medical condition. Dr. Williams breached that duty by failing to follow-up on the blood test that he ordered for Nicholas for the purpose of ruling out a serious bacterial infection. His failure to do so fell below the prevailing professional standard of care and was a proximate cause of Nicholas' death because had he reviewed the results of the test, Dr. Williams would have (or, at least, should have) sent Nicholas to the emergency room for antibiotics.

It is a close question in my mind as to whether Nicholas' mother was comparatively negligent for failing to take Nicholas to the emergency room sooner. On one hand, she was following Dr. Williams advice by giving Nicholas Tylenol and Motrin to reduce his fever and by only taking him to the emergency room if the fever continued despite the medications. On the other hand, it is clear from the expert medical testimony that she could not have been truthful when she testified that Nicholas' temperature was "normal" (i.e., 98.6 degrees) throughout the day on January 9, 1998, and, as a result, she might bear some responsibility for not bringing Nicholas to the emergency room until it was too late. The jury rejected the Department's argument that Nicholas' mother was comparatively negligent and, on balance, I agree with the jury's conclusion on that issue.

The damages awarded by the jury are reasonable. The damage award should, however, be reduced by $35,000 to reflect the settlement that the claimants received from Martin Memorial Hospital. It would be a windfall to the claimants if the claim bill was not reduced by the amount of that settlement because the jury specifically found that the hospital's lab was not negligent and the claimants' medical expert testified that he had no criticism of the care provided to Nicholas in the hospital's emergency room. Each parent's share of the claim

bill should be reduced by $17,500 (i.e., half of the $35,000 settlement) because they split the settlement equally.

ATTORNEY'S FEES AND LOBBYIST'S FEES: The claimants' attorney submitted an affidavit stating that attorney's fees related to this claim bill, inclusive of lobbyist's fees and costs, will be limited to 25 percent of the final claim in accordance with s. 768.28(8), F.S.

LEGISLATIVE HISTORY: This is the fourth year that this claim has been presented to the Senate. It was first presented in 2004 (SB 26), and then again in 2005 (SB 42) and 2006 (SB 52). No Special Master hearings were held on the prior years' Senate bills. The House Special Master recommended favorable consideration of the claim, as presented in HB 235 in 2004.

OTHER ISSUES: The bill authorizes and directs payment of $1.5 million to Ms. Alvarez and $900,000 to Mr. Patnode, which is consistent with the allocation of damages by the jury and the final judgment. However, the proceeds received to date -- the $35,000 settlement with Martin Memorial Hospital and the $200,000 partial satisfaction of the judgment by the Clinic -- have been split equally between Ms. Alvarez and Mr. Patnode after payment of attorney's fees and costs.

RECOMMENDATIONS: For the reasons set forth above, I recommend that SB 46 be reported FAVORABLY, as amended.

Respectfully submitted,

T. Kent Wetherell
Senate Special Master

cc: Senator Dave Aronberg
Faye Blanton, Secretary of the Senate
House Claims Committee

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 21, 2018:

The committee substitute:

- Reduces the award amounts to reflect partial payments previously made, specifically the $200,000 partial satisfaction of the judgement and $35,000 paid in settlement with the treating hospital, which is consistent with the original Special Master's Final Report from January 17, 2007.

892122

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2018	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Rodriguez) recommended the following:

Senate Amendment

Delete lines 46 - 62

and insert:

Section 2. The sum of $1,382,500 is appropriated from the General Revenue Fund to the Department of Health for the relief of Cristina Alvarez as compensation for the death of her son, Nicholas Patnode, a minor, due to the negligence of the Martin County Health Department.

Section 3. The Chief Financial Officer is directed to draw

892122

a warrant in favor of Cristina Alvarez in the sum of $1,382,500 upon funds of the Department of Health in the State Treasury, and the Chief Financial Officer is directed to pay the same out of such funds in the State Treasury.

Section 4. The sum of $782,500 is appropriated from the General Revenue Fund to the Department of Health for the relief of George Patnode as compensation for the death of his son, Nicholas Patnode, a minor, due to the negligence of the Martin County Health Department.

Section 5. The Chief Financial Officer is directed to draw a warrant in favor of George Patnode in the sum of $782,500 upon

By Senator Rodriguez

37-00064-18 201844__

A bill to be entitled

An act for the relief of Cristina Alvarez and George Patnode; providing appropriations to compensate them for the death of their son, Nicholas Patnode, a minor, due to the negligence of the Department of Health; providing for the repayment of Medicaid liens; providing a limitation on the payment of attorney fees; providing an effective date.

WHEREAS, on January 8, 1998, Nicholas Patnode, 5 months of age, was seen for a fever at the Martin County Health Department - Indiantown Clinic, and

WHEREAS, a blood test was ordered, the results of which were abnormal and consistent with bacteremia, a condition that requires immediate administration of antibiotics, and

WHEREAS, the results of the blood test were printed that day but not picked up from the printer at the clinic, and as a result, treatment was not begun and Nicholas Patnode's condition deteriorated, and

WHEREAS, several hours later, Nicholas Patnode's parents took him to Martin Memorial Medical Center, where a spinal tap confirmed a diagnosis of bacterial meningitis, and Nicholas Patnode was transferred to St. Mary's Hospital in critical condition, and

WHEREAS, a decision was made to discontinue life support due to irreversible brain damage, and Nicholas Patnode died on January 10, 1998, and

WHEREAS, Nicholas Patnode is survived by his parents, Cristina Alvarez and George Patnode, and

37-00064-18 201844__

WHEREAS, the actions of the Martin County Health Department demonstrated the failure to adhere to a reasonable level of care for Nicholas Patnode and resulted in his death, and

WHEREAS, after an unsuccessful attempt by Nicholas Patnode's parents to settle this claim, it proceeded to litigation, resulting in a judgment in favor of the parents in the amount of $2.6 million, and

WHEREAS, the Department of Health has paid $200,000 to Cristina Alvarez and George Patnode under the statutory limits of liability set forth in s. 768.28, Florida Statutes, NOW, THEREFORE,

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

Section 1. The facts stated in the preamble to this act are found and declared to be true.

Section 2. The sum of $1.5 million is appropriated from the General Revenue Fund to the Department of Health for the relief of Cristina Alvarez as compensation for the death of her son, Nicholas Patnode, a minor, due to the negligence of the Martin County Health Department.

Section 3. The Chief Financial Officer is directed to draw a warrant in favor of Cristina Alvarez in the sum of $1.5 million upon funds of the Department of Health in the State Treasury, and the Chief Financial Officer is directed to pay the same out of such funds in the State Treasury.

Section 4. The sum of $900,000 is appropriated from the General Revenue Fund to the Department of Health for the relief of George Patnode as compensation for the death of his son,

Nicholas Patnode, a minor, due to the negligence of the Martin County Health Department.

Section 5. The Chief Financial Officer is directed to draw a warrant in favor of George Patnode in the sum of $900,000 upon funds of the Department of Health in the State Treasury, and the Chief Financial Officer is directed to pay the same out of such funds in the State Treasury.

Section 6. The governmental entity responsible for payment of the warrants shall pay to the Agency for Health Care Administration the amount due under s. 409.910, Florida Statutes, before disbursing any funds to the claimants. The amount due to the agency shall be equal to all unreimbursed medical payments paid by Medicaid up to the date on which this act becomes a law. Such amounts shall be deducted in equal amounts from the award to each parent.

Section 7. The amount paid by the Department of Health pursuant to s. 768.28, Florida Statutes, and the amounts awarded under this act are intended to provide the sole compensation for all present and future claims arising out of the factual situation described in this act which resulted in the death of Nicholas Patnode. The total amount paid for attorney fees relating to this claim may not exceed 25 percent of the total amount awarded under this act.

Section 8. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

SB 44
Bill Number (if applicable)

Topic Patrode Relief Bill (Claims Bill)

Amendment Barcode (if applicable)

Name Jonathan Gilbert

Job Title Attorney for Patrode

Address _____ Phone _____
Street

Orlando
City *State* *Zip*

Email _____

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Patrode Family and Colling Gilbert Wright & Carter

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 590 (608810)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Garcia and others
SUBJECT:	Child Welfare
DATE:	February 22, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Fav/CS**
2.	Tulloch	Cibula	JU	**Favorable**
3.	Sneed	Williams	AHS	**Recommend: Fav/CS**
4.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 590 makes a number of changes to the laws relating to relative and nonrelative caregivers for children in out-of-home foster care. The most significant changes required by the bill are as follows:

- Directing the Department of Children and Families (DCF or department), in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, to develop a statewide Family Finding Program.
- Requiring court determination at each judicial hearing throughout the dependency process that the DCF or other appropriate agency engaged in family finding.
- Renaming of the Relative Caregiver Program to the Kinship Care Program and recognition of "fictive kin," as a person unrelated to a child by blood but who has such a close emotional relationship with the child that he or she may be regarded as part of the family or kin.
- Directing that program payments to relatives or qualifying nonrelatives are no longer delayed and begin when the child comes into a relative's or qualifying nonrelative's care at the current relative caregiver rate under s. 39.5085, F.S.
- Establishing Kinship Navigator programs by community-based care lead agencies to provide support and assistance to relative and nonrelative caregivers.
- Extending the maintenance adoption subsidy to age 21 for eligible young adults.
- Extending program services to age 21 for eligible young adults who have not achieved permanency.

- Establishing a Title IV-E Guardianship Assistance Program pilot in two DCF circuits.

The bill also amends the Rilya Wilson Act, s. 39.604, F.S., as follows:

- To provide an alternative to fulltime enrollment in a child care program for foster children under the age of three whose caregiver stays home all day or works less than fulltime.
- To appoint a surrogate parent to make educational decisions if appropriate, and provide for educational stability and transitions.

The DCF is requesting 12 additional full-time equivalent (FTE) positions and is projected to incur additional costs up to $3,207,326 in FY 2018-2019 and $4,230,000 annually thereafter. Local governments, specifically the six sheriff's offices conducting child protective investigations, are collectively expected to incur additional costs of $157,500 in FY 2018-2019 and $315,000 annually thereafter. By locating relatives or nonrelatives to care for children who have entered out-of-home care, the Family Finder and Kinship Navigator programs may generate savings to partially or fully offset the cost of the additional DCF staff and the fiscal impact on the county sheriff's offices.

Sections 1, 5, and 12 of the bill are effective January 1, 2019, and the remainder of the bill is effective July 1, 2018.

II. Present Situation:

Relative and Nonrelative Caregivers

When children cannot remain safely with their parents, placement with relatives is preferred over placement in foster care with nonrelatives. Caseworkers try to identify and locate a relative or relatives who can safely care for the children while parents receive services to help them address the issues that brought the children to the attention of child welfare. Placement with relatives — or kinship care — provides permanency for children and helps them maintain family connections. Kinship care is the raising of children by grandparents, other extended family members, and non-relative adults with whom they have a close, family-like relationship, such as godparents and close family friends.[1]

Kinship care may "be formal and involve a training and licensure process for the caregivers, monthly payments to help defray the costs of caring for the [child], and support services[.]"[2] Kinship care also may "be informal" and "involve only an assessment process to ensure the

[1] U.S. Department of Health & Human Services, Administration for Children & Families, Children's Bureau, Child Welfare Information Gateway, *About Kinship Care*, https://www.childwelfare.gov/topics/outofhome/kinship/about/ (last visited Feb. 4, 2018).

[2] John McLennan, PhD, Social Work and Family Violence Theories, Assessment, and Intervention at 88, (Springer Publishing Co., LLC, 2010), https://books.google.com/books?id=nHHWSsUvXwwC&pg=PA88&lpg=PA88&dq=one-fourth+of+the+children+in+out-of-home+care+are+living+with+relatives&source=bl&ots=0w8X1YFtl0&sig=qdPfe5h2r0l8t3YR2zxN3rce5mQ&hl=en&sa=X&ved=0ahUKEwikze--io3ZAhWprFkKHV5wCJUQ6AEIPDAD#v=onepage&q=one-fourth%20of%20the%20children%20in%20out-of-home%20care%20are%20living%20with%20relatives&f=false (last visited Feb. 4, 2018).

safety and suitability of the home along with supportive services for the child and caregivers."[3] "Approximately one-fourth of [the] children in out-of-home care are living with relatives."[4]

According to the National Conference of State Legislatures,

> Nearly 3 million American children are cared for by relatives other than their parents. Child welfare agencies in many states rely on extended families, primarily grandparents, to provide homes for children who cannot safely remain with their parents. In fact, relatives care for 27 percent of children in foster care—about 107,000—according to the Adoption and Foster Care Analysis and Reporting System.[5]

In Florida, there were 24,069 children in out-of-home care as of December 31, 2017, More than half of those children, 13,579, were placed with approved relatives and "fictive kin" non-relatives,[6] while 10,490 were placed in licensed foster care, group care, or in another placement.[7]

Relative Caregiver Program

The Relative Caregiver Program was established in 1998[8] for the purpose of recognizing the importance of family relationships and providing additional placement options and incentives to help achieve permanency and stability for many children who are otherwise at risk of foster care placement. The program provides financial assistance to qualified relatives. Within available funding, the Relative Caregiver Program is also required to provide caregivers with family support and preservation services, school readiness assistance, and other available services in order to support the child's safety, growth, and healthy development. Children living with caregivers who are receiving assistance under the program are also eligible for Medicaid coverage.[9]

In 2014,[10] the Legislature expanded the Relative Caregiver Program to include nonrelatives who a child may have a close relationship with who are not a blood relative or a relative by marriage. Those nonrelatives are eligible for financial assistance if they are able and willing to care for the child and provide a safe, stable home environment. The court must find that a proposed placement is in the best interest of the child.[11]

---

[3] *Id.*
[4] *Id.*
[5] National Conference of State Legislatures, *Supporting Relative Caregivers of Children* (Feb. 13, 2017), http://www.ncsl.org/research/human-services/relative-caregivers.aspx (last visited Feb. 4, 2018).
[6] "Fictive kin" is defined by the bill in section 1 (s. 39.4015(2)(d)) as "an individual who is unrelated to the child by either birth or marriage, but has such a close emotional relationship with the child that he or she may be considered part of the family."
[7] Florida Department of Children and Families, *Children in Out-of-Home Care – Statewide* (Jan. 10, 2018), http://www.dcf.state.fl.us/programs/childwelfare/dashboard/c-in-ooh.shtml (last visited Feb. 4, 2018).
[8] Ch. 1998-78, Laws of Fla.
[9] Section 39.5085, F.S.
[10] Ch. 2014-224, Laws of Fla.
[11] Section 39.5085(2)(a)3., F.S.

Under the Relative Caregiver Program, the statewide average monthly rate for children placed by the court with relatives or nonrelatives who are not licensed as foster homes may not exceed 82 percent of the statewide average foster care rate. Additionally, the cost of providing the assistance to any caregiver in the program may not exceed the cost of providing out-of-home care in an emergency shelter or in foster care.[12]

Financial Assistance

The Relative Caregiver Program also provides monthly cash assistance to relatives who meet eligibility rules and have custody of a child under age 18 who has been adjudicated dependent by a Florida court and placed in their home by the Department of Children and Families Child Welfare/Community Based Care (CW/CBC) contracted provider.[13] As demonstrated by the charts below, the monthly cash assistance amount is higher than the Temporary Cash Assistance for one child but less than the amount paid for a child in the foster care program.

Monthly cash assistance:

Age of Child	Relative and Nonrelative Caregivers[14]	Foster Parents[15]	Residential Group Home Placement[16]
Age 0 through 5 years	$242	$439	$3,355 per month average[17]
Age 6 through 12 years	$249	$451	
Age 13 through 18 years	$298	$527	
These are monthly benefit amounts per child			

Temporary cash assistance for relative caregivers:

Number of Children	Monthly Benefit
1	$180
2	$241
3	$303
These are monthly benefit amounts per total number of children[18]	

Additionally, while reimbursement for children in foster care or in residential group homes begins at the time the child is placed, the monthly benefit payment for relative and nonrelative

[12] Section 39.5085(2)(d), F.S.
[13] Section 39.5085, F.S.
[14] Fla. Admin. Code Ann. r. 65C-28.008 (2018). Department of Children and Families, *Temporary Cash Assistance Fact Sheet*, 5-6 (July 2012), http://www.dcf.state.fl.us/programs/access/docs/tcafactsheet.pdf (last visited Feb. 4, 2018).
[15] Office of Program Policy Analysis and Government Accountability, *Characteristics of Children in Foster Homes and Groups Homes*, 13 (Apr. 17, 2017) http://www.oppaga.state.fl.us/monitordocs/Presentations/P17-18.pdf (last visited Feb. 4, 2018).
[16] *Id*. at 15.
[17] *Id*. The average amount is derived from dividing the residential group care expenditures from 2014-2015, $89,778,347, by the average number of children from 2014-2015, 2,230, which equals $40,259.35 per child per year. This number was divided by 12 months to reach the monthly average per child.
[18] *See supra* n. 13 at 6 (reflecting a portion of the chart).

caregivers does not begin until the child has been adjudicated dependent.[19] Adjudication typically takes 2 months to a year. During this time, a nonrelative caregiver receives *no* benefit, and a relative caregiver may be eligible only for temporary cash assistance if in close enough consanguinity to the child.[20] Once the child has been adjudicated dependent, the relative becomes eligible for the full Relative Caregiver Program benefit amount.[21]

Child Care Assistance

The cost of participating in the school readiness program is subsidized in part or fully by the funding of the local early learning coalition for eligible children.[22] Criteria have been established for the children who are to receive priority for participating in the program at no cost or at a subsidized rate.[23] However, to the extent that subsidized child care is not available, the cost of child care is assumed by the caregiver.[24]

Fostering Connections to Success and Increasing Adoptions Act (Fostering Connections)

The federal Fostering Connections to Success and Increasing Adoptions Act of 2008 (Fostering Connections) was designed to improve the lives of children and youth in foster care and increase the likelihood that they will be able to leave the foster care system to live permanently with relative caregivers or adoptive families.[25] The law accomplishes this, in part, by allowing states to extend foster care services and maintenance adoption subsidy payments for children leaving foster care and adoptive families to the age of 21 and to establish a subsidized guardianship assistance program for relative caregivers.

Extended Foster Care

In 2013, the Legislature exercised the option of providing for extended foster care, which applies to young adults aged 18 to 21 who have not achieved permanency prior to their 18th birthdays.[26] The program builds on independent living assistance services that were previously available to young adults who "aged-out" of the foster care system.[27] Extended foster care services are available to young adults who are living in licensed care on their 18th birthday and who are:

- Completing secondary education or a program leading to an equivalent credential;
- Enrolled in an institution that provides postsecondary or vocational education;
- Participating in a program or activity designed to promote or eliminate barriers to employment;

---

[19] Section 39.5085(2)(a), F.S. (providing that *dependent* children may be placed with a relative or nonrelative caregiver).
[20] *See supra* n. 14 at 4 ("A child must live in the home of a parent or a relative who is a blood relative of the child. The degree of relationship to the child can be no greater than first cousin once removed.").
[21] *See supra* n. 13.
[22] Office of Early Learning, *School Readiness Payment Rates for Children Concurrently Enrolled in the VPK Program*, http://www.floridaearlylearning.com/sites/www/Uploads/files/Oel%20Resources/Rules%20Guidance%20and%20Proposed%20Rules/Issued%20Program%20Guidance/440.50_ConcurrentPaymentRates_Final_ADA.pdf (last visited Feb. 5, 2018).
[23] Office of Early Learning, *School Readiness Eligibility Priorities*, http://www.floridaearlylearning.com/coalitions/school_readiness_eligibility_priorities.aspx (last visited Feb. 5, 2018).
[24] Fla. Admin. Code Ann. r. 65C-13.030(2)(d)4. (2014).
[25] P.L. 110-351.
[26] Ch. 2013-178, L.O.F.
[27] Section 409.1451, F.S.

- Employed for at least 80 hours per month; or
- Unable to participate in programs or activities listed above full time due to a physical intellectual, emotional, or psychiatric condition that limits participation.[28]

Program eligibility is also contingent on the living situation of a young adult. Participants are required to live independently, but in an environment in which they are provided supervision, case management, and support services by either DCF or a relevant CBC. Examples of such an environment include college dormitories, shared housing, and foster family homes.[29]

Adoption Assistance

The department currently provides financial assistance to families who adopt children with special needs or who are otherwise difficult to place in an adoptive home.[30] This assistance is made available in several ways. DCF may grant a maintenance subsidy to families (maintenance adoption subsidy or MAS), which is an annual payment intended to subsidize the costs of caring for an eligible child. The department may also offer a subsidy to family for any medical costs associated with a child's specific needs. In addition, the department is authorized to offer a nonrecurring reimbursement to an eligible family for costs associated with formalizing an adoption, which may include attorney's fees, court costs, travel expenses, and other related costs. Adoption assistance, in these various forms, may be offered to families who adopt an eligible child until the 18th birthday of such a child.[31]

To date, Florida has chosen not to take advantage of the provision of federal Fostering Connections Act that allows the maintenance adoption subsidy to be continued until a young adult reaches age 21.

Title IV-E Guardianship Assistance Program

The third primary provision of Fostering Connections is the creation of a federally supported Guardianship Assistance Program (GAP) for relatives. The GAP gives states the option of using federal Title IV-E funds to support kinship guardianship payments for children living in the homes of relative caregivers who become the children's legal guardians.[32]

The federal Fostering Connections Act and Increasing Adoptions Act promotes permanency for children living with kin by providing states with the option to use federal Title IV-E funding for kinship guardianship subsidies. If a child meets certain Title IV-E eligibility standards, he or she may also be eligible for a GAP subsidy if:

---

[28] Section 39.6251(2), F.S.
[29] Section 39.6251(4), F.S
[30] Section 409.166, F.S.
[31] *Id*.
[32] Mark F. Testa and Leslie Cohen. *"Pursuing Permanence for Children in Foster Care: Issues and Options for Establishing a Federal Guardianship Assistance Program in New York State."* School of Social Work, The University of North Carolina at Chapel Hill. June 2010, *available at*: https://ocfs.ny.gov/main/reports/Pursuing%20Permanence%20for%20Children%20in%20Foster%20Care%20June%202010.pdf. (last visited February 21, 2018).

- The child has been removed from his or her family's home pursuant to a voluntary placement agreement or as a result of a judicial determination that allowing the child to remain in the home would be contrary to the child's welfare;
- The child is eligible for federal foster care maintenance payments under Title IV-E of the Social Security Act for at least six consecutive months while residing in the home of the prospective relative guardian who is licensed or approved as meeting the licensure requirements as a foster family home;
- Returning home or adoption is not an appropriate permanency option for the child;
- The child demonstrates a strong attachment to the prospective relative guardian and the relative guardian has a strong commitment to caring permanently for the child; and
- The child has been consulted regarding the guardianship arrangement (applicable to children age 14 and older).[33]

Likewise, a prospective guardian must meet certain conditions to qualify for a GAP subsidy. He or she:

- Must be the eligible child's relative or close fictive kin;
- Must have undergone fingerprint-based criminal record checks and child abuse and neglect registry checks;
- Must be a licensed foster parent and approved for guardianship assistance by the relevant state department;
- Must display a strong commitment to caring permanently for the child; and
- Must have obtained legal guardianship of the child after the guardianship assistance agreement has been negotiated and finalized with the department.[34]

Federal guidance on GAP implementation recognizes that many relative caregivers may find the foster care licensure process burdensome. Accordingly, states are granted the authority to determine what constitutes a "non-safety" licensure standard and, on a case-by-case basis, offer waivers to those standards when appropriate.[35]

To date, Florida has chosen not to implement this provision of Fostering Connections and relies on the established Relative Caregiver Program to provide assistance to caregivers.

Title IV-E Waivers

First authorized by Congress in 1994, the goal of permitting waivers of specific Title IV-E requirements is to allow states to demonstrate alternative and innovative practices that achieve federal child welfare policy goals in a manner that is cost neutral to the federal Treasury. Each project has a specific approval period which is typically five years, must be determined to cost the federal government no more in Title IV-E support than it would without the waiver project, and must be independently evaluated.[36]

---

[33] 42 U.S.C. § 673(d)(3)(A)
[34] 42 U.S.C. § 671(a)(20(D) and 673(d)(3)(A).
[35] U.S. Department of Health and Human Services, Agency for Children and Families, Program Instruction U.S. Department of Health and Human Services, Agency for Children and Families, Program Instruction ACYF-CB-PI-10-01, July 9, 2010.
[36] Emelie Stoltzfus, *Child Welfare: An Overview of Federal Programs and their Current Funding*, CONGRESSIONAL RESEARCH SERVICE, January 10, 2017, p. 13-15, *available at*: https://fas.org/sgp/crs/misc/R43458.pdf. (last accessed

Currently 26 states, including Florida, have approved child welfare demonstration projects commonly referred to as Title IV-E waivers. Under the terms and conditions of their specific waiver agreement, each state is permitted to use federal Title IV-E foster care funds to provide services and assistance to children and their families, even if the children or the services or assistance would not otherwise be considered eligible.

Title IV-E waiver projects vary significantly from state to state in terms of geographic and program scope. Some operate on a statewide basis while others are limited to specific regions or counties in the state. The projects may focus on different age groups of children and different service needs or circumstances, such as children:

- Entering care for the first time;
- At risk of entering care;
- Transitioning from group care to home; and
- With substance-abusing parents.[37]

A smaller number of projects address other issues, such as:

- Preventing or reducing the use of group care for children in foster care;
- Addressing behavioral health needs of children;
- Addressing needs of caregivers with substance use disorders; and
- Reducing placement instability for children in foster care.[38]

Florida's Title IV-E Waivers

Florida's original Title IV-E waiver was effective on October 1, 2006, and was in effect for five years. Key features of the waiver were:

- A capped allocation of funds, similar to a block grant, distributed to community-based care lead agencies for service provision;
- Flexibility to use funds for a broader array of services beyond out-of-home care; and
- Ability to serve children who did not meet Title IV-E criteria.[39]

The federal government extended Florida's original waiver to 2014, and then approved a renewal retroactively beginning October 1, 2013. The renewal is authorized until September 30, 2018. The renewal waiver's terms and conditions include the following goals:

- Improving child and family outcomes through flexible use of Title IV-E funds;
- Providing a broader array of community-based services and increasing the number of children eligible for services; and

February 7, 2018).

[37] U.S. Department of Health and Human Services, Administration of Children and Families, Children Bureau, *Summary of Child Welfare Waiver Demonstration by Jurisdictions,* June 2016, *available at*: http://www.acf.hhs.gov/sites/default/files/cb/waiver_summary_table_active.pdf. (last visited February 7, 2018).

[38] James Bell and Associates, *Summary of the Title IV-E Child Welfare Waiver Demonstrations, prepared for Children's Bureau, ACYF, ACF, HHS*, August 2016, *available at*: http://www.acf.hhs.gov/sites/default/files/cb/cw_waiver_summary2016.pdf. (last visited February 7, 2018).

[39] Amy C. Vargo et al., *Final Evaluation Report, IV-E Waiver Demonstration Evaluation, SFY 11-12,* March 15, 2012, *available at*: http://www.centerforchildwelfare.org/kb/LegislativeMandatedRpts/IV-EWaiverFinalReport3-28-12.pdf. (last visited February 7, 2018).

- Reducing administrative costs associated with the provision of child welfare services by removing current restrictions on Title IV-E eligibility and on the types of services that may be paid for using Title IV-E funds.[40]

Like the original waiver, the renewal waiver also involves a capped allocation of funds, flexibility to use the federal IV-E funds for a wider array of services, and expanded eligibility for children.[41]

Under current law, the U.S. Department of Health and Human Services is not authorized to grant any new child welfare waivers, and no state may operate a waiver project after September 30, 2019.[42] Therefore, Florida will revert to more restrictive Title IV-E federal funding requirements after September 30, 2018, or 2019 if the waiver is renewed for an additional year.

Additional Information

Committee staff[43] conducted telephone/video conferences with dependency judges statewide who identified the following issues related to the use of relative caregivers for children placed in out-of-home care:

- **Unexpected caregiving responsibility –** Foster parents are licensed, trained, and expect to take children into their homes; whereas, relatives are more often than not asked to take in children of family members suddenly and without time or help for any preparation.
- **Lack of knowledge about trauma** – While foster parents receive training, relative caregivers do not typically know how to deal with the trauma to which the children may have been exposed.
- **Dysfunctional family dynamics –** Relatives have additional stress and issues due to the fact that they are caring for children of other family members.
- **Increased use of family finding in order to identify family members earlier in the process –** In circuits where it is used, family finding works well to identify more family members and identify them earlier in the process, either during investigations or at the shelter hearing. In some circuits, the use of family finding is sporadic and not utilized throughout the life of the dependency case. Parents are often embarrassed and do not want family members to know they are involved with the child welfare system. Older children who know their relatives are often overlooked as a source of contact information.
- **Delays in process –** Delays in getting the results from home studies and fingerprint submissions is problematic. Also, delays in the Interstate Compact for the Placement of Children (ICPC)[44] process, which establishes procedures for ensuring the safety and stability of placements of children across state lines, cause further delays in placing children with out-of-state relatives. Judicial decisions with interstate placement implications must comply with the Compact.

[40] Personal communication from JooYeun Chang, Associate Commissioner with the Children's Bureau, to Esther Jacobo, Interim Secretary of the Department of Children and Families, *available at*: http://www.centerforchildwelfare.org/kb/GenIVE/WaiverTErms2013-2018.pdf. (last visited February 7, 2018).
[41] *Id*.
[42] §1130(a)(2) and (d)(2) of the Social Security Act.
[43] Surveys and studies conducted by the staff of the Senate Committee on Children, Families and Elder Affairs.
[44] Section 409.408, F.S.

- **Lack of services and support for families –** In some areas of the state, there is inadequate support for caregivers because there is no formal program to provide information, referral, training, legal services, and other follow-up services. As a result, grandparents and other relatives raising children are not being linked to the benefits and supports that they or the children in their care need.
- **Fewer benefits for children in care –** Children in out-of-home care are only eligible for some benefits if they are or have been in a licensed placement. For example, children in relative care are eligible for tuition and fee exemptions for postsecondary education,[45] but they are *not* typically eligible for independent living financial support and services.[46]
- **Caseworker "neglect" –**When a relative will not or cannot immediately commit to become a fulltime caregiver, the caseworker often forgets about the caregiver. There is little or no effort made to include the relative in other aspects of the child's life or improve the home so that the relative may be able to become a fulltime caregiver.
- **Lack of time and skill to effectively engage with relatives –** A number of circuits reported that while caseworkers generally do a good job, they frequently do not have the time to effectively deal with relatives who may become caregivers for children due either to large caseloads or to a lack of appropriate skills. Caseworkers often feel that placement with a relative is a "safe placement" and pay less attention to those placements.
- **Access to services should be the same regardless of placement –** Currently, access to services and supports for a child in out-of-home care vary depending on what type of placement the child is in.

In addition to speaking with judges around the state, committee staff[47] spoke with leadership, program staff, and relative caregivers with community-based care lead agencies across the state. Four major issues affecting the ability of relatives and nonrelatives to care for children placed in their care were identified:

- Sporadic and ineffective use of family finding. Family finding is defined as an intensive relative search and engagement technique to identify family of and other close adults to children in foster care, who will be involved in developing and carrying out a plan for the emotional and legal permanency of a child.
- Inadequate support of caregivers in some areas of the state due to a lack of formal kinship navigator programs designed to provide information, referral, and follow-up services. As a result, grandparents and other relatives raising children are not being linked to the benefits and supports that they or the children in their care need.
- Inadequate financial support or delays in receiving financial support.
- The obligation for relative caregivers to assume what may be a large portion of child care/early education expenses for a child in their care.

Notably, provisions of the bill address three of these four issues.

[45] Section 1009.25, F.S.
[46] Section 409.1451, F.S.
[47] *See supra*, n. 25.

Circuit	Lead Agency
Shaded rows indicate community-based care lead agencies with whom committee staff communicated.	
1 Escambia, Okaloosa, Santa Rosa, and Walton Counties	Lakeview Center, Families First Network
2 & 14 Franklin, Gadsden, Jefferson, Leon, Liberty, Wakulla Counties and Bay, Calhoun, Gulf, Holmes, Jackson, Washington Counties	Big Bend Community Based Care, Inc.
3 & 8 Columbia, Dixie, Hamilton, Lafayette, Madison, Suwannee, Taylor Counties and Alachua, Baker, Bradford, Gilchrist, Levy, Union Counties	Partnership for Strong Families
4 Duval and Nassau Counties	Family Support Services of North Florida Inc.
4 Clay County	Kids First of Florida, Inc.
7 St. Johns County	St Johns County Board of County Commissioners
7 Flagler, Volusia, and Putnam Counties	Community Partnership for Children, Inc.
12 DeSoto, Manatee, and Sarasota Counties	Sarasota Family YMCA, Inc.
6 Pasco and Pinellas Counties	Eckerd Community Alternatives
13 Hillsborough County	Eckerd Community Alt.,
20 Charlotte, Collier, Glades, Hendry and Lee Counties	Children's Network of SW Florida
5 Citrus, Hernando, Lake, Marion and Sumter Counties	Kids Central, Inc.
9 & 18 Orange, Osceola County and Seminole Counties	Community Based Care of Central Florida
18 Brevard County	Brevard Family Partnership
10 Hardee, Highlands, and Polk Counties	Heartland For Children
19 Indian River, Martin, Okeechobee, and St. Lucie Counties	Devereux CBC
15 & 17 Palm Beach County and Broward County	ChildNet Inc.
11 & 16 Miami-Dade County and Monroe County	Our Kids of Miami-Dade/Monroe, Inc.

