

Professions and Public Health Subcommittee

Tuesday, March 23, 2021
12:45 PM – 3:45 PM
Mashburn Hall (306 HOB)

Meeting Packet

Chris Sprowls
Speaker

Will Robinson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Professions & Public Health Subcommittee

Start Date and Time: Tuesday, March 23, 2021 12:45 pm

End Date and Time: Tuesday, March 23, 2021 03:45 pm

Location: Mashburn Hall (306 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

HB 183 Office of Minority Health and Health Equity by Brown, Joseph
HB 397 Cardiovascular Emergency Protocols and Training by DiCeglie, McClure
HB 627 Alzheimer's Disease and Dementia-Related Disorders Education by Salzman, Plakon
HB 631 Optometry by Rizo
HB 805 Volunteer Ambulance Services by Caruso
HB 1373 Rare Disease Advisory Council by DuBose
HB 1381 Maternal Health Outcomes by Brown
HB 1483 Solicitation of Non-medical Services by Yarborough
HB 1627 Continuing Chiropractic Education by Maggard

Consideration of the following bill(s) with proposed committee substitute(s):

PCS for HB 247 -- Telehealth Practice Standards
PCS for HB 431 -- Practice of Physician Assistants
PCS for HB 1579 -- Health Care Practitioner Discipline

This meeting will be live-streamed on https://thefloridachannel.org/. Persons who wish to attend must register at www.myfloridahouse.gov, and pick up a pass at the Legislative Welcome Center on the 4th Floor of the Capitol beginning one hour before the start of the meeting. Audience seating will be socially distanced and will be available on a first-come, first-served basis. Registration closes three hours before the meeting starts.

NOTICE FINALIZED on 03/19/2021 4:19PM by Osborne.Erin

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 183 Office of Minority Health and Health Equity
SPONSOR(S): Brown
TIED BILLS: **IDEN./SIM. BILLS:** SB 404

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Rahming	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In Florida, minority populations experience higher rates of illness and death from health conditions such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, mental health, asthma, and obesity. The Office of Minority Health and Health Equity (Office), housed within the Department of Health (DOH), is responsible for helping to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental, and other factors which impact health. Under current law, the Office is required to be headed by a Senior Health Equity Officer. The responsibilities of the Senior Health Equity Officer include, but are not limited to, administering the Closing the Gap grant program in a manner that maximizes the impact of the grants in achieving health equity.

HB 183 requires the Office to develop and promote the statewide implementation of policies, programs, and practices that increase health equity for racial and ethnic minority populations in Florida. The bill also requires the Office to work with other state agencies, organizations, and providers to improve the health of racial and ethnic minority populations through data analysis and the development of health policies and programs that will help eliminate health disparities. The bill authorizes the Office to serve as a liaison to and assist the federal Offices of Minority Health and Regional Health Operations, as appropriate, and requires the Office to maintain and annually update specific information on its website.

The bill has significant, negative fiscal impacts on the DOH. See Fiscal Comments.

The bill has no impact on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Present Situation

Health disparities—inequities in the quality of health, health care and health outcomes experienced by groups based on social, racial, ethnic, economic and environmental characteristics—persist nationwide.[1]

In Florida, minority populations experience higher rates of illness and death from health conditions such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, mental health, asthma, and obesity.[2] Poor health outcomes for Blacks, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders are also apparent when comparing their health indicators to Florida's general population.[3]

The Office of Minority Health and Health Equity

In 2004, the Florida Legislature established the Office of Minority Health to serve as the coordinating office within the DOH for consultative services and training in the areas of cultural and linguistic competency, coordination, partnership building, program development and implementation, and other related comprehensive efforts to address the health needs of Florida's minority and underrepresented populations statewide.[4]

In 2016, the Florida Legislature re-named the office the Office of Minority Health and Health Equity (Office).[5] The Office is responsible for helping to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental, and other factors which impact health.[6]

The DOH currently gathers, analyzes, and publishes data regarding disparities in health status and access to health care services on its Florida Health Community Health Assessment Resource Tool Set (FLHealthCHARTS) website, but not on quality of health care.[7] However, the federal Agency for Healthcare Research and Quality does publish data on the quality of healthcare and provides a list of measures and supporting data that can be viewed by race and ethnicity at the state level.[8]

Under current law, the Office is not required to develop and promote statewide implementation of any policies, programs, and practices that may increase health equity for racial and ethnic minority populations in Florida. The Office is also not required to work with other state agencies, organizations, and providers or the federal government to improve the health of racial and ethnic minority populations through data analysis and the development of health policies and programs that will help eliminate health disparities. Rather, the Office is statutorily required to be headed by a Senior Health Equity Officer.[9]

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[1] National Conference of State Legislatures (NCSL), Health Disparities Overview, https://www.ncsl.org/research/health/health-disparities-overview.aspx (last visited Feb. 3, 2021).
[2] Florida Department of Health (DOH), *Health Equity Profile 2019, Health Equity Profile - State Total, Florida 2019*, http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHProfile (last visited Mar. 7, 2021).
[3] *Id*.
[4] Florida Department of Health (DOH), *Minority Health and Health Equity,* http://www.floridahealth.gov/programs-and-services/minority-health/index.html (last visited Mar. 7, 2021).
[5] S. 20.43(9), Florida Statutes.
[6] DOH, *Minority Health Liaisons*, http://www.floridahealth.gov/programs-and-services/minority-health/minority-health-liaisons.html (last visited Feb. 28, 2021).
[7] DOH, *Agency Legislative Bill Analysis for HB 183* (2021), at 7.
[8] Agency for Healthcare Research and Quality, *National Healthcare Quality and Disparities Reports: Florida*, https://nhqrnet.ahrq.gov/inhqrdr/Florida/benchmark/summary/All_Measures/All_Topics (last visited February 28, 2021).
[9] S. 20.43(9), Florida Statutes.

Minority Health Initiatives

Closing the Gap Grant Program

The Office administers multiple health promotion programs including the "Closing the Gap" (CTG) grant program.[10] In 2000, the Legislature created the CTG grant program to improve health outcomes and eliminate racial and ethnic health disparities in Florida by providing grants to increase community-based health and disease prevention activities.[11]

Grants are awarded for one year through a proposal process, and may be renewed annually subject to the availability of funds and the grantee's achievement of quality standards, objectives, and outcomes.[12] Proposals for grants must include:[13]

- The purpose and objectives of the proposed project, including the particular racial or ethnic disparity the project will address from one or more of the following priority areas:
    - Increasing adult and child immunization rates in certain racial and ethnic populations;
    - Improving neighborhood social determinates of health, such as transportation, safety, and food access, as outlined by the Centers for Disease Control and Prevention (CDC), or
    - Decreasing racial and ethnic disparities in:
        - Maternal and infant mortality rates;
        - Morbidity and mortality rates relating to cancer;
        - Morbidity and mortality rates relating to HIV/AIDS;
        - Morbidity and mortality rates relating to cardiovascular disease;
        - Morbidity and mortality rates relating to diabetes;
        - Morbidity and mortality rates relating to sickle cell disease;
        - Morbidity and mortality rates relating to Lupus; or
        - Oral health care.
- The target population and its relevance;
- Methods for obtaining baseline health status data and assessment of community health needs;
- Mechanisms for mobilizing community resources and gaining local commitment;
- Development and implementation of health promotion and disease prevention interventions;
- Mechanisms and strategies for evaluating the project's objectives, procedures, and outcomes;
- A proposed work plan, including a timeline for implementing the project; and
- The likelihood that project activities will occur and continue in the absence of funding. [14]

As the head of the Office, the Senior Health Equity Officer is required to:[15]

- Administer the CTG grant program in a manner that maximizes the impact of the grants in achieving health equity;
- Evaluate the awarded grants to assess the effectiveness and efficiency of the use of funds and to determine best practices;
- Disseminate information on best practices to stakeholders; and
- Ensure that the assessments inform future grant award decisions.

The Office's CTG grant program responsibilities include:[16]

[10] Florida Department of Health, *Minority Health*, http://www.floridahealth.gov/%5C/programs-and-services/minority-health/index.html (last visited Mar. 15, 2021).
[11] Ss. 381.7353–381.7356, F.S. *See also*, *Closing the Gap Grant*, http://www.floridahealth.gov/programs-and-services/minority-health/closing-the-gap.html (last visited Feb. 28, 2021).
[12] S. 381.7356(4), F.S.
[13] S. 381.7355, F.S.
[14] *Id*.
[15] S. 20.43(9), F.S.
[16] DOH, *supra* note 7, at 3.

- Publicizing the availability of funds and establishing an application process for submitting a grant proposal.
- Providing technical assistance and training, including a statewide meeting promoting best practice programs, as requested, to grant recipients.
- Developing uniform data reporting requirements for the purpose of evaluating the performance of the grant recipients and demonstrating improved health outcomes.
- Developing a monitoring process to evaluate progress toward meeting grant objectives.
- Coordinating with existing community-based programs, such as chronic disease community intervention programs, cancer prevention and control programs, diabetes control programs, the Healthy Start program, the Florida Kidcare Program, the HIV/AIDS program, immunization programs, and other related programs at the state and local levels, to avoid duplication of effort and promote consistency.

Implementation of the CTG grant program is subject to a specific appropriation provided in the General Appropriations Act.[17]

Minority Health Liaisons

The Office relies on county health departments and other programs within the DOH to achieve its goals.[18] The Minority Health Liaisons (MHLs), comprised of a representative from each of the 67 county health departments, are the link between local communities and the Office.[19]
The objective of the Office and the MHLs is to improve the health of all residents and visitors across Florida, primarily through increasing public awareness of the importance of minority health and partnering initiatives focused on minority health issues statewide.[20] The Office helps to facilitate these partnerships by coordinating with county health departments, central office divisions/bureaus, and statewide stakeholders, and providing technical assistance to the MHLs on issues related to minority health, health disparities, and other health issues within the state.[21]

Key components of the Office-MHL partnership include:[22]

- Sharing information on minority health and health disparities;
- Coordinating events, such as Take a Loved One to the Doctor Day, National Minority Health Month, and other nationally recognized observances;
- Promoting state and local activities and events to raise awareness of programs and services available to minorities and the underserved populations; and
- Helping meet the mission of the DOH by achieving its primary responsibilities in eliminating health disparities.

