Tab 1	**CS/SB 402** by **HP, Harrell**; (Similar to CS/CS/H 00767) Assisted Living Facilities					
884902	D	S	RCS	AHS, Harrell	Delete everything after	02/18 07:38 PM

Tab 2	**CS/SB 744** by **HP, Hooper (CO-INTRODUCERS) Gruters**; (Similar to CS/CS/H 00351) Podiatric Medicine

Tab 3	**SB 916** by **Baxley**; (Similar to H 00833) Program of All-Inclusive Care for the Elderly					
729942	A	S	RCS	AHS, Baxley	Delete L.72 - 90:	02/19 07:59 AM

Tab 4	**CS/SB 1120** by **CF, Harrell**; (Compare to CS/CS/CS/H 00649) Substance Abuse Services					
851674	A	S	RCS	AHS, Harrell	Delete L.62 - 179:	02/19 08:03 AM

Tab 5	**SB 1344** by **Harrell**; (Similar to CS/H 01163) Intermediate Care Facilities					
180258	A	S	RCS	AHS, Harrell	Delete L.33 - 70:	02/18 07:48 PM

Tab 6	**CS/SB 1370** by **HP, Harrell**; (Similar to CS/CS/H 00763) Patient Safety Culture Surveys					
354582	A	S	RCS	AHS, Harrell	btw L.139 - 140:	02/19 08:21 AM

Tab 7	**CS/SB 1440** by **CF, Powell**; (Identical to CS/H 00945) Children's Mental Health

Tab 8	**CS/SB 1548** by **CF, Perry (CO-INTRODUCERS) Hutson**; (Compare to CS/H 00043) Child Welfare

Tab 9	**CS/SB 1676** by **HP, Albritton**; (Compare to CS/H 00607) Direct Care Workers					
823308	A	S	RCS	AHS, Albritton	Delete L.135 - 412:	02/19 05:33 PM
226548	A	S	RCS	AHS, Albritton	btw L.418 - 419:	02/19 05:33 PM
106048	AA	S	RCS	AHS, Albritton	Delete L.11:	02/19 05:33 PM
899862	A	S	RCS	AHS, Albritton	Delete L.419:	02/19 05:33 PM
364268	AA	S	RCS	AHS, Albritton	Delete L.62 - 63:	02/19 05:33 PM
745926	AA	S	RCS	AHS, Harrell	Delete L.185 - 192:	02/19 05:33 PM
946852	AA	S	RCS	AHS, Albritton	Delete L.296 - 299:	02/19 05:33 PM

Tab 10	**CS/SB 1748** by **CF, Hutson (CO-INTRODUCERS) Perry**; (Compare to H 07085) Child Welfare

Tab 11	**CS/SB 1764** by **HP, Flores**; (Compare to CS/CS/H 01255) Midwifery

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Bean, Chair
Senator Harrell, Vice Chair

MEETING DATE: Tuesday, February 18, 2020
TIME: 4:00—6:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Harrell, Vice Chair; Senators Book, Diaz, Farmer, Flores, Hooper, Passidomo, Rader, and Rouson

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 402** Health Policy / Harrell (Similar CS/CS/H 767)	Assisted Living Facilities; Clarifying that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; removing restrictions on the method by which a facility may send a report to the Agency for Health Care Administration; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator, etc. HP 11/05/2019 Fav/CS AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0
2	**CS/SB 744** Health Policy / Hooper (Similar CS/CS/H 351)	Podiatric Medicine; Providing that a supervising physician may authorize a licensed physician assistant to perform services under the direction of a licensed podiatric physician under certain circumstances; defining the term "physician" to include podiatric physicians; authorizing the Board of Podiatric Medicine to require a specified number of continuing education hours related to the safe and effective prescribing of controlled substances as a condition for licensure renewal, etc. HP 02/04/2020 Fav/CS AHS 02/18/2020 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 916** Baxley (Similar H 833)	Program of All-Inclusive Care for the Elderly; Authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve certain applicants to provide benefits pursuant to the Program of All-Inclusive Care for the Elderly (PACE); specifying requirements and procedures for the submission, publication, review, and initial approval of applications; requiring prospective PACE organizations that are granted initial approval to apply within a certain timeframe for federal approval, etc. HP 01/21/2020 Not Considered HP 01/28/2020 Favorable AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0
4	**CS/SB 1120** Children, Families, and Elder Affairs / Harrell (Compare CS/CS/H 649, S 704)	Substance Abuse Services; Specifying that certified recovery residence administrators and certain persons associated with certified recovery residences are subject to certain background screenings; requiring, rather than authorizing, the exemption from disqualification from employment for certain substance abuse service provider personnel; deleting a provision relating to background screenings for certain persons associated with applicant recovery residences; providing criminal penalties for violations relating to recovery residence patient referrals, etc. CF 01/28/2020 Fav/CS AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0
5	**SB 1344** Harrell (Similar CS/H 1163)	Intermediate Care Facilities; Requiring certain facilities that have been granted a certificate-of-need exemption to demonstrate and maintain compliance with specified criteria; providing an exemption from a certificate-of-need requirement for certain intermediate care facilities; prohibiting the Agency for Health Care Administration from granting an additional exemption to a facility unless a certain condition is met, etc. HP 01/28/2020 Favorable AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
6	**CS/SB 1370** Health Policy / Harrell (Similar CS/H 763)	Patient Safety Culture Surveys; Requiring certain licensed facilities to biennially conduct an anonymous patient safety culture survey using a specified federal publication; requiring the agency to collect, compile, and publish patient safety culture survey data submitted by facilities; revising requirements for the submission of health care data to the agency, etc. HP 02/11/2020 Fav/CS AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 10 Nays 0
7	**CS/SB 1440** Children, Families, and Elder Affairs / Powell (Identical CS/H 945, Compare CS/H 7065)	Children's Mental Health; Requiring the Department of Children and Families and the Agency for Health Care Administration to identify certain children and adolescents who use crisis stabilization services during specified fiscal years; including crisis response services provided through mobile response teams in the array of services available to children and adolescents; requiring managing entities to develop and implement plans promoting the development of a coordinated system of care for certain services; requiring the agency to conduct, or contract for, the testing of provider network databases maintained by Medicaid managed care plans for specified purposes, etc. CF 02/04/2020 Fav/CS AHS 02/18/2020 Favorable AP	Favorable Yeas 10 Nays 0
8	**CS/SB 1548** Children, Families, and Elder Affairs / Perry (Compare CS/H 43, H 111, H 679, CS/H 1105, H 7085, S 88, CS/S 1324)	Child Welfare; Requiring the Florida Court Educational Council to establish certain standards for instruction of specified circuit court judges; deleting a requirement for the Department of Children and Families to report certain information to the Legislature; providing court procedures and requirements relating to deceased parents of a dependent child; authorizing the department to take certain actions without a court order, etc. CF 01/28/2020 Temporarily Postponed CF 02/04/2020 Fav/CS AHS 02/18/2020 Favorable AP	Favorable Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
9	**CS/SB 1676** Health Policy / Albritton (Compare CS/H 607, CS/H 7053)	Direct Care Workers; Authorizing a nursing home facility to use paid feeding assistants in accordance with specified federal law under certain circumstances; prohibiting paid feeding assistants from counting toward compliance with minimum staffing standards; authorizing an unlicensed person to assist with self-administration of certain treatments; authorizing a home health aide to administer certain prescription medications under certain conditions, etc. HP 01/28/2020 Temporarily Postponed HP 02/04/2020 Fav/CS AHS 02/18/2020 Fav/CS AP	Fav/CS Yeas 7 Nays 3
10	**CS/SB 1748** Children, Families, and Elder Affairs / Hutson (Compare H 7085)	Child Welfare; Requiring that child support payments be deposited into specified trust funds; authorizing the Agency for Health Care Administration to access certain records; requiring certain documentation in the case plan when a child is placed in a qualified residential treatment program; requiring certain screening requirements for residential group home employees, etc. CF 01/28/2020 Temporarily Postponed CF 02/04/2020 Fav/CS AHS 02/18/2020 Favorable AP	Favorable Yeas 10 Nays 0
11	**CS/SB 1764** Health Policy / Flores (Compare CS/CS/H 1255)	Midwifery; Revising responsibilities of licensed midwives providing in-hospital and out-of-hospital births; revising the requirements for the uniform patient informed consent form used by licensed midwives providing out-of-hospital births, etc. HP 02/04/2020 Fav/CS AHS 02/18/2020 Favorable AP	Favorable Yeas 10 Nays 0
	Other Related Meeting Documents		

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 402 (831164)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Harrell
SUBJECT:	Assisted Living Facilities
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 402 amends various statutes related to the regulation of an assisted living facility (ALF). The bill:

- Allows the use of certain physical restraints in ALFs, including any device the resident chooses to use and is able to remove or avoid independently.
- Requires ALFs to submit a preliminary adverse incident report and final report through the Agency for Health Care Administration's (AHCA) online portal, or by electronic mail if the portal is offline.
- Revises adverse incident reporting notifications for the AHCA and requirements for ALFs.
- Authorizes unlicensed ALF staff to change the bandages of residents for minor cuts and abrasions.
- Authorizes a resident or his or her representative, designee, surrogate, guardian, or attorney, as applicable, to contract for services with a third party and provides requirements for third-party communication with the facility and requires an ALF to document that it received such communication.
- Removes the requirement for ALF staff assisting with the self-administration of medication to read the label of the medication to the resident. Instead, the bill requires staff to, in the presence of the resident, confirm the medication is correct and advise the resident of the medication name and dosage. The bill also allows the resident to sign a waiver to opt-out of being orally advised and provides the waiver that must be immediately updated each time the resident's medications and dosage change.

- Allows ALFs to admit residents that require 24-hour nursing care, residents that are receiving hospice services, or residents who are bedridden that meet specific criteria.
- Clarifies the requirements for a resident to be admitted to and retained in an ALF.
- Requires each resident to have a medical examination performed no longer than 60 days prior to or up to 30 days after admission to the ALF and requires the AHCA to adopt a form in rule that may be used by the health care practitioner performing the medical examination.
- Amends the Resident Bill of Rights to allow the State Long-Term Care Ombudsman Program to provide assistance to a resident who needs to be relocated due to the closure of a facility.
- Requires an ALF to notify a resident's representative or designee of the need for health care services and assist in making appointments if an underlying condition of dementia or cognitive impairment is determined to exist. If the resident does not have a representative or designee or the ALF cannot reach their representative or designee, the ALF must arrange for the necessary care and services to treat the condition with an appropriate health care provider.
- Amends the AHCA's rulemaking authority to account for technological advances in the provision of care, safety, and security.
- Clarifies who may approve an ALF's comprehensive emergency management plan and allows an ALF to submit the plan up to 30 days after receiving a license.
- Requires the AHCA to conduct a full inspection instead of an abbreviated biennial licensure inspection to review the key quality-of-care standards for a facility that has a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program.
- Consolidates provisions related to firesafety into its own section of law rather than being intermingled with the AHCA's rulemaking authority.
- Amends several provisions related to the ALF administrator core competency curriculum and examination to clarify that the AHCA must adopt an outline and learning objectives for such curriculum.

The bill does not have a fiscal impact on state revenues or expenditures.

The bill takes effect July 1, 2020.

II. Present Situation:

An ALF is a residential establishment, or part of a residential establishment, that provides housing, meals, and one or more personal services for a period exceeding 24 hours to one or more adults who are not relatives of the owner or administrator.[1] A personal service is direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[2] Activities of daily living include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[3]

[1] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[2] Section 429.02(17), F.S.
[3] Section 429.02(1), F.S.

An ALF is required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[4] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.[5] If, as determined by the facility administrator or health care provider, a resident no longer meets the criteria for continued residency or the facility is unable to meet the resident's needs, the resident must be discharged in accordance with the Resident Bill of Rights.[6]

There are 3,069 licensed ALFs in Florida having a total of 107,144 beds.[7] An ALF must have a standard license issued by the Agency for Health Care Administration (AHCA) under part I of ch. 429, F.S., and part II of ch. 408, F.S. In addition to a standard license, an ALF may have one or more specialty licenses that allow an ALF to provide additional care. These specialty licenses include limited nursing services,[8] limited mental health,[9] and extended congregate care.[10]

ALF Staff Training

Administrators and Managers

Administrators and other ALF staff must meet minimum training and education requirements established in rule by the AHCA,[11] that are intended to assist ALFs in appropriately responding to the needs of residents, maintaining resident care and facility standards, and meeting licensure requirements.[12]

The current ALF core training requirements established by the AHCA consist of a minimum of 26 hours of training and passing a competency test. Administrators and managers must successfully complete the core training requirements within three months after becoming an ALF administrator or manager. The minimum passing score for the competency test is 75 percent.[13]

Administrators and managers must participate in 12 hours of continuing education in topics related to assisted living every two years.[14] A newly-hired administrator or manager, who has successfully completed the ALF core training and continuing education requirements, is not required to retake the core training. An administrator or manager who has successfully completed the core training but has not maintained the continuing education requirements, must retake the ALF core training and retake the competency test.[15]

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[4] *See* Rule 59A-36.007, F.A.C., for specific minimum standards.
[5] Section 429.26, F.S., and Rule 59A-36.006, F.A.C.
[6] Section 429.28, F.S.
[7] Agency for Health Care Administration, Health Care Finder. *See* http://www.floridahealthfinder.gov/facilitylocator/ListFacilities.aspx (last visited October 30, 2019).
[8] Section 429.07(3)(c), F.S.
[9] Section 429.075, F.S.
[10] Section 429.07(3)(b), F.S.
[11] Rule 59A-36.011, F.A.C.
[12] Section 429.52(1), F.S.
[13] Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with part II of chapter 468, F.S., are exempt from this requirement.
[14] Rule 59A-36.011, F.A.C.
[15] *Id.*

Staff with Direct Care Responsibilities

Facility administrators or managers are required to provide or arrange for six hours of in-service training for facility staff who provide direct care to residents.[16] Staff training requirements must generally be met within 30 days after staff begin employment at the facility; however, staff must have at least one hour of infection control training before providing direct care to residents. Nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard six hours of in-service training, staff must complete one hour of elopement training and one hour of training on "do not resuscitate" orders. The staff may be required to complete training on special topics such as self-administration of medication and Alzheimer's disease, if applicable.

Inspections and Surveys

The AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:
- Prior to the issuance of a license;
- Prior to biennial renewal of a license;
- When there is a change of ownership;
- To monitor ALFs licensed to provide limited nursing services or extended congregate care services;
- To monitor ALFs cited in the previous year for a class I or class II violation or for four or more uncorrected class III violations;
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents;
- If the AHCA has reason to believe an ALF is violating a provision of part III of ch. 429, F.S., relating to adult day care centers or an administrative rule;
- To determine if cited deficiencies have been corrected; or
- To determine if an ALF is operating without a license.[17]

An applicant for licensure renewal is eligible for an abbreviated biennial survey by the AHCA if the applicant does not have any:
- Class I, class II, or uncorrected class III violations;
- Confirmed complaints from the long-term care ombudsman council[18] which were reported to the AHCA by the council; or
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[19]

[16] *Id.*
[17] Section 429.34, F.S.
[18] Florida's Long-Term Care Ombudsman Program was founded in 1975 as a result of the federal Older Americans Act, which grants a special set of residents' rights to individuals who live in long-term care facilities such as nursing homes, assisted living facilities and adult family care homes. Volunteer ombudsmen seek to ensure the health, safety, welfare and rights of these residents throughout Florida. *See* http://ombudsman.myflorida.com/AboutUs.php (last visited on October 30, 2019).
[19] Rule 59A-36.023, F.A.C.

III. Effect of Proposed Changes:

The bill amends various sections in ch. 429, F.S., related to the regulation of ALFs. In addition to technical and conforming changes:

Section 1 amends s. 429.02, F.S., to define "assistive device" to mean any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently. Additionally, the bill amends the definition of "extended congregate care" to make conforming and technical changes and "physical restraint" to eliminate specific examples of what qualifies as a physical restraint and to specify that a device the resident chooses to use and is able to remove does not qualify as a physical restraint.

Section 2 amends s. 429.07, F.S., to specify that required written progress reports maintained on the services offered by extended congregate care and limited nursing services must cover only those services offered by the ALF, not those offered by third parties.

Section 3 amends s. 429.11, F.S., to specify that a county or municipality may not issue a business tax receipt, rather than an occupational license, to an ALF without first determining that the ALF is licensed by the AHCA. This is a technical change in terminology.

Section 4 amends s. 429.176, F.S., to specify that when an ALF changes administrators, the owner of the ALF must provide the AHCA with documentation that the new administrator meets educational requirements (in addition to core training requirements that are already required) within 90 days of the change.

Section 5 amends s. 429.23, F.S., to require ALFs to submit the adverse incident preliminary report and final report through AHCA's online portal, or by electronic mail if the portal is offline, instead of by facsimile or United States Mail. The bill also adds language to prevent an ALF from being fined for failing to submit a final report until three days after AHCA notifies the ALF that the final report is due if the incident is determined to, in fact, not be an adverse incident. The bill also eliminates the requirement that each ALF file a monthly report with the AHCA that includes any liability claim filed against it.

Section 6 amends s. 429.255, F.S., to authorize unlicensed ALF staff to change the bandages of residents for minor cuts and abrasions. The bill also authorizes a resident or his or her representative, designee, surrogate, guardian, or attorney, as applicable, to contract for services with a third party, provided the resident meets the criteria for residency and continued residency. The third-party is required to communicate with the facility regarding the resident's condition and the services being provided in accordance with the facility's policies. The ALF is required to document that it received such communication.

Section 7 amends s. 429.256, F.S., to include transdermal patches in the list of medications that unlicensed ALF staff may assist a resident in self-administering. The bill also clarifies that assistance with the self-administration of medication includes:

- A staff member confirming that the medication is intended for the resident and orally advising the resident of the medication's name and dosage.[20] The resident may sign a written waiver to opt-out of being orally advised the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of the medications, and must immediately be updated each time the resident's medications or dosages change; and
- A staff member assisting with the self-administration of a medication that is prescribed "as needed" if the resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.[21]

Section 8 amends s. 429.26, F.S., to require that each resident receive a medical examination by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse within 60 days before admission to the facility or within 30 days after admission to the facility. The practitioner performing the examination must fill out and sign a form that reflects the resident's condition on the date the examination is performed. The bill specifies that the medical examination form required for admittance to an ALF does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission or continued residency. The form used may be the practitioner's own form or a form adopted by the AHCA in rule, both of which must include the following information on the resident:

- Height, weight, and known allergies.
- Significant medical history and diagnoses.
- Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.
- Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining practitioner, including any known history of wandering or elopement.
- Nursing, treatment, or therapy service requirements.
- Whether assistance is needed for ambulating, eating, or transferring.
- Special dietary instructions.
- Whether the resident has any communicable diseases, including necessary precautions that are necessary due to such diseases.
- Whether the resident is bedridden and the presence of any pressure sores.
- Whether the resident needs 24-hour nursing supervision or psychiatric care.
- A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance, or needs medication administration.

The bill establishes criteria that for a resident's appropriateness for admission or continued residency, including:

- A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

[20] Current law requires the staff member read the label on the medication. It is unclear whether the label must be read to the resident, however.
[21] Current law requires the resident to be competent.

- A facility may admit or retain a resident who requires the use of assistive devices.[22]
- A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including if applicable, staffing for nursing care.
- A facility may not retain a resident who requires 24-hour nursing supervision, except for a resident who is enrolled in hospice services pursuant to part IV of chapter 400.
- A facility may not admit or retain a resident who is bedridden[23] except that:
  - A bedridden resident may be admitted or retained if he or she is receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility.
  - A facility may retain a bedridden resident if the resident is bedridden for no more than seven days or up to 14 days if the facility is licensed to provide extended congregate care.

Additionally, the bill amends the requirement that an ALF must arrange for the necessary care and services to treat a resident who has developed dementia or cognitive impairment to instead require the ALF to notify the resident's designee or representative of the need for such health care services and to assist in making appointments for the resident. If the resident's designee or representative cannot be located or is unresponsive, the ALF retains the requirement to arrange the necessary care for the resident.

Section 9 amends s. 429.28, F.S., to require that a document stating the reasons for relocation of a resident be provided to the resident or the resident's representative; and to clarify the AHCA rulemaking and inspection authority required by the resident's bill of rights.

Section 10 amends s. 429.31, F.S., to provide relocation assistance to a resident of an ALF whose residency is being terminated due to closure of the facility. Specifically, the bill requires the notice of relocation or termination to state that the resident may contact the State Long-Term Care Ombudsman Program for assistance with relocation and must include the statewide toll-free telephone number of the program. The bill requires an ALF to notify the AHCA of its plans to discontinue facility operation. Further, the bill requires the AHCA, upon receiving notice of a facility's voluntary or involuntary termination, to immediately inform the State Long-Term Care Ombudsman Program so they can provide assistance with relocation to the resident.

Section 11 amends s. 429.41, F.S., to:

- Clarify that the AHCA may account for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility in its rules.

[22] The term "assistive devices" is defined in section 1 of the bill.

[23] The bill defines "bedridden" as a resident who is confined to a bed because of the inability to: move, turn, or reposition without total physical assistance; transfer to a chair or wheelchair without total physical assistance; or sit safely in a chair or wheelchair without personal assistance or a physical restraint.

- Remove language regarding firesafety standards that are being placed in new section 429.435, F.S. (See section 12 of the bill).
- Clarify that rule requirements for maintenance and sanitary conditions include furnishings for resident bedrooms or sleeping areas, locking devices and linens, but do not include requirements that are duplicative of those in ch. 553, or ss. 381.006, 381.0072, and 633.206, F.S. The bill also requires that the rules clearly delineate the respective responsibilities of the AHCA's licensure and survey staff and the county health departments to ensure that inspections are not duplicative and allows the AHCA to collect fees[24] for food service inspections conducted by the county health department and transfer such fees to the Department of Health.
- Remove the requirement that comprehensive emergency management plans be made available for review by appropriate volunteer organizations and require that an ALF submit its plan to the county emergency management agency within 30 days after being issued a license rather than requiring the plan to be approved prior to the issuance of the license.
- Allow the use of physical restraints (as defined in section 1 of the bill) other than Posey restraints[25] in accordance with the AHCA rules. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician.
- Require the establishment of specific ALF elopement drill requirements, in addition to elopement policies and procedures on resident elopment, and require administrators and direct care staff to review elopement procedures to address resident elopment as part of the elopement drill.
- Allow the AHCA to use an abbreviated survey for an ALF that has had a confirmed ombudsman council complaint or licensure complaint unless such complaint results in a class I, II, or uncorrected class III violation.
- Require the AHCA to adopt key quality-of-care standards in rule and eliminate the requirement to incorporate input from the state long-term care ombudsman council and representatives of provider groups.

Section 12 creates s. 429.435, F.S., to consolidate requirements relating to uniform fire safety standards for ALFs into the new section. The requirements of this section are transposed from s. 429.41, F.S.

Section 13 amends s. 429.52, F.S., to require the AHCA, in conjunction with ALF providers, to develop core training requirements for administrators consisting of core training learning objectives. The bill also requires the AHCA to adopt a curriculum outline that includes the learning objectives.

The bill requires staff assisting with the self-administration of medication to complete six additional hours of training before providing such assistance and two hours of continuing education annually thereafter. The bill also specifies that topics covered in the preservice orientation for ALF staff are not required to be covered again in staff in-service training and that all required in-service training may be completed in a single course.

[24] The quarterly fee of $300 is established in current law under s. 381.0072, F.S.
[25] Posey restraints are a generic term for a restraint that restricts a patient's free movement while the patient is in bed.

Additionally the bill requires the AHCA to establish core trainer registration and removal requirements.

Section 14 establishes an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 429.02, 429.07, 429.11, 429.176, 429.23, 429.255, 429.256, 429.26, 429.28, 429.31, 429.41, and 429.52.

This bill creates section 429.435 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial 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 18, 2020:
The committee substitute:

- Removes the definitions of "abuse", "exploitation", and "neglect".
- Amends the definition of "extended congregate care" to make conforming and technical changes.
- Clarifies that a facility that is licensed to provide extended congregate care services must maintain a written progress report on each person who receives nursing services from the facility's staff. Previously, the bill did not specify nursing services.
- Removes the provision from the definition of "adverse incident" to only include events associated with the ALF's intervention rather than the resident's underlying disease or condition.
- Revises adverse incident reporting notifications for the AHCA and requirements for ALFs.
- Authorizes unlicensed ALF staff to change the bandages of residents for minor cuts and abrasions.
- Provides for a resident a resident or his or her representative, designee, surrogate, guardian, or attorney, as applicable, to contract for services with a third party. The third-party is required to communicate with the facility regarding the resident's condition and the services. The ALF is required to document that it received such communication.
- Clarifies that residents who receive assistance with the self-administration of medication must be orally advised of the medication's name and dosage and allows a resident to sign a waiver to opt-out of being orally advised. The waiver must include specified information and immediately be updated each time the resident's medications or dosages change.
- Clarifies the medical examination form must (formerly may) be used only as an informative tool to determine the appropriateness of the resident's admission to or continued residency on the facility.
- Amends the Resident Bill of Rights to allow the State Long-Term Care Ombudsman Program to provide assistance to a resident who needs to be relocated due to the closure of a facility.
- Removes the prohibition against geriatric chairs as an allowable use of physical restraints.
- Makes technical and conforming changes.

CS by Health Policy on November 5, 2019:
The CS:

- Amends the definition of "neglect" to include the failure to prevent sexual abuse.
- Maintains current law requiring an ALF to submit a preliminary adverse incident report to the AHCA within one business day of the incident occurring.
- Prevents AHCA from fining an ALF for not filing a full adverse incident report until three days after the AHCA provides the ALF with a reminder that the report is due.
- Specifies that the medical examination required for admittance to an ALF is not a guarantee of admission, continued residency, or services to be delivered and that the medical examination is to be used as an informative tool to assist in the determination of the appropriateness of the resident's admission or continued residency.
- Specifies that an ALF must still arrange the necessary care and services to treat a resident with dementia or other similar condition if the ALF cannot locate the resident's representative or he or she is not responsive.
- Specifies ss. 381.006 and 381.0072, F.S., in requiring that ALF rules not conflict with or duplicate provisions in the specified sections. Currently, the bill specifies the entire chapter of law.
- Maintains current law authority for AHCA to adopt rules over elopement policies and procedures.
- Specifies that the six hours of training necessary to provide assistance with medication is in addition to other required training.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/18/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Present subsections (7) through (27) of section 429.02, Florida Statutes, are redesignated as subsections (8) through (28), respectively, a new subsection (7) is added to that section, and present subsections (11) and (18) are amended, to read:

429.02 Definitions.—When used in this part, the term:

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(7) "Assistive device" means any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or recliner lift that a resident is able to operate independently.

(12) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (18) which ~~(17) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that ~~which~~ may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(19) ~~(18)~~ "Physical restraint" means a device that ~~which~~ physically limits, restricts, or deprives an individual of movement or mobility, including~~, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include~~ any device that is ~~which was~~ not specifically manufactured as a restraint but is ~~which has been~~ altered, arranged, or otherwise used for that ~~this~~ purpose. The term does ~~shall~~ not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

Section 2. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—


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(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services, directly or through contract, beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if he or she is determined appropriate for admission to the extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be


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provided and whether the designation applies to all or part of the facility. This designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

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The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which ~~that~~ demonstrates compliance with all the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living facility requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives nursing services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the

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facility at least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

4. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes

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in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) ~~s. 429.26(4)~~ and the facility must develop a preliminary service plan for the individual.

7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and

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needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k).

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This designation may be made at the time of initial licensure or licensure renewal, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies to provide limited nursing services must have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services <u>from the facility's staff</u>. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit the facility at least annually to monitor residents who are receiving limited nursing services and to

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determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 3. Subsection (7) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

(7) A county or municipality may not issue <u>a business tax receipt</u> ~~an occupational license~~ that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed

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to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing business tax receipts ~~occupational licenses~~ sufficient instruction for making such determinations.

Section 4. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 5. Subsections (3), (4), and (5) of section 429.23, Florida Statutes, are amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident, through the agency's online portal or, if the portal is offline, by electronic mail, ~~facsimile, or United States mail,~~ a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the status of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days, through the agency's online portal or, if the portal is offline,

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by electronic mail, ~~facsimile, or United States mail,~~ a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) Three business days before the deadline for the submission of the full report required under subsection (4), the agency shall send by electronic mail a reminder to the facility's administrator and other specified facility contacts. Within 3 business days after the agency sends the reminder, a facility is not subject to any administrative or other agency action for failing to withdraw the preliminary report if the facility determines the event was not an adverse incident or for failing to file a full report if the facility determines the event was an adverse incident ~~Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part~~.

Section 6. Paragraphs (a) and (b) of subsection (1) of section 429.255, Florida Statutes, are amended, paragraph (d) is added to that subsection, and subsection (4) of that section is amended, to read:

429.255 Use of personnel; emergency care.—

(1)(a) Persons under contract to the facility, facility staff, or volunteers, who are licensed according to part I of chapter 464, or those persons exempt under s. 464.022(1), ~~and~~

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~~others as defined by rule,~~ may administer medications to residents, take residents' vital signs, change residents' bandages for minor cuts and abrasions, manage individual weekly pill organizers for residents who self-administer medication, give prepackaged enemas ordered by a physician, observe residents, document observations on the appropriate resident's record, and report observations to the resident's physician~~, and contract or allow residents or a resident's representative, designee, surrogate, guardian, or attorney in fact to contract with a third party, provided residents meet the criteria for appropriate placement as defined in s. 429.26~~. Nursing assistants certified pursuant to part II of chapter 464 may take residents' vital signs as directed by a licensed nurse or physician.

(b) All staff of ~~in~~ facilities licensed under this part shall exercise their professional responsibility to observe residents, to document observations on the appropriate resident's record, and to report the observations to the resident's physician. However, the owner or administrator of the facility shall be responsible for determining that the resident receiving services is appropriate for residence in the facility.

(d) A resident or his or her representative, designee, surrogate, guardian, or attorney in fact, as applicable, may contract for services with a third party, provided the resident meets the criteria for residency and continued residency as defined in s. 429.26. The third party must communicate with the facility regarding the resident's condition and the services being provided in accordance with the facility's policies. The facility must document that it received such communication.

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(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection (3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription’s label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident’s surrogate, guardian, or attorney in fact. For the

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purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and dosage ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container. The resident may sign a written waiver to opt out of being orally advised of the medication name and dosage. The waiver must identify all of the medications intended for the resident, including names and dosages of such medications, and must immediately be updated each time the resident's medications or dosages change.

(4) Assistance with self-administration does not include:

(e) The use of irrigations or debriding agents used in the treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the

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medication and understands the purpose for taking the medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed

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hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident, including, if applicable, staffing for nursing care.

(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or

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attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4) ~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5)(a) ~~(4) If possible,~~ Each resident must ~~shall~~ have been examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed only by the practitioner, must ~~report~~

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~~shall~~ be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued residency ~~stay~~ in the facility.

(b) The medical examination form may be used only to record the practitioner's direct observation of the patient at the time of examination and must include the patient's medical history. Such form does not guarantee admission to, continued residency in, or the delivery of services at the facility and must be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes ~~report shall become~~ a permanent part of the facility's record of the resident ~~at the facility~~ and must ~~shall~~ be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(c) The medical examination form must include all of the following information about the resident:

1. Height, weight, and known allergies.

2. Significant medical history and diagnoses.

3. Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.

4. Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining

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practitioner, including any known history of wandering or elopement.

5. Nursing, treatment, or therapy service requirements.

6. Whether the resident needs assistance for ambulating, eating, or transferring.

7. Special dietary instructions.

8. Whether the resident has any communicable diseases, including precautions that are necessary due to such diseases.

9. Whether the resident is bedridden and the presence of any pressure sores.

10. Whether the resident needs 24-hour nursing supervision or psychiatric care.

11. A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance with medications, or needs medication administration.

~~(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.~~

(6) Any resident accepted in a facility and placed by ~~the~~

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~~department or~~ the Department of Children and Families must ~~shall~~ have been examined by medical personnel within 30 days before placement in the facility. The examination must ~~shall~~ include an assessment of the appropriateness of placement in a facility. The findings of this examination must ~~shall~~ be recorded on the examination form provided by the agency. The completed form must ~~shall~~ accompany the resident and ~~shall~~ be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident, provided that ~~providing~~ it was completed within 90 days before ~~prior to~~ admission to the facility. The ~~applicable~~ Department of Children and Families shall provide to the facility administrator any information about the resident which ~~that~~ would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The ~~applicable~~ Department of Children and Families shall advise and assist the facility administrator when ~~where~~ the special needs

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of residents who are recipients of optional state supplementation require such assistance.

(7) The facility shall ~~must~~ notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for ~~shall arrange, with the appropriate health care provider,~~ the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is nonresponsive, the facility shall arrange with an appropriate health care provider for the necessary care and services to treat the condition.

(8) The Department of Children and Families may require an examination for supplemental security income and optional state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the

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facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(9)~~(10)~~ Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraph (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility.

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Every resident of a facility shall have the right to:

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine whether the facility is complying with this part ~~general compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Subsections (1) and (2) of section 429.31,

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Florida Statutes, are amended to read:

429.31 Closing of facility; notice; penalty.—

(1) In addition to the requirements of part II of chapter 408, the facility shall inform, in writing, the agency and each resident or the next of kin, legal representative, or agency acting on each resident's behalf, of the fact and the proposed time of discontinuance of operation, following the notification requirements provided in s. 429.28(1)(k). In the event a resident has no person to represent him or her, the facility shall be responsible for referral to an appropriate social service agency for placement.

(2) Immediately upon the notice by the agency of the voluntary or involuntary termination of such operation, the agency shall inform the State Long-Term Care Ombudsman Program and monitor the transfer of residents to other facilities and ensure that residents' rights are being protected. The agency, in consultation with the Department of Children and Families, shall specify procedures for ensuring that all residents who receive services are appropriately relocated.

Section 11. Subsections (1), (2), and (5) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is residential and noninstitutional in design or nature and may

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allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. ~~Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~,~~ ~~policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, the requirements in s. 381.006, s. 381.0072, chapter 553, or s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are


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not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination.—An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.—~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the~~

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~~alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan


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is subject to review and approval by the county ~~local~~ emergency management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate volunteer organizations must be given the opportunity to review the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.~~

(d) ~~(e)~~ License application and license renewal, transfer of ownership, proper management of resident funds and personal

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property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, levying and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use of Posey restraints is prohibited. Other physical restraints may

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be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements and policies and procedures on resident elopement. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills, which must include a review of the facility's procedures to address resident elopement. Facilities shall document participation in the drills.

(2) In adopting any rules pursuant to this part, the agency shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to

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this section may not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care licenses a building or part of a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. ~~Except for uniform firesafety standards,~~ The agency shall adopt by rule separate and distinct standards for facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must be appropriate for a noninstitutional residential environment; however, the structure may not be more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The agency may make other distinctions among types of facilities as necessary to enforce this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the agency relative to the physical characteristics of facilities and the types of care offered.

(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility

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that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations;~~,~~ uncorrected class III violations; or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program~~, confirmed ombudsman council complaints, or confirmed licensure complaints~~ within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency shall adopt by rule ~~develop~~ the key quality-of-care standards ~~with input from the State Long-Term Care Ombudsman Council and representatives of provider groups for incorporation into its rules~~.

Section 12. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.—Uniform firesafety standards for assisted living facilities that are residential board and care occupancies shall be established by the State Fire Marshal pursuant to s. 633.206.

(1) EVACUATION CAPABILITY.—A firesafety evacuation capability determination shall be conducted within 6 months after the date of initial licensure of an assisted living facility, if required.

(2) FIRESAFETY REQUIREMENTS.—

(a) The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, must be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

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(b) A local government or a utility may charge fees that do not exceed the actual costs incurred by the local government or the utility for the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.

(c) All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

(d) An assisted living facility that was issued a building permit or certificate of occupancy before July 1, 2016, at its option and after notifying the authority having jurisdiction, may remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. A facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to or rehabilitate the facility in compliance with NFPA 101, 1994 edition, and may use the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy was issued before July 1, 2016, which undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or which seeks to use features not authorized under the 1994 or 1995 editions of the Life Safety Code, shall thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206 and the Florida Fire Prevention Code in effect for assisted living facilities as adopted by the State Fire Marshal.

Section 13. Section 429.52, Florida Statutes, is amended to read:

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429.52 Staff training and educational requirements ~~programs; core educational requirement~~.—

(1) ~~Effective October 1, 2015,~~ Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's personnel record.

(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage ~~completion~~ of the core competency test ~~training and educational requirements~~. The required core competency test ~~training and education~~ must cover at least the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and identifying and reporting abuse,

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neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related disorders.

(4) A ~~new~~ facility administrator must complete the required core training ~~and education~~, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.

(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

(6) Staff ~~involved with the management of medications and~~ assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or~~,~~ a licensed

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pharmacist before providing assistance~~, or agency staff~~. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this ~~additional~~ training.

(7) ~~Other~~ Facility staff shall participate in inservice training relevant to their job duties as specified by agency rule ~~of the agency~~. Topics covered during the preservice orientation are not required to be repeated during inservice training. A single certificate of completion which covers all required inservice training topics may be issued to a participating staff member if the training is provided in a single training course.

(8) If the agency determines that there are problems in a facility which could be reduced through specific staff training ~~or education~~ beyond that already required under this section, the agency may require~~,~~ and provide, or cause to be provided, the training ~~or education~~ of any personal care staff in the facility.

(9) The agency shall adopt rules related to these training and education requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop and administer the competency test. The agency shall adopt a curriculum outline with learning objectives to be used by core trainers~~, which shall be used~~ as the minimum core training content requirements. The agency shall consult with representatives of stakeholder associations and agencies in the development of the curriculum outline.

(10) The core training required by this section ~~other than the preservice orientation~~ must be conducted by persons

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registered with the agency as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the agency with proof of completion of the ~~minimum~~ core training ~~education~~ requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5).

(11) A person seeking to register as a core trainer also must ~~also~~:

(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years after being core certified;

(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;

(c) Have been previously employed as a core trainer for the agency or department; or

(d) Meet other qualification criteria as defined in rule, which the agency is authorized to adopt.

(12) The agency shall adopt rules to establish core trainer registration and removal requirements.

Section 14. This act shall take effect July 1, 2020.

================ 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

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and insert:

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; defining and revising terms; amending s. 429.07, F.S.; requiring assisted living facilities that provide certain services to maintain a written progress report on each person receiving services from the facility's staff; conforming a cross-reference; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; amending s. 429.176, F.S.; requiring an owner of a facility to provide certain documentation to the Agency for Health Care Administration within a specified timeframe; amending s. 429.23, F.S.; authorizing a facility to send certain reports regarding adverse incidents through the agency's online portal; requiring the agency to send reminders by electronic mail to certain facility contacts regarding submission deadlines for such reports within a specified timeframe; amending s. 429.255, F.S.; authorizing certain persons to change a resident's bandage for a minor cut or abrasion; authorizing certain persons to contract with a third-party to provide services to a resident under certain circumstances; providing requirements relating to the third-party provider; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing

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cardiopulmonary resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; revising the types of medications that may be self-administered; revising provisions relating to assistance with the self-administration of such medications; requiring a person assisting with a resident's self-administration of medication to confirm and advise the patient of specified information; authorizing a resident to opt out of such advisement through a signed waiver; providing requirements for such waiver; revising provisions relating to certain medications that are not self-administered with assistance; amending s. 429.26, F.S.; including medical examinations in the criteria used for admission to an assisted living facility; providing specified criteria for determination of appropriateness for admission to and continued residency in an assisted living facility; prohibiting such facility from admitting certain individuals; defining the term "bedridden"; authorizing a facility to retain certain individuals under certain conditions; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a form; providing limitations on the use of such form; providing requirements for the content of the form; revising provisions relating to the placement of residents by the Department of Children and Families; requiring a

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facility to notify a resident's representative or designee of specified information under certain circumstances; requiring the facility to arrange with an appropriate health care provider for the care and services needed to treat a resident under certain circumstances; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; requiring facilities to provide written notice of relocation or termination of residency from a facility to the resident or the resident's legal guardian; revising provisions related to a licensure survey required by the agency; deleting a requirement that the agency adopt certain rules; amending s. 429.31, F.S.; revising notice requirements for facilities that are terminating operations; requiring the agency to inform the State Long-Term Ombudsman Program immediately upon notice of a facility's termination of operations; amending s. 429.41, F.S.; revising legislative intent; revising provisions related to rules the agency, in consultation with the Department of Children and Families and the Department of Health, is required to adopt regarding minimum standards of resident care; requiring county emergency management agencies, rather than local emergency management agencies, to review and approve or disapprove of a facility's comprehensive emergency management plan; requiring a facility to submit a comprehensive emergency management plan to the county emergency management

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agency within a specified timeframe; prohibiting the use of Posey restraints; authorizing the use of other restraints under certain circumstances; revising the criteria under which a facility must be fully inspected; creating s. 429.435, F.S.; requiring the State Fire Marshall to establish uniform firesafety standards for assisted living facilities; providing for a firesafety evacuation capability determination within a specified timeframe under certain circumstances; requiring the State Fire Marshall to use certain standards from a specified national association to determine the uniform firesafety standards to be adopted; authorizing local governments and utilities to charge certain fees relating to fire sprinkler systems; requiring licensed facilities to have an annual fire inspection; specifying certain code requirements for facilities that undergo a specific alteration or rehabilitation; amending s. 429.52, F.S.; revising certain provisions relating to facility staff training and educational requirements; requiring the agency, in conjunction with providers, to establish core training requirements for facility administrators; revising the training and continuing education requirements for facility staff who assist residents with the self-administration of medications; revising provisions relating to the training responsibilities of the agency; requiring the agency to contract with another entity to administer a certain competency test; requiring the agency to adopt

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a curriculum outline with learning objectives to be used by core trainers; conforming provisions to changes made by the act; providing an effective date.

By the Committee on Health Policy; and Senator Harrell

588-01170-20 2020402c1

A bill to be entitled

An act relating to assisted living facilities; amending s. 429.02, F.S.; defining and redefining terms; amending s. 429.07, F.S.; clarifying that an assisted living facility licensed to provide extended congregate care services or limited nursing services must maintain a written progress report on each person receiving services from the facility's staff; conforming a cross-reference; amending s. 429.11, F.S.; prohibiting a county or municipality from issuing a business tax receipt, rather than an occupational license, to a facility under certain circumstances; amending s. 429.176, F.S.; amending educational requirements for an administrator who is replacing another administrator; amending s. 429.23, F.S.; removing restrictions on the method by which a facility may send a report to the Agency for Health Care Administration; requiring the agency to send a reminder to the facility 3 business days prior to the deadline for submission of the full report; removing a requirement that each facility file reports of liability claims; amending s. 429.255, F.S.; clarifying that the absence of an order not to resuscitate does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator; amending s. 429.256, F.S.; requiring a person assisting with a resident's self-administration of medication to confirm that the medication is

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intended for that resident and to orally advise the resident of the medication name and purpose; amending s. 429.26, F.S.; including medical examinations within criteria used for admission to an assisted living facility; providing specified criteria for determination of appropriateness for admission and continued residency at an assisted living facility; defining the term "bedridden"; requiring that a resident receive a medical examination within a specified timeframe after admission to a facility; requiring that such examination be recorded on a specified form; providing limitations on the use of such form; providing minimum requirements for such form; conforming a provision to changes made by the act; eliminating the role of the Department of Elderly Affairs in certain provisions relating to the placement of residents in assisted living facilities; requiring a facility to notify a resident's representative or designee of the need for health care services and to assist in making appointments for such care and services under certain circumstances; requiring the facility to arrange for necessary care and services if no resident representative or designee is available or responsive; removing provisions relating to the retention of certain residents in a facility; amending s. 429.28, F.S.; revising residents' rights relating to a safe and secure living environment; amending s. 429.41, F.S.; revising legislative intent; removing a provision to conform to

changes made by the act; removing a redundant provision authorizing the Agency for Health Care Administration to adopt certain rules; removing provisions relating to firesafety requirements, which are relocated to another section; requiring county emergency management agencies, rather than local emergency management agencies, to review and approve or disapprove of a facility's comprehensive emergency management plan; requiring a facility to submit a comprehensive emergency management plan to the county emergency management agency within a specified timeframe after its licensure; revising the criteria under which a facility must be fully inspected; revising standards for the care of residents provided by a facility; prohibiting the use of geriatric chairs and Posey restraints in facilities; authorizing other physical restraints to be used under certain conditions and in accordance with certain rules; requiring the agency to establish resident elopement drill requirements; requiring that elopement drills include a review of a facility's procedures to address elopement; revising the criteria under which a facility must be fully inspected; revising provisions requiring the agency to adopt by rule key quality-of-care standards; creating s. 429.435, F.S.; revising uniform firesafety standards for assisted living facilities, which are relocated to this section; amending s. 429.52, F.S.; revising provisions relating to facility staff training and educational

requirements; requiring the agency, in conjunction with providers, to establish core training requirements for facility administrators; revising continuing education requirements for facility staff who assist residents with the self-administration of medications; revising the training requirements for facility staff; revising provisions relating to the training responsibilities of the agency; requiring the agency to contract with another entity to administer a certain competency test; requiring the department to adopt a curriculum outline to be used by core trainers; providing an effective date.

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

Section 1. Present subsections (1) through (5), (6) through (10), (11) through (15), and (16) through (27) of section 429.02, Florida Statutes, are redesignated as subsections (2) through (6), (8) through (12), (14) through (18), and (20) through (31), respectively, new subsections (1), (7), (13), and (19) are added, and present subsections (11) and (18) of that section are amended, to read:

429.02 Definitions.—When used in this part, the term:

(1) "Abuse" has the same meaning as in s. 415.102.

(7) "Assistive device" means any device designed or adapted to help a resident perform an action, a task, an activity of daily living, or a transfer; prevent a fall; or recover from a fall. The term does not include a total body lift or a motorized sit-to-stand lift, with the exception of a chair lift or

recliner lift that a resident is able to operate independently.

(13) "Exploitation" has the same meaning as in s. 415.102.

(14) ~~(11)~~ "Extended congregate care" means acts beyond those authorized in subsection (21) which ~~(17) that~~ may be performed pursuant to part I of chapter 464 by persons licensed thereunder while carrying out their professional duties, and other supportive services that ~~which~~ may be specified by rule. The purpose of such services is to enable residents to age in place in a residential environment despite mental or physical limitations that might otherwise disqualify them from residency in a facility licensed under this part.

(19) "Neglect" has the same meaning as in s. 415.102. For purposes other than reporting requirements within this part, "neglect" may also include the failure to prevent sexual abuse as defined in s. 415.102.

(22) ~~(18)~~ "Physical restraint" means a device that ~~which~~ physically limits, restricts, or deprives an individual of movement or mobility, including~~, but not limited to, a half-bed rail, a full-bed rail, a geriatric chair, and a posey restraint. The term "physical restraint" shall also include~~ any device that is ~~which was~~ not specifically manufactured as a restraint but is ~~which has been~~ altered, arranged, or otherwise used for that ~~this~~ purpose. The term does ~~shall~~ not include any device that the resident chooses to use and is able to remove or avoid independently, or any bandage material used for the purpose of binding a wound or injury.

Section 2. Paragraphs (b) and (c) of subsection (3) of section 429.07, Florida Statutes, are amended to read:

429.07 License required; fee.—

(3) In addition to the requirements of s. 408.806, each license granted by the agency must state the type of care for which the license is granted. Licenses shall be issued for one or more of the following categories of care: standard, extended congregate care, limited nursing services, or limited mental health.

(b) An extended congregate care license shall be issued to each facility that has been licensed as an assisted living facility for 2 or more years and that provides services, directly or through contract, beyond those authorized in paragraph (a), including services performed by persons licensed under part I of chapter 464 and supportive services, as defined by rule, to persons who would otherwise be disqualified from continued residence in a facility licensed under this part. An extended congregate care license may be issued to a facility that has a provisional extended congregate care license and meets the requirements for licensure under subparagraph 2. The primary purpose of extended congregate care services is to allow residents the option of remaining in a familiar setting from which they would otherwise be disqualified for continued residency as they become more impaired. A facility licensed to provide extended congregate care services may also admit an individual who exceeds the admission criteria for a facility with a standard license, if he or she is determined appropriate for admission to the extended congregate care facility.

1. In order for extended congregate care services to be provided, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be

provided and whether the designation applies to all or part of the facility. This designation may be made at the time of initial licensure or relicensure, or upon request in writing by a licensee under this part and part II of chapter 408. The notification of approval or the denial of the request shall be made in accordance with part II of chapter 408. Each existing facility that qualifies to provide extended congregate care services must have maintained a standard license and may not have been subject to administrative sanctions during the previous 2 years, or since initial licensure if the facility has been licensed for less than 2 years, for any of the following reasons:

a. A class I or class II violation;

b. Three or more repeat or recurring class III violations of identical or similar resident care standards from which a pattern of noncompliance is found by the agency;

c. Three or more class III violations that were not corrected in accordance with the corrective action plan approved by the agency;

d. Violation of resident care standards which results in requiring the facility to employ the services of a consultant pharmacist or consultant dietitian;

e. Denial, suspension, or revocation of a license for another facility licensed under this part in which the applicant for an extended congregate care license has at least 25 percent ownership interest; or

f. Imposition of a moratorium pursuant to this part or part II of chapter 408 or initiation of injunctive proceedings.

The agency may deny or revoke a facility's extended congregate care license for not meeting the criteria for an extended congregate care license as provided in this subparagraph.

2. If an assisted living facility has been licensed for less than 2 years, the initial extended congregate care license must be provisional and may not exceed 6 months. The licensee shall notify the agency, in writing, when it has admitted at least one extended congregate care resident, after which an unannounced inspection shall be made to determine compliance with the requirements of an extended congregate care license. A licensee with a provisional extended congregate care license which ~~that~~ demonstrates compliance with all the requirements of an extended congregate care license during the inspection shall be issued an extended congregate care license. In addition to sanctions authorized under this part, if violations are found during the inspection and the licensee fails to demonstrate compliance with all assisted living facility requirements during a followup inspection, the licensee shall immediately suspend extended congregate care services, and the provisional extended congregate care license expires. The agency may extend the provisional license for not more than 1 month in order to complete a followup visit.

3. A facility that is licensed to provide extended congregate care services shall maintain a written progress report on each person who receives services from the facility's staff which describes the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse, or appropriate designee, representing the agency shall visit the facility at

least twice a year to monitor residents who are receiving extended congregate care services and to determine if the facility is in compliance with this part, part II of chapter 408, and relevant rules. One of the visits may be in conjunction with the regular survey. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall serve as part of the team that inspects the facility. The agency may waive one of the required yearly monitoring visits for a facility that has:

a. Held an extended congregate care license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

4. A facility that is licensed to provide extended congregate care services must:

a. Demonstrate the capability to meet unanticipated resident service needs.

b. Offer a physical environment that promotes a homelike setting, provides for resident privacy, promotes resident independence, and allows sufficient congregate space as defined by rule.

c. Have sufficient staff available, taking into account the physical plant and firesafety features of the building, to assist with the evacuation of residents in an emergency.

d. Adopt and follow policies and procedures that maximize resident independence, dignity, choice, and decisionmaking to permit residents to age in place, so that moves due to changes

in functional status are minimized or avoided.

e. Allow residents or, if applicable, a resident's representative, designee, surrogate, guardian, or attorney in fact to make a variety of personal choices, participate in developing service plans, and share responsibility in decisionmaking.

f. Implement the concept of managed risk.

g. Provide, directly or through contract, the services of a person licensed under part I of chapter 464.

h. In addition to the training mandated in s. 429.52, provide specialized training as defined by rule for facility staff.

5. A facility that is licensed to provide extended congregate care services is exempt from the criteria for continued residency set forth in rules adopted under s. 429.41. A licensed facility must adopt its own requirements within guidelines for continued residency set forth by rule. However, the facility may not serve residents who require 24-hour nursing supervision. A licensed facility that provides extended congregate care services must also provide each resident with a written copy of facility policies governing admission and retention.

6. Before the admission of an individual to a facility licensed to provide extended congregate care services, the individual must undergo a medical examination as provided in s. 429.26(5) ~~s. 429.26(4)~~ and the facility must develop a preliminary service plan for the individual.

7. If a facility can no longer provide or arrange for services in accordance with the resident's service plan and

needs and the facility's policy, the facility must make arrangements for relocating the person in accordance with s. 429.28(1)(k).

(c) A limited nursing services license shall be issued to a facility that provides services beyond those authorized in paragraph (a) and as specified in this paragraph.

1. In order for limited nursing services to be provided in a facility licensed under this part, the agency must first determine that all requirements established in law and rule are met and must specifically designate, on the facility's license, that such services may be provided. This designation may be made at the time of initial licensure or licensure renewal, or upon request in writing by a licensee under this part and part II of chapter 408. Notification of approval or denial of such request shall be made in accordance with part II of chapter 408. An existing facility that qualifies to provide limited nursing services must have maintained a standard license and may not have been subject to administrative sanctions that affect the health, safety, and welfare of residents for the previous 2 years or since initial licensure if the facility has been licensed for less than 2 years.

2. A facility that is licensed to provide limited nursing services shall maintain a written progress report on each person who receives such nursing services <u>from the facility's staff</u>. The report must describe the type, amount, duration, scope, and outcome of services that are rendered and the general status of the resident's health. A registered nurse representing the agency shall visit the facility at least annually to monitor residents who are receiving limited nursing services and to

determine if the facility is in compliance with applicable provisions of this part, part II of chapter 408, and related rules. The monitoring visits may be provided through contractual arrangements with appropriate community agencies. A registered nurse shall also serve as part of the team that inspects such facility. Visits may be in conjunction with other agency inspections. The agency may waive the required yearly monitoring visit for a facility that has:

a. Had a limited nursing services license for at least 24 months;

b. No class I or class II violations and no uncorrected class III violations; and

c. No ombudsman council complaints that resulted in a citation for licensure.

3. A person who receives limited nursing services under this part must meet the admission criteria established by the agency for assisted living facilities. When a resident no longer meets the admission criteria for a facility licensed under this part, arrangements for relocating the person shall be made in accordance with s. 429.28(1)(k), unless the facility is licensed to provide extended congregate care services.

Section 3. Subsection (7) of section 429.11, Florida Statutes, is amended to read:

429.11 Initial application for license; provisional license.—

(7) A county or municipality may not issue <u>a business tax receipt</u> ~~an occupational license~~ that is being obtained for the purpose of operating a facility regulated under this part without first ascertaining that the applicant has been licensed

to operate such facility at the specified location or locations by the agency. The agency shall furnish to local agencies responsible for issuing business tax receipts ~~occupational licenses~~ sufficient instruction for making such determinations.

Section 4. Section 429.176, Florida Statutes, is amended to read:

429.176 Notice of change of administrator.—If, during the period for which a license is issued, the owner changes administrators, the owner must notify the agency of the change within 10 days and provide documentation within 90 days that the new administrator meets educational requirements and has completed the applicable core educational requirements under s. 429.52. A facility may not be operated for more than 120 consecutive days without an administrator who has completed the core educational requirements.

Section 5. Subsections (2) through (5) of section 429.23, Florida Statutes, are amended to read:

429.23 Internal risk management and quality assurance program; adverse incidents and reporting requirements.—

(2) Every facility licensed under this part is required to maintain adverse incident reports. For purposes of this section, the term~~,~~ "adverse incident" means:

(a) An event over which facility personnel could exercise control which is associated with the facility's intervention, rather than as a result of the resident's underlying disease or condition, and the injury results in:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. Any condition that required medical attention to which the resident has not given his or her consent, including failure to honor advanced directives;

6. Any condition that requires the transfer of the resident from the facility to a unit providing more acute care due to the incident rather than the resident's condition before the incident; or

7. A report made ~~An event that is reported~~ to law enforcement or its personnel for investigation; or

(b) Resident elopement, if the elopement places the resident at risk of harm or injury.

(3) Licensed facilities shall provide within 1 business day after the occurrence of an adverse incident~~, by electronic mail, facsimile, or United States mail,~~ a preliminary report to the agency on all adverse incidents specified under this section. The report must include information regarding the identity of the affected resident, the type of adverse incident, and the result ~~status~~ of the facility's investigation of the incident.

(4) Licensed facilities shall provide within 15 days~~, by electronic mail, facsimile, or United States mail,~~ a full report to the agency on all adverse incidents specified in this section. The report must include the results of the facility's investigation into the adverse incident.

(5) The agency shall send, by electronic mail, reminders to the facility's administrator and other specified facility contacts 3 business days before the deadline for the submission of the full report. If the facility determines that the event is not an adverse incident, the facility must withdraw the

preliminary report. Until 3 business days after the agency provides the reminder, facilities shall not be subject to any administrative or other action for failing to file a full report if the facility determined that the event was not an adverse incident after filing the preliminary report. ~~Each facility shall report monthly to the agency any liability claim filed against it. The report must include the name of the resident, the dates of the incident leading to the claim, if applicable, and the type of injury or violation of rights alleged to have occurred. This report is not discoverable in any civil or administrative action, except in such actions brought by the agency to enforce the provisions of this part.~~

Section 6. Subsection (4) of section 429.255, Florida Statutes, is amended to read:

429.255 Use of personnel; emergency care.—

(4) Facility staff may withhold or withdraw cardiopulmonary resuscitation or the use of an automated external defibrillator if presented with an order not to resuscitate executed pursuant to s. 401.45. The agency shall adopt rules providing for the implementation of such orders. Facility staff and facilities may not be subject to criminal prosecution or civil liability, nor be considered to have engaged in negligent or unprofessional conduct, for withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator pursuant to such an order and rules adopted by the agency. The absence of an order not to resuscitate executed pursuant to s. 401.45 does not preclude a physician from withholding or withdrawing cardiopulmonary resuscitation or use of an automated external defibrillator as otherwise permitted by law.

Section 7. Subsection (2), paragraph (b) of subsection (3), and paragraphs (e), (f), and (g) of subsection (4) of section 429.256, Florida Statutes, are amended to read:

429.256 Assistance with self-administration of medication.—

(2) Residents who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

(3) Assistance with self-administration of medication includes:

(b) In the presence of the resident, confirming that the medication is intended for that resident, orally advising the resident of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(4) Assistance with self-administration does not include:

(e) The use of irrigations or debriding agents used in the

treatment of a skin condition.

(f) Assisting with rectal, urethral, or vaginal preparations.

(g) Assisting with medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the unlicensed person, and ~~at~~ the ~~request of a competent~~ resident requesting the medication is aware of his or her need for the medication and understands the purpose for taking the medication.

Section 8. Section 429.26, Florida Statutes, is amended to read:

429.26 Appropriateness of placements; examinations of residents.—

(1) The owner or administrator of a facility is responsible for determining the appropriateness of admission of an individual to the facility and for determining the continued appropriateness of residence of an individual in the facility. A determination must ~~shall~~ be based upon an evaluation ~~assessment~~ of the strengths, needs, and preferences of the resident, a medical examination, the care and services offered or arranged for by the facility in accordance with facility policy, and any limitations in law or rule related to admission criteria or continued residency for the type of license held by the facility under this part. The following criteria apply to the determination of appropriateness for admission and continued residency of an individual in a facility:

(a) A facility may admit or retain a resident who receives

a health care service or treatment that is designed to be provided within a private residential setting if all requirements for providing that service or treatment are met by the facility or a third party.

(b) A facility may admit or retain a resident who requires the use of assistive devices.

(c) A facility may admit or retain an individual receiving hospice services if the arrangement is agreed to by the facility and the resident, additional care is provided by a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident can be met at the facility. The resident must have a plan of care which delineates how the facility and the hospice will meet the scheduled and unscheduled needs of the resident.

(d)1. Except for a resident who is receiving hospice services as provided in paragraph (c), a facility may not admit or retain a resident who is bedridden or who requires 24-hour nursing supervision. For purposes of this paragraph, the term "bedridden" means that a resident is confined to a bed because of the inability to:

a. Move, turn, or reposition without total physical assistance;

b. Transfer to a chair or wheelchair without total physical assistance; or

c. Sit safely in a chair or wheelchair without personal assistance or a physical restraint.

2. A resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 7 consecutive days.

3. If a facility is licensed to provide extended congregate care, a resident may continue to reside in a facility if, during residency, he or she is bedridden for no more than 14 consecutive days.

(2) A resident may not be moved from one facility to another without consultation with and agreement from the resident or, if applicable, the resident's representative or designee or the resident's family, guardian, surrogate, or attorney in fact. In the case of a resident who has been placed by the department or the Department of Children and Families, the administrator must notify the appropriate contact person in the applicable department.

(3) ~~(2)~~ A physician, physician assistant, or advanced practice registered nurse ~~practitioner~~ who is employed by an assisted living facility to provide an initial examination for admission purposes may not have financial interests ~~interest~~ in the facility.

(4) ~~(3)~~ Persons licensed under part I of chapter 464 who are employed by or under contract with a facility shall, on a routine basis or at least monthly, perform a nursing assessment of the residents for whom they are providing nursing services ordered by a physician, except administration of medication, and shall document such assessment, including any substantial changes in a resident's status which may necessitate relocation to a nursing home, hospital, or specialized health care facility. Such records shall be maintained in the facility for inspection by the agency and shall be forwarded to the resident's case manager, if applicable.

(5) ~~(4)~~ ~~If possible,~~ Each resident must ~~shall~~ have been

examined by a licensed physician, a licensed physician assistant, or a licensed advanced practice registered nurse ~~practitioner~~ within 60 days before admission to the facility or within 30 days after admission to the facility, except as provided in s. 429.07. The information from the medical examination must be recorded on the practitioner's form or on a form adopted by agency rule. The ~~signed and completed~~ medical examination form, signed by the practitioner, must ~~report shall~~ be submitted to the owner or administrator of the facility, who shall use the information contained therein to assist in the determination of the appropriateness of the resident's admission to or ~~and~~ continued residency ~~stay~~ in the facility. The medical examination form may be used only to record the health care provider's direct observation of the patient at the time of examination and must include any known medical history. The medical examination form is not a guarantee of admission, continued residency, or the delivery of services and may be used only as an informative tool to assist in the determination of the appropriateness of the resident's admission to or continued residency in the facility. The medical examination form, reflecting the resident's condition on the date the examination is performed, becomes ~~report shall become~~ a permanent part of the facility's record of the resident ~~at the facility~~ and must ~~shall~~ be made available to the agency during inspection or upon request. An assessment that has been completed through the Comprehensive Assessment and Review for Long-Term Care Services (CARES) Program fulfills the requirements for a medical examination under this subsection and s. 429.07(3)(b)6.

(6) The medical examination form submitted under subsection

(5) must include the following information relating to the resident:

(a) Height, weight, and known allergies.

(b) Significant medical history and diagnoses.

(c) Physical or sensory limitations, including the need for fall precautions or recommended use of assistive devices.

(d) Cognitive or behavioral status and a brief description of any behavioral issues known or ascertained by the examining practitioner, including any known history of wandering or elopement.

(e) Nursing, treatment, or therapy service requirements.

(f) Whether assistance is needed for ambulating, eating, or transferring.

(g) Special dietary instructions.

(h) Whether he or she has any communicable diseases, including necessary precautions.

(i) Whether he or she is bedridden and the status of any pressure sores that he or she has.

(j) Whether the resident needs 24-hour nursing supervision or psychiatric care.

(k) A list of current prescribed medications as known or ascertained by the examining practitioner and whether the resident can self-administer medications, needs assistance, or needs medication administration.