Judicial Hearings and Review

When the department removes a child from his or her home, a series of dependency court proceedings must occur to adjudicate the child dependent and place him or her in out-of-home care, as indicated by the chart below:

Proceeding		Reference
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The court determines whether the child is to remain in out-of-home care.	s. 39.402, F.S.
Arraignment Hearing	An arraignment hearing occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Adjudicatory Hearing	An adjudicatory trial is held within 30 days of arraignment, to determine whether a child is dependent.	s. 39.507, F.S.
Disposition Hearing	Disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews and orders the case plan for the family and the appropriate placement of the child.	s. 39.521, F.S.
Review Hearing	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.

As noted above, current law provides for specific findings and determinations to be made by the court at each hearing.

The Rilya Wilson Act

Background

The Rilya Wilson Act is named for a four-year-old girl who disappeared from state custody and whose disappearance went unnoticed for 15 months. Rilya's caregiver provided several stories concerning Rilya's whereabouts, one being that someone from the Department of Children and Families removed Rilya from her home sometime in January 2001. However, the department was unaware that Rilya was missing until April 2002. While Rilya's caregiver (who is suspected, but not convicted, of killing Rilya) was sentenced to 55 years in prison in 2013 for offenses connected to Rilya's disappearance (including aggravated child abuse), Rilya remains missing.[48]

With the disappearance of Rilya Wilson, the responsibility of the state to ensure the safety of children in its care received heightened attention. To ensure the safety and well-being of children in its custody or under its supervision, DCF was required to provide for more frequent and continuous face-to-face contact with children, particularly those under the age of five. The Rilya Wilson Act provides such increased visibility of these very young children by requiring that these children participate in an approved early education or child care program. In turn, these early education or child care programs are bound to report certain incidences of the child's nonattendance or absence to the DCF.[49]

[48] The Miami Herald, Geralyn Graham gets 55 years in Rilya Wilson foster child abuse case, *available at*: http://www.miamiherald.com/latest-news/article1947207.html. (last visited Feb. 5, 2018).
[49] Section 39.604, F.S. ("Rilya Wilson Act").

Early Education and Child Care Programs

Participation in early child care and learning programs under the Rilya Wilson Act is intended not only to minimize further abuse and neglect, but also to reverse the developmental effects that abuse, neglect, and abandonment can have on children.[50]

Early education and child care programs are provided in Florida through the school readiness program under ss. 1001.213 and 1002.82, F.S. With the establishment of the school readiness program, the different early education and child care programs and their funding sources were merged for the delivery of a comprehensive program of school readiness services to be designed and administered through local early learning coalitions.[51] The school readiness program is housed with the Office of Early Learning at the Department of Education.[52]

Current law requires that each early learning coalition give priority for participation in the school readiness program according to specified criteria, with an at-risk child being second on the priority list.[53] An at-risk child is defined as the following:[54]

- A child from a family under investigation by the Department of Children and Families or a designated sheriff's office for child abuse, neglect, abandonment, or exploitation.
- A child who is in a diversion program provided by the Department of Children and Families or its contracted provider and who is from a family that is actively participating and complying in department-prescribed activities, including education, health services, or work.
- A child from a family that is under supervision by the Department of Children and Families or a contracted service provider for abuse, neglect, abandonment, or exploitation.
- A child placed in court-ordered, long-term custody or under the guardianship of a relative or nonrelative after termination of supervision by the Department of Children and Families or its contracted provider.
- A child in the custody of a parent who is a victim of domestic violence residing in a certified domestic violence center.
- A child in the custody of a parent who is considered homeless as verified by a Department of Children and Families certified homeless shelter.

As mentioned earlier, the cost of participating in the school readiness program is subsidized in part or fully by the funding of the local early learning coalition for eligible children.[55] Criteria have been established for the children who are to receive priority for participating in the program

[50] Section 39.604(2), F.S. (**"**The Legislature recognizes that children who are in the care of the state due to abuse, neglect, or abandonment are at increased risk of poor school performance and other behavioral and social problems. It is the intent of the Legislature that children who are currently in the care of the state be provided with an age-appropriate education program to help ameliorate the negative consequences of abuse, neglect, or abandonment.").
[51] Sections 1002.82 and 1002.83, F.S.
[52] Section 1002.82, F.S.
[53] Section 1002.87, F.S.
[54] Section 1002.81, F.S.
[55] Office of Early Learning, *School Readiness Payment Rates for Children Concurrently Enrolled in the VPK Program*, http://www.floridaearlylearning.com/sites/www/Uploads/files/Oel%20Resources/Rules%20Guidance%20and%20Proposed%20Rules/Issued%20Program%20Guidance/440.50_ConcurrentPaymentRates_Final_ADA.pdf (last visited Feb. 5, 2018).

at no cost or at a subsidized rate.[56] However, to the extent that subsidized child care is not available, the cost of child care is assumed by the caregiver.[57]

Regardless of whether a school readiness program provider is licensed, the program must "comply with the reporting requirements of the Rilya Wilson Act for each at-risk child under the age of school entry who is enrolled in the school readiness program."[58] Under the Rilya Wilson Act, children from birth to the age of school entry who are in the state's care due to abuse, neglect, or abandonment and who are enrolled in early education or child care programs must participate in the program five days a week.[59] This participation must be reflected in any case plan required by ch. 39, F.S. However, the court in approving or revising the case plan, may waive the requirement to participate five days a week.[60]

The Rilya Wilson Act also provides that:

- Withdrawal from the program is prohibited unless prior written approval is provided by the department or the community-based lead agency.[61]
- The person with whom the child is living is required to report any absence to the program on the day of the absence. Failure to report an absence results in the absence being considered unexcused, and the early education or child care program is required to report any unexcused absence or seven consecutive excused absences to the department or community-based lead agency.[62]
- Reports of two consecutive unexcused absences or seven consecutive excused absences are to result in a site visit to the child's residence. Children who are found missing during the site visit are to be reported as missing to law enforcement and the procedures for locating missing children initiated. If the children are not found to be missing, the parent or caregiver is to be informed that it is a violation of the case plan if the child does not attend the early education or child care program.[63]
- After two such site visits, action to notify the court of the parent or caregiver's non-compliance with the care plan is to be initiated.[64]

III. Effect of Proposed Changes:

Section 1 creates s. 39.4015, F.S., relating to family finding, to require the Department of Children and Families (DCF), in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, to develop a formal family finding program to be implemented statewide by child protective investigators and community-based care lead agencies. Family finding is required as soon as a child comes to the attention of the DCF and throughout the duration of the case. The DCF or community-based care lead agency

[56] Office of Early Learning, *School Readiness Eligibility Priorities*, http://www.floridaearlylearning.com/coalitions/school_readiness_eligibility_priorities.aspx (last visited Feb. 5, 2018).
[57] Fla. Admin. Code Ann. r. 65C-13.030(2)(d)4. (2014).
[58] Section 1002.87, F.S.
[59] Section 39.604(3), F.S.
[60] *Id.*
[61] Section 39.604(4)(a), F.S.
[62] Section 39.604(4)(b)1., F.S.
[63] Section 39.604(4)(b)2.-3., F.S.
[64] Section 39.604(4)(b)4., F.S.

must specifically document strategies taken to locate and engage relatives and kin. Strategies of engagement are provided in the bill.

The DCF and the community-based care lead agencies must use diligent efforts in family finding, must continue those efforts until multiple relatives and kin are identified, and must go beyond a basic computer search by exploring alternative tools and methodologies. Efforts to be used by the DCF and the community-based care lead agency are provided in the bill.

The court is required to inquire and make a determination regarding family finding at each stage of the case, including the shelter care hearing pursuant to s. 39.402. The court is to place its determinations on the record as to whether the DCF or community-based care lead agency has reasonably engaged in family finding. The level of reasonableness is to be determined by the length of the case and time the DCF or community-based care lead agency has had to begin or continue the process.

Section 1 is effective January 1, 2019.

Section 2 amends s. 39.402, F.S., relating to placement in a shelter, to require educational records of children under the age of school entry to be provided, to require a judge rather than a school superintendent to appoint a surrogate parent for a child under the age of school entry, if necessary, and to require the court to make a determination relating to family finding.

Section 3 amends s. 39.506, F.S., relating to arraignment hearings, to require the court to make a determination relating to family finding.

Section 4 amends s. 39.507, F.S., relating to adjudicatory hearings and orders of adjudication, to require the court to make a determination relating to family finding.

Section 5 amends s. 39.5085, F.S., relating to the Kinship Care Program, to provide that both relative and nonrelative caregivers receive financial assistance in the amount currently required for the Relative Caregiver Program with the payments to begin at the time a child comes into their care.

The bill also requires each community-based care lead agency to establish a kinship navigator program that must:

- Be coordinated with other state or local agencies that promote service coordination or provide information and referral services;
- Be planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;
- Establish a toll-free telephone hotline to provide information to link kinship caregivers to specified entities;
- Provide outreach to kinship care families; and
- Promote partnerships between public and private agencies and relevant governmental agencies to increase their knowledge of the needs of kinship care families to promote better services for those families.

Section 5 is effective January 1, 2019.

Section 6 amends s. 39.521, F.S., relating to disposition hearings and powers of disposition, to require the court to make a determination relating to family finding and to require educational records of children under the age of school entry to be provided.

Section 7 amends s. 39.6012, F.S., relating to case plan tasks and services, to require documentation of case plan requirements under s. 39.604, F.S.

Section 8 amends s. 39.604, F.S., relating to the Rilya Wilson Act, to clarify attendance and reporting requirements related to children in out-of-home care who are attending a child care or early education program. The bill also provides for the appointment of a surrogate parent[65], if appropriate, and provides for educational stability and transitions.

Section 9 amends s. 39.6251, F.S., relating to continuing care for young adults, to conform to additional federal requirements for extending foster care to the age of 21.

Section 10 amends s. 39.701, F.S., relating to judicial review, to require the court to appoint a surrogate parent if the child is under the age of school entry, and to require the court to determine if the department and community-based care lead agency has reasonably engaged in family finding.

Section 11 amends s. 409.166, F.S., relating to the adoption assistance program, to provide for the extension of maintenance adoption subsidy payments to the age of 21 for eligible young adults and to provide eligibility requirements. The bill also requires that all prospective adoptive homes complete an adoptive home study in order to qualify for a maintenance adoption subsidy (MAS).

The extension of the MAS to age 21 for those children who were adopted at age 16 or 17 will allow the state to earn additional federal revenues under Title IV-E. At present, the MAS payments expire when a child reaches the age of 18. Without these changes, the state would not meet federal requirements for earning Title IV-E funds associated with extended foster care.

Section 12 amends s. 414.045, F.S., relating to the cash assistance program, to conform a provision to changes made by the bill. This section of bill is effective January 1, 2019.

Section 13 amends s. 1009.25, F.S., relating to fee exemptions, to conform a provision to changes made by the bill.

Section 14 creates an unnumbered section of the Florida Statutes, requiring the department to establish a Title IV-E GAP pilot program in two DCF circuits effective August 1, 2018.

[65] Section 39.0016(1)(c), F.S. (A "surrogate parent" is "an individual appointed to act in the place of a parent in educational decision making and in safeguarding a child's rights under the Individuals with Disabilities Education Act [IDEA] and this section.").

The establishment of a GAP program would serve as a means of mitigating the loss of federal revenues to the state that will result from the expiration of Florida's Title IV-E waiver. The program will provide the state with an alternative vehicle for earning federal revenues under Title IV-E, while also offering enhanced cash benefits to certain permanent guardians and the children in their care.

It is currently unknown how many Relative Caregiver Program participants will successfully transition to GAP or how many relatives and fictive kin will enter the program in the future. The federally-subsidized GAP will require caregivers to meet many of the licensure standards applicable to family foster homes, set forth in s. 409.175, F.S. The department has the authority to waive non-safety licensure standards on a case-by-case basis, but some relatives or fictive kin will be unable to, or prefer not to, meet its requirements. This means that under the bill, some relatives and fictive kin will enter GAP, but some will not. For those who do not, relatives will be eligible for child only TANF funding, but non-relatives will not be able to obtain payment to support caring for the child.

Establishment of a pilot program may provide information as to whether statewide implementation of GAP benefits children and their families.

Section 15 provides that, except as otherwise expressly provided in the bill, the effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The department currently has 19 contracts with the community-based care (CBC) lead agencies. To implement the family finder and kinship navigator programs in the bill, CBCs may need to hire additional staff. One CBC (Eckerd Community Alternatives) currently employs a family finder at a salary of $52,500, including taxes and benefits.

The combined projected costs for the remaining 18 CBCs could total $945,000 per year.[66] Since the programs are effective January 1, 2019, the total cost for Fiscal Year 2018-2019 would be $472,500.

C. Government Sector Impact:

Summary:
Overall, to implement this bill, the DCF is requesting 12 additional full-time equivalent (FTE) positions in FY 2018-2019 and is expected to incur additional costs up to $3,207,326 in FY 2018-2019 and $4,230,000 annually thereafter. Local governments, specifically the six sheriff's offices conducting child protective investigations, are collectively expected to incur additional costs of $157,500 in FY 2018-2019 and $315,000 annually thereafter. A brief explanation of the various fiscal impacts is noted below.

Local Government:
The six counties in which the county sheriff's offices provide child protective investigations (Hillsborough, Pasco, Pinellas, Broward, Manatee, and Seminole) are provided grants from the Department of Children and Families (DCF). This bill directs the DCF to work collaboratively with these sheriff's offices to develop family finding processes. These sheriff's offices may need additional staff to implement the family finding program procedures. The estimated cost for six new sheriff's office staff is $157,500 in FY 2018-2019 and $315,000 annually thereafter. [67]

Department of Children and Families:
The DCF estimates it will need two additional staff positions in each one of its six regions to support the family finding and kinship navigator programs. According to the DCF, the annual cost for these 12 additional full-time equivalent (FTE) positions totals $315,000 in Fiscal Year 2018-2019 and $630,000 for each following fiscal year.[68]

The bill will result in additional relative and non-relative caregiver payments by directing payments to begin at the time the child is placed with the caregiver rather than the current payment which begins several months later when the child is adjudicated dependent by the court. The DCF estimates the earlier monthly payments may cost the state an additional $3.6 million each year.[69] The bill makes advanced caregiver payments effective January 1, 2019; therefore, the total cost for Fiscal Year 2018-2019 is expected to be $1.8 million. Additionally, DCF estimates a one-time cost between $384,696 and $464,256[70] for technology updates to the FLORIDA system to provide for the earlier issuance of payments.

The family finding and kinship navigator programs may facilitate the placement of children with kin caregivers who would have otherwise entered a more expensive care

[66] Department of Children and Families, *Senate Bill 590*, p. 8 (Oct. 24, 2017) (on file with the Senate Judiciary Committee).
[67] *Id.*
[68] *Id.* at p. 7.
[69] *Id.*
[70] *Id.* at p. 8.

setting, resulting in costs savings that may offset program expenditures. The cost of placing a child with a relative or non-relative caregiver is between $2,904 and $3,576 per year per child (depending on the child's age), while placement in a group home facility averages over $40,000 per year per child. An increase in relative and non-relative caregivers could lead to decreased expenditures for foster care and residential group home care.

The bill requires the DCF to operate a pilot Title IV-E Guardianship Assistance Program (GAP) in two DCF circuits effective August 1, 2018. No new Relative Caregiver or Nonrelative Caregiver applicants will be approved in these circuits during the pilot period. Assuming no more than 60 days for licensing GAP caregiver applicants, monthly GAP room and board payments could be made available to program participants as early as October 2018. The DCF will require additional nonrecurring funding of $628,070 for Fiscal Year 2018-2019 to implement the GAP Pilot program and provide for GAP monthly room and board payments and nonrecurring assistance up to $2,000 per care giver to cover legal and other expenses.

GAP Pilot Cost Summary:	**FY 2018-19**
Licensing Staff	$ 360,283
Program Management Staff	180,242
GAP Room & Board Payments	389,610
One-time Legal Costs for Eligible Caregivers	5,200
Total Costs for GAP Pilot Program	$ 935,335
Less: Relative/Nonrelative Caregiver Room & Board Payments	(307,265)
Net Costs for GAP Pilot Program	$ 628,070

The above funding includes Other Personal Services funding for licensing specialists and two program managers, one for each circuit. The program managers will assist with the design and implementation of the pilot program, as well as the establishment of policies and procedures for future GAP Program statewide expansion.

The bill also modifies two existing DCF programs to align with federal Title IV-E requirements and enable the department to earn additional Title IV-E federal funding for services. First, though the Extended Foster Care program extends services to age 21 for young adults who have not achieved permanency and who have met certain requirements. Secondly, adoption subsidy payments are extended to age 21 for children who experienced late-stage adoptions (were adopted at age 16 or 17). Funding for these initiatives is included in Senate Bill 2500, the Senate Fiscal Year 2018-2019 General Appropriations Bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

The bill substantially amends ss. 39.402, 39.506, 39.507, 39.5085, 39.521, 39.6012, 39.604, 39.6251, 39.701, 409.166, 414.045, and 1009.25 of the Florida Statutes.

The bill creates s. 39.4015 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 21, 2018:
The committee substitute:

- Amends s. 39.6251, F.S., extending foster care services to age 21 for young adults who have not achieved permanency and who have met certain requirements, to conform to federal Title IV-E requirements.
- Amends s. 409.166, F.S., extending maintenance adoption subsidy payments to the age of 21 for children who were adopted at age 16 or 17, to conform to federal Title IV-E requirements.
- Requires that all prospective adoptive homes complete an adoption home study in order to qualify for maintenance adoption subsidy payments.
- Removes provisions and requirements related to early intervention referrals to Early Steps or FDLRS Child Find.
- Requires the establishment of a Title IV-E GAP pilot program in two circuits effective August 1, 2018.

CS by Children, Families, and Elder affairs on December 4, 2017:

- Amends ss. 39.402, 39.506, 39.507, 39.521, and 39.701, F.S., relating to judicial hearings, to require a determination by the court relating to family finding.
- Adds a task to the case plan requirements required under s. 39.604, F.S.
- Requires that children under the age of three and children ages 3 to 5 years who are victims of substantiated child abuse or neglect be referred for an early intervention assessment by Early Steps or FDLRS Child Find as appropriate.
- Provides for the appointment of a surrogate parent if appropriate, and provides for educational stability and transitions in child care and early education program settings.

B. Amendments:

None.

497732

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2018	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Effective January 1, 2019, section 39.4015, Florida Statutes, is created to read:

39.4015 Family finding.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that every child who is in out-of-home care has the goal of finding a permanent home, whether

achieved by reunifying the child with his or her parents or finding another permanent connection, such as adoption or legal guardianship with a relative or nonrelative who has a significant relationship with the child.

(b) The Legislature finds that while legal permanency is important to a child in out-of-home care, emotional permanency helps increase the likelihood that children will achieve stability and well-being and successfully transition to independent adulthood.

(c) The Legislature also finds that research has consistently shown that placing a child within his or her own family reduces the trauma of being removed from his or her home, is less likely to result in placement disruptions, and enhances prospects for finding a permanent family if the child cannot return home.

(d) The Legislature further finds that the primary purpose of family finding is to facilitate legal and emotional permanency for children who are in out-of-home care by finding and engaging their relatives.

(e) It is the intent of the Legislature that every child in out-of-home care be afforded the advantages that can be gained from the use of family finding to establish caring and long-term or permanent connections and relationships for children and youth in out-of-home care, as well as to establish a long-term emotional support network with family members and other adults who may not be able to take the child into their home but who want to stay connected with the child.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Diligent efforts" means the use of methods and

techniques including, but not limited to, interviews with immediate and extended family and kin, genograms, eco-mapping, case mining, cold calls, and specialized computer searches.

(b) "Family finding" means an intensive relative search and engagement technique used in identifying family and other close adults for children in out-of-home care and involving them in developing and carrying out a plan for the emotional and legal permanency of a child.

(c) "Family group decisionmaking" is a generic term that includes a number of approaches in which family members and fictive kin are brought together to make decisions about how to care for their children and develop a plan for services. The term includes family team conferencing, family team meetings, family group conferencing, family team decisionmaking, family unity meetings, and team decisionmaking, which may consist of several phases and employ a trained facilitator or coordinator.

(d) "Fictive kin" means an individual who is unrelated to the child by either birth or marriage, but has such a close emotional relationship with the child that he or she may be considered part of the family.

(3) FAMILY-FINDING PROGRAM.—The department, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, shall develop a formal family-finding program to be implemented statewide by child protective investigators and community-based care lead agencies.

(a) Family finding is required as soon as a child comes to the attention of the department and throughout the duration of the case, and finding and engaging with as many family members


497732

and fictive kin as possible for each child who may help with care or support for the child is considered a best practice. The department or community-based care lead agency must specifically document strategies taken to locate and engage relatives and kin. Strategies of engagement may include, but are not limited to, asking the relatives and kin to:

1. Participate in a family group decisionmaking conference, family team conferencing, or other family meetings aimed at developing or supporting the family service plan;

2. Attend visitations with the child;

3. Assist in transportation of the child;

4. Provide respite or child care services; or

5. Provide actual kinship care.

(b) The department and the community-based care lead agencies must use diligent efforts in family finding, must continue those efforts until multiple relatives and kin are identified, and must go beyond basic searching tools by exploring alternative tools and methodologies. Efforts by the department and the community-based care lead agency may include, but are not limited to:

1. Searching for and locating adult relatives and kin.

2. Identifying and building positive connections between the child and the child’s relatives and fictive kin.

3. Supporting the engagement of relatives and fictive kin in social service planning and delivery of services and creating a network of extended family support to assist in remedying the concerns that led to the child becoming involved with the child welfare system, when appropriate.

4. Maintaining family connections, when possible.

497732

5. Keeping siblings together in care, when in the best interest of each child and when possible.

(c) A basic computer search using the Internet or attempts to contact known relatives at a last known address or telephone number do not constitute effective family finding.

(d) The court's inquiry and determination regarding family finding should be made at each stage of the case, including a shelter hearing conducted pursuant to s. 39.402. The court shall place its determinations on the record as to whether the department or community-based care lead agency has reasonably engaged in family finding. The level of reasonableness is to be determined by the length of the case and the amount of time the department or community-based care lead agency has had to begin or continue the process.

(4) RULEMAKING.—The department shall adopt rules to implement this section.

Section 2. Paragraphs (c) and (d) of subsection (11) of section 39.402, Florida Statutes, and subsection (17) of that section are amended to read:

39.402 Placement in a shelter.—

(11)

(c) The court shall request that the parents consent to provide access to the child's child care records, early education program records, or other educational records and provide information to the court, the department or its contract agencies, and any guardian ad litem or attorney for the child. If a parent is unavailable or unable to consent or withholds consent and the court determines access to the records and information is necessary to provide services to the child, the

court shall issue an order granting access.

(d) The court may appoint a surrogate parent or may refer the child to the district school superintendent for appointment of a surrogate parent if the child has or is suspected of having a disability and the parent is unavailable pursuant to s. 39.0016(3)(b). If the child is under the age of school entry, the court must make the appointment.

(17) At the shelter hearing, the court shall inquire of the parent whether the parent has relatives who might be considered as a placement for the child. The parent shall provide to the court and all parties identification and location information regarding the relatives. The court shall advise the parent that the parent has a continuing duty to inform the department of any relative who should be considered for placement of the child. The court shall place its determinations on the record as to whether the department or community-based care lead agency has reasonably engaged in family finding. The level of reasonableness is to be determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

Section 3. Present subsection (9) of section 39.506, Florida Statutes, is redesignated as subsection (10), and a new subsection (9) is added to that section, to read:

39.506 Arraignment hearings.—

(9) The court shall review whether the department or community-based care lead agency has reasonably engaged in family finding and make a written determination as to its findings. The level of reasonableness is determined by the length of the case and amount of time the department or


497732

community-based care lead agency has had to begin or continue the process.

Section 4. Paragraphs (c) and (d) of subsection (7) of section 39.507, Florida Statutes, are amended to read:

39.507 Adjudicatory hearings; orders of adjudication.—

(7)

(c) If a court adjudicates a child dependent and the child is in out-of-home care, the court shall inquire of the parent or parents whether the parents have relatives who might be considered as a placement for the child. ~~The court shall advise the parents that, if the parents fail to substantially comply with the case plan, their parental rights may be terminated and that the child's out-of-home placement may become permanent.~~ The parent or parents shall provide to the court and all parties identification and location information of the relatives. The court shall review whether the department or community-based care lead agency has reasonably engaged in family finding and make a written determination as to its findings. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

(d) The court shall advise the parents that, if they fail to substantially comply with the case plan, their parental rights may be terminated and that the child's out-of-home placement may become permanent.

Section 5. Effective January 1, 2019, section 39.5085, Florida Statutes, is amended to read:

39.5085 Kinship Care ~~Relative Caregiver~~ Program.—

(1) LEGISLATIVE FINDINGS AND INTENT.—


497732

(a) The Legislature finds that an increasing number of relatives and fictive kin are assuming the responsibility of raising children because the parents of these children are unable to care for them.

(b) The Legislature also finds that these kinship caregivers perform a vital function by providing homes for children who would otherwise be at risk of foster care placement and that kinship care is a crucial option in the spectrum of out-of-home care available to children in need.

(c) The Legislature finds that children living with kinship caregivers experience increased placement stability, are less likely to reenter care if they are reunified with their parents, and have better behavioral and mental health outcomes.

(d) The Legislature further finds that these kinship caregivers may face a number of difficulties and need assistance to support the health and well-being of the children they care for. These needs include, but are not limited to, financial assistance, legal assistance, respite care, child care, specialized training, and counseling.

(e) It is the intent of the Legislature to provide for the establishment and implementation of procedures and protocols that are likely to increase and adequately support appropriate and safe kinship care placements.

(2) DEFINITIONS.—As used this section, the term:

(a) "Fictive kin" means an individual who is unrelated to the child by either birth or marriage, but has such a close emotional relationship with the child that he or she may be considered part of the family.

(b) "Kinship care" means the full-time care of a child

497732

placed in out-of-home care by the court in the home of a relative or fictive kin.

(c) "Kinship navigator program" means a statewide program designed to ensure that kinship caregivers are provided with necessary resources for the preservation of the family.

(d) "Relative" means an individual who is caring full time for a child placed in out-of-home care by the court and who:

1. Is related to the child within the fifth degree by blood or marriage to the parent or stepparent of the child; or

2. Is related to a half-sibling of that child within the fifth degree by blood or marriage to the parent or stepparent.

(3) FINANCIAL ASSISTANCE.—The department shall provide financial assistance to all caregivers who qualify under this subsection.

(a) Relatives or fictive kin caring for a child who has been placed with them by the court shall receive a monthly caregiver benefit, beginning when the child is placed with them. The amount of the benefit payment is based on the child's age within a payment schedule established by rule of the department. The cost of providing the assistance described in this section to any caregiver may not exceed the cost of providing out-of-home care in emergency shelter or foster care.

(b) Caregivers who receive assistance under this section must be capable, as determined by a home study, of providing a physically safe environment and a stable, supportive home for the children under their care and must assure that the children's well-being is met, including, but not limited to, the provision of immunizations, education, and mental health services, as needed.


497732

(c) Caregivers who qualify for and receive assistance under this section are not required to meet foster care licensing requirements under s. 409.175.

(d) Children receiving cash benefits under this section are not eligible to simultaneously receive WAGES cash benefits under chapter 414.

(d) A caregiver may not receive a benefit payment if the parent or stepparent of the child resides in the home. However, a caregiver may receive the benefit payment for a minor parent who is in his or her care, as well as for the minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is receiving a benefit payment when a parent, other than an eligible minor parent, or stepparent moves into the home, the payment must be terminated no later than the first day of the month following the move, allowing for 10-day notice of adverse action.

(e) Children living with caregivers who are receiving assistance under this section are eligible for Medicaid coverage.

(4) ADDITIONAL ASSISTANCE AND SERVICES.—

(a) The purpose of a kinship navigator program is to help relative caregivers and fictive kin in the child welfare system to navigate the broad range of services available to them and the children from public, private, community, and faith-based organizations.

(b) By January 1, 2019, each community-based care lead agency shall establish a kinship navigator program. In order to meet the requirements of a kinship navigator program, the

program must:

1. Be coordinated with other state or local agencies that promote service coordination or provide information and referral services, including any entities that participate in the Florida 211 Network, to avoid duplication or fragmentation of services to kinship care families;

2. Be planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;

3. Establish a toll-free telephone hotline to provide information to link kinship caregivers, kinship support group facilitators, and kinship service providers to:

a. One another;

b. Eligibility and enrollment information for federal, state, and local benefits;

c. Relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services; and

d. Relevant knowledge related to legal options available for child custody, other legal assistance, and help in obtaining legal services.

4. Provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials; and

5. Promote partnerships between public and private agencies, including schools, community-based or faith-based organizations, and relevant governmental agencies, to increase their knowledge of the needs of kinship care families to promote better services for those families.


497732

(5) RULEMAKING.—The department shall adopt rules to implement this section.

~~(1) It is the intent of the Legislature in enacting this section to:~~

~~(a) Provide for the establishment of procedures and protocols that serve to advance the continued safety of children by acknowledging the valued resource uniquely available through grandparents, relatives of children, and specified nonrelatives of children pursuant to subparagraph (2)(a)3.~~

~~(b) Recognize family relationships in which a grandparent or other relative is the head of a household that includes a child otherwise at risk of foster care placement.~~

~~(c) Enhance family preservation and stability by recognizing that most children in such placements with grandparents and other relatives do not need intensive supervision of the placement by the courts or by the department.~~

~~(d) Recognize that permanency in the best interests of the child can be achieved through a variety of permanency options, including permanent guardianship under s. 39.6221 if the guardian is a relative, by permanent placement with a fit and willing relative under s. 39.6231, by a relative, guardianship under chapter 744, or adoption, by providing additional placement options and incentives that will achieve permanency and stability for many children who are otherwise at risk of foster care placement because of abuse, abandonment, or neglect, but who may successfully be able to be placed by the dependency court in the care of such relatives.~~

~~(e) Reserve the limited casework and supervisory resources of the courts and the department for those cases in which~~

~~children do not have the option for safe, stable care within the family.~~

~~(f) Recognize that a child may have a close relationship with a person who is not a blood relative or a relative by marriage and that such person should be eligible for financial assistance under this section if he or she is able and willing to care for the child and provide a safe, stable home environment.~~

~~(2)(a) The Department of Children and Families shall establish, operate, and implement the Relative Caregiver Program by rule of the department. The Relative Caregiver Program shall, within the limits of available funding, provide financial assistance to:~~

~~1. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.~~

~~2. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.~~

~~3. Nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or~~


497732

~~abandonment and subsequent placement with the nonrelative caregiver under this chapter. The court must find that a proposed placement under this subparagraph is in the best interest of the child.~~

~~4. A relative or nonrelative caregiver, but the relative or nonrelative caregiver may not receive a Relative Caregiver Program payment if the parent or stepparent of the child resides in the home. However, a relative or nonrelative may receive the Relative Caregiver Program payment for a minor parent who is in his or her care, as well as for the minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is currently receiving the payment, the Relative Caregiver Program payment must be terminated no later than the first of the following month after the parent or stepparent moves into the home, allowing for 10-day notice of adverse action.~~

~~The placement may be court-ordered temporary legal custody to the relative or nonrelative under protective supervision of the department pursuant to s. 39.521(1)(c)3., or court-ordered placement in the home of a relative or nonrelative as a permanency option under s. 39.6221 or s. 39.6231 or under former s. 39.622 if the placement was made before July 1, 2006. The Relative Caregiver Program shall offer financial assistance to caregivers who would be unable to serve in that capacity without the caregiver payment because of financial burden, thus exposing the child to the trauma of placement in a shelter or in foster care.~~

~~(b) Caregivers who receive assistance under this section~~


497732

~~must be capable, as determined by a home study, of providing a physically safe environment and a stable, supportive home for the children under their care and must assure that the children's well-being is met, including, but not limited to, the provision of immunizations, education, and mental health services as needed.~~

~~(c) Relatives or nonrelatives who qualify for and participate in the Relative Caregiver Program are not required to meet foster care licensing requirements under s. 409.175.~~

~~(d) Relatives or nonrelatives who are caring for children placed with them by the court pursuant to this chapter shall receive a special monthly caregiver benefit established by rule of the department. The amount of the special benefit payment shall be based on the child's age within a payment schedule established by rule of the department and subject to availability of funding. The statewide average monthly rate for children judicially placed with relatives or nonrelatives who are not licensed as foster homes may not exceed 82 percent of the statewide average foster care rate, and the cost of providing the assistance described in this section to any caregiver may not exceed the cost of providing out-of-home care in emergency shelter or foster care.~~

~~(e) Children receiving cash benefits under this section are not eligible to simultaneously receive WAGES cash benefits under chapter 414.~~

~~(f) Within available funding, the Relative Caregiver Program shall provide caregivers with family support and preservation services, flexible funds in accordance with s. 409.165, school readiness, and other available services in order~~


497732

~~to support the child's safety, growth, and healthy development. Children living with caregivers who are receiving assistance under this section shall be eligible for Medicaid coverage.~~

~~(g) The department may use appropriate available state, federal, and private funds to operate the Relative Caregiver Program. The department may develop liaison functions to be available to relatives or nonrelatives who care for children pursuant to this chapter to ensure placement stability in extended family settings.~~

Section 6. Paragraph (e) of subsection (1) of section 39.521, Florida Statutes, is amended to read:

39.521 Disposition hearings; powers of disposition.—

(1) A disposition hearing shall be conducted by the court, if the court finds that the facts alleged in the petition for dependency were proven in the adjudicatory hearing, or if the parents or legal custodians have consented to the finding of dependency or admitted the allegations in the petition, have failed to appear for the arraignment hearing after proper notice, or have not been located despite a diligent search having been conducted.