The Office's Website

Currently, there are no statutory requirements relating to the maintenance of the Office's website, including what information should be maintained on it or how often it should be updated.

Effect of Proposed Bill

HB 183 requires the Office of Minority Health and Health Equity to develop and promote the statewide implementation of policies, programs, and practices that increase health equity for racial and ethnic minority populations in Florida.

[17] *Id*.
[18] DOH, *supra* note 6.
[19] *Id*.
[20] *Id*.
[21] *Id*.
[22] *Id*.

The bill also requires the Office to use all available resources and pursue funding opportunities to achieve the bill's purpose and work with other state agencies, organizations, and providers to:

- Gather and analyze data regarding disparities in health status, quality of health care, and access to health care services for racial and ethnic minority populations in Florida;
- Develop mechanisms that support better information dissemination and education about health disparities and improve access to and delivery of health care services to racial and ethnic minority populations in Florida;
- Support the MHLs by facilitating access to and the exchange of information related to health promotion, preventive health services, and education in the appropriate use of care;
- Conduct demonstration projects and evaluations to ensure the success and sustainability of policies, programs, and practices that increase health equity in Florida;
- Promote the use of community health workers to improve the cultural competency of services and build individual and community self-sufficiency;
- Gather and analyze data regarding the prevalence of racial and ethnic minority populations at risk of involvement with the criminal justice system, the juvenile justice system, and the foster care system or at risk for homelessness, and any disparities in such involvement or access to appropriate behavioral health services by those populations when compared to other populations in this state;
- Promote the creation of or participation in programs that divert individuals with mental health and substance use disorders from the criminal justice system and ensure the availability of quality behavioral health services to the populations at risk of involvement with the criminal justice system, the juvenile justice system, and the foster care system or at risk for homelessness; and
- Develop and implement programs that improve access to health care services for individuals with limited proficiency in the English language by providing access to bilingual providers or interpretive services.

HB 183 requires the Office to maintain and annually update the following information on its website:

- Current state data on health disparities and issues affecting racial and ethnic minority populations;
- Information about and links to resources available to racial and ethnic minority populations in Florida;
- Resources for providers who wish to improve cultural competency, understand health disparities, and increase the quality of and access to health care services for racial and ethnic minority populations in Florida; and
- Contact information for local minority health liaisons.

The bill requires one representative from each county health department to serve as the MHL and requires MHLs to assist the Office in implementation of the bill. The bill also authorizes the Office to serve as a liaison to and assist the federal Offices of Minority Health and Regional Health Operations, as appropriate.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.735, F.S., relating to the Office of Minority Health and Health Equity.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The DOH will experience an increase in workload and operational costs to implement this bill.[23] The anticipated fiscal impact to implement the bill is $6,079,202, of which $5,728,124 is recurring and $351,078 is non-recurring.[24] This includes 11 full time equivalent employees in the central office and 67 OPS staff in the County Health Departments, one in each county to serve as the MHL.

The bill requires the DOH to "gather and analyze data regarding the prevalence of racial and ethnic minority populations at risk of involvement with the criminal justice system, the juvenile justice system, and the foster care system or at risk for homelessness, and any disparities in such involvement or access to appropriate behavioral health services by those populations when compared to other populations in this state." This may have significant technology and fiscal impacts to the DOH's technology systems and staff and may also require interagency agreements with the Florida Department of Children and Families (DCF), the Florida Department of Corrections (FDC), and the Florida Department of Juvenile Justice (DJJ).[25] If the DCF, FDC, and/or DJJ do not already collect and/or electronically store these data, existing DOH data systems may have to be modified and/or new data systems created to accommodate this activity.[26]

The bill has an insignificant impact on the DOH's technology systems and staff as it relates to the annual update and maintenance of the Office's website; however, as it relates to the requirement that the DOH gather, analyze, and publish data on quality of health care, the fiscal impact is indeterminate.[27]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

[23] DOH, *supra* note 7, at 5.
[24] DOH, *supra* note 7, at 8.
[25] DOH, *supra* note 7, at 7.
[26] *Id*.
[27] *Id*.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Office of Minority Health and Health Equity; creating s. 381.735, F.S.; requiring the Office of Minority Health and Health Equity to develop and promote the statewide implementation of certain policies, programs, and practices; requiring one representative from each county health department to serve as a minority health liaison for a specified purpose; requiring the office to use all available resources and pursue funding opportunities to achieve this purpose; specifying duties for the office; requiring the office to maintain on its website specified information; requiring the office to serve as a liaison to and assist certain federal offices; authorizing the Department of Health to adopt rules; providing an effective date.

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

Section 1. Section 381.735, Florida Statutes, is created to read:

381.735 Office of Minority Health and Health Equity.—

(1) The Office of Minority Health and Health Equity established under s. 20.43(9) shall develop and promote the statewide implementation of policies, programs, and practices

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

that increase health equity in this state, including, but not limited to, increased access to and quality of health care services for racial and ethnic minority populations. One representative from each county health department shall serve as a minority health liaison to assist the office in implementing this section. The office shall use all available resources and pursue opportunities for increased funding to achieve the purpose of this section.

(2) The office shall coordinate with agencies, organizations, and providers across this state to do all of the following:

(a) Gather and analyze data regarding disparities in health status, quality of health care, and access to health care services for racial and ethnic minority populations in this state.

(b) Develop mechanisms that support better information dissemination and education about health disparities and improve access to and delivery of health care services to racial and ethnic minority populations in this state.

(c) Support minority health liaisons by facilitating access to and the exchange of information related to health promotion, preventive health services, and education in the appropriate use of care.

(d) Conduct demonstration projects and evaluations to ensure the success and sustainability of policies, programs, and

practices that increase health equity in this state.

(e) Promote the use of community health workers to improve the cultural competency of services and build individual and community self-sufficiency.

(f) Gather and analyze data regarding the prevalence of racial and ethnic minority populations at risk of involvement with the criminal justice system, the juvenile justice system, and the foster care system or at risk for homelessness, and any disparities in such involvement or access to appropriate behavioral health services by those populations when compared to other populations in this state.

(g) Promote the creation of or participation in programs that divert individuals with mental health and substance use disorders from the criminal justice system and ensure the availability of quality behavioral health services to the populations specified in paragraph (f).

(h) Develop and implement programs that improve access to health care services for individuals with limited proficiency in the English language by providing access to bilingual providers or interpretive services.

(3) The office shall maintain all of the following on its website, updated at least annually:

(a) Current data on health disparities and issues affecting racial and ethnic minority populations in this state.

(b) Information about and links to resources available to

racial and ethnic minority populations in this state.

(c) Resources for providers who wish to improve cultural competency, understand health disparities, and increase the quality of and access to health care services for racial and ethnic minority populations in this state. These resources must include, but need not be limited to, minority health literature, research, and referrals; capacity-building and technical assistance services; and training materials for implementing nationally recognized evidence-based practices for culturally and linguistically appropriate health care services.

(d) Contact information for local minority health liaisons.

(4) The office shall serve as a liaison to and assist the federal Offices of Minority Health and Regional Health Operations, as appropriate.

(5) The department may adopt rules to implement this section.

Section 2. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee
Representative Brown offered the following:

Amendment (with title amendment)

Remove lines 38-71 and insert:

health status, health outcomes, quality of health care, and access to health care services for racial and ethnic minority populations in this state.

(b) Develop mechanisms that support better information dissemination and education about health disparities which lead to improved access to and delivery of health care services to racial and ethnic minority populations in this state.

(c) Support minority health liaisons by facilitating access to and the exchange of information related to health promotion,

preventive health services, and education in the appropriate use of care.

(d) Develop and promote synergistic initiatives between programs, including, but not limited to, programs related to maternal and child health and human immunodeficiency virus and acquired immune deficiency syndrome, to mitigate health disparities for racial and ethnic minority populations in this state.

(e) Promote evaluations of demonstration projects and disseminate the evaluation findings to enhance the success and sustainability of policies, programs, and practices that increase health equity in this state.

(f) Promote the use of community health workers to improve the cultural competency of services and build individual and community self-sufficiency.

(g) Promote the development of programs that improve access to health care services for individuals with limited proficiency in the English language, including persons with disabilities.

(3) The department shall maintain all of the following on its

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

Remove lines 12-15 and insert:

requiring the Department of Health to maintain specified information on its website; requiring the office to serve as a

liaison to and assist certain federal offices; authorizing the department to adopt rules;

PCS for HB 247

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 247 Telehealth Practice Standards
SPONSOR(S): Professions & Public Health Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Professions & Public Health Subcommittee		Grabowski	McElroy

SUMMARY ANALYSIS

Telehealth is the remote provision of health care services through the use of technology. Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.

Current law defines telehealth broadly, but specifies that it does not include audio-only telephone calls, e-mail messages, or facsimile transmission. Health care services may be provided via telehealth by a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member, or a registered out-of-state-health care provider.

Practitioners have the ability to prescribe drugs via telehealth, but state and federal law limits the ability of practitioners to dispense controlled substances using telehealth. Controlled substances are drugs with an increased potential for patient abuse. At present, Florida law prohibits a telehealth provider from using telehealth services to prescribe a controlled substance except when treating:

- A psychiatric disorder;
- An inpatient at a hospital;
- A patient receiving hospice services; and
- A resident of a nursing home facility.

Federal law requires a practitioner to conduct at least one in-person medical evaluation prior to dispensing a controlled substance to a patient via telehealth.

PCS for HB 247 allows practitioners to prescribe schedule III, IV, and V controlled substances using telehealth services.