~~(5) Except as provided in s. 429.07, if a medical examination has not been completed within 60 days before the admission of the resident to the facility, a licensed physician, licensed physician assistant, or licensed nurse practitioner shall examine the resident and complete a medical examination~~

~~form provided by the agency within 30 days following the admission to the facility to enable the facility owner or administrator to determine the appropriateness of the admission. The medical examination form shall become a permanent part of the record of the resident at the facility and shall be made available to the agency during inspection by the agency or upon request.~~

(7)~~(6)~~ Any resident accepted in a facility and placed by ~~the department or~~ the Department of Children and Families must ~~shall~~ have been examined by medical personnel within 30 days before placement in the facility. The examination must ~~shall~~ include an assessment of the appropriateness of placement in a facility. The findings of this examination must ~~shall~~ be recorded on the examination form provided by the agency. The completed form must ~~shall~~ accompany the resident and ~~shall~~ be submitted to the facility owner or administrator. Additionally, in the case of a mental health resident, the Department of Children and Families must provide documentation that the individual has been assessed by a psychiatrist, clinical psychologist, clinical social worker, or psychiatric nurse, or an individual who is supervised by one of these professionals, and determined to be appropriate to reside in an assisted living facility. The documentation must be in the facility within 30 days after the mental health resident has been admitted to the facility. An evaluation completed upon discharge from a state mental hospital meets the requirements of this subsection related to appropriateness for placement as a mental health resident provided that ~~providing~~ it was completed within 90 days prior to admission to the facility. The ~~applicable~~ Department of

Children and Families shall provide to the facility administrator any information about the resident which ~~that~~ would help the administrator meet his or her responsibilities under subsection (1). Further, Department of Children and Families personnel shall explain to the facility operator any special needs of the resident and advise the operator whom to call should problems arise. The ~~applicable~~ Department of Children and Families shall advise and assist the facility administrator when ~~where~~ the special needs of residents who are recipients of optional state supplementation require such assistance.

(8) ~~(7)~~ The facility shall ~~must~~ notify a licensed physician when a resident exhibits signs of dementia or cognitive impairment or has a change of condition in order to rule out the presence of an underlying physiological condition that may be contributing to such dementia or impairment. The notification must occur within 30 days after the acknowledgment of such signs by facility staff. If an underlying condition is determined to exist, the facility must notify the resident's representative or designee of the need for health care services and must assist in making appointments for ~~shall arrange, with the appropriate health care provider,~~ the necessary care and services to treat the condition. If the resident does not have a representative or designee or if the resident's representative or designee cannot be located or is unresponsive, the facility shall arrange, with the appropriate health care provider, the necessary care and services to treat the condition.

(9) ~~(8)~~ The Department of Children and Families may require an examination for supplemental security income and optional

state supplementation recipients residing in facilities at any time and shall provide the examination whenever a resident's condition requires it. Any facility administrator; personnel of the agency, the department, or the Department of Children and Families; or a representative of the State Long-Term Care Ombudsman Program who believes a resident needs to be evaluated shall notify the resident's case manager, who shall take appropriate action. A report of the examination findings must ~~shall~~ be provided to the resident's case manager and the facility administrator to help the administrator meet his or her responsibilities under subsection (1).

~~(9) A terminally ill resident who no longer meets the criteria for continued residency may remain in the facility if the arrangement is mutually agreeable to the resident and the facility; additional care is rendered through a licensed hospice, and the resident is under the care of a physician who agrees that the physical needs of the resident are being met.~~

(10) Facilities licensed to provide extended congregate care services shall promote aging in place by determining appropriateness of continued residency based on a comprehensive review of the resident's physical and functional status; the ability of the facility, family members, friends, or any other pertinent individuals or agencies to provide the care and services required; and documentation that a written service plan consistent with facility policy has been developed and implemented to ensure that the resident's needs and preferences are addressed.

~~(11) No resident who requires 24-hour nursing supervision, except for a resident who is an enrolled hospice patient~~

~~pursuant to part IV of chapter 400, shall be retained in a facility licensed under this part.~~

Section 9. Paragraphs (a) and (k) of subsection (1) and subsection (3) of section 429.28, Florida Statutes, are amended to read:

429.28 Resident bill of rights.—

(1) No resident of a facility shall be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the Constitution of the State of Florida, or the Constitution of the United States as a resident of a facility. Every resident of a facility shall have the right to:

(a) Live in a safe and decent living environment, free from abuse, ~~and~~ neglect, and exploitation.

(k) At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care or the resident engages in a pattern of conduct that is harmful or offensive to other residents. In the case of a resident who has been adjudicated mentally incapacitated, the guardian shall be given at least 45 days' notice of a nonemergency relocation or residency termination. Reasons for relocation must ~~shall~~ be set forth in writing and provided to the resident or the resident's legal representative. In order for a facility to terminate the residency of an individual without notice as provided herein, the facility shall show good cause in a court of competent jurisdiction.

(3)(a) The agency shall conduct a survey to determine whether the facility is complying with this section ~~general~~

~~compliance with facility standards and compliance with residents' rights~~ as a prerequisite to initial licensure or licensure renewal. ~~The agency shall adopt rules for uniform standards and criteria that will be used to determine compliance with facility standards and compliance with residents' rights.~~

(b) In order to determine whether the facility is adequately protecting residents' rights, the licensure renewal ~~biennial~~ survey must ~~shall~~ include private informal conversations with a sample of residents and consultation with the ombudsman council in the district in which the facility is located to discuss residents' experiences within the facility.

Section 10. Section 429.41, Florida Statutes, is amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also promote ~~ensure~~ a safe and sanitary environment that is residential and noninstitutional in design or nature and may allow for technological advances in the provision of care, safety, and security, including the use of devices, equipment, and other security measures related to wander management, emergency response, staff risk management, and the general safety and security of residents, staff, and the facility. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. ~~Uniform firesafety standards for assisted~~

~~living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency may adopt rules to administer part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents,~~ The agency, in consultation with the Department of Children and Families and the Department of Health, shall adopt rules~~, policies, and procedures~~ to administer this part, which must include reasonable and fair minimum standards in relation to:

(a) The requirements for ~~and~~ maintenance and the sanitary condition of facilities, not in conflict with, or duplicative of, rules adopted pursuant to s. 381.006(16) and s. 381.0072 and standards established under chapter 553 and s. 633.206, relating to a safe and decent living environment, including furnishings for resident bedrooms or sleeping areas, locking devices, linens ~~plumbing, heating, cooling, lighting, ventilation, living space~~, and other housing conditions relating to hazards, which will promote ~~ensure~~ the health, safety, and welfare ~~comfort~~ of residents suitable to the size of the structure. The rules must clearly delineate the respective responsibilities of the agency's licensure and survey staff and the county health departments and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by county health departments and may transfer such fees to the Department of Health.

~~1. Firesafety evacuation capability determination.—An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.~~

~~2. Firesafety requirements.—~~

~~a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.~~

~~b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.~~

~~c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.~~

~~d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all~~

~~aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.~~

~~3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills, which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.~~

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the agency after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan is subject to review and approval by the county ~~local~~ emergency management agency. During its review, the county ~~local~~ emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. ~~Also, appropriate volunteer organizations must be given the opportunity to review~~

~~the plan.~~ The county ~~local~~ emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions. A facility must submit a comprehensive emergency management plan to the county emergency management agency within 30 days after issuance of a license.

(c) The number, training, and qualifications of all personnel having responsibility for the care of residents. The rules must require adequate staff to provide for the safety of all residents. Facilities licensed for 17 or more residents are required to maintain an alert staff for 24 hours per day.

~~(d) All sanitary conditions within the facility and its surroundings which will ensure the health and comfort of residents. The rules must clearly delineate the responsibilities of the agency's licensure and survey staff, the county health departments, and the local authority having jurisdiction over firesafety and ensure that inspections are not duplicative. The agency may collect fees for food service inspections conducted by the county health departments and transfer such fees to the Department of Health.~~

(d) ~~(c)~~ License application and license renewal, transfer of ownership, proper management of resident funds and personal property, surety bonds, resident contracts, refund policies, financial ability to operate, and facility and staff records.

(e) ~~(f)~~ Inspections, complaint investigations, moratoriums, classification of deficiencies, ~~levying~~ and enforcement of penalties~~, and use of income from fees and fines~~.

(f) ~~(g)~~ The enforcement of the resident bill of rights specified in s. 429.28.

(g) ~~(h)~~ The care ~~and maintenance~~ of residents provided by the facility, which must include~~, but is not limited to~~:

1. The supervision of residents;

2. The provision of personal services;

3. The provision of, or arrangement for, social and leisure activities;

4. The assistance in making arrangements ~~arrangement~~ for appointments and transportation to appropriate medical, dental, nursing, or mental health services, as needed by residents;

5. The management of medication stored within the facility and as needed by residents;

6. The dietary ~~nutritional~~ needs of residents;

7. Resident records; and

8. Internal risk management and quality assurance.

(h) ~~(i)~~ Facilities holding a limited nursing, extended congregate care, or limited mental health license.

(i) ~~(j)~~ The establishment of specific criteria to define appropriateness of resident admission and continued residency in a facility holding a standard, limited nursing, extended congregate care, and limited mental health license.

(j) ~~(k)~~ The use of physical or chemical restraints. The use of geriatric chairs or Posey restraints is prohibited. Other physical restraints may be used in accordance with agency rules when ordered ~~is limited to half-bed rails as prescribed and documented~~ by the resident's physician and consented to by ~~with the consent of~~ the resident or, if applicable, the resident's representative or designee or the resident's surrogate, guardian, or attorney in fact. Such rules must specify requirements for care planning, staff monitoring, and periodic

review by a physician. The use of chemical restraints is limited to prescribed dosages of medications authorized by the resident's physician and must be consistent with the resident's diagnosis. Residents who are receiving medications that can serve as chemical restraints must be evaluated by their physician at least annually to assess:

1. The continued need for the medication.

2. The level of the medication in the resident's blood.

3. The need for adjustments in the prescription.

(k) ~~(l)~~ The establishment of specific resident elopement drill requirements, policies, and procedures ~~on resident elopement~~. Facilities shall conduct a minimum of two resident elopement drills each year. All administrators and direct care staff shall participate in the drills, which must include a review of the facility's procedures to address resident elopement. Facilities shall document participation in the drills.

(2) In adopting any rules pursuant to this part, the agency shall make distinct standards for facilities based upon facility size; the types of care provided; the physical and mental capabilities and needs of residents; the type, frequency, and amount of services and care offered; and the staffing characteristics of the facility. Rules developed pursuant to this section may not restrict the use of shared staffing and shared programming in facilities that are part of retirement communities that provide multiple levels of care and otherwise meet the requirements of law and rule. If a continuing care facility licensed under chapter 651 or a retirement community offering multiple levels of care licenses a building or part of

a building designated for independent living for assisted living, staffing requirements established in rule apply only to residents who receive personal, limited nursing, or extended congregate care services under this part. Such facilities shall retain a log listing the names and unit number for residents receiving these services. The log must be available to surveyors upon request. ~~Except for uniform firesafety standards,~~ The agency shall adopt by rule separate and distinct standards for facilities with 16 or fewer beds and for facilities with 17 or more beds. The standards for facilities with 16 or fewer beds must be appropriate for a noninstitutional residential environment; however, the structure may not be more than two stories in height and all persons who cannot exit the facility unassisted in an emergency must reside on the first floor. The agency may make other distinctions among types of facilities as necessary to enforce this part. Where appropriate, the agency shall offer alternate solutions for complying with established standards, based on distinctions made by the agency relative to the physical characteristics of facilities and the types of care offered.

(3) Rules adopted by the agency shall encourage the development of homelike facilities that promote the dignity, individuality, personal strengths, and decisionmaking ability of residents.

(4) The agency may waive rules adopted under this part to demonstrate and evaluate innovative or cost-effective congregate care alternatives that enable individuals to age in place. Such waivers may be granted only in instances where there is reasonable assurance that the health, safety, or welfare of

residents will not be endangered. To apply for a waiver, the licensee shall submit to the agency a written description of the concept to be demonstrated, including goals, objectives, and anticipated benefits; the number and types of residents who will be affected, if applicable; a brief description of how the demonstration will be evaluated; and any other information deemed appropriate by the agency. Any facility granted a waiver shall submit a report of findings to the agency within 12 months. At such time, the agency may renew or revoke the waiver or pursue any regulatory or statutory changes necessary to allow other facilities to adopt the same practices. The agency may by rule clarify terms and establish waiver application procedures, criteria for reviewing waiver proposals, and procedures for reporting findings, as necessary to implement this subsection.

(5) The agency may use an abbreviated biennial standard licensure inspection that consists of a review of key quality-of-care standards in lieu of a full inspection in a facility that has a good record of past performance. However, a full inspection must be conducted in a facility that has a history of class I or class II violations; ~~,~~ uncorrected class III violations; or a class I, class II, or uncorrected class III violation resulting from a complaint referred by the State Long-Term Care Ombudsman Program~~, confirmed ombudsman council complaints, or confirmed licensure complaints~~ within the previous licensure period immediately preceding the inspection or if a potentially serious problem is identified during the abbreviated inspection. The agency shall adopt by rule ~~develop~~ the key quality-of-care standards ~~with input from the State Long-Term Care Ombudsman Council and representatives of provider~~

~~groups for incorporation into its rules~~.

Section 11. Section 429.435, Florida Statutes, is created to read:

429.435 Uniform firesafety standards.—Uniform firesafety standards for assisted living facilities, which are residential board and care occupancies, shall be established by the State Fire Marshal pursuant to s. 633.206.

(1) EVACUATION CAPABILITY.—A firesafety evacuation capability determination shall be conducted within 6 months after the date of initial licensure of an assisted living facility, if required.

(2) FIRESAFETY REQUIREMENTS.—

(a) The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, must be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

(b) A local government or a utility may charge fees that do not exceed the actual costs incurred by the local government or the utility for the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.

(c) All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

(d) An assisted living facility that was issued a building permit or certificate of occupancy before July 1, 2016, at its option and after notifying the authority having jurisdiction, may remain under the provisions of the 1994 and 1995 editions of

the National Fire Protection Association, Life Safety Code, NFPA 101 and 101A. A facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy was issued before July 1, 2016, which undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or which seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code, shall thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206 and the Florida Fire Prevention Code in effect for assisted living facilities as adopted by the State Fire Marshal.

Section 12. Section 429.52, Florida Statutes, is amended to read:

429.52 Staff training and educational requirements ~~programs; core educational requirement~~.—

(1) ~~Effective October 1, 2015,~~ Each new assisted living facility employee who has not previously completed core training must attend a preservice orientation provided by the facility before interacting with residents. The preservice orientation must be at least 2 hours in duration and cover topics that help the employee provide responsible care and respond to the needs of facility residents. Upon completion, the employee and the administrator of the facility must sign a statement that the employee completed the required preservice orientation. The facility must keep the signed statement in the employee's

personnel record.

(2) Administrators and other assisted living facility staff must meet minimum training and education requirements established by the agency by rule. This training and education is intended to assist facilities to appropriately respond to the needs of residents, to maintain resident care and facility standards, and to meet licensure requirements.

(3) The agency, in conjunction with providers, shall develop core training requirements for administrators consisting of core training learning objectives, a competency test, and a minimum required score to indicate successful passage ~~completion~~ of the core competency test ~~training and educational requirements~~. The required core competency test ~~training and education~~ must cover at least the following topics:

(a) State law and rules relating to assisted living facilities.

(b) Resident rights and identifying and reporting abuse, neglect, and exploitation.

(c) Special needs of elderly persons, persons with mental illness, and persons with developmental disabilities and how to meet those needs.

(d) Nutrition and food service, including acceptable sanitation practices for preparing, storing, and serving food.

(e) Medication management, recordkeeping, and proper techniques for assisting residents with self-administered medication.

(f) Firesafety requirements, including fire evacuation drill procedures and other emergency procedures.

(g) Care of persons with Alzheimer's disease and related

disorders.

(4) A ~~new~~ facility administrator must complete the required core training ~~and education~~, including the competency test, within 90 days after the date of employment as an administrator. Failure to do so is a violation of this part and subjects the violator to an administrative fine as prescribed in s. 429.19. Administrators licensed in accordance with part II of chapter 468 are exempt from this requirement. Other licensed professionals may be exempted, as determined by the agency by rule.

(5) Administrators are required to participate in continuing education for a minimum of 12 contact hours every 2 years.

(6) Staff ~~involved with the management of medications and~~ assisting with the self-administration of medications under s. 429.256 must complete a minimum of 6 additional hours of training provided by a registered nurse or~~,~~ a licensed pharmacist before providing assistance~~, or agency staff~~. Two hours of continuing education are required annually thereafter. The agency shall establish by rule the minimum requirements of this additional training.

(7) ~~Other~~ Facility staff shall participate in in-service training relevant to their job duties as specified by agency rule ~~of the agency~~. Topics covered during the preservice orientation are not required to be repeated during in-service training. A single certificate of completion that covers all required in-service training topics may be issued to a participating staff member if the training is provided in a single training course.

(8) If the agency determines that there are problems in a facility which could be reduced through specific staff training ~~or education~~ beyond that already required under this section, the agency may require~~,~~ and provide, or cause to be provided, the training ~~or education~~ of any personal care staff in the facility.

(9) The agency shall adopt rules related to these training and education requirements, the competency test, necessary procedures, and competency test fees and shall adopt or contract with another entity to develop and administer the competency test. The agency shall adopt a curriculum outline with learning objectives to be used by core trainers~~, which shall be used~~ as the minimum core training content requirements. The agency shall consult with representatives of stakeholder associations and agencies in the development of the curriculum outline.

(10) The core training required by this section ~~other than the preservice orientation~~ must be conducted by persons registered with the agency as having the requisite experience and credentials to conduct the training. A person seeking to register as a core trainer must provide the agency with proof of completion of the ~~minimum~~ core training ~~education~~ requirements, successful passage of the competency test established under this section, and proof of compliance with the continuing education requirement in subsection (5).

(11) A person seeking to register as a core trainer also must ~~also~~:

(a) Provide proof of completion of a 4-year degree from an accredited college or university and must have worked in a management position in an assisted living facility for 3 years

after being core certified;

(b) Have worked in a management position in an assisted living facility for 5 years after being core certified and have 1 year of teaching experience as an educator or staff trainer for persons who work in assisted living facilities or other long-term care settings;

(c) Have been previously employed as a core trainer for the agency or department; or

(d) Meet other qualification criteria as defined in rule, which the agency is authorized to adopt.

(12) The agency shall adopt rules to establish core trainer registration and removal requirements.

Section 13. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GAYLE HARRELL
25th District

January 17, 2020

Senator Aaron Bean
Senate Subcommittee on Health and Human Services
201 Capitol
404 S. Monroe Street
Tallahassee, FL 32399-1100

Chair Bean,

I respectfully request that SB 402 relating to Assisted Living Facilities be placed on the next available agenda for the Senate Subcommittee on Health and Human Services.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-18-20
Meeting Date

402
Bill Number (if applicable)

884902
Amendment Barcode (if applicable)

Topic SB 402 - Assisted Living Facilities

Name Jason Hand

Job Title VP Public Policy Florida Senior Living Association

Address 2292 Wednesday Street, Suite 1
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Tallahassee FL 32308
City *State* *Zip*

Phone 850-443-0024

Email jhand@floridaseniorliving.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Senior Living 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)

2/10/20
Meeting Date

402
Bill Number (if applicable)

Topic Assisted Living Facility

Amendment Barcode (if applicable)

Name Cynthia Henderson

Job Title

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing Atria Senior Living

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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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)

2/18/2020
Meeting Date

SB 402
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

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Email zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

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.

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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)

2/18/20
Meeting Date

SB 402
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing Leading Age Florida

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.

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2-18-20
Meeting Date

402
Bill Number (if applicable)

Topic SB 402 - Assisted Living Facilities

Amendment Barcode (if applicable)

Name Jason Hand

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Tallahassee FL 32308
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Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Senior Living 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.

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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)

2-18-20
Meeting Date

402
Bill Number (if applicable)

Topic Assisted Living Facilities

Amendment Barcode (if applicable)

Name Melanie Bostick

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Assisted Living 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

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 744
INTRODUCER:	Health Policy Committee; and Senators Hooper and Gruters
SUBJECT:	Podiatric Medicine
DATE:	February 17, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	Howard	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 744 provides that a supervising allopathic or osteopathic physician of a physician assistant (PA) may authorize a licensed PA to perform services under the direction of a podiatric physician who is a partner, a shareholder, or an employee of the same group practice as the supervising physician and the PA. The supervising physician is liable for the performance, the acts, and omissions of the PA. The bill authorizes:

- A PA to perform services under the direction of a licensed podiatric physician;
- A podiatric physician to supervise a medical assistant;
- The Board of Podiatric Medicine (BPM) to make rules regarding a podiatric physician's continuing education for license renewal and to approve course and program criteria, including two hours related to safe and effective prescribing of controlled substances; and
- Authorizes individuals to directly contract with podiatric physicians through direct health care agreements, for the provision of health care services.

The bill has an insignificant fiscal impact on the Department of Health that can be absorbed within existing resources.

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

II. Present Situation:

The Department of Health

The Legislature created the Department of Health (department) to protect and promote the health of all residents and visitors in the state.[1] The department is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[2] and professions within the department.[3]

Podiatric Medicine

Podiatric medicine is the diagnosis or medical, surgical, palliative, and mechanical treatment of ailments of the human foot or leg.[4] It also includes the amputation of the toes or other parts of the foot but does not include the amputation of the entire foot or leg. A podiatric physician is authorized to prescribe drugs specifically related to his or her scope of practice.[5]

The BPM was established to ensure that every podiatric physician practicing in this state meets minimum requirements for safe practice. The BPM, through efficient and dedicated organization, licenses, monitors, disciplines, educates, and when appropriate, rehabilitates practitioners to assure their competence in the service of the people of Florida.

Licensure Requirements

Florida law requires a podiatric physician to meet the following requirements for licensure:[6]

- Be at least 18 years of age;
- Has received a degree from a school or college of podiatric medicine or chiropody recognized and approved by the Council on Podiatry Education of the American Podiatric Medical Association;
- Have successfully completed one of the following clinical experience requirements:
  - One year of residency in a program approved by the BPM;[7] or
  - Ten years of continuous, active licensed practice of podiatric medicine in another state immediately preceding application and completion of at least the same continuing education requirements during those 10 years as are required of podiatric physicians licensed in this state;
- Successfully complete a background screening; and

[1] Section 20.43, F.S.
[2] Under s. 456.001(1), F.S., the term "board" is defined as any board or commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the department or, in some cases, within the department, MQA.
[3] Section 20.43, F.S.
[4] Section 461.003(5), F.S.
[5] Id.
[6] Section 461.006, F.S.
[7] Id. If it has been four or more years since the completion of the residency, an applicant must have two years of active, licensed practice of podiatric medicine in another jurisdiction in the four years immediately preceding application or successfully complete a board-approved postgraduate program or board-approved course within the year preceding application.

- Obtain passing scores on the national examinations administered by the National Board of Podiatric Medical Examiners.[8]

A license to practice podiatric medicine must be renewed biennially.

Continuing Education

A podiatric physician must complete 40 hours of continuing education as a part of the biennial licensure renewal, which must include:[9]

- One hour on risk management;
- One hour on the laws and rules related to podiatric medicine;
- Two hours on the prevention of medical errors;
- Two hours on HIV/AIDS (due for the first renewal only); and
- One hour on human trafficking (beginning January 1, 2021).[10]

Controlled Substance Prescribers

Effective July 1, 2018, every person registered with the U.S. Drug Enforcement Administration and authorized to prescribe controlled substances, must complete a two-hour continuing education course on prescribing controlled substances.[11] The course must include:

- Information on the current standards for prescribing controlled substances, particularly opiates;
- Alternatives to these standards;
- Non-pharmacological therapies;
- Prescribing emergency opioid antagonists; and
- The risks of opioid addiction following all stages of treatment in the management of acute pain.

The course can only be offered by a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A medical continuing education on the safe and effective prescribing of controlled substances each biennial license renewal.[12] Currently the course is provided for podiatric physicians by:[13]

- The Florida Medical Association;
- The Florida Osteopathic Medical Association;
- InforMed;
- Emergency Medicine Learning and Resource Center; and
- Florida Academy of Family Physicians.

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[8] Fla. Adm. Code R. 64B18-11.002,(2019).
[9] Section 461.007(3), F.S., and Fla. Adm. Code R. 64B18-17, (2019).
[10] Section 456.0341, F.S.
[11] Section 456.0301, F.S.
[12] Id.
[13] Department of Health, *Take Control of Controlled Substances*, available at http://www.flhealthsource.gov/FloridaTakeControl/ (last visited Jan. 30, 2020). To access the podiatric list of providers, select Podiatric Medicine.

This requirement does not apply to a licensee who is required by his or her applicable practice act to complete a minimum of two hours of continuing education on the safe and effective prescribing of controlled substances.[14] The requirement applies to podiatric physicians because their practice act does not specifically require two hours of continuing education on the safe and effective prescribing of controlled substances.

Physician Assistants (PAs)

Physician assistants (PAs) are regulated by the Board of Medicine (BOM) in conjunction with the Florida Council on Physician Assistants (PA Council) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (BOOM) for PAs licensed under ch. 459, F.S. The boards and PA Council are responsible for adopting the principles that a supervising physician must use for developing a PA's scope of practice, developing a formulary of drugs that may not be prescribed by a PA, and approving educational programs.[15]

Council on Physician Assistants

The PA Council consists of five members, including three physicians who are members of the BOM, one physician who is a member of the BOOM, and one licensed PA appointed by the Surgeon General.[16] Two of the physicians must be physicians who supervise physician assistants in their practice. The PA Council is responsible for:[17]

- Making recommendations to the department regarding the licensure of PAs;
- Developing rules for the regulation of PAs for consideration for adoption by the boards;
- Making recommendations to the boards regarding all matters relating to PAs;
- Addressing concerns and problems of practicing PAs to ensure patient safety; and
- Denying, restricting, or placing conditions on the license of a PA who fails to meet the licensing requirements.

Licensure and Regulation of PAs

An applicant for a PA license must apply to the department. The department must issue a license to a person certified by the PA Council as having met all of the following requirements:[18]

- Completed an approved PA training program;
- Obtained a passing score on the National Commission on Certification of Physician Assistants examination;
- Acknowledged any prior felony convictions;
- Submitted to a background screening and have no disqualifying offenses;[19]
- Acknowledged any previous revocation or denial of licensure in any state; and

[14] *Supra* note 11.
[15] Sections 458.347(4) and (6), F.S., and 459.022(4) and (6), F.S.
[16] Sections 458.347(9), F.S., and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307, F.S., and 459.004, F.S., respectively.
[17] Id.
[18] Sections 458.347(7), F.S., and 459.022(7), F.S.
[19] Section 456.0135, F.S.

- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle, a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.[20] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.[21]

PA Scope of Practice

PAs may practice only under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[22] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[23] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.[24]

The BOM and the BOOM have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate is dependent upon the:[25]

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[26] A supervising physician may delegate the authority for a PA to:

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[20] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[21] National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at https://www.nccpa.net/CertificationProcess (last visited Jan. 31, 2020).
[22] Sections 458.347(2)(f), and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[23] Fla. Adm. Code R. 64B8-30.012 and 64B15-6.010 (2019).
[24] Sections 458.347(15), F.S. and 459.022(15), F.S.
[25] Fla. Adm. Code R. 64B8-30.001 and 64B15-6.001 (2019).
[26] Id. "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication.

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the PA Council;[27]
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under chapter 395, F.S., or at a health care clinic or nursing homes licensed under ch. 400, F.S.;[28] and
- Any other service that is not expressly prohibited in chs. 458 and 459, F.S., or the rules adopted under each.[29]

Currently, podiatric physicians are not authorized to supervise or delegate tasks or procedures to PAs.

Medical Assistants

Section 458.3485, F.S., defines a "medical assistant" as a professional, multiskilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician. This practitioner:

- Assists with patient care management;
- Executes administrative and clinical procedures; and
- Often performs managerial and supervisory functions.

Competence in the field also requires that a medical assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.

A medical assistant performs his or her duties under the direct supervision and responsibility of a licensed physician. A medical assistant may:

- Perform clinical procedures, including:
  - Performing aseptic procedures;
  - Taking vital signs;
  - Preparing patients for the physician's care;
  - Performing venipunctures and nonintravenous injections; and
  - Observing and reporting patients' signs or symptoms;
- Administer basic first aid;
- Assist with patient examinations or treatments;
- Operate office medical equipment;
- Collect routine laboratory specimens as directed by the physician;
- Administer medication as directed by the physician;
- Perform basic laboratory procedures;

[27] Sections 458.347(4)(f) and 459.022(e), F.S., directs the Council to establish a formulary listing the medicinal drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008 and 64B15-6.0038, F.A.C., prohibits PAs from prescribing; general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a seven-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.

[28] Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.

[29] Sections 458.347(4) and 459.022(4), F.S.

- Perform office procedures, including all general administrative duties required by the physician; and
- Perform dialysis procedures, including home dialysis.

Medical assistants are not required to be licensed, certified, or registered to practice in Florida but may obtain the designation of a certified medical assistant. However, a medical assistant may obtain the designation of certified medical assistant if he or she receives a certification from a program accredited by the National Commission for Certifying Agencies, a national or state medical association, or an entity approved by the BOM.

Currently, podiatric physicians are not authorized to supervise or delegate tasks or procedures to medical assistants.

Direct Health Care Agreements

Section 624.27, F.S., authorizes the use of a direct health care agreements between a health care provider and a patient. A direct health care agreement is a contract between a health care provider and a patient, a patient's legal representative, or a patient's employer, which must:

- Be in writing;
- Be signed by the health care provider, or his or her agent, and the patient, the patient's legal representative, or the patient's employer;
- Allow either party to terminate the agreement by giving the other party at least 30 days' advance written notice;
- Allow immediate termination of the agreement for a violation of physician-patient relationship or a breach of the terms of the agreement;
- Describe the scope of health care services that are covered by the monthly fee;
- Specify the monthly fee and any fees for health care services not covered under the agreement;
- Specify the duration of the agreement and any automatic renewal provisions;
- Offer a refund to the patient of monthly fees paid in advance if the health care provider stops offering health care services for any reason;
- State that the agreement is not health insurance and that the health care provider will not bill the patient's health insurance policy or plan for reimbursement of any health care services covered under the agreement;
- State that the agreement does not qualify as minimum essential coverage to satisfy the individual shared responsibility provision of the federal Patient Protection and Affordable Care Act; and
- State that the agreement is not workers' compensation insurance and may not replace the employer's workers' compensation obligations.

A direct health care agreement is not considered health insurance and is exempt from the Florida Insurance Code, and the Office of Insurance Regulation does not have authority to regulate such agreements.[30]

[30] Section 624.27(2), F.S.

Currently, s. 624.27, F.S., pertains to direct health care agreement contracts with allopathic physicians, osteopathic physicians, chiropractic physicians, nurses, or dentists, or a health care group practice, for health care services that are within the competency and training of the health care provider. Direct health care agreement contracts with a podiatric physician for the provision of health care services are not contemplated under the statute.

III. Effect of Proposed Changes:

Podiatric Physician Direction of Physician Assistants and Medical Assistants

The bill amends the practice acts for allopathic and osteopathic physicians in ss. 458.347 and 459.022, F.S., respectively, to provide that a supervising allopathic or osteopathic physician may authorize a licensed PA to perform services under the direction of a licensed podiatric physician who is a partner, a shareholder, or an employee of the same group practice, as defined in s. 456.053(3), F.S., as the supervising physician and the PA. Under the bill, the supervising physician is liable for the performance, the acts, and omissions of the PA.

The bill amends s. 458.3485, F.S., to authorize podiatric physicians to supervise medical assistants.

The bill creates ss. 461.0145 and 461.0155, F.S., within the podiatric medicine practice act, to provide that:

- A licensed PA may perform services under the direction of a licensed podiatric physician; and
- A medical assistant may be supervised by a podiatric physician.

Direct Health Care Agreements

The bill amends s. 624.27, F.S., authorizing individuals to directly contract with podiatric physicians through direct health care agreements for the provision of health care services without such contracts being considered insurance. The bill retains the contract requirements under current law for other health care practitioners offering direct health care agreements and applies them to such contracts with podiatric physicians.

Continuing Education

The bill amends s. 461.007, F.S., to provide that the continuing education hours the Board of Podiatric Medicine (BPM) is authorized to require of podiatrists for licensure renewal must include a minimum of two hours of continuing education related to the safe and effective prescribing of controlled substances. The criteria for such continuing education courses must be approved by the BPM.

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

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 744 has an insignificant fiscal impact on the Department of Health (department) that can be absorbed within existing resources.[31] The department will experience a non-recurring increase in workload associated with the development of an application for physician assistants specific to the practice of podiatric medicine, or an update of present applications to support this specialized field, which current resources are adequate to absorb.

The department will incur an increase in workload associated with updating and maintenance of the Physician Assistant website, online renewals, online applications, etc., which current resources are adequate to absorb.

[31] Florida Department of Health Agency Analysis on SB 744 (December 6, 2019)(on file with the Senate Appropriations Subcommittee on Health and Human Services).

The department will update the Licensing and Enforcement Information Database System (LEIDS) licensure system to accommodate the new specialized license type for Physician Assistant, which current resources are adequate to absorb.

The department may experience a recurring increase in revenue related to additional applications for licensure. It is unknown if the addition of a specialized license type for physician assistants will result in an increase in license applications, initial licensure, and renewal fees; therefore, the fiscal impact cannot be calculated.

VI. Technical Deficiencies:

The bill defines "physician" in s. 458.4385, F.S., relating to medical assistants, as a person who is licensed as a physician under ch. 458 or as a podiatric physician under ch. 461, F.S. This definition excludes physicians licensed under ch. 459, F.S., and could be interpreted to specifically exclude osteopathic physicians from supervising medical assistants.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.347, 458.3485, 459.022, 461.007, and 624.27.

This bill creates the following sections of the Florida Statutes: 461.0145 and 461.0155.

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 4, 2020:
The CS:

- Deletes the authority in the underlying bill of a podiatric physician, or group of podiatric physicians, to supervise up to four PAs and delegate tasks to PAs in the same manner as supervising allopathic and osteopathic physicians;
- Deletes the underlying bill's provision for podiatric physicians' independent and collective liability for any errors or omissions by the PA;
- Permits a podiatric physician, who is a partner, a shareholder, or an employee of the same group practice as the PA and the supervising allopathic or osteopathic physician, to "direct," not "supervise," a PA in the group practice;
- Imposes liability for the performance, errors, or omissions of the PA, while being directed by the podiatric physician, on the supervising allopathic or osteopathic physician;
- Eliminates any expansion of the number of members on the Council of PAs; and
- Deletes the underlying bill's authority for the BPM to develop the following for PAs working in a podiatric practice:

- The scope of practice;
- The formulary of drugs that PAs may not prescribe; and
- PA educational programs.

B. Amendments:

None.

By the Committee on Health Policy; and Senators Hooper and Gruters

588-03100-20 2020744c1

A bill to be entitled

An act relating to podiatric medicine; amending ss. 458.347 and 459.022, F.S.; providing that a supervising physician may authorize a licensed physician assistant to perform services under the direction of a licensed podiatric physician under certain circumstances; specifying that the supervising physician is liable for the performance and the acts and omissions of such physician assistant; amending s. 458.3485, F.S.; defining the term "physician" to include podiatric physicians; amending s. 461.007, F.S.; authorizing the Board of Podiatric Medicine to require a specified number of continuing education hours related to the safe and effective prescribing of controlled substances as a condition for licensure renewal; creating s. 461.0145, F.S.; authorizing a licensed physician assistant to perform services under the direction of a licensed podiatric physician under certain circumstances; creating s. 461.0155, F.S.; providing for governance of podiatric physicians who are supervising medical assistants; amending s. 624.27, F.S.; revising the definition of the term "health care provider" to include podiatric physicians; providing an effective date.

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

Section 1. Paragraph (i) is added to subsection (4) of section 458.347, Florida Statutes, to read:

588-03100-20 2020744c1

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(i) A supervising physician may authorize a licensed physician assistant to perform services under the direction of a podiatric physician licensed under chapter 461 who is a partner, a shareholder, or an employee of the same group practice, as defined in s. 456.053(3), as the supervising physician and the physician assistant. The supervising physician is liable for the performance and the acts and omissions of such physician assistant.

Section 2. Subsection (1) of section 458.3485, Florida Statutes, is amended to read:

458.3485 Medical assistant.—

(1) DEFINITIONS ~~DEFINITION~~.—As used in this section:~~,~~

(a) "Medical assistant" means a professional multiskilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician. This practitioner assists with patient care management, executes administrative and clinical procedures, and often performs managerial and supervisory functions. Competence in the field also requires that a medical assistant adhere to ethical and legal standards of professional practice, recognize and respond to emergencies, and demonstrate professional characteristics.

(b) "Physician" means a person who is licensed as a physician under this chapter or as a podiatric physician under chapter 461.

Section 3. Paragraph (h) is added to subsection (4) of section 459.022, Florida Statutes, to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(h) A supervising physician may authorize a licensed physician assistant to perform services under the direction of a podiatric physician licensed under chapter 461 who is a partner, a shareholder, or an employee of the same group practice, as defined in s. 456.053(3), as the supervising physician and the physician assistant. The supervising physician is liable for the performance and the acts and omissions of such physician assistant.

Section 4. Subsection (3) of section 461.007, Florida Statutes, is amended to read:

461.007 Renewal of license.—

(3) The board may by rule prescribe continuing education, not to exceed 40 hours biennially, as a condition for renewal of a license, including at least 2 hours of continuing education related to the safe and effective prescribing of controlled substances. The criteria for such programs or courses shall be approved by the board.

Section 5. Section 461.0145, Florida Statutes, is created to read:

461.0145 Physician assistants.—A licensed physician assistant may perform services under the direction of a licensed podiatric physician in accordance with ss. 458.347(4) and 459.022(4).

Section 6. Section 461.0155, Florida Statutes, is created to read:

461.0155 Medical assistants.—A podiatric physician who is supervising a medical assistant is governed by s. 458.3485.

Section 7. Paragraph (b) of subsection (1) of section

624.27, Florida Statutes, is amended to read:

624.27 Direct health care agreements; exemption from code.—

(1) As used in this section, the term:

(b) "Health care provider" means a health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, or chapter 466, or a health care group practice, who provides health care services to patients.

Section 8. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

2/18/20 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 744

Meeting Date *Bill Number (if applicable)*

Topic Podiatric Medicine *Amendment Barcode (if applicable)*

Name Corinne Mixon

Job Title Lobbyist

Address 511 N. Adams Phone 766-5795

Street

Tallahassee FL 32301 Email corinne.mixon@gmail.com

City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information Waive Speaking: ☑ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Florida Academy of Physician Assistants

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)

2/18
Meeting Date

744
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Podiatry

Name Chris Hansen

Job Title Ballard Partners

Address 201 E. Park Ave., 5th Floor
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850/577-0444

Email Chansen@ballardpartners.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Podiatric Medical Assoc.

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/SB 916 (370180)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services and Senator Baxley
SUBJECT:	Program of All-Inclusive Care for the Elderly
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Kibbey	Brown	HP	**Favorable**
2.	Howard	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/SB 916 codifies the Program of All-Inclusive Care for the Elderly (PACE) in section 430.84, Florida Statutes. First authorized in 1998, the PACE became operational in Miami-Dade County in 2003 but has not been codified in state law. More than 2,000 Medicaid managed care eligible recipients are currently enrolled in PACE organizations in eight counties. The bill:

- Establishes a statutory process for the review, approval, and oversight of future and current PACE organizations.
- Authorizes the Agency for Health Care Administration (AHCA), in consultation with the Department of Elder Affairs (DOEA), to approve entities that have submitted the required application and data to the federal Centers for Medicare and Medicaid Services (CMS) as PACE organizations pursuant to federal regulations.
- Requires all PACE organizations to meet specific quality and performance standards established by the federal CMS.
- Provides that the AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations.
- Exempts all PACE organizations from the requirements of ch. 641, F.S., which regulates health maintenance organizations, prepaid health clinics, and other health care service programs.
- Provides that an approved PACE participant residing in a specific geographic area may transfer their PACE approval and assign their PACE contract to any other person meeting federal requirements. Such approved transfer must include the transfer of any funds the

Legislature appropriated to a PACE, and all future appropriations with respect to such PACEs must be made to the approved transferee.

The bill does not repeal or alter any law in effect on June 30, 2020, which authorized a geographic service area and initial enrollees for a prospective PACE organization.

The bill has no fiscal impact on state revenues or expenditures.

The bill is effective July 1, 2020.

II. Present Situation:

Program of All-Inclusive Care for the Elderly

The Program of All-Inclusive Care for the Elderly (PACE) is a capitated benefit model authorized by the federal Balanced Budget Act of 1997 (BBA)[1] that features a comprehensive service delivery system and integrated federal Medicare and state Medicaid financing mechanism. The model, which was tested through the federal Centers for Medicare and Medicaid Services (CMS) demonstration projects beginning in the mid-1980s,[2] was developed to address the needs of long-term care clients, providers, and payers.

The PACE operates as a three-way agreement between the federal government, the state administering agency, and a PACE organization. In Florida, the PACE is a Florida Medicaid long-term care managed care plan option providing comprehensive long-term and acute care services which support Medicaid and Medicare enrollees who would otherwise qualify for Medicaid nursing facility services.[3]

The PACE is a unique federal/state partnership. The BBA established the PACE model of care as a permanent entity within the Medicare program and enabled states to provide PACE services to Medicaid beneficiaries as an optional state plan service without a Medicaid waiver.

The federal government established the PACE organization requirements and application process; however, the state is responsible for oversight of the application process, which includes reviewing the initial application and providing an on-site readiness review before a PACE organization can be authorized to serve participants. An approved PACE organization must sign a contract with the federal CMS and the state Medicaid agency.

The PACE is administered by the Department of Elder Affairs (DOEA) in consultation with the Agency for Health Care Administration (AHCA). The DOEA oversees the contracted PACE

[1] Specifically, services under the PACE program are authorized under Section 1905(a)(26) of the Social Security Act.
[2] United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, *CMS Manual System: Pub. 100-11 Programs of All-Inclusive Care for the Elderly (PACE) Manual* (issued June 9, 2011), *available at* https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/pace111c01.pdf (last visited Jan. 14, 2020).
[3] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Jan. 14, 2020).

organizations but is not a party to the contract between the federal CMS, the AHCA, and the PACE organizations.[4] The DOEA, the AHCA, and the federal CMS must approve any applications for new PACE organizations if expansion is authorized by the Legislature through the necessary appropriation of the state matching funds.

A PACE organization must be part of either a city, county, state, or tribal government; a private not-for-profit 501(c)(3) organization; or for-profit entity that is primarily engaged in providing PACE services and must also:

- Have a governing board that includes participant representation;
- Be able to provide the complete service package regardless of frequency or duration of services;
- Have a physical site and staff to provide primary care, social services, restorative therapies, personal care and supportive services, nutritional counseling, recreational therapy, and meals;
- Have a defined service area;
- Have safeguards against conflicts of interest;
- Have a demonstrated fiscal soundness;
- Have a formal participant bill of rights; and
- Have a process to address grievances and appeals.[5]

Eligibility and Benefits

The PACE participants must be at least 55 years of age, live in the PACE center service area, meet eligibility requirements for nursing home care, pursuant to a Comprehensive Assessment and Review for Long-Term Care Services (CARES) pre-admission screening, and be able to live in a community setting without jeopardizing their health or safety. The PACE becomes the sole source of services for these Medicare and Medicaid eligible enrollees. Additionally, by electing to enroll in the PACE, the participant agrees to forgo other options for medical services and receive all of their services through the PACE organization.[6]

Under the PACE, an interdisciplinary team consisting of professional and paraprofessional staff assesses participants' needs, develops care plans, and delivers all services, including acute care and nursing facility services when necessary, which are integrated to provide a seamless delivery model. In most cases, a PACE organization provides social and medical services in a health center with supplemental services through in-home and referral services as necessary. The PACE service package must include all Medicare and Medicaid covered services and other services determined necessary by the multidisciplinary team for the care of the PACE participant.[7]

Before being approved to operate and deliver services, PACE organizations are required to provide evidence of the necessary financial capital to deliver the benefits and services, which include a combined adult day care center and primary care clinic, transportation, and full range of clinical and support staff with the interdisciplinary team of professionals.[8]

[4] *Id.*
[5] *Supra* note 2.
[6] *Id.*
[7] *Id.*
[8] *Supra* note 3, at 4.

By federal law, the first three contract years for a PACE organization are considered a trial period, and the PACE organization is subject to annual reviews to ensure compliance.[9] The site visit reviews include:

- A comprehensive assessment of an organization's fiscal soundness;
- A comprehensive assessment of the organization's capacity to provide all PACE services to all enrolled participants;
- A detailed analysis of the PACE organization's substantial compliance with all the federal statutory requirements and accompanying federal regulations; and
- Compliance with any other elements the Secretary of the U.S. Department of Health and Human Services (Secretary) or the state's administering agency considers necessary and appropriate.[10]

Review of the PACE organization may continue after the trial period by the Secretary or the administering state agency as appropriate, depending upon the PACE organization's performance and compliance with requirements and regulations.

No deductibles, copayments, coinsurance, or other cost-sharing can be charged by a PACE organization. No other limits relating to amount, duration, or scope of services that might otherwise apply in Medicaid are permitted.[11] The PACE enrollee must accept the PACE center physician as his or her new Medicare primary care physician, if enrolled in Medicare.[12]

Quality of Care Requirements

Each PACE organization is required to develop, implement, maintain, and evaluate an effective data-driven Quality Assurance and Performance Improvement (QAPI) program. The program must incorporate all aspects of the PACE organization's operations, which allows for the identification of areas that need performance improvement. The organization's written QAPI plan must be reviewed by the PACE organization's governing body at least annually. At a minimum, the plan should address the following areas:

- Utilization of services in the PACE organization, especially in key services;
- Participant and caregiver satisfaction with services;
- Data collected during patient assessments to determine if individual and organizational-level outcomes were achieved within a specified time period;
- Effectiveness and safety of direct and contracted services delivered to participants; and
- Outcomes in the organization's non-clinical areas.[13]

[9] *See* 42 U.S.C. s. 1395eee(e)(4)(A)(2020).
[10] *Id.*
[11] *Supra* note 2.
[12] Department of Elder Affairs and Agency for Health Care Administration, *Program of All-Inclusive Care for the Elderly and Statewide Medicaid Managed Care Long-term Care Program Comparison Report* (January 14, 2014), *available at* https://ahca.myflorida.com/Medicaid/recent_presentations/PACE_Evaluation_2014.pdf (last visited Jan. 14, 2020).
[13] *Id.*

Florida PACE

The Florida PACE project was initially authorized in ch. 98-327, Laws of Florida, under the administration of the DOEA operating in consultation with the AHCA.[14] Florida's first PACE organization, located in Miami-Dade County, began serving enrollees in February 2003 with a total of 150 slots. Since then, the Legislature has approved additional slots either as part of the General Appropriations Act (GAA) or general law.

In 2011, the Legislature moved administrative responsibility for the PACE program from the DOEA to the AHCA as part of the expansion of Medicaid managed care into the Statewide Medicaid Managed Care (SMMC) program.[15] Participation by the PACE in the SMMC program is not subject to the procurement requirements or regional plan number limits normally applicable to SMMC plans. Instead, PACE plans may continue to provide services to individuals at such levels and enrollment caps as authorized by the GAA.[16]

Currently, four PACE organizations[17] operate in Florida and provide services to participants within specific zip codes in Broward, Miami-Dade, Charlotte, Collier, Lee, Palm Beach, Sarasota, and Pinellas counties. There are 2,253 individuals enrolled in the four Florida PACE organizations.[18]

The current PACE approval process requires any entity interested in becoming a PACE organization to submit a comprehensive PACE application to the AHCA, which sets forth details about the adult day care center, staffing, provider network, financial solvency and pro forma financial projections, and policies and procedures, among other elements. The application is similar in detail to the provider applications submitted by managed care plans seeking to provide medical care to Medicaid recipients. PACE providers operating in the same geographic region must establish that there is adequate demand for services so that each provider will be viable. The application requires that documentation be submitted demonstrating that PACE providers in the same geographic region are not competing for the same potential enrollees.

The AHCA and the DOEA review the application and, when the entity has satisfied all requirements, conduct an on-site survey of the entity's readiness to serve PACE enrollees. Once all requirements are met, including full licensure of the PACE center, staffing for key positions, and signed provider network contracts, the AHCA certifies to the federal CMS that the PACE site is ready. At that time, the federal CMS reviews the application and readiness certification and, if all requirements are satisfied, executes a three-way agreement with the PACE provider and the AHCA. The PACE provider may then begin enrolling members, subject to an appropriation to fund the slots.

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[14] Chapter 2011-135, s. 24, L.O.F., repealed s. 430.707, F.S., effective October 1, 2013, as part of the expansion of Medicaid managed care.
[15] Chapter 2011-135, s. 24, L.O.F., repealed s. 430.707, F.S., effective October 1, 2013.
[16] Section 409.981(4), F.S.
[17] *See* the Department of Elder Affairs, Program for All-Inclusive Care for the Elderly http://elderaffairs.state.fl.us/doea/pace.php (last visited Feb. 10, 2020).
[18] Agency for Health Care Administration, Florida Statewide Medicaid Monthly Enrollment Report Program Enrollment by Region (December 2019) available at http://ahca.myflorida.com/medicaid/Finance/data_analytics/enrollment_report/index.shtml (last visited Feb. 10, 2020).

Enrollment and Organizational Slots

Slots are authorized by the Legislature for a specific PACE area; however, slots may not always be fully funded in the same year the program is authorized. Some PACE providers need additional time to complete the application process, obtain necessary licensures, or to finalize operations.

Funding and Rates

Each year since the PACE's inception, the Legislature has appropriated funds for PACE organizations through proviso language in the GAA or through one of the GAA's accompanying implementing or conforming bills.[19] These directives provide specific slot increases or decreases by county or authorization for implementation of a new program. In 2013, Governor Rick Scott vetoed all county allocations with the exception of Palm Beach County, noting that the state's focus should be on the implementation of the SMMC and that effectiveness and the need for additional PACE slots should be re-evaluated after that transition was completed.[20]

PACE organizations receive a capitated Medicaid payment for each enrolled Medicaid long-term care recipient and an enhanced Medicare payment for Medicare enrollees for acute care services from the federal government. The payment amount is established in the GAA and is based on estimates that have been forecast by the Social Services Estimating Conference for the PACE.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership between the federal and state governments where the federal government establishes the structure for the program and pays a share of the cost. Each state operates its own Medicaid program under a state plan that must be approved by the federal CMS. The plan outlines current Medicaid eligibility standards, policies, and reimbursement methodologies.

To qualify for nursing home care under Medicaid, both an individual's income and assets are reviewed. Additionally, a personal needs allowance is applied as part of the eligibility determination process.[21] The current standard income limit in Florida for institutional care or services under the home and community based services waiver is $2,313 for an individual and $4,626 for a couple. There is also an asset limit for either category of $2,000 for an individual or $3,000 for a couple.[22]

In Florida, the Medicaid program is administered by the AHCA. The AHCA, however, delegates certain functions to other state agencies, including the Department of Children and Families

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[19] Chapter 2013-40, L.O.F.

[20] Governor Rick Scott, *Veto Message - SB 1500* (May 20, 2013), p. 28, *available at* http://www.flgov.com/wp-content/uploads/2013/05/Message1.pdf (last visited Jan. 14, 2020).

[21] The personal needs allowance (PNA) of an individual is defined as that portion of an individual's income that is protected to meet the individual's personal needs while in an institution. *See* Department of Children and Families, *Glossary (Chapter 4600) "Personal Needs Allowance," p. 19,* http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/4600.pdf (last visited Jan. 15, 2020).

[22] Department of Children and Families, *SSI-Related Program-Financial Eligibility Standards: January 2019*, http://www.dcf.state.fl.us/programs/access/docs/esspolicymanual/a_09.pdf (last visited Jan. 15, 2020).

(DCF), the Agency for Persons with Disabilities (APD), and the DOEA. The AHCA has overall responsibility for the program and qualifies providers, sets payment levels, and pays for services.

The DCF is responsible for determining financial eligibility for Medicaid recipients. The APD operates one of the larger waiver programs under Medicaid, the Home and Community-Based Services (HCBS) Waiver program, serving individuals with developmental disabilities.

Pursuant to s. 409.985, F.S., the DOEA assesses Medicaid recipients to determine if they require nursing home level of care. Specifically, the DOEA determines whether an individual:

- Requires nursing home placement as evidenced by the need for medical observation throughout a 24-hour period and requires medically complex care to be performed on a daily basis under the direct supervision of a health professional because of mental or physical incapacitation;
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires care to be performed on a daily basis under the supervision of a health professional because of mental or physical incapacitation; or
- Requires or is at imminent risk of nursing home placement as evidenced by the need for observation throughout a 24-hour period and requires limited care to be performed on a daily basis under the supervision of a health professional because of mild mental or physical incapacitation.

Floridians who need nursing home care, but do not qualify for Medicaid, must pay from their own funds or through insurance.

Long-Term Care Managed Care

In 2011, HB 7107[23] was signed into law, increasing the use of managed care plans in Medicaid. The law required both Medicaid LTC services and Managed Medical Assistance (MMA) services to be provided through managed care plans.

LTC Managed Care plans participating in SMMC are required to provide minimum benefits that include nursing home care as well as home and community based services. The minimum benefits include:

- Nursing home care;
- Services provided in assisted living facilities;
- Hospice;
- Adult day care;
- Medical equipment and supplies, including incontinence supplies;
- Personal care;
- Home accessibility adaptation;
- Behavior management;
- Home delivered meals;
- Case management;

[23] Chapter 2011-134, L.O.F.

- Therapies, including physical, respiratory, speech, and occupational;
- Intermittent and skilled nursing;
- Medication administration;
- Medication management;
- Nutritional assessment and risk reduction;
- Caregiver training;
- Respite care;
- Transportation; and
- Personal emergency response system.

III. Effect of Proposed Changes:

Section 1 creates s. 430.84, F.S., and codifies the Program of All-Inclusive Care for the Elderly (PACE) within the Florida Statutes. Currently, the program does not have an implementing statute and has been operationalized through annual appropriations, proviso, or bills designed to implement the state budget or conform statute to provisions of the state budget.

Program Creation

The bill authorizes the AHCA, in consultation with the DOEA, to approve entities that have submitted the required application and data to the federal CMS as PACE organizations pursuant to 42 U.S.C. s. 1395eee (2019). Applications, as required by the federal CMS, will be reviewed by the AHCA on an ongoing basis, in consultation with the DOEA for initial approval as PACE organizations. Notice of applications must be published in the Florida Administrative Register.

A prospective PACE organization must submit an application to the AHCA before submitting a request for program funding. An applicant for a PACE program must meet the following requirements:

- Provide evidence that the applicant can meet all of the federal regulations and requirements established by the federal CMS by the proposed implementation date;
- Provide market studies which include an estimate of the potential number of participants and which show the geographic area the applicant proposes to serve;
- Develop a business plan of operation, including pro forma financial statement and projections based on the planned implementation date;
- Show evidence of regulatory compliance and meet market studies requirements, if the applicant is an existing PACE organization which seeks to expand to an additional service area;
- Serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic area and that area must not overlap with or include any part of a geographic service area that was previously authorized by the Legislature and that is specific to another prospective PACE organization; and
- Submit its complete federal PACE application to the AHCA and the federal CMS within 12 months after date of initial state approval. If the organization fails to timely meet this requirement, the state approval of the application is void.

Quality and Reporting

All PACE organizations are required to meet specific quality and performance standards established by the federal CMS. The AHCA has the responsibility to oversee and monitor Florida's PACE and the contracted organizations through the data and reports submitted periodically to the AHCA and the federal CMS.

The bill exempts all PACE organizations from the requirements of chapter 641, the chapter of Florida law that regulates health maintenance organizations, prepaid health clinics, and other health care service programs.

The bill authorizes that any person whom the agency has approved to enroll participants residing in a specific geographic area in a PACE may transfer such approval, and assign its PACE contract, to any other person meeting federal requirements upon the prior approval of the agency and subject to any other required federal approval. Such approved transfer must include the transfer of any funds the Legislature appropriated to the PACE, and all future appropriations must be made to the approved transferee.

The bill does not repeal or alter any law in effect on June 30, 2020, which authorized a geographic service area and initial enrollees for a prospective PACE organization.

Section 2 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Additional private sector providers that meet the criteria to be a Program of All-Inclusive Care for the Elderly (PACE) organization and achieve eligibility confirmation status could be approved as PACE sites. Expansion of PACE sites would also mean additional individuals in the community would have access to these services.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

In subsection (4) of section 430.84, the bill directs the AHCA to oversee and monitor the PACE program by using data and reports that the PACE organizations submit periodically to the AHCA and federal CMS. This subsection requires PACE organizations to meet standards established by the federal CMS. The AHCA is in the process of developing additional state standards for PACE organizations that will allow comparisons and evaluation between the PACE and the Statewide Medicaid Managed Care Long-Term Care (LTC) program. The bill currently limits the AHCA's oversight to only federal CMS standards. The AHCA has indicated that it may not be able to compare PACE and the LTC managed care program and ensure comparable quality and patient outcomes.[24]

VIII. Statutes Affected:

This bill creates section 430.84 of the Florida Statutes.

IX. Additional Information:

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

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 18, 2020:
The committee substitute:

[24] Agency for Health Care Administration, *Senate Bill 916 Analysis* (Nov. 4, 2019) (on file with the Senate Committee on Health Policy).

- Authorizes approved PACE participants to transfer their PACE approval, assign their PACE contract, and transfer any Legislative approved funding to any other person meeting federal requirements;
- Requires that a geographic service area served by a PACE participant must not overlap with or include any part of a geographic service area that was previously authorized by the Legislature and that is specific to another prospective PACE organization; and
- Clarifies that the bill does not repeal or alter any law in effect on June 30, 2020, which authorized a geographic service area and initial enrollees for a prospective PACE organization.

B. Amendments:

None.

729942

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 72 - 90

and insert:

geographic service area. The proposed geographic service area must not overlap with or include any part of a geographic service area that was previously authorized by the Legislature and that is specific to another prospective PACE organization.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously

729942

authorized by the agency or the Legislature must meet the requirements set forth in paragraphs (a) and (b).

(d) Any prospective PACE organization that is granted initial state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines established by the CMS, to the agency and the CMS within 12 months after the date of initial state approval, or such approval is void.

(4) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports periodically submitted by PACE organizations to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

(5) TRANSFER OF APPROVAL AND ASSIGNMENT OF PACE CONTRACT.—Any person whom the agency has approved to enroll participants residing in a specific geographic area in a Program of All-Inclusive Care for the Elderly may transfer such approval, and assign its PACE contract, to any other person meeting federal requirements upon the prior approval of the agency and subject to any other required federal approval. Such approved transfer must include the transfer of any funds the Legislature appropriated to such Program of All-Inclusive Care for the Elderly, and all future appropriations with respect to such Program of All-Inclusive Care for the Elderly must be made to the approved transferee.

(6) CONSTRUCTION.—This section is subject to, and does not

729942

repeal or alter, any law in effect on June 30, 2020, which authorized a geographic service area and initial enrollees for a prospective PACE organization.

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

And the title is amended as follows:

Delete line 15

and insert:

organizations from certain requirements; authorizing the transfer of PACE approvals and the assignment of PACE contracts if certain conditions are met; specifying a requirement for future appropriations to approved transferees; providing construction; providing an

By Senator Baxley

12-00748A-20 2020916__

A bill to be entitled

An act relating to the Program of All-Inclusive Care for the Elderly; creating s. 430.84, F.S.; defining terms; authorizing the Agency for Health Care Administration, in consultation with the Department of Elderly Affairs, to approve certain applicants to provide benefits pursuant to the Program of All-Inclusive Care for the Elderly (PACE); specifying requirements and procedures for the submission, publication, review, and initial approval of applications; requiring prospective PACE organizations that are granted initial approval to apply within a certain timeframe for federal approval; providing accountability requirements; exempting PACE organizations from certain requirements; providing an effective date.

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

Section 1. Section 430.84, Florida Statutes, is created to read:

430.84 Program of All-Inclusive Care for the Elderly.—

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

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

(b) "Applicant" means an entity that has filed an application with the agency for consideration as a Program of All-Inclusive Care for the Elderly (PACE) organization.

(c) "CMS" means the Centers for Medicare and Medicaid

12-00748A-20 2020916__

Services within the United States Department of Health and Human Services.

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

(e) "PACE organization" means an entity under contract with the agency to deliver PACE services.

(f) "Participant" means an individual receiving services from a PACE organization and who has been determined by the department to need the level of care required under the state Medicaid plan for coverage of nursing facility services.

(2) PROGRAM CREATION.—The agency, in consultation with the department, may approve entities that have submitted applications required by the CMS to the agency for review and consideration which contain the data and information required in subsection (3) to provide benefits pursuant to the PACE program as established in 42 U.S.C. s. 1395eee and in accordance with the requirements set forth in this section.

(3) PACE ORGANIZATION SELECTION.—The agency, in consultation with the department, shall on a continuous basis review and consider applications required by the CMS for PACE which have been submitted to the agency by entities seeking initial state approval to become PACE organizations. Notice of such applications must be published in the Florida Administrative Register.

(a) A prospective PACE organization shall submit application documents to the agency before requesting program funding. Application documents submitted to and reviewed by the agency, in consultation with the department, must include all of the following:

1. Evidence that the applicant is able to meet all of the

applicable federal regulations and requirements established by the CMS for participation as a PACE organization by the proposed implementation date.

2. Market studies, including an estimate of the number of potential participants and the geographic service area in which the applicant proposes to serve.

3. A business plan of operation, including pro forma financial statements and projections, based on the proposed implementation date.

(b) Each applicant must propose to serve a unique and defined geographic service area without duplication of services or target populations. No more than one PACE organization may be authorized to provide services within any unique and defined geographic service area.

(c) An existing PACE organization seeking authority to serve an additional geographic service area not previously authorized by the agency or the Legislature must meet the requirements set forth in paragraphs (a) and (b).

(d) Any prospective PACE organization that is granted initial state approval by the agency, in consultation with the department, shall submit its complete federal PACE application, in accordance with the application process and guidelines established by the CMS, to the agency and the CMS within 12 months after the date of initial state approval, or such approval is void.

(4) ACCOUNTABILITY.—All PACE organizations must meet specific quality and performance standards established by the CMS for the PACE program. The agency shall oversee and monitor the PACE program and organizations based upon data and reports

periodically submitted by PACE organizations to the agency and the CMS. A PACE organization is exempt from the requirements of chapter 641.

Section 2. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

COMMITTEES:
Ethics and Elections, *Chair*
Appropriations Subcommittee on Education
Education
Finance and Tax
Health Policy
Judiciary

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR DENNIS BAXLEY
12th District

January 29, 2020

The Honorable Chairman Aaron Bean
405 Senate Office Building
Tallahassee, Florida 32399

Dear Chairman Bean,

I would like to request that SB 916 Program of All-Inclusive Care for the Elderly be heard in the next Health Policy Committee meeting.

This bill establishes a statutory process for the review, approval, and oversight of future current PACE organizations. It provides notification requirements for PACE organization applications.

Also, this bill codifies AHCA and the Department of Elder Affairs to provide monitoring and oversight of PACE organizations.