(e) The court shall, in its written order of disposition, include all of the following:

1. The placement or custody of the child.

2. Special conditions of placement and visitation.

3. Evaluation, counseling, treatment activities, and other actions to be taken by the parties, if ordered.

4. The persons or entities responsible for supervising or monitoring services to the child and parent.

5. Continuation or discharge of the guardian ad litem, as

appropriate.

6. The date, time, and location of the next scheduled review hearing, which must occur within the earlier of:

a. Ninety days after the disposition hearing;

b. Ninety days after the court accepts the case plan;

c. Six months after the date of the last review hearing; or

d. Six months after the date of the child's removal from his or her home, if no review hearing has been held since the child's removal from the home.

7. If the child is in an out-of-home placement, child support to be paid by the parents, or the guardian of the child's estate if possessed of assets which under law may be disbursed for the care, support, and maintenance of the child. The court may exercise jurisdiction over all child support matters, shall adjudicate the financial obligation, including health insurance, of the child's parents or guardian, and shall enforce the financial obligation as provided in chapter 61. The state's child support enforcement agency shall enforce child support orders under this section in the same manner as child support orders under chapter 61. Placement of the child shall not be contingent upon issuance of a support order.

8.a. If the court does not commit the child to the temporary legal custody of an adult relative, legal custodian, or other adult approved by the court, the disposition order must ~~shall~~ include the reasons for such a decision and ~~shall include~~ a written determination as to whether ~~diligent efforts were made by~~ the department and the community-based care lead agency reasonably engaged in family finding in attempting to locate an adult relative, legal custodian, or other adult willing to care


497732

for the child in order to present that placement option to the court instead of placement with the department. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

b. If no suitable relative is found and the child is placed with the department or a legal custodian or other adult approved by the court, both the department and the court shall consider transferring temporary legal custody to an adult relative approved by the court at a later date, but neither the department nor the court is obligated to so place the child if it is in the child's best interest to remain in the current placement.

~~For the purposes of this section, "diligent efforts to locate an adult relative" means a search similar to the diligent search for a parent, but without the continuing obligation to search after an initial adequate search is completed.~~

9. Other requirements necessary to protect the health, safety, and well-being of the child, to preserve the stability of the child's child care, early education program, or any other educational placement, and to promote family preservation or reunification whenever possible.

Section 7. Paragraph (b) of subsection (2) and paragraph (a) of subsection (3) of section 39.6012, Florida Statutes, are amended to read:

39.6012 Case plan tasks; services.—

(2) The case plan must include all available information that is relevant to the child's care including, at a minimum:

(b) A description of the plan for ensuring that the child receives safe and proper care and that services are provided to the child in order to address the child's needs. To the extent available and accessible, the following health, mental health, and education information and records of the child must be attached to the case plan and updated throughout the judicial review process:

1. The names and addresses of the child's health, mental health, and educational providers;

2. The child's grade level performance;

3. The child's school record or, if the child is under the age of school entry, any records from a child care program, early education program, or preschool program;

4. Documentation of compliance or noncompliance with the attendance requirements under s. 39.604, if the child is enrolled in a child care program, early education program, or preschool program;

5.~~4.~~ Assurances that the child's placement takes into account proximity to the school in which the child is enrolled at the time of placement;

6. ~~5. A record of~~ The child's immunizations;

7.~~6.~~ The child's known medical history, including any known health problems;

8.~~7.~~ The child's medications, if any; and

9.~~8.~~ Any other relevant health, mental health, and education information concerning the child.

(3) In addition to any other requirement, if the child is in an out-of-home placement, the case plan must include:

(a) A description of the type of placement in which the

child is to be living and, if the child has been placed with the department, whether the department and the community-based care lead agency have reasonably engaged in family finding to locate an adult relative, legal custodian, or other adult willing to care for the child in order to present that placement option to the court instead of placement with the department.

Section 8. Section 39.604, Florida Statutes, is amended to read:

39.604 Rilya Wilson Act; short title; legislative intent; requirements; attendance; stability and transitions ~~reporting responsibilities~~.—

(1) SHORT TITLE.—This section may be cited as the "Rilya Wilson Act."

(2) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that children from birth to age 5 years are particularly vulnerable to maltreatment and that they enter out-of-home care in disproportionately high numbers.

(b) The Legislature also finds that children who are abused or neglected are at high risk of experiencing physical and mental health problems and problems with language and communication, cognitive development, and social and emotional development.

(c) The Legislature also finds that providing early intervention and services, as well as quality child care and early education programs to support the healthy development of these young children, can have positive effects that last throughout childhood and into adulthood.

(d) The Legislature also finds that the needs of each of these children are unique, and while some children may be best

497732

served by a quality child care or early education program, others may need more attention and nurturing that can best be provided by a stay-at-home caregiver ~~The Legislature recognizes that children who are in the care of the state due to abuse, neglect, or abandonment are at increased risk of poor school performance and other behavioral and social problems~~.

(e) It is the intent of the Legislature that children who are ~~currently~~ in out-of-home ~~the~~ care ~~of the state~~ be provided with an age-appropriate developmental child care or early education arrangement that is in the best interest of the child ~~education program~~ to help ameliorate the negative consequences of abuse, neglect, or abandonment.

(3) REQUIREMENTS.—

1. A child from birth to the age of school entry, who is under court-ordered protective supervision or in out-of-home care and is ~~the custody of the Family Safety Program Office of the Department of Children and Families or a community-based lead agency, and~~ enrolled in an ~~a licensed~~ early education or child care program must attend the program 5 days a week unless the court grants an exception due to the court determining it is in the best interest of a child from birth to age 3 years:

a. With a stay-at-home caregiver to remain at home.

b. With a caregiver who works less than full time to attend an early education or child care program fewer than 5 days a week.

2. Notwithstanding s. 39.202, the department ~~of Children and Families~~ must notify operators of an ~~the licensed~~ early education or child care program, subject to the reporting requirements of this act, of the enrollment of any child from


497732

birth to the age of school entry, under court-ordered protective supervision or in out-of-home care. If ~~the custody of the Family Safety Program Office of the Department of Children and Families or a community-based lead agency. When~~ a child is enrolled in an early education or child care program ~~regulated by the department~~, the child's attendance in the program must be a required task ~~action~~ in the safety plan or the case plan developed for the child pursuant to this chapter. ~~An exemption to participating in the licensed early education or child care program 5 days a week may be granted by the court.~~

(4) ATTENDANCE ~~AND REPORTING REQUIREMENTS~~.—

1.~~(a)~~ A child enrolled in an ~~a licensed~~ early education or child care program who meets the requirements of paragraph (b) ~~subsection (3)~~ may not be withdrawn from the program without the prior written approval of the department ~~Family Safety Program Office of the Department of Children and Families~~ or the community-based care lead agency.

2.a.~~(b)1.~~ If a child covered by this section is absent from the program on a day when he or she is supposed to be present, the person with whom the child resides must report the absence to the program by the end of the business day. If the person with whom the child resides, whether the parent or caregiver, fails to timely report the absence, the absence is considered to be unexcused. The program shall report any unexcused absence or seven consecutive excused absences of a child who is enrolled in the program and covered by this act to the ~~local designated staff of the Family Safety Program Office of the~~ department ~~of Children and Families~~ or the community-based care lead agency by the end of the business day following the unexcused absence or

seventh consecutive excused absence.

b.~~2.~~ The department or community-based care lead agency shall conduct a site visit to the residence of the child upon receiving a report of two consecutive unexcused absences or seven consecutive excused absences.

c.~~3.~~ If the site visit results in a determination that the child is missing, the department or community-based care lead agency shall follow the procedure set forth in s. 39.0141 ~~report the child as missing to a law enforcement agency and proceed with the necessary actions to locate the child pursuant to procedures for locating missing children~~.

d.~~4.~~ If the site visit results in a determination that the child is not missing, the parent or caregiver shall be notified that failure to ensure that the child attends the ~~licensed~~ early education or child care program is a violation of the safety plan or the case plan. If more than two site visits are conducted pursuant to this subsection, staff shall ~~initiate action to~~ notify the court of the parent or caregiver's noncompliance with the case plan.

(5) EDUCATIONAL STABILITY.—Just as educational stability is important for school-age children, it is also important to minimize disruptions to secure attachments and stable relationships with supportive caregivers of children from birth to school age and to ensure that these attachments are not disrupted due to placement in out-of-home care or subsequent changes in out-of-home placement.

(a) A child must be allowed to remain in the child care or early educational setting that he or she attended before entry into out-of-home care, unless the program is not in the best


497732

interest of the child.

(b) If it is not in the best interest of the child for him or her to remain in his or her child care or early education setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, child care and educational staff, and educational surrogate, if one has been appointed, to determine the best setting for the child. Such setting may be a child care provider that receives a Gold Seal Quality Care designation pursuant to s. 402.281, a provider participating in a quality rating system, a licensed child care provider, a public school provider, or a license-exempt child care provider, including religious-exempt and registered providers, and non-public schools.

(c) The department and providers of early care and education shall develop protocols to ensure continuity if children are required to leave a program because of a change in out-of-home placement.

(6) TRANSITIONS.—In the absence of an emergency, if a child from birth to school age leaves a child care or early education program, the transition must be pursuant to a plan that involves cooperation and sharing of information among all persons involved, that respects the child's developmental stage and associated psychological needs, and that allows for a gradual transition from one setting to another.

Section 9. Paragraph (b) of subsection (6) and subsection (7) of section 39.6251, Florida Statutes, are amended to read:

39.6251 Continuing care for young adults.—

(6) A young adult who is between the ages of 18 and 21 and who has left care may return to care by applying to the


497732

community-based care lead agency for readmission. The community-based care lead agency shall readmit the young adult if he or she continues to meet the eligibility requirements in this section.

(b) Within 30 days after the young adult has been readmitted to care, the community-based care lead agency shall assign a case manager to update the case plan and the transition plan and to arrange for the required services. Updates to the case plan and the transition plan and arrangements for the required services ~~Such activities~~ shall be undertaken in consultation with the young adult. The department shall petition the court to reinstate jurisdiction over the young adult. Notwithstanding s. 39.013(2), the court shall resume jurisdiction over the young adult if the department establishes that he or she continues to meet the eligibility requirements in this section.

(7) During each period of time that a young adult is in care, the community-based lead agency shall provide regular case management reviews that must include at least monthly contact with the case manager. ~~If a young adult lives outside the service area of his or her community-based care lead agency, monthly contact may occur by telephone.~~

Section 10. Paragraph (c) of subsection (2) of section 39.701, Florida Statutes, is amended to read:

39.701 Judicial review.—

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(c) *Review determinations.*—The court and any citizen review panel shall take into consideration the information contained in

the social services study and investigation and all medical, psychological, and educational records that support the terms of the case plan; testimony by the social services agency, the parent, the foster parent or legal custodian, the guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall seek to determine:

1. If the parent was advised of the right to receive assistance from any person or social service agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate parent or may itself appoint a surrogate parent under the


497732

Individuals with Disabilities Education Act and s. 39.0016. If the child is under the age of school entry, the court must make the appointment.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation contract between the parent and the social service agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. The frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best interest of the child.

8. The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

9. Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the child's best interests and special needs, and including maintaining stability in the child's educational placement, as documented by assurances from the community-based care provider that:

a. The placement of the child takes into account the


497732

appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

10. Whether the department or community-based care lead agency continues to reasonably engage in family finding. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to continue the process.

11. ~~10.~~ A projected date likely for the child's return home or other permanent placement.

12. ~~11.~~ When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the efforts of the social service agency to secure party participation in a case plan were sufficient.

13. ~~12.~~ For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

14. ~~13.~~ If amendments to the case plan are required. Amendments to the case plan must be made as provided in ~~under~~ s. 39.6013.

Section 11. Subsections (4) and (5) of section 409.166,

 497732

Florida Statutes, are amended to read:

409.166 Children within the child welfare system; adoption assistance program.—

(4) ADOPTION ASSISTANCE.—

(a) For purposes of administering payments under paragraph (d), the term:

1. "Child" means an individual who has not attained 21 years of age.

2. "Young adult" means an individual who has attained 18 years of age but who has not attained 21 years of age.

(b) ~~(a)~~ A maintenance subsidy shall be granted only when all other resources available to a child have been thoroughly explored and it can be clearly established that this is the most acceptable plan for providing permanent placement for the child. The maintenance subsidy may not be used as a substitute for adoptive parent recruitment or as an inducement to adopt a child who might be placed without providing a subsidy. However, it shall be the policy of the department that no child be denied adoption if providing a maintenance subsidy would make adoption possible. The best interest of the child shall be the deciding factor in every case. This section does not prohibit foster parents from applying to adopt a child placed in their care. Foster parents or relative caregivers must be asked if they would adopt without a maintenance subsidy.

(c) ~~(b)~~ The department shall provide adoption assistance to the adoptive parents, subject to specific appropriation, in the amount of $5,000 annually, paid on a monthly basis, for the support and maintenance of a child until the 18th birthday of such child or in an amount other than $5,000 annually as

497732

determined by the adoptive parents and the department and memorialized in a written agreement between the adoptive parents and the department. The agreement shall take into consideration the circumstances of the adoptive parents and the needs of the child being adopted. The amount of subsidy may be adjusted based upon changes in the needs of the child or circumstances of the adoptive parents. Changes may ~~shall~~ not be made without the concurrence of the adoptive parents. However, in no case shall the amount of the monthly payment exceed the foster care maintenance payment that would have been paid during the same period if the child had been in a foster family home.

(d) Effective January 1, 2019, adoption assistance payments may be made for a child whose adoptive parent entered into an adoption assistance agreement after the child reached 16 years of age but before the child reached 18 years of age if the child is:

1. Completing secondary education or a program leading to an equivalent credential;

2. Enrolled in an institution that provides postsecondary or vocational education;

3. Participating in a program or activity designed to promote or eliminate barriers to employment;

4. Employed for at least 80 hours per month; or

5. Unable to participate in programs or activities listed in subparagraphs 1.-4. full time due to a physical, intellectual, emotional, or psychiatric condition that limits participation. Any such barrier to participation must be supported by documentation in the child's case file or school or medical records.


497732

(e) A child or young adult receiving benefits through the adoption assistance program is not eligible to simultaneously receive relative caregiver benefits under s. 39.5085 or postsecondary education services and support under s. 409.1451.

(f) ~~(e)~~ The department may provide adoption assistance to the adoptive parents, subject to specific appropriation, for medical assistance initiated after the adoption of the child for medical, surgical, hospital, and related services needed as a result of a physical or mental condition of the child which existed before the adoption and is not covered by Medicaid, Children's Medical Services, or Children's Mental Health Services. Such assistance may be initiated at any time but shall terminate on or before the child's 18th birthday.

(5) ELIGIBILITY FOR SERVICES.—

(a) As a condition of providing adoption assistance under this section and before the adoption is finalized, the adoptive parents must have an approved adoption home study and must enter into an adoption-assistance agreement with the department which specifies the financial assistance and other services to be provided.

(b) A child who is handicapped at the time of adoption is ~~shall be~~ eligible for services through the Children's Medical Services network established under part I of chapter 391 if the child was eligible for such services before ~~prior to~~ the adoption.

Section 12. Effective January 1, 2019, paragraph (b) of subsection (1) of section 414.045, Florida Statutes, is amended to read:

414.045 Cash assistance program.—Cash assistance families


497732

include any families receiving cash assistance payments from the state program for temporary assistance for needy families as defined in federal law, whether such funds are from federal funds, state funds, or commingled federal and state funds. Cash assistance families may also include families receiving cash assistance through a program defined as a separate state program.

(1) For reporting purposes, families receiving cash assistance shall be grouped into the following categories. The department may develop additional groupings in order to comply with federal reporting requirements, to comply with the data-reporting needs of the board of directors of CareerSource Florida, Inc., or to better inform the public of program progress.

(b) *Child-only cases.*—Child-only cases include cases that do not have an adult or teen head of household as defined in federal law. Such cases include:

1. Children in the care of caretaker relatives, if the caretaker relatives choose to have their needs excluded in the calculation of the amount of cash assistance.

2. Families in the Kinship Care ~~Relative Caregiver~~ Program as provided in s. 39.5085.

3. Families in which the only parent in a single-parent family or both parents in a two-parent family receive supplemental security income (SSI) benefits under Title XVI of the Social Security Act, as amended. To the extent permitted by federal law, individuals receiving SSI shall be excluded as household members in determining the amount of cash assistance, and such cases shall not be considered families containing an

adult. Parents or caretaker relatives who are excluded from the cash assistance group due to receipt of SSI may choose to participate in work activities. An individual whose ability to participate in work activities is limited who volunteers to participate in work activities shall be assigned to work activities consistent with such limitations. An individual who volunteers to participate in a work activity may receive child care or support services consistent with such participation.

4. Families in which the only parent in a single-parent family or both parents in a two-parent family are not eligible for cash assistance due to immigration status or other limitation of federal law. To the extent required by federal law, such cases shall not be considered families containing an adult.

5. To the extent permitted by federal law and subject to appropriations, special needs children who have been adopted pursuant to s. 409.166 and whose adopting family qualifies as a needy family under the state program for temporary assistance for needy families. Notwithstanding any provision to the contrary in s. 414.075, s. 414.085, or s. 414.095, a family shall be considered a needy family if:

a. The family is determined by the department to have an income below 200 percent of the federal poverty level;

b. The family meets the requirements of s. 414.095(2) and (3) related to residence, citizenship, or eligible noncitizen status; and

c. The family provides any information that may be necessary to meet federal reporting requirements specified under Part A of Title IV of the Social Security Act.

497732

Families described in subparagraph 1., subparagraph 2., or subparagraph 3. may receive child care assistance or other supports or services so that the children may continue to be cared for in their own homes or in the homes of relatives. Such assistance or services may be funded from the temporary assistance for needy families block grant to the extent permitted under federal law and to the extent funds have been provided in the General Appropriations Act.

Section 13. Paragraph (d) of subsection (1) of section 1009.25, Florida Statutes, is amended to read:

1009.25 Fee exemptions.—

(1) The following students are exempt from the payment of tuition and fees, including lab fees, at a school district that provides workforce education programs, Florida College System institution, or state university:

(d) A student who is or was at the time he or she reached 18 years of age in the custody of a kinship caregiver ~~relative or nonrelative~~ under s. 39.5085 or who was adopted from the Department of Children and Families after May 5, 1997. Such exemption includes fees associated with enrollment in applied academics for adult education instruction. The exemption remains valid until the student reaches 28 years of age.

Section 14. The Department of Children and Families shall establish and operate a pilot Title IV-E Guardianship Assistance Program in two circuits in Florida effective August 1, 2018. The program will provide payments at a rate of $333 per month for persons who meet the Title IV-E eligibility requirements as outlined in s. 473(d)(1)(A) of the Social Security Act.


497732

(a) For purposes of administering this program, the term:

1. "Child" means an individual who has not attained 21 years of age.

2. "Young adult" means an individual who has attained 18 years of age but who has not attained 21 years of age.

3. "Fictive kin" means a person unrelated by birth, marriage, or adoption who has an emotionally significant relationship, which possesses the characteristics of a family relationship, to a child.

(b) Caregivers enrolled in the Relative Caregiver or Nonrelative Caregiver Program prior to August 1, 2018, are not eligible to participate in the Title IV-E Guardianship Assistance Program pilot. Effective August 1, 2018, eligible caregivers enrolled in the pilot may not simultaneously have payments made on the child's behalf through the Relative Caregiver Program under s. 39.5085, postsecondary education services and supports under s. 409.1451, or child-only cash assistance under chapter 414.

(c) Notwithstanding s. 39.5085, in the two circuits where the Title IV-E Guardianship Assistance Program pilot is established, the Relative Caregiver Program will discontinue accepting applications effective July 31, 2018.

(d) Notwithstanding s. 409.145(4), in the two circuits where the Title IV-E Guardianship Assistance Program pilot is established, the room and board rate for guardians who are eligible for the program will be $333 per month.

(e) Notwithstanding s. 409.175(11)(a), in the two circuits where the Title IV-E Guardianship Assistance Program pilot is established, an exception of licensing standards may be provided

497732

for those standards where a waiver has been granted.

Section 15. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2018.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled to

An act relating to child welfare; creating s. 39.4015, F.S.; providing legislative findings and intent; defining terms; requiring the Department of Children and Families, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, to develop a statewide family-finding program; requiring the implementation of family finding by a specified date; requiring the department and community-based care lead agencies to document strategies taken to engage relatives and kin; providing strategies to engage relatives and kin; requiring the department and community-based care lead agencies to use diligent efforts in family finding; providing that certain actions do not constitute family finding; requiring determinations by the court; requiring the department to adopt rules; amending s. 39.402, F.S.; requiring the court to request that parents consent to providing access to additional records; requiring a judge to appoint a surrogate parent for certain children;

497732

requiring the court to place on the record its determinations regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing guidelines for determining reasonableness; amending ss. 39.506; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing guidelines for determining reasonableness; amending s. 39.507 F.S.; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing guidelines for determining reasonableness; requiring the court to advise parents that their parental rights may be terminated and the child's out-of-home placement may become permanent under certain circumstances; amending s. 39.5085, F.S.; providing legislative findings and intent; defining terms; requiring the department to provide financial assistance to kinship caregivers who meet certain requirements; providing eligibility criteria for such financial assistance; providing that children living with caregivers who are receiving financial assistance are eligible for Medicaid coverage; providing the purpose of a kinship navigator program; requiring each community-based care lead agency to establish a kinship navigator program by a certain date; providing requirements for programs; requiring the department to adopt rules; deleting provisions


497732

related to the Relative Caregiver Program; amending s. 39.521, F.S.; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding ; providing guidelines for determining reasonableness; conforming provisions to changes made by the act; amending s. 39.6012, F.S.; revising the types of records that must be attached to a case plan and updated throughout the judicial review process; requiring that documentation of the family-finding efforts of the department and the community-based care lead agency be included in certain case plans; amending s. 39.604, F.S.; revising legislative findings and intent; revising enrollment and attendance requirements for children in an early education or child care program; conforming cross-references; providing requirements and procedures for maintaining the educational stability of a child during the child's placement in out-of-home care, or subsequent changes in out-of-home placement; requiring that a child's transition from a child care or early education program be pursuant to a plan that meets certain requirements; amending s. 39.6251, F.S.; requiring the case manager for a young adult in foster care to consult with the young adult when updating the case plan and the transition plan and arrangements; deleting a provision authorizing case management reviews to be conducted by telephone under certain circumstances; amending s. 39.701, F.S.; requiring the


497732

court to appoint a surrogate parent if the child is under the age of school entry; requiring the court to determine if the department and community-based lead agency has continued to reasonably engaged in family finding; providing guidelines for determining the level of reasonableness; amending s. 409.166, F.S.; defining terms; providing conditions for the department to provide adoption assistance payments to adoptive parents of certain children; providing that children and young adults receiving benefits through the adoption assistance program are ineligible for other specified benefits and services; providing additional conditions for eligibility for adoption assistance; amending ss. 414.045 and 1009.25, F.S.; conforming provisions to changes made by the act; requiring the Department of Children and Families to create a pilot Title IV-E Guardianship Assistance Program; providing definitions; specifying eligibility and limitations;

By the Committee on Children, Families, and Elder Affairs; and Senators Garcia and Campbell

586-01782-18 2018590c1

A bill to be entitled

An act relating to child welfare; creating s. 39.4015, F.S.; providing legislative findings and intent; defining terms; requiring the Department of Children and Families, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, to develop a statewide family-finding program; requiring the implementation of family finding by a specified date; requiring the department and community-based care lead agencies to document strategies taken to engage relatives and kin; providing strategies to engage relatives and kin; requiring the department and community-based care lead agencies to use diligent efforts in family finding; providing that certain actions do not constitute family finding; requiring determinations by the court; requiring the department to adopt rules; amending s. 39.402, F.S.; requiring the court to request that parents consent to providing access to additional records; requiring a judge to appoint a surrogate parent for certain children; requiring the court to place on the record its determinations regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing guidelines for determining reasonableness; amending ss. 39.506; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing

586-01782-18 2018590c1

guidelines for determining reasonableness; amending s. 39.507 F.S.; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding; providing guidelines for determining reasonableness; requiring the court to advise parents that their parental rights may be terminated and the child's out-of-home placement may become permanent under certain circumstances; amending s. 39.5085, F.S.; providing legislative findings and intent; defining terms; requiring the department to provide financial assistance to kinship caregivers who meet certain requirements; providing eligibility criteria for such financial assistance; providing that children living with caregivers who are receiving financial assistance are eligible for Medicaid coverage; providing the purpose of a kinship navigator program; requiring each community-based care lead agency to establish a kinship navigator program by a certain date; providing requirements for programs; requiring the department to adopt rules; deleting provisions related to the Relative Caregiver Program; amending s. 39.521, F.S.; requiring the court to make a determination regarding the department's or the community-based lead agency's reasonable engagement in family finding ; providing guidelines for determining reasonableness; conforming provisions to changes made by the act; amending s. 39.6012, F.S.; revising the types of records that must be attached to a case plan

and updated throughout the judicial review process; requiring that documentation of the family-finding efforts of the department and the community-based care lead agency be included in certain case plans; amending s. 39.604, F.S.; revising legislative findings and intent; providing requirements and procedures for referring certain children to the Early Steps Program; requiring the Early Steps Program to screen or evaluate all children referred to the program by the department or its contracted agencies; requiring the service coordinator of the Early Steps Program to forward certain information to the department and the community-based care lead agency; requiring the dependency court to appoint a surrogate parent for certain children under certain circumstances; requiring the department or a community-based care lead agency to refer a child to the Child Find program of the Florida Diagnostic and Learning Resources System under certain circumstances; requiring a caregiver to choose certain providers to care for children in out-of-home care; revising enrollment and attendance requirements for children in an early education or child care program; conforming cross-references; providing requirements and procedures for maintaining the educational stability of a child during the child's placement in out-of-home care, or subsequent changes in out-of-home placement; requiring that a child's transition from a child care or early education program be pursuant to a plan that

meets certain requirements; amending s. 39.701, F.S.; requiring the court to appoint a surrogate parent if the child is under the age of school entry; requiring the court to determine if the department and community-based lead agency has continued to reasonably engaged in family finding; providing guidelines for determining the level of reasonableness; amending ss. 414.045 and 1009.25, F.S.; conforming provisions to changes made by the act; providing effective dates.

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

Section 1. Effective January 1, 2019, section 39.4015, Florida Statutes, is created to read:

39.4015 Family finding.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that every child who is in out-of-home care has the goal of finding a permanent home, whether achieved by reunifying the child with his or her parents or finding another permanent connection, such as adoption or legal guardianship with a relative or nonrelative who has a significant relationship with the child.

(b) The Legislature finds that while legal permanency is important to a child in out-of-home care, emotional permanency helps increase the likelihood that children will achieve stability and well-being and successfully transition to independent adulthood.

(c) The Legislature also finds that research has

consistently shown that placing a child within his or her own family reduces the trauma of being removed from his or her home, is less likely to result in placement disruptions, and enhances prospects for finding a permanent family if the child cannot return home.

(d) The Legislature further finds that the primary purpose of family finding is to facilitate legal and emotional permanency for children who are in out-of-home care by finding and engaging their relatives.

(e) It is the intent of the Legislature that every child in out-of-home care be afforded the advantages that can be gained from the use of family finding to establish caring and long-term or permanent connections and relationships for children and youth in out-of-home care, as well as to establish a long-term emotional support network with family members and other adults who may not be able to take the child into their home but who want to stay connected with the child.

(2) DEFINITIONS.—As used in this section, the term:

(a) "Diligent efforts" means the use of methods and techniques including, but not limited to, interviews with immediate and extended family and kin, genograms, eco-mapping, case mining, cold calls, and specialized computer searches.

(b) "Family finding" means an intensive relative search and engagement technique used in identifying family and other close adults for children in out-of-home care and involving them in developing and carrying out a plan for the emotional and legal permanency of a child.

(c) "Family group decisionmaking" is a generic term that includes a number of approaches in which family members and

fictive kin are brought together to make decisions about how to care for their children and develop a plan for services. The term includes family team conferencing, family team meetings, family group conferencing, family team decisionmaking, family unity meetings, and team decisionmaking, which may consist of several phases and employ a trained facilitator or coordinator.

(d) "Fictive kin" means an individual who is unrelated to the child by either birth or marriage, but has such a close emotional relationship with the child that he or she may be considered part of the family.

(3) FAMILY-FINDING PROGRAM.—The department, in collaboration with sheriffs' offices that conduct child protective investigations and community-based care lead agencies, shall develop a formal family-finding program to be implemented statewide by child protective investigators and community-based care lead agencies.

(a) Family finding is required as soon as a child comes to the attention of the department and throughout the duration of the case, and finding and engaging with as many family members and fictive kin as possible for each child who may help with care or support for the child is considered a best practice. The department or community-based care lead agency must specifically document strategies taken to locate and engage relatives and kin. Strategies of engagement may include, but are not limited to, asking the relatives and kin to:

1. Participate in a family group decisionmaking conference, family team conferencing, or other family meetings aimed at developing or supporting the family service plan;

2. Attend visitations with the child;

3. Assist in transportation of the child;

4. Provide respite or child care services; or

5. Provide actual kinship care.

(b) The department and the community-based care lead agencies must use diligent efforts in family finding, must continue those efforts until multiple relatives and kin are identified, and must go beyond basic searching tools by exploring alternative tools and methodologies. Efforts by the department and the community-based care lead agency may include, but are not limited to:

1. Searching for and locating adult relatives and kin.

2. Identifying and building positive connections between the child and the child's relatives and fictive kin.

3. Supporting the engagement of relatives and fictive kin in social service planning and delivery of services and creating a network of extended family support to assist in remedying the concerns that led to the child becoming involved with the child welfare system, when appropriate.

4. Maintaining family connections, when possible.

5. Keeping siblings together in care, when in the best interest of each child and when possible.

(c) A basic computer search using the Internet or attempts to contact known relatives at a last known address or telephone number do not constitute effective family finding.

(d) The court's inquiry and determination regarding family finding should be made at each stage of the case, including a shelter hearing conducted pursuant to s. 39.402. The court shall place its determinations on the record as to whether the department or community-based care lead agency has reasonably

engaged in family finding. The level of reasonableness is to be determined by the length of the case and the amount of time the department or community-based care lead agency has had to begin or continue the process.

(4) RULEMAKING.—The department shall adopt rules to implement this section.

Section 2. Paragraphs (c) and (d) of subsection (11) of section 39.402, Florida Statutes, and subsection (17) of that section are amended to read:

39.402 Placement in a shelter.—

(11)

(c) The court shall request that the parents consent to provide access to the child's child care records, early education program records, or other educational records and provide information to the court, the department or its contract agencies, and any guardian ad litem or attorney for the child. If a parent is unavailable or unable to consent or withholds consent and the court determines access to the records and information is necessary to provide services to the child, the court shall issue an order granting access.

(d) The court may appoint a surrogate parent or may refer the child to the district school superintendent for appointment of a surrogate parent if the child has or is suspected of having a disability and the parent is unavailable pursuant to s. 39.0016(3)(b). If the child is under the age of school entry, the court must make the appointment.