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

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Telehealth

Telehealth is not a type of health care service but rather is a mechanism for delivery of health care services. Health care professionals use telehealth as a platform to provide traditional health care services in a non-traditional manner. These services include, among others, preventative medicine and the treatment of chronic conditions.[1]

Telehealth, in its modern form,[2] started in the 1960s in large part driven by the military and space technology sectors.[3] Specifically, telehealth was used to remotely monitor physiological measurements of certain military and space program personnel. As this technology became more readily available to the civilian market, telehealth began to be used for linking physicians with patients in remote, rural areas. As advancements were made in telecommunication technology, the use of telehealth became more widespread to include not only rural areas but also urban communities. Due to recent technology advancements and general accessibility, the use of telehealth has spread rapidly and is now becoming integrated into the ongoing operations of hospitals and healthcare systems around the country.[4] In fact, there are currently an estimated 200 telehealth networks, with 3,000 service sites in the U.S.[5]

Telehealth is used to address several problems in the current health care system. Inadequate access to care is one of the primary obstacles to obtaining quality health care.[6] This occurs in both rural areas and urban communities.[7] Telehealth reduces the impact of this issue by providing a mechanism to deliver quality health care, irrespective of the location of a patient or a health care professional. Cost is another barrier to obtaining quality health care.[8] This includes the cost of travel to and from the health care facility, as well as related loss of wages from work absences. Costs are reduced through telehealth by decreasing the time and distance required to travel to the health care professional. Two more issues addressed through telehealth are the reutilization of health care services and hospital readmission. These often occur due to a lack of proper follow-up care by the patient[9] or a chronic condition.[10] These issues however can potentially be avoided through the use of telehealth and telemonitoring.[11]

Regulation of Telehealth in Florida

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[1] U.S. Department of Health and Human Services, *Report to Congress: E-Health and Telemedicine*, (August 2016), available at https://aspe.hhs.gov/system/files/pdf/206751/TelemedicineE-HealthReport.pdf (last visited May 6, 2019).
[2] Historically, telehealth can be traced back to the mid to late 19th century with one of the first published accounts occurring in the early 20th century when electrocardiograph data were transmitted over telephone wires. See *supra* note **Error! Bookmark not defined.** at p. 9.
[3] *Id.*
[4] American Telemedicine Association, *Telehealth Basics*, available at https://www.americantelemed.org/resource/why-telemedicine/ (last visited May 6, 2019).
[5] *Id.*
[6] *Id.*
[7] *Id*.
[8] *Id.*
[9] Post-surgical examination subsequent to a patient's release from a hospital is a prime example. Specifically, infection can occur without proper follow-up and ultimately leads to a readmission to the hospital.
[10] For example, diabetes is a chronic condition which can benefit by treatment through telehealth.
[11] Telemonitoring is the process of using audio, video, and other telecommunications and electronic information processing technologies to monitor the health status of a patient from a distance.

Service Providers

In 2019, the Legislature passed and the Governor signed CS/CS/HB 23, which established a framework for telehealth services in Florida law.[12] The act broadly defines telehealth as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to:

- Assessment, diagnosis, consultation, treatment, and monitoring of a patient;
- Transfer of medical data;
- Patient and professional health-related education;
- Public health services; and
- Health administration.

Telehealth does not include audio-only telephone calls, e-mail messages, or facsimile transmission under Florida law.[13]

Health care services may be provided via telehealth by a Florida-licensed health care practitioner, a practitioner licensed under a multistate health care licensure compact of which Florida is a member,[14] or a registered out-of-state-health care provider.[15]

Florida-licensed telehealth providers, as well as those licensed under a multistate health care licensure compact of which Florida is a member, must be one of the following health care practitioners.[16]

- Behavioral Analyst
- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist
- Dentist
- Dental hygienist
- Midwife
- Speech therapist
- Occupational therapist
- Radiology technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical physicist
- Emergency Medical Technician
- Paramedic
- Massage therapist
- Optician
- Hearing aid specialist
- Clinical laboratory personnel
- Respiratory therapist
- Physical therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic trainer
- Clinical social worker
- Marriage and family therapist
- Mental health counselor

Out-of-state telehealth providers must register biennially with DOH or the applicable board to provide telehealth services, within the relevant scope of practice established by Florida law and rule, to patients in this state. To register or renew registration as an out-of-state telehealth provider, the health care professional must:

- Hold an active and unencumbered license, which is substantially similar to a license issued to a Florida practitioner in the same profession, in a U.S. state or jurisdiction and
- Not have been subject to licensure disciplinary action during the five years before submission of the registration application;[17]
- Not be subject to a pending licensure disciplinary investigation or action;
- Not have had license revoked in any state or jurisdiction;

[12] Ch. 2019-137, L.O.F.
[13] S. 456.47(1), F.S.
[14] Florida is a member of the Nurse Licensure Compact. *See* s. 464.0095, F.S.
[15] *Supra* note 22.
[16] These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.
[17] The bill requires DOH to consult the National Practitioner Data Bank to verify whether adverse information is available for the registrant.

- Designate a registered agent in this state for the service of process;
- Maintain professional liability coverage or financial responsibility, which covers services provided to patients not located in the provider's home state, in the same amount as required for Florida-licensed practitioners;[18] and
- Prominently display a link to the DOH website, described below, which provides public information on registered telehealth providers.[19]

Standards of Practice

Current law sets the standard of care for telehealth providers at the same level as the standard of care for health care practitioners or health care providers providing in-person health care services to patients in this state. This ensures that a patient receives the same standard of care irrespective of the modality used by the health care professional to deliver the services. A patient receiving telehealth services may be in any location at the time services are rendered and a telehealth provider may be in any location when providing telehealth services to a patient.[20]

Practitioners may perform a patient evaluation using telehealth. A practitioner using telehealth is not required to research a patient's medical history or conduct a physical examination of the patient before providing telehealth services to the patient if the telehealth provider is capable of conducting a patient evaluation in a manner consistent with the applicable standard of care sufficient to diagnose and treat the patient when using telehealth.

Controlled Substances

Florida Law

Chapter 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act, classifies controlled substances into five categories, called schedules. These schedules regulate the manufacture, distribution, preparation, and dispensing of the substances listed therein. The distinguishing factors between the different drug schedules are the "potential for abuse"[21] of the substance and whether there is a currently accepted medical use for the substance.[22]

The controlled substance schedules are as follows:

- Schedule I substances have a high potential for abuse and currently have no accepted medical use in the United States, including substances such as cannabis and heroin.[23]
- Schedule II substances have a high potential for abuse and have a currently accepted but severely restricted medical use in the United States, including substances such as raw opium, fentanyl, and codeine.[24]
- Schedule III substances have a potential for abuse less than the substances contained in Schedules I and II and have a currently accepted medical use in the United States, including substances such as stimulants and anabolic steroids.[25]
- Schedule IV substances have a low potential for abuse relative to substances in Schedule III and have a currently accepted medical use in the United States, including substances such as benzodiazepines and barbiturates.[26]

[18] Florida law requires physicians, acupuncturists, chiropractic physicians, dentists, anesthesiologist assistants, advanced practice registered nurses, and licensed midwives to demonstrate $100,000 per claim and an annual aggregate of $300,000 of professional responsibility (*see* ss. 458.320 and 459.0085, F.S.; r. 64B1-12.001. F.A.C; r. 64B2-17.009, F.A.C.; 64B5-17.0105, F.A.C.; rr. 64B8-31.006 and 64B15-7.006, F.A.C.; r. 64B9-4.002, F.A.C.; and r. 64B24-7.013, F.A.C.; respectively). Podiatric physicians must demonstrate professional responsibility in the amount of $100,000 (*see* r. 64B18-14.0072, F.A.C.).
[19] S. 456.47(4), F.S.
[20] S. 456.47(2), F.S.
[21] S. 893.035(3)(a), F.S., defines "potential for abuse" to mean that a substance has properties as a central nervous system stimulant or depressant or a hallucinogen that create a substantial likelihood of its being: 1) used in amounts that create a hazard to the user's health or safety of the community; 2) diverted from legal channels and distributed through illegal channels; or 3) taken on the user's own initiative rather than on the basis of professional medical advice.
[22] *See* s. 893.03, F.S.
[23] S. 893.03(1), F.S.
[24] S. 893.03(2), F.S.
[25] S. 893.03(3), F.S.

- Schedule V substances have a low potential for abuse relative to the substances in Schedule IV and have a currently accepted medical use in the United States, including substances such as mixtures that contain small quantities of opiates, narcotics, or stimulants.[27]

Federal Law

The Federal Controlled Substances Act[28] also classifies controlled substances into schedules based on the potential for abuse and whether there is a currently accepted medical use for the substance. The Drug Enforcement Administration (DEA) is required to consider the following when determining where to schedule a substance:[29]

- The substance's actual or relative potential for abuse;
- Scientific evidence of the substance's pharmacological effect, if known;
- The state of current scientific knowledge regarding the substance;
- The substance's history and current pattern of abuse;
- The scope, duration, and significance of abuse;
- What, if any, risk there is to public health;
- The substance's psychic or physiological dependence liability; and
- Whether the substance is an immediate precursor of a substance already controlled.

Telehealth Prescribing of Controlled Substances

Federal law specifically prohibits prescribing controlled substances via the Internet without an in-person evaluation:[30]

> No controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act may be delivered, distributed, or dispensed by means of the Internet without a valid prescription.[31]

The in-person medical evaluation requires that the patient be in the physical presence of the provider without regard to the presence or conduct of other professionals.[32] However, the Ryan Haight Online Pharmacy Consumer Protection Act,[33] signed into law in October 2008, created a pathway for telehealth practitioners to dispense controlled substances via telehealth. The practitioner is still subject to the requirement that all controlled substance prescriptions be issued for a legitimate purpose by a practitioner acting in the usual course of professional practice. But, once an in-person evaluation of the patient has occurred, the practitioner may provide future prescriptions for controlled substances for that patient using telehealth services.[34]

Florida law currently prohibits a telehealth provider from using telehealth services to prescribe a controlled substance except when treating:

- A psychiatric disorder;
- An inpatient at a hospital licensed under ch. 395, F.S.;
- A patient receiving hospice services as defined under s. 400.601, F.S.;
- A resident of a nursing home facility as defined under s. 400.021(12), F.S.

Effect of Proposed Changes

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[26] S. 893.03(4), F.S.
[27] S. 893.03(5), F.S.
[28] 21 U.S.C. § 812.
[29] 21 U.S.C. § 811(c).
[30] 21 CFR §829
[31] A valid prescription is defined as one issued by a practitioner who has conducted at least one in-person medical evaluation of the patient.
[32] 21 CFR § 829(e)(2).
[33] Ryan Haight Online Consumer Protection Act of 2008, Public Law 110-425 (H.R. 6353).
[34] *Supra* note 40.