Thank you for your favorable consideration.

Onward & Upward,

Senator Dennis K. Baxley
Senate District 12

DKB/dd

cc: Tonya Kidd, Staff Director

320 Senate Office Building, 404 South Monroe St, Tallahassee, Florida 32399-1100 ● (850) 487-5012
Email: baxley.dennis@flsenate.gov

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/18/2020
Meeting Date

SB 916
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Program of All-Inclusive Care for the Elderly

Name Zayne smith

Job Title Associate State Director

Address 215 South Monroe Suite 603
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850.228.4243

Email zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

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)

2-18-20
Meeting Date

SB 914
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic PACE

Name J. Keith Arnold

Job Title Lobbyist

Address 101 N. Monroe St.
Street

Tallahassee, Fla. 32301
City *State* *Zip*

Phone 239-560-4731

Email Keith.Arnold@bipc.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FLA. PACE Providers Assn.

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 1120 (137486)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Children, Families, and Elder Affairs Committee; and Senator Harrell
SUBJECT:	Substance Abuse Services
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1120 addresses individuals who have been disqualified from employment with substance abuse treatment or recovery residence service providers following a failed background screening by requiring the Department of Children and Families (DCF) to provide exemptions from employment disqualification for certain offenses. The bill condenses several background screening sections of ch. 397, F.S., into a single set of requirements. Additionally, the bill modifies patient-brokering laws to exempt discounts, waivers of payment, or payments not prohibited by the federal anti-kickback statute or regulations. The bill also applies such exemptions to all payment methods used by federal health care programs, and provides that patient-brokering constitutes a first-degree misdemeanor.

The bill is expected to have an insignificant fiscal impact on state government. The bill may result in a positive, yet indeterminate fiscal impact on private health care providers.

The bill takes effect on July 1, 2020.

II. Present Situation:

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.[1] Substance use disorder occurs when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.[2] Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance use disorder.[3] Brain imaging studies of persons with substance use disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.[4]

Substance Abuse Treatment in Florida

The Department of Children and Families (DCF) administers a statewide system of safety net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services.

The DCF provides treatment for substance abuse through a community-based provider system that serves adolescents and adults affected by substance misuse, abuse or dependence.[5] The department regulates substance abuse treatment by licensing individual treatment components under ch. 397, F.S., and ch. 65D-30, F.A.C.

In 2017 several changes were made to the DCF's licensure program for substance abuse treatment providers in ch. 397, F.S.[6] The changes included revisions to the licensure application requirements that require applicants to provide detailed information about the clinical services they provide.

Recovery Residences

Recovery residences function under the premise that individuals benefit in their recovery by residing in an alcohol and drug-free environment. Recovery residences are designed to be

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[1] *World Health Organization. Substance Abuse*, available at http://www.who.int/topics/substance_abuse/en/ (last visited January 22, 2020**).**
[2] Substance Abuse and Mental Health Services Administration, *Substance Use Disorders*, available at http://www.samhsa.gov/disorders/substance-use (last visited January 22, 2020).
[3] National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, available at https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction (last **visited** January 22, 2020).
[4] *Id.*
[5] Department of Children and Families, *Treatment for Substance Abuse*, http://www.myflfamilies.com/service-programs/substance-abuse/treatment-and-detoxification (last visited January 22, 2020**).**
[6] Ch. 2017-173, L.O.F.

financially self-sustaining through rent and fees paid by residents, and there is no limit on the length of stay for those who abide by the rules.[7]

Section 397.311, F.S., defines a recovery residence as a residential dwelling unit, or other form of group housing, offered or advertised through any means, including oral, written, electronic, or printed means, by any person or entity as a residence that provides a peer-supported, alcohol-free, and drug-free living environment. A 2009 Connecticut study notes the following: "Sober houses do not provide treatment, [they are] just a place where people in similar circumstances can support one another in sobriety. Because they do not provide treatment, they typically are not subject to state regulation."[8]

Voluntary Certification of Recovery Residences in Florida

Florida does not license recovery residences. Instead, in 2015 the Legislature enacted sections 397.487–397.4872, F.S., which establish voluntary certification programs for recovery residences and recovery residence administrators, implemented by private credentialing entities.

While certification is voluntary, Florida law incentivizes certification. Since July 1, 2016, Florida has prohibited licensed substance abuse service providers from referring patients to a recovery residence unless the recovery residence is certified and is actively managed by a certified recovery residence administrator.[9] Referrals by licensed service providers to uncertified recovery residences are limited to those licensed service providers under contract with a managing entity as defined in s. 394.9082, F.S.; referrals by a recovery residence to a licensed service provider when the recovery residence or its owners, directors, operators, or employees do not benefit, directly or indirectly, from the referral; and referrals before July 1, 2018 by a licensed service provider to that licensed service provider's wholly owned subsidiary.[10]

Background Screening Under Ch. 435, F.S.

Chapter 435, F.S., addresses background screening requirements for persons seeking employment or for employees in positions that require a background screening. An employer[11] may not hire, select, or otherwise allow an employee to have contact with a vulnerable person[12] that would place the employee in a role that requires a background screening until the screening process is completed and demonstrates the absence of any grounds for the denial or termination of employment. If the screening process shows any grounds for the denial or termination of employment, the employer may not hire, select, or otherwise allow the employee to have contact

[7] Department of Children and Families, *Recovery Residence Report* (October 1, 2013), available at https://www.myflfamilies.com/service-programs/samh/publications/docs/SoberHomesPR/DCFProvisoRpt-SoberHomes.pdf (last visited February 11, 2020).
[8] Office of Legislative Services, Connecticut General Assembly, *Sober Homes*, 2009-R-0316 (September 2, 2009), available at https://www.cga.ct.gov/2009/rpt/2009-R-0316.htm (last visited February 11, 2020).
[9] Section 397.4873(1), F.S.
[10] Section 397.4873(2), F.S.
[11] Section 435.02(3), F.S., defines "employer" as any person or entity required by law to conduct screening of employees pursuant to ch. 435, F.S..
[12] Section 415.102(28), F.S., defines "vulnerable adult" as a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging.

with any vulnerable person that would place the employee in a role that requires background screening unless the employee is granted an exemption for disqualification by the agency[13] as provided under s. 435.07, F.S.[14]

If an employer becomes aware that an employee has been arrested for a disqualifying offense, the employer must remove the employee from contact with any vulnerable person that places the employee in a role that requires a background screening until the arrest is resolved in a way that the employer determines that the employee is still eligible for employment under ch. 435, F.S.[15] The employer must terminate the employment of any of its personnel found to be in noncompliance with the minimum standards of ch. 435, F.S., or place the employee in a position for which background screening is not required unless the employee is granted an exemption from disqualification pursuant to s. 435.07, F.S.[16]

An employer may hire an employee to a position that requires a background screening before the employee completes the screening process for training and orientation purposes. However, the employee may not have direct contact with vulnerable persons until the screening process is completed and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment.[17]

Sections 435.03 and 435.04, F.S., outline the screening requirements. There are two levels of background screening: level 1 and level 2:

- Level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[18] and may include criminal records checks through local law enforcement agencies.[19]
- Level 2 screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through the FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[20]

The security background investigations under s. 435.04, F.S., for level 2 screening must ensure that no persons subject to this section have been arrested for and are awaiting final disposition of, have been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or have been adjudicated delinquent, and the record has not been sealed or expunged for, any offense listed in s. 435.04(2), F.S., or a similar law of another jurisdiction.[21]

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[13] Section 435.02(1), F.S., defines "agency" as any state, county, or municipal agency that grants licenses or registration permitting the operation of an employer, or is itself an employer, or that otherwise facilitates the screening of employees pursuant to ch.435, F.S. If there is no state agency or the municipal or county agency chooses not to conduct employment screening, "agency" means the Department of Children and Families.
[14] Section 435.06(2)(a), F.S.
[15] Section 435.06(2)(b), F.S.
[16] Section 435.06(2)(c), F.S.
[17] Section 435.06(2)(d), F.S.
[18] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. Available at https://www.nsopw.gov/ (last visited January 22, 2020**).**
[19] Section 435.03(1), F.S.
[20] Section 435.04(1)(a), F.S.
[21] Section 435.04(2), F.S.

Additionally, such investigations must ensure that no person subject to s. 435.04, F.S., has been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to any offense that constitutes domestic violence in s. 741.28, F.S., whether such act was committed in this state or another jurisdiction.[22]

For both levels of screening, the person required to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening under ch. 435, F.S.,[23] and must supply any missing criminal or other necessary information upon request to the requesting employer or agency within 30 days after receiving the request for the information.[24] Every employee must attest, subject to penalty of perjury, to meeting the requirements for qualifying for employment pursuant ch. 435, F.S., and agreeing to inform the employer immediately if arrested for any of the disqualifying offenses while employed by the employer.[25]

For level 1 screening, the employer must submit the information necessary for screening to the Florida Department of Law Enforcement (FDLE) within 5 working days after receiving it. The FDLE must conduct a search of its records and respond to the employer or agency. The employer must inform the employee whether screening has revealed any disqualifying information.[26]

For level 2 screening, the employer or agency must submit the information necessary for screening to the FDLE within 5 working days after receiving it. The FDLE must perform a criminal history record check of its records and request that the FBI perform a national criminal history record check. The FDLE must respond to the employer or agency, and the employer or agency must inform the employee whether screening has revealed disqualifying information.[27]

Each employer licensed or registered with an agency must conduct level 2 screening and must submit to the agency annually or at the time of license renewal, under penalty of perjury, a signed attestation attesting to compliance with the provisions of ch. 435, F.S.[28]

Individuals Requiring Background Screening Under ch. 397, F.S.

Only certain individuals affiliated with substance abuse treatment providers require background screening. Section 397.4073, F.S., requires all owners, directors, chief financial officers, and clinical supervisors of service providers, service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services, and peer specialists who have direct contact with individuals receiving services, to undergo level 2 background screenings. The credentialing entity for recovery residences must deny an application if any of these individuals has been found guilty of, plead nolo contendere to, or had an adjudication of guilt withheld for, any offense listed in s. 408.809(4), F.S., unless the department has issued an exemption under s. 397.4073, F.S.

[22] Section 435.04(3), F.S.
[23] Section 435.05(1)(a), F.S.
[24] Section 435.05(1)(d), F.S.
[25] Section 435.05(2), F.S
[26] Section 435.05(1)(b), F.S.
[27] Section 435.05(1)(c), F.S.
[28] Section 435.05(3), F.S

Regarding recovery residences, ss. 397.487(6), F.S., 397.4871(5), F.S., and 408.809, F.S., each require level 2 background screening for all recovery residence owners, directors, and chief financial officers, and for administrators seeking certification.

Exemptions from Disqualification for Employment

Section 435.07(1), F.S., authorizes the head of the appropriate agency to grant to any employee otherwise disqualified from employment due to certain disqualifying offenses an exemption from such disqualification. For a felony, three years must have elapsed since the applicant for the exemption has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed. No waiting period applies to misdemeanors.

Additionally, s. 435.07(2), F.S., provides that persons employed, or applicants for employment, by treatment providers who treat adolescents 13 years of age and older who are disqualified from employment solely because of certain crimes may be exempted from disqualification from employment, without applying the 3-year waiting period. The crimes specified under the statute are:[29]

- Section 796.07(2)(e), F.S., (prostitution-related offenses);
- Section 810.02(4), F.S., (unarmed burglary of a structure);
- Section 812.014(2), F.S., (third degree grand theft);
- Section 817.563, F.S., (sale of imitation controlled substance);
- Section 831.01, F.S., (forgery);
- Section 832.02, F.S., (offenses involving uttering or publishing a forged instrument);
- Section 893.13, F.S., (controlled substances offenses, excluding drug trafficking); and
- Section 893.147, F.S., (drug paraphernalia offenses).

Section 397.4073(4), F.S., authorizes the DCF to grant any service provider personnel an exemption from disqualification as provided in s. 435.07, F.S. Additionally, the department may grant exemptions from disqualification to service provider personnel whose background checks indicate crimes under ss. 817.563, 893.13 (controlled substances offenses, excluding drug trafficking), or 893.147, F.S., or grant exemptions from disqualification which would limit service provider personnel to working with adults in substance abuse treatment facilities. The DCF must render a decision on the application for exemption from disqualification within 60 days after the department receives the completed application. Individuals are permitted to work under supervision for up to 90 days in programs or facilities that treat co-occurring substance use and mental health disorders while the DCF evaluates their applications for an exemption from disqualification, so long as it has been five or more years since the individuals have completed all non-monetary conditions associated with their most recent disqualifying offense.

Section 397.4872(1), F.S., provides that the individual exemptions to staff disqualification or administrator ineligibility may be requested if a recovery residence deems the decision will benefit the program. Requests for exemptions must be submitted in writing to the DCF within 20 days after the denial by the credentialing entity and must include a justification for the exemption. Subsection (2) provides, with some exceptions, the DCF may exempt a person from ss. 397.487(6), and 397.4871(5), F.S., if it has been at least three years since the person has

[29] Section 435.07(2), F.S.

completed or been lawfully released from confinement, supervision, or sanction for the disqualifying offense.

Patient Brokering

In Florida, it is unlawful for any person, including a health care provider or health care facility, to engage in patient brokering.[30] Patient brokering is paying to induce, or make a payment in return for, a referral of a patient to or from a health care provider or health care facility. Such payments include commissions, benefits, bonuses, rebates, kickbacks, bribes, split-fee arrangements, in cash or in kind, provided directly or indirectly.[31] A person who violates the patient brokering statute commits a felony of the third degree.[32] If the violation involves 10 to 19 patients, the person commits a felony of the second degree.[33] If the violation involves more than 20 patients, the person commits a felony of the first degree.[34]

However, there are a number of exceptions to the prohibition on patient brokering, which means health care providers or other entities can engage in practices that involve some types of payment without committing a crime. These exceptions include:[35]

- Any discount, payment, waiver of payment, or payment expressly authorized by the federal anti-kickback statute or regulations;
- Any payment, compensation or financial arrangements within a group practice, provided such payment, compensation, or arrangement is not to or from persons who are not members of the group practice;
- Payments to a health care provider or health care facility for professional consultation services;
- Commissions, fees, or other remuneration lawfully paid to insurance agents;
- Payments by a health insurer who reimburses, provides, offers to provide, or administers health, mental health, or substance abuse goods or services under a health benefit plan;
- Payments to or by a health care provider or health care facility that has contracted with a health insurer, health care purchasing group, or the Medicare or Medicaid program to provide health, mental health, or substance abuse goods or services under a health benefit;
- Lawfully authorized insurance advertising gifts;
- Commissions or fees paid to a nurse registry for referring persons providing health care services to clients of the nurse registry;
- Certain payments by health care providers or health care facilities to a health, mental health, or substance abuse information service that provides information upon request and without charge to consumers about provider of health care good or services to enable consumers to select appropriate providers of facilities; and
- Certain payments authorized for assisted living facilities.

[30] Section 817.505, F.S.
[31] Section 817.505(1), F.S.
[32] Punishable by a term of imprisonment not to exceed 5 years and a fine of $50,000.
[33] Punishable by a term of imprisonment not to exceed 15 years and a fine of $100,000.
[34] Punishable by a term of imprisonment not to exceed 30 years and a fine of $500,000.
[35] Section 817.505(3), F.S.

Until 2019, the patient brokering statute did not apply to any discount, payment, waiver of payment, or payment practice that was not prohibited by the federal anti-kickback statute. In 2019, the Legislature enacted legislation that applied this exception to only those payment practices expressly authorized under federal law.[36] This change created uncertainty for those using payment arrangements that were not prohibited under federal law but also not expressly authorized.

Federal Anti-Kickback Statute

Federal law prohibits payment for the referral of an individual to a person for furnishing or arranging to furnish any item or service for which payment may be made under a federal health care program.[37] Violation of the federal anti-kickback statute is a felony that is punishable by a fine of up to $25,000 or up to five years in prison, or both.[38] However, there are several exceptions to the federal statute, including, but not limited to:[39]

- Discounts properly disclosed and appropriately reflected in the costs claimed and charges made by the provider or entity;
- Payments between employers and employees for employment in the provision of covered items or services;
- Certain payments to a group purchasing organization;
- Waivers of co-insurance;
- Certain risk-sharing agreements; and
- The waiver of any cost-sharing provisions by a pharmacy.

Payment arrangements that do not specifically meet one of the exceptions are reviewed on a case-by-case basis to determine if the parties have the requisite criminal intent.[40] The Office of the Inspector General within the U.S. Department of Health and Human Services, is proposing additional exceptions to the anti-kickback statute, including payment arrangements that are currently used by health care practitioners but are not specifically authorized under the statute.[41]

III. Effect of Proposed Changes:

Section 1 amends s. 397.4073, F.S., requiring that certified recovery residence owners, directors, chief financial officers, and certified recovery residence administrators are subject to level 2 background screening as provided under s. 408.809, F.S., and ch. 435, F.S. These positions already require a level 2 background screening under current law; the bill streamlines the background screening language in ch. 397, F.S., to one section of statute rather than two sections.

The bill also requires the DCF to grant applications for exemption from employment disqualification for service providers that treat adolescents aged 13 or older whose background

[36] Chapter 2019-59, L.O.F.
[37] 42 U.S.C., s. 1320a-7b(b).
[38] *Id.*
[39] *Id.*
[40] U.S. Department of Health and Human Services, *HHS Office of Inspector General Fact Sheet: Notice of Proposed Rulemaking OIG-0936-AA10-P*, (Oct. 2019), available at https://oig.hhs.gov/authorities/docs/2019/CoordinatedCare_FactSheet_October2019.pdf (last visited February 11, 2020).
[41] *Id.*

checks indicate crimes referenced in s. 397.4073(4)(b), F.S., provided that at least five years (or three years if certified as a Peer Specialist) have elapsed since the applicant for an exemption from disqualification has completed, or has been lawfully released from confinement, supervision, or a nonmonetary condition imposed by a court for the applicant's most recent disqualifying offense under s. 397.417, F.S., and the applicant has not been arrested for any criminal offense within the past three years. Currently, the DCF has discretion in whether or not to grant such applications.

Section 2 amends s. 397.487, F.S., by removing language related to level 2 background screenings for certified recovery residence owners, directors, chief financial officers, and certified recovery residence administrators made obsolete by moving the background screening requirement to s. 397.4073, F.S.

Section 3 amends s. 397.4872, F.S., by removing language related to exemptions from disqualification made obsolete by the bill.

Section 4 amends s. 397.4873, F.S., providing that anyone who willfully and knowingly facilitates patient brokering is guilty of a first-degree misdemeanor.

Section 5 amends s. 817.505, F.S., revising the patient brokering statute such that it does not apply to any discount, payment, waiver of payment, payment practice, or payment scheme that is expressly authorized by the federal anti-kickback statute or regulations.

The bill also makes such exception applicable to any payment scheme, regardless of whether it involves services paid in whole or in part by a federal health care program designated in the federal anti-kickback statute or regulations.

Section 6 amends s. 397.4871, F.S., by adding offenses listed under s. 408.809, F.S., to those currently referenced in s. 435.04(2), F.S., for recovery residence administrator certification. The offenses added by incorporating s. 408.809, F.S., include financial crimes such as Medicaid fraud, forgery, and patient brokering. The bill also amends statutory references for determining whether the DCF can grant a background screening exemption for recovery residence administrators from s. 397.4872, F.S., to s. 397.4073, F.S. or s. 435.07, F.S.

Section 7 amends s. 435.07, F.S., by requiring the DCF to exempt individuals disqualified during background screening for committing specific offenses. The crimes specified in the bill are:

- Section. 777.04, F.S., (Attempt to commit a criminal offense, solicitation of another person to commit a criminal offense, or conspiracy to commit a criminal offense);
- Section 796.07(2)(e), F.S., (Person 18 years of age or older to offer to commit, or to commit, or to engage in, prostitution, lewdness, or assignation);
- Section 810.02(4), F.S., (Burglary);
- Section 812.014(2)(c), F.S., (Grand theft);
- Section 817.563, F.S., (Sale of controlled substances);
- Section 831.01, F.S. (Forgery);
- Section 831.02, F.S., (Uttering forged instruments);

- Section 893.13, F.S., (Sale, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, controlled substances); and
- Section 893.147, F.S., (Use, possession, manufacture, delivery, transportation, advertisement, or retail sale of drug paraphernalia, specified machines, and materials).

Section 8 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

According to the DCF, substance use treatment providers and recovery residences may realize savings by being able to fill positions faster with the changes identified in the bill.[42] Additionally, PCS/CS/SB 1120 alleviates confusion on which payment arrangements are permissible under the state patient brokering law. This may result in increased revenues for the private sector resulting from more allowable payment agreement options between health care providers.[43]

[42] *Id*.
[43] Department of Children and Families Agency Analysis of HB 649. On file with the Senate Committee on Children, Families, and Elder Affairs.

C. Government Sector Impact:

The bill is expected to have an insignificant fiscal impact on the DCF.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 397.4073, 397.487, 397.4871, 397.4872, 397.4873, 435.07, and 817.505.

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 18, 2020:
The committee substitute:

- Requires DCF to grant applicants exemptions from disqualifying offenses under s. 435.07, F.S., provided that at least three years has elapsed for a certified peer specialist, or five years has passed for a non-certified substance abuse treatment or recovery residence service provider, since completion or release from confinement, supervision, or nonmonetary conditions imposed by the court, and has not been arrested for any criminal offense within the past three years.

CS by Children, Families, and Elder Affairs on January 28, 2020:

- Provides that anyone who willfully and knowingly facilitates patient brokering is guilty of a first-degree misdemeanor.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 62 - 179

and insert:

pursuant to this paragraph, provided that 5 years or more, or, in the case of a peer specialist certified pursuant to s. 397.417, 3 years or more, have elapsed since the applicant for an exemption from disqualification has completed or has been lawfully released from confinement, supervision, or a nonmonetary condition imposed by a court for the applicant's


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most recent disqualifying offense under this subsection and the applicant for exemption has not been arrested for any criminal offense within the past 3 years.

Section 2. Subsection (6) of section 397.487, Florida Statutes, is amended to read:

397.487 Voluntary certification of recovery residences.—

~~(6) All owners, directors, and chief financial officers of an applicant recovery residence are subject to level 2 background screening as provided under s. 408.809 and chapter 435. A recovery residence is ineligible for certification, and a credentialing entity shall deny a recovery residence's application, if any owner, director, or chief financial officer has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809(4) or s. 435.04(2) unless the department has issued an exemption under s. 397.4073 or s. 397.4872. In accordance with s. 435.04, the department shall notify the credentialing agency of an owner's, director's, or chief financial officer's eligibility based on the results of his or her background screening.~~

Section 3. Section 397.4872, Florida Statutes, is amended to read:

397.4872 ~~Exemption from disqualification;~~ Publication.—

~~(1) Individual exemptions to staff disqualification or administrator ineligibility may be requested if a recovery residence deems the decision will benefit the program. Requests for exemptions must be submitted in writing to the department within 20 days after the denial by the credentialing entity and must include a justification for the exemption.~~

~~(2) The department may exempt a person from ss. 397.487(6) and 397.4871(5) if it has been at least 3 years since the person has completed or been lawfully released from confinement, supervision, or sanction for the disqualifying offense. An exemption from the disqualifying offenses may not be given under any circumstances for any person who is a:~~

~~(a) Sexual predator pursuant to s. 775.21;~~

~~(b) Career offender pursuant to s. 775.261; or~~

~~(c) Sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.~~

~~(3)~~ By April 1, 2016, each credentialing entity shall submit a list to the department of all recovery residences and recovery residence administrators certified by the credentialing entity that hold a valid certificate of compliance. Thereafter, the credentialing entity must notify the department within 3 business days after a new recovery residence or recovery residence administrator is certified or a recovery residence or recovery residence administrator's certificate expires or is terminated. The department shall publish on its website a list of all recovery residences that hold a valid certificate of compliance. The department shall also publish on its website a list of all recovery residence administrators who hold a valid certificate of compliance. A recovery residence or recovery residence administrator shall be excluded from the list upon written request to the department by the listed individual or entity.

Section 4. Present subsections (4), (5), and (6) of section 397.4873, Florida Statutes, are redesignated as subsections (5),


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(6), and (7), respectively, a new subsection (4) is added to that section, and subsection (1) of that section is republished, to read:

397.4873 Referrals to or from recovery residences; prohibitions; penalties.—

(1) A service provider licensed under this part may not make a referral of a prospective, current, or discharged patient to, or accept a referral of such a patient from, a recovery residence unless the recovery residence holds a valid certificate of compliance as provided in s. 397.487 and is actively managed by a certified recovery residence administrator as provided in s. 397.4871.

(4) In addition to any other punishment provided by law, any person who willfully and knowingly violates subsection (1) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Paragraph (a) of subsection (3) of section 817.505, Florida Statutes, is amended to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to the following payment practices:

(a) Any discount, payment, waiver of payment, or payment practice not prohibited ~~expressly authorized~~ by 42 U.S.C. s. 1320a-7b(b) ~~42 U.S.C. s. 1320a-7b(b)(3)~~ or regulations promulgated ~~adopted~~ thereunder, regardless of whether such discount, payment, waiver of payment, or payment practice involves items or services for which payment may be made in whole or in part under federal health care programs as defined


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in 42 U.S.C. s. 1320a-7b(f), as that definition exists on July 1, 2020.

Section 6. Subsection (5) of section 397.4871, Florida Statutes, is amended to read:

397.4871 Recovery residence administrator certification.—

(5) All applicants are subject to level 2 background screening as provided under chapter 435. An applicant is ineligible, and a credentialing entity shall deny the application, if the applicant has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809 or s. 435.04(2) unless the department has issued an exemption under s. 397.4073 or s. 435.07 ~~s. 397.4872~~. In accordance with s. 435.04, the department shall notify the credentialing agency of the applicant's eligibility based on the results of his or her background screening.

Section 7. Subsection (2) 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.

(2) Persons employed, or applicants for employment, by treatment providers who treat adolescents 13 years of age and older who are disqualified from employment solely because of crimes under s. 796.07(2)(e), s. 810.02(4), s. 812.014(2)(c), s. 817.563, s. 831.01, s. 831.02, s. 893.13, or s. 893.147, or any


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related criminal attempt, solicitation, or conspiracy under s. 777.04, shall ~~may~~ be exempted from disqualification from employment pursuant to this chapter, provided that 5 years or more, or, in the case of a certified peer specialist pursuant to s. 397.417, 3 years or more, have elapsed since the applicant for an exemption from disqualification has completed or has been lawfully released from confinement, supervision, or a nonmonetary condition imposed by a court for the applicant's most recent disqualifying offense under this subsection and the applicant for exemption has not been arrested for any criminal offense within the past 3 years ~~without application of the waiting period in subparagraph (1)(a)1~~.

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

Delete line 9

and insert:

abuse service provider personnel; revising eligibility for exemption from disqualification from employment for such personnel; amending s. 397.487,

By the Committee on Children, Families, and Elder Affairs; and Senator Harrell

586-02769-20 20201120c1

A bill to be entitled

An act relating to substance abuse services; amending s. 397.4073, F.S.; specifying that certified recovery residence administrators and certain persons associated with certified recovery residences are subject to certain background screenings; requiring, rather than authorizing, the exemption from disqualification from employment for certain substance abuse service provider personnel; amending s. 397.487, F.S.; deleting a provision relating to background screenings for certain persons associated with applicant recovery residences; amending s. 397.4872, F.S.; deleting provisions relating to exemptions from disqualification for certain persons associated with recovery residences; amending s. 397.4873, F.S.; providing criminal penalties for violations relating to recovery residence patient referrals; amending s. 817.505, F.S.; revising provisions relating to payment practices exempt from prohibitions on patient brokering; amending ss. 397.4871 and 435.07, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) and paragraph (b) of subsection (4) of section 397.4073, Florida Statutes, are amended to read:

397.4073 Background checks of service provider personnel.—

586-02769-20 20201120c1

(1) PERSONNEL BACKGROUND CHECKS; REQUIREMENTS AND EXCEPTIONS.—

(a) For all individuals screened on or after July 1, 2020 ~~2019~~, background checks shall apply as follows:

1. All owners, directors, chief financial officers, and clinical supervisors of service providers are subject to level 2 background screening as provided under s. 408.809 and chapter 435. Inmate substance abuse programs operated directly or under contract with the Department of Corrections are exempt from this requirement.

2. All service provider personnel who have direct contact with children receiving services or with adults who are developmentally disabled receiving services are subject to level 2 background screening as provided under s. 408.809 and chapter 435.

3. All peer specialists who have direct contact with individuals receiving services are subject to level 2 background screening as provided under s. 408.809 and chapter 435.

4. All certified recovery residence owners, directors, chief financial officers, and certified recovery residence administrators are subject to level 2 background screening as provided under s. 408.809 and chapter 435.

(4) EXEMPTIONS FROM DISQUALIFICATION.—

(b) Since rehabilitated substance abuse impaired persons are effective in the successful treatment and rehabilitation of individuals with substance use disorders, for service providers which treat adolescents 13 years of age and older, service provider personnel whose background checks indicate crimes under s. 796.07(2)(e), s. 810.02(4), s. 812.014(2)(c), s. 817.563, s.

831.01, s. 831.02, s. 893.13, or s. 893.147, and any related criminal attempt, solicitation, or conspiracy under s. 777.04, shall ~~may~~ be exempted from disqualification from employment pursuant to this paragraph.

Section 2. Subsection (6) of section 397.487, Florida Statutes, is amended to read:

397.487 Voluntary certification of recovery residences.—

~~(6) All owners, directors, and chief financial officers of an applicant recovery residence are subject to level 2 background screening as provided under s. 408.809 and chapter 435. A recovery residence is ineligible for certification, and a credentialing entity shall deny a recovery residence's application, if any owner, director, or chief financial officer has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809(4) or s. 435.04(2) unless the department has issued an exemption under s. 397.4073 or s. 397.4872. In accordance with s. 435.04, the department shall notify the credentialing agency of an owner's, director's, or chief financial officer's eligibility based on the results of his or her background screening.~~

Section 3. Section 397.4872, Florida Statutes, is amended to read:

397.4872 ~~Exemption from disqualification;~~ Publication.—

~~(1) Individual exemptions to staff disqualification or administrator ineligibility may be requested if a recovery residence deems the decision will benefit the program. Requests for exemptions must be submitted in writing to the department within 20 days after the denial by the credentialing entity and must include a justification for the exemption.~~

~~(2) The department may exempt a person from ss. 397.487(6) and 397.4871(5) if it has been at least 3 years since the person has completed or been lawfully released from confinement, supervision, or sanction for the disqualifying offense. An exemption from the disqualifying offenses may not be given under any circumstances for any person who is a:~~

~~(a) Sexual predator pursuant to s. 775.21;~~

~~(b) Career offender pursuant to s. 775.261; or~~

~~(c) Sexual offender pursuant to s. 943.0435, unless the requirement to register as a sexual offender has been removed pursuant to s. 943.04354.~~

~~(3)~~ By April 1, 2016, each credentialing entity shall submit a list to the department of all recovery residences and recovery residence administrators certified by the credentialing entity that hold a valid certificate of compliance. Thereafter, the credentialing entity must notify the department within 3 business days after a new recovery residence or recovery residence administrator is certified or a recovery residence or recovery residence administrator's certificate expires or is terminated. The department shall publish on its website a list of all recovery residences that hold a valid certificate of compliance. The department shall also publish on its website a list of all recovery residence administrators who hold a valid certificate of compliance. A recovery residence or recovery residence administrator shall be excluded from the list upon written request to the department by the listed individual or entity.

Section 4. Present subsections (4), (5), and (6) of section

397.4873, Florida Statutes, are redesignated as subsections (5), (6), and (7), respectively, a new subsection (4) is added to that section, and subsection (1) of that section is republished, to read:

397.4873 Referrals to or from recovery residences; prohibitions; penalties.—

(1) A service provider licensed under this part may not make a referral of a prospective, current, or discharged patient to, or accept a referral of such a patient from, a recovery residence unless the recovery residence holds a valid certificate of compliance as provided in s. 397.487 and is actively managed by a certified recovery residence administrator as provided in s. 397.4871.

(4) In addition to any other punishment provided by law, any person who willfully and knowingly violates subsection (1) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Paragraph (a) of subsection (3) of section 817.505, Florida Statutes, is amended to read:

817.505 Patient brokering prohibited; exceptions; penalties.—

(3) This section shall not apply to the following payment practices:

(a) Any discount, payment, waiver of payment, or payment practice not prohibited ~~expressly authorized~~ by 42 U.S.C. s. 1320a-7b(b) ~~42 U.S.C. s. 1320a-7b(b)(3)~~ or regulations promulgated ~~adopted~~ thereunder regardless of whether such discount, payment, waiver of payment, or payment practice involves items or services for which payment may be made in

whole or in part under federal health care programs as defined in 42 U.S.C. s. 1320a-7b(f), as that definition exists on July 1, 2020.

Section 6. Subsection (5) of section 397.4871, Florida Statutes, is amended to read:

397.4871 Recovery residence administrator certification.—

(5) All applicants are subject to level 2 background screening as provided under chapter 435. An applicant is ineligible, and a credentialing entity shall deny the application, if the applicant has been found guilty of, or has entered a plea of guilty or nolo contendere to, regardless of adjudication, any offense listed in s. 408.809 or s. 435.04(2) unless the department has issued an exemption under s. 397.4073 or s. 435.07 ~~s. 397.4872~~. In accordance with s. 435.04, the department shall notify the credentialing agency of the applicant's eligibility based on the results of his or her background screening.

Section 7. Subsection (2) 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.

(2) Persons employed, or applicants for employment, by treatment providers who treat adolescents 13 years of age and older who are disqualified from employment solely because of crimes under s. 796.07(2)(e), s. 810.02(4), s. 812.014(2)(c), s.

817.563, s. 831.01, s. 831.02, s. 893.13, or s. 893.147, or any related criminal attempt, solicitation, or conspiracy under s. 777.04, shall ~~may~~ be exempted from disqualification from employment pursuant to this chapter without application of the waiting period in subparagraph (1)(a)1.

Section 8. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GAYLE HARRELL
25th District

January 28, 2020

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 1120 – Substance Abuse Services** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

February 18, 2020
Meeting Date

1120
Bill Number (if applicable)

Topic Substance abuse services

Amendment Barcode (if applicable)

Name Josh Aubuchon

Job Title attorney

Address 315 S. Calhoun
Street

Phone 224-7000

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Health Law Section, Florida Bar

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)

2/18/20
Meeting Date

1120
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Substance Abuse Services

Name Shane Messer

Job Title Legislative Affairs Director

Address 316 E Park
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850/224-6048

Email Sparlg messer@fbha.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Cancil 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)

Meeting Date	Bill Number (if applicable)
	1120

Topic Substance Abuse

Amendment Barcode (if applicable)

Name Beth Lapasky

Job Title Consultant

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City *State* *Zip*

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Speaking: [X] For [ ] Against [ ] Information

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

Representing Informed Families of Florida

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] 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/SB 1344 (891388)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services and Senator Harrell
SUBJECT:	Intermediate Care Facilities
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

I. Summary:

PCS/SB 1344 establishes a new certificate of need (CON) exemption for an intermediate care facility for the developmentally disabled (ICFDD) for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. The bill specifies requirements that the ICFDD must meet in order to obtain the CON exemption and establishes additional licensure criteria for an ICFDD that has been granted the CON exemption.

The bill will have a negative yet indeterminate fiscal impact on the Florida Medicaid program and the Agency for Health Care Administration.

The bill takes effect on July 1, 2020.

II. Present Situation:

Intermediate Care Facilities for the Developmentally Disabled

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

The licensure of ICFDDs is controlled by Part VIII of ch. 400, F.S., and Chapter 59A-26, F.A.C. Additionally, as a health care facility, as defined in s. 408.032, F.S., prior to obtaining licensure,

[1] *See* s. 393.063(12), F.S.

the ICFDD applicant must obtain a CON from the Agency for Health Care Administration (AHCA).

CON Overview

In Florida, a CON is a written statement issued by the AHCA evidencing community need for a new, converted, expanded, or otherwise significantly modified health care facility or health service, including hospices. The Florida CON program has three levels of review: comparative, expedited, and exempt.[2] Florida's CON program has existed since July 1973. From 1974 through 1986, the specifics of the program were largely dictated by the federal National Health Planning and Resources Development Act of 1974 (Act), which established minimum requirements regarding the type of services subject to CON review, review procedures, and review criteria.[3] Each state was required to have a CON program in compliance with the Act as a condition for obtaining federal funds for health programs. The Act was repealed in 1986.[4]

Determination of Need, Application, and Review Processes

A CON is predicated on a determination of need. The future need for services and projects is known as the "fixed need pool,"[5] which the AHCA publishes for each batching cycle. Rule 59C-1, F.A.C., provides need formulas to calculate the fixed need pool for certain services, including NICU services,[6] adult and child psychiatric services,[7] adult substance abuse services,[8] and comprehensive rehabilitation services.[9]

Upon determining that a need exists, the AHCA accepts applications for CON based on batching cycles. CON application fees include a base fee of $10,000 and an additional fee of 1.5 cents for each dollar of the proposed project expenditures up to a maximum combined total of $50,000.[10] A batching cycle is a means of grouping, for comparative review, of CON applications submitted for beds, services, or programs having a like CON need methodology or licensing category in the same planning horizon and the same applicable district or subdistrict.[11]

[2] *See* s. 408.036, F.S. and Rule 59C-1.004, F.A.C.
[3] Pub. Law No. 93-641, 42 U.S.C. s. 300k et seq.
[4] Mitchell, Matthew D., Certificate of Need Laws: Are They Achieving Their Goals? Mercatus Center, George Mason University, available at: www.mercatus.org › system › files › mitchell-con-qa-mop-mercatus-v2 (last visited January 30, 2020).
[5] Rule 59C-1.002(19), F.A.C., defines "fixed need pool" as the identified numerical need, as published in the Florida Administrative Register, for new beds or services for the applicable planning horizon established by the AHCA in accordance with need methodologies which are in effect by rule at the time of publication of the fixed need pools for the applicable batching cycle.
[6] Rule 59C-1.042(3), F.A.C.
[7] Rule 59C-1.040(4), F.A.C.
[8] Rule 59C-1.041(4), F.A.C.
[9] Rule 59C-1.039(5), F.A.C.
[10] Section 408.038, F.S.
[11] Rule 59C-1.002(5), F.A.C. Note: s. 408.032(5), F.S., establishes the 11 district service areas in Florida.

Severe Maladaptive Behaviors

Maladaptive behaviors are those behaviors that are disruptive, destructive, aggressive, or significantly repetitive.[12] The Florida Agency for Persons with Disabilities (APD) has developed a Global Behavioral Service Need Matrix (Matrix) in order to classify the severity of person's maladaptive behavior.[13] The Matrix categorizes symptoms of maladaptive behaviors such as behavior frequency, behavioral impact, physical aggression to others, police involvement, property destruction, and elopement/wandering, among others. Each symptom is ranked on a scale of one to six, with one being the least severe and six being the most severe. If a symptom is not present, it is ranked as a zero. Based on their behavior score, the person will be evaluated for services. The initial evaluation period is 12 months and then the frequency of evaluations afterwards depends on the severity of the person's score, with a need level of six being evaluated more frequently than a need level of one.[14]

III. Effect of Proposed Changes:

The bill amends s. 408.036, F.S., to create a CON exemption for a new ICFDD which has a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. In order to obtain the exemption, The ICFDD must not have had a license denied, revoked, or suspended within the 36 months preceding the request for an exemption and must have at least 10 years of experience serving individuals with severe maladaptive behaviors in this state. The AHCA is prohibited from granting an additional exemption to an ICFDD that has been granted an exemption under these provisions unless the facility has been licensed and operational for a period of at least two years. Additionally, the bill specifies that the exemption does not require a specific appropriation.

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

- The total number of beds per home within the facility may not exceed eight, with each resident having his or her own bedroom and bathroom. Each eight-bed home must be co-located on the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.
- A minimum of 16 beds within the facility must be designated for individuals with severe maladaptive behaviors who have been assessed using the Matrix with a score of at least Level 4 and up to Level 6, or assessed using criteria deemed appropriate by the AHCA regarding the need for a specialized placement in an ICFDD.
- The applicant has not had a facility license denied, revoked, or suspended within the 36 months preceding the request for exemption.
- The applicant must have at least 10 years of experience serving individuals with severe maladaptive behaviors in the state.

[12] Fulton, Elizabeth et al. "Reducing maladaptive behaviors in preschool-aged children with autism spectrum disorder using the early start denver model." Frontiers in pediatrics vol. 2 40. available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4023017/ (last visited on Jan. 24, 2020).
[13] Available at http://apdcares.org/news/news/2011/ib-matrix-instructions.pdf (last visited on February 3, 2020).
[14] *Id.*

- The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.
- The applicant must make available medical and nursing services 24 hours per day, 7 days per week.
- The applicant must demonstrate a history of using interventions that are least restrictive and that follow a behavioral hierarchy.
- The applicant must maintain a policy prohibiting the use of mechanical restraints.

The bill takes effect on July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

PCS/SB 1344 may have a positive but indeterminate fiscal impact on ICFDD applicants that obtain the newly created CON exemption.

C. Government Sector Impact:

The bill will have a negative yet indeterminate fiscal impact on the Florida Medicaid program by incentivizing the creation of ICFDDs that accept individuals with developmental disabilities who have severe maladaptive behaviors or mental health

issues. The negative fiscal impact to the Medicaid program may be offset by the positive fiscal impact to the Home and Community-Based Services (HCBS) Waiver as a result of transferring individuals from the HCBS Waiver to Medicaid.

The AHCA may incur costs related to the licensing and surveying of additional ICFDDs.[15]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.962 and 408.036.

IX. Additional Information:

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

Recommended CS by Appropriations Subcommittee on Health and Human Services on February 18, 2020:
The committee substitute increases the severity of maladaptive behaviors an ICFDD must serve in order to be eligible for the CON exemption from a level 3 to 6 on the Matrix, to a level 4 to 6.

B. Amendments:

None.

[15] Agency for Health Care Administration, *Senate Bill 1344 Fiscal Analysis* (January 26, 2020) (on file with the Senate Subcommittee on Health and Human Services).

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/18/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 33 - 70

and insert:

of at least Level 4 and up to Level 6, or assessed using the criteria deemed appropriate by the Agency for Health Care Administration regarding the need for a specialized placement in an intermediate care facility for the developmentally disabled.

(c) The applicant has not had a facility license denied, revoked, or suspended within the 36 months preceding the request

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for exemption.

(d) The applicant must have at least 10 years of experience serving individuals with severe maladaptive behaviors in the state.

(e) The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.

(f) The applicant must make available medical and nursing services 24 hours per day, 7 days per week.

(g) The applicant must demonstrate a history of using interventions that are least restrictive and that follow a behavioral hierarchy.

(h) The applicant must maintain a policy prohibiting the use of mechanical restraints.

Section 2. Paragraph (o) is added to subsection (3) of section 408.036, Florida Statutes, to read:

408.036 Projects subject to review; exemptions.—

(3) EXEMPTIONS.—Upon request, the following projects are subject to exemption from subsection (1):

(o) For a new intermediate care facility for the developmentally disabled as defined in s. 408.032 which has a total of 24 beds, comprising three eight-bed homes, for use by individuals exhibiting severe maladaptive behaviors and co-occurring psychiatric diagnoses requiring increased levels of behavioral, medical, and therapeutic oversight. The applicant must not have had a license denied, revoked, or suspended within the 36 months preceding the request for exemption and must have at least 10 years of experience serving individuals with severe


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maladaptive behaviors in this state. The agency may not grant an exemption to an applicant that has been granted an exemption under this paragraph unless the facility awarded the exemption has been

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

And the title is amended as follows:

Delete line 10

and insert:

from granting an additional exemption to an applicant

By Senator Harrell

25-01156A-20 20201344__

A bill to be entitled

An act relating to intermediate care facilities; amending s. 400.962, F.S.; requiring certain facilities that have been granted a certificate-of-need exemption to demonstrate and maintain compliance with specified criteria; amending s. 408.036, F.S.; providing an exemption from a certificate-of-need requirement for certain intermediate care facilities; prohibiting the Agency for Health Care Administration from granting an additional exemption to a facility unless a certain condition is met; providing that a specific legislative appropriation is not required for such exemption; providing an effective date.

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

Section 1. Subsection (6) is added to section 400.962, Florida Statutes, to read:

400.962 License required; license application.—

(6) An applicant that has been granted a certificate-of-need exemption under s. 408.036(3)(o) must also demonstrate and maintain compliance with the following criteria:

(a) The total number of beds per home within the facility may not exceed eight, with each resident having his or her own bedroom and bathroom. Each eight-bed home must be colocated on the same property with two other eight-bed homes and must serve individuals with severe maladaptive behaviors and co-occurring psychiatric diagnoses.

(b) A minimum of 16 beds within the facility must be

25-01156A-20 20201344__

designated for individuals with severe maladaptive behaviors who have been assessed using the Agency for Persons with Disabilities' Global Behavioral Service Need Matrix with a score of at least Level 3 and up to Level 6, or assessed using the criteria deemed appropriate by the Agency for Health Care Administration regarding the need for a specialized placement in an intermediate care facility for the developmentally disabled.

(c) The applicant has not had a facility license denied, revoked, or suspended within the 36 months preceding the request for exemption.

(d) The applicant must have at least 10 years of experience serving individuals with severe maladaptive behaviors in the state.

(e) The applicant must implement a state-approved staff training curriculum and monitoring requirements specific to the individuals whose behaviors require higher intensity, frequency, and duration of services.

(f) The applicant must make available medical and nursing services 24 hours per day, 7 days per week.

(g) The applicant must demonstrate a history of using interventions that are least restrictive and that follow a behavioral hierarchy.

(h) The applicant must maintain a policy prohibiting the use of mechanical restraints.

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Section 3. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GAYLE HARRELL
25th District

January 28, 2020

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 1344 – Intermediate Care Facilities** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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2/18/20
Meeting Date

SB 1344
Bill Number (if applicable)

Topic Intermediate Care Facilities

Amendment Barcode (if applicable)

Name Suzanne Sewell

Job Title President & CEO

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Street

Phone 850-294-6762

Tallahassee FL 32301
City *State* *Zip*

Email ssewell@floridahcf.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing FL Association of Rehabilitation Facilities

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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 1370 (651134)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Harrell
SUBJECT:	Patient Safety Culture Surveys
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1370 amends several sections of law to require each hospital and ambulatory surgical center (ASC), including facilities operating exclusively as state facilities, to conduct a patient safety culture survey at least biennially. The bill specifies that facilities must use the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality, requires the survey to be anonymous, allows facilities to contract for the administration of the survey, and requires each facility to submit survey data to the Agency for Health Care Administration (AHCA).

The bill requires the Florida Center for Health Information and Transparency (Florida Center) to customize the survey with additional questions and to collect, compile, and publish aggregated survey data.

The bill authorizes one full-time equivalent (FTE) position with an associated salary rate of 46,560, and $75,306 in recurring funds and $87,171 in nonrecurring funds from the Health Care Trust Fund, in Fiscal Year 2020-2021 to the AHCA to implement the bill. See Section V.

The bill takes effect July 1, 2020.

II. Present Situation:

Health Care Facility Regulation

Hospitals

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

Ambulatory Surgical Centers

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

AHCA Regulation of Hospitals and ASCs

There are 306 licensed hospitals and 479 licensed ASCs in the State of Florida.[5] As part of state and federal regulatory oversight, the AHCA conducts onsite inspections of hospitals and ASCs to evaluate factors such as:

- Management and administration;
- Nursing services;
- Social services;
- Dietary services;
- Laboratory services; and
- Compliance with state and federal fire safety codes.

The AHCA's regulatory inspections occur periodically, according to specific guidelines for each facility type, and to investigate complaints and serious incidents. The AHCA also conducts annual risk management inspections in each licensed hospital. When deficiencies are found, a report is generated to the facility for corrective action. When necessary, the AHCA staff conducts follow-up surveys or recommend sanctions, fines, and de-certifications when appropriate.

Section 1865(a)(1) of the Social Security Act permits providers and suppliers "accredited" by an approved national accreditation organization (AO) to be exempt from routine surveys by state survey agencies to determine compliance with Medicare conditions. Accreditation by an AO is

[1] Section 395.002(12), F.S.
[2] *Id.*
[3] Section 395.002(3), F.S.
[4] Sections 395.001-1065, F.S., and Part II, Chapter 408, F.S.
[5] Agency for Health Care Administration, *House Bill 763 Analysis* (December 4, 2019) (on file with the Senate Committee on Health Policy).

voluntary and is not required for Medicare certification or participation in the Medicare program. Hospitals and ASCs, when accredited, are deemed exempt from the AHCA routine inspections. Currently, 285 hospitals and 404 ASCs are accredited.[6]

Adverse Incidents

The AHCA manages serious patient injury reporting, tracking, trending, and problem resolution programs in hospitals, ASCs, assisted living facilities, nursing homes, and certain health maintenance organizations, as directed by the Florida Statutes. The term "adverse incident" is defined in s. 395.0197(5), F.S., for purposes of reporting to the AHCA from hospitals and ASCs. Section 395.0197(5), F.S., also provides a list of adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, that must be reported by the facility to the AHCA within 15 calendar days after its occurrence.

The definition and the list are not identical. Due to this inconsistency, some facilities have communicated uncertainty to the AHCA about whether or not to report certain incidents. This feedback indicates that some hospitals may be under-reporting some incidents while others may be over-reporting. During calendar year 2018, 15 hospitals were cited by the AHCA for failure to submit adverse incident reports while no ASCs were cited.[7]

Adverse incidents are self-reported by the facilities once they determine that an incident meets the statutory definition. The AHCA receives and reviews more than 5,000 adverse incident reports annually. The most frequently reported outcomes from hospitals and ASCs are patient death, a patient requiring surgery that is unrelated to their admitting diagnosis, and surgery to remove a foreign object from a previous surgery. The AHCA publishes quarterly and annual statistics for adverse incidents as required by law. The number of adverse incidents reported from hospitals and ASCs over the previous five calendar years are shown in the following table:[8]

Adverse Incidents Reported to the AHCA		
Calendar Year	**Hospitals**	**ASCs**
2019*	617	70
2018	636	77
2017	520	62
2016	470	58
2015	483	69
2014	427	80

**12-month estimate based on 11 months of data*

Patient Safety Culture Surveys

Organizational culture refers to the beliefs, values, and norms shared by staff throughout the organization that influence their actions and behaviors. Patient safety culture is the extent to

[6] *Supra* note 5.
[7] *Id*.
[8] *Id.*

which these beliefs, values, and norms support and promote patient safety.[9] Patient safety culture can be measured by determining what is rewarded, supported, expected, and accepted in an organization as it relates to patient safety.[10] In a safe culture, employees are guided by an organization-wide commitment to safety in which each member upholds his or her own safety norms and those of co-workers.

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

In 2004, the federal Agency for Healthcare Research and Quality (AHRQ) released the Hospital Survey on Patient Safety Culture (SOPS 1.0), a staff survey designed to help hospitals assess the culture of safety in their institutions by measuring how their staff perceive various aspects of patient safety culture.[11] The survey occurs once every two years and has since been implemented in hundreds of hospitals across the United States and in other countries.

In 2018, the federal AHRQ began developing a new version of the survey, with the goal of shortening the survey.[12] A pilot test was conducted with 25 hospitals, the data from which were used to examine the survey's reliability. In 2019, the federal AHRQ released a new version of the survey, the SOPS 2.0.[13]

The survey asks respondents to indicate to what degree they agree or disagree with a statement, how often something occurs, or provide a specific number or grade. Excerpts of the survey follow.

- Teamwork
  - In this unit, we work together as an effective team.
  - During busy times, staff in this unit help each other.
  - There is a problem with disrespectful behavior by those working in this unit.
  - When one area in this unit gets really busy, others help out.
- Supervisor/Manager, or Clinical Leader Support for Patient Safety
  - My supervisor/manager, or clinical leader seriously considers staff suggestions for improving patient safety.
  - My supervisor/manager, or clinical leader wants us to work faster during busy times, even if it means taking shortcuts.
  - My supervisor/manager, or clinical leader takes action to address patient safety concerns that are brought to their attention.
- Hospital Management Support for Patient Safety

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[9] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, p. 3, (March 2018) *available at* https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalsopsreport.pdf (last viewed Feb. 6, 2020).

[10] *Id.*

[11] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Hospital Survey on Patient Safety Culture*, (March 2018) *available at* http://www.ahrq.gov/professionals/quality-patient-safety/patientsafetyculture/hospital/index.html (last viewed Feb. 6, 2020).

[12] U.S Department of Health and Human Services, Agency for Healthcare Research and Quality, *Pilot Test Results from the 2019 AHRQ Surveys on Patient Safety Culture (SOPS) Hospital Survey Version 2.0*, p. 2, (September 2019) *available at* http://www.ahrq.gov/sites/default/files/wysiwyg/sops/surveys/hospital/hsops2-pilot-results-parti.pdf (last viewed Feb. 6, 2020).

[13] The survey is *available at* http://www.ahrq.gov/sops/surveys/hospital/index.html (last viewed Feb. 6, 2020).

  - Hospital management provides adequate resources to improve patient safety.
  - The actions of hospital management show that patient safety is a top priority.
  - Hospital management seems interested in patient safety only after an adverse event happens.
- Communication Openness
  - In this unit, staff speak up if they see something that may negatively affect patient care.
  - When staff in this unit see someone with more authority doing something unsafe for patients, they speak up.
  - In this unit, staff are afraid to ask questions when something does not seem right.
- Handoffs and Information Exchange
  - When transferring patients from one unit to another, important information is often left out.
  - During shift changes, important patient care information is often left out.
  - During shift changes, there is adequate time to exchange all key patient care information.
- Patient Safety Grade- Poor, Fair, Good, Very Good, Excellent
  - How would you rate your unit/work area on patient safety?[14]

The federal AHRQ developed a comparative database on the survey, composed of data from U.S. hospitals that administered the survey and voluntarily submitted the data.[15] The database allows hospitals to compare their patient safety culture survey results to those of other hospitals in support of patient safety culture improvement.[16] The federal AHRQ utilizes the database to publish a biennial report presenting non-identifiable statistics on the patient safety culture of all participating hospitals. In 2018, 630 hospitals submitted survey results to the database. However, only 306 of those hospitals submitted surveys in 2016. As a result, to identify trends, comparisons can only be drawn from the data submitted by those 306 hospitals.[17]

The federal AHRQ also developed the Ambulatory Surgery Center Survey on Patient Safety Culture in response to interest from ASCs in assessing patient safety culture in their facilities. This survey is designed specifically for ASC staff and asks for their opinions about the culture of patient safety in their facility.[18] In 2014, the federal AHRQ conducted a pilot study on the use of the Patient Safety Culture survey in 59 ASCs.[19] The pilot study was intended to help ASCs assess the extent to which their culture emphasizes the importance of patient safety by viewing the patient safety culture survey results of the ASCs participating in the study.[20] The study was also used to prove the reliability and structure of the questions and items contained the in the

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[14] *Id.*
[15] The database is *available at* http://www.ahrq.gov/sops/databases/hospital/index.html (last viewed Feb. 6, 2020).
[16] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *2018 User Database Report-Hospital Survey on Patient Safety Culture*, at p. 1, *available at* https://www.ahrq.gov/sites/default/files/wysiwyg/sops/quality-patient-safety/patientsafetyculture/2018hospitalsopsreport.pdf (last viewed Feb. 6, 2020).
[17] *Id.* at p. 29.
[18] The survey is available at https://www.ahrq.gov/sops/surveys/asc/index.html. (last viewed Feb. 6, 2020).
[19] U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality, *Results From the 2014 AHRQ Ambulatory Surgery Center Survey on Patient Safety Culture Pilot Study*, (April 2015) *available at* https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/quality-patient-safety/patientsafetyculture/asc/resources/asc_pilotstudy.pdf (last viewed Feb. 6, 2020).
[20] *Id.* at p. 1.

survey. Based on the testing and input from the federal AHRQ and a technical expert panel, the survey was determined to be reliable and it was made available for industry use.

Florida Center for Health Information and Transparency

The Florida Center for Health Information and Transparency (Florida Center) provides a comprehensive health information system (information system) that includes the collection, compilation, coordination, analysis, indexing, dissemination, and utilization of health-related data. The Florida Center is housed within the AHCA.[21]

Offices within the Florida Center, which serve different functions, are:

- Data Collection and Quality Assurance, which collects patient discharge data from all licensed acute care hospitals (including psychiatric and comprehensive rehabilitation units), comprehensive rehabilitation hospitals, ambulatory surgical centers and emergency departments.
- Risk Management and Patient Safety, which conducts in-depth analyses of reported incidents to determine what happened and how the facility responded to the incident.
- Data Dissemination and Communication, which maintains the AHCA's health information website, provides technical assistance to data users, and creates consumer brochures and other publications.
- Health Information Exchange and Policy Analysis, which monitors innovations in health information technology, informatics, and the exchange of health information and provides a clearinghouse of technical resources on health information exchange, electronic prescribing, privacy and security, and other relevant issues.[22]

The Florida Center electronically collects patient data from every Florida licensed inpatient hospital, ASC, emergency department, and comprehensive rehabilitation hospital on a quarterly basis. The data is validated for accuracy and maintained in three major databases: the hospital inpatient database, the ambulatory surgery database, and the emergency department database.

- The hospital inpatient database contains records for each patient stay at Florida acute care facilities, including long-term care hospitals and psychiatric hospitals. These records contain extensive patient information including discharge records, patient demographics, admission information, medical information, and charge data. This database also includes comprehensive inpatient rehabilitation data on patient-level discharge information from Florida's licensed freestanding comprehensive inpatient rehabilitation hospitals and acute care hospital distinct part rehabilitation units.[23]
- The ambulatory surgery database contains "same-day surgery" data on reportable patient visits to Florida health care facilities, including freestanding ambulatory surgery centers, short-term acute care hospitals, lithotripsy centers, and cardiac catheterization laboratories. Ambulatory surgery data records include, but are not limited to, patient demographics, medical information, and charge data.[24]

[21] Section 408.05, F.S.
[22] See *Florida Center for Health Information and Transparency*, available at http://ahca.myflorida.com/SCHS/ (last visited on Feb. 11, 2020).
[23] See s. 408.061, F.S., and ch. 59E-7, F.A.C.
[24] See s. 408.061, F.S., and ch. 59B-9, F.A.C.

- The emergency department database collects reports of all patients who visited an emergency department, but were not admitted for inpatient care. Reports are electronically submitted to the AHCA and include the hour of arrival, the patient's chief complaint, principal diagnosis, race, ethnicity, and external causes of injury.[25]

The Florida Center maintains www.FloridaHealthFinder.gov, which was established to assist consumers in making informed health care decisions and lead to improvements in quality of care in Florida. The website provides a wide array of search and comparative tools to the public that allows easy access to information on hospitals, ambulatory surgery centers, emergency departments, hospice providers, physician volume, health plans, nursing homes, and prices for prescription drugs in Florida.

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

The Florida Center also runs Florida Health Price Finder[26] which provides consumers with the ability to research and compare health care costs in Florida at the national, state and local levels. Supported by a database of more than 15 million lines of insurance claim data sourced directly from Florida insurers, the website displays costs as Care Bundles representing the typical set of services a patient receives as part of treatment for a specific medical conditions. Care Bundles are broken down into logical steps, which may include one or more procedures and tests and the 295 care bundles currently available on Florida Health Price Finder account for 90 percent of consumer searches on national pricing websites.

III. Effect of Proposed Changes:

Section 1 amends s. 395.1012, F.S., to require that each hospital and ASC[27] must, at least biennially, conduct a patient safety culture survey using the Hospital Survey on Patient Safety Culture developed by the federal AHRQ. The facility:

- Must conduct the survey anonymously to encourage completion of the survey by staff working at the facility;
- May contract for administration of the survey;
- Must submit the survey data to the AHCA in a format specified in rule and including the survey participation rate;
- May develop an internal action plan between surveys to identify measures to improve the survey and submit the plan to the AHCA

Section 3 amends s. 408.05, F.S., to require the Florida Center to collect, compile, and publish patient safety culture survey data and designate the use of updated versions of the survey as they occur. The Florida Center is also required to:

[25] *Id*.
[26] See https://pricing.floridahealthfinder.gov/#! (last visited Feb. 11, 2020).
[27] Including hospitals and ASCs operating exclusively as state facilities.

- Customize the survey to:
  - Generate data regarding the likelihood of a respondent to seek care for the respondent and the respondent's family at the surveying facility, both in general and within the respondent's specific unit or work area; and
  - Revise the units or work areas identified in the survey to include a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.
- Publish the survey results for each facility, in the aggregate, by composite measure as defined in the survey and the units or work areas within the facility.

Sections 2 and **4** amend ss. 395.1055 and 408.061, F.S., respectively, to make conforming and cross-reference changes.

Section 5 authorizes one full-time equivalent (FTE) position with an associated salary rate of 46,560, and $75,306 in recurring funds and $87,171 in nonrecurring funds from the Health Care Trust Fund, to the AHCA to implement the provisions of the bill.

Section 6 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Hospitals and ASCs that are required to complete and submit a patient safety culture survey or surveys under PCS/CS/SB 1370 will incur an indeterminate cost to fulfill that requirement.

C. Government Sector Impact:

The AHCA has not provided a fiscal impact estimate for SB 1370 or CS/SB 1370. However, under HB 763, which is similar to CS/SB 1370, the AHCA reported[28] that it will be required to collect, compile, and prepare the survey results for publication. Data collection will require developing new information technology applications or infrastructure, or both, to accept the survey data files electronically from each of, at least, 776 facilities. Survey data collection must include identity verification to ensure that the party submitting data on behalf of a facility is properly authorized to do so, along with a validation process to ensure that submitted data files are complete and meet required specifications.

The AHCA also reported that, under HB 763, its staff will be required to compile the submitted data for publication. Due to the number of facilities reporting, the AHCA estimates the need for one full-time analyst to perform these functions and to monitor and report facility compliance. The costs associated with internal development of a reporting portal for facilities to submit their survey data are estimated based on known development costs associated with recent and relatively similar reporting projects. The secure data submission portal will need to include identity verification, validation of data specifications, documentation of the date and time of submission, and reporting requirements. The costs for the AHCA to build such a system were estimated at $60,000 in the first year.

Publication of survey findings or scores at the facility level will require custom programming to the AHCA's existing consumer transparency website, FloridaHealthFinder.gov. The development of new transparency tools in recent years have had associated vendor costs ranging from $6,400 to $30,000, depending on the size and scope of the new function or tool. The publication of the patient safety culture survey data would be a significant endeavor, requiring the AHCA's contracted vendor to create search functionality, publication, and integration of results for all of the state's licensed hospitals and ASCs. The AHCA's rough estimate of associated programming and web-design costs was approximately $25,000 in the first year and $2,000 recurring annually thereafter.

The AHCA estimated the need for one analyst to manage the survey vendor contract, perform data analysis functions, monitor facility compliance, and analyze and report noncompliant facilities to the AHCA licensure staff for regulatory follow-up as needed. Comparable contracts managed by the AHCA are administered by a Government Analyst II level staff member. The AHCA reported that the patient safety culture survey program

[28] *Supra* note 5.

would be a significant implementation, and, in order for it to be successful, the program will require, at a minimum, a dedicated contract manager who also has data analysis skills and experience.