(17) At the shelter hearing, the court shall inquire of the parent whether the parent has relatives who might be considered as a placement for the child. The parent shall provide to the

court and all parties identification and location information regarding the relatives. The court shall advise the parent that the parent has a continuing duty to inform the department of any relative who should be considered for placement of the child. The court shall place its determinations on the record as to whether the department or community-based care lead agency has reasonably engaged in family finding. The level of reasonableness is to be determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

Section 3. Present subsection (9) of section 39.506, Florida Statutes, is redesignated as subsection (10), and a new subsection (9) is added to that section, to read:

39.506 Arraignment hearings.—

(9) The court shall review whether the department or community-based care lead agency has reasonably engaged in family finding and make a written determination as to its findings. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

Section 4. Paragraphs (c) and (d) of subsection (7) of section 39.507, Florida Statutes, are amended to read:

39.507 Adjudicatory hearings; orders of adjudication.—

(7)

(c) If a court adjudicates a child dependent and the child is in out-of-home care, the court shall inquire of the parent or parents whether the parents have relatives who might be considered as a placement for the child. ~~The court shall advise~~

~~the parents that, if the parents fail to substantially comply with the case plan, their parental rights may be terminated and that the child's out-of-home placement may become permanent.~~ The parent or parents shall provide to the court and all parties identification and location information of the relatives. The court shall review whether the department or community-based care lead agency has reasonably engaged in family finding and make a written determination as to its findings. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

(d) The court shall advise the parents that, if they fail to substantially comply with the case plan, their parental rights may be terminated and that the child's out-of-home placement may become permanent.

Section 5. Effective January 1, 2019, section 39.5085, Florida Statutes, is amended to read:

39.5085 Kinship Care ~~Relative Caregiver~~ Program.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that an increasing number of relatives and fictive kin are assuming the responsibility of raising children because the parents of these children are unable to care for them.

(b) The Legislature also finds that these kinship caregivers perform a vital function by providing homes for children who would otherwise be at risk of foster care placement and that kinship care is a crucial option in the spectrum of out-of-home care available to children in need.

(c) The Legislature finds that children living with kinship

caregivers experience increased placement stability, are less likely to reenter care if they are reunified with their parents, and have better behavioral and mental health outcomes.

(d) The Legislature further finds that these kinship caregivers may face a number of difficulties and need assistance to support the health and well-being of the children they care for. These needs include, but are not limited to, financial assistance, legal assistance, respite care, child care, specialized training, and counseling.

(e) It is the intent of the Legislature to provide for the establishment and implementation of procedures and protocols that are likely to increase and adequately support appropriate and safe kinship care placements.

(2) DEFINITIONS.—As used this section, the term:

(a) "Fictive kin" means an individual who is unrelated to the child by either birth or marriage, but has such a close emotional relationship with the child that he or she may be considered part of the family.

(b) "Kinship care" means the full-time care of a child placed in out-of-home care by the court in the home of a relative or fictive kin.

(c) "Kinship navigator program" means a statewide program designed to ensure that kinship caregivers are provided with necessary resources for the preservation of the family.

(d) "Relative" means an individual who is caring full time for a child placed in out-of-home care by the court and who:

1. Is related to the child within the fifth degree by blood or marriage to the parent or stepparent of the child; or

2. Is related to a half-sibling of that child within the

fifth degree by blood or marriage to the parent or stepparent.

(3) FINANCIAL ASSISTANCE.—The department shall provide financial assistance to all caregivers who qualify under this subsection.

(a) Relatives or fictive kin caring for a child who has been placed with them by the court shall receive a monthly caregiver benefit, beginning when the child is placed with them. The amount of the benefit payment is based on the child's age within a payment schedule established by rule of the department. The cost of providing the assistance described in this section to any caregiver may not exceed the cost of providing out-of-home care in emergency shelter or foster care.

(b) Caregivers who receive assistance under this section must be capable, as determined by a home study, of providing a physically safe environment and a stable, supportive home for the children under their care and must assure that the children's well-being is met, including, but not limited to, the provision of immunizations, education, and mental health services, as needed.

(c) Caregivers who qualify for and receive assistance under this section are not required to meet foster care licensing requirements under s. 409.175.

(d) Children receiving cash benefits under this section are not eligible to simultaneously receive WAGES cash benefits under chapter 414.

(d) A caregiver may not receive a benefit payment if the parent or stepparent of the child resides in the home. However, a caregiver may receive the benefit payment for a minor parent who is in his or her care, as well as for the minor parent's

child, if both children have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is receiving a benefit payment when a parent, other than an eligible minor parent, or stepparent moves into the home, the payment must be terminated no later than the first day of the month following the move, allowing for 10-day notice of adverse action.

(e) Children living with caregivers who are receiving assistance under this section are eligible for Medicaid coverage.

(4) ADDITIONAL ASSISTANCE AND SERVICES.—

(a) The purpose of a kinship navigator program is to help relative caregivers and fictive kin in the child welfare system to navigate the broad range of services available to them and the children from public, private, community, and faith-based organizations.

(b) By January 1, 2019, each community-based care lead agency shall establish a kinship navigator program. In order to meet the requirements of a kinship navigator program, the program must:

1. Be coordinated with other state or local agencies that promote service coordination or provide information and referral services, including any entities that participate in the Florida 211 Network, to avoid duplication or fragmentation of services to kinship care families;

2. Be planned and operated in consultation with kinship caregivers and organizations representing them, youth raised by kinship caregivers, relevant governmental agencies, and relevant community-based or faith-based organizations;

3. Establish a toll-free telephone hotline to provide information to link kinship caregivers, kinship support group facilitators, and kinship service providers to:

a. One another;

b. Eligibility and enrollment information for federal, state, and local benefits;

c. Relevant training to assist kinship caregivers in caregiving and in obtaining benefits and services; and

d. Relevant knowledge related to legal options available for child custody, other legal assistance, and help in obtaining legal services.

4. Provide outreach to kinship care families, including by establishing, distributing, and updating a kinship care website, or other relevant guides or outreach materials; and

5. Promote partnerships between public and private agencies, including schools, community-based or faith-based organizations, and relevant governmental agencies, to increase their knowledge of the needs of kinship care families to promote better services for those families.

(5) RULEMAKING.—The department shall adopt rules to implement this section.

~~(1) It is the intent of the Legislature in enacting this section to:~~

~~(a) Provide for the establishment of procedures and protocols that serve to advance the continued safety of children by acknowledging the valued resource uniquely available through grandparents, relatives of children, and specified nonrelatives of children pursuant to subparagraph (2)(a)3.~~

~~(b) Recognize family relationships in which a grandparent~~

~~or other relative is the head of a household that includes a child otherwise at risk of foster care placement.~~

~~(c) Enhance family preservation and stability by recognizing that most children in such placements with grandparents and other relatives do not need intensive supervision of the placement by the courts or by the department.~~

~~(d) Recognize that permanency in the best interests of the child can be achieved through a variety of permanency options, including permanent guardianship under s. 39.6221 if the guardian is a relative, by permanent placement with a fit and willing relative under s. 39.6231, by a relative, guardianship under chapter 744, or adoption, by providing additional placement options and incentives that will achieve permanency and stability for many children who are otherwise at risk of foster care placement because of abuse, abandonment, or neglect, but who may successfully be able to be placed by the dependency court in the care of such relatives.~~

~~(e) Reserve the limited casework and supervisory resources of the courts and the department for those cases in which children do not have the option for safe, stable care within the family.~~

~~(f) Recognize that a child may have a close relationship with a person who is not a blood relative or a relative by marriage and that such person should be eligible for financial assistance under this section if he or she is able and willing to care for the child and provide a safe, stable home environment.~~

~~(2)(a) The Department of Children and Families shall establish, operate, and implement the Relative Caregiver Program~~

~~by rule of the department. The Relative Caregiver Program shall, within the limits of available funding, provide financial assistance to:~~

~~1. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.~~

~~2. Relatives who are within the fifth degree by blood or marriage to the parent or stepparent of a child and who are caring full-time for that dependent child, and a dependent half-brother or half-sister of that dependent child, in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the relative under this chapter.~~

~~3. Nonrelatives who are willing to assume custody and care of a dependent child in the role of substitute parent as a result of a court's determination of child abuse, neglect, or abandonment and subsequent placement with the nonrelative caregiver under this chapter. The court must find that a proposed placement under this subparagraph is in the best interest of the child.~~

~~4. A relative or nonrelative caregiver, but the relative or nonrelative caregiver may not receive a Relative Caregiver Program payment if the parent or stepparent of the child resides in the home. However, a relative or nonrelative may receive the Relative Caregiver Program payment for a minor parent who is in his or her care, as well as for the minor parent's child, if~~

~~both children have been adjudicated dependent and meet all other eligibility requirements. If the caregiver is currently receiving the payment, the Relative Caregiver Program payment must be terminated no later than the first of the following month after the parent or stepparent moves into the home, allowing for 10-day notice of adverse action.~~

~~The placement may be court-ordered temporary legal custody to the relative or nonrelative under protective supervision of the department pursuant to s. 39.521(1)(c)3., or court-ordered placement in the home of a relative or nonrelative as a permanency option under s. 39.6221 or s. 39.6231 or under former s. 39.622 if the placement was made before July 1, 2006. The Relative Caregiver Program shall offer financial assistance to caregivers who would be unable to serve in that capacity without the caregiver payment because of financial burden, thus exposing the child to the trauma of placement in a shelter or in foster care.~~

~~(b) Caregivers who receive assistance under this section must be capable, as determined by a home study, of providing a physically safe environment and a stable, supportive home for the children under their care and must assure that the children's well-being is met, including, but not limited to, the provision of immunizations, education, and mental health services as needed.~~

~~(c) Relatives or nonrelatives who qualify for and participate in the Relative Caregiver Program are not required to meet foster care licensing requirements under s. 409.175.~~

~~(d) Relatives or nonrelatives who are caring for children placed with them by the court pursuant to this chapter shall receive a special monthly caregiver benefit established by rule of the department. The amount of the special benefit payment shall be based on the child's age within a payment schedule established by rule of the department and subject to availability of funding. The statewide average monthly rate for children judicially placed with relatives or nonrelatives who are not licensed as foster homes may not exceed 82 percent of the statewide average foster care rate, and the cost of providing the assistance described in this section to any caregiver may not exceed the cost of providing out-of-home care in emergency shelter or foster care.~~

~~(e) Children receiving cash benefits under this section are not eligible to simultaneously receive WAGES cash benefits under chapter 414.~~

~~(f) Within available funding, the Relative Caregiver Program shall provide caregivers with family support and preservation services, flexible funds in accordance with s. 409.165, school readiness, and other available services in order to support the child's safety, growth, and healthy development. Children living with caregivers who are receiving assistance under this section shall be eligible for Medicaid coverage.~~

~~(g) The department may use appropriate available state, federal, and private funds to operate the Relative Caregiver Program. The department may develop liaison functions to be available to relatives or nonrelatives who care for children pursuant to this chapter to ensure placement stability in extended family settings.~~

Section 6. Paragraph (e) of subsection (1) of section

39.521, Florida Statutes, is amended to read:

39.521 Disposition hearings; powers of disposition.—

(1) A disposition hearing shall be conducted by the court, if the court finds that the facts alleged in the petition for dependency were proven in the adjudicatory hearing, or if the parents or legal custodians have consented to the finding of dependency or admitted the allegations in the petition, have failed to appear for the arraignment hearing after proper notice, or have not been located despite a diligent search having been conducted.

(e) The court shall, in its written order of disposition, include all of the following:

1. The placement or custody of the child.

2. Special conditions of placement and visitation.

3. Evaluation, counseling, treatment activities, and other actions to be taken by the parties, if ordered.

4. The persons or entities responsible for supervising or monitoring services to the child and parent.

5. Continuation or discharge of the guardian ad litem, as appropriate.

6. The date, time, and location of the next scheduled review hearing, which must occur within the earlier of:

a. Ninety days after the disposition hearing;

b. Ninety days after the court accepts the case plan;

c. Six months after the date of the last review hearing; or

d. Six months after the date of the child's removal from his or her home, if no review hearing has been held since the child's removal from the home.

7. If the child is in an out-of-home placement, child

support to be paid by the parents, or the guardian of the child's estate if possessed of assets which under law may be disbursed for the care, support, and maintenance of the child. The court may exercise jurisdiction over all child support matters, shall adjudicate the financial obligation, including health insurance, of the child's parents or guardian, and shall enforce the financial obligation as provided in chapter 61. The state's child support enforcement agency shall enforce child support orders under this section in the same manner as child support orders under chapter 61. Placement of the child shall not be contingent upon issuance of a support order.

8.a. If the court does not commit the child to the temporary legal custody of an adult relative, legal custodian, or other adult approved by the court, the disposition order must ~~shall~~ include the reasons for such a decision and ~~shall include~~ a written determination as to whether ~~diligent efforts were made by~~ the department and the community-based care lead agency reasonably engaged in family finding in attempting to locate an adult relative, legal custodian, or other adult willing to care for the child in order to present that placement option to the court instead of placement with the department. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to begin or continue the process.

b. If no suitable relative is found and the child is placed with the department or a legal custodian or other adult approved by the court, both the department and the court shall consider transferring temporary legal custody to an adult relative approved by the court at a later date, but neither the

department nor the court is obligated to so place the child if it is in the child's best interest to remain in the current placement.

~~For the purposes of this section, "diligent efforts to locate an adult relative" means a search similar to the diligent search for a parent, but without the continuing obligation to search after an initial adequate search is completed.~~

9. Other requirements necessary to protect the health, safety, and well-being of the child, to preserve the stability of the child's child care, early education program, or any other educational placement, and to promote family preservation or reunification whenever possible.

Section 7. Paragraph (b) of subsection (2) and paragraph (a) of subsection (3) of section 39.6012, Florida Statutes, are amended to read:

39.6012 Case plan tasks; services.—

(2) The case plan must include all available information that is relevant to the child's care including, at a minimum:

(b) A description of the plan for ensuring that the child receives safe and proper care and that services are provided to the child in order to address the child's needs. To the extent available and accessible, the following health, mental health, and education information and records of the child must be attached to the case plan and updated throughout the judicial review process:

1. The names and addresses of the child's health, mental health, and educational providers;

2. The child's grade level performance;

3. The child's school record or, if the child is under the age of school entry, any records from a child care program, early education program, or preschool program;

4. Documentation of compliance or noncompliance with the attendance requirements under s. 39.604, if the child is enrolled in a child care program, early education program, or preschool program;

5.~~4.~~ Assurances that the child's placement takes into account proximity to the school in which the child is enrolled at the time of placement;

6. ~~5. A record of~~ The child's immunizations;

7.~~6.~~ The child's known medical history, including any known health problems;

8.~~7.~~ The child's medications, if any; and

9.~~8.~~ Any other relevant health, mental health, and education information concerning the child.

(3) In addition to any other requirement, if the child is in an out-of-home placement, the case plan must include:

(a) A description of the type of placement in which the child is to be living and, if the child has been placed with the department, whether the department and the community-based care lead agency have reasonably engaged in family finding to locate an adult relative, legal custodian, or other adult willing to care for the child in order to present that placement option to the court instead of placement with the department.

Section 8. Section 39.604, Florida Statutes, is amended to read:

39.604 Rilya Wilson Act; short title; legislative intent; early intervention; child care; early education; preschool

~~requirements; attendance and reporting responsibilities~~.—

(1) SHORT TITLE.—This section may be cited as the "Rilya Wilson Act."

(2) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that children from birth to age 5 years are particularly vulnerable to maltreatment and that they enter out-of-home care in disproportionately high numbers.

(b) The Legislature also finds that children who are abused or neglected are at high risk of experiencing physical and mental health problems and problems with language and communication, cognitive development, and social and emotional development.

(c) The Legislature also finds that providing early intervention and services, as well as quality child care and early education programs to support the healthy development of these young children, can have positive effects that last throughout childhood and into adulthood.

(d) The Legislature also finds that the needs of each of these children are unique, and while some children may be best served by a quality child care or early education program, others may need more attention and nurturing that can best be provided by a stay-at-home caregiver ~~The Legislature recognizes that children who are in the care of the state due to abuse, neglect, or abandonment are at increased risk of poor school performance and other behavioral and social problems~~.

(e) It is the intent of the Legislature that children who are ~~currently~~ in out-of-home ~~the~~ care ~~of the state~~ be provided with an age-appropriate developmental child care or early education arrangement that is in the best interest of the child

~~education program~~ to help ameliorate the negative consequences of abuse, neglect, or abandonment.

(3) EARLY INTERVENTION FOR CHILDREN UNDER THE AGE OF THREE.—The Child Abuse Prevention and Treatment Act, 42 U.S.C. ss. 5101, et seq., and federal the Individuals with Disabilities Education Act requires states to have provisions and procedures for referring to early intervention services children who are under the age of 3 years and involved in substantiated cases of child abuse or neglect, or who are affected by substance abuse or withdrawal symptoms from prenatal drug exposure.

(a) *Referral process.*—A child from birth to age 36 months who is determined to be a victim of any substantiated case of child abuse or neglect or who is affected by substance abuse or withdrawal symptoms from prenatal drug exposure, shall be referred to the Early Steps Program under s. 391.301, according to the following criteria:

1. Children who will remain in the home of their parents or legal guardian without referral to a community-based care lead agency for services shall be referred to the Early Steps Program by the protective investigator handling the case within 48 hours of verification of the abuse or neglect.

2. When there is an indication that they may have an established condition or developmental delay, children who will remain in the home of their parents or legal guardian and who are referred to a community-based care lead agency for services must be referred to the Early Steps Program by the community-based care lead agency case worker during the case plan development process within 7 days after the identification of an established condition or possible developmental delay. The

community-based care lead agency shall follow up to determine whether the child has been found eligible for Part C services and shall support the participation of the eligible children's families in the Early Steps Program. Support may include, but need not be limited to:

a. Assistance with transportation, if necessary;

b. Providing written information about the Early Steps Program; and

c. Followup with the family and encouraging the child's participation in the Early Steps Program.

3. Children being placed into shelter care for referral to a community-based care lead agency for out-of-home placement must receive an initial assessment during the case plan development process and may be referred to the Early Steps Program according to the following criteria:

a. Children who are not referred for a comprehensive behavioral health assessment under the Medicaid program must be referred to the Early Steps Program by the case worker during the case plan development process for the child. The referral must be documented in the case plan.

b. Children who are referred for a comprehensive behavioral health assessment under the Medicaid program must be referred to the Early Steps Program by the community-based care lead agency case worker if their comprehensive behavioral health assessment flags them as potentially having a developmental delay or an established condition. The referral must be documented in the case plan. The Early Steps Program referral form must be accompanied by the comprehensive behavioral health assessment that flagged the child as potentially having a developmental

delay or an established condition.

(b) *Screening and evaluation.*—The local Early Steps Program shall screen or evaluate all children referred by the department or its contracted agencies. The information on the outcome of a child's screening or evaluation, and any recommended services on the child's individualized family support plan, shall be forwarded by the Early Steps Program's service coordinator to the department and the community-based care lead agency for consideration in development of the child's case plan.

(c) *Appointment of surrogate parent.*—Federal law requires parental consent and participation at every stage of the early intervention process after referral. A dependency court shall appoint a surrogate parent under s. 39.0016 for a child from birth to age 36 months whose parents are unavailable or unwilling to provide consent for services when the child has been determined to be a victim of any substantiated case of child abuse or neglect or is affected by substance abuse or withdrawal symptoms from prenatal drug exposure and has been referred to the Early Steps Program under s. 391.301.

(4) EARLY INTERVENTION FOR CHILDREN AGES THREE YEARS TO FIVE YEARS.—The federal Individuals with Disabilities Education Act requires states to develop a comprehensive Child Find program to locate children who are potentially eligible for services, including children who are involved in substantiated cases of child abuse or neglect, and link them to early intervention services. If the department or a community-based care lead agency suspects that a child is a victim of substantiated child abuse or neglect, the child must be referred to the Child Find program of the Florida Diagnostic and Learning

Resources System for assessment.

(5) CHILD CARE, EARLY EDUCATION PROGRAMS, PRESCHOOL.—Research has found that the quality of child care, early education programs, and preschool programs is important to the cognitive, language, and social development of young children, with consistent and emotionally supportive care being of great benefit to children and their families. Children who receive high-quality early childhood care and education have better math, language, and social skills as they enter school, and, as they grow older, require less remedial education, progress further in school, and have fewer interactions with the justice system. Significant involvement of parents in early childhood care and education may help reduce the incidence of maltreatment of children and may be beneficial to children and families who are already involved in the child welfare system by virtue of establishing caring relationships in a supportive learning environment that assists parents in establishing social support networks, accessing information about parenting and child development, and receiving referrals to other services.

(a) *Early child care and education preference*.—Care for children in out-of-home care shall be chosen by the caregiver according to the following order:

1. Providers who receive a Gold Seal Quality Care designation pursuant to s. 402.281, or providers participating in a quality rating system;

2. Licensed child care providers;

3. Public school providers; and

4. License-exempt child care providers, including religious-exempt and registered providers, and non-public

schools. These providers must be participating in the school readiness program through the local early learning coalition.

(b) *Enrollment*

~~(3) REQUIREMENTS.—~~

1. A child from birth to the age of school entry, who is under court-ordered protective supervision or in out-of-home care and is ~~the custody of the Family Safety Program Office of the Department of Children and Families or a community-based lead agency, and~~ enrolled in an ~~a licensed~~ early education or child care program must attend the program 5 days a week unless the court grants an exception due to the court determining it is in the best interest of a child from birth to age 3 years:

a. With a stay-at-home caregiver to remain at home.

b. With a caregiver who works less than full time to attend an early education or child care program fewer than 5 days a week.

2. Notwithstanding s. 39.202, the department ~~of Children and Families~~ must notify operators of an ~~the licensed~~ early education or child care program, subject to the reporting requirements of this act, of the enrollment of any child from birth to the age of school entry, under court-ordered protective supervision or in out-of-home care. If ~~the custody of the Family Safety Program Office of the Department of Children and Families or a community-based lead agency. When~~ a child is enrolled in an early education or child care program ~~regulated by the department~~, the child's attendance in the program must be a required task ~~action~~ in the safety plan or the case plan developed for the child pursuant to this chapter. ~~An exemption to participating in the licensed early education or child care~~

~~program 5 days a week may be granted by the court.~~

(c)~~(4)~~ *Attendance* ~~ATTENDANCE AND REPORTING REQUIREMENTS~~.—

1.~~(a)~~ A child enrolled in an ~~a licensed~~ early education or child care program who meets the requirements of paragraph (b) ~~subsection (3)~~ may not be withdrawn from the program without the prior written approval of the department ~~Family Safety Program Office of the Department of Children and Families~~ or the community-based care lead agency.

2.a.~~(b)1.~~ If a child covered by this section is absent from the program on a day when he or she is supposed to be present, the person with whom the child resides must report the absence to the program by the end of the business day. If the person with whom the child resides, whether the parent or caregiver, fails to timely report the absence, the absence is considered to be unexcused. The program shall report any unexcused absence or seven consecutive excused absences of a child who is enrolled in the program and covered by this act to the ~~local designated staff of the Family Safety Program Office of the~~ department ~~of Children and Families~~ or the community-based care lead agency by the end of the business day following the unexcused absence or seventh consecutive excused absence.

b.~~2.~~ The department or community-based care lead agency shall conduct a site visit to the residence of the child upon receiving a report of two consecutive unexcused absences or seven consecutive excused absences.

c.~~3.~~ If the site visit results in a determination that the child is missing, the department or community-based care lead agency shall follow the procedure set forth in s. 39.0141 ~~report the child as missing to a law enforcement agency and proceed~~

~~with the necessary actions to locate the child pursuant to procedures for locating missing children~~.

d.~~4.~~ If the site visit results in a determination that the child is not missing, the parent or caregiver shall be notified that failure to ensure that the child attends the ~~licensed~~ early education or child care program is a violation of the safety plan or the case plan. If more than two site visits are conducted pursuant to this paragraph ~~subsection~~, staff shall ~~initiate action to~~ notify the court of the parent or caregiver's noncompliance with the case plan.

(6) EDUCATIONAL STABILITY.—Just as educational stability is important for school-age children, it is also important to minimize disruptions to secure attachments and stable relationships with supportive caregivers of children from birth to school age and to ensure that these attachments are not disrupted due to placement in out-of-home care or subsequent changes in out-of-home placement.

(a) A child must be allowed to remain in the child care or early educational setting that he or she attended before entry into out-of-home care, unless the program is not in the best interest of the child.

(b) If it is not in the best interest of the child for him or her to remain in his or her child care or early education setting upon entry into out-of-home care, the caregiver must work with the case manager, guardian ad litem, child care and educational staff, and educational surrogate, if one has been appointed, to determine the best setting for the child. Such setting may be a child care provider that receives a Gold Seal Quality Care designation pursuant to s. 402.281, a provider

participating in a quality rating system, a licensed child care provider, a public school provider, or a license-exempt child care provider, including religious-exempt and registered providers, and non-public schools.

(c) The department and providers of early care and education shall develop protocols to ensure continuity if children are required to leave a program because of a change in out-of-home placement.

(7) TRANSITIONS.—In the absence of an emergency, if a child from birth to school age leaves a child care or early education program, the transition must be pursuant to a plan that involves cooperation and sharing of information among all persons involved, that respects the child's developmental stage and associated psychological needs, and that allows for a gradual transition from one setting to another.

Section 9. Paragraph (c) of subsection (2) of section 39.701, Florida Statutes, is amended to read:

39.701 Judicial review.—

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(c) *Review determinations.*—The court and any citizen review panel shall take into consideration the information contained in the social services study and investigation and all medical, psychological, and educational records that support the terms of the case plan; testimony by the social services agency, the parent, the foster parent or legal custodian, the guardian ad litem or surrogate parent for educational decisionmaking if one has been appointed for the child, and any other person deemed appropriate; and any relevant and material evidence submitted to

the court, including written and oral reports to the extent of their probative value. These reports and evidence may be received by the court in its effort to determine the action to be taken with regard to the child and may be relied upon to the extent of their probative value, even though not competent in an adjudicatory hearing. In its deliberations, the court and any citizen review panel shall seek to determine:

1. If the parent was advised of the right to receive assistance from any person or social service agency in the preparation of the case plan.

2. If the parent has been advised of the right to have counsel present at the judicial review or citizen review hearings. If not so advised, the court or citizen review panel shall advise the parent of such right.

3. If a guardian ad litem needs to be appointed for the child in a case in which a guardian ad litem has not previously been appointed or if there is a need to continue a guardian ad litem in a case in which a guardian ad litem has been appointed.

4. Who holds the rights to make educational decisions for the child. If appropriate, the court may refer the child to the district school superintendent for appointment of a surrogate parent or may itself appoint a surrogate parent under the Individuals with Disabilities Education Act and s. 39.0016. If the child is under the age of school entry, the court must make the appointment.

5. The compliance or lack of compliance of all parties with applicable items of the case plan, including the parents' compliance with child support orders.

6. The compliance or lack of compliance with a visitation

contract between the parent and the social service agency for contact with the child, including the frequency, duration, and results of the parent-child visitation and the reason for any noncompliance.

7. The frequency, kind, and duration of contacts among siblings who have been separated during placement, as well as any efforts undertaken to reunite separated siblings if doing so is in the best interest of the child.

8. The compliance or lack of compliance of the parent in meeting specified financial obligations pertaining to the care of the child, including the reason for failure to comply, if applicable.

9. Whether the child is receiving safe and proper care according to s. 39.6012, including, but not limited to, the appropriateness of the child's current placement, including whether the child is in a setting that is as family-like and as close to the parent's home as possible, consistent with the child's best interests and special needs, and including maintaining stability in the child's educational placement, as documented by assurances from the community-based care provider that:

a. The placement of the child takes into account the appropriateness of the current educational setting and the proximity to the school in which the child is enrolled at the time of placement.

b. The community-based care agency has coordinated with appropriate local educational agencies to ensure that the child remains in the school in which the child is enrolled at the time of placement.

10. Whether the department or community-based care lead agency continues to reasonably engage in family finding. The level of reasonableness is determined by the length of the case and amount of time the department or community-based care lead agency has had to continue the process.

11. ~~10.~~ A projected date likely for the child's return home or other permanent placement.

12. ~~11.~~ When appropriate, the basis for the unwillingness or inability of the parent to become a party to a case plan. The court and the citizen review panel shall determine if the efforts of the social service agency to secure party participation in a case plan were sufficient.

13. ~~12.~~ For a child who has reached 13 years of age but is not yet 18 years of age, the adequacy of the child's preparation for adulthood and independent living. For a child who is 15 years of age or older, the court shall determine if appropriate steps are being taken for the child to obtain a driver license or learner's driver license.

14. ~~13.~~ If amendments to the case plan are required. Amendments to the case plan must be made as provided in ~~under~~ s. 39.6013.

Section 10. Effective January 1, 2019, paragraph (b) of subsection (1) of section 414.045, Florida Statutes, is amended to read:

414.045 Cash assistance program.—Cash assistance families include any families receiving cash assistance payments from the state program for temporary assistance for needy families as defined in federal law, whether such funds are from federal funds, state funds, or commingled federal and state funds. Cash

assistance families may also include families receiving cash assistance through a program defined as a separate state program.

(1) For reporting purposes, families receiving cash assistance shall be grouped into the following categories. The department may develop additional groupings in order to comply with federal reporting requirements, to comply with the data-reporting needs of the board of directors of CareerSource Florida, Inc., or to better inform the public of program progress.

(b) *Child-only cases.*—Child-only cases include cases that do not have an adult or teen head of household as defined in federal law. Such cases include:

1. Children in the care of caretaker relatives, if the caretaker relatives choose to have their needs excluded in the calculation of the amount of cash assistance.

2. Families in the Kinship Care ~~Relative Caregiver~~ Program as provided in s. 39.5085.

3. Families in which the only parent in a single-parent family or both parents in a two-parent family receive supplemental security income (SSI) benefits under Title XVI of the Social Security Act, as amended. To the extent permitted by federal law, individuals receiving SSI shall be excluded as household members in determining the amount of cash assistance, and such cases shall not be considered families containing an adult. Parents or caretaker relatives who are excluded from the cash assistance group due to receipt of SSI may choose to participate in work activities. An individual whose ability to participate in work activities is limited who volunteers to

participate in work activities shall be assigned to work activities consistent with such limitations. An individual who volunteers to participate in a work activity may receive child care or support services consistent with such participation.

4. Families in which the only parent in a single-parent family or both parents in a two-parent family are not eligible for cash assistance due to immigration status or other limitation of federal law. To the extent required by federal law, such cases shall not be considered families containing an adult.

5. To the extent permitted by federal law and subject to appropriations, special needs children who have been adopted pursuant to s. 409.166 and whose adopting family qualifies as a needy family under the state program for temporary assistance for needy families. Notwithstanding any provision to the contrary in s. 414.075, s. 414.085, or s. 414.095, a family shall be considered a needy family if:

a. The family is determined by the department to have an income below 200 percent of the federal poverty level;

b. The family meets the requirements of s. 414.095(2) and (3) related to residence, citizenship, or eligible noncitizen status; and

c. The family provides any information that may be necessary to meet federal reporting requirements specified under Part A of Title IV of the Social Security Act.

Families described in subparagraph 1., subparagraph 2., or subparagraph 3. may receive child care assistance or other supports or services so that the children may continue to be

cared for in their own homes or in the homes of relatives. Such assistance or services may be funded from the temporary assistance for needy families block grant to the extent permitted under federal law and to the extent funds have been provided in the General Appropriations Act.

Section 11. Paragraph (d) of subsection (1) of section 1009.25, Florida Statutes, is amended to read:

1009.25 Fee exemptions.—

(1) The following students are exempt from the payment of tuition and fees, including lab fees, at a school district that provides workforce education programs, Florida College System institution, or state university:

(d) A student who is or was at the time he or she reached 18 years of age in the custody of a kinship caregiver ~~relative or nonrelative~~ under s. 39.5085 or who was adopted from the Department of Children and Families after May 5, 1997. Such exemption includes fees associated with enrollment in applied academics for adult education instruction. The exemption remains valid until the student reaches 28 years of age.

Section 12. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2018.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 758
INTRODUCER:	Health Policy Committee and Senator Gibson and others
SUBJECT:	Diabetes Educators
DATE:	February 20, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**
2.	Loe	Williams	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 758 establishes diabetes educators as a new health care profession regulated by the Department of Health (DOH). The bill provides requirements for registration of diabetes educators, and authorizes the DOH to develop rules for renewal procedures, fees, and disciplinary action. The DOH must implement the registration and regulation of the diabetes educator by July 1, 2019.

The DOH will incur additional costs relating to the regulation of diabetes educators; however, the regulatory fees, authorized under the bill to be established by rule, will offset the increase in expenditures.

The effective date of the bill is July 1, 2018.

II. Present Situation:

Diabetes is a group of diseases in which the body produces too little insulin,[1] is unable to use insulin efficiently, or both. When diabetes is not controlled, glucose and fats remain in the blood and eventually cause damage to vital organs.

[1] Insulin is a hormone that allows glucose (sugar) to enter cells and be converted to energy. Merriam-Webster, *available at* http://www.merriam-webster.com/dictionary/insulin (last visited Jan. 31, 2018).