PCS for 247 allows practitioners to prescribe Schedule III, IV, and V controlled substances using telehealth services and retains current law restrictions on prescribing Schedule II controlled substances through telehealth.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.47, F.S.; relating to use of telehealth to provide services.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to telehealth practice standards; amending s. 456.47, F.S.; revising prohibition on prescribing controlled substances through telehealth; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 456.47, Florida Statutes, is amended to read:

456.47 Use of telehealth to provide services.—

(2) PRACTICE STANDARDS.—

(c) A telehealth provider may not use telehealth to prescribe a controlled substance listed in Schedule II of section 893.03 unless the controlled substance is prescribed for the following:

1. The treatment of a psychiatric disorder;

2. Inpatient treatment at a hospital licensed under chapter 395;

3. The treatment of a patient receiving hospice services as defined in s. 400.601; or

4. The treatment of a resident of a nursing home facility as defined in s. 400.021.

Section 2. This act shall take effect July 1, 2021.

HB 397

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 397 Cardiovascular Emergency Protocols and Training
SPONSOR(S): DiCeglie
TIED BILLS: **IDEN./SIM. BILLS:** SB 766

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Guzzo	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked. If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attack treatment is most effective if provided when symptoms first occur. Emergency assistance to a person having a heart attack is usually provided by emergency medical technicians (EMTs), paramedics, or a bystander who attempts to administer cardiopulmonary resuscitation (CPR).

Current law requires the medical director of an emergency medical services (EMS) provider to issue standing orders and protocols to its EMTs and paramedics to ensure that patients are transported to facilities that offer a type and level of care appropriate to the patient's medical condition.

The Department of Health (DOH) is responsible for certifying 911 public safety telecommunicators (911 PSTs). To become certified as a 911 PST an applicant is required to receive 232 hours of training, which must include successful completion of a CPR certification class. A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal. Current law does not require the 20-hours of continuing education to include CPR training.

HB 397 requires DOH to annually send a list of providers of adult cardiovascular services to the medical director of each licensed EMS provider. It further requires DOH to develop a sample heart attack triage assessment tool to be posted on its website and distributed to each licensed EMS provider. In addition, the bill requires EMS providers to use a substantially similar assessment tool and requires EMS medical directors to develop and implement assessment, treatment, and transport protocols to ensure heart attack patients are transported to the most appropriate hospital.

The bill also requires a 911 PST to receive two hours of biennial telecommunicator CPR training in order to have their certification renewed. Further, the bill requires DOH to establish a procedure to monitor compliance with the training requirements and authorizes DOH to adjust state revenue funds to a public safety agency based on its employees' compliance with the requirements.

The bill has an insignificant, negative fiscal impact on DOH which can be absorbed within current resources. The bill has no fiscal impact on local government.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Heart Attacks

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked.[1] If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attacks most often occur as a result of ischemic heart disease – also known as coronary heart disease or coronary artery disease, which is caused by plaque build-up inside the coronary arteries. Eventually, an area of plaque can rupture inside of an artery causing a blood clot to form on the plaque's surface. If the blood clot becomes large enough, it can mostly or completely block blood flow through a coronary artery. If the blockage isn't treated quickly, the portion of heart muscle fed by the artery begins to die. Heart attack treatment is most effective if provided when symptoms first occur.[2]

911 Public Safety Telecommunicators

Out-of-hospital cardiac arrest (OHCA) describes the sudden, unexpected loss of heart function, breathing, and consciousness. [3] Every year an estimated 350,000 people have cardiac arrest in the United States in an out-of-hospital environment and only one out of 10 victims survive.[4] 911 public safety telecommunicators (911 PSTs) along with the 911-caller are often the first responders and it is the 911 PST's job to transform the caller into a lay rescuer by instructing them how to perform CPR.[5]

The Department of Health (DOH) is responsible for certifying 911 PSTs.[6] To become certified as a 911 PST an applicant is required to receive 232 hours of training, which must include successful completion of a CPR certification class.[7] A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal, which does not currently include CPR training.[8]

There are currently 8,861 certified 911 PSTs.[9]

Emergency Medical Transport Services

Prehospital life support transport services fall into two general categories – basic life support services (BLS) and advanced life support services (ALS).

BLS services include the assessment or treatment by a person qualified under part III of ch. 401, F.S., through the use of techniques described in the EMT-Basic National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards of the U.S. Department of Transportation.[10] The term includes the administration of oxygen and other techniques that have been

[1] U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, *Heart Attack,* available at https://www.nhlbi.nih.gov/health-topics/heart-attack (last visited Mar. 20, 2021).
[2] Id.
[3] Michael Christopher, *Telecommunicator Cardiopulmonary Resuscitation – A Policy Statement from the American Heart Association,* AHA Journals, Mar. 24, 2020, available at https://www.ahajournals.org/doi/10.1161/CIR.0000000000000744 (last visited Mar. 20, 2021).
[4] Id.
[5] Id.
[6] Section 401.465(2), F.S.
[7] Rule 64J-3.001, F.A.C.
[8] Rule 64J-3.003, F.A.C.
[9] Florida Department of Health, Agency Analysis of 2021 HB 397, (Feb. 24, 2021).
[10] United States Department of Transportation, National Highway Traffic Safety Administration, *National Emergency Medical Services Education Standards*, (January 2009), *available at* https://www.ems.gov/pdf/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited March 20, 2021).

approved and are performed under specific conditions.[11] BLS services are usually performed by EMTs.[12]

ALS services include patient assessment or treatment including the implementation of advanced medical skills such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards.[13] ALS services can be performed on site and are usually provided by physicians or paramedics.[14]

The medical director of an EMS provider is required to issue standing orders and protocols to its EMTs and paramedics to ensure that patients are transported to facilities that offer a type and level of care appropriate to the patient's medical condition.[15] There is currently no express statutory requirement for EMS medical directors to develop and implement transport protocols for heart attack patients.

Adult Cardiovascular Services

There are two levels of hospital program licensure for Adult Cardiovascular Services (ACS). A Level I program is authorized to perform adult percutaneous cardiac intervention (PCI)[16] without onsite cardiac surgery and a Level II program is authorized to perform PCI with onsite cardiac surgery.[17]

For a hospital seeking a Level I ACS program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has: [18]

- Provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations; or
- Discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease;[19] and that it has formalized, written transfer agreement with a hospital that has a Level II program.

A hospital seeking a Level II program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:

- Performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations; or
- Discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

The Agency for Health Care Administration currently maintains a list on its website of hospitals with Level I and Level II ACS programs.[20]

[11] Sections 401.23(7) and (8), F.S.
[12] Ryynanen, et. al, *Is advanced life support better than basic life support in prehospital care? A systematic review*, Scand J Trauma Resusc. Emerg. Med. 2010; 18: 62, (November 23, 2010), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001418/ (last visited March 11, 2021).
[13] Sections 401.23(1) and (2), F.S.
[14] Ryynanen, et. al, supra note 18.
[15] Rule 64J-1.004, F.A.C.
[16] Percutaneous cardiac intervention (PCI), commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease.
[17] Section 395.1055(18)(a), F.S.
[18] S. 408.0361(3)(b), F.S.
[19] Heart condition caused by narrowed heart arteries. This is also called "coronary artery disease" and "coronary heart disease."
[20] Agency for Health Care Administration, Hospital & Outpatient Services Unit, Reports, Cardiovascular – Level I and II ACS, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Reports.shtml (last visited Mar. 20, 2021).

Effect of the Bill

HB 397 requires DOH to annually send a list of providers of adult cardiovascular services to the medical director of each licensed EMS provider. It further requires DOH to develop a sample heart attack triage assessment tool to be posted on its website and distributed to each licensed EMS provider. In addition, the bill requires EMS providers to use a substantially similar assessment tool and requires EMS medical directors to develop and implement assessment, treatment, and transport protocols to ensure heart attack patients are transported to the most appropriate hospital.

The bill also requires a 911 PST to receive two hours of biennial telecommunicator CPR training in order to have their certification renewed. Further, the bill requires DOH to establish a procedure to monitor compliance with the training requirements and authorizes DOH to adjust state revenue funds to a public safety agency based on its employees' compliance with the requirements.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 395.3042, F.S., relating to emergency medical services providers; triage and transportation of heart attack victims to an adult cardiovascular services provider.
Section 2: Amends s. 401.465, F.S., relating to 911 public safety telecommunicator certification.
Section 3: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an insignificant, negative fiscal impact on DOH which can be absorbed within current resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires DOH to establish a procedure to monitor adherence to the training requirements created by the bill and authorizes DOH to adjust state grant or shared revenue funds to a public safety agency as defined in s. 365.171(3)(d), F.S., based on its employees' adherence or failure to adhere to such requirements. [21] DOH does not currently have regulatory authority over public safety agencies as defined in s. 365.171(3)(d), F.S.[22]

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[21] Public safety agency means a functional division of a public agency which provides firefighting, law enforcement, medical, or other emergency services.
[22] *Supra* note 9.

A bill to be entitled

An act relating to cardiovascular emergency protocols and training; creating s. 395.3042, F.S.; requiring the Department of Health to send a list of certain providers of adult cardiovascular services to specified persons and entities annually; requiring the department to develop a sample heart attack-triage assessment tool to be posted on its website and distributed to licensed emergency medical services providers; requiring such providers to use the assessment tool; requiring medical directors of such providers to develop and implement certain specified protocols; requiring that such protocols include the development and implementation of certain plans; requiring the compliance of certain licensed emergency medical services providers; amending s. 401.465, F.S.; providing a definition for the term "telecommunicator cardiopulmonary resuscitation training"; conforming cross-references; requiring certain 911 public safety telecommunicators to receive biannual telecommunicator cardiopulmonary resuscitation training; requiring the department to establish a procedure to monitor adherence to the training requirements; authorizing the department to adjust state grants or shared revenue funds to certain entities based on their

employees' adherence or failure to adhere to the training requirements; providing an effective date.

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

Section 1. Section 395.3042, Florida Statutes, is created to read:

395.3042 Emergency medical services providers; triage and transportation of heart attack victims to an adult cardiovascular services provider.—

(1) By June 1 of each year, the department shall send a list of providers of Level I and Level II adult cardiovascular services to the medical director of each licensed emergency medical services provider in the state.

(2) The department shall develop a sample heart attack-triage assessment tool. The department must post this sample assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider. Each licensed emergency medical services provider must use a heart attack-triage assessment tool that is substantially similar to the sample heart attack-triage assessment tool provided by the department.