The bill appropriates one full-time equivalent position and $75,306 in recurring funds and $87,171 in nonrecurring funds from the Health Care Trust Fund, to the AHCA to implement the bill in Fiscal Year 2020-2021.[29]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The AHCA recommends that hospitals and ASCs be required under the bill to contract with an independent third-party organization to administer the surveys in order to ensure anonymity of responses and encourage honesty from respondents. Under this recommendation, each facility would be required to capture and provide data from a statistically valid sample of employees in order to ensure that findings are representative of the facility as a whole.[30]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 395.1012, 395.1055, 408.05, and 408.061.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial 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 18, 2020:
The committee substitute authorizes a position and an appropriation.

CS by Health Policy on February 11, 2020:
The CS replaces requirements in the underlying bill with the requirement that each hospital and ASC conduct a patient safety culture survey at least biennially. The CS eliminates the exemption for facilities operating exclusively as state facilities.

The CS specifies that facilities must use the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality, requires the survey to be anonymous, allows facilities to contract for the administration of the survey, and requires that each facility must submit survey data to the AHCA.

The bill requires the Florida Center to customize the survey with additional questions and to collect, compile, and publish aggregated survey data.

[29] *Id.*
[30] *Id.*

B. Amendments:

None.

354582

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 139 and 140

insert:

Section 5. For the 2020-2021 fiscal year, one full-time equivalent position with associated salary rate of 46,560 is authorized and the sums of $75,306 in recurring funds and $87,171 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration for the purpose of implementing the requirements of this act.

354582

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 18
15 and insert:
16 providing appropriations; providing an effective date.

By the Committee on Health Policy; and Senator Harrell

588-03488-20 20201370c1

A bill to be entitled

An act relating to patient safety culture surveys; amending s. 395.1012, F.S.; requiring certain licensed facilities to biennially conduct an anonymous patient safety culture survey using a specified federal publication; authorizing facilities to contract for the administration of the survey; requiring facilities to biennially submit patient safety culture survey data to the Agency for Health Care Administration; authorizing facilities to develop an internal action plan for a specified purpose and submit such plan to the agency; amending s. 395.1055, F.S.; conforming a cross-reference; amending s. 408.05, F.S.; requiring the agency to collect, compile, and publish patient safety culture survey data submitted by facilities; amending s. 408.061, F.S.; revising requirements for the submission of health care data to the agency; providing an effective date.

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

Section 1. Subsection (4) is added to section 395.1012, Florida Statutes, to read:

395.1012 Patient safety.—

(4) Each licensed facility must, at least biennially, conduct a patient safety culture survey using the Hospital Survey on Patient Safety Culture developed by the federal Agency for Healthcare Research and Quality. Each facility shall conduct the survey anonymously to encourage completion of the survey by

588-03488-20 20201370c1

staff working in or employed by the facility. Each facility may contract to administer the survey. Each facility shall biennially submit the survey data to the agency which must be in a format specified by rule and include the survey participation rate. Each facility may develop an internal action plan between conducting surveys to identify measures to improve the survey and submit the plan to the agency.

Section 2. Paragraph (d) of subsection (14) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(14)

(d) Each onsite inspection must include all of the following:

1. An inspection of the program's physical facilities, clinics, and laboratories.

2. Interviews with support staff and hospital administrators.

3. A review of:

a. Randomly selected medical records and reports, including, but not limited to, advanced cardiac imaging, computed tomography, magnetic resonance imaging, cardiac ultrasound, cardiac catheterization, and surgical operative notes.

b. The program's clinical outcome data submitted to the Society of Thoracic Surgeons and the American College of Cardiology pursuant to s. 408.05(3)(l) ~~s. 408.05(3)(k)~~.

c. Mortality reports from cardiac-related deaths that occurred in the previous year.

d. Program volume data from the preceding year for

interventional and electrophysiology catheterizations and surgical procedures.

Section 3. Present paragraphs (d) through (k) of subsection (3) of section 408.05, Florida Statutes, are redesignated as paragraphs (e) through (l), respectively, a new paragraph (d) is added to that subsection, and present paragraph (j) of that subsection is amended, to read:

408.05 Florida Center for Health Information and Transparency.—

(3) HEALTH INFORMATION TRANSPARENCY.—In order to disseminate and facilitate the availability of comparable and uniform health information, the agency shall perform the following functions:

(d)1. Collect, compile, and publish patient safety culture survey data submitted by a facility pursuant to s. 395.1012.

2. Designate the use of updated versions of the survey as they occur, and customize the survey to:

a. Generate data regarding the likelihood of a respondent to seek care for the respondent and the respondent's family at the surveying facility, both in general and within the respondent's specific unit or work area; and

b. Revise the units or work areas identified in the survey to include a pediatric cardiology patient care unit and a pediatric cardiology surgical services unit.

3. Publish the survey results for each facility, in the aggregate, by composite measure as defined in the survey and the units or work areas within the facility.

(k) ~~(j)~~ Conduct and make available the results of special health surveys, including facility patient safety culture

surveys, health care research, and health care evaluations conducted or supported under this section. Each year the center shall select and analyze one or more research topics that can be investigated using the data available pursuant to paragraph (c). The selected topics must focus on producing actionable information for improving quality of care and reducing costs. The first topic selected by the center must address preventable hospitalizations.

Section 4. Paragraph (a) of subsection (1) of section 408.061, Florida Statutes, is amended to read:

408.061 Data collection; uniform systems of financial reporting; information relating to physician charges; confidential information; immunity.—

(1) The agency shall require the submission by health care facilities, health care providers, and health insurers of data necessary to carry out the agency's duties and to facilitate transparency in health care pricing data and quality measures. Specifications for data to be collected under this section shall be developed by the agency and applicable contract vendors, with the assistance of technical advisory panels including representatives of affected entities, consumers, purchasers, and such other interested parties as may be determined by the agency.

(a) Data submitted by health care facilities, including the facilities as defined in chapter 395, shall include, but are not limited to: case-mix data, patient admission and discharge data, hospital emergency department data which shall include the number of patients treated in the emergency department of a licensed hospital reported by patient acuity level, data on

hospital-acquired infections as specified by rule, data on complications as specified by rule, data on readmissions as specified by rule, with patient and provider-specific identifiers included, actual charge data by diagnostic groups or other bundled groupings as specified by rule, facility patient safety culture surveys, financial data, accounting data, operating expenses, expenses incurred for rendering services to patients who cannot or do not pay, interest charges, depreciation expenses based on the expected useful life of the property and equipment involved, and demographic data. The agency shall adopt nationally recognized risk adjustment methodologies or software consistent with the standards of the Agency for Healthcare Research and Quality and as selected by the agency for all data submitted as required by this section. Data may be obtained from documents such as, but not limited to: leases, contracts, debt instruments, itemized patient statements or bills, medical record abstracts, and related diagnostic information. Reported data elements shall be reported electronically in accordance with rule 59E-7.012, Florida Administrative Code. Data submitted shall be certified by the chief executive officer or an appropriate and duly authorized representative or employee of the licensed facility that the information submitted is true and accurate.

Section 5. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Health Policy, *Chair*
Appropriations Subcommittee on Health and Human Services, *Vice Chair*
Appropriations Subcommittee on Criminal and Civil Justice
Children, Families, and Elder Affairs
Military and Veterans Affairs and Space

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR GAYLE HARRELL
25th District

February 12, 2020

Senator Aaron Bean
405 Senate Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Bean,

I respectfully request that **SB 1370 – Patient Safety Culture Surveys** be placed on the next available agenda for the Appropriations Subcommittee on Health and Human Services Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Gayle

Senator Gayle Harrell
Senate District 25

Cc: Tonya Kidd, Staff Director
Robin Jackson, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019
❒ 310 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5025

Senate's Website: *www.flsenate.gov*

BILL GALVANO
President of the Senate

DAVID SIMMONS
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-18-20
Meeting Date

1370
Bill Number (if applicable)

Topic Patient Safety Culture Surveys

Amendment Barcode (if applicable)

Name Matthew Choy

Job Title

Address 136 S. Bronough Street
Street

Phone 850-521-1200

Tallahassee FL 32301
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chamber of Commerce

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)

2-18-2020
Meeting Date

1370
Bill Number (if applicable)

Topic Culture of Safety Surveys

Amendment Barcode (if applicable)

Name Martha DeCastro

Job Title VP for Nursing & Clinical Care Policy

Address 306 E. College Avenue
Street

Phone 850-222-9800

TLH FL 32301
City *State* *Zip*

Email Martha@fha.org

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Florida Hospital 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

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 1440
INTRODUCER:	Children, Families, and Elder Affairs Committee and Senator Powell
SUBJECT:	Children's Mental Health
DATE:	February 17, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Delia	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1440 requires the Department of Children and Families (DCF) and the Agency for Health Care Administration (AHCA) to identify children, adolescents, and young adults age 25 and under, who are the highest users of crisis stabilization services and collaboratively take action to meet the behavioral health needs of such children. The bill directs these agencies to jointly submit a quarterly report to the Legislature during Fiscal Years 2020-2021 and 2021-2022 on the actions taken by both agencies to better serve these individuals.

The bill requires the behavioral health managing entities (MEs) to develop a plan that promotes the development and implementation of a coordinated system of care for children, adolescents, and young adults to integrate behavioral health services provided through state-funded child serving systems, to facilitate access to mental health and substance abuse treatment and services. The bill requires the DCF to contract with the MEs for crisis response services provided through mobile response teams (MRTs) to provide immediate, onsite behavioral health services 24 hours per day, seven days per week with onsite response time of 60 minutes from the time the request for services is made.

In order to procure contracts with MRTs, the MEs must collaborate with local sheriff's offices and public schools in the selection process. The bill also requires that the provider establish response protocols with local law enforcement agencies, community-based care (CBC) lead agencies, the child welfare system, and the Department of Juvenile Justice (DJJ), and requires access to psychiatrists or psychiatric nurse practitioners, and requires MRTs to refer children,

adolescents, or young adults and their families to an array of crisis response services that address their individual needs.

The bill requires the ME to promote the use of available crisis intervention services by requiring contracted providers to provide to parents and caregivers who receive safety-net behavioral health services with MRT contact information.

The bill amends foster parent preservice training requirements to include local MRT contact information and requires community-based care (CBC) lead agencies to provide MRT contact information to all individuals that provide care for dependent children.

The bill revises the requirements for plans that must be submitted by school districts in order to receive mental health assistance allocation funding to include the development of memoranda of understanding (MOU) with the respective ME to refer students to community-based behavioral health providers and coordinate care for the students between the school-based and community-based providers. The bill requires that school districts use the services of the MRTs to the extent that they are available.

The bill requires DCF and AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of such services and submit a joint report to the Governor and Legislature. The bill also requires the AHCA to regularly test managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

The bill has an indeterminate, but likely insignificant, fiscal impact on state expenditures. See Section V.

The bill takes effect July 1, 2020.

II. Present Situation:

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Behavioral Health Managing Entities

In 2001, the Legislature authorized the DCF to implement behavioral health managing entities (MEs) as the management structure for the delivery of local mental health and substance abuse services.[1] The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized the DCF to implement MEs statewide.[2] Full implementation of the

[1] Chapter 2001-191, Laws of Fla.
[2] Chapter 2008-243, Laws of Fla.

statewide managing entity system occurred by April, 2013; all geographic regions are now served by a managing entity.[3]

The DCF contracts with seven MEs - Big Bend Community Based Care, Lutheran Services Florida, Central Florida Cares Health System, Central Florida Behavioral Health Network, Inc., Southeast Florida Behavioral Health, Broward Behavioral Health Network, Inc., and South Florida Behavioral Health Network, Inc., that in turn contract with local service providers[4] for the delivery of mental health and substance abuse services:[5]

Baker Act

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness and presenting a threat of harm to themselves or others. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[6] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[7]

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; and
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; or
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary Admissions

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients

[3] *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.
[4] Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.
[5] The Department of Children and Families, *Managing Entities*, https://www.myflfamilies.com/service-programs/samh/managing-entities/ (last visited Jan. 30, 2020).
[6] Sections 394.4625 and 394.463, F.S.
[7] Section 394.463(1), F.S.

under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[8]

Within the 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must occur:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[9]

Receiving facilities must give prompt notice[10] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[11] guardian advocate,[12] health care surrogate or proxy, attorney, and representative.[13] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[14]

Task Force Report on Involuntary Examination of Minors

In 2017, the Legislature created a task force within the DCF to address the issue of involuntary examination of minors age 17 years or younger. The task force was composed of stakeholders from the education, mental health, law enforcement, and legal fields. The task force reported its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives on November 15, 2017[15].

[8] Section 394.455(39), F.S. This term does not include a county jail.
[9] Section 394.463(2)(g), F.S.
[10] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. *See* s. 394.455(2), F.S.
[11] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. *See* s. 394.455(17), F.S.
[12] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. *See* s. 394.455(18), F.S.
[13] Section 394.4599(2)(b), F.S.
[14] Section 394.4599(c), F.S.
[15] The Department of Children and Families, Office of Substance Abuse and Mental Health, Task Force Report on Involuntary Examination of Minors, (Nov. 15, 2017), available at: http://www.dcf.state.fl.us/service-programs/samh/publications/ (last visited January 30, 2020).

Analysis by the Task Force

Based on an analysis of available data regarding involuntary examinations of minors, the task force found that:[16]

- Involuntary examinations for children occur in varying degrees across counties.
- There is an increasing trend statewide and in certain counties to initiate involuntary examinations of minors.
- The seasonal pattern shows that involuntary examinations are more common when school is in session.
- Some children have multiple involuntary examinations, although most children who have an involuntary examination have only one.
- Decreases in juvenile arrests correlate with increases of involuntary examinations of children, although it is important to note that the analyses did not show a causal link and there has been a long pattern of decreases in juvenile crime over more than a decade.
- While recent increases in involuntary examinations in certain counties are deserving of focus, a more important focus needs to be on counties that have high rates of involuntary examination. Counties with high rates are, for the most part, not the same counties with the recent increases.
- The most common involuntary examination for children is initiated by law enforcement based on evidence of harm to self.
- The majority of involuntary examinations initiated for children by mental health professionals are initiated by physicians, followed by licensed mental health counselors, and clinical social workers, with many fewer initiated by psychologists, psychiatric nurses, marriage and family therapists, and physicians' assistants.

Recommendations by the Task Force

The task force made six recommendations for encouraging alternatives to and eliminating inappropriate initiations of involuntary examinations of minors under the Baker Act:[17] The recommendations are:

- Fund an adequate network of prevention and early intervention services so that mental health challenges are addressed prior to becoming a crisis.
- Expand access to outpatient crisis intervention services and treatment.
- Create within the DCF the "Invest in the Mental Health of our Children" grant program to provide matching funds to counties that can be used to plan, implement, or expand initiatives that increase public safety, avert increased mental health spending, and improve the accessibility and effectiveness of prevention and intervention services for children who have a diagnosed mental illness or co-occurring mental health and substance use disorder.
- Encourage school districts, through legislative intent language, to adopt a standardized suicide assessment tool that school-based mental health professionals would implement prior to initiation of a Baker Act examination.[18]
- Revise s. 394.463, F.S., to include school psychologists licensed under ch. 490, F.S., on the list of mental health professionals who are qualified to initiate a Baker Act.

[16] *Id.*
[17] *Id.*
[18] The Task Force found that data supports the conclusion that implementation of risk assessment protocols significantly reduced the number of children and youth who received Baker Act initiations in school districts across the state.

- Require Youth Mental Health First Aid or Crisis Intervention Team (CIT)[19] training for school resource officers and other law enforcement officers who initiate Baker Act examinations from schools.

Additionally, the task force recommended amending s. 394.463, F.S., to increase the timeframe from the next working day to five working days in which a receiving facility has to submit forms to the DCF required by s. 394.463, F.S. The task force determined that this change would allow the department to capture data on whether the minor was admitted, released, or a petition filed with the court.[20]

The DCF subsequently released an updated version of the report in 2019.[21] The report revealed that some crisis stabilization units are not meeting the needs of children and adolescents with significant behavioral health needs, contributing to multiple exams.

The 2019 report found there were 205,781 involuntary examinations in Fiscal Year 2017-2018, 36,078 of which were of minors.[22] From Fiscal Years 2013-2014 to 2017-2018, statewide involuntary examinations increased nearly 19 percent for children.[23] Children have a larger increase in examinations compared to young adults ages 18 to 24 (over 14 percent) and adults (over 12 percent).[24] Additionally, nearly 23 percent of minors had multiple involuntary examinations in Fiscal Year 2017-2018, ranging from 2 to 19 examinations.[25] The DCF identified 21 minors who had more than 10 involuntary examinations in Fiscal Year 2017-2018, with a combined total of 285 initiations.[26] The DCF's review of medical records found:[27]

- Most initiations were a result of minors harming themselves and were predominately initiated by law enforcement (88 percent);
- Many minors were involved in the child welfare system and most experienced significant family dysfunction;
- Most had Medicaid health insurance;
- Most experienced multiple traumas such as abuse, bullying, exposure to violence, parental incarceration, and parental substance abuse and mental health issues;
- Most had behavioral disorders of childhood, such as ADHD or Oppositional Defiant Disorder, followed by mood disorders, followed by anxiety disorders;

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[19] U.S. Department of Health and Human Services, *Crisis Intervention Team (CIT) Methods for Using Data to Inform Practice: A Step-by-Step Guide*, 2018, available at: https://store.samhsa.gov/system/files/sma18-5065.pdf, states that: "CIT training is an effective law enforcement response program designed for first responders who handle crisis situations involving individuals with mental illness or co-occurring disorders. It emphasizes a partnership between law enforcement, the mental health and substance abuse treatment system, mental health advocacy groups, and consumers of mental health services and their families. Additionally, this training offers evidence-informed techniques designed to calm the individual in crisis down, reduces reliance on the Baker Act as a means of handling the crisis, and informs individuals of local resources that are available to people in need of mental health services and supports."

[20] *Id.*

[21] The Florida Department of Children and Families, Task Force Report on Involuntary Examination of Minors, 2019, (Nov. 2019), available at: https://www.myflfamilies.com/service-programs/samh/publications/ (last visited Jan. 31, 2020).

[22] *Id.*

[23] *Id.*

[24] *Id.*

[25] *Id.*

[26] *Id.*

[27] *Id.*

- Most involuntary examinations were initiated at home or at a behavioral health provider; and
- Discharge planning and care coordination by the receiving facilities was not adequate enough to meet the child's needs.

The 2019 report recommended:
- Increasing care coordination for minors with multiple involuntary examinations;
- Utilizing the wraparound care coordination approach for children with complex behavioral health needs and multi-system involvement to ensure one point of accountability and individualized care planning;
- Utilizing existing local review teams;
- Revising administrative rules to gather more information about actions taken after the initiation of exams, require electronic submission of forms, and improve care coordination and discharge planning;
- Funding an additional staff position in the DCF to provide technical assistance; and
- Ensuring that parents receive information about mobile crisis response teams and other community resources and supports upon child's discharge.

Mobile Response Teams

Mobile response teams (MRTs) provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.[28] Early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent. MRTs are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.[29] Telehealth can be used to provide direct services to individuals via video-conferencing systems, mobile phones, and remote monitoring. Telehealth can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.[30]

In Fiscal Year 2018-2019, the Legislature funded additional mobile response teams to serve areas of the state that were not being served by such teams at a total cost of $18.3 million.[31] There are currently 40 MRTs serving all 67 Florida counties, targeting services to individuals ages 25 and under. Recent MRT monthly reports showed an 80 percent statewide average of diverting individuals from involuntary examination.[32]

The DCF established a framework to guide procurement of MRTs. This framework suggests that the procurement:
- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;

[28] The Department of Children and Families, *Mobile Response Teams Framework*, (Aug. 29, 2018), p. 4, available at: https://www.myflfamilies.com/service-programs/samh/publications/docs/Mobile%20Response%20Framework.pdf (last visited Jan. 30, 2020).
[29] *Id.*
[30] *Id.*
[31] Chapter 2018-003, Laws of Fla.
[32] *Id.*

- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;
- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner; and
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

III. Effect of Proposed Changes:

Section 1 amends s. 394.493, F.S., requiring the DCF and the AHCA to identify children and adolescents that are high utilizers of crisis stabilization services beginning in Fiscal Years 2020-2021 through 2021-2022. The bill requires both agencies to use this information to meet the behavioral health needs of these children within existing resources. The bill also requires the DCF and the AHCA to jointly submit quarterly reports to the Legislature listing the actions taken to address those needs.

Section 2 amends s. 394.495 F.S., requiring the DCF to contract with the MEs for crisis response services provided through MRTs throughout the state to provide immediate, onsite behavioral health services to children and young adults through age 25. The bill provides that mobile response services must be available to children and young adults:

- With an emotional disturbance;
- Experiencing an acute mental health or emotional crisis;
- Experiencing escalating emotional or behavioral [health] symptoms that effect their ability to function within their community; or
- Children served by the child welfare system experiencing placement instability.

The bill requires mobile response services to respond to new requests for services within 60 minutes in the location where the crisis is occurring. Services must be responsive to the needs of the child, young adult, and their family. Services must be evidence-based, enabling the individuals served to independently and effectively deescalate, reducing the possibility for future crises. MRT services must include screening, standardized assessment, and referral to community services and engage children, young adults, and their families as active participants in the process when possible. The bill also requires that MRT providers develop a care plan, provide care coordination by facilitating referrals to community-based services, establish a process for obtaining informed consent, promote information sharing and the use of innovative technology, coordinate with the ME and other service providers and interested parties including schools, Multiagency Network for Students with Emotional/Behavioral Disabilities (SEDNET), the child welfare system, and the DJJ.

When procuring MRT providers under the bill, MEs must:

- Collaborate with local law enforcement agencies and public schools in the planning, development, evaluation and selection processes;
- Require that services must be available 24 hours a day, seven days a week, with onsite response time to the location of the crisis within 60 minutes;
- Require the MRT provider to establish protocols with law enforcement agencies, community-based care lead agencies (CBCs), the child welfare system, DJJ, and school districts pursuant to s. 1004.44, F.S.;
- Require access to a board certified or board eligible psychiatrist or psychiatric nurse practitioner; and
- Require MRTs to develop referral processes for individuals served to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services to address the immediate crisis.

Section 3 creates s. 394.4955, F.S., requiring each ME to develop a plan that promotes the development and effective implementation of a coordinated system of care to integrate services provided and funded through the state child serving systems to facilitate access to needed mental health services. The development of the plan must include a planning process led by the ME and must include the DCF, individuals served and their families, behavioral health providers, law enforcement agencies, school districts or superintendents, SEDNET, representatives from the child welfare system, the DJJ, early learning coalitions, the AHCA, the Agency for Persons with Disabilities, Medicaid managed medical assistance plans, and other community partners. The bill requires that during the planning process, the ME and the collaborating organizations consider the geographical distribution of the population, needs, and resources, and create separate plans for each county or multi-county area to maximize local collaboration and communication.

To the extent permitted by available resources, the local coordinated system of care must include the services listed in s. 394.495, F.S. The bill also requires each local plan to be integrated with the local designated receiving system plan developed under s. 394.4573, F.S., and must document each coordinated system of care through written memoranda of understanding or other binding arrangements. The ME and collaborating organizations must also create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and supports by making referrals to specialized treatment providers, if necessary, with follow-up to ensure services are received as part of the plan. MEs must complete plans by July 1, 2021, for submission to the DCF. The ME and collaborating organizations are required to implement the coordinated system of care as specified in the plan by July 1, 2022, and must review and update, as necessary, the plans every three years thereafter. When implementing the coordinated system of care, MEs must also identify gaps in the services arrays that are listed in s. 394.495, F.S., for each plan and include any relevant information in their needs assessment required by s. 394.9082, F.S.

Section 4 amends s. 394.9082, F.S., requiring the DCF to consider adolescents who require assistance in transitioning to services provided by the adult system of care when defining the priority populations that will benefit receiving care coordination. The bill requires MEs to include a list and descriptions of gaps in the array of services for children and adolescents identified pursuant to s. 394.4955, F.S., and recommendations for addressing these gaps. The bill also requires MEs to promote the use of available crisis intervention services by requiring contracted service providers to provide MRT contact information to parents and caregivers of

children, adolescents, and young adults between ages 18 and 25, who receive safety-net behavioral health services.

Section 5 amends s. 409.175, F.S., requiring preservice training for foster parents to include information about the local MRT, including contact information, as a means for addressing any behavioral health crisis or to prevent placement disruption.

Section 6 amends s. 409.967, F.S., requiring the AHCA to conduct or contract for systematic and continuous testing of provider network databases maintained by managed care plans in order to confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

Section 7 amends s. 409.988, F.S., requiring that the CBCs ensure that all individuals providing care for dependent children receive contact information for the local MRTs.

Section 8 amends s. 985.601, F.S., requiring the DJJ to participate in the planning process for promoting a coordinated system of care for children and adolescents established in section 3 of the bill.

Section 9 amends s. 1003.02, F.S., requiring district school boards to participate in the planning process for promoting a coordinated system of care for children and adolescents established in section 3 of the bill.

Section 10 amends s. 1004.44, F.S., requiring the Louis De La Parte Florida Mental Health Institute (FMHI)[33] within the University of South Florida, to develop a model response protocol for schools to utilize MRTs by August 1, 2020 and sets minimum requirements for the response protocol. The FMHI must consult with school districts that effectively work with MRTs, school districts that use MRTs less often, law enforcement agencies, the DCF, MEs, and MRT providers.

Section 11 amends s. 1006.04, F.S., requiring the SEDNET to participate in the planning process for promoting a coordinated system of care for children and adolescents as established in section 3 of the bill.

Section 12 amends s. 1011.62, F.S., to require school districts to enter into a memorandum of understanding (MOU) with MEs to facilitate referrals of students to community-based services and coordinate care for student services by school-based and community-based providers. The MOU must include a protocol to share information, coordinate care, and increase access to appropriate services.

The bill requires that school district policies, procedures, and contracts with service providers require that parents of students be provided with information about behavioral health services available through the school or local providers including MRT services. The school may provide

[33] The Louis De La Parte Florida Mental Health Institute is housed within the College of Behavioral and Community Sciences at the University of South Florida. Available at: https://www.usf.edu/cbcs/fmhi/.

this information through web-based directories or local guides if they are easy to understand and navigate by individuals who are unfamiliar with the behavioral health system. The bill also requires that school district policies, procedures, and contracts with service providers require the use MRT services to the extent that they are available. Each school district is required to establish policies and procedures to implement the model response protocol developed under s. 1004.44, F.S.

The bill also requires school districts to refer students or others living in the household of the student to behavioral health services available through other delivery systems or payers.

Section 13 requires the DCF and the AHCA to assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of services. The bill requires the DCF and the AHCA to review current laws regarding licensure and designation under s. 394.461, F.S., and compare standards to other states and national standards to make recommendations for improvements. This assessment shall address efforts by facilities to gather and assess information regarding the child or adolescent, to create comprehensive discharge plans to effectively address the needs of the child to help avoid or reduce the need for future crisis stabilization services.

The bill requires the DCF and the AHCA to jointly submit a report of the findings and recommendations to the Governor, the Senate President, and the Speaker of the House of Representatives by November 15, 2020.

Section 14 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector providers of behavioral health services for children, adolescents, and adults ages 25 and under, will need to revise policies and procedures, generate new forms, and provide training to service provider staff and administrators on the new requirements in the bill. Additional staff may be required for some providers to meet the increased need for services and revised patient response time requirements. The fiscal impact of these changes is indeterminate.

The additional responsibilities under the bill will create a significant fiscal impact for MRTs. Requiring services to be provided within 60 minutes of a request will be difficult to provide given the current strained capacity of MRTs and that MRTs often provide services remotely (via telehealth or other means of electronic communication). Additionally, there will be a significant fiscal impact to MRTs if the teams are responsible for on-going care. Currently, MRTs are responsible for the hand off and transition to ongoing behavioral health and wraparound services. The agency or agencies are responsible for providing ongoing services to ensure the active participation of parents and children and continued treatment.

C. Government Sector Impact:

Department of Children and Families

The DCF estimates that it will require one additional full-time employee (FTE) carry out the duties of coordinating care for children and adolescents that are high utilizers of crisis stabilization services. The department estimates the recurring cost for the position to be $85,281 from the General Revenue Fund.[34] However, the department should be able to absorb the additional workload within existing department resources.

To the extent more children and their families are referred to behavioral health services, a managing entity may incur an administrative workload increase.

The Agency for Health Care Administration

The AHCA estimates that it will require two additional FTEs to implement the behavioral health network adequacy requirements and data analysis outline in the bill. The agency estimates that the two staff positions will result in recurring costs of $173,174 with $86,587 being funded from the General Revenue Fund. However, the department should be able to absorb the additional workload within existing department resources.

[34] The Department of Children and Families Agency Analysis, HB 945, Dec. 19, 2019. On file with the Senate Children, Families, and Elder Affairs Committee.

School Districts

The bill requires all safe-school officers to complete mental health crisis intervention training. Previously, just school resource officers were required to complete this training. The bill also requires that each school district's plan, that must be submitted prior to the release of its Mental Health Assistance Allocation, include policies and contracts with services providers for referrals to behavioral health services. The fiscal impact to the school districts is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.493, 394.495, 394.9082, 409.175, 409.967, 409.988, 985.601, 1003.02, 1004.44, 1006.04, and 1011.62.

This bill creates section 394.4955 of the Florida Statutes.

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 Children, Families, and Elder Affairs on February 4, 2020:

- Requires the AHCA to continually test the managed care plan provider network databases to ensure that behavioral health providers are accepting enrollees and confirm that enrollees have access to behavioral health systems.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and Senator Powell

586-03119-20 20201440c1

A bill to be entitled

An act relating to children's mental health; amending s. 394.493, F.S.; requiring the Department of Children and Families and the Agency for Health Care Administration to identify certain children and adolescents who use crisis stabilization services during specified fiscal years; requiring the department and agency to collaboratively meet the behavioral health needs of such children and adolescents and submit a quarterly report to the Legislature; amending s. 394.495, F.S.; including crisis response services provided through mobile response teams in the array of services available to children and adolescents; requiring the department to contract with managing entities for mobile response teams to provide certain services to certain children, adolescents, and young adults; providing requirements for such mobile response teams; providing requirements for managing entities when procuring mobile response teams; creating s. 394.4955, F.S.; requiring managing entities to develop a plan promoting the development of a coordinated system of care for certain services; providing requirements for the planning process; requiring each managing entity to submit such plan by a specified date; requiring the entities involved in the planning process to implement such plan by a specified date; requiring that such plan be reviewed and updated periodically; amending s. 394.9082, F.S.; revising the duties of the department relating to

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priority populations that will benefit from care coordination; requiring that a managing entity's behavioral health care needs assessment include certain information regarding gaps in certain services; requiring a managing entity to promote the use of available crisis intervention services; amending s. 409.175, F.S.; revising requirements relating to preservice training for foster parents; amending s. 409.967, F.S.; requiring the agency to conduct, or contract for, the testing of provider network databases maintained by Medicaid managed care plans for specified purposes; amending s. 409.988, F.S.; revising the duties of a lead agency relating to individuals providing care for dependent children; amending s. 985.601, F.S.; requiring the Department of Juvenile Justice to participate in the planning process for promoting a coordinated system of care for children and adolescents; amending s. 1003.02, F.S.; requiring each district school board to participate in the planning process for promoting a coordinated system of care; amending s. 1004.44, F.S.; requiring the Louis de la Parte Florida Mental Health Institute to develop, in consultation with other entities, a model response protocol for schools; amending s. 1006.04, F.S.; requiring the educational multiagency network to participate in the planning process for promoting a coordinated system of care; amending s. 1011.62, F.S.; revising the elements of a plan required for school district funding under the mental

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

health assistance allocation; requiring the Department of Children and Families and the Agency for Health Care Administration to assess the quality of care provided in crisis stabilization units to certain children and adolescents; requiring the department and agency to review current standards of care for certain settings and make recommendations; requiring the department and agency to jointly submit a report to the Governor and the Legislature by a specified date; providing an effective date.

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

Section 1. Subsection (4) is added to section 394.493, Florida Statutes, to read:

394.493 Target populations for child and adolescent mental health services funded through the department.—

(4) Beginning with fiscal year 2020-2021 through fiscal year 2021-2022, the department and the Agency for Health Care Administration shall identify children and adolescents who are the highest utilizers of crisis stabilization services. The department and agency shall collaboratively take appropriate action within available resources to meet the behavioral health needs of such children and adolescents more effectively, and shall jointly submit to the Legislature a quarterly report listing the actions taken by both agencies to better serve such children and adolescents.

Section 2. Paragraph (q) is added to subsection (4) of section 394.495, Florida Statutes, and subsection (7) is added

to that section, to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(4) The array of services may include, but is not limited to:

(q) Crisis response services provided through mobile response teams.

(7)(a) The department shall contract with managing entities for mobile response teams throughout the state to provide immediate, onsite behavioral health crisis services to children, adolescents, and young adults ages 18 to 25, inclusive, who:

1. Have an emotional disturbance;

2. Are experiencing an acute mental or emotional crisis;

3. Are experiencing escalating emotional or behavioral reactions and symptoms that impact their ability to function typically within the family, living situation, or community environment; or

4. Are served by the child welfare system and are experiencing or are at high risk of placement instability.

(b) A mobile response team shall, at a minimum:

1. Respond to new requests for services within 60 minutes after such requests are made.

2. Respond to a crisis in the location where the crisis is occurring.

3. Provide behavioral health crisis-oriented services that are responsive to the needs of the child, adolescent, or young adult and his or her family.

4. Provide evidence-based practices to children, adolescents, young adults, and families to enable them to

independently and effectively deescalate and respond to behavioral challenges that they are facing and to reduce the potential for future crises.

5. Provide screening, standardized assessments, early identification, and referrals to community services.

6. Engage the child, adolescent, or young adult and his or her family as active participants in every phase of the treatment process whenever possible.

7. Develop a care plan for the child, adolescent, or young adult.

8. Provide care coordination by facilitating the transition to ongoing services.

9. Ensure there is a process in place for informed consent and confidentiality compliance measures.

10. Promote information sharing and the use of innovative technology.

11. Coordinate with the managing entity within the service location and other key entities providing services and supports to the child, adolescent, or young adult and his or her family, including, but not limited to, the child, adolescent, or young adult's school, the local educational multiagency network for severely emotionally disturbed students under s. 1006.04, the child welfare system, and the juvenile justice system.

(c) When procuring mobile response teams, the managing entity must, at a minimum:

1. Collaborate with local sheriff's offices and public schools in the planning, development, evaluation, and selection processes.

2. Require that services be made available 24 hours per

day, 7 days per week, with onsite response time to the location of the referred crisis within 60 minutes after the request for services is made.

3. Require the provider to establish response protocols with local law enforcement agencies, local community-based care lead agencies as defined in s. 409.986(3), the child welfare system, and the Department of Juvenile Justice. The response protocol with a school district shall be consistent with the model response protocol developed under s. 1004.44.

4. Require access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner.

5. Require mobile response teams to refer children, adolescents, or young adults and their families to an array of crisis response services that address individual and family needs, including screening, standardized assessments, early identification, and community services as necessary to address the immediate crisis event.

Section 3. Section 394.4955, Florida Statutes, is created to read:

394.4955 Coordinated system of care; child and adolescent mental health treatment and support.—

(1) Pursuant to s. 394.9082(5)(d), each managing entity shall develop a plan that promotes the development and effective implementation of a coordinated system of care which integrates services provided through providers funded by the state's child-serving systems and facilitates access by children and adolescents, as resources permit, to needed mental health treatment and services at any point of entry regardless of the time of year, intensity, or complexity of the need, and other

systems with which such children and adolescents are involved, as well as treatment and services available through other systems for which they would qualify.

(2)(a) The managing entity shall lead a planning process that includes, but is not limited to, children and adolescents with behavioral health needs and their families; behavioral health service providers; law enforcement agencies; school districts or superintendents; the multiagency network for students with emotional or behavioral disabilities; the department; and representatives of the child welfare and juvenile justice systems, early learning coalitions, the Agency for Health Care Administration, Medicaid managed medical assistance plans, the Agency for Persons with Disabilities, the Department of Juvenile Justice, and other community partners. An organization receiving state funding must participate in the planning process if requested by the managing entity.

(b) The managing entity and collaborating organizations shall take into consideration the geographical distribution of the population, needs, and resources, and create separate plans on an individual county or multi-county basis, as needed, to maximize collaboration and communication at the local level.

(c) To the extent permitted by available resources, the coordinated system of care shall include the array of services listed in s. 394.495.

(d) Each plan shall integrate with the local plan developed under s. 394.4573.

(3) By July 1, 2021, the managing entity shall complete the plans developed under this section and submit them to the department. By July 1, 2022, the entities involved in the

planning process shall implement the coordinated system of care specified in each plan. The managing entity and collaborating organizations shall review and update the plans, as necessary, at least every 3 years thereafter.

(4) The managing entity and collaborating organizations shall create integrated service delivery approaches within current resources that facilitate parents and caregivers obtaining services and support by making referrals to specialized treatment providers, if necessary, with follow up to ensure services are received.

(5) The managing entity and collaborating organizations shall document each coordinated system of care for children and adolescents through written memoranda of understanding or other binding arrangements.

(6) The managing entity shall identify gaps in the arrays of services for children and adolescents listed in s. 394.495 available under each plan and include relevant information in its annual needs assessment required by s. 394.9082.

Section 4. Paragraph (c) of subsection (3) and paragraphs (b) and (d) of subsection (5) of section 394.9082, Florida Statutes, are amended, and paragraph (t) is added to subsection (5) of that section, to read:

394.9082 Behavioral health managing entities.—

(3) DEPARTMENT DUTIES.—The department shall:

(c) Define the priority populations that will benefit from receiving care coordination. In defining such populations, the department shall take into account the availability of resources and consider:

1. The number and duration of involuntary admissions within

a specified time.

2. The degree of involvement with the criminal justice system and the risk to public safety posed by the individual.

3. Whether the individual has recently resided in or is currently awaiting admission to or discharge from a treatment facility as defined in s. 394.455.

4. The degree of utilization of behavioral health services.

5. Whether the individual is a parent or caregiver who is involved with the child welfare system.

6. Whether the individual is an adolescent, as defined in s. 394.492, who requires assistance in transitioning to services provided in the adult system of care.

(5) MANAGING ENTITY DUTIES.—A managing entity shall:

(b) Conduct a community behavioral health care needs assessment every 3 years in the geographic area served by the managing entity which identifies needs by subregion. The process for conducting the needs assessment shall include an opportunity for public participation. The assessment shall include, at a minimum, the information the department needs for its annual report to the Governor and Legislature pursuant to s. 394.4573. The assessment shall also include a list and descriptions of any gaps in the arrays of services for children or adolescents identified pursuant to s. 394.4955 and recommendations for addressing such gaps. The managing entity shall provide the needs assessment to the department.

(d) Promote the development and effective implementation of a coordinated system of care pursuant to ss. 394.4573 and 394.495 ~~s. 394.4573~~.

(t) Promote the use of available crisis intervention

services by requiring contracted providers to provide contact information for mobile response teams established under s. 394.495 to parents and caregivers of children, adolescents, and young adults between ages 18 and 25, inclusive, who receive safety-net behavioral health services.

Section 5. Paragraph (b) of subsection (14) of section 409.175, Florida Statutes, is amended to read:

409.175 Licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption.—

(14)

(b) As a condition of licensure, foster parents shall successfully complete preservice training. The preservice training shall be uniform statewide and shall include, but not be limited to, such areas as:

1. Orientation regarding agency purpose, objectives, resources, policies, and services;

2. Role of the foster parent as a treatment team member;

3. Transition of a child into and out of foster care, including issues of separation, loss, and attachment;

4. Management of difficult child behavior that can be intensified by placement, by prior abuse or neglect, and by prior placement disruptions;

5. Prevention of placement disruptions;

6. Care of children at various developmental levels, including appropriate discipline; ~~and~~

7. Effects of foster parenting on the family of the foster parent; and

8. Information about and contact information for the local

mobile response team as a means for addressing a behavioral health crisis or preventing placement disruption.

Section 6. Paragraph (c) of subsection (2) of section 409.967, Florida Statutes, is amended 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:

(c) *Access.*—

1. The agency shall establish specific standards for the number, type, and regional distribution of providers in managed care plan networks to ensure access to care for both adults and children. Each plan must maintain a regionwide network of providers in sufficient numbers to meet the access standards for specific medical services for all recipients enrolled in the plan. The exclusive use of mail-order pharmacies may not be sufficient to meet network access standards. Consistent with the standards established by the agency, provider networks may include providers located outside the region. A plan may contract with a new hospital facility before the date the hospital becomes operational if the hospital has commenced construction, will be licensed and operational by January 1, 2013, and a final order has issued in any civil or administrative challenge. Each plan shall establish and maintain an accurate and complete electronic database of contracted providers, including information about licensure or registration, locations and hours of operation, specialty credentials and other certifications, specific performance

indicators, and such other information as the agency deems necessary. The database must be available online to both the agency and the public and have the capability to compare the availability of providers to network adequacy standards and to accept and display feedback from each provider's patients. Each plan shall submit quarterly reports to the agency identifying the number of enrollees assigned to each primary care provider. The agency shall conduct, or contract for, systematic and continuous testing of the provider network databases maintained by each plan to confirm accuracy, confirm that behavioral health providers are accepting enrollees, and confirm that enrollees have access to behavioral health services.

2. Each managed care plan must publish any prescribed drug formulary or preferred drug list on the plan's website in a manner that is accessible to and searchable by enrollees and providers. The plan must update the list within 24 hours after making a change. Each plan must ensure that the prior authorization process for prescribed drugs is readily accessible to health care providers, including posting appropriate contact information on its website and providing timely responses to providers. For Medicaid recipients diagnosed with hemophilia who have been prescribed anti-hemophilic-factor replacement products, the agency shall provide for those products and hemophilia overlay services through the agency's hemophilia disease management program.

3. Managed care plans, and their fiscal agents or intermediaries, must accept prior authorization requests for any service electronically.

4. Managed care plans serving children in the care and

custody of the Department of Children and Families must maintain complete medical, dental, and behavioral health encounter information and participate in making such information available to the department or the applicable contracted community-based care lead agency for use in providing comprehensive and coordinated case management. The agency and the department shall establish an interagency agreement to provide guidance for the format, confidentiality, recipient, scope, and method of information to be made available and the deadlines for submission of the data. The scope of information available to the department shall be the data that managed care plans are required to submit to the agency. The agency shall determine the plan's compliance with standards for access to medical, dental, and behavioral health services; the use of medications; and followup on all medically necessary services recommended as a result of early and periodic screening, diagnosis, and treatment.

Section 7. Paragraph (f) of subsection (1) of section 409.988, Florida Statutes, is amended to read:

409.988 Lead agency duties; general provisions.—

(1) DUTIES.—A lead agency:

(f) Shall ensure that all individuals providing care for dependent children receive:

1. Appropriate training and meet the minimum employment standards established by the department.

2. Contact information for the local mobile response team established under s. 394.495.

Section 8. Subsection (4) of section 985.601, Florida Statutes, is amended to read:

985.601 Administering the juvenile justice continuum.—

(4) The department shall maintain continuing cooperation with the Department of Education, the Department of Children and Families, the Department of Economic Opportunity, and the Department of Corrections for the purpose of participating in agreements with respect to dropout prevention and the reduction of suspensions, expulsions, and truancy; increased access to and participation in high school equivalency diploma, vocational, and alternative education programs; and employment training and placement assistance. The cooperative agreements between the departments shall include an interdepartmental plan to cooperate in accomplishing the reduction of inappropriate transfers of children into the adult criminal justice and correctional systems. As part of its continuing cooperation, the department shall participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 9. Subsection (5) is added to section 1003.02, Florida Statutes, to read:

1003.02 District school board operation and control of public K-12 education within the school district.—As provided in part II of chapter 1001, district school boards are constitutionally and statutorily charged with the operation and control of public K-12 education within their school district. The district school boards must establish, organize, and operate their public K-12 schools and educational programs, employees, and facilities. Their responsibilities include staff development, public K-12 school student education including education for exceptional students and students in juvenile

justice programs, special programs, adult education programs, and career education programs. Additionally, district school boards must:

(5) Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 10. Present subsection (4) of section 1004.44, Florida Statutes, is redesignated as subsection (5), and a new subsection (4) is added to that section, to read:

1004.44 Louis de la Parte Florida Mental Health Institute.—There is established the Louis de la Parte Florida Mental Health Institute within the University of South Florida.

(4) By August 1, 2020, the institute shall develop a model response protocol for schools to use mobile response teams established under s. 394.495. In developing the protocol, the institute shall, at a minimum, consult with school districts that effectively use such teams, school districts that use such teams less often, local law enforcement agencies, the Department of Children and Families, managing entities as defined in s. 394.9082(2), and mobile response team providers.

Section 11. Paragraph (c) of subsection (1) of section 1006.04, Florida Statutes, is amended to read:

1006.04 Educational multiagency services for students with severe emotional disturbance.—

(1)

(c) The multiagency network shall:

1. Support and represent the needs of students in each school district in joint planning with fiscal agents of children's mental health funds, including the expansion of

school-based mental health services, transition services, and integrated education and treatment programs.

2. Improve coordination of services for children with or at risk of emotional or behavioral disabilities and their families by assisting multi-agency collaborative initiatives to identify critical issues and barriers of mutual concern and develop local response systems that increase home and school connections and family engagement.

3. Increase parent and youth involvement and development with local systems of care.

4. Facilitate student and family access to effective services and programs for students with and at risk of emotional or behavioral disabilities that include necessary educational, residential, and mental health treatment services, enabling these students to learn appropriate behaviors, reduce dependency, and fully participate in all aspects of school and community living.

5. Participate in the planning process for promoting a coordinated system of care for children and adolescents pursuant to s. 394.4955.

Section 12. Paragraph (b) of subsection (16) of section 1011.62, Florida Statutes, is amended to read:

1011.62 Funds for operation of schools.—If the annual allocation from the Florida Education Finance Program to each district for operation of schools is not determined in the annual appropriations act or the substantive bill implementing the annual appropriations act, it shall be determined as follows:

(16) MENTAL HEALTH ASSISTANCE ALLOCATION.—The mental health

assistance allocation is created to provide funding to assist school districts in establishing or expanding school-based mental health care; train educators and other school staff in detecting and responding to mental health issues; and connect children, youth, and families who may experience behavioral health issues with appropriate services. These funds shall be allocated annually in the General Appropriations Act or other law to each eligible school district. Each school district shall receive a minimum of $100,000, with the remaining balance allocated based on each school district's proportionate share of the state's total unweighted full-time equivalent student enrollment. Charter schools that submit a plan separate from the school district are entitled to a proportionate share of district funding. The allocated funds may not supplant funds that are provided for this purpose from other operating funds and may not be used to increase salaries or provide bonuses. School districts are encouraged to maximize third-party health insurance benefits and Medicaid claiming for services, where appropriate.

(b) The plans required under paragraph (a) must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services to students with one or more mental health or co-occurring substance abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care. At a minimum, the plans must include the following elements:

1. Direct employment of school-based mental health services providers to expand and enhance school-based student services and to reduce the ratio of students to staff in order to better align with nationally recommended ratio models. These providers include, but are not limited to, certified school counselors, school psychologists, school social workers, and other licensed mental health professionals. The plan also must identify strategies to increase the amount of time that school-based student services personnel spend providing direct services to students, which may include the review and revision of district staffing resource allocations based on school or student mental health assistance needs.

2. An interagency agreement or memorandum of understanding with the managing entity, as defined in s. 394.9082(2), that facilitates referrals of students to community-based services and coordinates care for students served by school-based and community-based providers. Such agreement or memorandum of understanding must address the sharing of records and information as authorized under s. 1006.07(7)(d) to coordinate care and increase access to appropriate services.

3.~~2.~~ Contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide a behavioral health staff presence and services at district schools. Services may include, but are not limited to, mental health screenings and assessments, individual counseling, family counseling, group counseling, psychiatric or psychological services, trauma-informed care, mobile crisis services, and behavior modification. These behavioral health services may be provided

on or off the school campus and may be supplemented by telehealth.

4.~~3.~~ Policies and procedures, including contracts with service providers, which will ensure that:

a. Parents of students are provided information about behavioral health services available through the students' school or local community-based behavioral health services providers, including, but not limited to, the mobile response team as established in s. 394.495 serving their area. A school may meet this requirement by providing information about and Internet addresses for web-based directories or guides of local behavioral health services as long as such directories or guides are easily navigated and understood by individuals unfamiliar with behavioral health delivery systems or services and include specific contact information for local behavioral health providers.

b. School districts use the services of the mobile response teams to the extent that such services are available. Each school district shall establish policies and procedures to carry out the model response protocol developed under s. 1004.44.

c. Students who are referred to a school-based or community-based mental health service provider for mental health screening for the identification of mental health concerns and ensure that the assessment of students at risk for mental health disorders occurs within 15 days of referral. School-based mental health services must be initiated within 15 days after identification and assessment, and support by community-based mental health service providers for students who are referred for community-based mental health services must be initiated

within 30 days after the school or district makes a referral.

d. Referrals to behavioral health services available through other delivery systems or payors for which a student or individuals living in the household of a student receiving services under this subsection may qualify, if such services appear to be needed or enhancements in those individuals' behavioral health would contribute to the improved well-being of the student.

5.~~4.~~ Strategies or programs to reduce the likelihood of at-risk students developing social, emotional, or behavioral health problems, depression, anxiety disorders, suicidal tendencies, or substance use disorders.

6.~~5.~~ Strategies to improve the early identification of social, emotional, or behavioral problems or substance use disorders, to improve the provision of early intervention services, and to assist students in dealing with trauma and violence.

Section 13. The Department of Children and Families and the Agency for Health Care Administration shall assess the quality of care provided in crisis stabilization units to children and adolescents who are high utilizers of crisis stabilization services. The department and agency shall review current standards of care for such settings applicable to licensure under chapters 394 and 408, Florida Statutes, and designation under s. 394.461, Florida Statutes; compare the standards to other states' standards and relevant national standards; and make recommendations for improvements to such standards. The assessment and recommendations shall address, at a minimum, efforts by each facility to gather and assess information

regarding each child or adolescent, to coordinate with other providers treating the child or adolescent, and to create discharge plans that comprehensively and effectively address the needs of the child or adolescent to avoid or reduce his or her future use of crisis stabilization services. The department and agency shall jointly submit a report of their findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2020.

Section 14. This act shall take effect July 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 4, 2020

I respectfully request that **Senate Bill #1440**, relating to Children's Mental Health, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Bobby Powell
Florida Senate, District 30

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/18/20
Meeting Date

1440
Bill Number (if applicable)

Topic Mental Health

Amendment Barcode (if applicable)

Name Angie Gallo

Job Title V.P Florida PTA

Address 1747 Orlando Central Pkwy Phone

Street

Orlando FL 32809 Email

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida PTA

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:	CS/SB 1548
INTRODUCER:	Children, Families, and Elder Affairs Committee; and Senators Perry and Hutson
SUBJECT:	Child Welfare
DATE:	February 17, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1548 makes a number of changes to current law applicable to children in out-of-home care.

Specifically, the bill:

- Requires the Florida Court Educational Council to establish certain standards, consistent with the purposes of ch. 39, F.S., for instruction of circuit court judges in dependency cases.
- Eliminates the requirement for the Department of Children and Families (DCF or department) to submit annual reports to the Governor and legislature on false reports of abuse allegations made to the Florida Abuse Hotline, and the Road-to-Independence Program.
- Authorizes the DCF to appoint all qualified evaluators who conduct suitability assessments for children in out-of-home care.
- Authorizes the DCF to adopt rules relating to qualified evaluators and implement Medicaid behavioral health utilization management programs for statewide in-patient psychiatric (SIPP) facilities with a contracted vendor.
- Creates an emergency modification of placement process that uses a probable cause standard to ensure child safety when a child is either abandoned by or must be immediately removed from a relative or nonrelative caregiver, or a licensed foster home.
- Resolves a conflict in ch. 39, F.S., concerning the timeframe for filing and serving a case plan.

- Clarifies the process for terminating court jurisdiction and department supervision in a dependency court action by relocating provisions concerning supervision and jurisdiction located throughout ch. 39, F.S., into a newly created s. 39.63, F.S.
- Creates s. 39.8025, F.S., to provide a lawful process to immediately protect children whose parents are deceased by committing them to the custody of the department and making them eligible for adoption.
- Clarifies that the department is not required to provide reasonable efforts to preserve and reunify the family if a court has found that the parent is registered as a sexual predator.
- Provides standing for an unsuccessful applicant to adopt a child who is permanently committed to the department to have the opportunity to prove that the department has unreasonably withheld its consent to the applicant. These amendments eliminate the need for an administrative appeal process for unsuccessful applicants and eliminates multiple competing adoption petitions by the approved and unsuccessful applicants.
- Requires a petition to adopt a child who is permanently committed to the department to demonstrate that the department has consented to the adoption or that the dependency court has entered an order waiving the department's consent.
- Provides that a dependent child's placement with a prospective adoptive parent after a dependency proceeding can only occur after a preliminary home study is completed that establishes the suitability of the home.

The bill is expected to have a positive fiscal impact on state government. See Section V.

The bill takes effect October 1, 2020.

II. Present Situation:

Judicial Education

The Florida Court Education Council was established in 1978 and charged with providing oversight of the development and maintenance of a comprehensive educational program for Florida judges and certain court support personnel. The Council's responsibilities include making budgetary, programmatic, and policy recommendations to the Supreme Court regarding continuing education for Florida judges and certain court professionals.

All judges new to the bench are required to complete the Florida Judicial College program during their first year of judicial service following selection to the bench. Taught by faculty consisting of experienced trial and appellate court judges, the College's curriculum includes:

- A comprehensive orientation program including an in-depth trial skills workshop, a mock trial experience, and other classes;
- Intensive substantive law courses incorporating education for new trial judges and those who are switching divisions;
- A separate program designed especially for new appellate judges;
- A mentor program providing new trial court judges one-to-one guidance from experienced judges.[1]

[1] The Florida Courts, *Information for New Judges*, *available at*: https://www.flcourts.org/Resources-Services/Judiciary-Education/Information-for-New-Judges (Last visited December 26, 2019).

All Florida county, circuit, appellate, and supreme court justices are required to comply with the following judicial education requirements:

- Each judge and justice shall complete a minimum of 30 credit hours of approved judicial education programs every three years.
- Each judge or justice must complete four hours of training in judicial ethics. Approved courses in fairness and diversity also can be used to fulfill this requirement.
- Every judge new to a level of trial court must complete the Florida Judicial College program in that judge's first year of judicial service following selection to that level of court.
- Every new appellate court judge or justice must, within two years following selection to that level of court, complete an approved appellate judge program. Every new appellate judge who has never been a trial judge or has never attended Phase I of the Florida Judicial College as a magistrate must attend Phase I of the Florida Judicial College within a year of the judge's appointment.[2]

To help judges satisfy this educational requirement, Florida Judiciary Education currently presents a variety of educational programs for new judges, experienced judges, and some court staff. About 900 hours of instruction are offered each year through live presentations and distance learning formats. This education helps judges and staff to enhance their legal knowledge, administrative skills, and ethical standards.

In addition, extensive information is available to judges handling dependency cases in the Dependency Benchbook. The benchbook is a compilation of promising and science-informed practices as well as a legal resource guide. It is a comprehensive tool for judges, providing information regarding legal and non-legal considerations in dependency cases. Topics covered include the importance of a secure attachment with a primary caregiver, the advantages of stable placements, and the effects of trauma on child development.[3]

Case Closure

Current law does not have a case closure statute that addresses when a court can terminate the department's supervision or the court's jurisdiction. Instead, the only section in ch. 39, F.S., that describes when these events can occur is s. 39.521, F.S., which addresses disposition. Section 39.521(1)(c)3., F.S., provides that protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, relative, or legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction at the court's discretion, and is a permanency option for the child. The order terminating the DCF's supervision must describe the powers of the child custodian and include the powers ordinarily granted to a guardian of a minor unless otherwise specified. Upon the court's termination of supervision by the department, further judicial reviews are not required if permanency of the child is established.

[2] Fla. R. Jud. Admin. 2.320 As amended through August 29, 2019, *available at*: https://casetext.com/rule/florida-court-rules/florida-rules-of-judicial-administration/part-iii-judicial-officers/rule-2320-continuing-judicial-education (Last visited December 26, 2019).
[3] The Florida Courts, *Dependency Benchbook*, *available at* https://www.flcourts.org/Resources-Services/Court-Improvement/Family-Courts/Dependency/Dependency-Benchbook (Last visited December 27, 2019).

Permanent Commitment of Orphaned Children

Presently, the department can adjudicate a child dependent if both parents are deceased, but there is no legal mechanism to permanently commit the child to the department for subsequent adoption.

The court in *F.L.M. v. Department of Children and Families*, 912 So. 2d 1264 (Fla. 4th DCA 2005), held that when the parents or guardians have died, they have not abandoned the child because the definition of abandonment contemplates the failure to provide a minor child with support and supervision while being able and the parents who died are no longer able to do so. Instead, the court held that an orphaned child without a legal custodian can be properly adjudicated dependent based upon s. 39.01(14)(e), F.S.,[4] in that the child has no parent or legal custodian capable of providing supervision and care. As such, the department relies upon s. 39.01, F.S., to adjudicate orphaned children dependent.

Section 39.811(2), F.S., allows a court to commit a child to the custody of the department for the purpose of adoption if the court finds that the grounds for termination of parental rights have been established by clear and convincing evidence. Section 39.806(1), F.S., outlines the available grounds for termination of parental rights. Those grounds include a written surrender voluntarily executed by the parent, abandonment, failure by the parent to substantially comply with a case plan, and egregious conduct on the part of the parent, among other grounds. All of the grounds available under s. 39.806(1), F.S., require that the parent engage in some kind of behavior that puts a child at risk. Because a deceased parent can no longer engage in any behavior, the department cannot seek the termination of a deceased parent's rights. Moreover, even if there was a legal ground to seek the termination of a deceased parent's rights, there may be benefits that the child is receiving such as social security benefits or an inheritance as a result of the parent's death that the department would not want to halt by seeking a termination of the deceased parent's rights. Because the department cannot seek termination of parental rights when both parents are deceased, courts are permanently committing children to the department's custody without meeting the requirements of s. 39.811(2), F.S. The dependency system is in need of a statute that permits an orphaned child to be permanently committed to the department for subsequent adoption without terminating the deceased parent's rights so as to allow the child to continue to receive death benefits.

Reasonable Efforts for Registered Sexual Predators

Currently, s. 39.806(1)(n), F.S., provides that grounds for termination of parental rights may be established when the parent is convicted of an offense that requires the parent to register as a sexual predator under s. 775.21, F.S.

Section 39.806(2), F.S., provides that the DCF is not required to provide reasonable efforts to preserve and reunify families if the court has determined that any of the events described in s. 39.806(1), F.S., have occurred. These are referred to as the "expedited termination of parental rights" grounds because the department does not need to obtain an adjudication of dependency

[4] This section is currently numbered as s. 39.01(15)(e), F.S.

and offer the parents a case plan for reunification before seeking termination of the parents' rights. These grounds include where the parent has committed egregious conduct, aggravated child abuse, and aggravated sexual battery. Because s. 39.806(1)(n), F.S., is not listed in s. 39.806(2), F.S., the department must provide a parent who is a convicted and registered sexual predator a case plan for reunification prior to seeking termination of that parent's rights pursuant to this particular ground for termination.

Department's Selection of Adoptive Placement

Currently, the department's ability to place a child in its custody for adoption and the court's review of the placement is provided for in s. 39.812, F.S. The statute provides the department may place a child in a home and the department's consent alone shall be sufficient. The dependency court retains jurisdiction over any child placed in the custody of the department until the child is adopted pursuant to ss. 39.811(9), 39.812(4), and 39.813, F.S. After custody of a child for subsequent adoption has been given to the department, the court has jurisdiction for the purpose of reviewing the status of the child and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, s. 39.811(9), F.S., provides that for good cause shown by the Guardian ad Litem for the child, the court may review the appropriateness of the adoptive placement of the child.

Where a child is available for adoption, the DCF through its contractors will receive applications to adopt the child. Some applicants are not selected because their adoption home study is denied. When there are two or more families with approved home studies, the department's rules route these conflicting applications through the adoption applicant review committee (AARC) for resolution. The decision of the AARC is then reviewed and the department issues its consent to one applicant while communicating its denial to the other applicants through certified letter. These letters are considered final agency action. Unsuccessful applicants have a "point of entry" to seek review of department action through the administrative hearing process under ch. 120, F.S. These hearings are heard by designated hearing officers within the department. The assignment of adoption disputes to the ch. 120, F.S., process did not originate with nor was it inspired by legislative directive. Instead, this process arose due to the opinion in *Department of Children & Family Services v. I.B. and D.B.*, 891 So. 2d 1168 (Fla. 1st DCA 2005). However, this process is inconsistent with legislative intent of permanency and resolution of all disputes through the ch. 39, F.S., process.

Florida law also permits individuals who the department has not approved to adopt a child, to initiate a ch. 63, F.S., legal action by filing a petition for adoption. Upon filing the petition, the petitioner must demonstrate pursuant to s. 63.062(7), F.S., that the department unreasonably withheld its consent to be permitted to adopt the child. Because ch. 63, F.S., permits anyone who meets the requirements of s. 63.042(2), F.S., to adopt and any petitioner may argue the department's consent to the adoption should be waived because it was unreasonably withheld, multiple parties may file a petition to adopt the same child. Indeed, there can be at least three legal proceedings simultaneously addressing the adoption of the child:

- Ch. 39, F.S., dependency proceedings.
- Ch. 63, F.S., adoption proceeding filed by the family who has the department's consent.
- Ch. 63, F.S., adoption proceeding filed by the applicant who asserts the department unreasonably withheld its consent.

Multiple competing adoption petitions require additional court hearings to resolve the conflict and leads to a delay of the child's adoption. These court proceedings often occur concurrently with the administrative hearing process, which can lead to disparate results.

Relative Home Studies in ch. 63, F.S., Intervention Proceedings

For children in the custody of the department, s. 63.082(6)(a), F.S., provides that if a parent executes a consent for placement of a minor with an adoption entity or qualified adoptive parents, but parental rights have not yet been terminated, the adoption consent is valid, binding, and enforceable by the court. After the parent executes the consent, s. 63.082(6)(b), F.S., permits the adoption entity to intervene in the dependency case as a party in interest and requires the adoption entity to provide the court with a copy of the preliminary home study of the prospective adoptive parents and any other evidence of the suitability of the placement. Section 63.082(6)(b), F.S., further provides that the home study provided by the adoption entity shall be sufficient unless the court has concerns regarding the qualifications of the home study provider or concerns that the home study may not be adequate to determine the best interests of the child.

Although s. 63.082(6), F.S., provides no exception for the completion of a preliminary home study before the court may transfer custody of the child to the prospective adoptive parents, parties have been able to intervene and accomplish a modification of placement without presenting the court with a home study by relying upon s. 63.092(3), F.S. This section provides that a preliminary home study in a nondependency proceeding is not required when the petitioner for adoption is a stepparent or a relative. Section 63.032(16), F.S., defines a "relative" to mean a person related by blood to the person being adopted within the third degree of consanguinity. As a result of this interpretation of the law, a relative who did not pass a department home study because of safety concerns in the home or disqualifying background offenses is permitted to intervene in a dependency action to obtain placement of the child. The department has no ability to ensure the safety of the child in these instances because the adoption entity upon the modification of placement takes over supervision of the child pursuant to s. 63.082(6)(f), F.S.