The most common forms of diabetes are:

- **Type 1**: Sometimes referred to as "juvenile diabetes," Type 1 is usually first diagnosed in children and adolescents and accounts for about five percent of all diagnosed cases. Type 1 diabetes is an autoimmune disease in which the body's own immune system destroys cells in the pancreas that produce insulin. Type 1 may be caused by genetics, the environment, or other risk factors. At this time, there is no method to prevent or cure Type 1 diabetes, and treatment requires the lifetime use of insulin by injection or pump.
- **Type 2**: Sometimes referred to as "adult-onset diabetes," Type 2 accounts for about 95 percent of all diagnosed diabetes in adults, and is usually associated with older age, obesity, lack of physical activity, family history, or a personal history of gestational diabetes. Studies have shown that healthy eating, regular physical activity, and weight loss can prevent or delay the onset of Type 2 diabetes or eliminate the symptoms and effects post-onset.
- **Gestational diabetes**: This type of diabetes develops and is diagnosed as a result of pregnancy in two to ten percent of pregnant women. Gestational diabetes can cause health problems during pregnancy for both the mother and child. Children whose mothers have gestational diabetes are at an increased risk of developing obesity and Type 2 diabetes.[2]

Complications of diabetes include:

- Heart disease;
- Stroke;
- High blood pressure (hypertension);
- Blindness and other eye problems;
- Kidney disease;
- Nervous system disorders;
- Vascular disease; and
- Amputations.[3]

Death rates for heart disease and the risk of stroke are about two to four times higher among adults with diabetes than among those without diabetes. Diabetes and its potential health consequences can be managed through physical activity, diet, self-management training, medication.[4]

People with pre-diabetes are at a high risk of developing Type 2 diabetes, heart disease, and stroke. Their blood glucose levels are higher than normal, but not high enough to be classified as diabetes.[5] Although an estimated 33 percent of adults in the United States have pre-diabetes, less than ten percent of them report having been told they have the condition. Thus, awareness of the risk is low. People with pre-diabetes who lose five to seven percent of their body weight and get

[2] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Report Card*, (2014), p. 4, *available at* http://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf, (last visited Jan. 31, 2018); See also U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *About Diabetes*, *available at* https://www.cdc.gov/diabetes/basics/diabetes.html (last visited Jan. 31, 2018).
[3] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Complications*, *available at* https://www.cdc.gov/diabetestv/diabetes-complications.html (last visited Jan. 31, 2018).
[4] *Id.*
[5] *See* Mayo Clinic, Patient Care and Health information, Diseases and Conditions, *Prediabetes*, https://www.mayoclinic.org/diseases-conditions/prediabetes/symptoms-causes/syc-20355278, (last visited Jan. 31, 2018).

at least 150 minutes per week of moderate physical activity can reduce the risk of developing Type 2 diabetes by 58 percent.[6]

Risk factors for diabetes include:[7]

- Being over the age of 45;
- Being overweight;
- Having a parent or sibling with diabetes;
- Having a minority family background;
- Developing gestational diabetes;
- Giving birth to a baby weighing nine pounds or more; and
- Being physically active less than three times per week.

Persons with any of the above risk factors are five to 15 times more likely to develop Type 2 diabetes.[8] The Centers for Disease Control and Prevention (CDC) estimates that as many as one out of every three American adults has pre-diabetes, and half of all Americans aged 65 years and older have pre-diabetes.[9]

In 2013, the American Diabetes Association (ADA)[10] released a report updating its earlier studies estimating the fiscal impact of diagnosed diabetes. In 2012, the total estimated cost of diagnosed diabetes in the United States was $245 billion, including $176 billion in direct medical costs and $69 billion in reduced productivity. This represents a 41 percent increase over the 2007 estimate. The largest components of these costs were hospital inpatient care (43 percent) and medications to treat complications (18 percent). People with diagnosed diabetes incur average medical costs of about $13,700 per year, of which about $7,900 is attributed to diabetes. Care for people with diagnosed diabetes accounts for more than one in five dollars spent on health care in the United States, and more than half of that is directly attributable to diabetes. Overall, average medical expenses for a person with diabetes are 2.3 times higher than they are for a person without diabetes.[11]

Diabetes in Florida

In Florida, it is estimated that over 2.4 million people have diabetes and over 5.8 million have pre-diabetes.[12] Over the past 20 years, the prevalence of diagnosed diabetes among Florida adults

---

[6] *Supra* note 2.
[7] *Id.*
[8] Florida Department of Health, *Prediabetes, What is Prediabetes?*, http://www.floridahealth.gov/diseases-and-conditions/diabetes/prediabetes.html (last visited Jan. 31, 2018).
[9] *Id.*
[10] The ADA was founded in 1940 by 26 physicians. It remained an organization for health care professionals during its first 30 years. In 1970, the Association welcomed general members. In the years since, it has grown to include a network of more than 1 million volunteers. See American Diabetes Association, *75 Years of Progress,* http://www.diabetes.org/about-us/75th-anniversary/ (last visited Jan. 31, 2018).
[11] American Diabetes Association, *Economic Costs of Diabetes in the U.S. in 2012*, Diabetes Care 36: 1033 – 1046, 2013, *available at*, http://care.diabetesjournals.org/content/36/4/1033.full.pdf+html (last visited Jan. 31, 2018).
[12] American Diabetes Association, (2015, December). Fast Facts - *Data and Statistics-About Diabetes*, a*vailable at* http://professional.diabetes.org/content/fast-facts-data-and-statistics-about-diabetes/?loc=dorg_statistics (last visited Jan. 31, 2018).

more than doubled, increasing from 5.2 percent in 1995 to 11.2 percent in 2014.[13] The CDC projects that one out of three adults could have diabetes by 2050 if trends continue due to an aging population more likely to develop Type 2 diabetes, increases in minority groups that are at high risk for Type 2 diabetes, and people with diabetes living longer.[14] This is of particular concern in Florida which has the largest population of adults ages 65 and older in the nation.[15]

In 2014, approximately one out of 10 mothers giving birth in Florida experienced gestational diabetes during their pregnancy. Gestational diabetes puts mothers at an increased risk of developing Type 2 diabetes later in life, increases the risk of birth complications, and increases the risk of the infant being obese and developing Type 2 diabetes in the future. While the data for diabetes in youth are somewhat limited, studies have shown that the number of youth being diagnosed with Type 2 diabetes is increasing. More than 18,000 new cases of Type 1 diabetes and more than 5,000 new cases of Type 2 diabetes are estimated to be diagnosed among U.S. youth younger than age 20 each year.[16]

Diabetes was the seventh leading cause of death in 2014 in Florida.[17] The prior year, diabetes had been the sixth leading cause of death. As a percentage of total deaths in the state, diabetes accounted for 2.9 percent of all deaths, and over a three year period (2012 - 2014), diabetes had an age adjusted death rate per 100,000 of 19.7, or 15,597 deaths.[18]

Florida's Diabetes Advisory Council

The Diabetes Advisory Council (DAC) was created by the Florida Legislature over 40 years ago, as mandated by s. 385.203, F.S., to "guide a statewide comprehensive approach to diabetes prevention, diagnosis, education, care, treatment, impact, and costs thereof." Members are appointed by the Governor to represent professional sectors involved in diabetes prevention and care, as well as citizens with diabetes and other citizen advocates. In 2015, the Florida Legislature required the DAC to prepare a report describing the public health consequences and financial impact on the state from all types of diabetes and associated complications. The legislation instructed the DAC to collaborate with the DOH, the Division of State Group Insurance (DSGI) within the Department of Management Services, and the Agency for Health Care Administration to collect data about diabetes and state programs that address diabetes, as well as develop an action plan to reduce the impact of diabetes.[19] Recommendation number five

---

[13] Florida Department of Health, Florida Diabetes Advisory Council, *2017 Florida Diabetes Report*, p.7., *available at*: http://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/dac-report-january2017.pdf (last visited Jan. 31, 2018).
[14] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Number of Americans with Diabetes Projected to Double or Triple by 2050*, *available at* https://www.cdc.gov/media/pressrel/2010/r101022.html (last visited Jan. 31, 2018).
[15] *Supra* note 13.
[16] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention *Diabetes Report Card 2014, available at* http://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf (Last visited Jan. 31, 2018).
[17] Florida Department of Health, *Florida Vital Statistics Annual Report 2017*, p. 18, http://www.flpublichealth.com/VSBOOK/pdf/2014/Deaths.pdf, (last visited Jan. 31, 2018).
[18] Florida Department of Health, *Florida Charts: Diabetes Deaths - Three Year Trends*, http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090 (last visited Jan. 31, 2018).
[19] *Supra* note 13.

includes recognizing and reimbursing diabetes educators for providing diabetes self-management education.[20]

ADA Standards of Medical Care in Diabetes

The ADA's "Standards of Medical Care in Diabetes," referred to as the "Standards of Care," are intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of the following:

- Diabetes care;
- General treatment goals; and
- Tools to evaluate the quality of care.[21]

The Standards of Care recommendations are not intended to preclude clinical judgment and must be applied in the context of excellent clinical care with adjustments for individual preferences, comorbidities, and other patient factors. The recommendations include screening, diagnostic, and therapeutic actions that are known or believed to favorably affect health outcomes of patients with diabetes.[22]

Diabetes Educators

The ADA defines a "diabetes educator" as "a health care professional who teaches people who have diabetes how to manage their diabetes."[23] Diabetes educators are found in hospitals, physician offices, managed care organizations, home health care, and other settings.[24]

- The State of Florida does not currently license or regulate diabetes educators. The existing scope of practice in Florida for most health care professions includes patient or client education, and that education can relate to diabetes.[25]

Kentucky enacted a diabetes educator law in 2013, and Indiana did so in 2016.[26] Both are under the respective state's Board of Medicine. Kentucky provides three paths for an individual to become licensed as a diabetes educator. An individual must file an application, pay a fee, and demonstrate completion of any one of the following:

- A board-approved course in diabetes education with demonstrable experience in the care of persons with diabetes under supervision that meets requirements specified in administrative regulations promulgated by the board;[27]

---

[20] *Id.* at pp. 64 - 65.
[21] American Diabetes Association, Diabetes Care 2018 Jan; 41(Supplement 1): S1-S2, *Introduction - Standards of Care in Diabetics – 2018*, http://care.diabetesjournals.org/content/41/Supplement_1/S1 (last visited Jan. 31, 2018).
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] See chs. 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 478, 480, 484, 486, 490; and 491, F.S.; and part I, part II, part III, part V, part X, part XIII, and part XIV of ch. 468, F.S.; and part III or part IV of ch. 483, F.S.
[26] See American Association of Diabetes Educators, *State Legislation* https://www.diabeteseducator.org/advocacy/state-legislation (last visited Jan. 31, 2018).
[27] 201 KAR 45:110 (2015), requires the apprentice diabetes educator to accumulate at least 750 hours of supervised work experience in five years with 250 of the hours being obtained in the 12 months preceding licensure application. The apprentice is required to interact with the supervisor at least two hours quarterly, one hour of which must be in person. A supervisor shall not supervise more than four apprentices at a time. The supervision process shall focus on: (a) Identifying

- The credentialing program of the American Association of Diabetes Educators (AADE) or the National Certification Board for Diabetes Educators (NCBDE); or
- An equivalent credentialing program as determined by the board.

Indiana's law is similar to Kentucky's as a diabetes educator license can be obtained by demonstrating completion of one of the following:

- The AADE core concepts course[28] with demonstrable experience in the care of individuals with diabetes under supervision that meets requirements specified in rules adopted by the board;
- The credentialing program of the AADE;
- The credentialing program of the NCBDE; or
- An equivalent credentialing program as determined by the board.

The AADE was founded in 1973 as a multi-disciplinary professional membership organization dedicated to improving diabetes care through education. It has more than 14,000 members including nurses, dietitians, pharmacists, and others. The AADE offers the Board Certified-Advanced Diabetes Management (BC-ADM) credential.[29]

Health care professionals who hold BC-ADM certification, if within their scope of practice, are trained to:

- Adjust medications;
- Treat and monitor complications and other comorbidities;
- Counsel patients on lifestyle modifications;
- Address psychosocial issues; and
- Participate in research and mentoring.

Certification as a BC-ADM requires a current active licensure or registration as a registered nurse, dietitian, pharmacist, physician, or physician assistant; a master's or higher level degree; and 500 clinical practice hours within 48 months prior to taking the certification exam.[30]

The NCBDE was established in 1986 as an independent organization that promotes the interests of diabetes educators and the public by granting certification to qualified health professionals. The NCBDE offers the Certified Diabetes Educator (CDE) credential. Individuals holding the CDE credential educate people affected by diabetes to manage the condition and promote self-management in order to optimize health outcomes.[31]

---

strengths, developmental needs, and providing direct feedback to foster the professional development of the apprentice diabetes educator; (b) Identifying and providing resources to facilitate learning and professional growth; (c) Developing awareness of professional and ethical responsibilities in the practice of diabetes education; and (d) Ensuring the safe and effective delivery of diabetes education services and fostering the professional competence and development of the apprentice diabetes educator.

[28] American Association of Diabetes Educators, *CORE Concepts Course On Line*, is available for a cost of between $386 - $586, *available at* https://www.diabeteseducator.org/education-career/online-courses/ccc-online, (last visited Jan. 31, 2018).

[29] The American Association of Diabetes Educators, *About AADE*, https://www.diabeteseducator.org/about-aade (last visited Jan. 31, 2018).

[30] *Id.*

[31] National Certification Board for Diabetes Educators, *History*, http://www.ncbde.org/about/history/ (last visited Jan. 31, 2018).

Certification as a CDE requires active licensure or registration as a psychologist, registered nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, dietitian with a Commission on Dietetic Registration (CDR), or a health professional with a master's degree or higher in social work. Professional practice experience, continuing education, and an examination are also required.[32]

The CDC has also established the CDC National Diabetes Recognition Program (NDRP) as part of the National Diabetes Prevention Program (NDPP).[33] The NDPP is a partnership of public and private organizations working to reduce the growing problem of lack of public education on prediabetes and Type 2 diabetes.[34] A key part of the NDPP is the lifestyle change program to prevent or delay Type 2 diabetes. Hundreds of in-person and online lifestyle change programs nationwide teach participants to make CDC-approved lasting lifestyle changes like eating healthier, adding physical activity into a daily routine, and improving coping skills. To ensure high quality, the CDC recognizes lifestyle change programs that meet certain standards and show they can achieve results. These standards include following an approved curriculum, facilitation by a trained lifestyle coach, and submitting data each year to show that the program is having an impact. The NDPP must use a lifestyle coach to deliver the program to participants. Many lifestyle coaches are registered dieticians or registered nurses, but no credentials are required,[35] and the CDC has a free lifestyle coach facilitator training guide available on its website.[36]

The AADE also offers NDPP diabetes lifestyle coach training based on the curriculum of the CDC in a two-day, in person course for $750 - $850 to acquire all the necessary skills to deliver a successful CDC NDRP/NDPP Program.[37]

The Sunrise Act and Sunrise Questionnaire

The Sunrise Act (the act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors when determining whether to regulate a new profession or occupation. The legislative intent of the act provides that:

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the state's police power be exercised only to the extent necessary for that purpose; and

[32] *Id*.
[33] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *Diabetes Prevention Recognition Program, Standards and Operating Procedures* (January 1, 2015), http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf (last visited Jan. 31, 2018).
[34] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *What Is the National DPP? available at* http://www.cdc.gov/diabetes/prevention/about/index.html (last visited Jan. 31, 2018).
[35] *Supra* note 32, at 25.
[36] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *National Diabetes Prevention Program, Life Coach Facilitation Guide*, http://www.cdc.gov/diabetes/prevention/pdf/curriculum_intro.pdf (last visited Jan. 31, 2018).
[37] American Association of Diabetes Educators, *AADE Diabetes Prevention Program Lifestyle Coach Training*, https://www.diabeteseducator.org/practice/diabetes-prevention-program/lifestyle-coach-training (last visited Jan. 31, 2018).

- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.

The Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

The act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees of reference.[38] This required information is traditionally compiled in a "Sunrise Questionnaire."

The Florida Senate Sunrise Questionnaire to aid the Legislature in determining the need to regulate diabetes educators has been provided to the Senate Health Policy Committee. The Senate Sunrise Questionnaire was received on March 30, 2017,[39] for similar proposed legislation in 2017.[40]

The Senate Sunrise Questionnaire indicates that the AADE is seeking regulation in Florida, and that in 2017 there were approximately 700 individuals who were members of the AADE in Florida, many having earned the CDE certification from the NCBDE or the BC-ADM.

The Questionnaire notes that practitioners typically deal with individuals with, or at-risk of, diabetes and related conditions to achieve behavioral change which will lead to better clinical outcomes and improved health status. The questionnaire notes that a physician typically refers a patient to a nurse who practices in diabetes education, nutritionist, dietician, or podiatrist for diabetic education. Registration would bring attention to the benefits of diabetes self-management training (DSMT) programs. The questionnaire further notes that marketplace factors will not be as effective as government regulation because places like grocery stores, drug

[38] See s. 11.62(4)(a)-(m), F.S.
[39] *See* Florida Senate Sunrise Questionnaire, Diabetes Educators, (March 30, 2017) (on file with the Senate Committee on Health Policy).
[40] See SB 1578 (2017 Regular Session).

stores, massage establishments, and spas offer diabetes education or wellness programs and these programs are not recognized by the American Diabetes Association. The restrictions on the practice of providing diabetes education may affect the public's access to these services.

III. Effect of Proposed Changes:

Section 1 amends s. 456.001, F.S., to modify the definition of "health care practitioner" to include persons "registered" under the various regulatory statutes. This will include the newly regulated "diabetes educator" registered under Part XVII of chapter 468.

Section 2 creates part XVII of ch. 468, F.S., entitled "Diabetes Educators," to establish a regulated profession in Florida. Registration is voluntary unless a person holds himself or herself out as a diabetes educator or provides diabetes self-management training (DSMT), as defined in the bill. However, a licensed health practitioner may provide services within the scope of his or her license.

The bill makes legislative findings that the provision of DSMT by unregistered and incompetent practitioners presents a danger to the public health and safety, and it is the intent of the Legislature to prohibit persons who fall below the minimum competency standards for a diabetes educator from providing DSMT in Florida.

The bill requires that the DOH issue a registration to an applicant who submits the following:

- Documentation of:
  - Certification as a Certified Diabetes Educator (CDE) by the National Certification Board for Diabetes Educators (NCBDE);
  - Certification in Board Certified-Advanced Diabetes Management (BC-ADM) by the American Association of Diabetes Educators (AADF); or
  - Completion of 250 practice hours of diabetes education, of which at least 100 hours must be earned in the calendar year preceding application, a passing score on the NCBDE registration examination, and licensure as a health care practitioner as defined in s. 456.001, F.S.

The bill requires the DOH to renew a registration upon receipt of a renewal application and a biennial renewal fee. The DOH is also required to adopt rules establishing procedures for biennial registration renewal.

The bill creates s. 468.934, F.S., to require the DOH to establish, by rule, the following fees:

- A nonrefundable application fee, not to exceed $100;
- An initial registration fee, not to exceed $100;
- A biennial renewal fee, not to exceed $80; and
- A fee for reactivation of an inactive registration, not to exceed $135.

The fees must be adequate to support the registration program.

The bill creates s. 468.935, F.S., to specify prohibited acts and create exemptions. A person may not provide DSMT or represent himself or herself as a diabetes educator, unless he or she is registered with the DOH under this part. This part does not prohibit or restrict a health care

practitioner as defined in ch. 456, F.S., from practicing within the scope of his or her profession. However, a licensed health care practitioner desiring to use the credential of diabetes educator must obtain additional training in diabetes education as noted above, pass the NCBDE examination, and register with the DOH.

A person employed by the federal government performing official duties is also exempt from registration.

The DOH is required to implement the provisions of the bill by July 1, 2019.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill requires the DOH to establish fees as follows:

- A nonrefundable application fee, not to exceed $100;
- An initial registration fee, not to exceed $100;
- A biennial renewal fee, not to exceed $80; and
- A fee for reactivation of an inactive registration, not to exceed $135.

B. Private Sector Impact:

For a licensed health care practitioner, the registration is voluntary. For others, one must be registered and pay the applicable fees to use the title of diabetes educator or to engage in DSMT.

C. Government Sector Impact:

The DOH will experience an increase in revenues associated with diabetes educator application and initial and renewal fees, but will incur an increase in workload and costs associated with the registration and regulation of diabetes educators. The fees must be adequate to regulate the profession.

VI. Technical Deficiencies:

The bill does not amend s. 20.43(3)(g), F.S., to include the newly created profession of diabetes educators in the listing of professions under the responsibility of the Division of Medical Quality Assurance.

VII. Related Issues:

The bill authorizes an independent practice without any medical oversight. The Dietetics and Nutrition Practice Council is under the BOM and those practitioners operate pursuant to physician's orders and oversight. The diabetes educator functions are similar to those of nurses who operate pursuant to physician or other advanced practitioner orders and oversight.

The bill does not distinguish the standards of practice of the diabetes educators from dieticians, nutritionists, or nurses who also follow ADA Standards.

VIII. Statutes Affected:

This bill substantially amends section 456.001 of the Florida Statutes.

This bill creates the following sections of the Florida Statutes: 468.931, 468.932, 468.933, 468.934, and 468.935.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on February 6, 2018:
Deletes certification as a clinical exercise physiologist, registered clinical exercise physiologist, or having a master's degree or higher in social work, in conjunction with 250 hours in diabetes education and passage of the NCBDE examination, as a pathway for registration as a diabetes educator.

B. Amendments:

None.

By the Committee on Health Policy; and Senators Gibson and Torres

588-02917-18 2018758c1

A bill to be entitled

An act relating to diabetes educators; amending s. 456.001, F.S.; redefining the term "health care practitioner" to include diabetes educators; creating part XVII of ch. 468, F.S., entitled "Diabetes Educators"; providing legislative findings and intent; requiring implementation by a specified date; defining terms; providing requirements for registration as a diabetes educator; requiring the Department of Health to renew a registration under certain circumstances; requiring the department to adopt rules for biennial renewal of registrations; requiring the department to establish specified fees; prohibiting an unregistered person from certain activities relating to diabetes self-management training; providing exemptions; authorizing the department to take disciplinary action against an applicant or registrant for specified violations; authorizing rulemaking; providing an effective date.

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

Section 1. Subsection (4) of section 456.001, Florida Statutes, is amended to read:

456.001 Definitions.—As used in this chapter, the term:

(4) "Health care practitioner" means any person licensed or registered under chapter 457; chapter 458; chapter 459; chapter 460; chapter 461; chapter 462; chapter 463; chapter 464; chapter 465; chapter 466; chapter 467; part I, part II, part III, part V, part X, part XIII, ~~or~~ part XIV, or part XVII of chapter 468; chapter 478; chapter 480; part III or part IV of chapter 483; chapter 484; chapter 486; chapter 490; or chapter 491.

588-02917-18 2018758c1

Section 2. Part XVII of chapter 468, Florida Statutes, consisting of sections 468.931 through 468.935, Florida Statutes, is created to read:

PART XVII

DIABETES EDUCATORS

468.931 Legislative findings and intent; implementation.—

(1) The Legislature finds that the provision of diabetes self-management training by unregistered and incompetent practitioners presents a danger to the public health and safety. Therefore, it is the intent of the Legislature to prohibit diabetes educators who fall below minimum competency standards or who otherwise present a danger to the public health and safety from providing diabetes self-management training in this state.

(2) The Department of Health must implement the provisions of this part by July 1, 2019.

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

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

(2) "Diabetes educator" means a health care practitioner registered under this part who has demonstrated a comprehensive knowledge of and experience in prediabetes, diabetes prevention, and diabetes education and who provides diabetes self-management training.

(3) "Diabetes self-management training" means the assessment and development of a plan of care for a person with diabetes through a collaborative process through which the

person gains the knowledge and skills necessary to modify behavior and successfully self-manage the disease as provided for in the national standards published by the American Diabetes Association.

468.933 Requirements for registration; registration renewal.—

(1) The department shall issue a registration to an applicant who has submitted to the department:

(a) A completed application in a form prescribed by the department.

(b) A registration fee, pursuant to s. 468.934.

(c)1. Proof of certification as a Certified Diabetes Educator by the National Certification Board for Diabetes Educators or certification in Board Certified—Advanced Diabetes Management by the American Association of Diabetes Educators; or

2. Proof of completion of at least 250 practice hours of diabetes education, of which at least 100 practice hours are earned in the calendar year immediately preceding application, and proof of passing the registration examination administered by the National Certification Board for Diabetes Educators; and proof of licensure as a health care practitioner as defined in s. 456.001.

(2) The department shall renew a registration under this section upon receipt of a renewal application and biennial renewal fee from a registrant. The department shall adopt rules establishing procedures for biennial renewal of registrations under this section.

468.934 Fees.—The department shall establish by rule the following fees to be paid by a person seeking registration or

registration renewal as a diabetes educator. The fees must be adequate to implement and administer this part:

(1) A nonrefundable application fee, which may not exceed $100.

(2) An initial registration fee, which may not exceed $100.

(3) A biennial renewal fee, which may not exceed $80.

(4) A fee for reactivation of an inactive registration, which may not exceed $135.

468.935 Prohibited acts; exemptions.—

(1) A person may not provide diabetes self-management training, or represent himself or herself as being a diabetes educator, unless he or she is registered pursuant to this part.

(2) This section does not prohibit or restrict:

(a) An emergency medical technician or paramedic licensed under chapter 401 or a health care practitioner as defined in s. 456.001 from engaging in, or practicing within, the scope of the occupation or profession for which he or she is licensed.

(b) A person employed by the Federal Government or any bureau, division, or agency of the Federal Government from discharging his or her official duties.

(3) The department may take disciplinary action pursuant to s. 456.072 against an applicant or registrant and may deny, revoke, or suspend registration or registration renewal for a violation of this section.

(4) The department may adopt rules to implement and administer this section.

Section 3. This act shall take effect July 1, 2018.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR AUDREY GIBSON
6th District

COMMITTEES:
Military and Veterans Affairs, Space, and Domestic Security, *Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Commerce and Tourism
Judiciary
Regulated Industries

JOINT COMMITTEE:
Joint Legislative Auditing Committee

February 8, 2018

Senator Anitere Flores, Chair
Appropriations Subcommittee on
Health and Human Services
201 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399-1100

Chair Flores:

I respectfully request that SB 758, relating to diabetes educators, be placed on the next committee agenda.

SB 758, provides requirements for registration as a diabetes educator and prohibits an unregistered person from certain activities relating to diabetes self-management training. The bill also requires the department to adopt rules for biennial registration renewal.

Thank you for your time and consideration.

Sincerely,

Audrey Gibson
State Senator
District 6

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Diabetes Educators

Name David Christian

Job Title Director - Govt Relations

Address 900 Hope Way
Street

Altamonte Springs, FL 32714
City *State* *Zip*

Phone 407/357-2493

Email david.christian@ahss.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

SB 758
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Health policy

Name Christopher Nuland

Job Title Lobbyist

Address 1000 Riverside Ave
Street

Jacksonville FL 32204
City *State* *Zip*

Phone 909-355-1555

Email nuland.lw@aol.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing American College of Physicians

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/2018
Meeting Date

758
Bill Number (if applicable)

Topic Diabetes Education

Amendment Barcode (if applicable)

Name Melanie Bostick

Job Title Vice President

Address _____ Phone _____
Street

_____ Email _____
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing American Assoc. of Diabetes Educators

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 1360 (580822)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Broxson
SUBJECT:	Child Welfare
DATE:	February 22, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Fav/CS**
2.	Sneed	Williams	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1360 makes a number of changes to the child welfare system related to fingerprinting a member of a household being considered as a prospective placement for a child in out-of-home care and the allocation formula used to distribute additional funding to community-based lead agencies (CBCs).

Specifically, the bill adds two federal Child Care and Development Block Grant Act requirements, not previously addressed in state law, to align background screening requirements for child care personnel. The change will allow the Department of Children and Families (DCF or department) to utilize out-of-state criminal history records results for the past five years. The bill also adds drug offenses to the list of disqualifying offenses in ch. 893, F.S., for child care personnel.

The bill makes changes to the equity allocation model for the community-based care lead agencies (CBCs) that contract with the department, by revising the formula that directs the allocation of new core services funding, to more closely align the model with factors that affect the CBC's performance.

The bill amends the definition of the term "abuse" to include the birth of a new child into a family during the course of an open dependency case for those parents or caregivers who are determined to lack the protective capacity to safely care for the children in the home, and have not substantially complied with their case plan, or met the conditions for return of the children

into the home. The bill requires parents to provide accurate contact information to the department, update the information as necessary, and contact the DCF or the CBC at least every 14 days.

The bill requires child care facilities, family day care homes, and large family child care homes to provide public service information related to distracted adults leaving children in vehicles to parents of enrolled children.

The bill authorizes the Walton County sheriff's office to assume responsibility for child protective investigations. By transferring existing recurring funding between appropriation categories within the DCF, funding for the sheriff's office of $860,607 is included in Senate Bill 2500, the Senate Fiscal Year 2018-2019 General Appropriations Bill.

The bill is not expected to have a fiscal impact on state government.

The bill is effective July 1, 2018.

II. Present Situation:

Limitations on Placement of a Child

When the Department of Children and Families (DCF or department) considers placement of a child in the child welfare system, the department must conduct a records check through the State Automated Child Welfare Information System (SACWIS) and a local and statewide criminal history records check on all persons under consideration for child placement, including all nonrelative placement decisions, and all members of the household, 12 years of age and older, of the person being considered.[1] This records check may include, but is not limited to, submission of fingerprints to the Department of Law Enforcement for processing and forwarding to the Federal Bureau of Investigation for state and national criminal history information.[2]

Current law prohibits the department from considering out-of-home placements with persons who have been convicted of a felony that falls within any of the following categories:

- Child abuse, abandonment, or neglect;
- Domestic violence;
- Child pornography or other felony in which a child was a victim of the offense; or
- Homicide, sexual battery, or other felony involving violence, other than felony assault or felony battery when an adult was the victim of the assault or battery.

In addition, DCF may not place a child with a person other than a parent if that person has been convicted of assault, battery, or a drug-related offense within the previous five years.[3]

[1] Section 39.0138, F.S.
[2] *Id*.
[3] Section 39.0138(3), F.S.

Community-Based Care Lead Agencies

Section 409.986, Florida Statutes, provides legislative intent for the department to contract with community-based care lead agencies (CBCs) to provide foster care and related services.[4] These services include family support and family preservation, independent living, emergency shelter, facility or family-based foster care, dependency case management, adoptions, services for victims of sexual exploitation, postplacement supervision, and family reunification. CBCs contract with a number of subcontractors for case management and direct care services to children and their families, and must give priority to services that are evidence-based and trauma informed.[5]

There are 19 CBCs statewide, which together serve the state's 20 judicial circuits. Section 409.991, F.S., requires the department to allocate funds to the CBCs based on an equity allocation model. The model is designed to allocate funds among these lead agencies based on the differing needs and services required by the particular population served by each organization.

The model includes "core services funding," which is defined as all funds allocated to CBCs operating under contract with the DCF pursuant to s. 409.987, F.S., except funds appropriated for independent living, maintenance adoption subsidies, protective investigations training, or mental health wrap-around services; designated special projects; or those appropriated from nonrecurring funds.

Since Fiscal Year 2015-2016, recurring core services funding to each CBC has been based on the prior year's recurring base funding.[6] However, additional or new core services funding that becomes available is directed to be distributed based on the equity allocation model, as follows:

- 20 percent is allocated among all CBCs;
- 80 percent is allocated to CBCs that are currently funded below their equitable share. Funds are weighted based on each CBC's proportion of the total amount of funding below the equitable share.[7]

The equity allocation model requires that any additional core services funding be distributed to the CBCs based on the following factors:

- Proportion of the child population;
- Proportion of the child abuse hotline workload; and
- Proportion of children in care, weighted as 60 percent based on children in out-of-home care and 40 percent based on children in in-home care.[8]

These factors are then used by the DCF for funding allocation purposes, with the distribution of core services funds for each CBC calculated as follows:

- Proportion of the child population, weighted as 5 percent of the total;

[4] *Id*.
[5] Section 409.988, F.S.
[6] *Id*.
[7] *Id*.
[8] *Id*.