(3) The medical director of each licensed emergency medical services provider shall develop and implement assessment, treatment, and transport-destination protocols for

heart attack patients with the intent to assess, treat, and transport heart attack patients to the most appropriate hospital. Such protocols must include the development and implementation of plans for the triage and transport of patients with acute heart attack symptoms.

(4) Each emergency medical services provider licensed under chapter 401 must comply with this section.

Section 2. Subsections (3) and (4) of section 401.465, Florida Statutes, are renumbered as subsections (4) and (5), respectively, paragraphs (d) and (j) of subsection (2) of that section are amended, paragraph (d) is added to subsection (1) of that section, and a new subsection (3) is added to that section, to read:

401.465 911 public safety telecommunicator certification.—

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

(d) "Telecommunicator cardiopulmonary resuscitation training" means specific training, including continuous education, that is evidence based and contains nationally accepted guidelines for high-quality telecommunicator cardiopulmonary resuscitation with the recognition of out-of-hospital cardiac arrest over the telephone and the delivery of telephonic instructions for treating cardiac arrest and performing compression-only cardiopulmonary resuscitation.

(2) PERSONNEL; STANDARDS AND CERTIFICATION.—

(d) The department shall determine whether the applicant

meets the requirements specified in this section and in rules of the department and shall issue a certificate to any person who meets such requirements. Such requirements must include the following:

1. Completion of an appropriate 911 public safety telecommunication training program;

2. Certification under oath that the applicant is not addicted to alcohol or any controlled substance;

3. Certification under oath that the applicant is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

4. Submission of the application fee prescribed in subsection (4) ~~(3)~~;

5. Submission of a completed application to the department which indicates compliance with subparagraphs 1., 2., and 3.; and

6. Effective October 1, 2012, passage of an examination approved by the department which measures the applicant's competency and proficiency in the subject material of the public safety telecommunication training program.

(j)1. The requirement for certification as a 911 public safety telecommunicator is waived for a person employed as a sworn state-certified law enforcement officer, provided the officer:

a. Is selected by his or her chief executive to perform as

a 911 public safety telecommunicator;

b. Performs as a 911 public safety telecommunicator on an occasional or limited basis; and

c. Passes the department-approved examination that measures the competency and proficiency of an applicant in the subject material comprising the public safety telecommunication program.

2. A sworn state-certified law enforcement officer who fails an examination taken under subparagraph 1. must take a department-approved public safety telecommunication training program prior to retaking the examination.

3. The testing required under this paragraph is exempt from the examination fee required under subsection (4) ~~(3)~~.

(3) TELECOMMUNICATOR CARDIOPULMONARY RESUSCITATION TRAINING.—

(a) In addition to the certification and recertification requirements contained in this section, 911 public safety telecommunicators who take telephone calls and provide dispatch functions for emergency medical conditions shall also receive telecommunicator cardiopulmonary resuscitation training every 2 years.

(b) The department shall establish a procedure to monitor adherence to the training requirements of this subsection and may adjust state grant or shared revenue funds to a public safety agency as defined in s. 365.171(3)(d) based on its

employees' adherence or failure to adhere to such requirements.

Section 3. This act shall take effect July 1, 2021.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 431 Practice of Physician Assistants
SPONSOR(S): Professions & Public Health Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Professions & Public Health Subcommittee		Rahming	McElroy

SUMMARY ANALYSIS

Physician Assistants (PAs) are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

PCS for HB 431 revises the practice acts for PAs in chs. 458 and 459. The bill:

- Specifies which PA programs are approved for PA licensure and amends PA licensure and licensure renewal requirements;
- Authorizes PAs to authenticate any document with their signature, certification, stamp, verification, affidavit, or endorsement if the document may also be authenticated by a physician's signature, certification, stamp, verification, affidavit or endorsement;
- Removes the prohibition on PAs prescribing psychiatric medications for those under 18 years of age;
- Removes the restriction on the number of licensed PAs a physician may supervise at any one time;
- Removes the requirement that a PA notify a patient that he or she has the right to see a physician prior to the PA prescribing or dispensing a prescription;
- Authorizes PAs to procure medications and medical devices, with exceptions;
- Authorizes PAs to supervise allopathic and osteopathic medical assistants;
- Authorizes PAs to directly bill and receive payment from third-party payors for the services they deliver;
- Removes obsolete language relating to prescriber numbers;
- Removes the requirement for a licensed PA to notify the DOH in writing within 30 days of employment or after any change in his or her supervising physician; and
- Removes the requirement that PA licensure applicants seeking prescribing authority provide course transcripts.

The bill has an insignificant, negative fiscal impact on the DOH, which can be absorbed within current resources.

The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Physician Assistants

Physician Assistants (PAs) are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

Council on Physician Assistants

The Council consists of five members including one physician who is a member of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and three licensed PAs appointed by the Surgeon General.[1] The appointed physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:[2]

- Making recommendations to the DOH 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 safety in the PAs' clinical practices;
- Denying, restricting, or placing conditions on the license of PAs who fail to meet the licensing requirements; and
- Establishing a formulary of medicinal drugs that PAs may not prescribe.[3]

Licensure and Regulation of PAs

An applicant for a PA license must apply to the DOH, and the DOH must issue a license to a person certified by the Council as having met all of the following requirements:[4]

- Is at least 18 years old;
- Obtained a passing score an entry-level examination approved by the boards, including, but not limited to those examinations administered by the National Commission on Certification of Physician Assistants;
- Completed the application form and paid the applicable application fee;
- Completed the an approved PA training program accredited by a specified organization[5] or community college that has met specified criteria;[6]
- Acknowledged any prior felony convictions;
- Acknowledged any previous revocation or denial of licensure in any state;
- 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; and
- Submitted to a background screening and have no disqualifying offenses.[7]

[1] Ss. 458.347(9) 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 and 459.004, F.S., respectively.
[2] *Id*.
[3] S. 458.347(4)(f), F.S.
[4] Ss. 458.347(7) and 459.022(7), F.S.
[5] The Commission on Accreditation of Allied Health Programs or its successor organization. *Id*.
[6] S. 458.347(6), F.S.
[7] S. 456.0135, F.S.

The DOH may issue a temporary license to a recent approved program graduate who expects to take the first National Commission on Certification of Physician Assistants administered examination available for registration after the applicant's graduation.[8] If an applicant has completed all licensure requirements and is awaiting the next scheduled meeting of the Council, the DOH may issue up to two temporary licenses to practice.[9] The temporary license expires 30 days after an applicant receives his or her scores of the proficiency examination and authorizes an applicant who has passed the examination to be granted permanent licensure.[10] Applicants who fail the examination can no longer hold a temporary license, unless they reapply for a 1-year extension of the temporary license.[11]

Within 30 days after gaining employment as a PA, licensed PAs must provide written notice with specified information to the DOH or after any subsequent changes in the supervising physician. PAs must renew their licenses biennially. During each biennial renewal cycle PAs must complete 100 hours of continuing medical education (CME) or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.[12] To maintain certification, PAs must also take a recertification examination every 10 years.[13]

PA Education

PA education programs are typically three years and award master's degrees.[14] Many programs require students to have health care experience as a condition for admission.[15] PA students receive classroom training in:[16]

- Anatomy;
- Physiology;
- Biochemistry;
- Pharmacology;
- Physical diagnosis;
- Pathophysiology;
- Microbiology;
- Clinical laboratory science;
- Behavioral science; and
- Medical Ethics.

A PA student must also complete approximately 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities.[17] A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.[18]

[8] Ss. 458.347(7) and 459.002(7), F.S.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] Ss. 458.347(7)(c) and 459.022(7)(c), F.S.
[13] National Commission on Certification of Physician Assistants, *Maintaining Certification*, https://www.nccpa.net/CertificationProcess (last visited Feb. 15, 2021).
[14] American Academy of PAs, *Become a PA*, https://www.aapa.org/career-central/become-a-pa/ (last visited Feb. 15, 2021).
[15] *Id*.
[16] *Id*.
[17] *Id*.
[18] *Id*.

PA Scope of Practice

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[19] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[20] The supervising physician may not supervise more than four PAs at any time and may not be required to review and cosign charts or medical records prepared by a PA under their supervision.[21] The supervising physician is also responsible and liable for any acts or omissions of the PA.[22]

The Boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to responsibly exercise control and provide direction over the services of the PA. Whether the supervision of a PA is adequate, is dependent upon the: [23]

- 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[24] based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[25] A supervising physician may delegate the authority for a fully licensed PA to:[26]

- Prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed in the formulary[27] established by the Council and:
    - The PA notifies a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription;
    - The supervising physician notifies the DOH of his or her intention to delegate such authority; and
    - The PA completes a minimum of 10 CME hours in the specialty practice in which the PA has prescriptive privileges with each licensure renewal. Three of the 10 CME hours that allopathic PAs are required to take must consist of a continuing education course on the safe and effective prescribing of specified controlled substances. Presently, osteopathic PAs do not have this requirement. [28]
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of chapter 400, F.S.;[29] and

[19] Ss. 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.
[20] Rr. 64B8-30.012 and 64B15-6.010, F.A.C.
[21] Ss. 458.347(3) and 459.022 (3), F.S.
[22] Ss. 458.347(15) and 459.022(15), F.S.
[23] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[24] "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 easy availability of the supervising physician to the physician assistant, which includes the ability to communicate by telecommunications. The supervising physician must be within reasonable physical proximity. *See* Rr. 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[25] Rr. 64B8-30.012(2), F.A.C., and 64B15-6.010(2), F.A.C.
[26] Ss. 458.347(4)(e) and 459.022(4)(e), F.S.
[27] Ss. 458.347(4)(f), F.S., and 459.022(4)(e). The formulary in rr. 64B8-30.008, F.A.C., 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 7-day supply. The rules also authorize PAs to order medicinal drugs for a hospitalized patient of the supervising physician and administer medicinal drugs under the direction and supervision of the physician.
[28] Ss. 458.347(4)(e) and 459.022(4)(e), F.S.
[29] Ss. 459.347(4)(f) and 459.022(4)(f), F.S. 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.

- Perform any other service that is not expressly prohibited in ch. 458, F.S., ch. 459, F.S., or the rules adopted thereunder.