Licensing Requirements – Institutional Investigations

There are situations where a person is named in some capacity in a report and that, after an investigation of institutional abuse, neglect, or abandonment is closed, the person is not identified as a caregiver responsible for the alleged abuse, neglect, or abandonment. Chapter 39, F.S., currently provides that the information contained in the report may not be used in any way to adversely affect the interests of that person. However, the chapter also provides that if a person is a licensee of the department and is named in any capacity in three or more reports within a 5-year period, the department may review the reports and determine if information contained is relevant to determine if said person's license should be renewed or revoked.

Section 39.302(7)(a), F.S., establishes the fact that a person named in some capacity in a report may not be used in any way to adversely affect the interests of that person after an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report. However, if a person is a licensee of the department and is named in any capacity in three or more reports

within a 5-year period, the department may review the reports and determine if information contained is relevant to determine if said person's license should be renewed or revoked.

Qualified Evaluator

Currently, the Agency for Health Care Administration (AHCA) has statutory authority to adopt rules for the registration of qualified evaluators, to establish procedures for selecting the evaluators to conduct the reviews, and to establish a reasonable cost-efficient fee schedule for qualified evaluators. The AHCA is required to contract with a vendor (in this case the department) who would then be responsible for maintaining the Qualified Evaluator Network (QEN). In 2016, the Legislature moved the positions and funding to the DCF to exercise its responsibility of maintaining the QEN, but s. 39.407, F.S., still references the AHCA as having authority over the QEN.

Child Care

To protect the health and welfare of children, it is the intent of the Legislature to develop a regulatory framework that promotes the growth and stability of the child care industry and facilitates the safe physical, intellectual, motor, and social development of the child. To that end, the Child Care Regulation Program is responsible for regulating programs that provide services that meet the statutory definition of "child care." This is accomplished through the inspection of licensed child care programs to ensure the consistent statewide application of child care standards established in statute and rule, and the registration of child care providers not subject to inspection. The department regulates licensed child care facilities, licensed family day care homes, licensed large family child care homes, and licensed mildly ill facilities in 62 of the 67 counties in Florida.

"Child care" is defined as "the care, protection, and supervision of a child, for a period of less than 24 hours a day on a regular basis, which supplements parental care, enrichment, and health supervision for the child, in accordance with his or her individual needs, and for which a payment, fee, or grant is made for care."[5] If a child care program meets this statutory definition of child care, it is subject to regulation by the department/local licensing agencies, unless specifically excluded or exempted from regulation by statute. Every program determined to be subject to licensing must meet the applicable licensing standards established by ss. 402.301-402.319, F. S., and rules.

- The current definition in s. 402.302, F.S., allows the family day care operation to occur in any occupied residence, thus allowing for operators to utilize additional residences to operate the family day care home.
- Current language in s. 402.305, F.S., allows for child care personnel to complete training in cardiopulmonary resuscitation. The term "training" in this statute has always been interpreted and implemented as certification. Certification ensures that child care personnel have actually demonstrated an ability to implement cardiopulmonary resuscitation training. This section of statute is the primary issue in a pending challenge on the rule development process.
- Currently, providers are not required to notify the department when they begin offering transportation services.

[5] Section 402.302(1), F.S.

- Child care providers are required to provide parents with information at different times throughout the year as required in ss. 402.305, 402.313, and 403.3131, F.S. The dates for provision of different kinds of information is staggered.

III. Effect of Proposed Changes:

Section 1 amends s. 25.385,F.S., relating to standards for instruction of circuit and county court judges in handling domestic violence cases, to require the Florida Court Educational Council to establish standards for instruction of circuit court judges who have responsibility for dependency cases. The standards for instruction must be consistent with and reinforce the purposes of ch. 39, F.S., particularly the purpose of ensuring that a permanent placement is achieved as soon as possible for every child in foster care and that no child remains in foster care longer than 1 year. The instruction must be provided on a periodic and timely basis and by specified entities.

Section 2 amends s. 39.205, F.S., relating to penalties for false reporting of child abuse, abandonment and neglect, to remove the requirement of an annual report to the Legislature on the number of reports referred.

Section 3 amends s. 39.302, F.S., relating to protective investigations of institutional investigations, to require the department to review any and all reports within a 5-year period, if a person is a licensee of the department and is named in any capacity within the report.

Section 4 amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examinations, to make a technical change to agree with the law that was changed in 2016 to move responsibility for the appointment of Qualified Evaluators to the department from the AHCA.[6]

Section 5 creates s. 39.5035, F.S., relating to deceased parents, to provide a process for the permanent commitment of a child to the DCF for the purpose of adoption when both parents are deceased. Specifically, this section:

- Provides that, where both parents of a child are deceased and the child does not have a legal custodian through a probate or guardianship proceeding, an attorney for the department, or any person who has knowledge of the facts alleged or is informed of them and believes that they are true, may initiate a proceeding seeking an adjudication of dependency and permanent commitment of the child to the custody of the department.
- Provides that, when a child has been placed in shelter status by order of the court and not yet adjudicated, a petition for adjudication and permanent commitment must be filed within 21 days after the shelter hearing. In all other cases, the petition must be filed within a reasonable time after the date the child was referred to protective investigation or after the petitioner becomes aware of the facts supporting the petition.
- Provides that, when a petition for adjudication and permanent commitment or a petition for permanent commitment has been filed, the clerk of court shall set the case before the court

[6] The statutes were changed in 2016 and AHCA was required to assign all rights, obligations, and other interest in and under contract pertaining to Qualified Evaluator Network services to DCF. However, s. 39.407(6)(b), F.S., was inadvertently omitted from the changes and still requires AHCA to appoint the qualified evaluators. AHCA continues to have statutory authority to adopt rules for the registration of qualified evaluators and to establish a cost efficient fee schedule for qualified evaluators.

for an adjudicatory hearing to be held as soon as possible, but no later than 30 days after the petition is filed.

- Provides notice of the date, time, and place of the adjudicatory hearing for the petition for adjudication and permanent commitment or the petition for permanent commitment and requires a copy of the petition be served upon specified individuals
- Provides that adjudicatory hearings must be conducted by the judge without a jury, applying the rules of evidence in use in civil cases and adjourning the hearings from time to time as necessary. In a hearing on a petition for adjudication and permanent commitment or a petition for permanent commitment, the court must consider whether the petitioner has established by clear and convincing evidence that both parents of the child are deceased, and that the child does not have a legal custodian through a probate or guardianship proceeding. The presentation of a certified copy of the death certificate for each parent constitutes evidence of the parents' deaths and no further evidence is required to establish that element.
- Provides when the adjudicatory hearing is on a petition for adjudication and permanent commitment, within 30 days after conclusion of the adjudicatory hearing, the court must enter a written order.
- Provides when the adjudicatory hearing is on a petition for permanent commitment, within 30 days after conclusion of the adjudicatory hearing, the court must enter a written order.

Section 6 amends s. 39.521, F.S., relating to disposition hearings, to eliminate the description of how long protective supervision can continue and under what circumstances the court can terminate protective supervision. Instead, protective supervision will now be fully addressed in newly created s. 39.63, F.S.

Section 7 amends s. 39.522, F.S., relating to postdisposition change of custody, to create an emergency modification of placement that will enable the department and the judiciary to take immediate action to protect children at risk of abuse, abandonment, or neglect who have already been subject to disposition. Specifically, the section:

- Clarifies that the statute applies to a modification of placement if a child must be removed from the parent's custody while the department is supervising the placement of the child after the child is returned to the parent.
- Provides that at any time, an authorized agent of the department or a law enforcement officer may remove a child from a court-ordered placement and take the child into custody if the child's current caregiver requests immediate removal of the child from the home or if the circumstances meet the criteria of probable cause. It also provides requirements and sets timelines for motions and petitions to be filed, considerations for the court before issuing an order, requirements for a home study if a placement is changed, and cause for the court to conduct an evidentiary hearing. The standard for changing custody of the child will be whether a preponderance of the evidence establishes that a change is in the best interest of the child. When applying this standard, the court must consider the continuity of the child's placement in the same out-of-home residence as a factor.

Section 8 amends s. 39.6011, F.S., relating to case plan development, to require the department to file the case plan with the court and serve a copy on the parties:

- Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the date the child was placed in out-of-home care. All such case plans must be approved by the court.
- Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted, or if the court does not approve the case plan at the disposition hearing. The case plan acceptance hearing must occur within 30 days after the disposition hearing to review and approve the case plan.

Section 9 creates s. 39.63, F.S., relating to case closure, to provide that unless the circumstances relating to young adults in extended foster care apply, the court must close the judicial case by terminating protective supervision and jurisdiction. This statute clarifies the requirements that must be met to ensure child safety before jurisdiction and supervision is terminated.

Section 10 amends s. 39.806, F.S., relating to grounds for termination of parental rights, to provide that reasonable efforts to preserve and reunify families are not required if a court has determined that any of the events described in s. 39.806(1), F.S., have occurred. Consequently, the DCF will no longer need to make reasonable efforts if a parent has been convicted of an offense that requires the parent to register as a sexual predator.

Section 11 amends s. 39.811, F.S., relating to disposition, to provide that the court will retain jurisdiction over any child for whom custody is given to a social service agency until the child is adopted after termination of parental rights or permanent commitment. It also provides that the department's decision to deny an application to adopt a specific child who is under the court's jurisdiction is reviewable only through the process established in s. 39.812(4), F.S., and is not subject to the provisions of ch. 120, F.S.

Section 12 amends s. 38.812, F.S., relating to postdisposition relief and petition for adoption, to provide that the DCF may place a child who is in the department's custody with an agency as defined in s. 63.032, F.S., with a child-caring agency registered under s. 409.176, F.S., or in a family home for prospective subsequent adoption without the need for a court order unless as otherwise provided in this section. It also authorizes the department, without the need for a court order, to allow prospective adoptive parents to visit with the child to determine whether adoptive placement would be appropriate. Additionally, it provides procedures when the department has denied an individual's application to adopt a child.

Section 13 amends s. 39.820, F.S., relating to definitions, to include the Statewide Guardian Ad Litem Office in the definition of the term "guardian ad litem."

Section 14 amends s. 63.062, F.S., relating to persons required to consent to adoption, to provide that when a minor has been permanently committed to the department for subsequent adoption, the department must consent to the adoption, or the court order finding of consent must be attached to the petition to adopt.

Section 15 amends s. 63.082, F.S., relating to execution of consent to adopt, to provide that a preliminary home study is required for all prospective parents regardless of whether that individual is a stepparent or a relative, and that the exemption in s. 63.092(3), F.S., does not

apply when a minor child is under department supervision or subject to the jurisdiction of the dependency court as a result of the filing of a shelter petition, a dependency petition, or a petition for termination of parental rights pursuant to ch. 39, F.S.

Section 16 amends s. 402.302, relating to definitions, to specify that family day care home operations must occur in the operator's primary residence and that the capacity is limited to children present in the home during operations.

Section 17 amends s. 402.305, F.S., relating to licensing standards, to clarify that at least one child care facility staff person must receive a certification for completion of a cardiopulmonary resuscitation course.

Sections 402.305(9)(b) and (c), F.S., are amended to align the dates for providers on when information is to be shared with parents or guardians.

Section 402.305(10), F.S., is amended to specify that, prior to providing transportation services, a child care facility, family day care home, or large family child care home is required to notify the DCF for approval to begin the service to ensure that all standards have been verified as compliant. Currently, providers are not required to notify the department when they begin offering transportation services. The amendment clarifies that family or large family child care homes are not responsible for children being transported by a parent or guardian.

Section 18 amends s. 402.313, F.S., relating to family day care homes, to align the dates for providers on when information is to be shared with parents or guardians.

Section 19 amends s. 402.3131, F.S., relating to large family day care homes, to align the dates for providers on when information is to be shared with parents or guardians.

Section 20 amends s. 409.1451, F.S., relating to the Road-to-Independence Program, to eliminate the requirement to submit an annual report.

Section 21 provides an effective date of October 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The DCF has reported that there is a potential cost savings of $1.2 million due to the reduction in the projected number of administrative hearings that would need to be conducted for contested adoption selections.[7]

Additionally, Pinellas, Hillsborough, and Sarasota counties would be required to adopt standards that address the minimum standards in the changes to ch. 402, F.S. This is expected to have an insignificant fiscal impact on these counties.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 25.385, 39.205, 39.302, 39.407, 39.521, 39.522, 39.6011, 39.806, 39.811, 39.812, 39.820, 63.062, 63.082, 402.302, 402.305, 402.313, 402.3131, and 409.1451.

This bill creates the following sections of the Florida Statutes: 39.5035 and 39.63.

[7] The Department of Children and Families, 2020 Agency Legislative Bill Analysis, SB 1548, November 25, 2019.

IX. Additional Information:

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

CS by Children, Families, and Elder Affairs on February 4, 2020:

- Removes the following from the bill:
  - Changes to s. 39.01, F.S., relating to dependency definitions, revising the definition of the term "parent."
  - Changes to s. 39.402, F.S., relating to placement in a shelter, providing requirements for the court when establishing paternity at a shelter hearing.
  - Changes to s. 39.503, F.S., relating to the identity or location of a parent, revising procedures and requirements relating to the unknown identity or location of a parent of a dependent child and providing that a person does not have standing under certain circumstances.
  - Changes to s. 39.801, F.S., relating to procedures and jurisdiction related to termination of parental right procedures, clarifying that personal service of a termination of parental rights petition is required only on a prospective parent who has been both identified and located.
  - Changes to s. 39.803, F.S., relating to the identity or location of parent unknown after filing of termination of parental rights petition, revising procedures and requirements relating to the unknown identity or location of a parent of a dependent child after the filing of a petition for termination of parental rights and providing that a person does not have standing under certain circumstances.
  - Creation of s. 742.0211, F.S., relating to proceedings applicable to dependent children, defining the term "dependent child," providing requirements and procedures for the determination of paternity when a child is dependent, providing the burden of proof for certain paternity complaints, and providing applicability.
- Adds the following to the bill:
  - Changes to s. 39.820, F.S. relating to definitions, adding the Statewide Guardian Ad Litem Office to the definition of the term "guardian ad litem."

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and Senators Perry and Hutson

586-03120A-20 20201548c1

A bill to be entitled

An act relating to child welfare; amending s. 25.385, F.S.; requiring the Florida Court Educational Council to establish certain standards for instruction of specified circuit court judges; amending s. 39.205, F.S.; deleting a requirement for the Department of Children and Families to report certain information to the Legislature; amending s. 39.302, F.S.; requiring the department to review certain reports under certain circumstances; amending s. 39.407, F.S.; transferring certain duties to the department from the Agency for Health Care Administration; creating s. 39.5035, F.S.; providing court procedures and requirements relating to deceased parents of a dependent child; providing requirements for petitions for adjudication and permanent commitment for certain children; amending s. 39.521, F.S.; deleting provisions relating to protective supervision; deleting provisions relating to the court's authority to enter an order ending its jurisdiction over a child under certain circumstances; amending s. 39.522, F.S.; providing requirements for a modification of placement of a child under the supervision of the department; amending s. 39.6011, F.S.; providing timeframes in which case plans must be filed with the court and be provided to specified parties; creating s. 39.63, F.S.; providing procedures and requirements for closing a case under chapter 39; amending s. 39.806, F.S.; conforming cross-references; amending s. 39.811, F.S.; expanding conditions under

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which a court retains jurisdiction; providing when certain decisions relating to adoption are reviewable; amending s. 39.812, F.S.; authorizing the department to take certain actions without a court order; authorizing certain persons to file a petition to adopt a child without the department's consent; providing standing requirements; providing a standard of proof; providing responsibilities of the court in such cases; amending s. 39.820, F.S.; revising the definition of the term "guardian ad litem"; amending s. 63.062, F.S.; requiring the department to consent to certain adoptions; providing exceptions; amending s. 63.082, F.S.; providing construction; amending s. 402.302, F.S.; revising definitions; amending s. 402.305, F.S.; requiring a certain number of staff persons at child care facilities to be certified in certain safety techniques; requiring child care facilities to provide certain information to parents at the time of initial enrollment and annually thereafter; revising minimum standards for child care facilities, family day care homes, and large family child care homes relating to transportation; requiring child care facilities, family day care homes, and large family child care homes to be approved by the department to transport children in certain situations; amending s. 402.313, F.S.; requiring family day care homes to provide certain information to parents at the time of enrollment and annually thereafter; amending s. 402.3131, F.S.; requiring

large family child care homes to provide certain information to parents at the time of enrollment and annually thereafter; amending s. 409.1451, F.S.; deleting a reporting requirement of the department and the Independent Living Services Advisory Council; providing an effective date.

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

Section 1. Section 25.385, Florida Statutes, is amended to read:

25.385 Standards for instruction of circuit and county court judges ~~in handling domestic violence cases~~.—

(1) The Florida Court Educational Council shall establish standards for instruction of circuit and county court judges who have responsibility for domestic violence cases, and the council shall provide such instruction on a periodic and timely basis.

~~(2)~~ As used in this section:

(a) The term "domestic violence" has the meaning set forth in s. 741.28.

(b) "Family or household member" has the meaning set forth in s. 741.28.

(2) The Florida Court Educational Council shall establish standards for instruction of circuit court judges who have responsibility for dependency cases. The standards for instruction must be consistent with and reinforce the purposes of chapter 39, with emphasis on ensuring that a permanent placement is achieved as soon as possible and that a child should not remain in foster care for longer than 1 year. This

instruction must be provided on a periodic and timely basis and may be provided by or in consultation with current or retired judges, the Department of Children and Families, or the Statewide Guardian Ad Litem Office established in s. 39.8296.

Section 2. Subsection (7) of section 39.205, Florida Statutes, is amended to read:

39.205 Penalties relating to reporting of child abuse, abandonment, or neglect.—

(7) The department shall establish procedures for determining whether a false report of child abuse, abandonment, or neglect has been made and for submitting all identifying information relating to such a report to the appropriate law enforcement agency ~~and shall report annually to the Legislature the number of reports referred~~.

Section 3. Subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(a) However, if such a person is a licensee of the department and is named in any capacity in a report ~~three or~~

~~more reports~~ within a 5-year period, the department must ~~may~~ review the report ~~those reports~~ and determine whether the information contained in the report ~~reports~~ is relevant for purposes of determining whether the person's license should be renewed or revoked. If the information is relevant to the decision to renew or revoke the license, the department may rely on the information contained in the report in making that decision.

(b) Likewise, if a person is employed as a caregiver in a residential group home licensed pursuant to s. 409.175 and is named in any capacity in a report ~~three or more reports~~ within a 5-year period, the department must ~~may~~ review the report ~~all reports~~ for the purposes of the employment screening as defined in s. 409.175(2)(m) ~~required pursuant to s. 409.145(2)(c)~~.

Section 4. Subsection (6) of section 39.407, Florida Statutes, is amended to read:

39.407 Medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.—

(6) Children who are in the legal custody of the department may be placed by the department, without prior approval of the court, in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395 for residential mental health treatment only as provided in ~~pursuant to~~ this section or may be placed by the court in accordance with an order of involuntary examination or involuntary placement entered under ~~pursuant to~~ s. 394.463 or s. 394.467. All children placed in a residential treatment program under this subsection must have a guardian ad litem appointed.

(a) As used in this subsection, the term:

1. "Residential treatment" means placement for observation, diagnosis, or treatment of an emotional disturbance in a residential treatment center licensed under s. 394.875 or a hospital licensed under chapter 395.

2. "Least restrictive alternative" means the treatment and conditions of treatment that, separately and in combination, are no more intrusive or restrictive of freedom than reasonably necessary to achieve a substantial therapeutic benefit or to protect the child or adolescent or others from physical injury.

3. "Suitable for residential treatment" or "suitability" means a determination concerning a child or adolescent with an emotional disturbance as defined in s. 394.492(5) or a serious emotional disturbance as defined in s. 394.492(6) that each of the following criteria is met:

a. The child requires residential treatment.

b. The child is in need of a residential treatment program and is expected to benefit from mental health treatment.

c. An appropriate, less restrictive alternative to residential treatment is unavailable.

(b) Whenever the department believes that a child in its legal custody is emotionally disturbed and may need residential treatment, an examination and suitability assessment must be conducted by a qualified evaluator who is appointed by the department ~~Agency for Health Care Administration~~. This suitability assessment must be completed before the placement of the child in a residential treatment center for emotionally disturbed children and adolescents or a hospital. The qualified evaluator must be a psychiatrist or a psychologist licensed in

Florida who has at least 3 years of experience in the diagnosis and treatment of serious emotional disturbances in children and adolescents and who has no actual or perceived conflict of interest with any inpatient facility or residential treatment center or program.

(c) Before a child is admitted under this subsection, the child shall be assessed for suitability for residential treatment by a qualified evaluator who has conducted a personal examination and assessment of the child and has made written findings that:

1. The child appears to have an emotional disturbance serious enough to require residential treatment and is reasonably likely to benefit from the treatment.

2. The child has been provided with a clinically appropriate explanation of the nature and purpose of the treatment.

3. All available modalities of treatment less restrictive than residential treatment have been considered, and a less restrictive alternative that would offer comparable benefits to the child is unavailable.

A copy of the written findings of the evaluation and suitability assessment must be provided to the department, to the guardian ad litem, and, if the child is a member of a Medicaid managed care plan, to the plan that is financially responsible for the child's care in residential treatment, all of whom must be provided with the opportunity to discuss the findings with the evaluator.

(d) Immediately upon placing a child in a residential

treatment program under this section, the department must notify the guardian ad litem and the court having jurisdiction over the child and must provide the guardian ad litem and the court with a copy of the assessment by the qualified evaluator.

(e) Within 10 days after the admission of a child to a residential treatment program, the director of the residential treatment program or the director's designee must ensure that an individualized plan of treatment has been prepared by the program and has been explained to the child, to the department, and to the guardian ad litem, and submitted to the department. The child must be involved in the preparation of the plan to the maximum feasible extent consistent with his or her ability to understand and participate, and the guardian ad litem and the child's foster parents must be involved to the maximum extent consistent with the child's treatment needs. The plan must include a preliminary plan for residential treatment and aftercare upon completion of residential treatment. The plan must include specific behavioral and emotional goals against which the success of the residential treatment may be measured. A copy of the plan must be provided to the child, to the guardian ad litem, and to the department.

(f) Within 30 days after admission, the residential treatment program must review the appropriateness and suitability of the child's placement in the program. The residential treatment program must determine whether the child is receiving benefit toward the treatment goals and whether the child could be treated in a less restrictive treatment program. The residential treatment program shall prepare a written report of its findings and submit the report to the guardian ad litem

and to the department. The department must submit the report to the court. The report must include a discharge plan for the child. The residential treatment program must continue to evaluate the child's treatment progress every 30 days thereafter and must include its findings in a written report submitted to the department. The department may not reimburse a facility until the facility has submitted every written report that is due.

(g)1. The department must submit, at the beginning of each month, to the court having jurisdiction over the child, a written report regarding the child's progress toward achieving the goals specified in the individualized plan of treatment.

2. The court must conduct a hearing to review the status of the child's residential treatment plan no later than 60 days after the child's admission to the residential treatment program. An independent review of the child's progress toward achieving the goals and objectives of the treatment plan must be completed by a qualified evaluator and submitted to the court before its 60-day review.

3. For any child in residential treatment at the time a judicial review is held pursuant to s. 39.701, the child's continued placement in residential treatment must be a subject of the judicial review.

4. If at any time the court determines that the child is not suitable for continued residential treatment, the court shall order the department to place the child in the least restrictive setting that is best suited to meet his or her needs.

(h) After the initial 60-day review, the court must conduct

a review of the child's residential treatment plan every 90 days.

(i) The department must adopt rules for implementing timeframes for the completion of suitability assessments by qualified evaluators and a procedure that includes timeframes for completing the 60-day independent review by the qualified evaluators of the child's progress toward achieving the goals and objectives of the treatment plan which review must be submitted to the court. The Agency for Health Care Administration must adopt rules for the registration of qualified evaluators, the procedure for selecting the evaluators to conduct the reviews required under this section, and a reasonable, cost-efficient fee schedule for qualified evaluators.

Section 5. Section 39.5035, Florida Statutes, is created to read:

39.5035 Deceased parents; special procedures.—

(1)(a)1. If both parents of a child are deceased and a legal custodian has not been appointed for the child through a probate or guardianship proceeding, then an attorney for the department or any other person, who has knowledge of the facts whether alleged or is informed of the alleged facts and believes them to be true, may initiate a proceeding by filing a petition for adjudication and permanent commitment.

2. If a child has been placed in shelter status by order of the court but has not yet been adjudicated, a petition for adjudication and permanent commitment must be filed within 21 days after the shelter hearing. In all other cases, the petition must be filed within a reasonable time after the date the child

was referred to protective investigation or after the petitioner first becomes aware of the facts that support the petition for adjudication and permanent commitment.

(b) If both parents or the last living parent dies after a child has already been adjudicated dependent, an attorney for the department or any other person who has knowledge of the facts alleged or is informed of the alleged facts and believes them to be true may file a petition for permanent commitment.

(2) The petition:

(a) Must be in writing, identify the alleged deceased parents, and provide facts that establish that both parents of the child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding.

(b) Must be signed by the petitioner under oath stating the petitioner's good faith in filing the petition.

(3) When a petition for adjudication and permanent commitment or a petition for permanent commitment has been filed, the clerk of court shall set the case before the court for an adjudicatory hearing. The adjudicatory hearing must be held as soon as practicable after the petition is filed, but no later than 30 days after the filing date.

(4) Notice of the date, time, and place of the adjudicatory hearing and a copy of the petition must be served on the following persons:

(a) Any person who has physical custody of the child.

(b) A living relative of each parent of the child, unless a living relative cannot be found after a diligent search and inquiry.

(c) The guardian ad litem for the child or the representative of the guardian ad litem program, if the program has been appointed.

(5) Adjudicatory hearings shall be conducted by the judge without a jury, applying the rules of evidence in use in civil cases and adjourning the hearings from time to time as necessary. At the hearing, the judge must determine whether the petitioner has established by clear and convincing evidence that both parents of the child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding. A certified copy of the death certificate for each parent is sufficient evidence of proof of the parents' deaths.

(6) Within 30 days after an adjudicatory hearing on a petition for adjudication and permanent commitment:

(a) If the court finds that the petitioner has met the clear and convincing standard, the court shall enter a written order adjudicating the child dependent and permanently committing the child to the custody of the department for the purpose of adoption. A disposition hearing shall be scheduled no later than 30 days after the entry of the order, in which the department shall provide a case plan that identifies the permanency goal for the child to the court. Reasonable efforts must be made to place the child in a timely manner in accordance with the permanency plan and to complete all steps necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings every 6 months to review the progress being made toward

permanency for the child.

(b) If the court finds that clear and convincing evidence does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding, but that a preponderance of the evidence establishes that the child does not have a parent or legal custodian capable of providing supervision or care, the court shall enter a written order adjudicating the child dependent. A disposition hearing shall be scheduled no later than 30 days after the entry of the order as provided in s. 39.521.

(c) If the court finds that clear and convincing evidence does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding and that a preponderance of the evidence does not establish that the child does not have a parent or legal custodian capable of providing supervision or care, the court shall enter a written order so finding and dismissing the petition.

(7) Within 30 days after an adjudicatory hearing on a petition for permanent commitment:

(a) If the court finds that the petitioner has met the clear and convincing standard, the court shall enter a written order permanently committing the child to the custody of the department for purposes of adoption. A disposition hearing shall be scheduled no later than 30 days after the entry of the order, in which the department shall provide an amended case plan that identifies the permanency goal for the child to the court. Reasonable efforts must be made to place the child in a timely

manner in accordance with the permanency plan and to complete all steps necessary to finalize the permanent placement of the child. Thereafter, until the adoption of the child is finalized or the child reaches the age of 18 years, whichever occurs first, the court shall hold hearings every 6 months to review the progress being made toward permanency for the child.

(b) If the court finds that clear and convincing evidence does not establish that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding, the court shall enter a written order denying the petition. The order has no effect on the child's prior adjudication. The order does not bar the petitioner from filing a subsequent petition for permanent commitment based on newly discovered evidence that establishes that both parents of a child are deceased and that a legal custodian has not been appointed for the child through a probate or guardianship proceeding.

Section 6. Paragraph (c) of subsection (1) and subsections (3) and (7) of section 39.521, Florida Statutes, are 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.

(c) When any child is adjudicated by a court to be dependent, the court having jurisdiction of the child has the power by order to:

1. Require the parent and, when appropriate, the legal guardian or the child to participate in treatment and services identified as necessary. The court may require the person who has custody or who is requesting custody of the child to submit to a mental health or substance abuse disorder assessment or evaluation. The order may be made only upon good cause shown and pursuant to notice and procedural requirements provided under the Florida Rules of Juvenile Procedure. The mental health assessment or evaluation must be administered by a qualified professional as defined in s. 39.01, and the substance abuse assessment or evaluation must be administered by a qualified professional as defined in s. 397.311. The court may also require such person to participate in and comply with treatment and services identified as necessary, including, when appropriate and available, participation in and compliance with a mental health court program established under chapter 394 or a treatment-based drug court program established under s. 397.334. Adjudication of a child as dependent based upon evidence of harm as defined in s. 39.01(35)(g) demonstrates good cause, and the court shall require the parent whose actions caused the harm to submit to a substance abuse disorder assessment or evaluation and to participate and comply with treatment and services identified in the assessment or evaluation as being necessary. In addition to supervision by the department, the court, including the mental health court program or the treatment-based drug court program, may oversee the progress and compliance with

treatment by a person who has custody or is requesting custody of the child. The court may impose appropriate available sanctions for noncompliance upon a person who has custody or is requesting custody of the child or make a finding of noncompliance for consideration in determining whether an alternative placement of the child is in the child's best interests. Any order entered under this subparagraph may be made only upon good cause shown. This subparagraph does not authorize placement of a child with a person seeking custody of the child, other than the child's parent or legal custodian, who requires mental health or substance abuse disorder treatment.

2. Require, if the court deems necessary, the parties to participate in dependency mediation.

3. Require placement of the child either under the protective supervision of an authorized agent of the department in the home of one or both of the child's parents or in the home of a relative of the child or another adult approved by the court, or in the custody of the department. ~~Protective supervision continues until the court terminates it or until the child reaches the age of 18, whichever date is first. Protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion, and shall in either case be considered a permanency option for the child. The order terminating supervision by the department must set forth the powers of the custodian of the child and include the powers~~

~~ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the department, further judicial reviews are not required if permanency has been established for the child.~~

4. Determine whether the child has a strong attachment to the prospective permanent guardian and whether such guardian has a strong commitment to permanently caring for the child.

(3) When any child is adjudicated by a court to be dependent, the court shall determine the appropriate placement for the child as follows:

(a) If the court determines that the child can safely remain in the home with the parent with whom the child was residing at the time the events or conditions arose that brought the child within the jurisdiction of the court and that remaining in this home is in the best interest of the child, then the court shall order conditions under which the child may remain or return to the home and that this placement be under the protective supervision of the department for not less than 6 months.

(b) If there is a parent with whom the child was not residing at the time the events or conditions arose that brought the child within the jurisdiction of the court who desires to assume custody of the child, the court shall place the child with that parent upon completion of a home study, unless the court finds that such placement would endanger the safety, well-being, or physical, mental, or emotional health of the child. Any party with knowledge of the facts may present to the court evidence regarding whether the placement will endanger the safety, well-being, or physical, mental, or emotional health of

the child. If the court places the child with such parent, it may do either of the following:

1. Order that the parent assume sole custodial responsibilities for the child. The court may also provide for reasonable visitation by the noncustodial parent. The court may then terminate its jurisdiction over the child.

2. Order that the parent assume custody subject to the jurisdiction of the circuit court hearing dependency matters. The court may order that reunification services be provided to the parent from whom the child has been removed, that services be provided solely to the parent who is assuming physical custody in order to allow that parent to retain later custody without court jurisdiction, or that services be provided to both parents, in which case the court shall determine at every review hearing which parent, if either, shall have custody of the child. The standard for changing custody of the child from one parent to another or to a relative or another adult approved by the court shall be the best interest of the child.

(c) If no fit parent is willing or available to assume care and custody of the child, place the child in the temporary legal custody of an adult relative, the adoptive parent of the child's sibling, or another adult approved by the court who is willing to care for the child, under the protective supervision of the department. The department must supervise this placement until the child reaches permanency status in this home, and in no case for a period of less than 6 months. Permanency in a relative placement shall be by adoption, long-term custody, or guardianship.

(d) If the child cannot be safely placed in a nonlicensed

placement, the court shall commit the child to the temporary legal custody of the department. Such commitment invests in the department all rights and responsibilities of a legal custodian. The department may ~~shall~~ not return any child to the physical care and custody of the person from whom the child was removed, except for court-approved visitation periods, without the approval of the court. Any order for visitation or other contact must conform to the provisions of s. 39.0139. The term of such commitment continues until terminated by the court or until the child reaches the age of 18. After the child is committed to the temporary legal custody of the department, all further proceedings under this section are governed by this chapter.

~~Protective supervision continues until the court terminates it or until the child reaches the age of 18, whichever date is first. Protective supervision shall be terminated by the court whenever the court determines that permanency has been achieved for the child, whether with a parent, another relative, or a legal custodian, and that protective supervision is no longer needed. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion, and shall in either case be considered a permanency option for the child. The order terminating supervision by the department shall set forth the powers of the custodian of the child and shall include the powers ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the department, no further judicial reviews are required, so long as permanency has been established for the child.~~

~~(7) The court may enter an order ending its jurisdiction over a child when a child has been returned to the parents, provided the court shall not terminate its jurisdiction or the department's supervision over the child until 6 months after the child's return. The department shall supervise the placement of the child after reunification for at least 6 months with each parent or legal custodian from whom the child was removed. The court shall determine whether its jurisdiction should be continued or terminated in such a case based on a report of the department or agency or the child's guardian ad litem, and any other relevant factors; if its jurisdiction is to be terminated, the court shall enter an order to that effect.~~

Section 7. Section 39.522, Florida Statutes, is amended to read:

39.522 Postdisposition change of custody.—The court may change the temporary legal custody or the conditions of protective supervision at a postdisposition hearing, without the necessity of another adjudicatory hearing. If a child has been returned to the parent and is under protective supervision by the department and the child is later removed again from the parent's custody, any modifications of placement shall be done under this section.

(1) At any time, an authorized agent of the department or a law enforcement officer may remove a child from a court-ordered placement and take the child into custody if the child's current caregiver requests immediate removal of the child from the home or if there is probable cause as required in s. 39.401(1)(b). The department shall file a motion to modify placement within 1 business day after the child is taken into custody. Unless all

parties agree to the change of placement, the court must set a hearing within 24 hours after the filing of the motion. At the hearing, the court shall determine whether the department has established probable cause to support the immediate removal of the child from his or her current placement. The court may base its determination on a sworn petition, testimony, or an affidavit and may hear all relevant and material evidence, including oral or written reports, to the extent of its probative value even though it would not be competent evidence at an adjudicatory hearing. If the court finds that probable cause is not established to support the removal of the child from the placement, the court shall order that the child be returned to his or her current placement. If the caregiver admits to a need for a change of placement or probable cause is established to support the removal, the court shall enter an order changing the placement of the child. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria in chapter 39. If the child's placement is modified based on a probable cause finding, the court must conduct a subsequent evidentiary hearing, unless waived by all parties, on the motion to determine whether the department has established by a preponderance of the evidence that maintaining the new placement of the child is in the best interest of the child. The court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child.

(2) ~~(1)~~ At any time before a child is residing in the permanent placement approved at the permanency hearing, a child who has been placed in the child's own home under the protective

supervision of an authorized agent of the department, in the home of a relative, in the home of a legal custodian, or in some other place may be brought before the court by the department or by any other party ~~interested person~~, upon the filing of a petition ~~motion~~ alleging a need for a change in the conditions of protective supervision or the placement. If the parents or other legal custodians deny the need for a change, the court shall hear all parties in person or by counsel, or both. Upon the admission of a need for a change or after such hearing, the court shall enter an order changing the placement, modifying the conditions of protective supervision, or continuing the conditions of protective supervision as ordered. The standard for changing custody of the child is determined by a preponderance of the evidence that establishes that a change is in ~~shall be~~ the best interest of the child. When applying this standard, the court shall consider the continuity of the child's placement in the same out-of-home residence as a factor when determining the best interests of the child. If the child is not placed in foster care, then the new placement for the child must meet the home study criteria and court approval under ~~pursuant to~~ this chapter.

(3) ~~(2)~~ In cases where the issue before the court is whether a child should be reunited with a parent, the court shall review the conditions for return and determine whether the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home with an in-home safety plan prepared or approved by the department will not be detrimental to the child's safety, well-being, and physical, mental, and

emotional health.

(4)~~(3)~~ In cases where the issue before the court is whether a child who is placed in the custody of a parent should be reunited with the other parent upon a finding that the circumstances that caused the out-of-home placement and issues subsequently identified have been remedied to the extent that the return of the child to the home of the other parent with an in-home safety plan prepared or approved by the department will not be detrimental to the child, the standard shall be that the safety, well-being, and physical, mental, and emotional health of the child would not be endangered by reunification and that reunification would be in the best interest of the child.

Section 8. Subsection (8) of section 39.6011, Florida Statutes, is amended to read:

39.6011 Case plan development.—

(8) The case plan must be filed with the court and copies provided to all parties, including the child if appropriate:~~,~~ ~~not less than 3 business days before the disposition hearing.~~

(a) Not less than 72 hours before the disposition hearing, if the disposition hearing occurs on or after the 60th day after the date the child was placed in out-of-home care; or

(b) Not less than 72 hours before the case plan acceptance hearing, if the disposition hearing occurs before the 60th day after the date the child was placed in out-of-home care and a case plan has not been submitted under this subsection, or if the court does not approve the case plan at the disposition hearing.

Section 9. Section 39.63, Florida Statutes, is created to read:

39.63 Case closure.—Unless s. 39.6251 applies, the court shall close the judicial case for all proceedings under this chapter by terminating protective supervision and its jurisdiction as provided in this section.

(1) If a child is placed under the protective supervision of the department, the protective supervision continues until such supervision is terminated by the court or until the child reaches the age of 18, whichever occurs first. The court shall terminate protective supervision when it determines that permanency has been achieved for the child and supervision is no longer needed. If the court adopts a permanency goal of reunification with a parent or legal custodian from whom the child was initially removed, the court must retain jurisdiction and the department must supervise the placement for a minimum of 6 months after reunification. The court shall determine whether its jurisdiction should be continued or terminated based on a report of the department or the child's guardian ad litem. The termination of supervision may be with or without retaining jurisdiction, at the court's discretion.

(2) The order terminating protective supervision must set forth the powers of the legal custodian of the child and include the powers originally granted to a guardian of the person of a minor unless otherwise specified.

(3) Upon the court's termination of supervision by the department, further judicial reviews are not required.

(4) The court must enter a written order terminating its jurisdiction over a child when the child is returned to his or her parent. However, the court must retain jurisdiction over the child for a minimum of 6 months after reunification and may not

terminate its jurisdiction until the court determines that protective supervision is no longer needed.

(5) If a child was not removed from the home, the court must enter a written order terminating its jurisdiction over the child when the court determines that permanency has been achieved.

(6) If a child is placed in the custody of a parent and the court determines that reasonable efforts to reunify the child with the other parent are not required, the court may, at any time, order that the custodial parent assume sole custodial responsibilities for the child, provide for reasonable visitation by the noncustodial parent, and terminate its jurisdiction over the child. If the court previously approved a case plan that requires services to be provided to the noncustodial parent, the court may not terminate its jurisdiction before the case plan expires unless the court finds by a preponderance of the evidence that it is not likely that the child will be reunified with the noncustodial parent within 12 months after the child was removed from the home.

(7) When a child has been adopted under a chapter 63 proceeding, the court must enter a written order terminating its jurisdiction over the child in the chapter 39 proceeding.

Section 10. Paragraph (e) of subsection (1) and subsection (2) of section 39.806, Florida Statutes, are amended to read:

39.806 Grounds for termination of parental rights.—

(1) Grounds for the termination of parental rights may be established under any of the following circumstances:

(e) When a child has been adjudicated dependent, a case plan has been filed with the court, and:

1. The child continues to be abused, neglected, or abandoned by the parent or parents. The failure of the parent or parents to substantially comply with the case plan for a period of 12 months after an adjudication of the child as a dependent child or the child's placement into shelter care, whichever occurs first, constitutes evidence of continuing abuse, neglect, or abandonment unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to reunify the parent and child. The 12-month period begins to run only after the child's placement into shelter care or the entry of a disposition order placing the custody of the child with the department or a person other than the parent and the court's approval of a case plan having the goal of reunification with the parent, whichever occurs first; ~~or~~

2. The parent or parents have materially breached the case plan by their action or inaction. Time is of the essence for permanency of children in the dependency system. In order to prove the parent or parents have materially breached the case plan, the court must find by clear and convincing evidence that the parent or parents are unlikely or unable to substantially comply with the case plan before time to comply with the case plan expires; or~~.~~

3. The child has been in care for any 12 of the last 22 months and the parents have not substantially complied with the case plan so as to permit reunification under s. 39.522(3) ~~s. 39.522(2)~~ unless the failure to substantially comply with the case plan was due to the parent's lack of financial resources or to the failure of the department to make reasonable efforts to

reunify the parent and child.

(2) Reasonable efforts to preserve and reunify families are not required if a court of competent jurisdiction has determined that any of the events described in paragraphs (1)(b)-(d) or paragraphs (1)(f)-(n) ~~(1)(f)-(m)~~ have occurred.

Section 11. Subsection (9) of section 39.811, Florida Statutes, is amended to read:

39.811 Powers of disposition; order of disposition.—

(9) After termination of parental rights or a written order of permanent commitment entered under s. 39.5035, the court shall retain jurisdiction over any child for whom custody is given to a social service agency until the child is adopted. The court shall review the status of the child's placement and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, for good cause shown by the guardian ad litem for the child, the court may review the appropriateness of the adoptive placement of the child. The department's decision to deny an application to adopt a child who is under the court's jurisdiction is reviewable only through a motion to file a chapter 63 petition as provided in s. 39.812(4), and is not subject to chapter 120.

Section 12. Subsections (1), (4), and (5) of section 39.812, Florida Statutes, are amended to read:

39.812 Postdisposition relief; petition for adoption.—

(1) If the department is given custody of a child for subsequent adoption in accordance with this chapter, the department may place the child with an agency as defined in s. 63.032, with a child-caring agency registered under s. 409.176, or in a family home for prospective subsequent adoption without

the need for a court order unless otherwise required under this section. The department may allow prospective adoptive parents to visit with a child in the department's custody without a court order to determine whether the adoptive placement would be appropriate. The department may thereafter become a party to any proceeding for the legal adoption of the child and appear in any court where the adoption proceeding is pending and consent to the adoption, and that consent alone shall in all cases be sufficient.

(4) The court shall retain jurisdiction over any child placed in the custody of the department until the case is closed as provided in s. 39.63 ~~the child is adopted~~. After custody of a child for subsequent adoption has been given to the department, the court has jurisdiction for the purpose of reviewing the status of the child and the progress being made toward permanent adoptive placement. As part of this continuing jurisdiction, for good cause shown by the guardian ad litem for the child, the court may review the appropriateness of the adoptive placement of the child.

(a) If the department has denied a person's application to adopt a child, the denied applicant may file a motion with the court within 30 days after the issuance of the written notification of denial to allow him or her to file a chapter 63 petition to adopt a child without the department's consent. The denied applicant must allege in its motion that the department unreasonably withheld its consent to the adoption. The court, as part of its continuing jurisdiction, may review and rule on the motion.

1. The denied applicant only has standing in the chapter 39

proceeding to file the motion in paragraph (a) and to present evidence in support of the motion at a hearing, which must be held within 30 days after the filing of the motion.

2. At the hearing on the motion, the court may only consider whether the department's review of the application was consistent with its policies and made in an expeditious manner. The standard of review by the court is whether the department's denial of the application is an abuse of discretion. The court may not compare the denied applicant against another applicant to determine which placement is in the best interests of the child.

3. If the denied applicant establishes by a preponderance of the evidence that the department unreasonably withheld its consent, the court shall enter an order authorizing the denied applicant to file a petition to adopt the child under chapter 63 without the department's consent.

4. If the denied applicant does not prove by a preponderance of the evidence that the department unreasonably withheld its consent, the court shall enter an order so finding and dismiss the motion.

5. The standing of the denied applicant in the chapter 39 proceeding is terminated upon entry of the court's order.

(b) When a licensed foster parent or court-ordered custodian has applied to adopt a child who has resided with the foster parent or custodian for at least 6 months and who has previously been permanently committed to the legal custody of the department and the department does not grant the application to adopt, the department may not, in the absence of a prior court order authorizing it to do so, remove the child from the

foster home or custodian, except when:

1.~~(a)~~ There is probable cause to believe that the child is at imminent risk of abuse or neglect;

2.~~(b)~~ Thirty days have expired following written notice to the foster parent or custodian of the denial of the application to adopt, within which period no formal challenge of the department's decision has been filed; ~~or~~

3.~~(c)~~ The foster parent or custodian agrees to the child's removal; or~~.~~

4. The department has selected another prospective adoptive parent to adopt the child and either the foster parent or custodian has not filed a motion with the court to allow him or her to file a chapter 63 petition to adopt a child without the department's consent, as provided under paragraph (a), or the court has denied such a motion.

(5) The petition for adoption must be filed in the division of the circuit court which entered the judgment terminating parental rights, unless a motion for change of venue is granted under ~~pursuant to~~ s. 47.122. A copy of the consent executed by the department must be attached to the petition, unless such consent is waived under subsection (4) ~~pursuant to s. 63.062(7)~~. The petition must be accompanied by a statement, signed by the prospective adoptive parents, acknowledging receipt of all information required to be disclosed under s. 63.085 and a form provided by the department which details the social and medical history of the child and each parent and includes the social security number and date of birth for each parent, if such information is available or readily obtainable. The prospective adoptive parents may not file a petition for adoption until the

judgment terminating parental rights becomes final. An adoption proceeding under this subsection is governed by chapter 63.

Section 13. Section 39.820, Florida Statutes, is amended to read:

39.820 Definitions.—As used in this chapter ~~part~~, the term:

(1) "Guardian ad litem" as referred to in any civil or criminal proceeding includes the following: The Statewide Guardian Ad Litem Office, which includes circuit ~~a certified~~ guardian ad litem programs; ~~program,~~ a duly certified volunteer, a staff member, a staff attorney, a contract attorney, or ~~certified~~ a pro bono attorney working on behalf of a guardian ad litem ~~or the program; staff members of a program office~~; a court-appointed attorney; or a responsible adult who is appointed by the court to represent the best interests of a child in a proceeding as provided for by law, including, but not limited to, this chapter, who is a party to any judicial proceeding as a representative of the child, and who serves until discharged by the court.

(2) "Guardian advocate" means a person appointed by the court to act on behalf of a drug dependent newborn pursuant to the provisions of this part.

Section 14. Subsection (7) of section 63.062, Florida Statutes, is amended to read:

63.062 Persons required to consent to adoption; affidavit of nonpaternity; waiver of venue.—

(7) If parental rights to the minor have previously been terminated, the adoption entity with which the minor has been placed for subsequent adoption may provide consent to the adoption. In such case, no other consent is required. If the

minor has been permanently committed to the department for subsequent adoption, the department must consent to the adoption or, in the alternative, the court order entered under s. 39.812(4) finding that the department ~~The consent of the department shall be waived upon a determination by the court that such consent is being~~ unreasonably withheld its consent must be attached to the petition to adopt, and ~~if~~ the petitioner must file ~~has filed with the court~~ a favorable preliminary adoptive home study as required under s. 63.092.

Section 15. Paragraph (b) of subsection (6) of section 63.082, Florida Statutes, is amended to read:

63.082 Execution of consent to adoption or affidavit of nonpaternity; family social and medical history; revocation of consent.—

(6)

(b) Upon execution of the consent of the parent, the adoption entity must ~~shall~~ be permitted to intervene in the dependency case as a party in interest and must provide the court that acquired jurisdiction over the minor, pursuant to the shelter order or dependency petition filed by the department, a copy of the preliminary home study of the prospective adoptive parents and any other evidence of the suitability of the placement. The preliminary home study must be maintained with strictest confidentiality within the dependency court file and the department's file. A preliminary home study must be provided to the court in all cases in which an adoption entity has intervened under ~~pursuant to~~ this section. The exemption in s. 63.092(3) from the home study for a stepparent or relative does not apply if a minor is under the supervision of the department

or is otherwise subject to the jurisdiction of the dependency court as a result of the filing of a shelter petition, dependency petition, or termination of parental rights petition under chapter 39. Unless the court has concerns regarding the qualifications of the home study provider, or concerns that the home study may not be adequate to determine the best interests of the child, the home study provided by the adoption entity is ~~shall be deemed to be~~ sufficient and no additional home study needs to be performed by the department.

Section 16. Subsections (8) and (9) of section 402.302, Florida Statutes, are amended to read:

402.302 Definitions.—As used in this chapter, the term:

(8) "Family day care home" means an occupied primary residence leased or owned by the operator in which child care is regularly provided for children from at least two unrelated families and which receives a payment, fee, or grant for any of the children receiving care, whether or not operated for profit. Household children under 13 years of age, when on the premises of the family day care home or on a field trip with children enrolled in child care, must ~~shall~~ be included in the overall capacity of the licensed home. A family day care home is ~~shall be~~ allowed to provide care for one of the following groups of children, which shall include household children under 13 years of age:

(a) A maximum of four children from birth to 12 months of age.

(b) A maximum of three children from birth to 12 months of age, and other children, for a maximum total of six children.

(c) A maximum of six preschool children if all are older

than 12 months of age.

(d) A maximum of 10 children if no more than 5 are preschool age and, of those 5, no more than 2 are under 12 months of age.

(9) "Household children" means children who are related by blood, marriage, or legal adoption to, or who are the legal wards of, the family day care home operator, the large family child care home operator, or an adult household member who permanently or temporarily resides in the home. Supervision of the operator's household children shall be left to the discretion of the operator unless those children receive subsidized child care through the school readiness program under ~~pursuant to~~ s. 1002.92 to be in the home.

Section 17. Paragraph (a) of subsection (7), paragraphs (b) and (c) of subsection (9), and subsection (10) of section 402.305, Florida Statutes, are amended to read:

402.305 Licensing standards; child care facilities.—

(7) SANITATION AND SAFETY.—

(a) Minimum standards shall include requirements for sanitary and safety conditions, first aid treatment, emergency procedures, and pediatric cardiopulmonary resuscitation. The minimum standards shall require that at least one staff person trained and certified in cardiopulmonary resuscitation, as evidenced by current documentation of course completion, must be present at all times that children are present.

(9) ADMISSIONS AND RECORDKEEPING.—

(b) At the time of initial enrollment and annually thereafter ~~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 for Disease Control and Prevention.

(c) At the time of initial enrollment and annually thereafter ~~During the months of April and September of each year~~, at a minimum, each facility shall provide parents of children enrolled in the facility 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 that 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.

(10) TRANSPORTATION SAFETY.—

(a) Minimum standards for child care facilities, family day care homes, and large family child care homes ~~shall~~ include all of the following:

1. Requirements for child restraints or seat belts in vehicles used by ~~child care~~ facilities and ~~large family child care~~ homes to transport children.~~,~~

2. Requirements for annual inspections of such ~~the~~ vehicles.~~,~~

3. Limitations on the number of children which may be

transported in such ~~the~~ vehicles.~~,~~

4. Procedures to avoid leaving children in vehicles when transported by the facility, and accountability for children transported by the child care facility.

(b) Before providing transportation services or reinstating transportation services after a lapse or discontinuation of longer than 30 days, a child care facility, family day care home, or large family child care home must be approved by the department to transport children. Approval by the department is based on the provider's demonstration of compliance with all current rules and standards for transportation.

(c) A child care facility, family day care home, or large family child care home is not responsible for the safe transport of children when they are being transported by a parent or guardian.

Section 18. Subsections (14) and (15) of section 402.313, Florida Statutes, are amended to read:

402.313 Family day care homes.—

(14) At the time of initial enrollment and annually thereafter ~~During the months of August and September of each year~~, each family day care home shall provide parents of children enrolled in the home 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 for Disease Control and Prevention.

(15) At the time of initial enrollment and annually thereafter ~~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 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 information about resources with suggestions to avoid this occurrence. The department shall develop a flyer or brochure with this information that 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 19. Subsections (8), (9), and (10) of section 402.3131, Florida Statutes, are amended to read:

402.3131 Large family child care homes.—

(8) Before ~~Prior to~~ being licensed by the department, large family child care homes must be approved by the state or local fire marshal in accordance with standards established for child care facilities.

(9) At the time of initial enrollment and annually thereafter ~~During the months of August and September of each year~~, each large family child care home shall provide parents of children enrolled in the home 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 for Disease Control and Prevention.

(10) At the time of initial enrollment and annually

thereafter ~~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 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 that 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 20. Subsection (6) and paragraphs (b) and (e) of subsection (7) of section 409.1451, Florida Statutes, are amended to read:

409.1451 The Road-to-Independence Program.—

(6) ACCOUNTABILITY.—The department shall develop outcome measures for the program and other performance measures ~~in order~~ to maintain oversight of the program. ~~No later than January 31 of each year, the department shall prepare a report on the outcome measures and the department's oversight activities and submit the report to the President of the Senate, the Speaker of the House of Representatives, and the committees with jurisdiction over issues relating to children and families in the Senate and the House of Representatives. The report must include:~~

~~(a) An analysis of performance on the outcome measures developed under this section reported for each community-based~~

~~care lead agency and compared with the performance of the department on the same measures.~~

~~(b) A description of the department's oversight of the program, including, by lead agency, any programmatic or fiscal deficiencies found, corrective actions required, and current status of compliance.~~

~~(c) Any rules adopted or proposed under this section since the last report. For the purposes of the first report, any rules adopted or proposed under this section must be included.~~

(7) INDEPENDENT LIVING SERVICES ADVISORY COUNCIL.—The secretary shall establish the Independent Living Services Advisory Council for the purpose of reviewing and making recommendations concerning the implementation and operation of the provisions of s. 39.6251 and the Road-to-Independence Program. The advisory council shall function as specified in this subsection until the Legislature determines that the advisory council can no longer provide a valuable contribution to the department's efforts to achieve the goals of the services designed to enable a young adult to live independently.

~~(b) The advisory council shall report to the secretary on the status of the implementation of the Road-to-Independence Program, efforts to publicize the availability of the Road-to-Independence Program, the success of the services, problems identified, recommendations for department or legislative action, and the department's implementation of the recommendations contained in the Independent Living Services Integration Workgroup Report submitted to the appropriate substantive committees of the Legislature by December 31, 2013. The department shall submit a report by December 31 of each year~~

~~to the Governor, the President of the Senate, and the Speaker of the House of Representatives which includes a summary of the factors reported on by the council and identifies the recommendations of the advisory council and either describes the department's actions to implement the recommendations or provides the department's rationale for not implementing the recommendations.~~

~~(c) The advisory council report required under paragraph (b) must include an analysis of the system of independent living transition services for young adults who reach 18 years of age while in foster care before completing high school or its equivalent and recommendations for department or legislative action. The council shall assess and report on the most effective method of assisting these young adults to complete high school or its equivalent by examining the practices of other states.~~

Section 21. This act shall take effect October 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 5, 2020

I respectfully request that **Senate Bill #1548**, relating to Child Welfare, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

W. Keith Perry

Senator Keith Perry
Florida Senate, District 8

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)

02/18/20
Meeting Date

~~SB~~ 1548
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name John Paul Fiore

Job Title Legislative Specialist

Address 1317 Winewood Blvd
Street

Phone 488-9410

Tallahassee FL 32399
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Dept. of Children and Families

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)

02/18/20
Meeting Date

1548
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name ~~John Doe~~ Patricia Medlock

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Tallahassee FL 32399
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Speaking: ☐ For ☐ Against ☑ Information

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

Representing Dept. of Children and Families

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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 1676 (281464)
INTRODUCER:	Appropriations Subcommittee on Health and Human Services; Health Policy Committee; and Senator Albritton
SUBJECT:	Direct Care Workers
DATE:	February 20, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.	McKnight	Kidd	AHS	**Recommend: Fav/CS**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

PCS/CS/SB 1676 expands the scope of practice and defines relevant terms for registered nurses (RNs), certified nursing assistants (CNAs), and home health aides (HHAs). The bill:

- Authorizes nursing home facilities to use paid feeding assistants if the assistant has completed a 12 hour program developed by the Agency for Health Care Administration (AHCA). The bill clarifies that paid feeding assistants do not count toward minimum staffing standards.
- Authorizes an RN to delegate any task, including the administration of medications, except controlled substances, to a CNA or HHA for a patient of a home health agency, if the RN determines that the CNA or the HHA is competent to perform the task, the task is delegable under federal law, and certain other requirements are met.
- Requires the AHCA, in consultation with the Board of Nursing, to establish standards and procedures by rule that a CNA and HHA must follow when administering medication to a patient of a home health agency.
- Establishes disciplinary actions for RNs that knowingly delegate responsibilities to a person that is not qualified by training, experience, certification, or licensure to perform them.

- Requires a Direct Care Workforce Survey (survey), created by the AHCA, to be completed and submitted at license renewal (every two years) for over 6,000 providers[1], including: nursing homes, assisted living facilities, home health agencies, and homemaker and companion services providers.
- Requires the ACHA to analyze the results of the survey and publish the information monthly on its website.
- Creates the Excellence in Home Health Program (program) within the AHCA for the purpose of awarding designations to home health agencies and nurse registries that meet specified criteria. The AHCA is required to adopt rules establishing criteria for the program and annually evaluate home health agencies or nurse registries that apply for program designation.
- Establishes a physician student loan repayment program within the Department of Health (DOH).
- Establishes the Patient Access to Primary Care Pilot Program within the DOH to provide primary health care services in "primary care health professional shortage areas" by allowing Advanced Practice Registered Nurses (APRN) who meet certain criteria to engage in the autonomous practice of advanced or specialized nursing without the supervision of a physician.

The bill appropriates three full-time equivalent (FTE) positions with an associated salary rate of 125,887, three other personal services (OPS) positions, and $400,764 in recurring funds and $408,731 in nonrecurring funds from the Health Care Trust Fund, in Fiscal Year 2020-2021 to the AHCA to manage stakeholder input and develop rules related to expansion of HHA and CNA duties, and create and implement the survey and program.

The bill's requirements to establish a physician student loan repayment program and the Patient Access to Primary Care Pilot Program has a significant negative fiscal impact on the Department of Health. See Section V.

The bill takes effect upon becoming a law, except as otherwise expressly provided in the bill.

II. Present Situation:

The Agency for Health Care Administration

The Agency for Health Care Administration (AHCA) is created in s. 20.42, F.S. The AHCA is the chief health policy and planning entity for the state and its Division of Health Quality Assurance (HQA) is responsible for, among other things, health facility licensure, inspection, and regulatory enforcement. The HQA is funded with more than $49 million in state and federal funds. It licenses or certifies and regulates 40 different types of health care providers, including hospitals, nursing homes, assisted living facilities (ALFs), and home health agencies. In total, the AHCA licenses, certifies, regulates, or provides exemptions for more than 48,000 providers. [2]

[1] Agency for Health Care Administration, *CS/SB 1676 Bill Analysis* (Feb. 14, 2020) (on file with the Senate Appropriations Subcommittee on Health and Human Services).
[2] Agency for Health Care Administration, *Division of Health Quality Assurance* http://ahca.myflorida.com/MCHQ/index.shtml (last visited Jan. 26, 2020).

Florida Nursing Homes

Nursing homes provide 24-hour-per-day nursing care, case management, health monitoring, personal care, nutritional meals and special diets, physical, occupational, and speech therapy, social activities, and respite care for those who are ill or physically infirm.[3] Nursing care is provided by licensed practical nurses (LPNs) and registered nurses (RNs). Personal care is provided by certified nursing assistants (CNAs) and can include help with bathing, dressing, eating, walking, and physical transfer (like moving from a bed to a chair).[4]

A nursing home may also provide services like dietary consultation, laboratory, X-ray, pharmacy services, laundry, and pet therapy visits. Some facilities may provide special services like dialysis, tracheotomy, or ventilator care as well as Alzheimer's or hospice care.

Pursuant to s. 400.141, F.S., every nursing home in Florida must comply with all administrative and care standards set out in the AHCA rules and must:

- Be under the administrative direction and charge of a licensed administrator.[5]
- Appoint a physician medical director.[6]
- Have available the regular, consultative, and emergency services of one or more physicians.
- Provide residents with the use of a community pharmacy of their choice.
- Provide access for residents to dental and other health-related services, recreational services, rehabilitative services, and social work services.
- Be permitted and encouraged by the AHCA to provide other needed services, including, but not limited to, respite, therapeutic spa, and adult day services to nonresidents of the facility.
- Maintain the facility premises and equipment and conduct its operations in a safe and sanitary manner.
- Provide a wholesome and nourishing diet, if the licensee furnishes food services, sufficient to meet generally accepted standards of proper nutrition for its residents and provide such therapeutic diets as may be prescribed by physicians if the nursing home furnishes food services.
- Keep records of:
  - Resident admissions and discharges;
  - Medical and general health status, including:
    - Medical records;
    - Personal and social history;
    - Identity and address of next of kin or other persons who may have responsibility for the affairs of the resident;
    - Individual resident care plans, including, but not limited to:
      - Prescribed services;
      - Service frequency and duration; and
      - Service goals.

[3] Agency for Health Care Administration, Division of Health Quality Assurance, Long Term Care Service Units, *Nursing Homes, available at* https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Long_Term_Care/Index_LTCU.shtml (last visited Jan. 26, 2020).
[4] Agency for Health Care Administration, FloridaHealthFinder.gov; Consumer Guides, *Nursing Home Care In Florida, available at* https://www.floridahealthfinder.gov/reports-guides/NursingHomesFL.aspx# (Last visited Jan. 24, 2020).
[5] 59A-4.103(4)(b), F.A.C.
[6] 59A-4.1075, F.A.C.

- Keep fiscal records of its operations and conditions.
- Furnish copies of personnel records for employees affiliated with such facility, to any other facility licensed by this state requesting this information.
- Publicly display a poster provided by the AHCA containing information for the:
  - State's abuse hotline;
  - State Long-Term Care Ombudsman;
  - AHCA consumer hotline;
  - Advocacy Center for Persons with Disablities;
  - Florida Statewide Advocacy Council; and
  - Medicaid Fraud Control Unit.
- Comply with state minimum-staffing requirements, as set by AHCA rule, including the number and qualifications of all personnel having responsibility for resident care, such as:
  - Management;
  - Medical;
  - Nursing;
  - Other professional personnel;
  - Nursing assistants;
  - Orderlies; and
  - Other support personnel.
- Ensure that any program for dining and use of a hospitality attendant is developed and implemented under the supervision of the facility director of nursing.
- Maintain general and professional liability insurance coverage or proof of financial responsibility as required by statute.
- Require all CNAs to chart in a resident's medical records, by the end of his or her shift, all services provided, including:
  - Assistance with activities of daily living,
  - Eating,
  - Drinking, and
  - All offers to a resident for nutrition and hydration for those residents whose plan of care or assessment indicates a risk for malnutrition or dehydration.
- Provide to all consenting residents immunizations against influenza before November 30 each year.
- Assess each resident within five business days after admission for eligibility for pneumococcal vaccination or revaccination.
- Annually encourage all employees to receive immunizations against influenza viruses.[7]

Nursing Home Staffing Standards

Section 400.23(3), F.S., requires the AHCA to adopt rules providing minimum staffing requirements for nursing home facilities. The requirements must include:

- A minimum weekly average of 3.6 hours of direct care per resident per day provided by a combination of CNAs and licensed nursing staff. A week is defined as Sunday through Saturday.