- Proportion of child abuse hotline workload, weighted as 15 percent of the total; and
- Proportion of children in care, weighted as 80 percent of the total.[9]

Child Care Licensure

The department has responsibility for regulation of child care facilities, family day care homes, and large family child care homes, including those that are also School Readiness providers. Current law requires personnel of these providers to have good moral character based upon screening.[10] Additionally, some entities caring for children are not subject to regulation by DCF's child care program but their personnel are subject to background screening.[11] Screening must be conducted as provided in ch. 435, F.S., using Level 2 standards.[12]

Child Care and Development Block Grant

The Office of Child Care (OCC) of the United States Department of Health and Human Services supports low-income working families by providing access to affordable, high-quality child care. OCC works with state, territory and tribal governments to provide support for children and their families to promote family economic self-sufficiency and to help children succeed in school and life through affordable, high-quality early care and afterschool programs.[13]

Florida's Office of Early Learning (OEL)[14] provides state-level administration for the School Readiness program. The School Readiness program is a state-federal partnership between OEL and the Office of Child Care of the United States Department of Health and Human Services.[15] The School Readiness program receives funding from a mix of state and federal sources, including the federal Child Care and Development Block Grant (CCDBG), the federal Temporary Assistance for Needy Families (TANF) block grant, general revenue and other state funds. The School Readiness program subsidizes for child care services and early childhood education for low-income families and for children in protective services who are at risk of abuse, neglect, or abandonment, and for children with disabilities.

The program uses a variety of providers, such as licensed and unlicensed child care providers and public and nonpublic schools.[16] The Department of Children and Families (DCF), Office of Child Care Regulation, as the agency responsible for the state's child care provider licensing program, regulates many, but not all, child care providers that provide early learning programs.[17]

---

[9] *Id*.
[10] Section 402.305, F.S.
[11] For example, a child care facility that is an integral part of a church or parochial schools meeting certain requirements. Section 402.316, F.S.
[12] *Id*.
[13] U.S. Department of Health and Human Services, Office of Child Care, *What We Do*, (August 19, 2016) http://www.acf.hhs.gov/programs/occ/about/what-we-do (last visited February 6, 2018).
[14] In 2013, the Legislature established the Office of Early Learning in the Office of Independent Education and Parental Choice within the Department of Education (DOE). 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 Voluntary Prekindergarten Education Program. Section 1001.213, F.S.
[15] Part VI, ch. 1002, F.S.
[16] Section 1002.88(1)(a), F.S.
[17] See ss. 402.301-319, F.S., and part VI, ch. 1002, F.S.

On November 19, 2014, the Child Care and Development Block Grant (CCDBG) Act of 2014 was signed into law. The new law prescribed health and safety requirements that apply to school readiness program providers and required better information to parents and the general public about available child care choices.

Based on the new requirements of the block grant, to continue to receive federal funding, states must require that screening for child care staff include searches of the National Sex Offender Registry, as well as searches of state criminal records, sex offender registry and child abuse and neglect registry of any state in which the child care personnel resided during the preceding five years.[18] Additionally, a state must make ineligible for employment by school readiness providers any person who is registered, or is required to be registered, on a state sex offender registry or the National Sex Offender Registry[19] or has been convicted of:

- Murder;
- Child abuse or neglect;
- A crime against children, including child pornography;
- Spousal abuse;
- A crime involving rape or sexual assault;
- Kidnapping;
- Arson;
- Physical assault or battery;
- A drug-related offense committed during the preceding five years; or
- A violent misdemeanor committed as an adult against a child, including the following crimes: child abuse, child endangerment, sexual assault, or a misdemeanor involving child pornography.[20]

In 2016, the Legislature aligned the state's child care personnel screening standards with the CCDBG Act of 2014 requirements, specifying new screening requirements in ch. 402, F.S., and including these limitations on granting disqualifications in ch. 435, F.S.[21]

Parental Responsibilities and Terminations of Parental Rights

Parents involved in the child welfare system have a number of responsibilities they must carry out in order to be reunified with their children, if permanency is a goal. A primary responsibility is to comply with the case plan. Parental lack of compliance with a case plan constitutes grounds for termination of parental rights. Specifically, noncompliance is shown if a parent fails to substantially comply for 12 months after the child's adjudication of dependency or if a child has been in care for 12 of the last 22 months, or a parent materially breaches the case plan such that noncompliance is likely before the expiration of time to comply. However, generally if noncompliance is due to the parent's lack of financial resources or the department's failure to make reasonable efforts, grounds for termination are not established.[22]

[18] Pub. Law No. 113-186, 128 Stat. 1971, Sec. 658H(b)
[19] 42 U.S.C. s. 9858f(c)(1)(C).
[20] 42 U.S.C. s. 9858f(c)(1).
[21] Chapter 2016-238, Laws of Fla.
[22] Section 39.806, F.S.

Section 39.6011, F.S., requires the case plan to contain a written notice that a parent's noncompliance with the case plan may lead to the termination of parental rights. This message is also delivered by the judge during the hearing on the child's placement in a shelter[23] and the adjudicatory hearing.[24]

The U.S. Department of Health and Human Services, through the Children's Bureau, conducts periodic Child and Family Services Reviews (CFSR) in each state. As authorized by federal law, these reviews assess state compliance with the federal requirements for child welfare systems in Title IV-B and Title IV-E of the Social Security Act. In particular, the Children's Bureau examines whether desired child outcomes are being achieved and whether the child welfare system is structured appropriately and operates effectively. Reviews are conducted every 4 years.

The report summarizing Florida's most recent results was issued in late 2016. The report indicated the following related to achieving permanency:

- Despite establishing timely and appropriate permanency goals, case review results found that agencies and courts struggle to make concerted efforts to achieve identified permanency goals in a timely manner.
- Delays in achieving reunification and guardianship goals are affected by case plans not being updated timely to reflect the current needs of the family, delays in referral for services, and any failure to engage parents.
- The agency and court do not make concerted efforts to achieve the goal of adoption timely in nearly half of applicable cases.
- Barriers affecting timely adoptions include the lack of concurrent planning when a parent's compliance level is minimal, and providing parents additional time to work on case plan goals.
- In over half of applicable cases, the agency failed to make concerted efforts to provide services, removed children without providing appropriate services, or did not monitor safety plans and engage the family in needed safety-related services.[25]

The report also concluded that there are concerns with gaps in key services, long waiting lists, insurance barriers, and an inability to tailor services to meet the cultural needs of the diverse population. Substance abuse and domestic violence are the main reasons for agency involvement. The review found that substance abuse, in particular, contributes to various safety concerns for children. Stakeholders noted that there are major gaps in services to address both substance abuse and domestic violence in the non-metro areas of the state.[26]

This indicates that while lack of case plan compliance by parents causes delays in permanency, inadequacies in the system are also contributing factors.

[23] Section 39.402(18), F.S.
[24] Section 39.507(7)(c), F.S.
[25] U.S. Department Of Health And Human Services, Children's Bureau, Child and Family Services Reviews, Florida Final Report, 2016, *available at*: http://centerforchildwelfare.org/qa/CFSRTools/2016%20CFSR%20Final%20Report.pdf. (last visited February 21, 2018.
[26] *Id*.

Sheriffs Conducting Child Protective Investigations

Child protective investigation units are responsible for receiving and responding to reports of child abuse and neglect, which involves whether the report meets the criteria to be accepted for a protective investigation, gathering information, and making a determination of whether child maltreatment occurred or the child is at risk of abuse or neglect.

The DCF has been authorized to enter into contracts with county sheriffs to provide child protective investigations since 1998.[27] Currently, the department is responsible for performing child protective investigations in 61 counties statewide. Sheriff's offices in 6 counties (Broward, Manatee, Pinellas, Seminole, Hillsborough, and Pasco) are responsible for performing child protective investigations.[28] Child protective investigations in Walton County are conducted by DCF staff.[29] The department currently employs 12 full-time equivalent (FTE) positions to provide these investigative services for the county.

The department is also required to enter into agreements with the jurisdictionally responsible county sheriffs' offices and local police departments that will assume the lead in conducting any potential criminal investigations arising from allegations of child abuse, abandonment, or neglect.[30] The following types of calls to the DCF Child Abuse Hotline are automatically transferred to the appropriate county sheriff's office:

- Reports of known or suspected child abuse by an adult other than a parent, legal custodian, caregiver, or other person responsible for the child's welfare, as defined in s. 39.01, F.S.;
- Reports involving juvenile sexual abuse or a child who has exhibited inappropriate sexual behavior; and
- Reports of an instance of known or suspected child abuse involving impregnation of a child under 16 years of age by a person 21 years of age or older solely under s. 827.04(3), F.S.[31]

All child protective investigations, regardless of the entity administering this function, must be done in accordance with state and federal laws, and regulations. The county sheriffs must conduct investigations, at a minimum, in accordance with the performance standards and outcome measures established by the Legislature for protective investigations conducted by the department. Each individual child protective investigator must complete, at a minimum, the training provided to and required of protective investigators employed by the department.[32]

Funds for providing child protective investigations must be identified in the annual appropriation made to the department, which shall award grants to the respective sheriffs' offices. Funds for child protective investigations may not be integrated into the sheriffs' regular budgets. Budgetary data and other data relating to the performance of child protective investigations must be maintained separately from all other records of the sheriffs' offices and reported to the department as specified in the grant agreement.[33]

[27] Section 39.3065, F.S.
[28] Those county sheriffs are Broward, Hillsborough, Manatee, Pasco, Pinellas and Seminole.
[29] Staff in Walton County include 12 positions that are responsible for child protective investigative functions.
[30] Section 39.306, F.S.
[31] Section 39.201, F.S.
[32] Section 39.3065, F.S.
[33] Id.

The grants funding from DCF is from several sources, including state general revenue and federal funds from the Welfare Transition Trust Fund (Temporary Assistance for Needy Families Block Grant), Social Services Block Grant Trust Fund, Child Welfare Training Trust Fund, Federal Grants Trust Fund, and Title IV-E funds.

Performance and Cost

DCF and the sheriff's offices generally use similar investigative processes and procedures, although the higher level of funding for the sheriffs results in their investigators having greater resources than typically available to DCF investigators. Due to their law enforcement affiliation, child abuse investigators working for sheriffs also generally have greater access to training and specialists, as well as enhanced cooperation and community respect not always afforded to DCF investigators.[34] The additional resources available to sheriffs' offices enhance their investigators' ability to perform their job duties and the office's ability to attract and retain experienced investigators. Sheriffs:

- Have slightly lower overall investigator caseloads;
- Tend to have more investigative aides and support staff positions;
- Provide vehicles for investigators;
- Provide investigator uniforms;
- Provide additional equipment to investigators;
- Provide supplies for children awaiting placement, including diapers, formula, food, and clothes;
- Have well-equipped visitation rooms with furniture, rugs, toys, television, games, kitchens, and bathrooms to provide children with a comfortable and safe environment after removal, further enabling investigators to perform their job more easily;
- Provide investigators with office space either in the sheriff's office or collocated with or near community-based care lead agencies, which facilitates communication between supervisors and investigators and enhances accountability; and
- Often provide higher salaries for investigators, which enhances morale and also contributes to lower turnover. In addition to higher salaries, sheriffs' child protective investigators are normally awarded merit and cost-of-living raises.[35]

Child protective investigation units administered by sheriffs' offices also have advantages that are not entirely due to their higher state funding. Because sheriff's offices are law enforcement agencies, they can provide protective investigators with access to training and resource specialists, and a higher degree of cooperation with local law enforcement agencies and the community.[36]

[34] The Florida Legislature, Office of Program Policy Analysis and Government Accountability, Research Memorandum, *Sheriff's Offices Have Advantages for Conducting Child Abuse Investigations, but Quality Cannot be Directly Compared to DCF*, February 26, 2010.
[35] *Id*.
[36] *Id*.

However, the higher funding and other advantages enjoyed by the sheriff's offices does not appear to result in better outcomes and the cost per investigation is higher.[37]

Vehicular Heat Stroke Deaths in Children

Hyperthermia or vehicular heat stroke deaths have become much more prevalent in children since federal law required that children ride in the backseat due to the danger of front passenger seat airbags.[38] The national average number of these deaths is 39 per year.[39] Thirty-one percent of hyperthermia deaths involve children under the age of one.[40] Between 1998 and 2015, Florida had the second highest number of child deaths from vehicular heat stroke.[41]

Licensing Standards for Child Care Facilities and Large Family Child Care Homes Relating to Vehicles

The department establishes licensing standards that each licensed child care facility in the state must meet.[42] A child care facility is defined in Florida law as "any child care center or child care arrangement which provides child care for more than five children unrelated to the operator and which receives a payment, fee, or grant for any of the children receiving care, wherever operated, and whether or not operated for profit."[43]

A large family child care home is defined as an occupied residence in which child care is regularly provided for children from at least two unrelated families, which receives a payment, fee, or grant for any of the children receiving care, whether or not operated for profit, and which has at least two full-time child care personnel on the premises during the hours of operation.[44]

The department currently oversees just over 6,000 licensed child care entities including child care facilities, large family child care homes and family day care homes.[45] In addition, there are homes that are only registered by the agency, facilities that are exempt from licensure due to a religious affiliation,[46] and homes currently licensed by five counties in the state.[47] Of these

---

[37] The Department of Children and Families, Florida Sheriffs Performing Child Protective Investigations, Annual Program Performance Evaluation Report, Fiscal Year 2015-2016, *available at*: http://centerforchildwelfare.fmhi.usf.edu/kb/LegislativeMandatedRpts/AnnualSheriffPerfRptFY15-16.pdf. (last visited February 21, 2018)

[38] See Kids and Cars.org, Fact Sheet, *available at*: http://www.kidsandcars.org/files/2013/06/National-Stats-Chart-2017.jpg (last visited February 7, 2018); see also Gene Weingarten, Fatal Distraction: Forgetting a Child in the Backseat of a Car is a Horrifying Mistake. Is it a Crime?, THE WASHINGTON POST, Mar. 8, 2009, *available at*: http://www.washingtonpost.com/wp-dyn/content/article/2009/02/27/AR2009022701549.html (last visited February 7, 2018).

[39] *Id.*

[40] *Id*.

[41] California Department of Meteorology and Climate Science, *Heatstroke Deaths of Children in Vehicles by State, available at*: http://noheatstroke.org/state.htm (last visited February 7, 2018.

[42] See s. 402.305, F.S.

[43] See s. 402.302(2), F.S.

[44] See s. 402.302(11), F.S.

[45] Florida Department of Children and Families, DCF Quick Facts, 7 (Quarter 1, Fiscal Year 2017-2018), *available at*: http://www.dcf.state.fl.us/general-information/quick-facts/cc / (last visited February 7, 2018).

[46] See s. 402.316, F.S.

[47] See s. 402.306, F.S. Those five counties are Broward, Hillsborough, Palm Beach, Pinellas and Sarasota.

homes, a total 1,490 child care facilities and large family child care homes regulated by the department reported that they transport children.[48]

Statutory licensing standards for child care facilities are extensive and reference transportation and vehicles, including the requirement that minimum standards include accountability for children being transported.[49] The Florida Administrative Code provides requirements for licensed child care facilities and large family child care homes to follow in relation to vehicles that are owned, operated, or regularly used by the facility or home, as well as vehicles that provide transportation through a contract or agreement with an outside entity.[50]

Providers are required to maintain a driver's log for all children being transported. This log must include the child's name, date, time of departure, time of arrival, signature of driver, and signature of second staff member to verify the driver's log and that all children have left the vehicle. Upon arrival at the destination, the driver of the vehicle must mark each child off the log as the child departs the vehicle, conduct a physical inspection and visual sweep of the vehicle, and sign, date, and record the driver's log immediately to verify all children were accounted for and that the sweep was conducted. Upon arrival at the destination, a second staff member must also conduct a physical inspection and visual sweep of the vehicle and sign, date, and record the driver's log to verify all children were accounted for and that the driver's log is complete.[51]

Current standards for child care facilities and large family child care homes do not address providing information to parents related to being distracted and leaving a child in a vehicle.

III. Effect of Proposed Changes:

Section 1 amends s. 39.01, relating to definitions, to provide that the definition of the term "abuse" includes birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home.

Section 2 amends s. 39.0138, F.S., relating to criminal history and other records checks and the limits on placing a child, to allow the department to grant an exemption from a fingerprinting requirement to a household member with a physical, developmental, or cognitive disability that prevents him or her from being fingerprinted. The department is granted rulemaking authority to administer the provision. The section requires that if a fingerprint exemption is granted, a Level 1 background screening pursuant to s. 435.03, F.S., must be completed on the person who is granted the exemption.

The section also clarifies that "resisting arrest with violence" is a disqualifier for placement of a child in the home if the offense occurred within the previous five years rather than if the offense was committed at any time.

---

[48] Florida Department of Children and Families, 2018 Agency Legislative Bill Analysis, SB 486. On file with the Senate Committee on Children, Families and Elder Affairs.
[49] See s. 402.305, F.S
[50] See 65C-22.001(6) and 65C-20.13(8), F.A.C.
[51] *Id*.

Section 3 amends s. 39.3065, F.S., relating to sheriffs providing child protective investigations, to authorize the Walton County Sheriff to assume responsibility for the investigations beginning with the 2018-2019 fiscal year.

Section 4 amends s. 39.6012, F.S., relating to case plan tasks and services, to require parents to provide accurate contact information, including updates of contact information, to the department or the contracted case management agency. Parents must also proactively contact the department or the contracted case management agency at least every 14 calendar days to provide information on the status of case plan task completion, barriers to completion, and plans towards reunification.

Section 5 amends s. 39.6013, F.S., relating to case plan amendments, to require additional considerations by the court before determining whether to amend a case plan.

Section 6 amends s. 39.621, F.S., relating to permanency determinations by the court, to add as a factor for the court to consider in determining permanency at the permanency hearing, whether the frequency, duration, manner, and level of engagement of the parent or legal guardian meets the case plan requirements.

Section 7 amends s. 39.701, F.S., relating to judicial review, to provide that the court at the judicial review hearing must make written findings regarding the parent or legal guardian's compliance with the case plan and demonstrable change in parental capacity to achieve timely reunification.

Section 8 amends s. 63.092, F.S., relating to the requirements of preliminary home studies of intended adoptive parents, to:

- Require the "records check of the department's Central Abuse Registry" be provided directly to the entity conducting the home study to ensure the integrity of the results and protect the best interest of children being placed for adoption; and
- Allow licensed adoption agencies to use their professional judgement to determine the appropriate counseling and education, dependent upon the type of adoption and the child being adopted. The bill exempts adoptive parents in private adoptions from the training requirements in s. 409.175(14), F.S.

Section 9 amends s. 402.305, F.S., relating to licensure standards for child care facilities, to add two federal Child Care and Development Block Grant Act requirements not previously addressed in state law, to align background screening requirements for child care personnel with federal requirements. The change allows the department to utilize results from out-of-state employment history checks, criminal history records, sexual predator and sexual offender registries, and child abuse and neglect registry of any state in which the person resided during the past five years, and requires fingerprint submissions for child care personnel to comply with s. 435.12, F.S.

The bill also requires each child care facility to provide parents of enrolled children information relating to the potential hazard of becoming distracted and leaving a child in a vehicle. The department is directed to develop a flyer or brochure and post it on the agency website.

Section 10 amends s. 402.30501, F.S., relating to modification of introductory child care course for community college credit, to conform references to changes made by the bill.

Section 11 amends s. 402.313, F.S., relating to family day care homes, to add a requirement that such homes provide parents of enrolled children information relating to the potential hazard of becoming distracted and leaving a child in a vehicle. The department is to develop a flyer or brochure and post in on the agency website.

Section 12 amends s. 402.3231, F.S., relating to large family child care homes, to add a requirement that such homes provide parents of enrolled children information relating to the potential hazard of becoming distracted and leaving a child in a vehicle. The department is to develop a flyer or brochure and post in on the agency website.

Section 13 amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies, to define the term "severe disability" when determining whether a person should be exempt from being fingerprinted because of a physical, developmental, or cognitive disability. If a person is exempt from being fingerprinted, the department would be able to license the family foster home without fingerprinting all individuals in the home.

Section 14 amends s. 409.991, F.S., relating to allocation of funds for community-based care lead agencies, to modify the definition of the term "children in care" and revise the formula for the allocation of new core services funding to CBCs. Children in care will now include only new entries of children into out-of-home care over the most recent 24 months, instead of all children in out-of-home over the most recent 12 months. The term will also include children whose families have received family support services over the most recent 12 months. Children receiving in-home services will continue to be included over the most recent 12 months. The bill modifies the weights of children in care as 15 percent for family support services, 55 percent for children in out-of-home care, and 30 percent for children in in-home care.

The bill directs the department to distribute new core services funding to CBCs pursuant to the following amended equity allocation model:

- Proportion of the child population, remaining as 5 percent of the total;
- Proportion of child abuse hotline workload, weighted as 35 percent of the total rather than 15 percent; and
- Proportion of children in care, weighted as 60 percent of the total, rather than 80 percent. The
- proportion of children in care is calculated based on 55 percent weight for children in out-of-home care (instead of 60 percent), 30 percent weight for children in in-home care (instead of 40 percent), and 15 percent weight based on children in family support services which is a new category.

And lastly, the bill changes the distribution of new core services funding as follows:

- 70 percent is allocated among all CBCs;
- 30 percent is allocated to CBCs that are currently funded below their equitable share. Funds are weighted based on each CBC's proportion of total funding below their equitable share.

Section 15 amends s. 435.07, F.S., relating to exemptions from disqualification, to add drug offenses to the list of disqualifying offenses in Ch. 893, F.S., for child care personnel.

Section 16 amends s. 1002.55, F.S., relating to school-year prekindergarten programs delivered by private providers, to conform references to changes made by the bill.

Section 17 amends s. 1002.57, F.S., relating to prekindergarten director credentials, to conform references to changes made by the bill.

Section 18 amends s. 1002.59, F.S., relating to emergent literacy and performance standards, to conform references to changes made by the bill.

Section 19 directs the Division of Law Revision and Information to prepare a reviser's bill for the 2019 session of the Legislature to capitalize the first letter of each word of the term "child protection team" wherever it occurs in the Florida Statutes.

Section 20 provides an effective date of July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PCS/CS/SB 1360 revises the equity allocation model used for distributing funds among the CBCs. The bill will have an indeterminate fiscal impact on the individual CBCs. In the event that new core services funding is made available for the CBCs, it is expected that some will receive more funding than they would have under the previous formula, while others would receive less. The equity allocation model only affects how new core services funding will be distributed. As an example, if a new appropriation of $10 million was made for core services funding, the following chart shows the difference between the distribution under current law and under the bill. Conversely, if new core services

funding was not appropriated, the distribution of core services funding to the CBCs would remain unchanged from the previous year.

CBC Funding Formula Changes with $10 million of New Core Services Funding

		A	B	C	C-B	A+C
			New Core Services Funding			
	Community Based Care Lead Agencies	Base Core Services Funding	Current Allocation Formula	Proposed Formula	Difference Increase/ (Decrease)	Total Core Services Funding as Proposed
1	Lakeview Center (Families First Network)	34,290,074	105,127	458,847	353,720	34,748,921
2	Big Bend CBC	25,580,295	66,731	261,282	194,551	25,841,577
3	Partnership for Strong Families	22,519,522	434,857	358,068	(76,789)	22,877,590
4	Kids First of Florida	6,469,036	19,266	72,118	52,852	6,541,154
5	Family Support Services of North Florida	35,803,739	111,134	729,823	618,689	36,533,562
6	St Johns Board of County Commissioners (Family Integrity Program)	4,340,311	87,724	111,670	23,946	4,451,981
7	Community Partnership for Children	24,518,476	76,392	541,351	464,959	25,059,827
8	Kids Central	38,069,464	581,653	666,357	84,704	38,735,821
9	CBC of Central Florida	54,790,601	162,962	603,066	440,104	55,393,667
10	Heartland for Children	32,972,143	102,914	342,961	240,047	33,315,104
11	CBC of Brevard (Brevard Family Partnerships)	18,724,431	785,596	893,866	108,270	19,618,297
12	Eckerd (Pasco-Pinellas)	45,099,623	1,681,385	1,005,370	(676,015)	46,104,993
13	Sarasota Family YMCA	21,335,346	1,090,033	684,784	(405,249)	22,020,130
14	Eckerd (Hillsborough)	53,515,735	1,868,890	642,722	(1,226,168)	54,158,457
15	Children's Network of Southwest Florida	32,319,498	2,343,016	987,470	(1,355,546)	33,306,968
16	Devereux CBC	22,167,758	68,521	229,813	161,292	22,397,571
17	Childnet (Palm Beach)	32,340,871	85,128	291,121	205,993	32,631,992
18	ChildNet (Broward)	56,635,267	173,298	602,311	429,013	57,237,578
19	Our Kids of Miami and Monroe	73,469,270	155,373	517,000	361,627	73,986,270
	New Core Services Funding Total	**634,961,460**	**10,000,000**	**10,000,000**	**-**	**644,961,460**

	Current	Proposed
Equity Formula Factors (weighted):		
Percentage of Hotline Workload	15%	35%
Percentage of Children in Care	80%	60%
Percentage of population	5%	5%
Total	100%	100%
Allocation of New Funding (weighted):		
Percentage to All CBCs	20%	70%
Percentage to Below Equity	80%	30%
Total	100%	100%
Child in Care (weighted):		
In-Home	40%	30%
Out-of-Home Care (*)	60%	55%
Family Support Services	0%	15%
Total	100%	100%

* Out-of-home care weighted formula is changing from the number of children in out-of-home care during the last 12-month period to the number of children who "enter" out-of-home care during the last 24-month period.

Collectively, CBC lead agencies were appropriated $878 million for the 2017-2018 fiscal year. Funds are provided for core services as well as for specific programs such as maintenance adoptions subsidies, independent living, and others. The amount of core services funding for Fiscal Year 2017-2018 is included in the chart below, along with the projected expenditures for the year. Several CBCs are projected to have a funding deficit for the year. The change in the equity allocation model and its impact on the CBCs for

Fiscal Year 2018-2019 may provide some assistance to the CBCs if new core services funding were to be appropriated. At present, Senate Bill 2500, the Senate General Appropriations Bill, does not provide an increase for CBC core services funding.

CBC Funding and Projected Expenditures for Fiscal Year 2017-18:

	Lead Agency (CBC)	Core Services Funding, as Proposed	Carry Forward Balance at 7/1/2017	Total Available for Core Services	Projected Expenditures	Projected Surplus/ (Deficit)
1	Lakeview Center (Families First)	$ 34,748,921	$ (335,809)	$ 34,413,112	$ 34,354,262	$ 58,850
2	Big Bend CBC	25,841,577	475,457	26,317,034	26,948,787	(631,753)
3	Partnership for Strong Families	22,877,590	791,216	23,668,806	23,834,534	(165,728)
4	Kids First of Florida	6,541,154	2,211,230	8,752,384	6,359,075	2,393,309
5	Family Support Services of North Florida	36,533,562	3,245,015	39,778,577	38,607,796	1,170,781
6	St Johns Board of County Commissioners (Family Integrity)	4,451,981	47,667	4,499,648	4,599,449	(99,801)
7	Community Partnership for Children	25,059,827	(120,887)	24,938,940	25,924,237	(985,297)
8	Kids Central	38,735,821	525,144	39,260,965	41,201,380	(1,940,415)
9	CBC of Central Florida	55,393,667	(685,066)	54,708,601	56,331,476	(1,622,875)
10	Heartland for Children	33,315,104	2,621,067	35,936,171	33,985,259	1,950,912
11	CBC of Brevard (Brevard Family Partnerships)	19,618,297	(196,437)	19,421,860	19,662,875	(241,015)
12	Eckerd (Pasco-Pinellas)	46,104,993	(195,642)	45,909,351	49,168,798	(3,259,447)
13	Sarasota Family YMCA	22,020,130	21,398	22,041,528	25,489,660	(3,448,132)
14	Eckerd (Hillsborough)	54,158,457	(419,724)	53,738,733	57,342,155	(3,603,422)
15	Children's Network of Southwest Florida	33,306,968	2,652,269	35,959,237	36,419,221	(459,984)
16	Devereux CBC	22,397,571	974,362	23,371,933	22,234,210	1,137,723
17	Childnet (Palm Beach)	32,631,992	(1,612,908)	31,019,084	31,933,396	(914,312)
18	ChildNet (Broward)	57,237,578	(5,911,972)	51,325,606	58,039,744	(6,714,138)
19	Our Kids of Miami-Dade & Monroe	73,986,270	4,011,050	77,997,320	75,199,724	2,797,596
	Total	**$644,961,460**	**$ 8,097,430**	**$653,058,890**	**$667,636,038**	**$ (14,577,148)**

Source: FY 2017-18 budget projections provided by CBCs; Analysis by Department of Children and Families.

C. Government Sector Impact:

The bill authorizes the Walton County sheriff's office to assume responsibility for child protective investigations. The DCF currently conducts these investigations with 12 full-time equivalent (FTE) positions at a cost of $860,607 ($334,652 from the General Revenue Fund and $525,955 from various trust funds). By eliminating the FTE and the corresponding salary rate of 457,659, and transferring the recurring funding between appropriation categories, total funding of $860,607 is included in Senate Bill 2500, the Senate Fiscal Year 2018-2019 General Appropriations Bill for the outsourced services.

The bill is not expected to have a fiscal impact on state government.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends ss. 39.01, 39.0138, 39.3065, 39.6012, 39.6013, 39.621, 39.701, 63.092, 402.305, 402.313, 402.3131, 409.175, 409.991, 435.07, 402.30501, 1002.55, 1002.57 and 1002.59 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 21, 2018:
The CS:

- Amends the definition of the term "abuse" to include the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home;
- Requires parents to provide accurate contact information to the department, update the information as necessary and contact DCF or the CBC lead agency at least every 14 days;
- Authorizes the Walton County Sheriff to assume responsibility for child protective investigations beginning with the 2018-2019 fiscal year;
- Requires child care facilities, family day care homes and large family child care homes to provide parents of enrolled children information related to distracted adults leaving children in vehicles;
- Requires the "records check of the department's Central Abuse Registry" be provided directly to the entity conducting the home study to ensure the integrity of the results and protect the best interest of children being placed for adoption; and
- Allows licensed adoption agencies to use their professional judgement to determine the appropriate counseling and education, dependent upon the type of adoption and the child being adopted.

CS by Children, Families, and Elder Affairs on February 6, 2018:
The CS:

- Clarifies that a Level 1 background screening is required when an exemption is approved for placement of a child;
- Adds two federal Child Care and Development Block Grant Act requirements, not previously addressed in state law, to align background screening requirements for

child care personnel. The changes allow the department to use out-of-state criminal history records results for the past five years, and require fingerprint submissions for child care personnel to comply with s. 435.12, F.S;

- Adds drug offenses to the list of disqualifying offenses in Ch. 893, F.S., for child care personnel; and
- Adjusts the formula for the allocation of funding for the community-based care lead agencies.

B. Amendments:

None.

941496

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2018	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Broxson) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Subsection (2) of section 39.01, Florida Statutes, is amended to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(2) "Abuse" means any willful act or threatened act that results in any physical, mental, or sexual abuse, injury, or

941496

harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes the birth of a new child into a family during the course of an open dependency case when the parent or caregiver has been determined to lack the protective capacity to safely care for the children in the home and has not substantially complied with the case plan towards successful reunification or met the conditions for return of the children into the home. Abuse of a child includes acts or omissions. Corporal discipline of a child by a parent or legal custodian for disciplinary purposes does not in itself constitute abuse when it does not result in harm to the child.

Section 2. Subsections (2) through (7) of section 39.0138, Florida Statutes, are renumbered as subsections (3) through (8), respectively, present subsections (2) and (3) are amended, and a new subsection (2) is added to that section, to read:

39.0138 Criminal history and other records checks; limit on placement of a child.—

(2)(a) The department shall establish rules for granting an exemption from the fingerprinting requirements under subsection (1) for a household member who has a physical, developmental, or cognitive disability that prevents that person from safely submitting fingerprints.

(b) Before granting an exemption, the department or its designee shall assess and document the physical, developmental, or cognitive limitations that justify the exemption and the effect of such limitations on the safety and well-being of the child being placed in the home.

(c) If a fingerprint exemption is granted, a level 1

941496

screening pursuant to s. 435.03 shall be completed on the person who is granted the exemption.

(3) ~~(2)~~ The department may not place a child with a person other than a parent if the criminal history records check reveals that the person has been convicted of any felony that falls within any of the following categories:

(a) Child abuse, abandonment, or neglect;

(b) Domestic violence;

(c) Child pornography or other felony in which a child was a victim of the offense; or

(d) Homicide, sexual battery, or other felony involving violence, other than felony assault or felony battery when an adult was the victim of the assault or battery, or resisting arrest with violence.

(4) ~~(3)~~ The department may not place a child with a person other than a parent if the criminal history records check reveals that the person has, within the previous 5 years, been convicted of a felony that falls within any of the following categories:

(a) Assault;

(b) Battery; ~~or~~

(c) A drug-related offense; or

(d) Resisting arrest with violence.

Section 3. Paragraph (a) of subsection (3) of section 39.3065, Florida Statutes, is amended to read:

39.3065 Sheriffs of certain counties to provide child protective investigative services; procedures; funding.—

(3)(a) Beginning in fiscal year 1999-2000, the sheriffs of Pasco County, Manatee County, Broward County, and Pinellas

County shall ~~have the responsibility to~~ provide all child protective investigations in their respective counties. Beginning in fiscal year 2018-2019, the Sheriff of Walton County shall provide all child protective investigations in his or her county. Beginning in fiscal year 2000-2001, the Department of Children and Families is authorized to enter into grant agreements with sheriffs of other counties to perform child protective investigations in their respective counties.