Prescribing practitioners also required to register with the federal Drug Enforcement Administration. The DOH may also issue a prescriber number to the PA, which grants a PA authority for prescribing medicinal drugs authorized under current law.[30] The inclusion of the prescriber number creates a presumption that the PA is authorized to prescribe the medicinal drug and the prescription is valid.[31] Currently, when a PA indicates they want prescribing authority and submits the requisite training, rather than issue a "prescriber number," the DOH places a modifier on a PA's license so that its license verification page (shown below) indicates they are an authorized prescribing PA:[32]

Adverse Incident Reporting

A PA must report to the DOH any adverse incident occurring in an office practice setting within 15 days after the occurrence of the adverse incident.[33] The DOH must review each report to determine if discipline against the PA's license is warranted.[34]

An adverse incident in an office setting is defined as an event over which the PA could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:[35]

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
    - A wrong-site surgical procedure;
    - A wrong surgical procedure; or
    - A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any condition that required the transfer of a patient to a hospital from an ambulatory surgical center or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

Effect of Proposed Changes

PCS for HB 413 authorizes a PA to authenticate any document with their signature, certification, stamp, verification, affidavit, or endorsement if it may be so authenticated by a physician's signature, certification, stamp, verification, affidavit, or endorsement, including, but not limited to:

- Baker Act commitments;
- Do-not-resuscitate (DNR) orders or physician orders for the administration of life-sustaining procedures;
- Death certificates;
- School physicals;
- Medical evaluations for workers' compensation claims; and

[30] Ss. 459.347 (4)(e) and 459.022 (4)(e), F.S.
[31] *Id*.
[32] Email from Andrew Love, Director of Legislative Affairs, Florida Department of Health, RE: HB 431 Data Request, regarding issuance of prescriber numbers (Mar. 19, 2014).
[33] Ss. 458.351 and 459.026, F.S.
[34] Ss. 458.351(5) and 459.026(5), F.S.
[35] Ss. 458.351(4) and 459.026(4), F.S.

- Physical, occupational, speech therapy, home health services, or durable medical equipment orders.

The bill removes from current law:

- The prohibition on PAs prescribing psychiatric medications for those under 18 years of age;
- The restriction on the number of licensed PAs a physician may supervise at any one time;
- The requirement that a PA notify a patient that he or she has the right to see a physician prior to the PA prescribing or dispensing a prescription;
- The requirement for a licensed PA to notify the DOH in writing within 30 days of employment or after any change in his or her supervising physician; and
- Obsolete language relating to prescriber numbers.

The bill also authorizes PAs to:

- Procure drugs and medical devices, unless the medication is listed on the formulary;
- Supervise allopathic and osteopathic medical assistants; and
- Directly bill and receive payment from third-party payors for the services they deliver.

The bill maintains the requirement that the Council recommend PA education and training programs to the Board of Medicine or the Board of Osteopathic Medicine for approval, but specifies that the board may only approve PA programs accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc. The bill also amends the examination type that a PA is required to pass to obtain licensure, moving from an entry-level examination approved by the boards to the PANCE examination administered by the National Commission on Certification of Physician assistants or its successor entity.

The bill maintains the current age requirement for a PA applicant and adds additional licensure requirements including:

- Graduating from an approved program;
  - Specified graduation requirements must be met; and
- Obtaining a passing score on the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants or its successor organization.

The bill removes the allopathic PA only requirement for 10 CME hours in the specialty practice in which the PA has prescriptive privileges and requires three of the 100 CME hours required biennially for all PA licensure renewal consist of a course on the safe and effective prescribing of specified controlled substances.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 458.347, F.S., relating to physician assistants.
Section 2: Amends s. 459.022, F.S., relating to physician assistants.
Section 3: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The bill has an insignificant, negative fiscal impact on the DOH, which can be absorbed within current resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the practice of physician assistants; amending ss. 458.347 and 459.022, F.S.; F.S.; providing legislative intent; revising and providing definitions; authorizing a licensed physician assistant to provide a signature, certification, stamp, verification, affidavit, or endorsement for specified reasons; providing applicability; deleting a provision relating to the performance of medical services by a trainee; revising an accreditation requirement to come from the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor organization, or, if before 2001, its predecessor organization; authorizing a trainee to perform medical services within the scope of an approved program; revising physician assistant licensure requirements for each applicant recommended by the Council on Physician Assistants; providing direct billing and reimbursement requirements for a physician assistant; providing an effective date.

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

Section 1. Section 458.347, Florida Statutes, is amended

to read:

458.347 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training and experience in the field of medicine, to practice medicine in collaboration with physicians and other health practitioners to provide increased efficiency and to ensure high-quality medical services are available at a reasonable cost ~~encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare~~.

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that he or she can operate efficiently and effectively in the specialty areas in which he or she has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by physicians and to allow for innovative development of programs for the education of physician assistants.~~

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

(a) "Approved program" means a physician assistant program in the United States, or any possession or territory thereof,

accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor organization, or, if before 2001, its predecessor organization. ~~formally approved by the boards, for the education of physician assistants.~~

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(c) "Council" means the Council on Physician Assistants.

(d) "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a healthcare professional who meets qualifications defined in this chapter or chapter 459 and is licensed to practice medicine as provided in this chapter or chapter 459 ~~person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician~~.

(f) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

(g) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants or its successor agency ~~"Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants~~.

(h) "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time.~~ A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice shall be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver. ~~This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.~~

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and

established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant ~~and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician may procure drugs and medical devise unless the medication is listed on the formulary created pursuant to this paragraph ~~The physician assistant must~~

~~complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit~~.

~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain, in addition to the supervising physician's name, address, and telephone number~~,~~ of the physician assistant~~'s prescriber number~~. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed

under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f)1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. ~~The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.~~

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, a deletion, or a modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the

formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) A physician assistant may authenticate any document with their signature, certification, stamp, verification, affidavit or endorsement if it may be so authenticated by the

signature, certification, stamp, verification, affidavit or endorsement of a physician, including but not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463 (Baker Act);

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment;

3. Death certificates;

4. School physical examinations;

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02; and

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

~~(5) PERFORMANCE BY TRAINEES. Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

(6) PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician

assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant, Inc., ~~Commission on Accreditation of Allied Health Programs~~ or its successor organization or, if before 2001, its predecessor organization. ~~Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians.~~

(b) Notwithstanding any other provision of law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in~~

~~subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect.~~

(7) PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor organization.

b. For an applicant who graduated before December 31, 2020, has received a baccalaureate or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification from the boards as a physician assistant.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in subparagraph(a)2., but who passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants prior to 1986.

3.~~2.~~ Has obtained ~~satisfactorily passed~~ a passing ~~proficiency examination by an acceptable~~ score as established by the National Commission on Certification of Physician Assistants or its successor and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an

application fee not to exceed $300 as set by the boards. An application for licensure made by a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program specified in subsection (6).

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

(b)1. The license must be renewed biennially. Each renewal must include:

a. A renewal fee not to exceed $500 as set by the boards.

b. Acknowledgment of no felony convictions in the previous 2 years.

c. A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 458.3191 and must contain the same information required in s. 458.3191(1) and (2).

2. Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the

physician assistant workforce surveys to the boards.

3. The department shall adopt rules to implement this paragraph.

(c) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants or its successor organization. Three hours of the continuing medical education must consist of the safe and effective prescribing of controlled substances designated by the Florida Academy of Physician Assistants category I credit.

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(d)~~(e)~~ Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (6), who expects to take the first examination administered by the National Commission on Certification of Physician Assistants available for registration after the applicant's graduation, a temporary license. The temporary license shall expire 30 days after receipt of scores of the proficiency examination administered by the National

Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment but must comply with paragraph (d). An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(e)~~(f)~~ The Board of Medicine may impose any of the penalties authorized under ss. 456.072 and 458.331(2) upon a physician assistant if the physician assistant or the

supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(f)~~(g)~~ An application or other documentation required to be submitted to the department under this subsection may be submitted electronically.

(8) DELEGATION OF POWERS AND DUTIES.—The boards may delegate such powers and duties to the council as they may deem proper.

(9) COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on Physician Assistants is created within the department.

(a) The council shall consist of five members appointed as follows:

1. The chairperson of the Board of Medicine shall appoint one member who is a physician and member of the Board of Medicine who supervises a physician assistant in the physician's practice.

2. The chairperson of the Board of Osteopathic Medicine shall appoint one member who is a physician and member of the Board of Osteopathic Medicine who supervises a physician assistant in the physician's practice.

3. The State Surgeon General or his or her designee shall appoint three fully licensed physician assistants licensed under this chapter or chapter 459.

(b) Members shall be appointed to terms of 4 years, except

that of the initial appointments, two members shall be appointed to terms of 2 years, two members shall be appointed to terms of 3 years, and one member shall be appointed to a term of 4 years, as established by rule of the boards. Council members may not serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

1. Recommend to the department the licensure of physician assistants.

2. Develop all rules regulating the use of physician assistants by physicians under this chapter and chapter 459, except for rules relating to the formulary developed under paragraph (4)(f). The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with

particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all matters relating to physician assistants.

4. Address concerns and problems of practicing physician assistants in order to improve safety in the clinical practices of licensed physician assistants.

(d) When the council finds that an applicant for licensure has failed to meet, to the council's satisfaction, each of the requirements for licensure set forth in this section, the council may enter an order to:

1. Refuse to certify the applicant for licensure;

2. Approve the applicant for licensure with restrictions on the scope of practice or license; or

3. Approve the applicant for conditional licensure. Such conditions may include placement of the licensee on probation for a period of time and subject to such conditions as the council may specify, including but not limited to, requiring the licensee 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.

(10) INACTIVE AND DELINQUENT STATUS.—A license on inactive or delinquent status may be reactivated only as provided in s. 456.036.

(11) PENALTY.—Any person who has not been licensed by the

council and approved by the department and who holds himself or herself out as a physician assistant or who uses any other term in indicating or implying that he or she is a physician assistant commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.084 or by a fine not exceeding $5,000.

(12) DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—The boards may deny, suspend, or revoke a physician assistant license if a board determines that the physician assistant has violated this chapter.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (7) and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

(14) EXISTING PROGRAMS.—This section does not eliminate or supersede existing laws relating to other paramedical professions or services and is supplemental to all such existing laws relating to the licensure and practice of paramedical professions.