[7] Section 400.141, F.S.

- A minimum of 2.5 hours of direct care per resident per day provided by CNAs. A facility may not staff at a ratio of less than one CNA per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.
- Nursing assistants employed under s. 400.211(2), F.S., may be included in computing the staffing ratio for CNAs if their job responsibilities include only nursing-assistant-related duties.
- Each nursing home facility must document compliance with staffing standards and post daily the names of staff on duty for the benefit of facility residents and the public.
- Licensed nurses may be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.
- Non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing standards.

Section 400.23(3), F.S., also provides that LPNs who are providing nursing services in nursing home facilities may supervise the activities of other LPNs, CNAs, and other unlicensed personnel providing services in such facilities in accordance with rules adopted by the Board of Nursing (BON).

Nurse Practice Act

Florida's Nurse Practice Act is found in Part I of ch. 464, F.S. The purpose of the Nurse Practice Act is to ensure that every nurse practicing in this state meets minimum requirements for safe practice. It is the legislative intent that nurses who fall below minimum competency or who otherwise present a danger to the public are prohibited from practicing in this state.[8]

Registered Nurses

A registered nurse is any person licensed in this state or holding an active multistate license under the Nurse Practice Act to practice professional nursing. The practice of professional nursing means performing acts requiring substantial specialized knowledge, judgment, and nursing skill based on applied principles of psychological, biological, physical, and social sciences and includes, but is not limited to:

- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.
- The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner authorized by the laws of this state to prescribe such medications and treatments.
- The supervision and teaching of other personnel in the theory and performance of any of the acts described in this subsection.

[8] Section 464.002, F.S.

A professional nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.[9]

Licensed Practical Nurses

A licensed practical nurse is any person licensed in this state or holding an active multistate license under the Nurse Practice Act to practice practical nursing.[10] The practice of practical nursing means performing selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of an RN, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist; and the teaching of general principles of health and wellness to the public and to students other than nursing students. A practical nurse is responsible and accountable for making decisions based on the individual's educational preparation and experience in nursing.[11]

Certified Nursing Assistants

Florida's statutory governance for CNAs is found in part II of ch. 464, F.S. Section 464.201(5), F.S., defines the practice of a CNA as providing care and assisting persons with tasks relating to the activities of daily living. Activities of daily living include tasks associated with: personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, postmortem care, patient socialization and reality orientation, end-of-life care, cardiopulmonary resuscitation and emergency care, patients' rights, documentation of nursing-assistant services, and other tasks that a CNA may perform after training.[12]

Direct Care Staff

Federal law defines "direct care staff" as those individuals who, through interpersonal contact with nursing home residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long-term care facility (for example, housekeeping).[13]

Direct care staff are the primary providers of paid, hands-on care for more than 13 million elderly and disabled Americans. They assist individuals with a broad range of support, including preparing meals, helping with medications, bathing, dressing, getting about (mobility), and getting to planned activities on a daily basis.[14]

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[9] Section 464.003, F.S.
[10] Section 464.003(14), F.S.
[11] Section 464.003(17), F.S.
[12] Section 464.201, F.S.
[13] 42 CFR s. 483.70(q)(1)
[14] Understanding Direct Care Workers: a Snapshot of Two of America's Most Important Jobs, *Certified Nursing Assistants and Home Health Aides*, Khatutsky, et al., (March 2011), *available at* https://aspe.hhs.gov/basic-report/understanding-direct-care-workers-snapshot-two-americas-most-important-jobs-certified-nursing-assistants-and-home-health-aides#intro (last visited on Jan. 27, 2020).

Direct care staff fall into three main categories tracked by the U.S. Bureau of Labor Statistics: Nursing Assistants (usually known as CNAs), home health aides (HHAs), and Personal Care Aides:

- CNAs generally work in nursing homes, although some work in ALFs, other community-based settings, or hospitals. They assist residents with activities of daily living (ADLs) such as eating, dressing, bathing, and toileting. They also perform clinical tasks such as range-of motion exercises and blood pressure readings.
- HHAs provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or therapist. They may also perform light housekeeping tasks such as preparing food or changing linens.
- Personal Care Aides work in either private or group homes. They have many titles, including personal care attendant, home care worker, homemaker, and direct support professional. (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with ADLs, these aides often help with housekeeping chores, meal preparation, and medication management. They also help individuals go to work and remain engaged in their communities. A growing number of these workers are employed and supervised directly by consumers.[15]

The federal government requires training only for nursing assistants and HHAs who work in Medicare-certified and Medicaid-certified nursing homes and home health agencies. Such training includes training on residents' rights; abuse, neglect, and exploitation; quality assurance; infection control; and compliance and ethics; and specifies that direct care staff must be trained in effective communications.[16]

The Gold Seal Program

The Gold Seal Program (program) is a legislatively created award and recognition program, developed and implemented by the Governor's Panel on Excellence in Long-Term Care (Panel) for nursing facilities that demonstrate excellence in long-term care over a sustained period.[17] Facilities must meet the Panel's criteria for measuring quality of care and the following additional criteria to receive a program designation:

- No class I or class II deficiencies within the 30 months preceding application for the program.
- Evidence of financial soundness and stability according to standards adopted by the AHCA in rule.

[15] See *Who are Direct Care Workers?* available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited Jan. 27, 2020)
[16] 42 CFR s. 483.95
[17] Section 400.235, F.S. The panel is composed of three persons appointed by the Governor, to include a consumer advocate for senior citizens and two persons with expertise in the fields of quality management, service delivery excellence, or public sector accountability; three persons appointed by the Secretary of the Department of Elder Affairs, to include an active member of a nursing facility family and resident care council and a member of the University Consortium on Aging; a representative of the State Long-Term Care Ombudsman Program; one person appointed by the Florida Life Care Residents Association; one person appointed by the State Surgeon General; two persons appointed by the Secretary of Health Care Administration; one person appointed by the Florida Association of Homes for the Aging; and one person appointed by the Florida Health Care Association. Vacancies on the panel shall be filled in the same manner as the original appointments.

- Participate in a consumer satisfaction process and demonstrate the facility's efforts to act on the information gathered.
- Evidence of the involvement of families and members of the community in the facility on a regular basis.
- Have a stable workforce as evidenced by a relatively low turnover rate among CNAs and RNs within the 30 months preceding application for the program.
- Evidence that any complaints submitted to the State Long-Term Care Ombudsman Program within the 30 months preceding application for the program did not result in a licensure citation.
- Provide targeted in-service training to meet training needs identified by internal or external quality assurance efforts.

Home Health Agencies and Home Health Aides

Home health agencies deliver health and medical services and medical supplies through visits to private homes, ALFs, and adult family care homes. Some of the services include nursing care, physical therapy, occupational therapy, respiratory therapy, speech therapy, HHA services, and nutritional guidance. Medical supplies are restricted to drugs and biologicals prescribed by a physician. Along with services in the home, a home health agency can also provide staffing services in nursing homes and hospitals. Home health agencies differ in the quality of care and services they provide to patients. Home health agencies are required to be licensed and inspected by the state of Florida.[18]

The Home Health Consumer Assessment of Healthcare Providers & Systems (HHCAHPS) star ratings provide a snapshot of the four measures of patient experience of care. In addition, the HHCAHPS summary star rating combines all four HHCAHPS star ratings into a single, comprehensive metric. If a home health agency does not have an HHCAHPS summary star rating, it means that the home health agency did not have enough surveys completed to have star ratings calculated in a meaningful way. In addition to the patient survey results, the HHCAHPS star ratings summarize patient experience, which is one aspect of home health agency quality.[19]

Section 400.462(15), F.S., defines a "home health aide" as a person who is trained or qualified, as provided by the AHCA rule, to:

- Provide hands-on personal care;
- Perform simple procedures as an extension of therapy or nursing services;
- Assist in ambulation or exercises; or
- Assist in administering medications for which the person has received training established by the AHCA.

[18] Agency for Health Care Administration, FloridaHealthFinder.gov, Alternative to Nursing Homes, *Home Health Agencies, available at* https://www.floridahealthfinder.gov/reports-guides/NursingHomesFL.aspx#NHStay (last visited Jan. 26, 2020).
[19] U.S. Centers for Medicare & Medicaid Services, Medicare.gov, Home Health Compare, *Patient Survey Star Ratings available at https://www*.medicare.gov/homehealthcompare/About/Patient-Survey-Star-Ratings.html (last visited Jan. 26, 2020).

Assistance with Administering Medications

Rule 59A-18.0081, F.A.C., provides that a CNA or HHA referred by a nurse registry may assist with self-administration of medication if they have received a minimum of two hours of training covering the following content:

- State law and rule requirements with respect to the assistance with self-administration of medications in the home;
- Procedures for assisting the resident with self-administration of medication;
- Common types of medication;
- Recognition of side effects and adverse reactions; and
- Procedures to follow when patients appear to be experiencing side effects and adverse reactions.

The training must include verification that, for prescription medications, each CNA and HHA can read the prescription label and any instructions for the prescription. The rule provides that individuals who cannot read are not allowed to assist with prescription medications.

Healthcare Professional Shortage

The U.S. has a current health care provider shortage. As of December 31, 2019, the U.S. Department of Health and Human Services has designated 7,655 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,392 additional primary care physicians to eliminate the shortage), 6,820 Dental HPSAs (requiring 10,258 additional dentists to eliminate the shortage), and 6,117 Mental Health HPSAs (requiring 6,335 additional psychiatrists to eliminate the shortage).[20]

In Florida, there are 754 HPSAs just for primary care, dental care, and mental health. It would take 1,636 primary care, 1,270 dental care, and 407 mental health practitioners to eliminate these shortage areas.[21]

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)[22] can be licensed as one of the following:[23]

- Certified nurse practitioner (CNP);
- Certified nurse midwife (CNM);
- Clinical nurse specialist (CNS); or
- Certified registered nurse anesthetist (CRNA).

[20] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Sept. 30, 2019), available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited Feb. 18, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.
[21] *Id.*
[22] Section 464.003(3), F.S.
[23] Section 464.012(4), F.S.

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), provides by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices.[24] Additionally, the Board is responsible for administratively disciplining an APRN who commits prohibited acts. [25]

In Florida "advanced or specialized nursing practice" includes, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience.[26] Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[27] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[28]

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[29] A nursing specialty board must:[30]

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal.[31] The APRN must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the APRN as beneficiary.[32]

[24] *See* s. 464.004, F.S., and Rule 64B9-3, F.A.C.
[25] *See* ss. 464.018 and 456.072, F.S.
[26] Section 464.003(2), F.S.
[27] Section 464.012(3)-(4), F.S.
[28] *Id.*
[29] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[30] Rule 64B9-4.002(3), F.A.C.
[31] Rule 64B9-4.002, F.A.C. The DOH Form DH-MQA 1186, 01/09, "Financial Responsibility," is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.
[32] *Id.*

APRN Autonomy in Florida

Florida is a supervisory state. APRNs may perform only those nursing and medical practices delineated in a written physician protocol.[33] A physician providing primary health care services may supervise APRNs in up to four medical offices, in addition to the physician's primary practice location.

APRN Scope of Practice in Florida

Within the framework of the written protocol with a supervising physician, an APRN may:[34]

- Prescribe, dispense, administer, or order any drug;
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and
- Perform certain acts within his or her specialty.

Currently, APRNs in Florida are not authorized to sign certain documents such as a certificate to initiate the involuntary examination of a person under the Baker Act, the release of persons in receiving facilities under the Baker Act, or death certificates.[35]

III. Effect of Proposed Changes:

Sections 1 and 2 amend ss. 400.141 and 400.23, F.S., to provide that a licensed nursing home facility may use paid feeding assistants as defined in 42 C.F.R. s. 488.301, in accordance with 42 C.F.R. s. 483.60, if the paid feeding assistant has successfully completed a feeding assistant training program developed by the AHCA. The feeding assistant training program must consist of a minimum of 12 hours of education and training and must include all of the topics and lessons specified in the program curriculum. The program curriculum must include training in all of the following content areas:

- Feeding techniques.
- Assistance with feeding and hydration.
- Communication and interpersonal skills.
- Appropriate responses to resident behavior.
- Safety and emergency procedures, including the first aid procedure used to treat upper airway obstructions.
- Infection control.
- Residents' rights.
- Recognizing changes in residents which are inconsistent with their normal behavior, and the importance of reporting those changes to the supervisory nurse.

The AHCA is authorized to adopt rules to implement these provisions.

Section 3 amends s. 400.461, F.S., to make conforming changes.

[33] Section 464.012(3), F.S.
[34] Section 464.012(3)-(4), F.S.
[35] *See* ss. 382.008, and 394.463, F.S.

Sections 4 through 9 of the bill amend or create statutes within part III of ch. 400, F.S., relating to home health agencies.

Section 4 amends s. 400.462, F.S., to redefine "home health aide" to provide that, in addition to the definition's other provisions, a home health aide (HHA) may include a person who performs tasks delegated to him or her pursuant to ch. 464, F.S.

Section 5 amends s. 400.464, F.S., to provide that if a home health agency authorizes an RN to delegate tasks, including medication administration, to a CNA pursuant to ch. 464, F.S., or to a HHA pursuant to s. 400.490, F.S., the home health agency must ensure that such delegation meets the requirements of chs. 400 and 464, F.S., and applicable rules adopted under those chapters.

Section 6 amends s. 400.488, F.S., relating to provisions under which an unlicensed person may assist a patient with the self-administration of medication under certain circumstances, to provide that such medications include intermittent positive pressure breathing treatments and nebulizer treatments. The bill also provides that assistance with self-administered medication includes:

- In the presence of the patient, confirming that the medication is intended for that patient and orally advising the patient of the medication's name and purpose.
- When applying topical medications, the provision of routine preventative skin care and basic wound care.
- For intermittent positive pressure breathing treatments or for nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

Section 7 creates s. 400.489, F.S., to provide that a HHA may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the HHA:

- Has been delegated such task by an RN licensed under ch. 464, F.S.
- Has satisfactorily completed an initial six-hour training course approved by the AHCA.
- Has been found competent to administer medication to a patient in a safe and sanitary manner.

To remain qualified to administer medications as provided above, the bill requires a HHA to annually and satisfactorily complete a two-hour inservice training course in medication administration and medication error prevention approved by the AHCA. This inservice training course must be in addition to the annual inservice training hours required by the AHCA rules under current law.

The bill requires the AHCA, in consultation with the Board of Nursing (BON), to establish by rule standards and procedures that a HHA must follow when administering medication to a patient.

The training, determination of competency, and initial and annual validations required under this new section of statute must be conducted by an RN or a physician licensed under chs. 458 or 459, F.S.

Section 8 creates s. 400.490, F.S., to authorize a CNA or HHA to perform any task delegated by an RN as authorized in this part and in ch. 464, F.S., including, but not limited to, medication authorization.

Section 9 creates s. 400.52, F.S., to establish the Excellence in Home Health Program (program) for the purpose of awarding designations to home health agencies or nurse registries that meet specified criteria.

The AHCA is directed to adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

- Patient satisfaction.
- Patients requiring emergency care for wound infections.
- Patients admitted or readmitted to an acute care hospital.
- Patient improvement in the activities of daily living.
- Employee satisfaction.
- Quality of employee training.
- Employee retention rates.

The AHCA is directed to annually evaluate home health agencies and nurse registries seeking program designation. To receive program designation, a home health agency or nurse registry must:

- Apply on a form and in the manner designated by the AHCA rule;
- Be actively licensed and have been operating for at least 24 months before applying for program designation; and
- Have not had any licensure denials, revocations, or Class I, Class II, or uncorrected Class III deficiencies within the 24 months before the application for program designation.

A designation awarded under the program is not transferrable to another licensee, unless the existing home health agency or nurse registry is being relicensed in the name of an entity related to the current license-holder by common control or ownership, and there will be no change in the management, operation, or programs of the home health agency or nurse registry as a result of the relicensure.

Program designation expires on the same date as the home health agency's or nurse registry's license. A home health agency or nurse registry must reapply and be approved for program designation to continue using the designation in advertising and marketing. A home health agency or nurse registry may not use program designation in any advertising or marketing if the home health agency or nurse registry:

- Has not been awarded the designation;
- Fails to renew the designation upon expiration of the awarded designation;
- Has undergone a change in ownership that does not qualify for a transfer of the designation as described above; or

- Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the awarded designation.

The bill clarifies that an application for an award designation is not an application for licensure and that an award designation or denial by the AHCA does not constitute final agency action subject to ch. 120, F.S.

Section 10 creates s. 408.822, F.S., to establish a Direct Care Workforce Survey (survey). The bill defines the term "direct care worker" for purposes of the survey to mean a:

- CNA;
- HHA;
- Personal care assistant;
- Companion services or homemaker services provider;
- Paid feeding assistant trained under s. 400.141(1)(v), F.S.; or
- Provider of personal care as defined in s. 400.462(24), F.S., to individuals who are elderly, developmentally disabled, or chronically ill.

Under the bill, beginning January 1, 2021, nursing home facilities, assisted living facilities, home health agencies, companion services providers, and homemaker services providers applying for licensure renewal (every two years), must furnish the following information to the AHCA before the license will be renewed:

- The number of registered nurses and the number of direct care workers by category employed.
- The turnover and vacancy rates of registered nurses and direct care workers and contributing factors to these rates.
- The average employee wage for registered nurses and each category of direct care worker.
- The employment benefits provided for registered nurses and direct care workers and the average cost of such benefits to the employer and the employee.
- The type and availability of training for registered nurses and direct care workers.

An administrator or designee must attest that the information provided in the survey is true and accurate to the best of his or her knowledge. In addition, the AHCA is required to analyze the results of the surveys, and publish the results on its website, as well as update the information monthly.

Sections 11 and 12 of the bill amend or create statutes within part I of ch. 464, F.S., relating to the Nurse Practice Act.

Section 11 creates s. 464.0156, F.S., to authorize RNs to delegate a task to a CNA or a HHA if the registered nurse determines that the CNA or HHA is competent to perform the task, the task is delegable under federal law, and the task meets all of the following criteria:

- Is within the nurse's scope of practice.
- Frequently recurs in the routine care of a patient or group of patients.
- Is performed according to an established sequence of steps.
- Involves little or no modification from one patient to another.
- May be performed with a predictable outcome.

- Does not inherently involve ongoing assessment, interpretation, or clinical judgment.
- Does not endanger a patient's life or well-being.

If a CNA or HHA satisfies the qualifications and training requirements of the bill's newly created ss. 464.2035 or 400.489, F.S., an RN may also delegate to a CNA or HHA the administration of prescription medications to a patient of a home health agency, except controlled substances,[36] by the following routes: oral, transdermal,[37] ophthalmic, otic, rectal, inhaled, enteral,[38] or topical.

The BON, in consultation with the AHCA, is required to adopt rules to implement this section of the bill.

Section 12 amends s. 464.018, F.S., to add an additional ground for nursing disciplinary action when a nurse knowingly delegates responsibilities to a person that is not qualified by training, experience, certification, or licensure to perform them.

Section 13 creates s. 464.2035, F.S., to provide that a CNA may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medication to a patient of a home health agency if the CNA has:

- Been delegated such task by an RN;
- Satisfactorily completed an initial six-hour training course approved by the BON; and
- Been found competent to administer medication to such a patient in a safe and sanitary manner.

The training, determination of competency, and initial and annual validations must be conducted by a licensed RN or a physician licensed under chapter 458 or 459, F.S.

To remain qualified to administer medications as provided above, a CNA must annually and satisfactorily complete two hours of inservice training in medication administration and medication error prevention approved by the BON, in consultation with the AHCA. The inservice training required under the bill is in addition to other annual inservice training hours required under current law.

The bill requires the BON, in consultation with the AHCA, to establish by rule standards and procedures that a CNA must follow when administering medication to a patient of a home health agency.

Section 14 creates s. 381.40185, F.S., to require the Department of Health (DOH) to establish a physician student loan repayment program for physicians licensed under ch. 458 and 459. The physician must provide primary care services in a public health program, an independent

[36] Controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.
[37] *See* The Farlex Medical Dictionary, Transdermal, *available at* https://medical-dictionary.thefreedictionary.com/Transdermal (last visited Jan. 27, 2020). Transdermal means entering through the dermis, or skin, as in administration of a drug applied to the skin in ointment or patch form.
[38] *See* The Farlex Medical Dictionary, *Enteral, available at* https://medical-dictionary.thefreedictionary.com/enteral (last visited Jan. 27, 2020). Enteral means within, or by way of, the intestine or gastrointestinal tract, especially as distinguished from parenteral.

practice, or a group practice that serves low-income or Medicaid recipients and be located in a primary care health professional shortage area or medically underserved area. Implementation of the loan program is subject to legislative appropriation.

Section 15 amends the Nurse Practice Act to define an "advanced practice registered nurse - independent practitioner" or "APRN-IP" as an advanced practice registered nurse who is registered under s. 464.0123 to provide primary health care services without a protocol agreement or supervision in primary care health professional shortage areas.

The bill defines a "primary care health professional shortage area" as a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health resources and Services Administration, and which is located in a rural area, as defined by the Federal Office of Rural Health Policy (see section 16).

Section 16 creates s. 464.0123, F.S., to establish the Patient Access to Primary Care Pilot Program (Pilot Program) within the Department of Health (DOH). The Pilot Program will provide primary health care services in "primary care health professional shortage areas" by allowing Advanced Practice Registered Nurses (APRN) who meet certain criteria to engage in the autonomous practice of advanced or specialized nursing without the supervision of a physician.

The bill creates a nine member Council on Advanced Practice Registered Nurse Independent Practice within the DOH and requires the council to make recommendations on the registration of APRN-IPs and develop proposed rules to regulate the practice of APRN-IPs. All recommendations made by the council must be made by a majority of the members present.

Primary Care Certification Examination

The bill requires the DOH to approve at least one third party credentialing entity to develop and administer a primary care certification examination for APRN-IPs.

Registration

The bill requires that APRNs who practice without the supervision of a physician to register with the DOH as an APRN-IP and provide the following:

- Proof of experience as an APRN under the direct or indirect supervision of a physician for at least 10,000 hours within the last 6 years;
- Certifications and designations recognized and approved by the Board of Nursing, Board of Medicine, Board of Osteopathic Medicine, or the DOH;
- APRN education, work, and license history;
- Address in which the application will conduct practice;
- Criminal and regulatory disciplinary history; and
- Proof of professional liability insurance;

An APRN-IP must be renew their registration every 2 years and provide proof of 40 hours of continuing medical education hours.

Scope of Practice

The Board of Medicine and the Board of Osteopathic Medicine must adopt by rule the scope of practice for an APRN-IP. An APRN-IP cannot practice in a hospital licensed under ch. 395, F.S., or a facility licensed under ch. 400, F.S., except under an established written protocol with a supervising physician.

The bill requires APRN-IPs to report all adverse incidents to the DOH. The Board of Medicine or the Board of Nursing is authorized to take disciplinary action under certain circumstances.

The Pilot Program is repealed, unless saved from repeal by the Legislature, on July 1, 2031.

Section 17 amends s. 464.015, F.S., to limit who can use the title "Advanced Practice Registered Nurse Practitioner – Independent Practitioner" and the abbreviation "APRN-IP."

Section 18 amends s. 464.018, F.S., to authorize the Board of Nursing to take administrative action against an APRN-IP for the following:

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a slit-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;
- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Performing professional services that have not been authorized by the patient or his or her representative, except as provided by the Medical Consent Law and the Good Samaritan Act;
- Performing any procedure or prescribing any medicinal drug that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

Section 19 amends s. 381.026, F.S., to expand the definition of a "health care provider" to include an APRN-IP.

Section 20 amends s. 382.008, F.S., to allow an APRN-IPs to certify the cause of death and to file death certificates in the absence of a funeral director.

Section 21 makes conforming changes.

Section 22 amends s. 394.463 F.S., the Baker Act, to allow an APRN-IP to initiate an involuntary examination under certain circumstances.

Section 23 amends s. 397.501, F.S., the Marchman Act, to conform to the provisions of the bill.

Section 24 amends s. 456.053, F.S., to expand the definition of a "health care provider" and "sole provider" to include an APRN-IP.

Section 25 amends s. 626.9707, F.S., to conform to the provisions of the bill.

Section 26, 27, and 31 creates ss. 627.64025, 627.6621, and 641.31075 F.S., to prohibit certain health insurers and health maintenance organizations from requiring an insured to receive services from an APRN-IP or an advanced practice registered nurse rather than a primary care physician.

Section 28 amends 627.6699, F.S. to prohibit certain health insurers from requiring an insured to receive services from an APRN-IP or an advanced practice registered nurse rather than a primary care physician.

Section 29 amends s. 627.736, F.S., to conform to the provisions of the bill.

Section 30 amends s. 633.412, F.S., to allow APRN-IPs to conduct certain medical evaluations for firefighters applying for certification as a firefighter.

Section 32 amends s. 641.495, F.S., to allow HMOs to provide certain services though an APRN-IP.

Section 33 amends s. 744.3675, F.S., to allow an APRN-IP to examine and report on a ward's condition current level of capacity.

Section 34 amends s. 766.118, F.S., to expand the definition of "practitioner" to include an APRN-IP. This section limits noneconomic damages[39] for medical negligence of practitioners, including APRN-IPs, under certain circumstances.

Section 35 amends s. 768.135, F.S., to provide immunity from civil liability for APRN-IPs acting in good faith when performing certain medical evaluations.

Section 36 amends s. 960.28, F.S., to conform to the provisions of the bill.

Section 37 requires the Office of Program Policy Analysis and Government Accountability to submit a report to the Governor, the President of the Senate and the Speaker of the House of

[39] Section 766.202(8), F.S., defines "noneconomic damages" as nonfinancial losses that would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

Representatives by September 1, 2030. The report must include the impact of and recommendations regarding the continuance of the Pilot Program.

Section 38 provides that the Patient Access to Primary Care Pilot Program is repealed on July 1, 2031, unless reviewed and saved from repeal through reenactment by the Legislature. If the Legislature does not reenact the Pilot Program the text of the statutes that are amended in sections 15 and 17 through 36 of this bill will revert back to that in existence on the date this act became law (except that any other amendments to such text enacted other than by this bill must be preserved).

Section 39 appropriates three full-time equivalent (FTE) positions with an associated salary rate of 125,887, three other personal services (OPS) positions, and $400,764 in recurring funds and $408,731 in nonrecurring funds from the Health Care Trust Fund, in Fiscal Year 2020-2021 to the AHCA to manage stakeholder input and develop rules related to expansion of HHA and CNA duties, and create and implement the survey and program.

Section 40 provides that except as otherwise expressly provided in this act, the act shall take effect upon becoming a law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Home health agencies and nursing facilities may incur costs associated with the requirement to provide medication administration training to CNAs and HHAs. In addition, beginning in 2021, they may experience a workload increase associated with the bill's requirements related to survey reporting.

An APRN who applies for licensure as an APRN-IP to practice without the supervision of a physician will be able to provide primary care services in primary care health professional shortage areas. APRNs who have paid physicians for supervision will see cost savings if they register to practice autonomously.

C. Government Sector Impact:

The AHCA estimates the need for five additional full-time equivalent (FTE) positions, three other personal services (OPS) positions, and funding to manage stakeholder input and develop rules related to expansion of HHA and CNA duties, and create and implement the survey and program.[40] The bill appropriates three FTE positions with an associated salary rate of 125,887, three OPS positions, and $400,764 in recurring funds and $408,731 in nonrecurring funds from the Health Care Trust Fund, in Fiscal Year 2020-2021 to the AHCA to manage stakeholder input and develop rules related to expansion of HHA and CNA duties, and create and implement the survey and program.

CS/SB 1676 has a significant negative fiscal impact on the state expenditures. The bill will require the DOH to update information technology systems related to electronic death registrations to accept APRN-IPs as health care providers, and licensing of APRN-IPs. The DOH has estimated that the regulation of APRN-IPs will require an additional four FTE positions at a total cost of $226,291 ($202,019 recurring; $24,272 non-recurring) in the first year.[41]

The bill's requirement that the DOH establish a Physician Student Loan Repayment Program has a significant negative fiscal impact on state expenditures. The DOH estimates the additional need of two FTE to administer the loan program at a total cost of $143,173 ($131,037 recurring; $12,136 non-recurring) in the first year.[42] However, implementation of the loan program is subject to legislative appropriation.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

[40] *Supra* note 1.
[41] Florida Department of Health, *Senate Bill 1676 Fiscal Analysis* (February 18, 2020) (email on file with the Senate Subcommittee on Health and Human Services).
[42] *Id.*

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.026, 382.008, 382.011, 394.463, 397.501, 400.141, 400.23, 400.461, 400.462, 400.464, 400.488, 456.053, 464.003, 464.015, 464.018, 626.9707, 627.6699, 627.736, 633.412, 641.495, 744.3675, 766.118, 768.135, and 960.28

This bill creates the following sections of the Florida Statutes: 381.40185, 400.489, 400.490, 400.52, 408.822, 464.0123, 464.0156, 464.2035, 627.64025, 627.6621, and 641.31075.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial 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 18, 2020:
The committee substitute:

- Makes conforming and technical changes.
- Authorizes nurse registries to be eligible to receive award designations under the Excellence in Home Health Program (program).
- Clarifies that an application for an award designation is not an application for licensure and that an award designation or denial by the AHCA does not constitute final agency action subject to ch. 120, F.S.
- Removes nurse registries from the requirements of the Direct Care Workforce Survey.
- Clarifies that an RN's delegation of prescription medications to a CNA or HHA is specific to patients of a home health agency.
- Authorizes positions and an appropriation to the AHCA.
- Establishes a physician student loan repayment program within the Department of Health (DOH).
- Establishes the Patient Access to Primary Care Pilot Program within the DOH to provide primary health care services in "primary care health professional shortage areas" by allowing Advanced Practice Registered Nurses (APRN) who meet certain criteria to engage in the autonomous practice of advanced or specialized nursing without the supervision of a physician.
- Appropriates three FTE positions with an associated salary rate of 125,887, three OPS positions, and $400,764 in recurring funds and $408,731 in nonrecurring funds from the Health Care Trust Fund, in Fiscal Year 2020-2021 to the AHCA to manage stakeholder input and develop rules related to expansion of HHA and CNA duties, and create and implement the survey and program.
- Amends the effective date to provide that except as otherwise expressly provided in the bill, the bill takes effect upon becoming a law.

CS by Health Policy on February 4, 2020:
The CS:

- Removes from the underlying bill a provision for non-nursing staff providing eating assistance to residents of a nursing home to count toward the nursing home's compliance with minimum staffing standards;
- Authorizes nursing home facilities to use paid feeding assistants as defined under federal law if the assistant has completed a 12-hour program developed by the AHCA;
- Removes from the underlying bill the specific authorization within nursing home statutes for a CNA to perform any task delegated to him or her by an RN, including, medication administration, in a nursing home setting;
- Removes from the underlying bill provisions to establish a Home Care Services Registry; and
- Removes from the underlying bill the specific authorization within CNA statutes for a CNA to administer medications to nursing home residents if delegated such a task by an RN.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
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Appropriations Subcommittee on Health and Human Services (Albritton) recommended the following:

Senate Amendment (with title amendment)

Delete lines 135 - 412

and insert:

Section 3. Subsection (1) of section 400.461, Florida Statutes, is amended to read:

400.461 Short title; purpose.—

(1) This part, consisting of ss. 400.461-400.52 ~~ss. 400.461-400.518~~, may be cited as the "Home Health Services Act."

Section 4. Subsection (15) of section 400.462, Florida

Statutes, is amended to read:

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

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, ~~or~~ assists in administering medications as permitted in rule and for which the person has received training established by the agency under this part, or performs tasks delegated to him or her under chapter 464 ~~s. 400.497(1)~~.

Section 5. Present subsections (5) and (6) of section 400.464, Florida Statutes, are redesignated as subsections (6) and (7), respectively, a new subsection (5) is added to that section, and present subsection (6) of that section is amended, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) If a licensed home health agency authorizes a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant pursuant to chapter 464 or to a home health aide pursuant to s. 400.490, the licensed home health agency must ensure that such delegation meets the requirements of this chapter and chapter 464 and the rules adopted thereunder.

(7) ~~(6)~~ Any person, entity, or organization providing home health services which is exempt from licensure under subsection (6) ~~subsection (5)~~ may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a

statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant $100 for a certificate of exemption or charge the actual cost of processing the certificate.

Section 6. Subsections (2) and (3) of section 400.488, Florida Statutes, are amended to read:

400.488 Assistance with self-administration of medication.—

(2) Patients who are capable of self-administering their own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription’s label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient’s surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, ~~and~~ inhalers, intermittent positive pressure breathing treatments, and nebulizer treatments.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed,


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properly labeled container, from where it is stored and bringing it to the patient.

(b) In the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications, including providing routine preventative skin care and basic wound care.

(e) Returning the medication container to proper storage.

(f) For intermittent positive pressure breathing treatments or for nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

(g) ~~(f)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

Section 7. Section 400.489, Florida Statutes, is created to read:

400.489 Administration of medication by a home health aide; staff training requirements.—

(1) A home health aide may administer oral, transdermal,

ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the home health aide has been delegated such task by a registered nurse licensed under chapter 464; has satisfactorily completed an initial 6-hour training course approved by the agency; and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under chapter 464 or a physician licensed under chapter 458 or chapter 459.

(2) A home health aide must annually and satisfactorily complete a 2-hour inservice training course approved by the agency in medication administration and medication error prevention. The inservice training course shall be in addition to the annual inservice training hours required by agency rules.

(3) The agency, in consultation with the Board of Nursing, shall establish by rule standards and procedures that a home health aide must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 8. Section 400.490, Florida Statutes, is created to read:

400.490 Nurse-delegated tasks.—A certified nursing assistant or home health aide may perform any task delegated by a registered nurse as authorized in this part and in chapter

464, including, but not limited to, medication administration.

Section 9. Section 400.52, Florida Statutes, is created to read:

400.52 Excellence in Home Health Program.—

(1) There is created within the agency the Excellence in Home Health Program for the purpose of awarding program designations to home health agencies or nurse registries that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting standards relating to:

1. Patient satisfaction.

2. Patients requiring emergency care for wound infections.

3. Patients admitted or readmitted to an acute care hospital.

4. Patient improvement in the activities of daily living.

5. Employee satisfaction.

6. Quality of employee training.

7. Employee retention rates.

(b) The agency shall annually evaluate home health agencies and nurse registries seeking the program designation which apply on a form and in the manner designated by rule.

(3) To receive a program designation, the home health agency or nurse registry must:

(a) Be actively licensed and have been operating for at least 24 months before applying for the program designation. A designation awarded under the program is not transferable to another licensee, unless the existing home health agency or nurse registry is being relicensed in the name of an entity

related to the current licenseholder by common control or ownership and there will be no change in the management, operation, or programs of the home health agency or nurse registry as a result of the relicensure.

(b) Have not had any licensure denials, revocations, or Class I, Class II, or uncorrected Class III deficiencies within the 24 months before the application for the program designation.

(4) The program designation expires on the same date as the home health agency's or nurse registry's license. A home health agency or nurse registry must reapply and be approved biennially for the program designation to continue using the program designation in the manner authorized under subsection (5).

(5) A home health agency or nurse registry that is awarded a designation under the program may use the designation in advertising and marketing. A home health agency or nurse registry may not use the program designation in any advertising or marketing if the home health agency or nurse registry:

(a) Has not been awarded the designation;

(b) Fails to renew the designation upon expiration of the awarded designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the awarded designation.

(6) An application for an award designation under the program is not an application for licensure. A designation award or denial by the agency under this section does not constitute

final agency action subject to chapter 120.

Section 10. Section 408.822, Florida Statutes, is created to read:

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400, an assisted living facility licensed under part I of chapter 429, or a home health agency or companion services or homemaker services provider licensed under part III of chapter 400 shall furnish the following information to the agency in a survey on the direct care workforce:

(a) The number of registered nurses and the number of direct care workers by category employed by the licensee.

(b) The turnover and vacancy rates of registered nurses and direct care workers and the contributing factors to these rates.

(c) The average employee wage for registered nurses and each category of direct care worker.

(d) Employment benefits for registered nurses and direct care workers and the average cost of such benefits to the employer and the employee.

(e) Type and availability of training for registered nurses and direct care workers.

(3) An administrator or designee shall include the information required in subsection (2) on a survey form developed by the agency by rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey prior to the agency issuing the license renewal.

(5) The agency shall continually analyze the results of the surveys and publish the results on its website. The agency shall update the information published on its website monthly.

Section 11. Section 464.0156, Florida Statutes, is created to read:

464.0156 Delegation of duties.—

(1) A registered nurse may delegate a task to a certified nursing assistant certified under part II of this chapter or a home health aide as defined in s. 400.462, if the registered nurse determines that the certified nursing assistant or the home health aide is competent to perform the task, the task is delegable under federal law, and the task:

(a) Is within the nurse’s scope of practice.

(b) Frequently recurs in the routine care of a patient or group of patients.

(c) Is performed according to an established sequence of steps.

(d) Involves little or no modification from one patient to another.

(e) May be performed with a predictable outcome.

(f) Does not inherently involve ongoing assessment, interpretation, or clinical judgment.

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(g) Does not endanger a patient's life or well-being.

(2) A registered nurse may delegate to a certified nursing assistant or a home health aide the administration of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a patient of a home health agency, if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.

(3) The board, in consultation with the Agency for Health Care Administration, shall adopt rules to implement this section.

Section 12. Paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(r) Delegating professional responsibilities to a person when the nurse delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, certification, or licensure to perform them.

Section 13. Section 464.2035, Florida Statutes, is created to read:

464.2035 Administration of medication.—

(1) A certified nursing assistant may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or


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topical prescription medication to a patient of a home health agency if the certified nursing assistant has been delegated such task by a registered nurse licensed under part I of this chapter, has satisfactorily completed an initial 6-hour training course approved by the board, and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required under this section must be conducted by a registered nurse licensed under this chapter or a physician licensed under chapter 458 or chapter 459.

(2) A certified nursing assistant shall annually and satisfactorily complete 2 hours of inservice training in medication administration and medication error prevention approved by the board, in consultation with the Agency for Health Care Administration. The inservice training is in addition to the other annual inservice training hours required under this part.

(3) The board, in consultation with the Agency for Health Care Administration, shall establish by rule standards and procedures that a certified nursing assistant must follow when administering medication to a patient of a home health agency. Such rules must, at a

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

And the title is amended as follows:

Delete lines 10 - 51

and insert:

with minimum staffing standards; amending s. 400.461, F.S.; revising a short title; amending s. 400.462,

F.S.; revising the definition of the term "home health aide"; amending s. 400.464, F.S.; requiring a licensed home health agency that authorizes a registered nurse to delegate tasks to a certified nursing assistant to ensure that certain requirements are met; amending s. 400.488, F.S.; authorizing an unlicensed person to assist with self-administration of certain treatments; revising the requirements for such assistance; creating s. 400.489, F.S.; authorizing a home health aide to administer certain prescription medications under certain conditions; requiring the home health aide to meet certain training and competency requirements; requiring the training, determination of competency, and annual validations of home health aides to be conducted by a registered nurse or a physician; requiring a home health aide to complete annual inservice training in medication administration and medication error prevention, in addition to existing annual inservice training requirements; requiring the Agency for Health Care Administration, in consultation with the Board of Nursing, to establish by rule standards and procedures for medication administration by home health aides; creating s. 400.490, F.S.; authorizing a certified nursing assistant or home health aide to perform tasks delegated by a registered nurse; creating s. 400.52, F.S.; creating the Excellence in Home Health Program within the agency; requiring the agency to adopt rules establishing program criteria; requiring the agency to


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annually evaluate certain home health agencies and nurse registries that apply for a program designation; providing program designation eligibility requirements; providing that a program designation is not transferable, with an exception; providing for the expiration of awarded designations; requiring home health agencies and nurse registries to reapply biennially to renew the awarded program designation; authorizing a program designation award recipient to use the designation in advertising and marketing; prohibiting a home health agency or nurse registry from using a program designation in advertising or marketing under certain circumstances; providing that an application under the program is not an application for licensure; providing that certain actions by the agency are not subject to certain provisions; creating s. 408.822,

226548

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
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	.	
	.	

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

Senate Amendment (with title amendment)

Between lines 418 and 419

insert:

Section 13. For the 2020-2021 fiscal year, three full-time equivalent positions with associated salary rate of 125,887 and three other personal services positions are authorized, and the sums of $400,764 in recurring funds and $408,731 in nonrecurring funds from the Health Care Trust Fund are appropriated to the Agency for Health Care Administration, for the purpose of

226548

implementing the requirements of this act.

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

And the title is amended as follows:

Delete lines 93 - 94

and insert:

certified nursing assistant; providing an appropriation; providing an effective date.

106048

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
	.	
	.	
	.	

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

Senate Amendment to Amendment (226548)

Delete line 11

and insert:

implementing sections 400.52 and 408.822, Florida Statutes, as created by this act.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete line 419

and insert:

Section 13. Effective July 1, 2020, section 381.40185, Florida Statutes, is created to read:

381.40185 Physician Student Loan Repayment Program.—The Physician Student Loan Repayment Program is established to promote access to primary care by supporting qualified physicians who treat medically underserved populations in

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primary care health professional shortage areas or medically underserved areas.

(1) As used in this section, the term:

(a) "Department" means the Department of Health.

(b) "Loan program" means the Physician Student Loan Repayment Program.

(c) "Medically underserved area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(d) "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility that is designated by the Health Resources and Services Administration of the United States Department of Health and Human Services as a health professional shortage area as defined by federal regulation and that has a shortage of primary care professionals who serve Medicaid recipients and other low-income patients.

(e) "Public health program" means a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by the department.

(2) The department shall establish a physician student loan repayment program to benefit physicians licensed under chapter 458 or chapter 459 who demonstrate, as required by department rule, active employment providing primary care services in a public health program, an independent practice, or a group practice that serves Medicaid recipients and other low-income

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patients and that is located in a primary care health professional shortage area or in a medically underserved area.

(3) The department shall award funds from the loan program to repay the student loans of a physician who meets the requirements of subsection (2).

(a) An award may not exceed $50,000 per year per eligible physician.

(b) Only loans to pay the costs of tuition, books, medical equipment and supplies, uniforms, and living expenses may be covered.

(c) All repayments are contingent upon continued proof of eligibility and must be made directly to the holder of the loan. The state bears no responsibility for the collection of any interest charges or other remaining balances.

(d) A physician may receive funds under the loan program for at least 1 year, up to a maximum of 5 years.

(e) The department may only grant up to 10 new awards per fiscal year and shall limit the total number of physicians participating in the loan program to not more than 50 per fiscal year.

(4) A physician is no longer eligible to receive funds under the loan program if the physician:

(a) Is no longer employed by a public health program that meets the requirements of subsection (2);

(b) Ceases to participate in the Florida Medicaid program; or

(c) Has disciplinary action taken against his or her license by the Board of Medicine for a violation of s. 458.331 or by the Board of Osteopathic Medicine for a violation of s.

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459.015.

(5) The department shall adopt rules to implement the loan program.

(6) Implementation of the loan program is subject to legislative appropriation.

Section 14. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, present subsections (4) through (21) of section 464.003, Florida Statutes, are redesignated as subsections (5) through (22), respectively, and a new subsection (4) is added to that section, to read:

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

(4) "Advanced practice registered nurse - independent practitioner" or "APRN-IP" means an advanced practice registered nurse who is registered under s. 464.0123 to provide primary health care services without a protocol agreement or supervision in primary care health professional shortage areas.

Section 15. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, section 464.0123, Florida Statutes, is created to read:

464.0123 Patient Access to Primary Care Pilot Program.—

(1) PILOT PROGRAM.—The Patient Access to Primary Care Pilot Program is created for the purpose of providing primary health care services in primary care health professional shortage areas. The department shall implement this program.

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

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(a) "Council" means the Council on Advanced Practice Registered Nurse Independent Practice established in subsection (3).

(b) "Physician" means a person licensed under chapter 458 to practice medicine or a person licensed under chapter 459 to practice osteopathic medicine.

(c) "Primary care health professional shortage area" means a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration, and which is located in a rural area, as defined by the Federal Office of Rural Health Policy.

(3) COUNCIL ON ADVANCED PRACTICE REGISTERED NURSE INDEPENDENT PRACTICE.—

(a) The Council on Advanced Practice Registered Nurse Independent Practice is created within the department.

(b) The council shall consist of nine members appointed as follows by the rules of each applicable board:

1. The chair of the Board of Medicine shall appoint three members who are physicians and members of the Board of Medicine.

2. The chair of the Board of Osteopathic Medicine shall appoint three members who are physicians and members of the Board of Osteopathic Medicine.

3. The chair of the Board of Nursing shall appoint three advance practice registered nurses who have each completed at least 10,000 hours of supervised practice over a period of at least 5 years under a protocol with a supervising physician.

(c) The Board of Medicine members, the Board of Osteopathic Medicine members, and the Board of Nursing appointee members

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shall be appointed for terms of 4 years. The initial appointments shall be staggered so that 1 member from the Board of Medicine, 1 member from the Board of Osteopathic Medicine, and 1 appointee member from the Board of Nursing shall each be appointed for a term of 4 years; 1 member from the Board of Medicine, 1 member from the Board of Osteopathic Medicine, and 1 appointee member from the Board of Nursing shall each be appointed for a term of 3 years; and 1 member from the Board of Medicine, 1 member from the Board of Osteopathic Medicine, and 1 appointee member from the Board of Nursing shall each be appointed for a term of 2 years. Initial physician members appointed to the council must be physicians who have practiced with advanced practice registered nurses under a protocol in their practice.

(d) Council members may not serve more than two consecutive terms. The council shall annually elect a chair from among its members.

(e) All recommendations made by the council must be made by a majority of members present.

(f) The council shall:

1. Review applications for and recommend to the department the registration of APRN-IPs.

2. Develop proposed rules regulating the practice of APRN-IPs. The council shall also develop rules to ensure that the continuity of practice of APRN-IPs is maintained in primary care health professional shortage areas. The language of all proposed rules submitted by the council must be approved by the boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board

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rejects the council's proposed rule, that board must specify its objection to the council with particularity and include recommendations for the modification of the proposed rule. The Board of Medicine and the Board of Osteopathic Medicine shall each adopt a proposed rule developed by the council at each board's regularly scheduled meeting immediately following the council's submission of the proposed rule. A proposed rule submitted by the council may not be adopted by the boards unless both boards have accepted and approved the identical language contained in the proposed rule.

3. Make recommendations to the Board of Medicine regarding all matters relating to APRN-IPs.

4. Address concerns and problems of APRN-IPs in order to improve safety in the clinical practices of APRN-IPs.

(g) When the council finds that an applicant for licensure has failed to meet, to the council's satisfaction, each of the requirements for registration set forth in this section, the council may enter an order to:

1. Refuse to register the applicant;

2. Approve the applicant for registration with restrictions on the scope of practice or registration; or

3. Approve the applicant for limited registration with conditions. Such conditions may include placement of the registrant on probation for a period of time and subject to such conditions as the council may specify, including, but not limited to, requiring the registrant to undergo treatment, to attend continuing education courses, to work under the direct supervision of a physician licensed in this state, or to take corrective action, as determined by the council.

(4) REGISTRATION.—To be registered as an APRN-IP, an advanced practice registered nurse must apply to the department on forms developed by the department. The council shall review the application and recommend to the department the registration of the advanced practice registered nurse with the Board of Medicine as an APRN-IP if the applicant submits proof that he or she holds an unrestricted license issued under s. 464.012 and provides all of the following information:

(a) The name of each location at which the applicant has practiced as an advanced practice registered nurse pursuant to an established written protocol under the direct or indirect supervision of a physician for 10,000 hours occurring within the last 6 years and the names and addresses of all supervising physicians during that period.

(b) Any certification or designation that the applicant has received from a specialty or certification board that is recognized or approved by the Board of Nursing, the Board of Medicine, the Board of Osteopathic Medicine, or the department.

(c) The calendar years in which the applicant:

1. Received his or her initial advanced practice registered nurse certification, licensure, or registration;

2. Began practicing in any jurisdiction; and

3. Received initial advanced practice registered nurse licensure in this state.

(d) The address at which the applicant will primarily conduct his or her practice, if known.

(e) The name of each school or training program that the applicant has attended, with the months and years of attendance and the month and year of graduation, and a description of all

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graduate professional education completed by the applicant, excluding any coursework taken to satisfy continuing education requirements.

(f) Any appointment to the faculty of a school related to the profession which the applicant currently holds or has held within the past 10 years and an indication as to whether the applicant has had the responsibility for graduate education within the past 10 years.

(g) A description of any criminal offense of which the applicant has been found guilty, regardless of whether adjudication of guilt was withheld, or to which the applicant has pled guilty or nolo contendere. A criminal offense committed in another jurisdiction which would have been a felony or misdemeanor if committed in this state must be reported. If the applicant indicates to the department that a criminal offense is under appeal and submits a copy of the notice for appeal of that criminal offense, the department must state that the criminal offense is under appeal if the criminal offense is reported in the applicant's profile. If the applicant indicates to the department that a criminal offense is under appeal, the applicant must, within 15 days after the disposition of the appeal, submit to the department a copy of the final written order of disposition.

(h) A description of any disciplinary action as specified in s. 456.077, s. 458.320, or s. 464.018 or any similar disciplinary action in any other jurisdiction of the United States by a licensing or regulatory body; by a specialty board that is recognized by the Board of Nursing, the Board of Medicine, the Board of Osteopathic Medicine, or the department;

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or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken in lieu of or in settlement of a pending disciplinary case related to competence or character. If the applicant indicates to the department that a disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under appeal if the disciplinary action is reported in the applicant's profile. If the applicant indicates to the department that a disciplinary action is under appeal, the applicant must, within 15 days after the disposition of the appeal, submit to the department a copy of the final written order of disposition.

(i)1. Proof that he or she has obtained or will be obtaining and will maintain professional liability insurance coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined in s. 624.09, from one of the following:

a. An eligible surplus lines insurer as defined in s. 626.914(2);

b. A risk retention group as defined in s. 627.942, from the Joint Underwriting Association established under s. 627.351(4); or

c. A plan of self-insurance as provided in s. 627.357; or

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2. Proof that he or she has obtained and will be maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount of not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must be payable to the APRN-IP as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the APRN-IP or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical or nursing care and services while practicing as an APRN-IP.

(j) Documentation of completion within the last 5 years of three graduate-level semester hours, or the equivalent, in differential diagnosis and three graduate-level semester hours, or the equivalent, in pharmacology, and any additional coursework as recommended by the council. Such hours may not be continuing education courses.

(k) Any additional information that the council may require from the applicant, as determined by the council.

(5) REGISTRATION RENEWAL.—An APRN-IP registration shall be renewed biennially by applying to the department on forms developed by the department. An APRN-IP seeking registration renewal must provide documentation proving his or her completion of a minimum of 10 continuing medical education hours, in addition to the hours required to maintain his or her current and active APRN license. Such continuing medical education hours must be obtained from a statewide professional association of physicians or osteopathic physicians in this state which is

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accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A continuing medical education credit as part of biennial license renewal.

(6) PRACTITIONER PROFILE.—Upon issuing a registration or a renewal of registration, the department shall update the practitioner's profile, as described in s. 456.041, to reflect that the advanced practice registered nurse is registered as an APRN-IP.

(7) APRN-IP SCOPE OF PRACTICE.—An APRN-IP may provide primary health care services without a protocol agreement or supervision only in primary care health professional shortage areas.

(a) An APRN-IP may not practice in a hospital licensed under chapter 395 or in a facility licensed under chapter 400, except under an established written protocol with a supervising physician which is maintained at the hospital or facility.

(b) The council shall make recommendations to the Board of Medicine and the Board of Osteopathic Medicine for rules to establish the scope of practice for an APRN-IP. The first rule recommendations of the council must be submitted to the Board of Medicine and the Board of Osteopathic Medicine by December 1, 2020.

(c) The Board of Medicine and the Board of Osteopathic Medicine shall adopt by rule the scope of practice for an APRN-IP. Such rules must address, but are not limited to, all of the following topics:

1. The scope of the medical care, treatment, and services

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an APRN-IP may provide to patients.

2. Medical care, treatment, and services that are outside the scope of the practice of an APRN-IP.

3. Patient populations to which an APRN-IP may provide primary care, treatment, and services.

4. Patient populations to which an APRN-IP may not provide primary care, treatment, or services.

5. Patient populations which the APRN-IP must refer to a physician.

6. Guidelines for prescribing controlled substances for the treatment of chronic nonmalignant pain and acute pain, including evaluation of the patient, creation and maintenance of a treatment plan, obtaining informed consent and agreement for treatment, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations.

7. Referral relationships and protocols for the care and treatment of patients during nonbusiness hours with another APRN-IP or a physician who practices within 50 miles of the APRN-IP's primary practice location.

8. Referral relationships and protocols with physician specialists to provide care, treatment, and services to patients with medical needs that are outside of the scope of practice for the APRN-IP.

9. Referral relationships and protocols for the transfer and admission of a patient to a hospital licensed under chapter 395 or a nursing home facility licensed under part II of chapter 400.

10. Information regarding the credentials of the APRN-IP

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which must be disclosed to patients in a written informed consent to care and treatment, including, but not limited to, notification to the patient that the APRN-IP is not a physician and may not be referred to as a "doctor" or a "physician" in a medical setting.

11. Requirements relating to the APRN-IP practice's recordkeeping, record retention, and availability of records for inspection by the department.

12. Advertising restrictions and disclosure requirements for APRN-IPs, including that the APRN-IP may not be referred to as a "doctor" or a "physician" in a medical setting.

(8) REPORTS OF ADVERSE INCIDENTS BY APRN-IPs.—

(a) Any APRN-IP practicing in this state must notify the department if he or she was involved in an adverse incident.

(b) The required notification to the department must be submitted in writing by certified mail and postmarked within 15 days after the occurrence of the adverse incident.

(c) For purposes of notifying the department under this section, the term "adverse incident" means an event over which the APRN-IP could exercise control and which is associated in whole or in part with a medical intervention, rather than the condition for which such intervention occurred, and which results in any of the following patient injuries:

1. The death of a patient.

2. Brain or spinal damage to a patient.

3. The performance of medical care, treatment, or services on the wrong patient.

4. The performance of contraindicated medical care, treatment, or services on a patient.

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5. Any condition that required the transfer of a patient from the APRN-IP's practice location to a hospital licensed under chapter 395.

(d) The department shall review each incident and determine whether it potentially involved conduct by the APRN-IP which is grounds for disciplinary action, in which case s. 456.073 applies. Disciplinary action, if any, shall be taken by the Board of Medicine or the Board of Nursing, depending on the conduct involved, as determined by the department.

(e) The Board of Medicine shall adopt rules to implement this subsection.

(9) INACTIVE AND DELINQUENT STATUS.—An APRN-IP registration that is in an inactive or delinquent status may be reactivated only as provided in s. 456.036.

(10) CONSTRUCTION.—This section may not be construed to prevent third-party payors from reimbursing an APRN-IP for covered services rendered by the registered APRN-IP.

(11) RULEMAKING.—By July 1, 2021, the department shall adopt rules to implement this section.

(12) FUTURE REPEAL.—This section is repealed on July 1, 2031, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 16. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, present subsections (9) and (10) of section 464.015, Florida Statutes, are redesignated as subsections (10) and (11), respectively, a new subsection (9) is added to that section, and present subsection (9) of that

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section is amended, to read:

464.015 Titles and abbreviations; restrictions; penalty.—

(9) Only persons who hold valid registrations to practice as APRN-IPs in this state may use the title "Advanced Practice Registered Nurse - Independent Practitioner" and the abbreviations "A.P.R.N.-I.P." A health care practitioner or personnel within a health care facility may not refer to an APRN-IP as a "doctor" or a "physician" in a medical setting.

(10) ~~(9)~~ A person may not practice or advertise as, or assume the title of, registered nurse, licensed practical nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, certified nurse practitioner, ~~or~~ advanced practice registered nurse, or advanced practice registered nurse - independent practitioner; use the abbreviation "R.N.," "L.P.N.," "C.N.S.," "C.R.N.A.," "C.N.M.," "C.N.P.," ~~or~~ "A.P.R.N.," or "A.P.R.N.-I.P."; or take any other action that would lead the public to believe that person was authorized by law to practice as such or is performing nursing services pursuant to the exception set forth in s. 464.022(8) unless that person is licensed, certified, or authorized pursuant to s. 464.0095 to practice as such.

(11) ~~(10)~~ A violation of this section is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 17. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (r) is added to subsection (1) of section 464.018, Florida Statutes, to read:

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464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(r) For an APRN-IP registered under s. 464.0123, in addition to the grounds for discipline set forth in paragraph (p) and in s. 456.072(1), any of the following are grounds for discipline:

1. Paying or receiving any commission, bonus, kickback, or rebate from, or engaging in any split-fee arrangement in any form whatsoever with, a health care practitioner, an organization, an agency, or a person, either directly or implicitly, for referring patients to providers of health care goods or services, including, but not limited to, hospitals, nursing homes, clinical laboratories, ambulatory surgical centers, or pharmacies. This subparagraph may not be construed to prevent an APRN-IP from receiving a fee for professional consultation services.

2. Exercising influence within a patient's relationship with an APRN-IP for purposes of engaging a patient in sexual activity. A patient shall be presumed to be incapable of giving free, full, and informed consent to sexual activity with his or her APRN-IP.

3. Making deceptive, untrue, or fraudulent representations in or related to, or employing a trick or scheme in or related to, advanced practice registered nurse independent practice.

4. Soliciting patients, either personally or through an agent, by the use of fraud, intimidation, undue influence, or a form of overreaching or vexatious conduct. As used in this

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subparagraph, the term "soliciting" means directly or implicitly requesting an immediate oral response from the recipient.

5. Failing to keep legible medical records, as defined by rules of the Board of Medicine and the Board of Osteopathic Medicine, that identify the APRN-IP, by name and professional title, who is responsible for rendering, ordering, supervising, or billing for the patient's medically necessary care, treatment, services, diagnostic tests, or treatment procedures; and the medical justification for the patient's course of care and treatment, including, but not limited to, patient histories, examination results, and test results; drugs prescribed, dispensed, or administered; and reports of consultations or referrals.

6. Exercising influence on a patient to exploit the patient for the financial gain of the APRN-IP or a third party, including, but not limited to, the promoting or selling of services, goods, appliances, or drugs.

7. Performing professional services that have not been duly authorized by the patient or his or her legal representative, except as provided in s. 766.103 or s. 768.13.

8. Performing any procedure or prescribing any medication or therapy that would constitute experimentation on a human subject.

9. Delegating professional responsibilities to a person when the APRN-IP knows, or has reason to believe, that such person is not qualified by education, training, experience, or licensure to perform such responsibilities.

10. Committing, or conspiring with another to commit, an act that would coerce, intimidate, or preclude another APRN-IP

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from lawfully advertising his or her services.

11. Advertising or holding himself or herself out as having a certification in a specialty that the he or she has not received.

12. Failing to comply with the requirements of ss. 381.026 and 381.0261 related to providing patients with information about their rights and how to file a complaint.

13. Providing deceptive or fraudulent expert witness testimony related to advanced practice registered nurse independent practice.

Section 18. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (c) of subsection (2) of section 381.026, Florida Statutes, is amended to read:

381.026 Florida Patient's Bill of Rights and Responsibilities.—

(2) DEFINITIONS.—As used in this section and s. 381.0261, the term:

(c) "Health care provider" means a physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, ~~or~~ a podiatric physician licensed under chapter 461, or an APRN-IP registered under s. 464.0123.

Section 19. Effective July 1, 2020 and upon SB __, 2020 Regular Session, or similar legislation in the same legislative session or an extension thereof being adopted and becoming a law, paragraph (a) of subsection (2) and subsections (3), (4), and (5) of section 382.008, Florida Statutes, are amended to read:


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382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician or APRN-IP registered under s. 464.0123, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, APRN-IP registered under s. 464.0123, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, APRN-IP registered under s. 464.0123, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent’s primary or attending practitioner ~~physician~~ or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending practitioner ~~physician~~ or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge

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and belief. As used in this section, the term "primary or attending practitioner ~~physician~~" means a physician or an APRN-IP registered under s. 464.0123 who treated the decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.

(4) If the department or local registrar grants an extension of time to provide the medical certification of cause of death, the funeral director shall file a temporary certificate of death or fetal death which shall contain all available information, including the fact that the cause of death is pending. The decedent's primary or attending practitioner ~~physician~~ or the district medical examiner of the

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county in which the death occurred or the body was found shall provide an estimated date for completion of the permanent certificate.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, APRN-IP registered under s. 464.0123, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 20. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, subsection (1) of section 382.011, Florida Statutes, is amended to read:

382.011 Medical examiner determination of cause of death.—

(1) In the case of any death or fetal death due to causes or conditions listed in s. 406.11, any death that occurred more than 12 months after the decedent was last treated by a primary or attending physician or an APRN-IP registered under s. 464.0123 ~~as defined in s. 382.008(3)~~, or any death for which there is reason to believe that the death may have been due to an unlawful act or neglect, the funeral director or other person to whose attention the death may come shall refer the case to the district medical examiner of the county in which the death occurred or the body was found for investigation and determination of the cause of death.


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Section 21. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraphs (a) and (f) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient’s clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a ~~no~~

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time limit is not specified in the order, the order is ~~shall be~~ valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a clinical psychologist, a psychiatric nurse, an APRN-IP registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting

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the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

(f) A patient shall be examined by a physician, an APRN-IP registered under s. 464.0123, or a clinical psychologist, or by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, at a facility without unnecessary delay to determine if the criteria for involuntary services are met. Emergency treatment may be provided upon the order of a physician if the physician determines that such treatment is necessary for the safety of the patient or others. The patient may not be released by the receiving facility or its contractor without the documented approval of a psychiatrist or a clinical psychologist or, if the receiving facility is owned or operated by a hospital or health system, the release may also be approved by a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending emergency department physician with experience in the diagnosis and treatment of mental illness after completion of an involuntary examination pursuant to this subsection. A psychiatric nurse may not approve the release of a patient if the involuntary examination was initiated by a psychiatrist

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unless the release is approved by the initiating psychiatrist.

Section 22. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (a) of subsection (2) of section 397.501, Florida Statutes, is amended to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(2) RIGHT TO NONDISCRIMINATORY SERVICES.—

(a) Service providers may not deny an individual access to substance abuse services solely on the basis of race, gender, ethnicity, age, sexual preference, human immunodeficiency virus status, prior service departures against medical advice, disability, or number of relapse episodes. Service providers may not deny an individual who takes medication prescribed by a physician or an APRN-IP registered under s. 464.0123 access to substance abuse services solely on that basis. Service providers who receive state funds to provide substance abuse services may not, if space and sufficient state resources are available, deny access to services based solely on inability to pay.

Section 23. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraphs (i), (o), and (r) of subsection (3) and paragraph (g) of subsection (5) of section 456.053, Florida Statutes, are amended to read:

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456.053 Financial arrangements between referring health care providers and providers of health care services.—

(3) DEFINITIONS.—For the purpose of this section, the word, phrase, or term:

(i) "Health care provider" means a ~~any~~ physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461; an APRN-IP registered under s. 464.0123;~~,~~ or any health care provider licensed under chapter 463 or chapter 466.