Section 4. Paragraph (d) is added to subsection (1) of section 39.6012, Florida Statutes, to read:

39.6012 Case plan tasks; services.—

(1) The services to be provided to the parent and the tasks that must be completed are subject to the following:

(d) Parents must provide accurate contact information to the department or the contracted case management agency, update such information as appropriate, and make proactive contact with the department or the contracted case management agency at least every 14 calendar days to provide information on the status of case plan task completion, barriers to completion, and plans toward reunification.

Section 5. Subsections (6) and (7) of section 39.6013, Florida Statutes, are renumbered as subsections (7) and (8), respectively, and a new subsection (6) is added to that section, to read:

39.6013 Case plan amendments.—

(6) When determining whether to amend the case plan, the court must consider the length of time the case has been open, the level of parental engagement to date, the number of case plan tasks completed, the child's type of placement and


941496

attachment, and the potential for successful reunification.

Section 6. Subsection (5) of section 39.621, Florida Statutes, is amended to read:

39.621 Permanency determination by the court.—

(5) At the permanency hearing, the court shall determine:

(a) Whether the current permanency goal for the child is appropriate or should be changed;

(b) When the child will achieve one of the permanency goals; ~~and~~

(c) Whether the department has made reasonable efforts to finalize the permanency plan currently in effect; and

(d) Whether the frequency, duration, manner, and level of engagement of the parent or legal guardian's visitation with the child meets the case plan requirements.

Section 7. Paragraph (d) of subsection (2) of section 39.701, Florida Statutes, is amended to read:

39.701 Judicial review.—

(2) REVIEW HEARINGS FOR CHILDREN YOUNGER THAN 18 YEARS OF AGE.—

(d) *Orders.*—

1. Based upon the criteria set forth in paragraph (c) and the recommended order of the citizen review panel, if any, the court shall determine whether or not the social service agency shall initiate proceedings to have a child declared a dependent child, return the child to the parent, continue the child in out-of-home care for a specified period of time, or initiate termination of parental rights proceedings for subsequent placement in an adoptive home. Amendments to the case plan must be prepared as prescribed in s. 39.6013. If the court finds that

941496

the prevention or reunification efforts of the department will allow the child to remain safely at home or be safely returned to the home, the court shall allow the child to remain in or return to the home after making a specific finding of fact that the reasons for the creation of the case plan have been remedied to the extent that the child's safety, well-being, and physical, mental, and emotional health will not be endangered.

2. The court shall return the child to the custody of the parents at any time it determines that they have substantially complied with the case plan, if the court is satisfied that reunification will not be detrimental to the child's safety, well-being, and physical, mental, and emotional health.

3. If, in the opinion of the court, the social service agency has not complied with its obligations as specified in the written case plan, the court may find the social service agency in contempt, shall order the social service agency to submit its plans for compliance with the agreement, and shall require the social service agency to show why the child could not safely be returned to the home of the parents.

4. If, at any judicial review, the court finds that the parents have failed to substantially comply with the case plan to the degree that further reunification efforts are without merit and not in the best interest of the child, on its own motion, the court may order the filing of a petition for termination of parental rights, whether or not the time period as contained in the case plan for substantial compliance has expired.

5. Within 6 months after the date that the child was placed in shelter care, the court shall conduct a judicial review

hearing to review the child's permanency goal as identified in the case plan. At the hearing the court shall make findings regarding the likelihood of the child's reunification with the parent or legal custodian. In making such findings, the court shall consider the level of the parent or legal custodian's compliance with the case plan and demonstrated change in protective capacities compared to that necessary to achieve timely reunification within 12 months after the removal of the child from the home. The court shall also consider the frequency, duration, manner, and level of engagement of the parent or legal custodian's visitation with the child in compliance with the case plan. If the court makes a written finding that it is not likely that the child will be reunified with the parent or legal custodian within 12 months after the child was removed from the home, the department must file with the court, and serve on all parties, a motion to amend the case plan under s. 39.6013 and declare that it will use concurrent planning for the case plan. The department must file the motion within 10 business days after receiving the written finding of the court. The department must attach the proposed amended case plan to the motion. If concurrent planning is already being used, the case plan must document the efforts the department is taking to complete the concurrent goal.

6. The court may issue a protective order in assistance, or as a condition, of any other order made under this part. In addition to the requirements included in the case plan, the protective order may set forth requirements relating to reasonable conditions of behavior to be observed for a specified period of time by a person or agency who is before the court;

941496

and the order may require any person or agency to make periodic reports to the court containing such information as the court in its discretion may prescribe.

Section 8. Paragraphs (b) and (e) of subsection (3) of section 63.092, Florida Statutes, are amended to read:

63.092 Report to the court of intended placement by an adoption entity; at-risk placement; preliminary study.—

(3) PRELIMINARY HOME STUDY.—Before placing the minor in the intended adoptive home, a preliminary home study must be performed by a licensed child-placing agency, a child-caring agency registered under s. 409.176, a licensed professional, or an agency described in s. 61.20(2), unless the adoptee is an adult or the petitioner is a stepparent or a relative. If the adoptee is an adult or the petitioner is a stepparent or a relative, a preliminary home study may be required by the court for good cause shown. The department is required to perform the preliminary home study only if there is no licensed child-placing agency, child-caring agency registered under s. 409.176, licensed professional, or agency described in s. 61.20(2), in the county where the prospective adoptive parents reside. The preliminary home study must be made to determine the suitability of the intended adoptive parents and may be completed prior to identification of a prospective adoptive minor. A favorable preliminary home study is valid for 1 year after the date of its completion. Upon its completion, a signed copy of the home study must be provided to the intended adoptive parents who were the subject of the home study. A minor may not be placed in an intended adoptive home before a favorable preliminary home study is completed unless the adoptive home is also a licensed foster


941496

home under s. 409.175. The preliminary home study must include, at a minimum:

(b) Records checks of the department's central abuse registry, which the department shall provide to the entity conducting the preliminary home study, and criminal records correspondence checks under s. 39.0138 through the Department of Law Enforcement on the intended adoptive parents;

(e) Documentation of counseling and education of the intended adoptive parents on adoptive parenting, as determined by the entity conducting the preliminary home study. The training specified in s. 409.175(14) shall only be required for persons who adopt children from the department;

If the preliminary home study is favorable, a minor may be placed in the home pending entry of the judgment of adoption. A minor may not be placed in the home if the preliminary home study is unfavorable. If the preliminary home study is unfavorable, the adoption entity may, within 20 days after receipt of a copy of the written recommendation, petition the court to determine the suitability of the intended adoptive home. A determination as to suitability under this subsection does not act as a presumption of suitability at the final hearing. In determining the suitability of the intended adoptive home, the court must consider the totality of the circumstances in the home. A minor may not be placed in a home in which there resides any person determined by the court to be a sexual predator as defined in s. 775.21 or to have been convicted of an offense listed in s. 63.089(4)(b)2.

Section 9. Paragraphs (b) through (f) of subsection (2) of

941496

section 402.305, Florida Statutes, are redesignated as paragraphs (c) through (g), respectively, paragraph (a) of subsection (2) and subsections (9) and (10) are amended, and a new paragraph (b) is added to that subsection (2), to read:

402.305 Licensing standards; child care facilities.—

(2) PERSONNEL.—Minimum standards for child care personnel shall include minimum requirements as to:

(a) Good moral character based upon screening as defined in s. 402.302(15). This screening shall be conducted as provided in chapter 435, using the level 2 standards for screening set forth in that chapter, and must include employment history checks, a search of criminal history records, sexual predator and sexual offender registries, and child abuse and neglect registry of any state in which the current or prospective child care personnel resided during the preceding 5 years.

(b) Fingerprint submission for child care personnel, which shall comply with s. 435.12.

(9) ADMISSIONS AND RECORDKEEPING.—

(a) Minimum standards shall include requirements for preadmission and periodic health examinations, requirements for immunizations, and requirements for maintaining emergency information and health records on all children.

(b) During the months of August and September of each year, each child care facility shall provide parents of children enrolled in the facility detailed information regarding the causes, symptoms, and transmission of the influenza virus in an effort to educate those parents regarding the importance of immunizing their children against influenza as recommended by the Advisory Committee on Immunization Practices of the Centers

941496

for Disease Control and Prevention.

(c) During the months of April and September of each year, at a minimum, each facility shall provide parents of children enrolled in the facility with information regarding the potential for a distracted adult to fail to drop off a child at the facility and instead leave the child in the adult's vehicle upon arrival at the adult's destination. The child care facility shall also give parents information about resources with suggestions to avoid this occurrence. The department shall develop a flyer or brochure with this information, which shall be posted to the department's website, which child care facilities may choose to reproduce and provide to parents to satisfy the requirements of this paragraph.

(d) ~~(c)~~ Because of the nature and duration of drop-in child care, requirements for preadmission and periodic health examinations and requirements for medically signed records of immunization required for child care facilities shall not apply. A parent of a child in drop-in child care shall, however, be required to attest to the child's health condition and the type and current status of the child's immunizations.

(e) ~~(d)~~ Any child shall be exempt from medical or physical examination or medical or surgical treatment upon written request of the parent or guardian of such child who objects to the examination and treatment. However, the laws, rules, and regulations relating to contagious or communicable diseases and sanitary matters shall not be violated because of any exemption from or variation of the health and immunization minimum standards.

(10) TRANSPORTATION SAFETY.—Minimum standards shall include

941496

requirements for child restraints or seat belts in vehicles used by child care facilities and large family child care homes to transport children, requirements for annual inspections of the vehicles, limitations on the number of children in the vehicles, procedures to avoid leaving children in vehicles when transported by the facility, and accountability for children ~~being~~ transported by the child care facility. A child care facility is not responsible for children when they are transported by a parent or guardian.

Section 10. Section 402.30501, Florida Statutes, is amended to read:

402.30501 Modification of introductory child care course for community college credit authorized.—The Department of Children and Families may modify the 40-clock-hour introductory course in child care under s. 402.305 or s. 402.3131 to meet the requirements of articulating the course to community college credit. Any modification must continue to provide that the course satisfies the requirements of s. 402.305(2)(e) ~~s. 402.305(2)(d)~~.

Section 11. Subsection (15) is added to section 402.313, Florida Statutes, to read:

402.313 Family day care homes.—

(15) During the months of April and September of each year, at a minimum, each family day care home shall provide parents of children attending the family day care home with information regarding the potential for a distracted adult to fail to drop off a child at the family day care home and instead leave the child in the adult's vehicle upon arrival at the adult's destination. The family day care home shall also give parents


941496

information about resources with suggestions to avoid this occurrence. The department shall develop a flyer or brochure with this information, which shall be posted to the department's website, which family day care homes may choose to reproduce and provide to parents to satisfy the requirements of this subsection.

Section 12. Subsection (10) is added to section 402.3131, Florida Statutes, to read:

402.3131 Large family child care homes.—

(10) During the months of April and September of each year, at a minimum, each large family child care home shall provide parents of children attending the large family child care home with information regarding the potential for a distracted adult to fail to drop off a child at the large family child care home and instead leave the child in the adult's vehicle upon arrival at the adult's destination. The large family child care home shall also give parents information about resources with suggestions to avoid this occurrence. The department shall develop a flyer or brochure with this information, which shall be posted to the department's website, which large family child care homes may choose to reproduce and provide to parents to satisfy the requirements of this subsection.

Section 13. Paragraphs (l) and (m) of subsection (2) of section 409.175, Florida Statutes, are redesignated as paragraphs (m) and (n), respectively, a new paragraph (l) is added to that subsection, and paragraph (a) of subsection (6) of that section is amended, to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public


941496

records exemption.—

(2) As used in this section, the term:

(l) "Severe disability" means a physical, developmental, or cognitive limitation affecting an individual's ability to safely submit fingerprints.

(6)(a) An application for a license shall be made on forms provided, and in the manner prescribed, by the department. The department shall make a determination as to the good moral character of the applicant based upon screening. The department may grant an exemption from fingerprinting requirements, pursuant to s. 39.0138, for an adult household member who has a severe disability.

Section 14. Paragraph (e) of subsection (1) and subsections (2) and (4) of section 409.991, Florida Statutes, are amended to read:

409.991 Allocation of funds for community-based care lead agencies.—

(1) As used in this section, the term:

(e) "Proportion of children in care" means the proportion of the number of children in care receiving in-home services over the most recent 12-month period, the number of children whose families were receiving family support services during the most recent 12-month period, and the number of children who have entered into ~~in~~ out-of-home care with a case management overlay during the most recent 24-month ~~12-month~~ period. This subcomponent shall be weighted as follows:

1. Fifteen percent shall be based on children whose families are receiving family support services.

2.~~1.~~ Fifty-five ~~Sixty~~ percent shall be based on children in


941496

out-of-home care.

3.~~2.~~ Thirty ~~Forty~~ percent shall be based on children in in-home care.

(2) The equity allocation of core services funds shall be calculated based on the following weights:

(a) Proportion of the child population shall be weighted as 5 percent of the total.~~;~~

(b) Proportion of child abuse hotline workload shall be weighted as 35 ~~15~~ percent of the total.~~; and~~

(c) Proportion of children in care shall be weighted as 60 ~~80~~ percent of the total.

(4) Unless otherwise specified in the General Appropriations Act, any new core services funds shall be allocated based on the equity allocation model as follows:

(a) Seventy ~~Twenty~~ percent of new funding shall be allocated among all community-based care lead agencies.

(b) Thirty ~~Eighty~~ percent of new funding shall be allocated among community-based care lead agencies that are funded below their equitable share. Funds allocated pursuant to this paragraph shall be weighted based on each community-based care lead agency's relative proportion of the total amount of funding below the equitable share.

Section 15. Subsection (4) of section 435.07, Florida Statutes, is amended to read:

435.07 Exemptions from disqualification.—Unless otherwise provided by law, the provisions of this section apply to exemptions from disqualification for disqualifying offenses revealed pursuant to background screenings required under this chapter, regardless of whether those disqualifying offenses are

listed in this chapter or other laws.

(4)(a) Disqualification from employment under this chapter may not be removed from, nor may an exemption be granted to, any personnel who is found guilty of, regardless of adjudication, or who has entered a plea of nolo contendere or guilty to, any felony covered by s. 435.03 or s. 435.04 solely by reason of any pardon, executive clemency, or restoration of civil rights.

(b) Disqualification from employment under this chapter may not be removed from, nor may an exemption be granted to, any person who is a:

1. Sexual predator as designated pursuant to s. 775.21;

2. Career offender pursuant to s. 775.261; or

3. Sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.

(c) Disqualification from employment under this chapter may not be removed from, and an exemption may not be granted to, any current or prospective child care personnel, as defined in s. 402.302(3), and such a person is disqualified from employment as child care personnel, regardless of any previous exemptions from disqualification, if the person has been registered as a sex offender as described in 42 U.S.C. s. 9858f(c)(1)(C) or has been arrested for and is awaiting final disposition of, has been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, or has been adjudicated delinquent and the record has not been sealed or expunged for, any offense prohibited under any of the following provisions of state law or a similar law of another jurisdiction:

1. A felony offense prohibited under any of the following statutes:

a. Chapter 741, relating to domestic violence.

b. Section 782.04, relating to murder.

c. Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, aggravated manslaughter of a child, or aggravated manslaughter of an officer, a firefighter, an emergency medical technician, or a paramedic.

d. Section 784.021, relating to aggravated assault.

e. Section 784.045, relating to aggravated battery.

f. Section 787.01, relating to kidnapping.

g. Section 787.025, relating to luring or enticing a child.

h. Section 787.04(2), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending custody proceedings.

i. Section 787.04(3), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending dependency proceedings or proceedings concerning alleged abuse or neglect of a minor.

j. Section 794.011, relating to sexual battery.

k. Former s. 794.041, relating to sexual activity with or solicitation of a child by a person in familial or custodial authority.

l. Section 794.05, relating to unlawful sexual activity with certain minors.

m. Section 794.08, relating to female genital mutilation.

941496

n. Section 806.01, relating to arson.

o. Section 826.04, relating to incest.

p. Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

q. Section 827.04, relating to contributing to the delinquency or dependency of a child.

r. Section 827.071, relating to sexual performance by a child.

s. Chapter 847, relating to child pornography.

t. Chapter 893, relating to a drug abuse prevention and control offense, if that offense was committed in the preceding 5 years.

u.~~t.~~ Section 985.701, relating to sexual misconduct in juvenile justice programs.

2. A misdemeanor offense prohibited under any of the following statutes:

a. Section 784.03, relating to battery, if the victim of the offense was a minor.

b. Section 787.025, relating to luring or enticing a child.

c. Chapter 847, relating to child pornography.

3. A criminal act committed in another state or under federal law which, if committed in this state, constitutes an offense prohibited under any statute listed in subparagraph 1. or subparagraph 2.

Section 16. Paragraph (g) of subsection (3) of section 1002.55, Florida Statutes, is amended to read:

1002.55 School-year prekindergarten program delivered by private prekindergarten providers.—

(3) To be eligible to deliver the prekindergarten program,


941496

a private prekindergarten provider must meet each of the following requirements:

(g) The private prekindergarten provider must have a prekindergarten director who has a prekindergarten director credential that is approved by the office as meeting or exceeding the minimum standards adopted under s. 1002.57. Successful completion of a child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~ before the establishment of the prekindergarten director credential under s. 1002.57 or July 1, 2006, whichever occurs later, satisfies the requirement for a prekindergarten director credential under this paragraph.

Section 17. Subsections (3) and (4) of section 1002.57, Florida Statutes, are amended to read:

1002.57 Prekindergarten director credential.—

(3) The prekindergarten director credential must meet or exceed the requirements of the Department of Children and Families for the child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~, and successful completion of the prekindergarten director credential satisfies these requirements for the child care facility director credential.

(4) The department shall, to the maximum extent practicable, award credit to a person who successfully completes the child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~ for those requirements of the prekindergarten director credential which are duplicative of requirements for the child care facility director credential.

Section 18. Subsection (1) of section 1002.59, Florida Statutes, is amended to read:

941496

1002.59 Emergent literacy and performance standards training courses.—

(1) The office shall adopt minimum standards for one or more training courses in emergent literacy for prekindergarten instructors. Each course must comprise 5 clock hours and provide instruction in strategies and techniques to address the age-appropriate progress of prekindergarten students in developing emergent literacy skills, including oral communication, knowledge of print and letters, phonemic and phonological awareness, and vocabulary and comprehension development. Each course must also provide resources containing strategies that allow students with disabilities and other special needs to derive maximum benefit from the Voluntary Prekindergarten Education Program. Successful completion of an emergent literacy training course approved under this section satisfies requirements for approved training in early literacy and language development under ss. 402.305(2)(e)5. ~~402.305(2)(d)5.~~, 402.313(6), and 402.3131(5).

Section 19. The Division of Law Revision and Information is directed to prepare, with the assistance of the staffs of the appropriate substantive committees of the House of Representatives and the Senate, a reviser's bill for the 2019 Regular Session of the Legislature to capitalize the first letter of each word of the term "child protection team" wherever it occurs in Florida Statutes.

Section 20. This act shall take effect July 1, 2018.

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

And the title is amended as follows:

941496

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to child welfare; amending s. 39.01, F.S.; revising the definition of the term "abuse"; amending s. 39.0138, F.S.; requiring the Department of Children and Families to establish rules for granting exemptions from criminal history and certain other records checks required for persons being considered for placement of a child; requiring the department or its designee to assess the limitations that justify the exemption and the limitation's effects on the child before granting the exemption; requiring level 1 screening for persons granted such exemption; prohibiting placement of a child with persons convicted of a certain felony; amending s. 39.3065, F.S.; requiring the Sheriff of Walton County to provide all child protective investigations in the county beginning with a specified fiscal year; amending s. 39.6012, F.S.; requiring parents to make proactive contact with the department or contracted case management agency at regular intervals; amending s. 39.6013, F.S.; requiring the court to consider certain case details before amending a case plan; amending s. 39.621, F.S.; requiring the court, during permanency hearings, to determine case plan compliance; amending s. 39.701, F.S.; requiring the court, during judicial review hearings, to determine case plan compliance; amending s. 63.092, F.S.;

941496

requiring the department to release specified records to entities conducting preliminary home studies; providing that certain specified training is required only for persons who adopt children from the department; amending s. 402.305, F.S.; revising minimum requirements for child care personnel related to screening and fingerprinting; requiring child care facilities to provide information during specified months to parents intended to prevent children from being left in vehicles; requiring the department to develop a flyer or brochure containing specified information; specifying the minimum standards the department must adopt regarding transportation of children by child care facilities; specifying that a child care facility is not responsible for children when they are transported by a parent or guardian; amending ss. 402.313 and 402.3131, F.S.; requiring family day care homes and large family child care homes to provide information during specified months to parents intended to prevent children from being left in vehicles; requiring the department to develop a flyer or brochure containing specified information; amending s. 409.175, F.S.; defining the term "severe disability" and providing an exemption from fingerprint requirements for adult household members with severe disabilities; amending s. 409.991, F.S.; revising the equity allocation formula for community-based care lead agencies; amending s. 435.07, F.S.; revising the offenses that disqualify certain child

941496

care personnel from specified employment; amending ss. 402.30501, 1002.55, 1002.57, and 1002.59, F.S.; conforming cross-references; providing a directive to the Division of Law Revision and Information; providing an effective date.

By the Committee on Children, Families, and Elder Affairs; and Senator Broxson

586-02910-18 20181360c1

A bill to be entitled

An act relating to child welfare; amending s. 39.0138, F.S.; requiring the Department of Children and Families to establish rules for granting exemptions from criminal history and certain other records checks required for persons being considered for placement of a child; requiring level 1 screening for persons granted such exemption; prohibiting placement of a child with persons convicted of a certain felony; amending s. 402.305, F.S.; revising minimum requirements for child care personnel related to screening and fingerprinting; amending s. 409.175, F.S.; defining the term "severe disability" and providing an exemption from fingerprint requirements for adult household members with severe disabilities; amending s. 409.991, F.S.; revising the equity allocation formula for community-based care lead agencies; amending s. 435.07, F.S.; revising the offenses that disqualify certain child care personnel from specified employment; amending ss. 402.30501, 1002.59, 1002.55, and 1002.57, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsections (2) through (7) of section 39.0138, Florida Statutes, are redesignated as subsections (3) through (8), respectively, present subsections (2) and (3) are amended, and a new subsection (2) is added to that section, to read:

586-02910-18 20181360c1

39.0138 Criminal history and other records checks; limit on placement of a child.—

(2)(a) The department shall establish rules for granting an exemption from the fingerprinting requirements under subsection (1) for a household member who has a physical, developmental, or cognitive disability that prevents that person from safely submitting fingerprints.

(b) Before granting an exemption, the department or its designee shall assess and document the physical, developmental, or cognitive limitations that justified the exemption and the effect of such limitations on the safety and well-being of the child being placed in the home.

(c) If a fingerprint exemption is granted, a level 1 screening pursuant to s. 435.03 shall be completed on the person who is granted the exemption.

(3)~~(2)~~ The department may not place a child with a person other than a parent if the criminal history records check reveals that the person has been convicted of any felony that falls within any of the following categories:

(a) Child abuse, abandonment, or neglect;

(b) Domestic violence;

(c) Child pornography or other felony in which a child was a victim of the offense; or

(d) Homicide, sexual battery, or other felony involving violence, other than felony assault or felony battery when an adult was the victim of the assault or battery, or resisting arrest with violence.

(4)~~(3)~~ The department may not place a child with a person other than a parent if the criminal history records check

reveals that the person has, within the previous 5 years, been convicted of a felony that falls within any of the following categories:

(a) Assault;

(b) Battery; ~~or~~

(c) A drug-related offense; or

(d) Resisting arrest with violence.

Section 2. Paragraphs (b) through (f) of subsection (2) of section 402.305, Florida Statutes, are redesignated as paragraphs (c) through (g), respectively, paragraph (a) of that subsection is amended, and a new paragraph (b) is added to that subsection, to read:

402.305 Licensing standards; child care facilities.—

(2) PERSONNEL.—Minimum standards for child care personnel shall include minimum requirements as to:

(a) Good moral character based upon screening as defined in s. 402.302(15). This screening shall be conducted as provided in chapter 435, using the level 2 standards for screening set forth in that chapter, and shall include employment history checks, a search of criminal history records, sexual predator and sexual offender registries, and child abuse and neglect registry of any state in which the current or prospective child care personnel resided during the preceding 5 years.

(b) Fingerprint submission for child care personnel, which shall comply with s. 435.12.

Section 3. Paragraphs (l) and (m) of subsection (2) of section 409.175, Florida Statutes, are redesignated as paragraphs (m) and (n), respectively, a new paragraph (l) is added to that subsection, and paragraph (a) of subsection (6) of

that section is amended, to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(2) As used in this section, the term:

(l) "Severe disability" means a physical, developmental, or cognitive limitation affecting an individual's ability to safely submit fingerprints.

(6)(a) An application for a license shall be made on forms provided, and in the manner prescribed, by the department. The department shall make a determination as to the good moral character of the applicant based upon screening. The department may grant an exemption from fingerprinting requirements, pursuant to s. 39.0138, for an adult household member who has a severe disability.

Section 4. Paragraph (e) of subsection (1) and subsections (2) and (4) of section 409.991, Florida Statutes, are amended to read:

409.991 Allocation of funds for community-based care lead agencies.—

(1) As used in this section, the term:

(e) "Proportion of children in care" means the proportion of the number of children in care receiving in-home services over the most recent 12-month period, the number of children whose families are receiving family support services over the most recent 12-month period, and the number of children who have entered into ~~in~~ out-of-home care with a case management overlay during the most recent 24-month ~~12-month~~ period. This subcomponent shall be weighted as follows:

1. Fifteen percent shall be based on children whose families are receiving family support services.

2.~~1.~~ Fifty-five ~~Sixty~~ percent shall be based on children in out-of-home care.

3.~~2.~~ Thirty ~~Forty~~ percent shall be based on children in in-home care.

(2) The equity allocation of core services funds shall be calculated based on the following weights:

(a) Proportion of the child population shall be weighted as 5 percent of the total.~~;~~

(b) Proportion of child abuse hotline workload shall be weighted as 35 ~~15~~ percent of the total.~~; and~~

(c) Proportion of children in care shall be weighted as 60 ~~80~~ percent of the total.

(4) Unless otherwise specified in the General Appropriations Act, any new core services funds shall be allocated based on the equity allocation model as follows:

(a) Seventy ~~Twenty~~ percent of new funding shall be allocated among all community-based care lead agencies.

(b) Thirty ~~Eighty~~ percent of new funding shall be allocated among community-based care lead agencies that are funded below their equitable share. Funds allocated pursuant to this paragraph shall be weighted based on each community-based care lead agency's relative proportion of the total amount of funding below the equitable share.

Section 5. Subsection (4) of section 435.07, Florida Statutes, is amended to read:

435.07 Exemptions from disqualification.—Unless otherwise provided by law, the provisions of this section apply to

exemptions from disqualification for disqualifying offenses revealed pursuant to background screenings required under this chapter, regardless of whether those disqualifying offenses are listed in this chapter or other laws.

(4)(a) Disqualification from employment under this chapter may not be removed from, nor may an exemption be granted to, any personnel who is found guilty of, regardless of adjudication, or who has entered a plea of nolo contendere or guilty to, any felony covered by s. 435.03 or s. 435.04 solely by reason of any pardon, executive clemency, or restoration of civil rights.

(b) Disqualification from employment under this chapter may not be removed from, nor may an exemption be granted to, any person who is a:

1. Sexual predator as designated pursuant to s. 775.21;

2. Career offender pursuant to s. 775.261; or

3. Sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.

(c) Disqualification from employment under this chapter may not be removed from, and an exemption may not be granted to, any current or prospective child care personnel, as defined in s. 402.302(3), and such a person is disqualified from employment as child care personnel, regardless of any previous exemptions from disqualification, if the person has been registered as a sex offender as described in 42 U.S.C. s. 9858f(c)(1)(C) or has been arrested for and is awaiting final disposition of, has been convicted or found guilty of, or entered a plea of guilty or nolo contendere to, regardless of adjudication, or has been adjudicated delinquent and the record has not been sealed or

expunged for, any offense prohibited under any of the following provisions of state law or a similar law of another jurisdiction:

1. A felony offense prohibited under any of the following statutes:

a. Chapter 741, relating to domestic violence.

b. Section 782.04, relating to murder.

c. Section 782.07, relating to manslaughter, aggravated manslaughter of an elderly person or disabled adult, aggravated manslaughter of a child, or aggravated manslaughter of an officer, a firefighter, an emergency medical technician, or a paramedic.

d. Section 784.021, relating to aggravated assault.

e. Section 784.045, relating to aggravated battery.

f. Section 787.01, relating to kidnapping.

g. Section 787.025, relating to luring or enticing a child.

h. Section 787.04(2), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending custody proceedings.

i. Section 787.04(3), relating to leading, taking, enticing, or removing a minor beyond the state limits, or concealing the location of a minor, with criminal intent pending dependency proceedings or proceedings concerning alleged abuse or neglect of a minor.

j. Section 794.011, relating to sexual battery.

k. Former s. 794.041, relating to sexual activity with or solicitation of a child by a person in familial or custodial authority.

l. Section 794.05, relating to unlawful sexual activity with certain minors.

m. Section 794.08, relating to female genital mutilation.

n. Section 806.01, relating to arson.

o. Section 826.04, relating to incest.

p. Section 827.03, relating to child abuse, aggravated child abuse, or neglect of a child.

q. Section 827.04, relating to contributing to the delinquency or dependency of a child.

r. Section 827.071, relating to sexual performance by a child.

s. Chapter 847, relating to child pornography.

t. Chapter 893, relating to drug abuse prevention and control.

u.~~t.~~ Section 985.701, relating to sexual misconduct in juvenile justice programs.

2. A misdemeanor offense prohibited under any of the following statutes:

a. Section 784.03, relating to battery, if the victim of the offense was a minor.

b. Section 787.025, relating to luring or enticing a child.

c. Chapter 847, relating to child pornography.

3. A criminal act committed in another state or under federal law which, if committed in this state, constitutes an offense prohibited under any statute listed in subparagraph 1. or subparagraph 2.

Section 6. Section 402.30501, Florida Statutes, is amended to read:

402.30501 Modification of introductory child care course

for community college credit authorized.—The Department of Children and Families may modify the 40-clock-hour introductory course in child care under s. 402.305 or s. 402.3131 to meet the requirements of articulating the course to community college credit. Any modification must continue to provide that the course satisfies the requirements of s. 402.305(2)(e) ~~s. 402.305(2)(d)~~.

Section 7. Subsection (1) of section 1002.59, Florida Statutes, is amended to read:

1002.59 Emergent literacy and performance standards training courses.—

(1) The office shall adopt minimum standards for one or more training courses in emergent literacy for prekindergarten instructors. Each course must comprise 5 clock hours and provide instruction in strategies and techniques to address the age-appropriate progress of prekindergarten students in developing emergent literacy skills, including oral communication, knowledge of print and letters, phonemic and phonological awareness, and vocabulary and comprehension development. Each course must also provide resources containing strategies that allow students with disabilities and other special needs to derive maximum benefit from the Voluntary Prekindergarten Education Program. Successful completion of an emergent literacy training course approved under this section satisfies requirements for approved training in early literacy and language development under ss. 402.305(2)(e)5. ~~402.305(2)(d)5.~~, 402.313(6), and 402.3131(5).

Section 8. Paragraph (g) of subsection (3) of section 1002.55, Florida Statutes, is amended to read:

1002.55 School-year prekindergarten program delivered by private prekindergarten providers.—

(3) To be eligible to deliver the prekindergarten program, a private prekindergarten provider must meet each of the following requirements:

(g) The private prekindergarten provider must have a prekindergarten director who has a prekindergarten director credential that is approved by the office as meeting or exceeding the minimum standards adopted under s. 1002.57. Successful completion of a child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~ before the establishment of the prekindergarten director credential under s. 1002.57 or July 1, 2006, whichever occurs later, satisfies the requirement for a prekindergarten director credential under this paragraph.

Section 9. Subsections (3) and (4) of section 1002.57, Florida Statutes, are amended to read:

1002.57 Prekindergarten director credential.—

(3) The prekindergarten director credential must meet or exceed the requirements of the Department of Children and Families for the child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~, and successful completion of the prekindergarten director credential satisfies these requirements for the child care facility director credential.

(4) The department shall, to the maximum extent practicable, award credit to a person who successfully completes the child care facility director credential under s. 402.305(2)(g) ~~s. 402.305(2)(f)~~ for those requirements of the prekindergarten director credential which are duplicative of

requirements for the child care facility director credential.

Section 10. This act shall take effect July 1, 2018.