(15) LIABILITY.—Each supervising physician using a physician assistant is liable for any acts or omissions of the physician assistant acting under the physician's supervision and control.

(16) LEGAL SERVICES.—Legal services shall be provided to the council pursuant to s. 456.009(1).

(17) FEES.—The department shall allocate the fees collected under this section to the council.

Section 2. Section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training and experience in the field of medicine, to practice medicine in collaboration with physicians and other health practitioners to provide increased efficiency and to ensure high-quality medical services are available at a reasonable cost ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare~~.

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians~~

~~and to allow for innovative development of programs for the education of physician assistants.~~

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

(a) "Approved program" means a physician assistant program in the United States, or any possession or territory thereof, accredited by the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor organization, or, if before 2001, its predecessor organization. ~~formally approved by the boards, for the education of physician assistants.~~

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(c) "Council" means the Council on Physician Assistants.

(d) "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a healthcare professional who meets qualifications defined in this chapter or chapter 458 and is licensed to practice medicine as provided in this chapter or chapter 458 ~~person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician~~.

(f) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician

for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

(g) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination (PANCE) administered by the National Commission on Certification of Physician Assistants or its successor agency ~~"Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants~~.

(h) "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician~~

~~assistants at any one time.~~ A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(b) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice shall be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver. ~~This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.~~

(c) Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(d) A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant ~~and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is

registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician may procure drugs and medical devise unless the medication is listed on the formulary created pursuant to this paragraph ~~The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal~~.

~~4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain, in addition to the supervising physician's name, address, and telephone number~~,~~ of the physician assistant~~'s prescriber number~~. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.~~

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

(f)1. ~~The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply.~~

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 458, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, a deletion, or a modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having

prescribing authority under this section or s. 458.437, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (e).

(g)~~(f)~~ A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h)~~(g)~~ A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(i) A physician assistant may authenticate any document with their signature, certification, stamp, verification, affidavit or endorsement if it may be so authenticated by the signature, certification, stamp, verification, affidavit or endorsement of a physician, including but not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463 (Baker Act);

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment;

3. Death certificates;

4. School physical examinations;

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02; and

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter and chapter 458.

~~(5) PERFORMANCE BY TRAINEES. Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

(6) PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant, Inc., ~~Commission on Accreditation of Allied Health Programs~~ or its successor organization or, if before 2001, its predecessor organization.

(b) Notwithstanding any other provision of law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

(7) PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant, Inc., or its successor organization.

b. For an applicant who graduated before December 31, 2020, has received a baccalaureate or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has

graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification from the boards as a physician assistant.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in subparagraph(a)2., but who passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants prior to 1986.

3.~~2.~~ Has obtained ~~satisfactorily passed~~ a passing ~~proficiency examination by an acceptable~~ score as established by the National Commission on Certification of Physician Assistants or its successor and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An

application for licensure made by a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program specified in subsection (6).

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

(b)1. The licensure must be renewed biennially. Each renewal must include:

a. A renewal fee not to exceed $500 as set by the boards.

b. Acknowledgment of no felony convictions in the previous 2 years.

c. A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 459.0081 and must contain the same information required under s. 459.0081(1) and (2).

2. Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the physician assistant workforce surveys to the boards.

3. The department shall adopt rules to implement this paragraph.

(c) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants or its successor organization. Three hours of the continuing medical education must consist of the safe and effective prescribing of controlled substances designated by the Florida Academy of Physician Assistants category I credit.

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(d)~~(e)~~ Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (6), a temporary license to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice to physician assistant applicants based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be

reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed prior to employment, but must comply with paragraph (d). An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed, but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until she or he passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(e)~~(f)~~ The Board of Osteopathic Medicine may impose any of the penalties authorized under ss. 456.072 and 459.015(2) upon a physician assistant if the physician assistant or the supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(f)~~(g)~~ An application or other documentation required to

be submitted to the department under this subsection may be submitted electronically.

(8) DELEGATION OF POWERS AND DUTIES.—The boards may delegate such powers and duties to the council as they may deem proper.

(9) COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on Physician Assistants is created within the department.

(a) The council shall consist of five members appointed as follows:

1. The chairperson of the Board of Medicine shall appoint one member who is a physician and member of the Board of Medicine who supervises a physician assistant in the physician's practice.

2. The chairperson of the Board of Osteopathic Medicine shall appoint one member who is a physician and member of the Board of Osteopathic Medicine who supervises a physician assistant in the physician's practice.

3. The State Surgeon General or her or his designee shall appoint three fully licensed physician assistants licensed under chapter 458 or this chapter.

(b) Members shall be appointed to terms of 4 years, except that of the initial appointments, two members shall be appointed to terms of 2 years, two members shall be appointed to terms of 3 years, and one member shall be appointed to a term of 4 years, as established by rule of the boards. Council members may not

serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

1. Recommend to the department the licensure of physician assistants.

2. Develop all rules regulating the use of physician assistants by physicians under chapter 458 and this chapter, except for rules relating to the formulary developed under s. 458.347. The council shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all matters relating to physician assistants.

4. Address concerns and problems of practicing physician assistants in order to improve safety in the clinical practices of licensed physician assistants.

(d) When the council finds that an applicant for licensure has failed to meet, to the council's satisfaction, each of the requirements for licensure set forth in this section, the council may enter an order to:

1. Refuse to certify the applicant for licensure;

2. Approve the applicant for licensure with restrictions on the scope of practice or license; or

3. Approve the applicant for conditional licensure. Such conditions may include placement of the licensee on probation for a period of time and subject to such conditions as the council may specify, including but not limited to, requiring the licensee 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.

(10) INACTIVE AND DELINQUENT STATUS.—A license on inactive or delinquent status may be reactivated only as provided in s. 456.036.

(11) PENALTY.—Any person who has not been licensed by the council and approved by the department and who holds herself or himself out as a physician assistant or who uses any other term in indicating or implying that she or he is a physician assistant commits a felony of the third degree, punishable as

provided in s. 775.082 or s. 775.084 or by a fine not exceeding $5,000.

(12) DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—The boards may deny, suspend, or revoke a physician assistant license if a board determines that the physician assistant has violated this chapter.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (7) and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

(14) EXISTING PROGRAMS.—This section does not eliminate or supersede existing laws relating to other paramedical professions or services and is supplemental to all such existing laws relating to the licensure and practice of paramedical professions.

(15) LIABILITY.—Each supervising physician using a physician assistant is liable for any acts or omissions of the physician assistant acting under the physician's supervision and control.

(16) LEGAL SERVICES.—Legal services shall be provided to the council pursuant to s. 456.009(1).

(17) FEES.—The department shall allocate the fees collected under this section to the council.

Section 3. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 627 Alzheimer's Disease and Dementia-Related Disorders Education
SPONSOR(S): Salzman
TIED BILLS: **IDEN./SIM. BILLS:** SB 874

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Grabowski	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Alzheimer's disease is the most prevalent form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain. Alzheimer's disease accounts for 60 to 80 percent of dementia cases. There are an estimated 5.8 million people in the United States with Alzheimer's disease, including 5.6 million people aged 65 and older and 200,000 individuals under age 65 who have younger-onset Alzheimer's disease.

Florida has several programs and initiatives under the oversight of the Department of Elder Affairs (DOEA) that provide resources and support for individuals suffering from Alzheimer's disease and other dementia-related disorders. These include:

- The Alzheimer's Disease Initiative;
- The Purple Ribbon Task Force and Alzheimer's Disease State Plan;
- The Alzheimer's Disease Advisory Committee; and
- The Dementia Care and Cure Initiative.

The Florida Department of Health (DOH) licenses physicians, osteopathic physicians, and nursing professionals who provide care, among others, to patients with Alzheimer's disease and other dementia-related disorders.

The bill requires DOH, in partnership with DOEA and the Alzheimer's Association, to provide information to educate physicians and nursing professionals about Alzheimer's disease and dementia-related disorders. This effort will occur through existing public health and community outreach programs and include education on:

- The importance of early detection and timely diagnosis of cognitive impairment;
- Utilization of a validated cognitive assessment tool;
- The value of Medicare annual wellness visits for cognitive health;
- The use of the Medicare billing code for care planning for individuals with cognitive impairment;
- Methods to detect early warning signs of Alzheimer's disease and other types of dementia; and,
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and other types of dementia.

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

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Alzheimer's Disease

Alzheimer's disease is a form of dementia, a general term for memory loss. It is a progressive brain disorder that damages and eventually destroys brain cells, leading to memory loss and changes in the functions of the brain. Alzheimer's disease accounts for 60 to 80 percent of dementia cases. Alzheimer's disease is a progressive disease in which dementia symptoms worsen gradually over time. In the early stages of Alzheimer's disease, memory loss is mild; in late-stage, individuals lose the ability to carry on a conversation and respond to their environment. Currently, the disease has no cure, but treatment can temporarily slow the worsening of symptoms.[1]

There are an estimated 5.8 million people in the United States with Alzheimer's disease, including 5.6 million people aged 65 and older and 200,000 individuals under age 65 who have younger-onset Alzheimer's disease.[2] By 2050, the number of people age 65 and older with Alzheimer's disease in the U.S. is expected to nearly triple to a projected 13.8 million people.[3]

Florida has an increasing number of individuals with Alzheimer's disease. An estimated 560,000 Floridians have Alzheimer's disease.[4] The projected number of Floridians with Alzheimer's disease is estimated to increase by 28.6% to 720,000 individuals by 2025.[5]

Alzheimer's Disease Initiative

Section 430.503, F.S., creates the Alzheimer's Disease Initiative (ADI) within the Department of Elder Affairs (DOEA).[6] The Alzheimer's Disease Initiative is a statewide program that provides services to individuals and families affected by Alzheimer's disease. The ADI includes the following programs:[7]