(o)1. "Referral" means any referral of a patient by a health care provider for health care services, including, without limitation:

a.~~1.~~ The forwarding of a patient by a health care provider to another health care provider or to an entity which provides or supplies designated health services or any other health care item or service; or

b.~~2.~~ The request or establishment of a plan of care by a health care provider, which includes the provision of designated health services or other health care item or service.

2.~~3.~~ The following orders, recommendations, or plans of care do not ~~shall not~~ constitute a referral by a health care provider:

a. By a radiologist for diagnostic-imaging services.

b. By a physician specializing in the provision of radiation therapy services for such services.

c. By a medical oncologist for drugs and solutions to be prepared and administered intravenously to such oncologist's patient, as well as for the supplies and equipment used in connection therewith to treat such patient for cancer and the complications thereof.

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d. By a cardiologist for cardiac catheterization services.

e. By a pathologist for diagnostic clinical laboratory tests and pathological examination services, if furnished by or under the supervision of such pathologist pursuant to a consultation requested by another physician.

f. By a health care provider who is the sole provider or member of a group practice for designated health services or other health care items or services that are prescribed or provided solely for such referring health care provider's or group practice's own patients, and that are provided or performed by or under the direct supervision of such referring health care provider or group practice; provided, however, ~~that effective July 1, 1999,~~ a health care provider ~~physician licensed pursuant to chapter 458, chapter 459, chapter 460, or chapter 461~~ may refer a patient to a sole provider or group practice for diagnostic imaging services, excluding radiation therapy services, for which the sole provider or group practice billed both the technical and the professional fee for or on behalf of the patient, if the referring health care provider does not have an ~~physician has no~~ investment interest in the practice. The diagnostic imaging service referred to a group practice or sole provider must be a diagnostic imaging service normally provided within the scope of practice to the patients of the group practice or sole provider. The group practice or sole provider may accept no more than 15 percent of their patients receiving diagnostic imaging services from outside referrals, excluding radiation therapy services.

g. By a health care provider for services provided by an ambulatory surgical center licensed under chapter 395.


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h. By a urologist for lithotripsy services.

i. By a dentist for dental services performed by an employee of or health care provider who is an independent contractor with the dentist or group practice of which the dentist is a member.

j. By a physician for infusion therapy services to a patient of that physician or a member of that physician's group practice.

k. By a nephrologist for renal dialysis services and supplies, except laboratory services.

l. By a health care provider whose principal professional practice consists of treating patients in their private residences for services to be rendered in such private residences, except for services rendered by a home health agency licensed under chapter 400. For purposes of this sub-subparagraph, the term "private residences" includes patients' private homes, independent living centers, and assisted living facilities, but does not include skilled nursing facilities.

m. By a health care provider for sleep-related testing.

(r) "Sole provider" means one health care provider licensed under chapter 458, chapter 459, chapter 460, or chapter 461, or registered under s. 464.0123, who maintains a separate medical office and a medical practice separate from any other health care provider and who bills for his or her services separately from the services provided by any other health care provider. A sole provider may not ~~shall not~~ share overhead expenses or professional income with any other person or group practice.

(5) PROHIBITED REFERRALS AND CLAIMS FOR PAYMENT.—Except as provided in this section:

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(g) A violation of this section by a health care provider shall constitute grounds for disciplinary action to be taken by the applicable board pursuant to s. 458.331(2), s. 459.015(2), s. 460.413(2), s. 461.013(2), s. 463.016(2), s. 464.018, or s. 466.028(2). Any hospital licensed under chapter 395 found in violation of this section shall be subject to s. 395.0185(2).

Section 24. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, subsection (1) of section 626.9707, Florida Statutes, is amended to read:

626.9707 Disability insurance; discrimination on basis of sickle-cell trait prohibited.—

(1) An ~~No~~ insurer authorized to transact insurance in this state may not ~~shall~~ refuse to issue and deliver in this state any policy of disability insurance, whether such policy is defined as individual, group, blanket, franchise, industrial, or otherwise, which is currently being issued for delivery in this state and which affords benefits and coverage for any medical treatment or service authorized and permitted to be furnished by a hospital, a clinic, a health clinic, a neighborhood health clinic, a health maintenance organization, a physician, a physician's assistant, an advanced practice registered nurse, an APRN-IP registered under s. 464.0123 ~~practitioner~~, or a medical service facility or personnel solely because the person to be insured has the sickle-cell trait.

Section 25. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension

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thereof and becoming a law, section 627.64025, Florida Statutes, is created to read:

627.64025 APRN-IP services.—A health insurance policy that provides major medical coverage and that is delivered, issued, or renewed on or after January 1, 2021, may not require an insured to receive services from an APRN-IP registered under s. 464.0123 or an advanced practice registered nurse under the supervision of a physician in place of a primary care physician.

Section 26. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, section 627.6621, Florida Statutes, is created to read:

627.6621 APRN-IP services.—A group, blanket, or franchise health insurance policy that is issued, or renewed on or after January 1, 2021, may not require an insured to receive services from an APRN-IP registered under s. 464.0123 or an advanced practice registered nurse under the supervision of a physician in place of a primary care physician.

Section 27. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (g) is added to subsection (5) of section 627.6699, Florida Statutes, to read:

627.6699 Employee Health Care Access Act.—

(5) AVAILABILITY OF COVERAGE.—

(g) A health benefit plan covering small employers which is issued, or renewed on or after January 1, 2021, may not require an insured to receive services from an APRN-IP registered under

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s. 464.0123 or an advanced practice registered nurse under the supervision of a physician in place of a primary care physician.

Section 28. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (a) of subsection (1) of section 627.736, Florida Statutes, is amended to read:

627.736 Required personal injury protection benefits; exclusions; priority; claims.—

(1) REQUIRED BENEFITS.—An insurance policy complying with the security requirements of s. 627.733 must provide personal injury protection to the named insured, relatives residing in the same household, persons operating the insured motor vehicle, passengers in the motor vehicle, and other persons struck by the motor vehicle and suffering bodily injury while not an occupant of a self-propelled vehicle, subject to subsection (2) and paragraph (4)(e), to a limit of $10,000 in medical and disability benefits and $5,000 in death benefits resulting from bodily injury, sickness, disease, or death arising out of the ownership, maintenance, or use of a motor vehicle as follows:

(a) *Medical benefits.*—Eighty percent of all reasonable expenses for medically necessary medical, surgical, X-ray, dental, and rehabilitative services, including prosthetic devices and medically necessary ambulance, hospital, and nursing services if the individual receives initial services and care pursuant to subparagraph 1. within 14 days after the motor vehicle accident. The medical benefits provide reimbursement only for:

1. Initial services and care that are lawfully provided,

supervised, ordered, or prescribed by a physician licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, ~~or~~ a chiropractic physician licensed under chapter 460, or an APRN-IP registered under s. 464.0123 or that are provided in a hospital or in a facility that owns, or is wholly owned by, a hospital. Initial services and care may also be provided by a person or entity licensed under part III of chapter 401 which provides emergency transportation and treatment.

2. Upon referral by a provider described in subparagraph 1., followup services and care consistent with the underlying medical diagnosis rendered pursuant to subparagraph 1. which may be provided, supervised, ordered, or prescribed only by a physician licensed under chapter 458 or chapter 459, a chiropractic physician licensed under chapter 460, a dentist licensed under chapter 466, or an APRN-IP registered under s. 464.0123 or, to the extent permitted by applicable law and under the supervision of such physician, osteopathic physician, chiropractic physician, or dentist, by a physician assistant licensed under chapter 458 or chapter 459 or an advanced practice registered nurse licensed under chapter 464. Followup services and care may also be provided by the following persons or entities:

a. A hospital or ambulatory surgical center licensed under chapter 395.

b. An entity wholly owned by one or more physicians licensed under chapter 458 or chapter 459, chiropractic physicians licensed under chapter 460, APRN-IPs registered under s. 464.0123, or dentists licensed under chapter 466 or by such practitioners and the spouse, parent, child, or sibling of such

practitioners.

c. An entity that owns or is wholly owned, directly or indirectly, by a hospital or hospitals.

d. A physical therapist licensed under chapter 486, based upon a referral by a provider described in this subparagraph.

e. A health care clinic licensed under part X of chapter 400 which is accredited by an accrediting organization whose standards incorporate comparable regulations required by this state, or

(I) Has a medical director licensed under chapter 458, chapter 459, or chapter 460;

(II) Has been continuously licensed for more than 3 years or is a publicly traded corporation that issues securities traded on an exchange registered with the United States Securities and Exchange Commission as a national securities exchange; and

(III) Provides at least four of the following medical specialties:

(A) General medicine.

(B) Radiography.

(C) Orthopedic medicine.

(D) Physical medicine.

(E) Physical therapy.

(F) Physical rehabilitation.

(G) Prescribing or dispensing outpatient prescription medication.

(H) Laboratory services.

3. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. up to $10,000 if a physician

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licensed under chapter 458 or chapter 459, a dentist licensed under chapter 466, a physician assistant licensed under chapter 458 or chapter 459, ~~or~~ an advanced practice registered nurse licensed under chapter 464, or an APRN-IP registered under s. 464.0123 has determined that the injured person had an emergency medical condition.

4. Reimbursement for services and care provided in subparagraph 1. or subparagraph 2. is limited to $2,500 if a provider listed in subparagraph 1. or subparagraph 2. determines that the injured person did not have an emergency medical condition.

5. Medical benefits do not include massage as defined in s. 480.033 or acupuncture as defined in s. 457.102, regardless of the person, entity, or licensee providing massage or acupuncture, and a licensed massage therapist or licensed acupuncturist may not be reimbursed for medical benefits under this section.

6. The Financial Services Commission shall adopt by rule the form that must be used by an insurer and a health care provider specified in sub-subparagraph 2.b., sub-subparagraph 2.c., or sub-subparagraph 2.e. to document that the health care provider meets the criteria of this paragraph. Such rule must include a requirement for a sworn statement or affidavit.

Only insurers writing motor vehicle liability insurance in this state may provide the required benefits of this section, and such insurer may not require the purchase of any other motor vehicle coverage other than the purchase of property damage liability coverage as required by s. 627.7275 as a condition for


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providing such benefits. Insurers may not require that property damage liability insurance in an amount greater than $10,000 be purchased in conjunction with personal injury protection. Such insurers shall make benefits and required property damage liability insurance coverage available through normal marketing channels. An insurer writing motor vehicle liability insurance in this state who fails to comply with such availability requirement as a general business practice violates part IX of chapter 626, and such violation constitutes an unfair method of competition or an unfair or deceptive act or practice involving the business of insurance. An insurer committing such violation is subject to the penalties provided under that part, as well as those provided elsewhere in the insurance code.

Section 29. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, subsection (5) of section 633.412, Florida Statutes, is amended to read:

633.412 Firefighters; qualifications for certification.—A person applying for certification as a firefighter must:

(5) Be in good physical condition as determined by a medical examination given by a physician, surgeon, or physician assistant licensed under ~~to practice in the state pursuant to~~ chapter 458; an osteopathic physician, a surgeon, or a physician assistant licensed under ~~to practice in the state pursuant to~~ chapter 459; ~~or~~ an advanced practice registered nurse licensed under ~~to practice in the state pursuant to~~ chapter 464; or an APRN-IP registered under s. 464.0123. Such examination may include, but need not be limited to, the National Fire

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Protection Association Standard 1582. A medical examination evidencing good physical condition shall be submitted to the division, on a form as provided by rule, before an individual is eligible for admission into a course under s. 633.408.

Section 30. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, section 641.31075, Florida Statutes, is created to read:

641.31075 APRN-IP services.—A health maintenance contract that is issued, or renewed on or after January 1, 2021, may not require a subscriber to receive services from an APRN-IP registered under s. 464.0123 in place of a primary care physician or an advanced practice registered nurse under the supervision of a physician.

Section 31. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, subsection (8) of section 641.495, Florida Statutes, is amended to read:

641.495 Requirements for issuance and maintenance of certificate.—

(8) Each organization's contracts, certificates, and subscriber handbooks shall contain a provision, if applicable, disclosing that, for certain types of described medical procedures, services may be provided by physician assistants, advanced practice registered nurses, APRN-IPs registered under s. 464.0123 ~~nurse practitioners~~, or other individuals who are not licensed physicians.

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Section 32. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (b) of subsection (1) of section 744.3675, Florida Statutes, is amended to read:

744.3675 Annual guardianship plan.—Each guardian of the person must file with the court an annual guardianship plan which updates information about the condition of the ward. The annual plan must specify the current needs of the ward and how those needs are proposed to be met in the coming year.

(1) Each plan for an adult ward must, if applicable, include:

(b) Information concerning the medical and mental health conditions and treatment and rehabilitation needs of the ward, including:

1. A resume of any professional medical treatment given to the ward during the preceding year.

2. The report of a physician or an APRN-IP registered under s. 464.0123 who examined the ward no more than 90 days before the beginning of the applicable reporting period. The report must contain an evaluation of the ward's condition and a statement of the current level of capacity of the ward.

3. The plan for providing medical, mental health, and rehabilitative services in the coming year.

Section 33. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, paragraph (c) of subsection (1) of section 766.118, Florida Statutes, is amended to read:

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766.118 Determination of noneconomic damages.—

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

(c) "Practitioner" means any person licensed or registered under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, chapter 486, ~~or~~ s. 464.012, or s. 464.0123. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

Section 34. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, subsection (3) of section 768.135, Florida Statutes, is amended to read:

768.135 Volunteer team physicians; immunity.—

(3) A practitioner licensed or registered under chapter 458, chapter 459, chapter 460, ~~or~~ s. 464.012, or s. 464.0123 who gratuitously and in good faith conducts an evaluation pursuant to s. 1006.20(2)(c) is not liable for any civil damages arising from that evaluation unless the evaluation was conducted in a wrongful manner.

Section 35. Effective July 1, 2020, contingent upon SB __ or similar legislation taking effect on that same date after

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being adopted in the same legislative session or an extension thereof and becoming a law, subsection (2) of section 960.28, Florida Statutes, is amended to read:

960.28 Payment for victims' initial forensic physical examinations.—

(2) The Crime Victims' Services Office of the department shall pay for medical expenses connected with an initial forensic physical examination of a victim of sexual battery as defined in chapter 794 or a lewd or lascivious offense as defined in chapter 800. Such payment shall be made regardless of whether the victim is covered by health or disability insurance and whether the victim participates in the criminal justice system or cooperates with law enforcement. The payment shall be made only out of moneys allocated to the Crime Victims' Services Office for the purposes of this section, and the payment may not exceed $1,000 with respect to any violation. The department shall develop and maintain separate protocols for the initial forensic physical examination of adults and children. Payment under this section is limited to medical expenses connected with the initial forensic physical examination, and payment may be made to a medical provider using an examiner qualified under part I of chapter 464, excluding s. 464.003(15) ~~s. 464.003(14)~~; chapter 458; or chapter 459. Payment made to the medical provider by the department shall be considered by the provider as payment in full for the initial forensic physical examination associated with the collection of evidence. The victim may not be required to pay, directly or indirectly, the cost of an initial forensic physical examination performed in accordance with this section.

899862

Section 36. Effective July 1, 2020, contingent upon SB or similar legislation taking effect on that same date after being adopted in the same legislative session or an extension thereof and becoming a law, the Office of Program Policy Analysis and Government Accountability shall develop a report on the impact of and recommendations regarding the continuance of the Patient Access to Primary Care Pilot Program established in this act. The report shall include, but need not be limited to, improvements in access to primary care, the number of advanced practice registered nurse-independent practitioners participating in the program, cost savings or increases in services provided, the number of referrals to physicians by advanced practice registered nurse-independent practitioners participating in the program, any increase or decrease in the number of prescriptions written, and any increase or decrease in the cost of medications. In conducting such research and analysis, the office may consult with the Council on Advanced Practice Registered Nurse Independent Practice. The office shall submit the report and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by September 1, 2030.

Section 37. If s. 464.0123, Florida Statutes, is not saved from repeal through reenactment by the Legislature, the text of the statutes amended in sections 14 and 16 through 33 of this bill shall revert to that in existence on the date this act became a law, except that any amendments to such text enacted other than by this act shall be preserved and continue to operate to the extent that such amendments are not dependent upon the portions of text which expire pursuant to this section.

899862

Section 38. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

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

And the title is amended as follows:

Delete lines 93 - 94

and insert:

certified nursing assistants; creating s. 381.40185, F.S.; establishing the Physician Student Loan Repayment Program for a specified purpose; defining terms; requiring the Department of Health to establish the program; providing program eligibility requirements; providing for the award of funds from the program to repay the student loans of certain physicians; specifying circumstances under which a physician is no longer eligible to receive funds from the program; requiring the department to adopt rules; making implementation of the program subject to an appropriation; amending s. 464.003, F.S.; defining the term "advanced practice registered nurse - independent practitioner" (APRN-IP); creating s. 464.0123, F.S.; creating the Patient Access to Primary Care Pilot Program for a specified purpose; requiring the department to implement the program; defining terms; creating the Council on Advanced Practice Registered Nurse Independent Practice within the department; providing council membership requirements, terms, and duties; requiring the council to develop certain proposed rules; providing for the adoption of the


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proposed rules; authorizing the council to enter an order to refuse to register an applicant or to approve an applicant for restricted registration or conditional registration under certain circumstances; providing registration and registration renewal requirements; requiring the department to update the practitioner's profile to reflect specified information; providing limitations on the scope of practice of an APRN-IP; requiring the council to recommend rules regarding the scope of practice for an APRN-IP; providing for the adoption of such rules; requiring APRN-IPs to report adverse incidents to the department within a specified timeframe; defining the term "adverse incident"; providing construction; requiring the department to review adverse incidents and make specified determinations; providing for disciplinary action; requiring the Board of Medicine to adopt certain rules; providing for the reactivation of registration; providing construction; requiring the department to adopt rules by a specified date; providing for future repeal; amending s. 464.015, F.S.; prohibiting unregistered persons from using the title or abbreviation of APRN-IP; amending s. 464.018, F.S.; providing additional grounds for denial of a license or disciplinary action for APRN-IPs; amending s. 381.026, F.S.; revising the definition of the term "health care provider"; amending s. 382.008, F.S.; authorizing an APRN-IP to file a certificate of death or fetal death under certain circumstances; requiring

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the APRN-IP to provide certain information to the funeral director within a specified timeframe; defining the term "primary or attending practitioner"; conforming provisions to changes made by the act; amending s. 382.011, F.S.; conforming a provision to changes made by the act; amending s. 394.463, F.S.; authorizing APRN-IPs to examine patients and initiate involuntary examinations for mental illness under certain circumstances; amending s. 397.501, F.S.; prohibiting service providers from denying an individual certain services under certain circumstances; amending s. 456.053, F.S.; revising definitions; conforming provisions to changes made by the act; amending s. 626.9707, F.S.; prohibiting an insurer from refusing to issue and deliver certain disability insurance that covers any medical treatment or service furnished by an advanced practice registered nurse or an APRN-IP; creating s. 627.64025, F.S.; prohibiting certain health insurance policies from requiring an insured to receive services from an APRN-IP or a certain advanced practice registered nurse in place of a primary care physician; creating s. 627.6621, F.S.; prohibiting certain group, blanket, or franchise health insurance policies from requiring an insured to receive services from an APRN-IP or a certain advanced practice registered nurse in place of a primary care physician; amending s. 627.6699, F.S.; prohibiting certain health benefit plan covering small employers from requiring an insured to receive

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services from an APRN-IP or a certain advanced practice registered nurse in place of a primary care physician; amending s. 627.736, F.S.; requiring personal injury protection insurance to cover a certain percentage of medical services and care provided by an APRN-IP; providing for specified reimbursement of APRN-IPs; amending s. 633.412, F.S.; authorizing an APRN-IP to medically examine an applicant for firefighter certification; creating s. 641.31075, F.S.; prohibiting certain health maintenance contracts from requiring a subscriber to receive services from an APRN-IP or a certain advanced practice registered nurse in place of a primary care physician; amending s. 641.495, F.S.; requiring certain health maintenance organization documents to disclose specified information; amending s. 744.3675, F.S.; authorizing an APRN-IP to provide the medical report of a ward in an annual guardianship plan; amending s. 766.118, F.S.; revising the definition of the term "practitioner"; amending s. 768.135, F.S.; providing immunity from liability for an APRN-IP who provides volunteer services under certain circumstances; amending s. 960.28, F.S.; conforming a cross-reference; requiring the Office of Program Policy Analysis and Government Accountability to submit a report to the Governor and the Legislature by a specified date; providing requirements for the report; providing for the reversion of specified statutory sections under certain circumstances;

899862

providing effective dates, including contingent effective dates.

364268

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
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Appropriations Subcommittee on Health and Human Services (Albritton) recommended the following:

Senate Amendment to Amendment (899862)

Delete lines 62 - 63

and insert:

(a) Is no longer employed as required under subsection (2);

745926

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
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Appropriations Subcommittee on Health and Human Services (Harrell) recommended the following:

Senate Amendment to Amendment (899862) (with title amendment)

Delete lines 185 - 192
and insert:
(4) PRIMARY CARE CERTIFICATION EXAMINATION.—
(a) The department, in conjunction with one or more third-party credentialing entities, shall develop a primary care certification examination for advanced practice registered nurses seeking registration with the Board of Medicine as APRN-

745926

IPs. For purposes of this subsection, "third-party credentialing entity" means a department-approved independent organization that has met nationally recognized standards for developing and administering professional certification examinations and psychometric services.

(b) The department shall approve at least one third-party credentialing entity for the purpose of developing and administering a primary care competency-based certification examination. A third-party credentialing entity shall request approval in writing from the department on forms developed by the department. Within 90 days after the deadline that is established for receiving documentation from third-party credentialing entities seeking approval, the department must approve a third-party credentialing entity that demonstrates, to the department's satisfaction, that it is capable of complying with the requirements of this subsection. An approved third-party credentialing entity must:

1. Maintain an advisory committee of at least six members, including three representatives from the Board of Medicine and three representatives from the Board of Osteopathic Medicine, who shall each be appointed by the respective board chairs. The third-party credentialing entity may appoint additional members to the advisory committee with approval of the department.

2. Use the core competencies approved by the Board of Medicine and the Board of Osteopathic Medicine to establish certification standards, testing instruments, and recertification standards according to national psychometric standards.

3. Establish a process to administer the certification

745926

application, testing, award, and maintenance processes according to national psychometric standards.

4. Demonstrate the ability to administer biennial continuing education and certification renewal requirements for APRN-IPs.

5. Demonstrate the ability to administer an education provider program to approve qualified training entities and to provide precertification training to advanced practice registered nurses and continuing education opportunities to APRN-IPs.

(c) The Board of Medicine and the Board of Osteopathic Medicine shall approve the core competencies and related preservice curricula that ensure that each advanced practice registered nurse registered as an APRN-IP who will be providing primary medical care, treatment, and services to persons in primary care health professional shortage areas has obtained the knowledge, skills, and abilities to competently carry out primary medical care, treatment, and services. The department may contract for the delivery of preservice or any additional education or training for APRN-IPs to provide primary medical care, treatment, and services to persons in primary care health professional shortage areas if the curriculum satisfies the boards' approved core competencies.

(d) The department may adopt rules necessary to implement this subsection.

(5) REGISTRATION.—To be registered as an APRN-IP, an advanced practice registered nurse must apply to the department on forms developed by the department. The council shall review the application and recommend to the department the registration

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of the advanced practice registered nurse with the Board of Medicine as an APRN-IP if the applicant submits proof that he or she holds an unrestricted license issued under s. 464.012 and provides all of the following information:

(a) Documentation of a passing score on the primary care certification examination described in subsection (4).

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

And the title is amended as follows:

Between lines 1203 and 1204

insert:

requiring the department, in conjunction with third-party credentialing entities, to develop a primary care certification examination for advanced practice registered nurses seeking registration as APRN-IPs; defining the term "third-party credentialing entity"; requiring the department to approve one or more third-party credentialing entities to develop and administer the examination; requiring the department to act on requests for approvals from third-party credentialing entities within a specified timeframe; specifying requirements for approved third-party credentialing entities; requiring the Board of Medicine and the Board of Osteopathic Medicine to approve certain core competencies and related preservice curricula for a specified purpose; authorizing the department to contract for the delivery of specified education or training under certain circumstances; authorizing the department to adopt rules;

946852

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/19/2020	.	
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Appropriations Subcommittee on Health and Human Services (Albritton) recommended the following:

Senate Amendment to Amendment (899862)

Delete lines 296 - 299

and insert:

of a minimum of 40 continuing medical education hours. The required continuing medical education hours must include 3 hours on the safe and effective prescription of controlled substances; 2 hours on human trafficking; 2 hours on the prevention of medical errors; 2 hours on domestic violence; and 2 hours on suicide prevention, which must address suicide risk assessment,

946852

treatment, and management, if such topics are not required for licensure under this part. Such continuing medical education hours must be obtained in courses approved by the Board of Medicine or the Board of Osteopathic Medicine and offered by a statewide professional association of

By the Committee on Health Policy; and Senator Albritton

588-03099-20 20201676c1

A bill to be entitled

An act relating to direct care workers; amending s. 400.141, F.S.; authorizing a nursing home facility to use paid feeding assistants in accordance with specified federal law under certain circumstances; providing training program requirements; authorizing the Agency for Health Care Administration to adopt rules; amending s. 400.23, F.S.; prohibiting paid feeding assistants from counting toward compliance with minimum staffing standards; amending s. 400.462, F.S.; revising the definition of the term "home health aide"; amending s. 400.464, F.S.; requiring a licensed home health agency that authorizes a registered nurse to delegate tasks to a certified nursing assistant to ensure that certain requirements are met; amending s. 400.488, F.S.; authorizing an unlicensed person to assist with self-administration of certain treatments; revising the requirements for such assistance; creating s. 400.489, F.S.; authorizing a home health aide to administer certain prescription medications under certain conditions; requiring the home health aide to meet certain training and competency requirements; requiring the training, determination of competency, and annual validations of home health aides to be conducted by a registered nurse or a physician; requiring a home health aide to complete annual inservice training in medication administration and medication error prevention, in addition to existing annual inservice training requirements;

588-03099-20 20201676c1

requiring the Agency for Health Care Administration, in consultation with the Board of Nursing, to establish by rule standards and procedures for medication administration by home health aides; creating s. 400.490, F.S.; authorizing a certified nursing assistant or home health aide to perform tasks delegated by a registered nurse; creating s. 400.52, F.S.; creating the Excellence in Home Health Program within the agency; requiring the agency to adopt rules establishing program criteria; requiring the agency to annually evaluate certain home health agencies that apply for a program designation; providing program designation eligibility requirements; providing that a program designation is not transferrable, with an exception; providing for the expiration of awarded designations; requiring home health agencies to reapply biennially to renew the awarded program designation; authorizing a program designation award recipient to use the designation in advertising and marketing; prohibiting a home health agency from using a program designation in advertising or marketing under certain circumstances; creating s. 408.822, F.S.; defining the term "direct care worker"; requiring certain licensees to provide specified information about their employees in a survey beginning on a specified date; requiring that the survey be completed on a form adopted by the agency by rule and include a specified attestation; requiring licensees to submit such survey before the agency

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

renews their licenses; requiring the agency to continually analyze the results of such surveys and publish the results on the agency's website; requiring the agency to update such information monthly; creating s. 464.0156, F.S.; authorizing a registered nurse to delegate certain tasks to a certified nursing assistant or home health aide under certain conditions; providing the criteria that a registered nurse must consider in determining if a task may be delegated to a certified nursing assistant or a home health aide; authorizing a registered nurse to delegate prescription medication administration to a certified nursing assistant or home health aide, subject to certain requirements; providing an exception for certain controlled substances; requiring the Board of Nursing, in consultation with the agency, to adopt rules; amending s. 464.018, F.S.; subjecting a registered nurse to disciplinary action for delegating certain tasks to a person the registered nurse knows or has reason to know is unqualified to perform such tasks; creating s. 464.2035, F.S.; authorizing certified nursing assistants to administer certain prescription medications under certain conditions; requiring the certified nursing assistants to meet certain training and competency requirements; requiring the training, determination of competency, and annual validations of certified nursing assistants to be conducted by a registered nurse or a physician; requiring a certified nursing assistant to complete

annual inservice training in medication administration and medication error prevention in addition to existing annual inservice training requirements; requiring the board, in consultation with the agency, to adopt rules for medication administration by certified nursing assistants; providing an effective date.

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

Section 1. Paragraph (v) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(v) Be allowed to use paid feeding assistants as defined in 42 C.F.R. s. 488.301, and in accordance with 42 C.F.R. s. 483.60, if the paid feeding assistant has successfully completed a feeding assistant training program developed by the agency.

1. The feeding assistant training program must consist of a minimum of 12 hours of education and training and must include all of the topics and lessons specified in the program curriculum.

2. The program curriculum must include, but need not be limited to, training in all of the following content areas:

a. Feeding techniques.

b. Assistance with feeding and hydration.

c. Communication and interpersonal skills.

d. Appropriate responses to resident behavior.

e. Safety and emergency procedures, including the first aid procedure used to treat upper airway obstructions.

f. Infection control.

g. Residents' rights.

h. Recognizing changes in residents which are inconsistent with their normal behavior, and the importance of reporting those changes to the supervisory nurse.

The agency may adopt rules to implement this paragraph.

Section 2. Paragraph (b) of subsection (3) of section 400.23, Florida Statutes, is amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(3)

(b) Paid feeding assistants and nonnursing staff providing eating assistance to residents shall not count toward compliance with minimum staffing standards.

Section 3. Subsection (15) of section 400.462, Florida Statutes, is amended to read:

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

(15) "Home health aide" means a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, ~~or~~ assists in administering medications as permitted in rule and for which the person has received training established by the agency under this part, or performs tasks delegated to him or her under chapter 464 ~~s. 400.497(1)~~.

Section 4. Present subsections (5) and (6) of section 400.464, Florida Statutes, are redesignated as subsections (6) and (7), respectively, a new subsection (5) is added to that section, and present subsection (6) of that section is amended, to read:

400.464 Home health agencies to be licensed; expiration of license; exemptions; unlawful acts; penalties.—

(5) If a licensed home health agency authorizes a registered nurse to delegate tasks, including medication administration, to a certified nursing assistant pursuant to chapter 464 or to a home health aide pursuant to s. 400.490, the licensed home health agency must ensure that such delegation meets the requirements of this chapter and chapter 464 and the rules adopted thereunder.

(7)~~(6)~~ Any person, entity, or organization providing home health services which is exempt from licensure under subsection (6) ~~subsection (5)~~ may voluntarily apply for a certificate of exemption from licensure under its exempt status with the agency on a form that specifies its name or names and addresses, a statement of the reasons why it is exempt from licensure as a home health agency, and other information deemed necessary by the agency. A certificate of exemption is valid for a period of not more than 2 years and is not transferable. The agency may charge an applicant $100 for a certificate of exemption or charge the actual cost of processing the certificate.

Section 5. Subsections (2) and (3) of section 400.488, Florida Statutes, are amended to read:

400.488 Assistance with self-administration of medication.—

(2) Patients who are capable of self-administering their

own medications without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. Assistance with self-medication by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient's surrogate, guardian, or attorney in fact. For purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, and topical ophthalmic, otic, and nasal dosage forms, including solutions, suspensions, sprays, ~~and~~ inhalers, intermittent positive pressure breathing treatments, and nebulizer treatments.

(3) Assistance with self-administration of medication includes:

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient.

(b) In the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose ~~reading the label~~, opening the container, removing a prescribed amount of medication from the container, and closing the container.

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications, including providing routine preventative skin care and basic wound care.

(e) Returning the medication container to proper storage.

(f) For intermittent positive pressure breathing treatments or for nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

(g) ~~(f)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

Section 6. Section 400.489, Florida Statutes, is created to read:

400.489 Administration of medication by a home health aide; staff training requirements.—

(1) A home health aide may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications if the home health aide has been delegated such task by a registered nurse licensed under chapter 464; has satisfactorily completed an initial 6-hour training course approved by the agency; and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required in this section shall be conducted by a registered nurse licensed under chapter 464 or a physician licensed under chapter 458 or chapter 459.

(2) A home health aide must annually and satisfactorily complete a 2-hour inservice training course approved by the agency in medication administration and medication error prevention. The inservice training course shall be in addition to the annual inservice training hours required by agency rules.

(3) The agency, in consultation with the Board of Nursing, shall establish by rule standards and procedures that a home health aide must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 7. Section 400.490, Florida Statutes, is created to read:

400.490 Nurse-delegated tasks.—A certified nursing assistant or home health aide may perform any task delegated by a registered nurse as authorized in chapter 464, including, but not limited to, medication administration.

Section 8. Section 400.52, Florida Statutes, is created to read:

400.52 Excellence in Home Health Program.—

(1) There is created within the agency the Excellence in Home Health Program for the purpose of awarding program designations to home health agencies that meet the criteria specified in this section.

(2)(a) The agency shall adopt rules establishing criteria for the program which must include, at a minimum, meeting

standards relating to:

1. Patient satisfaction.

2. Patients requiring emergency care for wound infections.

3. Patients admitted or readmitted to an acute care hospital.

4. Patient improvement in the activities of daily living.

5. Employee satisfaction.

6. Quality of employee training.

7. Employee retention rates.

(b) The agency shall annually evaluate home health agencies seeking the program designation which apply on a form and in the manner designated by rule.

(3) To receive a program designation, the home health agency must:

(a) Be actively licensed and have been operating for at least 24 months before applying for the program designation. A designation awarded under the program is not transferrable to another licensee, unless the existing home health agency is being relicensed in the name of an entity related to the current licenseholder by common control or ownership and there will be no change in the management, operation, or programs of the home health agency as a result of the relicensure.

(b) Have not had any licensure denials, revocations, or Class I, Class II, or uncorrected Class III deficiencies within the 24 months before the application for the program designation.

(4) The program designation expires on the same date as the home health agency's license. A home health agency must reapply and be approved biennially for the program designation to

continue using the program designation in the manner authorized under subsection (5).

(5) A home health agency that is awarded a designation under the program may use the designation in advertising and marketing. A home health agency may not use the program designation in any advertising or marketing if the home health agency:

(a) Has not been awarded the designation;

(b) Fails to renew the designation upon expiration of the awarded designation;

(c) Has undergone a change in ownership that does not qualify for an exception under paragraph (3)(a); or

(d) Has been notified that it no longer meets the criteria for the award upon reapplication after expiration of the awarded designation.

Section 9. Section 408.822, Florida Statutes, is created to read:

408.822 Direct care workforce survey.—

(1) For purposes of this section, the term "direct care worker" means a certified nursing assistant, a home health aide, a personal care assistant, a companion services or homemaker services provider, a paid feeding assistant trained under s. 400.141(1)(v), or another individual who provides personal care as defined in s. 400.462 to individuals who are elderly, developmentally disabled, or chronically ill.

(2) Beginning January 1, 2021, each licensee that applies for licensure renewal as a nursing home facility licensed under part II of chapter 400; an assisted living facility licensed under part I of chapter 429; or a home health agency, nurse

registry, or companion services or homemaker services provider licensed under part III of chapter 400 shall furnish the following information to the agency in a survey on the direct care workforce:

(a) The number of registered nurses and the number of direct care workers by category employed by the licensee.

(b) The turnover and vacancy rates of registered nurses and direct care workers and the contributing factors to these rates.

(c) The average employee wage for registered nurses and each category of direct care worker.

(d) Employment benefits for registered nurses and direct care workers and the average cost of such benefits to the employer and the employee.

(e) Type and availability of training for registered nurses and direct care workers.

(3) An administrator or designee shall include the information required in subsection (2) on a survey form developed by the agency by rule which must contain an attestation that the information provided is true and accurate to the best of his or her knowledge.

(4) The licensee must submit the completed survey prior to the agency issuing the license renewal.

(5) The agency shall continually analyze the results of the surveys and publish the results on its website. The agency shall update the information published on its website monthly.

Section 10. Section 464.0156, Florida Statutes, is created to read:

464.0156 Delegation of duties.—

(1) A registered nurse may delegate a task to a certified

nursing assistant certified under part II of this chapter or a home health aide as defined in s. 400.462, if the registered nurse determines that the certified nursing assistant or the home health aide is competent to perform the task, the task is delegable under federal law, and the task:

(a) Is within the nurse's scope of practice.

(b) Frequently recurs in the routine care of a patient or group of patients.

(c) Is performed according to an established sequence of steps.

(d) Involves little or no modification from one patient to another.

(e) May be performed with a predictable outcome.

(f) Does not inherently involve ongoing assessment, interpretation, or clinical judgment.

(g) Does not endanger a patient's life or well-being.

(2) A registered nurse may delegate to a certified nursing assistant or a home health aide the administration of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications, if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812.

(3) The board, in consultation with the Agency for Health Care Administration, shall adopt rules to implement this section.

Section 11. Paragraph (r) is added to subsection (1) of

section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. 456.072(2) and 464.0095:

(r) Delegating professional responsibilities to a person when the nurse delegating such responsibilities knows or has reason to know that such person is not qualified by training, experience, certification, or licensure to perform them.

Section 12. Section 464.2035, Florida Statutes, is created to read:

464.2035 Administration of medication.—

(1) A certified nursing assistant may administer oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medication to a patient of a home health agency if the certified nursing assistant has been delegated such task by a registered nurse licensed under part I of this chapter, has satisfactorily completed an initial 6-hour training course approved by the board, and has been found competent to administer medication to a patient in a safe and sanitary manner. The training, determination of competency, and initial and annual validations required under this section must be conducted by a registered nurse licensed under this chapter or a physician licensed under chapter 458 or chapter 459.

(2) A certified nursing assistant shall annually and satisfactorily complete 2 hours of inservice training in medication administration and medication error prevention approved by the board, in consultation with the Agency for Health Care Administration. The inservice training is in

addition to the other annual inservice training hours required under this part.

(3) The board, in consultation with the Agency for Health Care Administration, shall establish by rule standards and procedures that a certified nursing assistant must follow when administering medication to a patient. Such rules must, at a minimum, address qualification requirements for trainers, requirements for labeling medication, documentation and recordkeeping, the storage and disposal of medication, instructions concerning the safe administration of medication, informed-consent requirements and records, and the training curriculum and validation procedures.

Section 13. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 10, 2020

I respectfully request that **Senate Bill #1676**, relating to Direct Care Workers, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ben Albritton
Florida Senate, District 26

File signed original with committee office

2020 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	CS for SB 1676
BILL TITLE:	Direct Care Workers
BILL SPONSOR:	Senator Ben Albritton
EFFECTIVE DATE:	July 1, 2020

COMMITTEES OF REFERENCE
1) N/A
2)
3)
4)
5)

CURRENT COMMITTEE
N/A

SIMILAR BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

PREVIOUS LEGISLATION	
BILL NUMBER:	N/A
SPONSOR:	N/A
YEAR:	N/A

IDENTICAL BILLS	
BILL NUMBER:	N/A
SPONSOR:	N/A

LAST ACTION:	N/A

Is this bill part of an agency package?
Y ___ N _X_

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	
LEAD AGENCY ANALYST:	Ruby Grantham, Bernard Hudson, Jacqueline Williams, Brian Smith
ADDITIONAL ANALYST(S):	Taylor Haddock, Kim Smoak
LEGAL ANALYST:	
FISCAL ANALYST:	

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

This bill allows nurses to delegate tasks to unlicensed staff in home health agencies if they meet certain requirements. This bill authorizes home health aides (HHAs) and certified nursing assistants (CNAs) to administer certain medications if the home health aide or CNA meets training and competency requirements.

The bill allows nursing homes to utilize paid feeding assistants to assist nursing home residents with eating as defined in federal nursing home regulations, 42 Code of Federal Regulation (CFR) s.488.301 in accordance with 42 CFR s.483.60. A paid feeding assistant must successfully complete the training program developed by the Agency for Health Care Administration (Agency, AHCA). Criteria for the training program curriculum is specified in the bill.

This bill establishes the Excellence in Home Health Program, which will be awarded by the Agency to home health agencies based on specified criteria.

The Agency will be required to create and collect a survey from certain licensed provide types regarding registered nurses and direct care employees such as turnover, benefits and staffing challenges. The survey will be completed upon biennial licensure renewal. The Agency will be required to analyze, publish, and update the employee information provided by providers specified in this section.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Currently, home health aides (HHAs) and certified nursing assistants (CNAs) are restricted from providing services that require licensure as a nurse[1]. These services include wound care and medication administration. Home health aides are not regulated as a profession in Florida; however, they must meet certain training and/or competency requirements in order to be employed or contracted with a home health agency or nurse registry licensed under chapter 400, part III, F.S. Nursing assistants are certified by the Department of Health under part II of chapter 464, F.S. and are restricted from providing services that require licensure under the Nurse Practice Act.[2]

The Agency licenses nursing homes, assisted living facilities, home health agencies, nurse registries and homemaker companion agencies. Currently, there are no licensure requirements for these providers to submit information to the Agency regarding employee turnover, wages, vacancies, benefits, or training as a condition of licensure renewal. The Agency does not publish information about direct care staff recruitment and retention issues.

Nursing Homes

Currently, 400.141 F.S.[3], does not include any reference to or address the use of paid feeding assistants, however, federal nursing home regulations authorize the use of paid feeding assistants in accordance with state law if they have completed a state-approved training program.

Under 400.23 F.S.[4], individuals who provide eating assistance to residents in nursing homes are not considered in the minimum staffing standards if they are not employed as nursing staff.

Under federal requirements nursing homes report staffing levels based on payroll data; this information is published on the federal Nursing Home Compare website.

Home Health Agencies and Nurse Registries

HHAs and CNAs may be employed or contracted with a home health agency or nurse registry licensed under chapter 400, part III, F.S. for the provision of services to an individual in the individual's home or place of residence. HHAs and CNAs either (1) employed or working with a licensed home health agency or (2) registered with a licensed nurse registry may also provide staffing services to a health care facility, school, or other business entity on a temporary or school-year basis. A CNA or HHA may not provide medical or other health care services that require specialized training or services that may be performed only by licensed health care professionals.

[1] Chapter 464, F.S
[2] Part I of Chapter 464, F.S.
[3] 400.141, F.S. Administration and management of nursing home facilities
[4] 400.23, F.S. Rules; evaluation and deficiencies; licensure status

Nurse registries do not employ staff who provide direct care to patients. Nurse Registries are staffing agencies that arrange for contract staff to provide services in health care facilities such as a hospital or nursing home and other settings such as schools.

Homemaker and Companion Services

A "homemaker" is a person who performs household chores that include housekeeping, meal planning and preparation, shopping assistance, and routine household activities for an elderly, handicapped or convalescent individual. A "companion" is a person who spends time with or assists an elderly, handicapped or convalescent individual and accompanies such individual on trips and outings and may prepare and serve meals to such individual. A homemaker or companion may not provide hands-on personal care to a client.

2. EFFECT OF THE BILL:

Federal regulations that govern home health agencies, hospitals, and ambulatory surgery centers participating in Medicare and Medicaid require that certain services and care be provided by licensed nurses. Delegating tasks to unlicensed staff in some cases would conflict with federal law. For example, Code of Federal Regulations 42 CFR 484.55 Condition of Participation: Comprehensive assessment of patients, also requires registered nurses in home health agencies, to assess patient care needs. Nurses are also required to review areas such as patient medications for adverse effects and reactions, drug interactions, duplicate therapy and non-compliance with drug therapy.

Nursing Homes

This bill (s. 400.141, F.S.) allows the use of paid feeding assistants as defined in 42 CFR s.488.301 in accordance with 42 CFR s.483.60. A paid feeding assistant is an individual who meets the requirements specified in 42 CFR s.483.60(h)(1) who is paid to feed residents by a facility, or who is used under an arrangement with another agency or organization. A facility may only use a paid feeding assistant if they have successfully completed the training program developed by the Agency, which may be adopted by rule to implement. The training program must consist of a minimum of 12 hours of education and training and must cover the following topics:

- Feeding Techniques.
- Assistance with feeding and hydration.
- Communication and interpersonal skills.
- Appropriate responses to resident behavior.
- Safety and emergency procedures, including the first aid procedure used to treat upper airway obstructions.
- Infection control.
- Residents' rights.
- Recognizing changes in residents which are inconsistent with their normal behavior, and the importance of reporting those changes to the supervisory nurse.

While criteria for the training program curriculum is specified in the bill, the bill does not provide for additional personnel/resources that will be needed in order to develop the training program.

Per the changes to s. 400.23, F.S., paid feeding assistants, in addition to non-nursing staff providing eating assistance, may not be counted towards nursing home minimum staffing standards.

Home Health Agencies and Nurse Registries

The proposed bill amends sections 400.462, 400.464, and 400.488, F.S. and creates section 400.490, F.S. to broaden the scope of services that HHAs and CNAs employed by or under contract with a home health agency can provide. These services include, but are not limited to, wound care and medication administration, and other services as delegated by a registered nurse licensed under chapter 464, F.S. The bill also creates section 400.489, F.S. and establishes specific medication-related training requirements, determination of competency, and annual validations of home health aides to be conducted by a registered nurse or a physician, and requires rulemaking authority by the agency in consultation with the Board of Nursing to develop standards and procedures related to medication administration. The bill authorizes HHAs and CNAs to perform routine preventative skin care and basic wound care in conjunction with the administration of topical medications. This is unclear as skin care and wound care involve more than the application of a prescribed topical medication and would not be considered medication administration. Would care is a separate, specific nursing service which may or may not include the administration of medication. The proposed language appears to allow HHAs and CNAs to perform wound care regardless of whether a topical medication is being administered of not. The bill does not provide requirements for HHAs and CNAs to complete wound care training or certification and this may conflict with nursing scope of practice authority. Due to the extensive work anticipated in developing these rules and working with stakeholders and the Board of Nursing, the Agency would require 1 Other Personal Services (OPS) paygrade 25 position for a year to manage this project.

The proposed statutory changes do not apply to nurse registries. Section 400.506(5)(b), F.S. explicitly prohibits HHAs and CNAs from providing medical or other health care services that require specialized training and that may be performed only by licensed health care professionals.

Delegation of Duties by a Registered Nurse

The bill creates section 464.0156, F.S. which provides criteria for delegation of certain nursing tasks by a registered nurse, including medication administration, to a certified nursing assistant or home health aide who has met the requirements outlined in law. The bill prohibits a registered nurse from delegating the administration of certain controlled substances. The Board of Nursing, in consultation with the Agency, is required to adopt rules to implement this section. Section 464.018, F.S. is amended to add a provision for disciplinary action to be taken against a nurse for delegating responsibilities to an unqualified person.

The bill creates section 464.2035, F.S., which authorizes certified nursing assistants to administer certain prescription medications and establishes the training and competency requirements that must be met. The proposed language requires a registered nurse or physician to conduct annual validations of certified nursing assistants administering medications. CNAs are also required to complete annual in-service training in medication administration and medication error prevention. The Board of Nursing, in consultation with the Agency, is required to adopt rules to implement this section.

Creation of the Excellence in Home Health Program

The bill creates section 400.52, F.S., and establishes the Excellence in Home Health Program within the Agency and requires the Agency to adopt rules establishing program criteria. The Agency is required to annually evaluate HHAs that apply for the program designation. The bill sets forth the program designation eligibility requirements, including designation expiration and biennial renewal, and provides that a program designation award is not transferrable. A home health agency that has been awarded the program designation award is authorized to use the designation in advertising and marketing, except under certain circumstances.

The Agency carries out the Governor's Panel for Excellence in Long Term Care Gold Seal Award for nursing homes which requires four staff to review applications, answer questions from applicants, evaluate ongoing compliance, and manage issuance of the award for a considerable portion of time. At any time, there are approximately 25-30 nursing homes that hold the Gold Seal Award of over 800 nursing homes; the low response rate is in part due to the high threshold for deficiencies that must be met to be eligible for the Gold Seal. Nursing homes have the strictest regulatory requirements of those licensed by the Agency. There are approximately 2,000 home health agencies. Since HHAs are cited for fewer deficiencies the Agency expects a significant number of HHAs to potentially qualify for the award. Staffing needs would be significant. The Agency would have to develop rules for the award and would require OPS support to manage rule development. One (1) paygrade 25 position and one (1) paygrade 24 position are needed to develop and maintain the Excellence in Home Health Award program and one (1) OPS paygrade 25 position for one year to promulgate the rules. Two (2) senior attorneys are needed to handle litigation.

Creation of a Direct Care Workforce Survey

The bill creates section 408.822 and requires a direct care workforce survey to be completed and submitted at license renewal for over 6,000 providers, including: nursing homes, assisted living facilities, home health agencies, nurse registries, and homemaker and companion services providers. The direct care workforce survey includes various information related to paid feeding assistants, registered nurses, and direct care workers. Several references in the survey address staff "employed by" the provider. Nurse registries do not "employ" direct care staff; direct care workers are under contract. The information about these contract staff may be meaningful to in the survey responses, but as drafted in the bill may be excluded since they are not employees.

The Agency is responsible for analyzing the results of the surveys and publishing the information monthly on its website. Since the results are collected a licensure renewal (every two years), results will not show a uniform point in time for all facilities. The Agency will make modification to the current licensing online system to collect survey results. The information collected will be displayed through Florida Health Finder. Although the Agency has not acquired a specific quote, estimated enhancements are forecasted to take 12 months and $424,000 in contract services to implement and an additional recurring $200,000 for system maintenance and enhancement. The Agency will need one (1) OPS paygrade 24 position to develop the survey and develop a process to manage and share the results and one (1) career service paygrade 24 position to develop and analyze the results of the surveys.

The bill will become effective on July 1, 2020.

Fiscal Summary

Expansion of HHA and CNA duties

1 OPS paygrade 25 staff for 1 year to address program, manage stakeholder input, and develop rules

Excellence in Home Care Program
2 full-time equivalent (FTEs) paygrade 24 and 25 to manage applications and inquiries, 1 OPS paygrade 24 for one year to handle all rules, and 2 senior attorneys to handle litigation.

Direct Care Workforce Survey
$424K in development costs (for year 1) to build the survey through modifications to existing Agency systems and $200K in recurring funding to support maintenance and enhancements. 1 FTE career service paygrade 24 and 1 OPS paygrade 24 (for 1 year) to develop and manage the workforce survey and analyze the results.

The system is expected to be available summer 2022.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y _X__ N ___

If yes, explain:	Agency may adopt rules to implement the training requirements for paid feeding assistants in nursing homes. Agency to establish standards and procedures for medication administration by home health aides. Agency shall adopt rules to establish criteria for the Excellence in Home Health Program. Board of Nursing to adopt rules for RN delegation of duties.
Is the change consistent with the agency's core mission?	Y _X__ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	Rule 59A-8.0095, F.A.C. for medication administration; Chapter 59A-8, F.A.C., adopt 2 new rules; one for Excellence in Home Health Program and one for Home Care Services Registry Board of Nursing – rule chapter unknown 59A-4, F.A.C., adopt rules to implement the training requirements for paid feeding assistants in nursing homes.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N __X_

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQUIRED BY THIS BILL? Y ___ N _X__

Board:	N/A
Board Purpose:	N/A
Who Appointments:	N/A

Appointee Term:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	None
Expenditures:	Year 1 - $ 981,210 Year 2 - $ 563,855 Year 3 - $ 563,855
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

FISCAL IMPACT:

	Year 1 (FY 2020-21)	Year 2 (FY 2021-22)	Year 3 (FY 2022-23)

1. Non-Recurring Impact:

Expenditures:

Expense (Agency Standard Expense Package)

Professional Staff	5.00	@	$ 4,126	$	20,630
Support Staff	0.00	@	3,741		-
Total Non-Recurring Expense	**5.00**			**$**	**20,630**

Operating Capital Outlay (Agency Standard Operating Capital Outlay Package)

-	-	@	$ -	$	-
-	-	@	-		-
Total Operating Capital Outlay				**$**	**-**

Total Non-Recurring Expenditures	**$**	**20,630**

2. Recurring Impact:

Revenues:						
-				$ -	$ -	$ -
-				-	-	-
-				-	-	-
Total Recurring Revenues				**$ -**	**$ -**	**$ -**
Expenditures:						
Salaries	**Class Code**	**FTEs**	**Pay Grade**	**Rate**		
Health Services & Facility Consultant	5894	1.00	24	41,106	$ 59,351	$ 59,351	$ 59,351
Program Administrator-SES	5916	1.00	425	43,675	63,060	63,060	63,060
Senior Attorney	7738	2.00	230	103,651	149,657	149,657	149,657
Medical Health Care Program Analyst	5875	1.00	24	41,106	59,351	59,351	59,351
-				-	-	-	-
-				-	-	-	-
Total Salary and Benefits		**5.00**		**229,537**	**$ 331,419**	**$ 331,419**	**$ 331,419**
OPS		**FTEs**					
Government Operations Consultant III		2.00			$ 116,790	$ -	$ -
Systems Project Analyst		1.00			55,935	-	-
-		0.00			-	-	-
-		0.00			-	-	-
Total OPS		**3.00**			**$ 172,726**	**$ -**	**$ -**
Expenses							
Professional Staff		5.00	@	$ 6,094	$ 30,470	$ 30,470	$ 30,470
Support Staff		0.00	@	5,107	-	-	-
-					-	-	-
Total Expenses					**$ 30,470**	**$ 30,470**	$ 30,470
Human Resources Services							
FTE Positions		5.00	@	$ 329	$ 1,645	$ 1,645	$ 1,645
OPS Positions		3.00	@	107	321	321	321
Total Human Resources Services					**$ 1,966**	**$ 1,966**	**$ 1,966**
Special Categories/Contracted Services							
100777 Contracted Services					$ 424,000	$ 200,000	$ 200,000
-					-	-	-
-					-	-	-
Total Special Categories/Contracted Services					**$ 424,000**	**$ 200,000**	**$ 200,000**
Total Recurring Expenditures					**$ 960,580**	**$ 563,855**	**$ 563,855**

3. Total Revenues and Expenditures:

Sub-Total Recurring Revenues	$ -	$ -	$ -
Total Revenues	**$ -**	**$ -**	**$ -**
Sub-Total Non-Recurring Expenditures	$ 20,630	$ -	$ -
Sub-Total Recurring Expenditures	960,580	563,855	563,855
Total Expenditures	**$ 981,210**	**$ 563,855**	**$ 563,855**
Net Impact (Total Revenues minus Total Expenditures)	**$ (981,210)**	**$ (563,855)**	**$ (563,855)**

4. Net Impact (By Fund)

Health Care Trust Fund (2003)	$ (981,210)	$ (563,855)	$ (563,855)

-	-	-	-
-	-	-	-
Net Impact (By Fund)	**$ (981,210)**	**$ (563,855)**	**$ (563,855)**

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y _X__ N ___

Revenues:	None
Expenditures:	Costs associated with additional training requirements
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	
Bill Section Number:	

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y _X__ N ___

If yes, describe the anticipated impact to the agency including any fiscal impact.	$424,000 in contract services to implement and an additional recurring $200,000 for Agency system enhancements to develop and maintain the Home Care Services Registry and Direct Care Workforce Survey.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y ___ N _X__

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic Ind. Practice APRNs

Name Jared Willis

Job Title Dir. of Gov't Relations

Address 2544 Blairstone Pines Dr. (*Street*)
Tallahassee FL 32301 (*City / State / Zip*)

Phone 284-1996

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing FL Osteopathic Medical Assoc

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)

18 FEB 2020
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic NURSE PRACTITIONERS

Name JEAN AERTKER

Job Title NURSE PRACTITIONER

Address 646 RIVIERA DRIVE
Street

TAMPA FL 33606
City *State* *Zip*

Phone 813 787 3175

Email DRAERTKER@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing SEVERAL NURSE PRACTITIONER GROUPS IN FLORIDA

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic _____

Name Doug Bell

Job Title _____

Address 119 S. Monroe St
Street

TLH
City *State* *Zip*

Phone 850 205 9000

Email doug.bell@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Chapter of the American Academy of Pediatrics

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/18/2020
Meeting Date

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1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic Scope of Practice

Name Aariha Ali

Job Title Medical Student

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Street
Tallahassee FL 32304
City *State* *Zip*

Phone 321-888-7812

Email aia19f@med.fsu.edu

Speaking: ☐ For ☒ Against ☐ Information

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

Representing N/A

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic _____

Name Chris Lyon

Job Title _____

Address 315 S. Calhoun St., Ste 830
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 222-5702

Email clyon@llw-law.com

Speaking: ☐ For ☐ Against ☑ Information

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

Representing Florida Association of Nurse Anesthetists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

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2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic Direct Care Workers

Name Michael Nuccio

Job Title Physician Assistant r

Address 675 Chipola Dr
Street

Marianna FL 32448
City *State* *Zip*

Phone 8506930764

Email florthopa@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of PAs

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic Direct Care Workers

Name Corinne Mixon

Job Title Lobbyist

Address 511 N. Adams St.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 766-5795

Email corinne.mixon@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Florida Academy of Physician Assistants

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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2/18/20
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable

Topic Direct Care Workers

Name Brewster Bevis

Job Title Senior Vice President

Address 516 N Adams St
Street

Phone 224-7173

Tallahassee FL 32301
City *State* *Zip*

Email bbevis@aif.com

Speaking: ☑ For ☐ Against ☐ Information

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

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/1

THE FLORIDA SENATE

APPEARANCE RECORD

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

2-18-2020
Meeting Date

1676
Bill Number (if applicable)

894862
Amendment Barcode (if applicable)

Topic Scope of Practice

Name Dan Schaefer

Job Title Medical Student

Address 1314 N Bronough st
Street
Tallahassee FL 32303
City *State* *Zip*

Phone 269-290-4876

Email ds12d@med.fsu.edu

Speaking: ☐ For ☒ Against ☐ Information

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

Representing n/a

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.

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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)

2/18/2020
Meeting Date

1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic Scope of Practice

Name Garrett Barr

Job Title N/A

Address 1817 W Call St
Street

Phone 239-839-1026

Tallahassee FL 32304
City *State* *Zip*

Email Gqbarr88@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Myself

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.

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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)

2/18/20
Meeting Date

SB 1676
Bill Number (if applicable)

899862
Amendment Barcode (if applicable)

Topic APRN INDEPENDENT PRACTICE

Name RONALD GIFFLER, M.D.

Job Title PRESIDENT

Address 1430 Piedmont Dr. E.
Street

Phone 850 224-6496

Tallahassee FL 32308
City *State* *Zip*

Email ronaldgiffler@att.net

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Medical 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.

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 4427 Herschel St
Street

Jacksonville, FL 32210
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Chapter 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.

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Rohan Joseph, MD

Job Title SURGEON

Address 2626 CARE DR, STE 206
Street

Phone 904-233-3051

TALLY FL 32312
City *State* *Zip*

Email rohan.joseph@hca healthcare.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Chapter, American College of Surgeons
Capital Medical, Escambia medical, Emerald Coast, Lee, Volusia + Collier medical Society

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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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)

2/18/20
Meeting Date

SB 1676
Bill Number (if applicable)

Topic Direct Care Workers

Amendment Barcode (if applicable)

Name Steve Bahmer

Job Title President / CEO

Address 1812 Riggins Rd
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850/671-3700

Email sbahmer@leadingagefl.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Leading Age Florida

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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)

Feb. 18, 2020
Meeting Date

SB 1676 C1
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Direct Care Workers

Name Tanya C. Jackson

Job Title

Address 150 S. Monroe St., Suite 303
Street
Tallahasssee FL 32301
City *State* *Zip*

Phone 850-445-0107

Email Tanya@PinPointResults.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing SEIU1199 Healthcare Workers East

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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)

2/18/20
Meeting Date

1670
Bill Number (if applicable)

Topic Home Care Association of America

Amendment Barcode (if applicable)

Name Jennifer Ungru

Job Title

Address Dean Mead
Street

Phone 850-999-4100

Email jungru@deanmead.com

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Home Care Association of America

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.

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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)

2/18/2020
Meeting Date

SB 1676
Bill Number (if applicable)

Topic Direct Care Workers

Amendment Barcode (if applicable)

Name Zayne smith

Job Title Associate State Director

Address 215 South Monroe Suite 603
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850.228.4243

Email zsmith@aarp.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing AARP

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Bob Asztalos

Job Title Chief Lobbyist

Address 307 W Park Ave
Street

Phone 850-224-3907

Tallahassee FL 32301
City *State* *Zip*

Email bAsztalos@fhca.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Health Care Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

Topic Independent Practice

Amendment Barcode (if applicable)

Name Pam Irwin

Job Title Exec Dir. Capital Medical Society

Address 8530 Charrington Forest Blvd
Street
Tallahassee FL 32312
City *State* *Zip*

Phone 8508779018

Email pirwin@capmed.org

Speaking: ☐ For ☐ Against ☐ Information

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

Representing self and Capital Medical Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Independent Practice

Name Maribel Lockwood, MD

Job Title radiologist

Address 51 Charles Ave
Street

Tallahassee, FL
City *State* *Zip*

Phone 8506947360

Email mulockwood@radassociates.com

Speaking: ☐ For ☑ Against ☐ Information

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

Representing self + Capital Medical Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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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)

2/18
Meeting Date

1676
Bill Number (if applicable)

Topic Direct Care / Scope

Amendment Barcode (if applicable)

Name Jim Daughton

Job Title

Address 119 S. Monroe Street
Street

Phone 205-9000

Tallahassee FL 32301
City *State* *Zip*

Email jim.daughton@mhdfirm.com

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Florida Academy of Family Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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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)

2/18/20
Meeting Date

1676
Bill Number (if applicable)

823308
Amendment Barcode (if applicable)

Topic FL Senate 1676

Name Bobby Lolley

Job Title Executive Director

Address 2249 Capital Circle
Street

Tallahassee FL. 32308
City *State* *Zip*

Phone 850-567-1951

Email BLolley@homecarefl.org

Speaking: ☐ For ☐ Against ☒ Information

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

Representing Home Care Association of Florida

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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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)

2/18
Meeting Date

1676
Bill Number (if applicable)

Topic Direct Care Workers / Scope

Amendment Barcode (if applicable)

Name Dr. Christy Alexander

Job Title

Address 328 DeSoto St.
Street

Tallahassee FL 32303
City *State* *Zip*

Phone 850 508-4006

Email christe.alexander@med.fsu.edu

Speaking: ☐ For ☑ Against ☐ Information

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

Representing Florida Academy of Family 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.

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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)

2/18/20
Meeting Date

SB 1676
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic ARNP independent practice

Name Seymaer R Rosen MD

Job Title Medical doctor

Address 4591 Barrie Dr
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-272 0350

Email Seymaerrosen@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

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

Representing self

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.

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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:	CS/SB 1748
INTRODUCER:	Children, Families, and Elder Affairs Committee; and Senators Hutson and Perry
SUBJECT:	Child Welfare
DATE:	February 17, 2020 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hendon	Hendon	CF	**Fav/CS**
2.	Sneed	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1748 makes changes to the child welfare statutes to conform to the federal Family First Prevention Services Act (FFPSA). The bill addresses prevention services, residential group care, and Florida claims funding under Title IV-E of the Social Security Act. The bill clarifies policies regarding the rates paid to certain foster parents and requires written agreements among the Department of Children and Families (department), community-based care lead agencies and the foster parent when negotiating rates that exceed the suggested monthly foster care rate.

The bill clarifies the requirements of the extended foster care program where children can remain in foster care to the age of 21, to align eligibility with the federal law regarding supervised independent living settings. The bill prohibits young adults from participating in extended foster care when they are in involuntary placements such as juvenile detention. The bill modifies the child support guidelines used in establishing child support payment amounts for parents of children in foster care. The bill reduces the time the department will monitor the placement of a child with a successor guardian from six months to three months prior to closing the case to permanent guardianship. The bill updates language regarding the state's Title IV-E plan and data reporting for children in all placement settings.