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

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Appropriations Subcommittee on Health and Human Services

BILL:	PCS/CS/SB 1422 (243598)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Banking and Insurance Committee and Senator Rouson
SUBJECT:	Insurance Coverage Parity for Mental Health and Substance Use Disorders
DATE:	February 23, 2018 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Johnson	Knudson	BI	**Fav/CS**
2.	Kidd	Williams	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1422 codifies the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and related regulations, which will provide the Office of Insurance Regulation (OIR) with the authority to ensure that individual and group policies and contracts of health insurers and health maintenance organizations are complying with these provisions. Generally, the MHPAEA requires benefits for mental health and substance use disorders to be in parity with medical and surgical benefits, as it relates to financial requirements, treatment limitations, in-network and out-of-network coverage, and annual and aggregate lifetime limits for applicable policies or contracts that provide mental health benefits.

The bill also requires health insurers and health maintenance organizations (HMOs) to submit an annual report to the OIR demonstrating their compliance with MHPAEA. Medicaid managed care plans are required to submit an annual report to the Agency for Health Care Administration (AHCA). The OIR is required to submit an annual report to the Legislature describing its methodology for verifying compliance with the MHPAEA.

The bill has no fiscal impact to the Agency for Health Care Administration (agency).

The Office of Insurance Regulation has indicated the need for one additional FTE with associated costs of $69,414, to be funded from the Insurance Regulatory Trust Fund.

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

II. Present Situation:

In 2016, there were 5,725 opioid-related deaths reported in Florida, which is a 35 percent increase from 2015.[1] Deaths caused by fentanyl increased by 97 percent in 2016. Occurrences of cocaine use increased by 57 percent and deaths caused by cocaine increased by 83 percent. In the United States, approximately 7.9 million adults had co-occurring disorders, which is the existence of both a mental health and a substance use disorder.[2]

Federal Mental Health Parity Laws

Commercial Plans

Prior to 1996, health insurance coverage for mental illness was generally not as comprehensive as coverage for medical and surgical benefits. In response, the Mental Health Parity Act[3] (MHPA) was enacted in 1996, which requires parity of medical and surgical benefits with mental health benefits for annual and aggregate lifetime limits of large group plans.

In 2008, Congress passed the Mental Health Parity and Addiction Equity Act[4] (MHPAEA), which generally applies to large group health plans.[5] The MHPAEA expanded parity of coverage to include financial requirements, treatment limitations, and in- and out-of-network coverage if a plan provided coverage for mental illness. The MHPAEA also applies to the treatment of substance use disorders.[6] Like the MHPA, the MHPAEA does not require large groups to provide benefits for mental health or substance use disorders. The MHPAEA contains a cost exemption, which allows a group health plan to receive a waiver, exempting them from some of the key requirements, if the plan demonstrates that costs increased at least 1 percent because of compliance.[7]

In 2010, the Patient Protection and Affordable Care Act[8] (PPACA) amended the MHPAEA to apply the provisions to individual health insurance coverage. The PPACA mandates that qualified health insurance must provide coverage of 10 essential health benefits,[9] including

---

[1] Florida Medical Examiners Commission, *2016 Medical Examiners Commission Drug Report* (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/2016AnnualDrugReport.pdf (last viewed Jan. 31, 2018).
[2] Substance Abuse and Mental Health Services Administration, *Co-occurring* Disorders, available at https://www.samhsa.gov/disorders/co-occurring (last viewed Jan. 31, 2018).
[3] Pub. L. No. 104-204.
[4] Pub. L. No. 110-343.
[5] See final regulations available at http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf (last viewed Jan. 31, 2018).
[6] 45 CFR ss. 146 and 160.
[7] Plans and issuers that make changes to comply with MHPAEA and incur an increased cost of at least 2 percent in the first year that MHPAEA applies to the plan or coverage or at least 1 percent in any subsequent plan year may claim an exemption from MHPAEA based on their increased cost. If such a cost is incurred, the plan or coverage is exempt from MHPAEA requirements for the plan or policy year following the year the cost was incurred. The plan sponsors or issuers must notify the plan beneficiaries that MHPAEA does not apply to their coverage. These exemptions last 1 year. After that, the plan or coverage is required to comply again; however, if the plan or coverage incurs an increased cost of at least 1 percent in that plan or policy year, the plan or coverage could claim the exemption for the following plan or policy year.
[8] Pub. L. No.111-148, as amended by Pub. L. No. 111-152.
[9] 45 CFR s. 156.115.

coverage for mental health and substance use disorders for individual and small group qualified health plans. The final rule, implementing these provisions, generally requires health insurers offering health insurance coverage in the individual and small group markets to comply with the requirements of the MHPAEA regulations in order to satisfy the essential health benefit requirement.[10]

Medicaid and CHIP Programs

In March 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on mental health parity for Medicaid and the Children's Health Insurance Program (CHIP).[11] The AHCA amended the Statewide Medicaid Managed Care (SMMC) contract to require Medicaid managed care organizations (MCOs) to comply with the mental health parity requirements no later than October 2, 2017.[12]

The CMS rule requires the Medicaid MCOs to comply with requirements for aggregate lifetime and annual dollar limits that apply to MCOs in states that cover both medical and surgical benefits and mental health or substance use disorder benefits under the Medicaid State Plan. In addition, Medicaid MCOs must comply with requirements for non-quantitative treatment limitations and must make available upon request the medical necessity criteria used for mental health or substance use disorder medical necessity determinations and the reason for denials of reimbursement for mental health or substance use disorder benefits.

The rule also requires, in instances where the full scope of medical and surgical and mental health and substance use disorder services are not provided through the MCO, that the state must review the mental health and substance use disorder services provided through the MCO and fee-for-service coverage to ensure that the full scope of services available to all enrollees of the MCO complies with the rule. According to the agency, this requirement does not apply to the Florida Medicaid program, as Medicaid has not created a behavioral health services "carve-out" and MCOs offer the full scope of behavioral health services.[13] The rule requires the state to ensure that all services are delivered to the enrollees of the MCO in compliance with the parity requirements. The agency is responsible for ensuring Medicaid MCOs' compliance with Medicaid managed care contracts. Generally under the MHPAEA final rule, the state is required to determine whether the overall Medicaid and CHIP delivery system is compliant with mental health and substance use disorder parity requirements. The MCOs are required to complete a parity analysis and inform the state of changes needed to the MCO contract.

President's Commission on Combating Drug Addiction and the Opioid Crisis

According to the President's Commission on Combating Drug Addiction and the Opioid Crisis, the MHPAEA has been the impetus for much progress towards parity for behavioral health coverage. Plans and employers have largely eliminated policies that are noncompliant, such as policies containing provisions such as dollar-limits, visit limits, and prohibitions on certain

[10] *See* 45 CFR 147.150 and 156.115 (78 FR 12834, Feb. 25, 2013).
[11] See 42 CFR 438, Subpart K – Parity in Mental Health and Substance Use Disorder Benefits.
[12] See Medicaid health plan contract Attachment II, Section XII.A.
[13] Agency for Health Care Administration, *Analysis of SB 1422* (Jan. 20, 2018) (on file with Senate Committee on Banking and Insurance).

treatment modalities that exist only for behavioral health benefits. The report noted the remaining noncompliance is harder for regulators to discern, such as, non-quantitative treatment limits (NQTLs).[14] These hurdles include medical necessity reviews that are more stringent on the behavioral health side than the medical or surgical side, limited provider networks, and onerous prior-authorization requirements. Further, it is often difficult to discern when a behavioral health benefit is on par with a medical/surgical benefit as different care settings and diagnoses have different policies regarding benefits, providers, and authorizations.[15] The Commission recommended that federal and state regulators should use a standardized tool that requires health plans to document and disclose their compliance strategies for non-quantitative treatment limitations (NQTL) parity.[16]

The Office of Insurance Regulation

The Florida Office of Insurance Regulation (OIR) licenses and regulates insurers, health maintenance organizations (HMOs), and other risk-bearing entities.[17] The Agency for Health Care Administration (agency) regulates the quality of care provided by HMOs under part III of ch. 641, F.S. Before receiving a certificate of authority from the OIR, an HMO must receive a Health Care Provider Certificate from the agency.[18] As part of the certification process used by the agency, an HMO must provide information to demonstrate that the HMO has the ability to provide quality of care consistent with the prevailing standards of care.[19]

The OIR reviews health insurance policies and contracts for compliance with MHPAEA. The OIR communicates any violations of MHPAEA to the insurer or HMO. If the insurer or HMO fails to correct the issue, the OIR would refer the issue to the appropriate federal regulator as a possible violation of federal law. According to the OIR, no referrals to the federal regulator relating to noncompliance have been required.[20]

Coverage for Mental and Nervous Disorders

Section 627.668, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for mental and nervous disorders for an appropriate additional premium that would include benefits delineated in this section.

Coverage for Substance Abuse

Section 627.669, F.S., requires insurers and HMOs offering group coverage to make available optional coverage for substance abuse that would include benefits listed in the section.

---

[14] Centers for Medicare and Medicaid, Frequently Asked Questions, Mental Health and Substance Use Disorder Parity Implementation (Oct. 27, 2016). See https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/FAQ-part-34_10-26-16_FINAL.PDF (last viewed Jan. 31, 2018).
[15] The President's Commission on Combating Drugs Addiction and the Opioid Crisis (Nov. 2017), available at http://www.fadaa.org/resource_center/documents/Opioid%20Commission%20Final%20Report%20-%20November%201%202017.pdf (last viewed Jan. 31, 2018).
[16] *Id*.
[17] Section 20.121(3)(a), F.S.
[18] Section 641.21(1), F.S.
[19] Section 641.495, F.S.
[20] Office of Insurance Regulation, *Analysis of SB 1422* (Dec. 12, 2017) (on file with Senate Banking and Insurance Committee).

Agency for Health Care Administration

The Agency for Health Care Administration (agency) is the state agency responsible for administration of the Medicaid program in Florida. Medicaid is a jointly funded program between the state and the federal government. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the agency under the Statewide Medicaid Managed Care (SMMC) program. The SMMC program has two components: the Managed Medical Assistance (MMA) program and the Long-term Care (LTC) Managed Care program. The agency contracts with managed care plans on a regional basis to provide services to eligible recipients. The benefit package offered by the MMA plans is comprehensive and covers all state plan benefits including mental health and substance abuse treatment services. Full implementation of the MMA program occurred in August 2014.

The agency conducted a review[21] of Florida Medicaid fee-for-service policy and practices relating to mental health and substance use disorder services and determined that Florida's robust behavioral health benefit complies with the quantitative limits. With regard to the non-quantitative limits, one area was identified in the provider network standards section of the SMMC contract, namely, ratios for network adequacy standards for psychiatrists versus primary care physicians. The agency amended the Medicaid MCO contracts to ensure the contracts aligned with parity requirements.

The current SMMC contract contains a requirement that the MCOs must comply with the federal rule, including any non-quantitative limits that the MCOs may impose through their credentialing, authorization, contracting, provider reimbursement, standards for accessing out-of-network providers, or other practices. To assist the MCOs in their efforts to achieve compliance, the state has directed the MCOs to the reference materials provided by CMS in the Parity Compliance Toolkit and Implementation Roadmap, which are publically available on the CMS website.[22] The agency has several existing avenues for monitoring MCOs' compliance with parity, including, but not limited to, the review of new or revised MCO policies and procedures (including utilization management), monitoring of provider and recipient complaints submitted to the Medicaid Complaint Operations Center, and monthly submission to the agency by the MCOs of complaint, grievance, and appeals reporting.

III. Effect of Proposed Changes:

Section 1 amends s. 409.967, F.S., relating to Medicaid managed care plan accountability. The provisions added to this section stipulate an annual analysis of mental health parity and reporting requirement for Medicaid MCOs, regarding mental health parity. The MCOs are required to submit the report to the agency no later than July 1, and the report must contain the following information:

[21] *Id.*
[22] See CMS, *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, (Jan. 17, 2017) available at https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf (last viewed Jan. 31, 2018).

- A description of the process used to develop or select the medical necessity criteria for mental or nervous disorder benefits, substance use disorder benefits, and medical and surgical benefits;
- Identification of all non-quantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits; and
- The results of an analysis demonstrating, that for the medical necessity criteria described above and for each NQTL, the analysis identifies the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the factors used to apply the criteria and NQTLs to medical and surgical benefits. It also establishes minimum criteria to be contained in the analysis. The analysis must include specific findings and conclusions reached by the MCO that the results of the analysis indicates that the MCO is in compliance with this section and MHPAEA, any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

Section 2 amends s. 627.6675, F.S., relating to conversion policies, to provide a technical, conforming cross-reference.

Section 3 transfers the provisions of s. 627.668, F.S., relating to optional coverage for mental and nervous disorders, to newly created s. 627.4193, F.S., and amends the section. The section provides that coverage for mental and nervous disorders, including substance use disorders, provided by individual and group policies or contracts, may not be less favorable than for physical illness in accordance with parity requirements of 45 C.F.R. s. 136(c)(2) and (3). The section also eliminates the requirement that insurers make available optional coverage for mental and nervous disorders.

The section requires every insurer, HMO, and nonprofit hospital and medical service plan corporation, which transacts individual or group health insurance or providing prepaid health care in Florida, to submit an annual report to the OIR, on or before July 1 of each year. The report must contain the same information outlined in the analysis of Section 1 above. The section requires the OIR to enforce the MHPAEA , any federal guidance or regulations relating to MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

The OIR is required to implement and enforce the applicable provisions of MHPAEA, including but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes performing market conduct examinations to determine compliance and responding to consumer complaints regarding possible violations.

Finally, the section requires the OIR to issue an annual report to the Legislature no later than December 31 of each year, which describes the methodology the OIR uses to verify compliance with MHPAEA, and to post the report on the OIR's website for public access.

Section 4 repeals s. 627.669, F.S, relating to optional coverage for substance use disorders.

Section 5 provides $69,414 in recurring funds from the Insurance Regulatory Trust Fund for one full-time equivalent to implement s. 627.4193, F.S.

Section 6 provides the effective date of the bill is July 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The new reporting requirement will have an indeterminate fiscal impact on the Medicaid managed care plans and commercial health insurers and health maintenance organizations.

The bill will provide policyholders and subscribers with additional protections for the resolution of coverage issues relating to mental health and substance use disorders parity.

C. Government Sector Impact:

Agency for Health Care Administration. There is no fiscal impact on the Florida Medicaid program.

Office of Insurance Regulation. The OIR has indicated the need for 1 FTE Financial Specialist $69,414 (Salary, Benefits, & Standard Expense Package for new FTE) to implement the provisions of the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 409.967, 627.6675, and 627.668.

This bill creates section 627.4193 of the Florida Statutes.

This bill repeals section 627.669 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

Recommended CS/CS by Appropriations Subcommittee on Health and Human Services on February 21, 2018:
The committee substitute provides an appropriation to the Office of Insurance Regulation to implement s. 627.4193, F.S.

CS by Banking and Insurance on February 6, 2018:
The CS provides technical and conforming changes.

B. Amendments:

None.

370074

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/21/2018	.	
	.	
	.	
	.	

Appropriations Subcommittee on Health and Human Services (Rouson) recommended the following:

Senate Amendment (with title amendment)

Between lines 307 and 308

insert:

Section 5. For the 2018-2019 fiscal year, the sum of $69,414 in recurring funds is appropriated from the Insurance Regulatory Trust Fund to the Office of Insurance Regulation, and one full-time equivalent position with salary rate of 47,858 is authorized, for the purpose of implementing s. 627.4193, Florida Statutes.

370074

11
12 ================ T I T L E A M E N D M E N T ================
13 And the title is amended as follows:
14 Delete line 34
15 and insert:
16 for substance abuse impaired persons; providing an
17 appropriation; providing an

By the Committee on Banking and Insurance; and Senator Rouson

597-02932-18 20181422c1

A bill to be entitled

An act relating to insurance coverage parity for mental health and substance use disorders; amending s. 409.967, F.S.; requiring contracts between the Agency for Health Care Administration and certain managed care plans to require the plans to submit a specified annual report to the agency relating to parity between mental health and substance use disorder benefits and medical and surgical benefits; amending s. 627.6675, F.S.; conforming a provision to changes made by the act; transferring, renumbering, and amending s. 627.668, F.S.; deleting certain provisions that require insurers, health maintenance organizations, and nonprofit hospital and medical service plan organizations transacting group health insurance or providing prepaid health care to offer specified optional coverage for mental and nervous disorders; requiring such entities transacting individual or group health insurance or providing prepaid health care to comply with specified provisions prohibiting the imposition of less favorable benefit limitations on mental health and substance use disorder benefits than on medical and surgical benefits; revising the standard for defining substance use disorders; requiring such entities to submit a specified annual report relating to parity between such benefits to the Office of Insurance Regulation; requiring the office to implement and enforce specified federal provisions, guidance, and regulations; specifying actions the

597-02932-18 20181422c1

office must take relating to such implementation and enforcement; requiring the office to issue a specified annual report to the Legislature; repealing s. 627.669, F.S., relating to optional coverage required for substance abuse impaired persons; providing an effective date.

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

Section 1. Paragraph (p) is added to subsection (2) of section 409.967, Florida Statutes, to read:

409.967 Managed care plan accountability.—

(2) The agency shall establish such contract requirements as are necessary for the operation of the statewide managed care program. In addition to any other provisions the agency may deem necessary, the contract must require:

(p) *Annual reporting relating to parity in mental health and substance use disorder benefits.*—Every managed care plan shall submit an annual report to the agency, on or before July 1, which contains all of the following information:

1. A description of the process used to develop or select the medical necessity criteria for:

a. Mental or nervous disorder benefits;

b. Substance use disorder benefits; and

c. Medical and surgical benefits.

2. Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not

be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

3. The results of an analysis demonstrating that for the medical necessity criteria described in subparagraph 1. and for each NQTL identified in subparagraph 2., as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

a. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

b. Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

c. Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL, as written, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;

d. Identify and describe the methods and analyses used, including the results of the analyses, to determine that

processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

e. Disclose the specific findings and conclusions reached by the managed care plan that the results of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section, the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and any federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

Section 2. Paragraph (b) of subsection (8) of section 627.6675, Florida Statutes, is amended to read:

627.6675 Conversion on termination of eligibility.—Subject to all of the provisions of this section, a group policy delivered or issued for delivery in this state by an insurer or nonprofit health care services plan that provides, on an expense-incurred basis, hospital, surgical, or major medical expense insurance, or any combination of these coverages, shall provide that an employee or member whose insurance under the group policy has been terminated for any reason, including discontinuance of the group policy in its entirety or with respect to an insured class, and who has been continuously insured under the group policy, and under any group policy providing similar benefits that the terminated group policy replaced, for at least 3 months immediately prior to

termination, shall be entitled to have issued to him or her by the insurer a policy or certificate of health insurance, referred to in this section as a "converted policy." A group insurer may meet the requirements of this section by contracting with another insurer, authorized in this state, to issue an individual converted policy, which policy has been approved by the office under s. 627.410. An employee or member shall not be entitled to a converted policy if termination of his or her insurance under the group policy occurred because he or she failed to pay any required contribution, or because any discontinued group coverage was replaced by similar group coverage within 31 days after discontinuance.

(8) BENEFITS OFFERED.—

(b) An insurer shall offer the benefits specified in s. 627.4193 ~~s. 627.668 and the benefits specified in s. 627.669~~ if those benefits were provided in the group plan.

Section 3. Section 627.668, Florida Statutes, is transferred, renumbered as section 627.4193, Florida Statutes, and amended, to read:

627.4193 ~~627.668~~ Requirements for mental health and substance use disorder benefits; reporting requirements ~~Optional coverage for mental and nervous disorders required; exception~~.—

(1) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state must comply with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s.

146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and must provide ~~shall make available to the policyholder as part of the application, for an appropriate additional premium under a group hospital and medical expense-incurred insurance policy, under a group prepaid health care contract, and under a group hospital and medical service plan contract,~~ the benefits or level of benefits specified in subsection (2) for the necessary care and treatment of mental and nervous disorders, including substance use disorders, as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, published by ~~standard nomenclature of~~ the American Psychiatric Association~~, subject to the right of the applicant for a group policy or contract to select any alternative benefits or level of benefits as may be offered by the insurer, health maintenance organization, or service plan corporation provided that, if alternate inpatient, outpatient, or partial hospitalization benefits are selected, such benefits shall not be less than the level of benefits required under paragraph (2)(a), paragraph (2)(b), or paragraph (2)(c), respectively~~.

(2) Under individual or group policies or contracts, inpatient hospital benefits, partial hospitalization benefits, and outpatient benefits consisting of durational limits, dollar amounts, deductibles, and coinsurance factors may ~~shall~~ not be less favorable than for physical illness, in accordance with 45 C.F.R. s. 146.136(c)(2) and (3) ~~generally, except that:~~

~~(a) Inpatient benefits may be limited to not less than 30 days per benefit year as defined in the policy or contract. If inpatient hospital benefits are provided beyond 30 days per benefit year, the durational limits, dollar amounts, and~~

~~coinsurance factors thereto need not be the same as applicable to physical illness generally.~~

~~(b) Outpatient benefits may be limited to $1,000 for consultations with a licensed physician, a psychologist licensed pursuant to chapter 490, a mental health counselor licensed pursuant to chapter 491, a marriage and family therapist licensed pursuant to chapter 491, and a clinical social worker licensed pursuant to chapter 491. If benefits are provided beyond the $1,000 per benefit year, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as applicable to physical illness generally.~~

~~(c) Partial hospitalization benefits shall be provided under the direction of a licensed physician. For purposes of this part, the term "partial hospitalization services" is defined as those services offered by a program that is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state. Alcohol rehabilitation programs accredited by an accrediting organization whose standards incorporate comparable regulations required by this state or approved by the state and licensed drug abuse rehabilitation programs shall also be qualified providers under this section. In a given benefit year, if partial hospitalization services or a combination of inpatient and partial hospitalization are used, the total benefits paid for all such services may not exceed the cost of 30 days after inpatient hospitalization for psychiatric services, including physician fees, which prevail in the community in which the partial hospitalization services are rendered. If partial hospitalization services benefits are provided beyond the limits~~

~~set forth in this paragraph, the durational limits, dollar amounts, and coinsurance factors thereof need not be the same as those applicable to physical illness generally.~~

(3) Insurers must maintain strict confidentiality regarding psychiatric and psychotherapeutic records submitted to an insurer for the purpose of reviewing a claim for benefits payable under this section. These records submitted to an insurer are subject to the limitations of s. 456.057, relating to the furnishing of patient records.

(4) Every insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state shall submit an annual report to the office, on or before July 1, which contains all of the following information:

(a) A description of the process used to develop or select the medical necessity criteria for:

1. Mental or nervous disorder benefits;

2. Substance use disorder benefits; and

3. Medical and surgical benefits.

(b) Identification of all nonquantitative treatment limitations (NQTLs) applied to both mental or nervous disorder and substance use disorder benefits and medical and surgical benefits. Within any classification of benefits, there may not be separate NQTLs that apply to mental or nervous disorder and substance use disorder benefits but do not apply to medical and surgical benefits.

(c) The results of an analysis demonstrating that for the medical necessity criteria described in paragraph (a) and for

each NQTL identified in paragraph (b), as written and in operation, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs to mental or nervous disorder and substance use disorder benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used to apply the criteria and NQTLs, as written and in operation, to medical and surgical benefits. At a minimum, the results of the analysis must:

1. Identify the factors used to determine that an NQTL will apply to a benefit, including factors that were considered but rejected;

2. Identify and define the specific evidentiary standards used to define the factors and any other evidentiary standards relied upon in designing each NQTL;

3. Identify and describe the methods and analyses used, including the results of the analyses, to determine that the processes and strategies used to design each NQTL, as written, for mental or nervous disorder and substance use disorder benefits are comparable to, and no more stringently applied than, the processes and strategies used to design each NQTL, as written, for medical and surgical benefits;

4. Identify and describe the methods and analyses used, including the results of the analyses, to determine that processes and strategies used to apply each NQTL, in operation, for mental or nervous disorder and substance use disorder benefits are comparable to and no more stringently applied than the processes or strategies used to apply each NQTL, in operation, for medical and surgical benefits; and

5. Disclose the specific findings and conclusions reached by the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation that the results of the analyses indicate that the insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation is in compliance with this section; MHPAEA; and any regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3).

(5) The office shall implement and enforce applicable provisions of MHPAEA and federal guidance or regulations relating to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3), and this section, which includes:

(a) Ensuring compliance by each insurer, health maintenance organization, and nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(b) Detecting violations by any insurer, health maintenance organization, or nonprofit hospital and medical service plan corporation transacting individual or group health insurance or providing prepaid health care in this state.

(c) Accepting, evaluating, and responding to complaints regarding potential violations.

(d) Reviewing, from consumer complaints, for possible parity violations regarding mental or nervous disorder and substance use disorder coverage.

(e) Performing parity compliance market conduct examinations, which include, but are not limited to, reviews of

medical management practices, network adequacy, reimbursement rates, prior authorizations, and geographic restrictions of insurers, health maintenance organizations, and nonprofit hospital and medical service plan corporations transacting individual or group health insurance or providing prepaid health care in this state.

(6) No later than December 31 of each year, the office shall issue a report to the Legislature which describes the methodology the office is using to check for compliance with MHPAEA; any federal guidance or regulations that relate to MHPAEA, including, but not limited to, 45 C.F.R. s. 146.136, 45 C.F.R. s. 147.160, and 45 C.F.R. s. 156.115(a)(3); and this section. The report must be written in nontechnical and readily understandable language and must be made available to the public by posting the report on the office's website and by other means the office finds appropriate.

Section 4. Section 627.669, Florida Statutes, is repealed.

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

The Florida Senate

Committee Agenda Request

To: Senator Anitere Flores, Chair

Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 6, 2018

I respectfully request that **Senate Bill #1422**, relating to Insurance Coverage Parity for Mental Health and Substance Use Disorders, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Darryl Rouson

Senator Darryl Rouson
Florida Senate, District 19

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

1422
Bill Number (if applicable)

Topic Mental Health

Amendment Barcode (if applicable)

Name Richard Chapman

Job Title

Address 11301 W 50th St Apt 1
Street

Tampa FL 33617
City *State* *Zip*

Phone 813-240-5061

Email richardchapman829@gmail

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/2018
Meeting Date

SB 1422
Bill Number (if applicable)

Topic Insurance Coverage Parity (For Mental Health and Substance Use Disorders)

Amendment Barcode (if applicable)

Name DOMINICA JANE BENNETT

Job Title

Address 303 HOPE BAY LOOP
Street

APOLLO BEACH FL 33572
City State Zip

Phone 719-338-3350

Email djbsplace@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/2018
Meeting Date

SB 1422
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Insurance Coverage Parity

Name Guy M. Bennett

Job Title RETIRED MILITARY OFFICER

Address 303 HOPE BAY LOOP
Street
APOLLO BEACH FL 33572
City *State* *Zip*

Phone 719-337-6640

Email guy@COLORADOMOVE.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-21-18
Meeting Date

1422
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic MA insurance

Name THAD LOWREY

Job Title VP GOV. AFFAIRS

Address 7720 WASHING ST.
Street

PORT RICHEY
City State Zip

Phone 727-992-8508

Email tlowrey@operpar.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing OPERATION PAR

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2.21.18
Meeting Date

1422
Bill Number (if applicable)

Topic Parity for Insurance Coverage for MH/SA

Amendment Barcode (if applicable)

Name Barney Bishop

Job Title CEO

Address 204 South Monroe Street
Street

Phone 510-9922

Tallahassee — *City* | FL — *State* | 32301 — *Zip*

Email Barney@BarneyBishop.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-21-18
Meeting Date

1422
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic MENTAL HEALTH

Name BETH LABASKY

Job Title Consultant

Address 1400 Village Square Blvd Ste 3-460
Street

Phone 850 322 7335

Tallahassee Fla 32312
City *State* *Zip*

Email bethlabasky@gt.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing INFORMED FAMILIES of FLORIDA
ALPHA 1 FOUNDATION

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

21 Feb 2018
Meeting Date

1422
Bill Number (if applicable)

Topic SAMH Parity

Amendment Barcode (if applicable)

Name Jill Gran

Job Title Senor Policy Director

Address 2868 Mahan Dr
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-878-2196

Email jill@myfbha.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Behavioral Health Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

1422
Bill Number (if applicable)

Topic Parity for Mental Health and Substance Use

Amendment Barcode (if applicable)

Name Shane Messer

Job Title Legislative Affairs Director

Address 316 East Park Ave
Street

Phone 850/322-6693

Tallahassee FL 32301
City *State* *Zip*

Email shane@fccmh.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Council for Behavioral Healthcare

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/21/18
Meeting Date

590
Bill Number (if applicable)

497732 DE
Amendment Barcode (if applicable)

Topic Ch. 39 Welfare

Name Victoria Zepp

Job Title Chief Policy and Research Officer

Address 411 E. College Ave
Street
TLH FL 32301
City *State* *Zip*

Phone 850.561.1107

Email VICTORIA@FLChildren.org

Speaking: ☑ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL Coalition for Children

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2.21.18
Meeting Date

590
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name Barney Bishop

Job Title CEO

Address 204 South Monroe Street
Street

Phone 510-9922

Tallahassee FL 32301
City *State* *Zip*

Email Barney@BarneyBishop.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

CourtSmart Tag Report

Room: SB 401 **Case No.:** **Type:**
Caption: Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 2/21/2018 3:58:15 PM
Ends: 2/21/2018 4:42:56 PM **Length: 00:44:42**

4:03:45 PM Sen. Flores
4:04:27 PM S 758
4:04:30 PM Sen. Gibson
4:05:57 PM Sen. Flores
4:06:03 PM Sen. Stargel
4:06:25 PM Sen. Gibson
4:07:05 PM Sen. Stargel
4:07:58 PM Sen. Gibson
4:08:32 PM Sen. Stargel
4:09:04 PM Sen. Gibson
4:10:29 PM Sen. Flores
4:10:36 PM David Christian, Director of Government Relations, Florida Hospital (waives in support)
4:10:40 PM Christopher Nuland, Lobbyist, American College of Physicians (waives in support)
4:10:48 PM Melanie Bostick, Vice President, American Association of Diabetic Educators
4:12:32 PM Sen. Stargel
4:13:05 PM M. Bostick
4:13:54 PM Sen. Stargel
4:14:10 PM M. Bostick
4:15:35 PM Sen. Flores
4:15:47 PM Sen. Gibson
4:17:16 PM Sen. Flores
4:17:43 PM S 42
4:17:52 PM Sen. Rodriguez
4:18:34 PM Sen. Flores
4:18:47 PM Jonathan Gilbert, Attorney for Brothers and Hughey, Colling Gilbert Wright and Carter (waives in support)
4:19:38 PM S 44
4:19:49 PM Sen. Rodrquez
4:20:21 PM Am. 892122
4:20:33 PM Sen. Flores
4:20:44 PM S 44 (cont.)
4:20:49 PM Jonathan Gilbert, Attorney for Patnode, Colling Gilbert Wright and Carter (waives in support)
4:21:09 PM Sen. Flores
4:21:28 PM S 18
4:21:43 PM Sen. Braynon
4:22:44 PM Sen. Flores
4:23:17 PM S 1360
4:23:24 PM Sen. Broxson
4:25:30 PM Am. 941496
4:26:04 PM Sen. Flores
4:26:20 PM S 1360 (cont.)
4:26:24 PM Barney Bishop, Chief Executive Officer, Florida Smart Justice Alliance
4:26:33 PM Sen. Flores
4:27:01 PM S 1422
4:27:08 PM Sen. Rouson
4:29:41 PM Am. 370074
4:29:53 PM S 1422 (cont.)
4:29:56 PM Richard Chapman,
4:32:20 PM Dominica Jane Bennett (waives in support)
4:32:26 PM Guy M. Bennett, Retired Military Officer (waives in support)
4:32:32 PM Thad Lowery, Vice President of Government Affairs, Operation PAR (waives in support)
4:32:38 PM Barney Bishop, Chief Executive Officer, Florida Smart Justice Alliance (waives in support)
4:32:43 PM Beth Labasky, Consultant, Informed Families of Florida and Alpha 1 Foundation (waives in support)

4:32:49 PM Jill Gran, Senior Policy Director, Florida Behavioral Health Association (waives in support)
4:32:56 PM Shane Messer, Legislative Affairs Director, Florida Council for Behavioral Healthcare (waives in support)
4:33:15 PM Sen. Flores
4:33:36 PM S 590
4:33:43 PM Am. 497732
4:33:53 PM Sen. Garcia
4:35:33 PM Sen. Rader
4:36:04 PM Sen. Garcia
4:36:51 PM Sen. Flores
4:36:51 PM Victoria Zepp, Chief Policy and Research Officer, Florida Coalition for Children
4:38:06 PM S 590 (cont.)
4:38:14 PM Barney Bishop, Chief Executive Officer, Florida Smart Justice Alliance (waives in support)
4:38:22 PM Sen. Garcia
4:39:27 PM Sen. Flores
4:40:43 PM Sen. Radar
4:42:48 PM Sen. Flores