The bill may have a positive fiscal impact on state government.

The bill takes effect July 1, 2020.

II. Present Situation:

The Bipartisan Budget Act of 2018 (HR 1892) was signed into law on February 9, 2018. Included in the act was the Family First Prevention Services Act (FFPSA), which has the potential to dramatically change child welfare systems across the country.[1] One of the major areas the FFPSA changed is the way Social Security Act Title IV-E[2] funds can be spent by states for child welfare services.

Title IV-E funds previously could be used only to help with the costs of foster care maintenance for eligible children; administrative expenses to manage the foster care program; training for staff, foster parents, and certain private agency staff; adoption assistance; and kinship guardianship assistance. Under the FFPSA, states with an approved Title IV-E plan have the option to use these funds for preventive services[3] that would allow "candidates for foster care" to stay with their parents or relatives. States will be reimbursed for prevention services for up to 12 months. A written, trauma-informed prevention plan must be created, and services will need to be evidence-based.[4]

The FFPSA also seeks to curtail the use of congregate or residential group care for children and instead places a new emphasis on family foster homes. With limited exceptions, the federal government will not reimburse states for children placed in residential group care settings for more than two weeks. Approved settings, known as qualified residential treatment programs, must use a trauma-informed treatment model and employ registered or licensed nursing staff and other licensed clinical staff. The act requires children to be formally assessed within 30 days of placement to determine if his or her needs can be met by family members, in a family foster home, or another approved setting. The act provides that certain institutions are exempt from the two-week limitation, but are generally limited to 12-month placements. To be eligible for federal reimbursement, the law generally limits the number of children allowed in a foster home to six.[5]

III. Effect of Proposed Changes:

Section 1 amends s. 39.01, F.S., providing definitions. The bill amends the definition of "case plan" to conform the definition to the federal language requiring documentation of "preventive" services.[6] The definition of "preventive services" is revised so that such services may be voluntary or court ordered.

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[1] National Conference of State Legislatures, Family First Prevention Services Act Update. Available at: https://www.ncsl.org/research/human-services/family-first-prevention-services-act-ffpsa.aspx. Last visited Jan. 24, 2020.
[2] Children and Family Services Reviews, Title IV-E: Federal Payments for Foster Care and Adoption Assistance. Available at: https://training.cfsrportal.acf.hhs.gov/section-2-understanding-child-welfare-system/2994. Last visited Feb. 10, 2020.
[3] Section 39.01(67), F.S., defines preventative services as social services and other supportive or rehabilitative services provided to the parent or legal custodian of the child and to the child for the purpose of averting the child's removal from the home or disruption of a family which may result in the placement of the child in foster care.
[4] *Id.*
[5] *Id.*
[6] Family First Prevention Services Act of 2017, section 111. See https://www.congress.gov/bill/115th-congress/house-bill/253/text?q=%7B%22search%22%3A%5B%22family+first+prevention+services+act%22%5D%7D&r=1. Last visited Jan. 23, 2020.

Section 2 amends s. 39.0135, F.S., requiring the Department of Children and Families (department) to deposit all child support payments made to the department into the Federal Grants Trust Fund for children who are determined Title IV-E eligible and the Operations and Maintenance Trust Fund for children who do not meet Title IV-E eligibility requirements. The department is federally required to report and treat child support payments for Title IV-E eligible children differently than Title IV-E ineligible children.[7]

Section 3 amends s. 39.202, F.S., relating to the confidentiality of reports of child abuse. The bill permits the Agency for Health Care Administration to receive reports of abuse and neglect as the agency is responsible for licensing hospitals under ch. 395, F.S., that provide mental health services. This is a new federal requirement.[8]

Section 4 amends s. 39.6011, F.S., relating to case plan development for dependent children. The bill requires the child's case plan to include documentation supporting a placement in a qualified residential treatment program.

Section 5 amends s. 39.6221, F.S., relating to permanent guardianship of a dependent child. The court can place a child with a relative or other adult approved by the court under a permanent guardianship when the court determines that reunification or adoption is not in the best interest of the child. The bill revises the criteria used by the court to grant permanent guardianship to include children who have been placed with a guardian for the preceding three months.

Section 6 amends s. 39.6251, F.S., providing for continuing care for young adults. Florida extended foster care to the age of 21. Young adults in extended foster care can reside in supervised independent living environments. The bill excludes those residing in juvenile detention centers, forestry camps, training schools, or any other detention facility programs operated primarily for the detention of delinquent youth as supervised independent living environments.

Section 7 amends s. 61.30, F.S., providing child support guidelines. The bill provides guidelines for establishing child support amounts for dependency cases. Specifically, the bill states that if the child is in an out-of-home placement, the amount of child support would be 10 percent of the parent's income.

Section 8 amends s. 409.145, F.S., relating to the care of dependent children and quality parenting. The bill requires that all residential group home employees meet level 2 background screening requirements pursuant to s. 39.0138 and ch. 435, F.S. This requirement for background screening in required under the federal Family First Prevention Services Act (FFPSA).[9]

Current law allows the department and the community-based care lead agency (CBC) to increase the foster care room and board rate when necessary. The bill excludes level I foster care room and board payments from this allowance. Level I foster care is when relatives care for the abused

[7] Florida Department of Children and Families, 2020 Agency Legislative Bill Analysis, SB 1748, Jan. 16, 2020. On file with the Committee on Children, Families, and Elder Affairs.
[8] *Id.*
[9] *Id.*

child and such relatives are provided an established rate of $333 per month.[10] The bill also requires written documentation between the region and the CBC when an enhanced foster care room and board payment is agreed upon.

Section 9 amends s. 409.1676, F.S., relating to comprehensive residential group care services to children who have extraordinary needs. The bill makes changes to comply with new federal requirements for the use of Title IV E funds.[11] Definitions are provided for a "qualifying assessment" as a department approved functional assessment conducted by a qualified individual to determine if a child needs placement in a qualified residential treatment program. The term "qualified individual" means a trained professional with experience with children and who does not have a conflict of interest with any placement setting. The term "qualified residential treatment program" has the same meaning of 42 U.S.C. s. 672. The federal code defines these programs as ones with a trauma-informed treatment model that is designed to address the needs, including any clinical needs, of children with serious emotional or behavioral disorders or disturbances and, with respect to a child, is able to implement the treatment identified for the child by the assessment. These programs could have registered or licensed nursing staff and other licensed clinical staff who provide care within the scope of their practice as defined by state law; are on-site according to the treatment model; and are available 24 hours a day and seven days a week. Such programs must be licensed by the department and be accredited by an independent organization.

The bill requires the CBC to ensure that each child placed in a qualified residential treatment program be assessed within 30 days of placement, maintain documentation, and limit placements to no more than 12 consecutive months or 18 nonconsecutive months. For children under the age of 13, placement is limited to 6 months. Stays longer than 6 months for these children must be approved by the department.

Section 10 amends s. 409.1678, F.S., relating to specialized placements of children who are victims of commercial sexual exploitation (human trafficking). The bill allows for safe houses and safe foster homes to serve victims of, or at risk of, human trafficking in the same setting with children of any population.

Section 11 repeals s. 409.1679, F.S., relating to reimbursement for comprehensive residential group care services to children who have extraordinary needs. This type of program is not used and is repealed by the bill.

Section 12 amends s. 409.175, F.S., relating to licensure of family foster homes, residential child-caring agencies, and child-placing agencies; public records exemption. The bill adds qualified residential treatment programs, human trafficking safe houses, and at-risk homes to the definition of a residential child-caring agency. This will ensure that the state can seek federal Title IV-E funding for such placements.[12]

[10] Section 409.145, F.S.
[11] *Supra* note 7.
[12] *Id.*

Section 13 amends s. 39.301, F.S., relating to the initiation of child abuse investigations to conform to changes made in the bill regarding preventive services.

Section 14 amends s. 39.302, F.S., relating to child abuse investigations for children residing in institutions to correct a cross reference.

Section 15 amends s. 39.402, F.S., relating to placement of children in temporary shelters to conform to changes made in the bill regarding preventive services.

Section 16 amends s. 39.501, F.S., relating to petitions for dependency to conform to changes made in the bill regarding preventive services.

Section 17 amends s. 39.6013, F.S., relating to case plan amendments to correct a cross reference.

Section 18 provides an effective date of July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 1748 revises the criteria the court uses to grant permanent guardianship to include children who have been placed with a guardian for the preceding 3 months rather than the current requirement of 6 months for those cases where the caregiver has been named as the successor guardian. The reduction by three months will result in a cost avoidance for the department and the CBCs for case management services, and for the courts that provide judicial case supervision. The total amount of the cost avoidance for state government is indeterminate.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 39.01, 39.0135, 39.202, 39.301, 39.302, 39.402, 39.501, 39.6011, 39.6013, 39.6221, 39.6251, 61.30, 409.145, 409.1676, 409.1678, and 409.175.

This bill repeals section 409.1679 of the Florida Statutes.

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 Children, Families, and Elder Affairs on February 4, 2020:

- The CS amends s. 39.407, F.S., to require an assessment of dependent children placed in a qualified residential treatment program.
- The CS retains and amends s. 409.1676, F.S., on residential care to set requirements for qualified residential treatment programs.

B. Amendments:

None.

By the Committee on Children, Families, and Elder Affairs; and Senators Hutson and Perry

A bill to be entitled

An act relating to child welfare; amending s. 39.01, F.S.; revising definitions; amending s. 39.0135, F.S.; requiring that child support payments be deposited into specified trust funds; amending s. 39.202, F.S.; authorizing the Agency for Health Care Administration to access certain records; amending s. 39.6011, F.S.; requiring certain documentation in the case plan when a child is placed in a qualified residential treatment program; amending s. 39.6221, F.S.; revising the conditions under which a court determines permanent guardian placement for a child; amending s. 39.6251, F.S.; specifying certain facilities that are not considered a supervised living arrangement; requiring a supervised living arrangement to be voluntary; amending s. 61.30, F.S.; providing a presumption for child support in certain proceedings under ch. 39; amending s. 409.145, F.S.; requiring certain screening requirements for residential group home employees; requiring a written agreement to modify foster care room and board rates; providing an exception; amending s. 409.1676, F.S.; revising legislative intent; revising and providing definitions; revising a provision requiring the department to contract with certain entities; revising requirements for lead agencies, not-for-profit corporations, and local government entities with which the department is contracted; deleting a provision authorizing the department to transfer casework responsibilities for

certain children to specified entities; providing responsibilities for lead care agencies; providing placement timeframes for the qualified residential treatment program; deleting a provision requiring that certain provisions be implemented to the extent of available appropriations contained in the annual General Appropriations Act; amending s. 409.1678, F.S.; revising a requirement and an authorization for safe houses; repealing s. 409.1679, F.S., relating to comprehensive residential group care requirements and reimbursement; amending s. 409.175, F.S.; revising definitions; amending ss. 39.301, 39.302, 39.402, 39.501, and 39.6013, F.S.; making technical changes and conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Subsections (11) and (67) of section 39.01, Florida Statutes, are amended to read:

39.01 Definitions.—When used in this chapter, unless the context otherwise requires:

(11) "Case plan" means a document, as described in s. 39.6011, prepared by the department with input from all parties. The case plan follows the child from the provision of preventive ~~voluntary~~ services through any dependency, foster care, or termination of parental rights proceeding or related activity or process.

(67) "Preventive services" means social services and other

supportive and rehabilitative services provided, either voluntarily or by court order, to the parent or legal custodian of the child and to the child or on behalf of the child for the purpose of averting the removal of the child from the home or disruption of a family which will or could result in the placement of a child in foster care. Social services and other supportive and rehabilitative services shall promote the child's developmental needs and need for physical, mental, and emotional health and a safe, stable, living environment; shall promote family autonomy; and shall strengthen family life, whenever possible.

Section 2. Section 39.0135, Florida Statutes, is amended to read:

39.0135 Federal Grants and Operations and Maintenance Trust Funds ~~Fund~~.—The department shall deposit all child support payments made to the department, equaling the cost of care, under ~~pursuant to~~ this chapter into the Federal Grants Trust Fund for Title IV-E eligible children and the Operations and Maintenance Trust Fund for children ineligible for Title IV-E. If the child support payment does not equal the cost of care, the total amount of the payment shall be deposited into the appropriate trust fund. The purpose of this funding is to care for children who are committed to the temporary legal custody of the department.

Section 3. Paragraphs (a) and (h) of subsection (2) of section 39.202, Florida Statutes, are amended to read:

39.202 Confidentiality of reports and records in cases of child abuse or neglect.—

(2) Except as provided in subsection (4), access to such

records, excluding the name of, or other identifying information with respect to, the reporter which shall be released only as provided in subsection (5), shall be granted only to the following persons, officials, and agencies:

(a) Employees, authorized agents, or contract providers of the department, the Department of Health, the Agency for Persons with Disabilities, the Agency for Health Care Administration, the Office of Early Learning, or county agencies responsible for carrying out:

1. Child or adult protective investigations;

2. Ongoing child or adult protective services;

3. Early intervention and prevention services;

4. Healthy Start services;

5. Licensure or approval of adoptive homes, foster homes, child care facilities, facilities licensed under chapters 393 and 394 ~~chapter 393~~, family day care homes, providers who receive school readiness funding under part VI of chapter 1002, or other homes used to provide for the care and welfare of children;

6. Employment screening for employees ~~caregivers~~ in residential group homes licensed by the department, the Agency for Persons with Disabilities, or the Agency for Health Care Administration; or

7. Services for victims of domestic violence when provided by certified domestic violence centers working at the department's request as case consultants or with shared clients.

Also, employees or agents of the Department of Juvenile Justice responsible for the provision of services to children, under

~~pursuant to~~ chapters 984 and 985.

(h) Any appropriate official of the department, the Agency for Health Care Administration, or the Agency for Persons with Disabilities who is responsible for:

1. Administration or supervision of the department's program for the prevention, investigation, or treatment of child abuse, abandonment, or neglect, or abuse, neglect, or exploitation of a vulnerable adult, when carrying out his or her official function;

2. Taking appropriate administrative action concerning an employee of the department or the agency who is alleged to have perpetrated child abuse, abandonment, or neglect, or abuse, neglect, or exploitation of a vulnerable adult; or

3. Employing and continuing employment of personnel of the department or the agency.

Section 4. Present subsections (6) through (9) of section 39.6011, Florida Statutes, are redesignated as subsections (7) through (10), respectively, and a new subsection (6) is added to that section, to read:

39.6011 Case plan development.—

(6) When a child is placed in a qualified residential treatment program, the case plan must include documentation outlining the most recent assessment for a qualified residential treatment program, the date of the most recent placement in a qualified residential treatment program, the treatment or service needs of the child, and preparation for the child to return home or be in an out-of-home placement. If a child is placed in a qualified residential treatment program for longer than the timeframes described in s. 409.1676, a copy of the

signed approval of such placement by the department must be included in the case plan.

Section 5. Paragraph (a) of subsection (1) of section 39.6221, Florida Statutes, is amended to read:

39.6221 Permanent guardianship of a dependent child.—

(1) If a court determines that reunification or adoption is not in the best interest of the child, the court may place the child in a permanent guardianship with a relative or other adult approved by the court if all of the following conditions are met:

(a) The child has been in the placement for not less than the preceding 6 months, or the preceding 3 months if the caregiver has been named as the successor guardian on the child's guardianship assistance agreement.

Section 6. Paragraph (a) of subsection (4) of section 39.6251, Florida Statutes, is amended to read:

39.6251 Continuing care for young adults.—

(4)(a) The young adult must reside in a supervised living environment that is approved by the department or a community-based care lead agency. The young adult shall live independently, but in an environment in which he or she is provided supervision, case management, and supportive services by the department or lead agency. Such an environment must offer developmentally appropriate freedom and responsibility to prepare the young adult for adulthood. For the purposes of this subsection, a supervised living arrangement may include a licensed foster home, licensed group home, college dormitory, shared housing, apartment, or another housing arrangement if the arrangement is approved by the community-based care lead agency

and is acceptable to the young adult. A young adult may continue to reside with the same licensed foster family or group care provider with whom he or she was residing at the time he or she reached the age of 18 years. A supervised living arrangement may not include detention facilities, forestry camps, training schools, or any other facility operated primarily for the detention of children or young adults who are determined to be delinquent. A young adult may not reside in any setting in which the young adult is involuntarily placed.

Section 7. Paragraph (a) of subsection (1) of section 61.30, Florida Statutes, is amended, and paragraph (d) is added to that subsection, to read:

61.30 Child support guidelines; retroactive child support.—

(1)(a) The child support guideline amount as determined by this section presumptively establishes the amount the trier of fact shall order as child support in an initial proceeding for such support or in a proceeding for modification of an existing order for such support, whether the proceeding arises under this or another chapter, except as provided in paragraph (d). The trier of fact may order payment of child support which varies, plus or minus 5 percent, from the guideline amount, after considering all relevant factors, including the needs of the child or children, age, station in life, standard of living, and the financial status and ability of each parent. The trier of fact may order payment of child support in an amount which varies more than 5 percent from such guideline amount only upon a written finding explaining why ordering payment of such guideline amount would be unjust or inappropriate. Notwithstanding the variance limitations of this section, the

trier of fact shall order payment of child support which varies from the guideline amount as provided in paragraph (11)(b) whenever any of the children are required by court order or mediation agreement to spend a substantial amount of time with either parent. This requirement applies to any living arrangement, whether temporary or permanent.

(d) In a proceeding under chapter 39, if the child is in an out-of-home placement, the presumptively correct amount of periodic support is 10 percent of the obligor's actual or imputed gross income. The court may deviate from this presumption as provided in paragraph (a).

Section 8. Paragraph (e) of subsection (2) and paragraph (f) of subsection (4) of section 409.145, Florida Statutes, are amended, and paragraph (h) is added to subsection (4) of that section, to read:

409.145 Care of children; quality parenting; "reasonable and prudent parent" standard.—The child welfare system of the department shall operate as a coordinated community-based system of care which empowers all caregivers for children in foster care to provide quality parenting, including approving or disapproving a child's participation in activities based on the caregiver's assessment using the "reasonable and prudent parent" standard.

(2) QUALITY PARENTING.—A child in foster care shall be placed only with a caregiver who has the ability to care for the child, is willing to accept responsibility for providing care, and is willing and able to learn about and be respectful of the child's culture, religion and ethnicity, special physical or psychological needs, any circumstances unique to the child, and

family relationships. The department, the community-based care lead agency, and other agencies shall provide such caregiver with all available information necessary to assist the caregiver in determining whether he or she is able to appropriately care for a particular child.

(e) *Employees of* ~~*Caregivers employed by*~~ *residential group homes.*—All employees, including persons who do not work directly with children, of a residential group home must meet the background screening requirements under s. 39.0138 and the level 2 standards for screening under chapter 435 ~~All caregivers in residential group homes shall meet the same education, training, and background and other screening requirements as foster parents~~.

(4) FOSTER CARE ROOM AND BOARD RATES.—

(f) Excluding level I family foster homes, the amount of the monthly foster care room and board rate may be increased upon agreement among the department, the community-based care lead agency, and the foster parent.

(h) All room and board rate increases, excluding increases under paragraph (b), must be outlined in a written agreement between the department and the community-based care lead agency.

Section 9. Section 409.1676, Florida Statutes, is amended to read:

409.1676 Comprehensive residential group care services ~~to children who have extraordinary needs~~.—

(1) It is the intent of the Legislature to provide comprehensive residential group care services~~, including residential care, case management, and other services, to children in the child protection system who have extraordinary~~

~~needs~~. These services are to be provided in a residential group care setting by a not-for-profit corporation or a local government entity under a contract with the Department of Children and Families or by a lead agency as described in s. 409.987. These contracts should be designed to provide an identified number of children with access to a full array of services for a fixed price. Further, it is the intent of the Legislature that the Department of Children and Families and the Department of Juvenile Justice establish an interagency agreement ~~by December 1, 2002~~, which describes respective agency responsibilities for referral, placement, service provision, and service coordination for children under the care and supervision of the department ~~dependent~~ and delinquent youth who are referred to these residential group care facilities. The agreement must require interagency collaboration in the development of terms, conditions, and performance outcomes for residential group care contracts serving the youth referred who are under the care and supervision of the department and delinquent ~~have been adjudicated both dependent and delinquent~~.

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

(a) ~~"Child with extraordinary needs" means a dependent child who has serious behavioral problems or who has been determined to be without the options of either reunification with family or adoption.~~

~~(b)~~ "Residential group care" means a living environment for children who are under the care and supervision of the department ~~have been adjudicated dependent and are expected to be in foster care for at least 6 months~~ with 24-hour-awake staff or live-in group home parents or staff. Each facility must be

appropriately licensed in this state as a residential child caring agency as defined in s. 409.175(2)(l) ~~and must be accredited by July 1, 2005. A residential group care facility serving children having a serious behavioral problem as defined in this section must have available staff or contract personnel with the clinical expertise, credentials, and training to provide services identified in subsection (4)~~.

~~(c) "Serious behavioral problems" means behaviors of children who have been assessed by a licensed master's-level human-services professional to need at a minimum intensive services but who do not meet the criteria of s. 394.492(7). A child with an emotional disturbance as defined in s. 394.492(5) or (6) may be served in residential group care unless a determination is made by a mental health professional that such a setting is inappropriate. A child having a serious behavioral problem must have been determined in the assessment to have at least one of the following risk factors:~~

~~1. An adjudication of delinquency and be on conditional release status with the Department of Juvenile Justice.~~

~~2. A history of physical aggression or violent behavior toward self or others, animals, or property within the past year.~~

~~3. A history of setting fires within the past year.~~

~~4. A history of multiple episodes of running away from home or placements within the past year.~~

~~5. A history of sexual aggression toward other youth.~~

(b) "Qualifying assessment" is a department-approved functional assessment administered by a qualified individual to recommend or affirm placement in a qualified residential

treatment program.

(c) "Qualified individual" means a trained professional with experience working with children or adolescents involved in the child welfare system and who is not employed by the department or lead agency and has no actual or perceived conflict of interest with any placement setting or program.

(d) "Qualified residential treatment program" has the same meaning as provided in 42 U.S.C. s. 672.

(3) The department~~, in accordance with a specific appropriation for this program,~~ shall contract with a not-for-profit corporation, a local government entity, or the lead agency that has been established in accordance with s. 409.987 for the performance of residential group care services described in this section. A lead agency that is currently providing residential care may provide this service directly with the approval of the local community alliance. The department or a lead agency may contract for more than one site in a county if that is determined to be the most effective way to achieve the goals set forth in this section.

(4) The lead agency, the contracted not-for-profit corporation, or the local government entity is responsible for a comprehensive assessment, a qualifying assessment, residential care, transportation, access to behavioral health services, recreational activities, clothing, supplies, and miscellaneous expenses associated with caring for these children; for necessary arrangement for or provision of educational services; and for assuring necessary and appropriate health and dental care.

~~(5) The department may transfer all casework~~

~~responsibilities for children served under this program to the entity that provides this service, including case management and development and implementation of a case plan in accordance with current standards for child protection services. When the department establishes this program in a community that has a lead agency as described in s. 409.987, the casework responsibilities must be transferred to the lead agency.~~

(5) ~~(6)~~ This section does not prohibit any provider of these services from appropriately billing Medicaid for services rendered, from contracting with a local school district for educational services, or from earning federal or local funding for services provided, as long as two or more funding sources do not pay for the same specific service that has been provided to a child.

(6) ~~(7)~~ The lead agency, not-for-profit corporation, or local government entity has the legal authority for children served under this program, as provided in chapter 39 or this chapter, as appropriate, to enroll the child in school, to sign for a driver license for the child, to cosign loans and insurance for the child, to sign for medical treatment, and to authorize other such activities.

(7) For children placed in a qualified residential treatment program, the lead agency shall:

(a) Ensure each child receives a qualifying assessment no later than 30 days after placement in the program.

(b) Maintain documentation of a child's placement as specified in s. 39.6011(6).

(c) Not place a child in a qualified residential treatment program for more than 12 consecutive months or 18 nonconsecutive

months, or if the child is under the age of 13 years, for more than 6 months, whether consecutive or nonconsecutive, without the signed approval of the department for the continued placement.

(d) Provide a copy of the qualifying assessment to the department; the guardian ad litem; and, if the child is a member of a Medicaid managed care plan, to the plan that is financially responsible for the child's care in residential treatment.

(8) Within 60 days after initial placement, the court must approve or disapprove the placement based on the qualified assessment, determination, and documentation made by the qualified evaluator, as well as any other factors the court deems fit.

(9) ~~(8)~~ The department shall provide technical assistance as requested and contract management services.

~~(9) The provisions of this section shall be implemented to the extent of available appropriations contained in the annual General Appropriations Act for such purpose.~~

(10) The department may adopt rules necessary to administer this section.

Section 10. Paragraph (c) of subsection (2) of section 409.1678, Florida Statutes, is amended to read:

409.1678 Specialized residential options for children who are victims of commercial sexual exploitation.—

(2) CERTIFICATION OF SAFE HOUSES AND SAFE FOSTER HOMES.—

(c) To be certified, a safe house must hold a license as a residential child-caring agency, as defined in s. 409.175, and a safe foster home must hold a license as a family foster home, as defined in s. 409.175. A safe house or safe foster home must

also:

1. Use strength-based and trauma-informed approaches to care, to the extent possible and appropriate.

2. Serve exclusively one sex.

3. Group child victims of commercial sexual exploitation by age or maturity level.

4. If a safe house, care for child victims of commercial sexual exploitation ~~in a manner that separates those children from children with other needs~~. ~~Safe houses and~~ Safe foster homes may care for other populations if the children who have not experienced commercial sexual exploitation do not interact with children who have experienced commercial sexual exploitation.

5. Have awake staff members on duty 24 hours a day, if a safe house.

6. Provide appropriate security through facility design, hardware, technology, staffing, and siting, including, but not limited to, external video monitoring or door exit alarms, a high staff-to-client ratio, or being situated in a remote location that is isolated from major transportation centers and common trafficking areas.

7. Meet other criteria established by department rule, which may include, but are not limited to, personnel qualifications, staffing ratios, and types of services offered.

Section 11. Section 409.1679, Florida Statutes, is repealed.

Section 12. Paragraphs (l) and (m) of subsection (2) of section 409.175, Florida Statutes, are 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) "Residential child-caring agency" means any person, corporation, or agency, public or private, other than the child's parent or legal guardian, that provides staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged. Such residential child-caring agencies include, but are not limited to, maternity homes, runaway shelters, group homes that are administered by an agency, emergency shelters that are not in private residences, qualified residential treatment programs as defined in s. 409.1676, human trafficking safe houses as defined in s. 409.1678, at-risk homes, and wilderness camps. Residential child-caring agencies do not include hospitals, boarding schools, summer or recreation camps, nursing homes, or facilities operated by a governmental agency for the training, treatment, or secure care of delinquent youth, or facilities licensed under s. 393.067 or s. 394.875 or chapter 397.

(m) "Screening" means the act of assessing the background of personnel or level II through level V family foster homes and includes, but is not limited to, criminal history checks as provided in s. 39.0138 and employment history checks as provided in chapter 435, using the level 2 standards for screening set forth in that chapter.

Section 13. Paragraph (a) of subsection (14) of section 39.301, Florida Statutes, is amended to read:

39.301 Initiation of protective investigations.—

(14)(a) If the department or its agent determines that a child requires immediate or long-term protection through medical or other health care or homemaker care, day care, protective supervision, or other services to stabilize the home environment, including intensive family preservation services through the Intensive Crisis Counseling Program, such services shall first be offered for voluntary acceptance unless:

1. There are high-risk factors that may impact the ability of the parents or legal custodians to exercise judgment. Such factors may include the parents' or legal custodians' young age or history of substance abuse, mental illness, or domestic violence; or

2. There is a high likelihood of lack of compliance with preventive ~~voluntary~~ services, and such noncompliance would result in the child being unsafe.

Section 14. Paragraph (b) of subsection (7) of section 39.302, Florida Statutes, is amended to read:

39.302 Protective investigations of institutional child abuse, abandonment, or neglect.—

(7) When an investigation of institutional abuse, neglect, or abandonment is closed and a person is not identified as a caregiver responsible for the abuse, neglect, or abandonment alleged in the report, the fact that the person is named in some capacity in the report may not be used in any way to adversely affect the interests of that person. This prohibition applies to any use of the information in employment screening, licensing, child placement, adoption, or any other decisions by a private adoption agency or a state agency or its contracted providers.

(b) Likewise, if a person is employed as a caregiver in a

residential group home licensed under ~~pursuant to~~ s. 409.175 and is named in any capacity in three or more reports within a 5-year period, the department may review all reports for the purposes of the employment screening required under s. 409.175(2)(m) ~~pursuant to s. 409.145(2)(c)~~.

Section 15. Subsection (15) of section 39.402, Florida Statutes, is amended to read:

39.402 Placement in a shelter.—

(15) The department, at the conclusion of the shelter hearing, shall make available to parents or legal custodians seeking preventive ~~voluntary~~ services any referral information necessary for participation in such identified services to allow the parents or legal custodians to begin the services as soon as possible. The parents' or legal custodians' participation in the services may not be considered an admission or other acknowledgment of the allegations in the shelter petition.

Section 16. Paragraph (d) of subsection (3) of section 39.501, Florida Statutes, is amended to read:

39.501 Petition for dependency.—

(3)

(d) The petitioner must state in the petition, if known, whether:

1. A parent or legal custodian named in the petition has previously unsuccessfully participated in preventive ~~voluntary~~ services offered by the department;

2. A parent or legal custodian named in the petition has participated in mediation and whether a mediation agreement exists;

3. A parent or legal custodian has rejected the preventive

~~voluntary~~ services offered by the department;

4. A parent or legal custodian named in the petition has not fully complied with a safety plan; or

5. The department has determined that preventive ~~voluntary~~ services are not appropriate for the parent or legal custodian and the reasons for such determination.

If the department is the petitioner, it shall provide all safety plans as defined in s. 39.01 involving the parent or legal custodian to the court.

Section 17. Subsection (8) of section 39.6013, Florida Statutes, is amended to read:

39.6013 Case plan amendments.—

(8) Amendments must include service interventions that are the least intrusive into the life of the parent and child, must focus on clearly defined objectives, and must provide the most efficient path to quick reunification or permanent placement given the circumstances of the case and the child's need for safe and proper care. A copy of the amended plan must be immediately given to the persons identified in s. 39.6011(8)(c) ~~s. 39.6011(7)(c)~~.

Section 18. This act shall take effect July 1, 2020.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 6, 2020

I respectfully request that **Senate Bill #1748**, relating to Child Welfare, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Travis Hutson
Florida Senate, District 7

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/18/20
Meeting Date

1748
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name John Paul Fiore

Job Title Legislative Specialist

Address 1317 Winewood Blvd.
Street

Phone 488-9410

Tallahassee FL 32399
City *State* *Zip*

Email

Speaking: ☐ For ☐ Against ☐ Information

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

Representing Dept. of Children and Families

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)

2/18/20
Meeting Date

1748
Bill Number (if applicable)

Topic Child Welfare

Amendment Barcode (if applicable)

Name Mike Cusick

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Speaking: ☐ For ☐ Against ☐ Information

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

Representing St. Augustine Youth Services

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:	CS/SB 1764
INTRODUCER:	Health Policy Committee and Senator Flores
SUBJECT:	Midwifery
DATE:	February 17, 2020
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.	Howard	Kidd	AHS	**Recommend: Favorable**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1764 amends s. 467.015, F.S., to establish additional requirements for midwives when participating in in-hospital or out-of-hospital births. The midwife must advise the patient of certain clinical outcomes and advise, but not require, the patient to consult an obstetrician for more information related to such clinical outcomes and increased risks; measure and record the vital signs upon initial contact with the patient; and transfer care of the patient to a hospital if specified complications occur.

The bill amends s. 467.016, F.S., to specify that the informed consent form developed by the Department of Health (department) is required to be used by a midwife only when providing an out-of-hospital birth. The bill also provides additional requirements on how the form must be signed and what information must be included on the form.

The bill has an insignificant fiscal impact on the department that can be absorbed within existing resources.

The bill takes effect July 1, 2020.

II. Present Situation:

Licensed Midwives

Midwifery is the practice of supervising the conduct of a normal labor and childbirth, with the informed consent of the parent, advising the parents as to the progress of childbirth, and rendering prenatal and postpartal care.[1] The department licenses and regulates the practice of midwifery in this state. The Council of Licensed Midwifery assists and advises the department on midwifery, including the development of rules relating to regulatory requirements, including but not limited to, training requirements, licensure examination, responsibilities of midwives, emergency care plans, and reports and records to be filed by licensed midwives.[2]

An individual must graduate from an approved midwifery program and pass a licensure examination to be eligible for licensure as a midwife.[3] A licensed midwife must submit a general emergency care plan that addresses consultation with other health care providers, emergency transfer protocols, and access to neonatal intensive care units and obstetrical units or other patient care areas with his or her application for licensure and licensure renewal.[4] A licensed midwife must also submit proof of professional liability coverage of at least $100,000, with an annual aggregate of at least $300,000.[5]

A licensed midwife must:[6]

- Accept only those patients who are expected to have a normal pregnancy, labor, and delivery;
- If a patient is not at low risk in her pregnancy, provide collaborative prenatal and postpartal care, within a written protocol with a physician who maintains supervision for directing the specific course of treatment;
- Ensure that each patient has signed an informed consent form approved by the department;
- Administer medicinal drugs pursuant to a prescription issued by a practitioner licensed under ch. 458, F.S., or ch. 459, F.S.;
- Prepare a written plan of action with the family to ensure continuity of medical care and to provide for immediate medical care if an emergency arises;
- Maintain appropriate equipment and supplies and instructing the patient and family regarding the preparation of the environment, if a home birth is planned;
- Instruct the patient in the hygiene of pregnancy and nutrition as it relates to prenatal care;
- Determine the progress of labor, and when birth is imminent, be immediately available until delivery is accomplished;
- Remain with the postpartal mother until the mother and neonate are stabilized;

[1] Section 467.003(8), F.S.
[2] Section 467.004, F.S.
[3] Section 467.011, F.S. Section 467.0125, F.S., provides for licensure by endorsement for applicants who hold a valid license to practice midwifery in another state.
[4] Section 467.017, F.S.
[5] Rule 64B24-7.013, F.A.C. An applicant does not have to submit proof of professional liability insurance if the applicant practices exclusively as an officer, employee, or agent of the federal government, practices only in conjunction with teaching duties at an approved midwifery school that provides such coverage on the applicant's behalf, or who does not practice midwifery in this state and provides proof of such.
[6] Section 467.015, F.S.

- Instill a prophylactic into each eye of the newborn infant within one hour after birth for the prevention of neonatal ophthalmia;[7] and
- Ensure that the care of mothers and infants throughout the prenatal, intrapartal, and postpartal periods conforms to department rules and the state's public health laws.

Risk Assessment

A licensed midwife must assess the risk status of each potential patient to determine whether the licensed midwife can accept the patient or continue caring for the patient.[8] The licensed midwife must obtain a detailed medical history, perform a physical examination, and assess family circumstances along with social and psychological factors. The department provides a scoring system for the factors by rule, which assigns each factor a value of one to three.[9] For example, heart disease assessed by a cardiologist which does not place the mother or fetus at any risk has a score of one and chronic hypertension has a score of three.

If the assessment results in a risk score of three or higher, the licensed midwife must consult with a physician who has obstetrical hospital privileges.[10] If there is a joint determination that the patient can be expected to have a normal pregnancy, labor, and delivery, the licensed midwife may provide services to the patient.[11]

Responsibilities during Pregnancy and Delivery

The Florida Administrative Code outlines a licensed midwife's responsibilities during the antepartum, intrapartum, and postpartum periods. During each of these periods, the licensed midwife must assess the patient for risk factors and either consult with or transfer the patient's care to a physician.

In the antepartum period, a licensed midwife must refer the patient for a consultation with a physician with hospital obstetrical privileges if one of the following occurs:
- Hematocrit of less than 33 percent at 37th week gestation or hemoglobin less than 11 gms/100 ml;
- Unexplained vaginal bleeding;
- Abnormal weight change defined as less than 12 or more than 50 pounds at term;
- Non-vertex presentation persisting past 37th week of gestation;
- Gestational age between 41 and 42 weeks;
- Genital herpes confirmed clinically or by culture at term;
- Documented asthma attack;
- Hyperemesis not responsive to supportive care; or
- Any other severe obstetrical, medical, or surgical problem.

A licensed midwife must transfer a patient if one of the following occurs:
- Genetic or congenital abnormalities or fetal chromosomal disorder;

[7] Section 383.04, F.S.
[8] Rule 64B24-7.004, F.A.C.
[9] Rule 64B24-7.004(3), F.A.C.
[10] Rule 64B24-7.004(1), F.A.C.
[11] Id.

- Multiple gestation;
- Pre-eclampsia;
- Intrauterine growth retardation;
- Thrombophlebitis;
- Pyelonephritis;
- Gestational diabetes confirmed by abnormal glucose tolerance test; or
- Laboratory evidence of Rh sensitization.

The licensed midwife may continue caring for the patient if the condition is resolved satisfactorily and the physician and licensed midwife determine that the patient is expected to have a normal pregnancy, labor, and delivery.[12]

During the intrapartum period or labor, the licensed midwife must consult with or refer or transfer a patient to a physician with hospital obstetrical privileges if one of the following occurs:[13]

- Premature labor, meaning labor occurring at less than 37 weeks of gestation;
- Premature rupture of membranes, meaning rupture occurring more than 12 hours before onset of regular active labor;
- Non-vertex presentation;
- Evidence of fetal distress;
- Abnormal heart tones;
- Moderate or severe meconium staining;
- Estimated fetal weight less than 2,500 grams or greater than 4,000 grams;
- Pregnancy induced hypertension;
- Failure to progress in active labor;
- Severe vulvar varicosities;
- Marked edema of cervix;
- Active bleeding;
- Prolapse of the cord;
- Active infectious process; or
- Other medical or surgical problems.

A licensed midwife may not perform any operative procedures other than clamping and cutting the umbilical cord, episiotomies, suturing to repair first and second degree lacerations, and artificial rupture of the membranes under certain conditions.[14] A licensed midwife may also not attempt to correct a fetal presentation and may not use artificial, forcible, or mechanical means to assist a birth.[15]

A licensed midwife must consult with or refer or transfer an infant under certain conditions, such as if the child has jaundice, respiratory problems, or major congenital anomalies.[16] The licensed midwife must consult with a physician or transfer a mother for emergency care if any postpartum

[12] Rule 64B24-7.007, F.A.C.
[13] Rule 64B24-7.008(4), F.A.C.
[14] Rule 64B24-7.008(5), F.A.C.
[15] Rules 64B24-7.008(6) and 64B24-7.008(8), F.A.C.
[16] Rule 64B24-7.009(2), F.A.C.

complications arise, such as retained placenta or postpartum hemorrhage.[17] The licensed midwife must stay with the mother and infant for at least two hours after the birth or until the mother's and infant's conditions are stable, whichever is longer.[18]

Adverse Incident Reporting

A licensed midwife must submit an adverse incident report to the department within 15 days of an adverse incident occurring, providing a summary of the events that occurred. An adverse incident is an event over which the licensed midwife could exercise control and one of the following occurs:[19]

- A maternal death that occurs during delivery or within 42 days after delivery;
- A maternal patient is transferred to a hospital intensive care unit;
- A maternal patient experiences hemorrhagic shock or requires a transfusion of more than four units of blood or blood products;
- A fetal or newborn death, including a stillbirth, attributable to an obstetrical delivery;
- A newborn patient is transferred to a hospital neonatal intensive care unit (NICU) due to a traumatic birth injury; or
- A newborn patient is transferred to a hospital NICU within 72 hours after birth if the newborn remains in the NICU for more than 72 hours.

The department must review the report and determine whether the incident involves conduct requiring disciplinary action against the licensed midwife's license.[20]

Informed Consent

A licensed midwife must obtain informed consent from the patient on a form developed by the department.[21] The form explains that licensed midwives care for women who have normal, uncomplicated pregnancies and are expecting a normal delivery of a healthy newborn.[22] In signing the informed consent form, the patient acknowledges that:[23]

- The licensed midwife has explained her training and experience;
- The patient is aware of the benefits of natural childbirth relating to avoidance of potential injury resulting from either invasive procedures, anesthesia, or surgical intervention;
- In order to obtain care by the midwife, the patient must:
  - Provide a complete medical, health, and maternity history;
  - Review risk factors and other requirements with the midwife;
  - Maintain a regular schedule for prenatal visits; and
  - Make a plan for emergency care, with the assistance of the midwife, for unforeseen complications that may arise during pregnancy and delivery, as well as any pediatric care necessary for the baby;

[17] Rule 64B24-7.009(5), F.A.C.
[18] Rule 64B24-7.009(4), F.A.C.
[19] Section 456.0495, F.S.
[20] Id.
[21] Section 467.016, F.S.
[22] Form DH-MQA 1047, Rev. 3/01, incorporated by reference in Rule 64B24-7.005, F.A.C., *available at* http://www.floridahealth.gov/licensing-and-regulation/midwifery/resources/_documents/midwife-consent.pdf (last visited Jan. 30, 2020).
[23] Id.

- The licensed midwife provided the status of the midwife's malpractice insurance, including the amount of insurance; and
- The patient had an opportunity to review and discuss information contained in the informed consent form, including; but not limited to the conditions which require the midwife to refer or transfer care.

The form also requires the patient to expressly authorize the licensed midwife to perform maternity services that are within the scope of the midwifery license and provides that a copy of the statute and rules are available upon request.[24]

III. Effect of Proposed Changes:

Section 1 amends s. 467.015, F.S., to require a midwife, whether providing an in-hospital or out-of-hospital birth, to:

- Upon acceptance of a patient into care, advise the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with an individual having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy. The licensed health care practitioner providing out-of-hospital births shall further advise, but may not require, the patient to consult an obstetrician for more information related to such clinical outcomes and increased risks.
- Prepare a written plan of action with the patient and the patient's family, if any, to ensure continuity of medical care throughout labor and delivery and to provide for immediate medical care if an emergency arises.
- Upon initial contact with the patient during the intrapartal period, measure and record the vital signs of the mother and fetus to serve as a baseline during labor and delivery.
- Transfer care of the patient to a hospital with obstetrical services in accordance with the written emergency plan if any of the following occurs or presents during labor or delivery or immediately thereafter:
  - An unexpected nonvertex presentation of the fetus;
  - Indication that the mother's uterus has ruptured;
  - Evidence of severe and persistent fetal or maternal distress;
  - Pregnancy-induced hypertension;
  - An umbilical cord prolapse;
  - An active infectious disease process; or
  - Any other severe emergent condition.

Section 2 amends s. 467.016, F.S., to require a midwife to obtain informed consent using a form developed by the department only when participating in out-of-hospital births. The form must be signed by the practitioner and the patient and a copy of the signed form must be provided to the patient. The form must include:

- A statement advising the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy.
- A detailed statement explaining to the patient hospital admitting privileges and the requirements for a health care practitioner to obtain and maintain such privileges.

[24] *Id.*

- Disclosure of each hospital and specific department, if any, where the health care practitioner providing out-of-hospital births has been granted admitting privileges, including the scope and duration of the admitting privileges, the current contact information for the specific hospital or department that has granted the health care practitioner admitting privileges, and a copy of documentation from the hospital or department providing proof of such admitting privileges. A health care practitioner providing out-of-hospital births who does not have admitting privileges at any hospital must explicitly state that fact on the form.

Section 3 provides that the bill takes effect July 1, 2020.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

CS/SB 1764 has an insignificant fiscal impact on the department that can be absorbed within existing resources.[25] The department may experience a recurring increase in

[25] Florida Department of Health fiscal impact statement on SB 1764 (February 12, 2020) (Email on file with the Senate Appropriations Subcommittee on Health and Human Services).

workload and costs associated with investigations for unlicensed activity related to out-of-hospital births. The impact is unknown, yet it is anticipated that current resources and budget authority are adequate to absorb.

The department will experience a non-recurring increase in workload associated with the development of a uniform patient informed consent form, which current resources are adequate to absorb.

VI. Technical Deficiencies:

The bill amends s. 467.015, F.S., relating to a list of responsibilities for midwives. The bill provides that a midwife must do everything on the list, regardless of whether the midwife is participating in an in-hospital or out-of-hospital birth. However, one aspect of the list is somewhat unclear because it provides a responsibility that "the licensed health care practitioner" must fulfill but only for out-of-hospital births. The latter aspect seems out of place in a list of responsibilities that must be observed in all cases, regardless of whether the birth is in-hospital or out-of-hospital. And, the term "licensed health care practitioner" could pertain to any of numerous types of practitioners, as opposed to midwives specifically.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 467.015 and 467.016.

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 February 4, 2020:
The CS eliminates all provisions of the underlying bill except that the CS requires a midwife, whether participating in an in-hospital or out-of-hospital birth, to:

- Upon acceptance of a patient into care, advise the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with an individual having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy. The licensed health care practitioner providing out-of-hospital births shall further advise, but may not require, the patient to consult an obstetrician for more information related to such clinical outcomes and increased risks.
- For written plans of action required under current law, prepare such plans with the patient and the patient's family, if any.
- Upon initial contact with the patient during the intrapartal period, measure and record the vital signs of the mother and fetus to serve as a baseline during labor and delivery.

- Transfer care of the patient to a hospital with obstetrical services in accordance with the written emergency plan if any of the following occurs or presents during labor or delivery or immediately thereafter:
  - An unexpected nonvertex presentation of the fetus;
  - Indication that the mother's uterus has ruptured;
  - Evidence of severe and persistent fetal or maternal distress;
  - Pregnancy-induced hypertension;
  - An umbilical cord prolapse;
  - Active infectious disease process; or
  - Any other severe emergent condition.

The CS changes the current law requirement for midwives to use an informed consent form to provide certain information to a patient. Under the CS, the informed consent form must be used only for out-of-hospital births and must be signed by the patient and the midwife, and a copy must be provided to the patient. The form must include, at a minimum:

- A statement advising the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy.
- A detailed statement explaining to the patient hospital admitting privileges and the requirements to obtain and maintain such privileges.
- Disclosure of each hospital and specific department, if any, where the health care practitioner providing out-of-hospital births has been granted admitting privileges, including the scope and duration of the admitting privileges, the current contact information for the specific hospital or department that has granted the health care practitioner admitting privileges, and a copy of documentation from the hospital or department providing proof of such admitting privileges. A health care practitioner providing out-of-hospital births who does not have admitting privileges at any hospital must explicitly state that fact on the form.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Flores

588-03103-20 20201764c1

A bill to be entitled

An act relating to midwifery; amending s. 467.015, F.S.; revising responsibilities of licensed midwives providing in-hospital and out-of-hospital births; amending s. 467.016, F.S.; revising the requirements for the uniform patient informed consent form used by licensed midwives providing out-of-hospital births; providing an effective date.

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

Section 1. Subsection (5) of section 467.015, Florida Statutes, is amended to read

467.015 Responsibilities of the midwife.—

(5) The midwife, whether providing an in-hospital or out-of-hospital birth, shall do all of the following:

(a) Upon acceptance of a patient into care, advise the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with an individual having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy. The licensed health care practitioner providing out-of-hospital births shall further advise, but may not require, the patient to consult an obstetrician for more information related to such clinical outcomes and increased risks.

(b) ~~(a)~~ Prepare a written plan of action with the patient and the patient's family, if any, to ensure continuity of medical care throughout labor and delivery and to provide for

588-03103-20 20201764c1

immediate medical care if an emergency arises. The family should have specific plans for medical care throughout the prenatal, intrapartal, and postpartal periods.

(c) ~~(b)~~ If a home birth is planned, instruct the patient and family regarding the preparation of the environment and ensure availability of equipment and supplies needed for delivery and infant care~~, if a home birth is planned~~.

(d) ~~(c)~~ Instruct the patient in the hygiene of pregnancy and nutrition as it relates to prenatal care.

(e) ~~(d)~~ Maintain equipment and supplies in conformity with the rules adopted pursuant to this chapter.

(f) Upon initial contact with the patient during the intrapartal period, measure and record the vital signs of the mother and fetus to serve as a baseline during labor and delivery.

(g) Transfer care of the patient to a hospital with obstetrical services in accordance with the written emergency plan if any of the following occurs or presents during labor or delivery or immediately thereafter:

1. An unexpected nonvertex presentation of the fetus;

2. Indication that the mother's uterus has ruptured;

3. Evidence of severe and persistent fetal or maternal distress;

4. Pregnancy-induced hypertension;

5. An umbilical cord prolapse;

6. An active infectious disease process; or

7. Any other severe emergent condition.

Section 2. Section 467.016, Florida Statutes, is amended to read:

467.016 Informed consent.—The department shall develop a uniform patient informed consent ~~client informed-consent~~ form to be used by the midwife providing out-of-hospital births to inform the patient ~~client~~ of the qualifications of a licensed midwife and the nature and risk of the procedures to be used by a midwife and to obtain the patient's ~~client's~~ consent for the provision of out-of-hospital birth ~~midwifery~~ services. The form must be signed by the patient and the midwife providing out-of-hospital births, and a copy must be provided to the patient. The form shall include, at a minimum, all of the following:

(a) A statement advising the patient of the clinical outcomes of births in low-risk patients during an out-of-hospital birth and any increased risks associated with having a vaginal birth after having a caesarean section, a breech birth, or a multiple gestation pregnancy.

(b) A detailed statement explaining to the patient hospital admitting privileges and the requirements for a health care practitioner to obtain and maintain such privileges.

(c) Disclosure of each hospital and specific department, if any, where the health care practitioner providing out-of-hospital births has been granted admitting privileges, including the scope and duration of the admitting privileges, the current contact information for the specific hospital or department that has granted the health care practitioner admitting privileges, and a copy of documentation from the hospital or department providing proof of such admitting privileges. A health care practitioner providing out-of-hospital births who does not have admitting privileges at any hospital must explicitly state that fact on the form.

Section 3. This act shall take effect July 1, 2020.

THE FLORIDA SENATE

APPEARANCE RECORD

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

2/18/20
Meeting Date

1764
Bill Number (if applicable)

Topic Childbirth / Midwifery

Amendment Barcode (if applicable)

Name Ron Watson

Job Title Lobbyist

Address 3738 Mardon Way
Street

Tallahassee FL 32309
City *State* *Zip*

Phone 850 567-1202

Email watson.strategies@comcast.net

Speaking: ☐ For ☒ Against ☐ Information

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

Representing Midwife Assoc of Florida

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: KN 412 **Case No.:** **Type:**
Caption: Senate Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 2/18/2020 4:02:55 PM
Ends: 2/18/2020 5:59:20 PM **Length: 01:56:26**

4:02:56 PM Sen. Bean (Chair)
4:04:25 PM S 916, Program of All Inclusive Care for the Elderly
4:04:37 PM Sen. Baxley
4:05:05 PM Am. 729942
4:05:09 PM Sen. Baxley
4:06:03 PM Am. 729942 (adopted)
4:06:06 PM S 916 (cont.)
4:06:24 PM Appearances: Keith Arnold, Lobbyist, Florida PACE Providers Association (speaks in support of the bill)
4:07:04 PM Zayne Smith, Associate State Director, AARP (waives in support of the bill)
4:07:23 PM Sen. Baxley
4:07:52 PM S 916 (reported favorably)
4:07:57 PM Sen. Baxley
4:08:13 PM S 1120, Substance Abuse Services
4:08:18 PM Sen. Harrell
4:09:27 PM Am. 851674
4:09:34 PM Sen. Harrell
4:10:28 PM Sen. Rouson
4:10:46 PM Sen. Harrell
4:11:08 PM Sen. Rouson
4:11:24 PM Sen. Harrell
4:11:56 PM Am. 851674 (adopted)
4:12:00 PM S 1120 (cont.)
4:12:02 PM Appearances: Beth Labasky, Consultant, Informed Families of Florida (waives in support of the bill)
4:12:12 PM Shane Messer, Legislative Affairs Director, Florida Council for Behavioral Healthcare (waives in support of the bill)
4:12:21 PM Josh Aubuchon, Attorney, Health Law Section, Florida Bar (waives in support of the bill)
4:12:40 PM Sen. Harrell
4:13:11 PM S 1120 (reported favorably)
4:13:19 PM S 744, Podiatric Medicine
4:13:26 PM Sen. Hooper
4:14:28 PM Sen. Rader
4:14:44 PM Sen. Hooper
4:14:53 PM Sen. Rader
4:15:36 PM Sen. Hooper
4:15:55 PM Sen. Rader
4:16:12 PM Sen. Hooper
4:16:14 PM Sen. Rader
4:16:19 PM Sen. Bean
4:16:25 PM Sen. Hooper
4:16:53 PM Sen. Rader
4:17:31 PM Alan Brown, Health Policy Staff
4:18:10 PM Sen. Hooper
4:18:55 PM Sen. Rader
4:19:02 PM Appearances: Chris Hansen, Ballard Partners, Florida Podiatric Medical Association (Speaks in support of the bill)
4:19:45 PM Corinne Mixon, Lobbyist, Florida Academy of Physician's Assistants (waives in support)
4:20:02 PM Sen. Hooper
4:20:38 PM S 744 (reported favorably)
4:20:52 PM S 1370, Patient Safety Culture Surveys
4:20:57 PM Sen. Harrell
4:22:03 PM Am. 354582
4:22:15 PM Sen. Harrell

4:22:43 PM Am. 354582 (adopted)
4:22:44 PM S 1370 (Cont.)
4:22:57 PM Sen. Rouson
4:23:15 PM Sen. Harrell
4:23:27 PM Sen. Rouson
4:23:51 PM Sen. Harrell
4:24:22 PM Sen. Rader
4:24:30 PM
4:24:55 PM Sen. Harrell
4:25:09 PM Sen. Rader
4:25:31 PM Sen. Harrell
4:25:42 PM Sen. Bean
4:25:48 PM Sen. Rader
4:26:00 PM Sen. Harrell
4:26:14 PM Appearances: Martha DeCastro, VP for Nursing & Clinical Care Policy, Florida Hospital Association (waives in support of the bill)
4:26:22 PM Matthew Choy, Lobbyist, Florida Chamber of Commerce (waives in support of the bill)
4:26:40 PM Sen. Harrell
4:27:05 PM S 1370 (reported favorably)
4:27:19 PM S 1748, Child Welfare
4:27:29 PM Sen. Hutson
4:28:32 PM Appearances: Mike Cusick, Lobbyist, St. Augustine Youth Services (waives in support of the bill)
4:28:41 PM John Paul Fiore, Legislative Specialist, Department of Children and Families (waives in support of the bill)
4:28:55 PM Sen. Hutson
4:29:39 PM S 1748 (reported favorably)
4:29:56 PM S 1548, Child Welfare
4:30:01 PM Sen. Perry
4:30:54 PM Appearances: John Paul Fiore, Legislative Specialist, Department of Children and Families (waives in support of the bill)
4:31:03 PM Patricia Medlock, Assistant Secretary, Department of Children and Families (waives in support of the bill)
4:31:47 PM S 1548 (reported favorably)
4:32:00 PM S 1764, Health Care/Midwifery
4:32:03 PM Sen. Flores
4:33:21 PM Sen. Rader
4:33:38 PM Sen. Flores
4:35:02 PM Appearances: Ron Watson, Lobbyist, Midwife Association of Florida (speaks against the bill)
4:36:57 PM Sen. Flores
4:37:37 PM S 1764 (reported favorably)
4:38:00 PM S 1344, Intermediate Care Facilities
4:38:05 PM Sen. Harrell
4:39:38 PM Am. 180258
4:39:44 PM Sen. Harrell
4:40:32 PM Am. 180258 (adopted)
4:40:35 PM S 1344 (cont.)
4:40:38 PM Appearances: Suzanne Sewell, President & CEO, Florida Association of Rehabilitation Facilities (speaks in support of the bill)
4:42:10 PM Sen. Farmer
4:43:06 PM Sen. Harrell
4:43:56 PM Sen. Farmer
4:44:37 PM Sen. Harrell
4:45:32 PM Sen. Farmer
4:45:36 PM Sen. Rader
4:45:52 PM Sen. Harrell
4:46:39 PM Sen. Rader
4:46:57 PM Sen. Harrell
4:47:39 PM Sen. Bean
4:48:03 PM Sen. Harrell
4:48:48 PM S 1334 (reported favorably)
4:48:53 PM S 1440, Children's Mental Health
4:49:06 PM Sen. Powell
4:50:12 PM Appearances: Angie Gallo, Vice-President, Florida PTA (waives in support of the bill)
4:50:54 PM Sen. Powell

4:51:56 PM S 1440 (reported favorably)
4:52:10 PM S 402, Assisted Living Facilities
4:52:16 PM Sen. Harrell
4:53:12 PM Am. 884902
4:53:21 PM Sen. Harrell
4:56:37 PM Jason Hand, VP of Public Policy, Florida Senior Living Association (waives in support of the amendment)
4:57:03 PM Sen. Flores
4:57:25 PM Sen. Harrell
4:58:11 PM Sen. Rader
4:58:51 PM Sen. Harrell
4:59:34 PM Sen. Rader
5:00:00 PM Sen. Harrell
5:01:03 PM Sen. Farmer
5:01:48 PM Sen. Harrell
5:01:57 PM Am. 884902 (adopted)
5:02:00 PM S 402 (cont.)
5:02:09 PM Appearances: Melanie Bostick, VP, Liberty Partners of Florida, Florida Assisted Living Association (waives in support of the bill)
5:02:14 PM J. Hand (waives in support of the bill)
5:02:21 PM Steve Bahmer, President/CEO, Leading Age Florida (waives in support of the bill)
5:02:28 PM Zayne Smith, Associate State Director, AARP (waives in support of the bill)
5:02:35 PM Cynthia Henderson, Atria Senior Living (waives in support of the bill)
5:02:48 PM Sen. Harrell
5:03:56 PM S 402 (reported favorably)
5:04:30 PM Recording Paused
5:09:09 PM Recording Resumed
5:09:10 PM S 1676, Direct Care Workers
5:09:13 PM Sen. Albritton
5:11:36 PM Sen. Rouson
5:11:58 PM Sen. Albritton
5:12:14 PM Sen. Rouson
5:12:22 PM Am. 823308
5:12:27 PM Sen. Albritton
5:13:36 PM Appearances: Matt Jordan, Lobbyist, Florida Society Respiratory Care (speaks in opposition to the amendment)
5:14:24 PM Bobby Lolley, Executive Director, Home Care Association of Florida (waives in support of the amendment)
5:15:01 PM Am. 823308 (adopted)
5:15:06 PM Am. 226548
5:15:15 PM Sen. Albritton
5:15:36 PM Am. 106048
5:15:43 PM Sen. Albritton
5:15:57 PM Am. 106048 (adopted)
5:16:02 PM Am. 226548 (cont.)
5:16:20 PM Am. 226548 (adopted)
5:16:28 PM Am. 899862
5:16:40 PM Sen. Albritton
5:22:12 PM Sen. Rouson
5:22:31 PM Sen. Albritton
5:23:28 PM Sen. Rouson
5:23:39 PM Sen. Albritton
5:25:07 PM Sen. Rouson
5:25:28 PM Sen. Albritton
5:25:40 PM Sen. Rouson
5:25:56 PM Sen. Albritton
5:27:04 PM Sen. Diaz
5:27:18 PM Sen. Albritton
5:27:48 PM Sen. Hooper
5:27:58 PM Sen. Flores
5:28:18 PM Sen. Albritton
5:28:44 PM Sen. Flores
5:28:44 PM Sen. Albritton

5:29:06 PM Sen. Flores
5:30:11 PM Sen. Harrell
5:30:34 PM Sen. Rader
5:30:43 PM Sen. Albritton
5:31:04 PM Sen. Flores
5:32:37 PM Sen. Albritton
5:32:52 PM Sen. Flores
5:33:27 PM Sen. Albritton
5:34:09 PM Sen. Flores
5:34:20 PM Sen. Albritton
5:34:44 PM Am. 364268
5:34:55 PM Sen. Albritton
5:35:08 PM Am. 364268 (adopted)
5:35:16 PM Am. 745926
5:35:22 PM Sen. Harrell
5:37:10 PM Am. 745926 (adopted)
5:37:17 PM Am. 946852
5:37:21 PM Sen. Albritton
5:38:05 PM Am. 946852 (adopted)
5:38:11 PM Am. 899862 (cont.)
5:38:25 PM Jared Willis, Director of Government Relations, Florida Osteopathic Medical Association (waives in opposition to the amendment)
5:38:37 PM Jean Aertker, Nurse Practitioner, Several Nurse Practitioner Groups in Florida (speaks in support of the amendment)
5:40:04 PM Aariha Ali, Medical Student (speaks in opposition to the amendment)
5:41:10 PM Doug Bell, Lobbyist, Florida Chapter of the American Academy of Pediatrics (waives in opposition to the amendment)
5:41:16 PM Chris Lyon, Lobbyist, Florida Association of Nurse Anesthetists (information only)
5:42:17 PM Michael Nuccio, Physician Assistant, Florida Academy of PAs (waives in opposition to the amendment)
5:42:41 PM Corrine Mixon, Lobbyist, Florida Academy of Physician Assistants (speaks in opposition to the amendment)
5:44:13 PM Brewster Bevis, Senior Vice President, Associated Industries of Florida (speaks in support of the amendment)
5:45:05 PM Dan Schaefer, Medical Student (speaks in opposition of the amendment)
5:45:54 PM Garioth Barr (waives in opposition to the amendment)
5:46:17 PM Ronald Giffler, M.D., President, Florida Medical Association (speaks in opposition to the amendment)
5:48:05 PM Sen. Harrell
5:50:24 PM Sen. Hooper
5:51:23 PM Sen. Farmer
5:53:09 PM Sen. Diaz
5:53:38 PM Sen. Rader
5:56:30 PM Am. 899862 (Adopted)
5:56:36 PM S 1676 (cont.)
5:56:37 PM Appearances: Chris Nuland, Lobbyist, Florida Chapter American College of Physicians (waives in opposition to the bill)
5:56:42 PM Rohan Joseph M.D., Florida Chapter, American College of Surgeons (waives in opposition to the bill)
5:56:45 PM Steve Bahmer, President/CEO, Leading Age Florida (waives in support of the bill)
5:56:47 PM Tanya Jackson, Lobbyist, SEIU1199 Healthcare Workers East (waives in support of the bill)
5:56:51 PM Jennifer Ungrll, Home Care Association of America (waives in support of the bill)
5:56:56 PM Zayne Smith, Associate State Director, AARP (waives in support of the bill)
5:56:57 PM Bob Asztalos, Chief Lobbyist, Florida Health Care Association (waives in support)
5:57:01 PM Pam Irwin, Executive Director, Capital Medical Society (waives in opposition to the bill)
5:57:06 PM Michael Lockwood M.D., Radiologist, Capital Medical Society (waives in opposition to the bill)
5:57:12 PM Jim Daughton, Lobbyist, Florida Academy of Family Physicians (waives in opposition to the bill)
5:57:17 PM B. Lolley (information only)
5:57:22 PM Dr. Christin Alexander, Florida Academy of Family Physicians (waives in opposition to the bill)
5:57:35 PM Seymour R. Rosen, M.D. (waives in opposition to the bill)
5:57:37 PM Sen. Albritton
5:58:45 PM S 1676 (reported favorably)
5:58:54 PM Sen. Rader
5:58:57 PM Sen. Book
5:59:02 PM Sen. Flores

5:59:07 PM Sen. Farmer
5:59:12 PM Sen. Flores