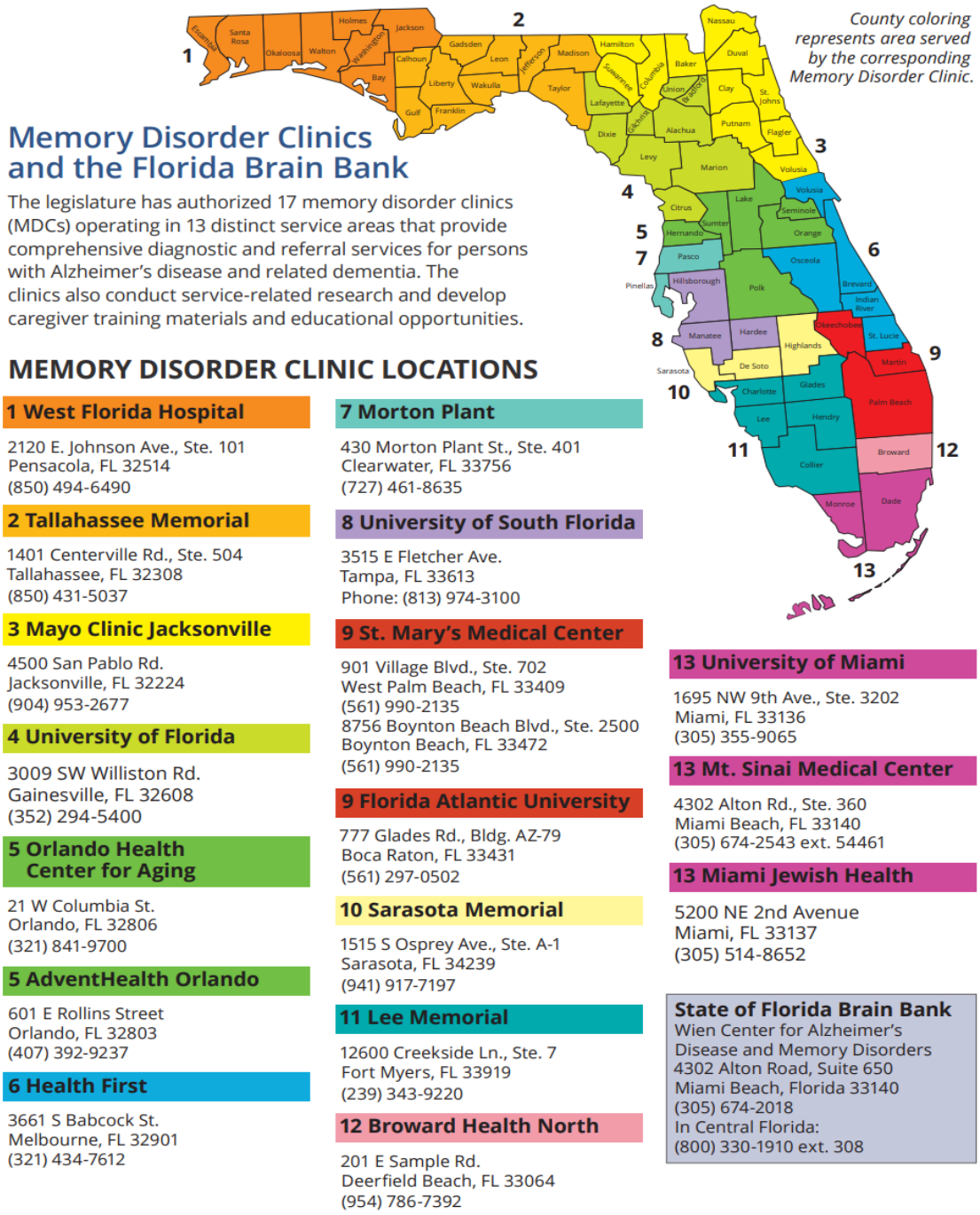
- Respite care and other support services for caregivers;
- Memory Disorder Clinics;
- Specialized Alzheimer's Adult Day Care Centers; and
- The Florida Alzheimer's Brain Bank, which is a service- and research-oriented network of regional sites which collect and study the brains of deceased dementia patients.[8]

[1] Alzheimer's Association, *What is Alzheimer's?*, http://www.alz.org/alzheimers_disease_what_is_alzheimers.asp (last accessed March 17, 2021).
[2] Alzheimer's Association, *2019 Alzheimer's Disease Facts and Figures*, https://www.alz.org/media/Documents/alzheimers-facts-and-figures-2019-r.pdf (last accessed March 17, 2021).
[3] Id.
[4] Alzheimer's Association, *Alzheimer's Statistics: Florida*, https://alz.org/getmedia/4d0840b6-0baa-4b97-8a0e-1775cfbf44a4/statesheet_florida (last accessed March 17, 2021).
[5] Id.
[6] S. 430.503(1), F.S.
[7] Florida Department of Elder Affairs, *Alzheimer's Disease Initiative,* http://elderaffairs.state.fl.us/doea/alz.php (last accessed March 17, 2021).
[8] Florida Department of Elder Affairs, *The Florida Brain Bank*, http://elderaffairs.state.fl.us/doea/BrainBank/docs/BrainBank-brochure.pdf (last accessed March 17, 2021).

Memory Disorder Clinics

Section 430.502(1), F.S., designates 17 memory disorder clinics (MDCs)[9] that provide comprehensive assessments, diagnostic services, and treatment to individuals who exhibit symptoms of Alzheimer's disease and related memory disorders. The MDCs operate in 13 distinct service areas.[10]

MDC Service Areas and Locations[11]



MDCs also develop training programs and materials and conduct training for caregivers, respite service providers, and health care professionals in the care of persons with Alzheimer's disease and related memory disorders.[12] In addition, MDCs conduct service-related research projects through model day

[9] S. 430.502(1), F.S.
[10] Florida Department of Elder Affairs, *Summary of Programs and Services 2019*, *available at* http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last accessed March 17, 2021).
[11] Id.
[12] *Supra* note 7.

care programs and respite care programs.[13] MDCs are established at medical schools, teaching hospitals, and public and private not-for-profit hospitals throughout the state in accordance with s. 430.502, F.S. MDCs served 9,753 clients in 2017-2018.[14]

Purple Ribbon Task Force and Alzheimer's Disease State Plan

Chapter 2012-172, Laws of Florida, created the Purple Ribbon Task Force. The task force was composed of 18 members with 6 members appointed by the Governor, 6 members appointed by the Speaker of the House of Representatives, and 6 members appointed by the President of the Senate.[15]

The law required the task force to conduct an interim study regarding Alzheimer's disease in the state and directed the Task Force to:[16]

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

Additionally, the law required the task force to submit a report in the form of an Alzheimer's disease state plan.[17] The 2013 completed report by the task force is the *State Plan on Alzheimer's Disease and Related Forms of Dementia.*[18] The state report included the task force's findings and recommendations. Upon submission of this report, pursuant to law, the Purple Ribbon Task Force terminated.

Current law requires DOEA to review and update the Alzheimer's disease state plan every three years. The state plan must include an assessment of the current and future impact of Alzheimer's disease, an examination of existing resources available to persons living with Alzheimer's disease, and other information regarding Alzheimer's disease trends and policies in the state.[19]

Alzheimer's Disease Advisory Committee

Section 430.501, F.S., establishes the Alzheimer's Disease Advisory Committee (Committee) to advise DOEA on legislative, programmatic, and administrative matters regarding individuals with Alzheimer's disease and their caretakers. The committee is established within DOEA and composed of 11 members appointed by the Governor, 2 members appointed by the Senate President (one of which must be a sitting Senator), and 2 members appointed by the Speaker of the House of Representatives (one of which must be a sitting Representative).[20] The Governor's appointments must reflect the following representation:[21]

- At least four members must be persons licensed pursuant to ch. 458 or 459, F.S., or hold a Ph.D. degree and be currently involved in research on Alzheimer's disease;
- At least four persons who have been caregivers of victims of Alzheimer's disease; and
- Whenever possible, a gerontologist, a geriatric psychiatrist, a geriatrician, a neurologist, a social worker, and a registered nurse.

Committee members are appointed to four-year staggered terms. The chair is elected by the Committee and serves a one-year term. The Committee may establish subcommittees as necessary to carry out the functions of the Committee. Currently, the Committee has four standing subcommittees

[13] Id.
[14] *Supra* note 10.
[15] Ch. 2012-172, Laws of Fla.
[16] Id.
[17] Id.
[18] Florida Department of Elder Affairs, *Purple Ribbon Task Force State Plan on Alzheimer's Disease and Related Forms of Dementia*, https://www.alz.org/media/Documents/florida-state-plan-august-2013.pdf (last accessed March 17, 2021).
[19] S. 430.501, F.S.
[20] Id.
[21] Id.

regarding clinical services, home- and community-based care, education and research, and legislative advocacy.[22]

The Committee is required to submit an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Secretary of Elder Affairs by September 1 of each year. The report must include recommendations on Alzheimer's disease policy, all state-funded Alzheimer's disease efforts, and proposed updates to the Alzheimer's disease state plan.

DOEA must use the report submitted by the Committee and collaborate with other organizations and professionals when updating the state plan. DOEA must submit the updated state plan every three years, beginning November 1, 2020, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Dementia Care and Cure Initiative

The DOEA announced the Dementia Care and Cure Initiative (DCCI) in 2015 to engage communities across the state to be more dementia-caring, promote better care for Floridians affected by dementia, and support research efforts to find a cure. In collaboration with Florida's 11 Area Agencies on Aging and 17 memory disorder clinics, participating DCCI communities organize task forces consisting of community professionals and stakeholders who work to bring about education, awareness of, and sensitivity regarding the needs of those affected by dementia.[23]

Health Care Licensure in Florida

Chapter 458, F.S., governs licensure and regulation of the practice of medicine by the Florida Board of Medicine in conjunction with Florida Department of Health (DOH). Physicians holding a Doctor of Medicine (M.D.) degree are licensed under this chapter.

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine in conjunction with DOH. Osteopathic Physicians holding a Doctor of Osteopathic Medicine (D.O.) are licensed under this chapter.

Chapter 464, F.S., provides for the licensure and regulations of the practice of nursing by the Florida Board of Nursing in conjunction with DOH. Individuals licensed under this chapter include registered nurses (RN), advanced practice registered nurses (APRN), licensed practical nurses (LPN), and certified nursing assistants (CNA).

Medicare Program

Medicare is a federal health insurance program for people 65 or older, people under 65 with certain disabilities, and people of any age with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant).[24] The program is administered by the Centers for Medicare and Medicaid Services in the U.S. Department of Health and Human Services.

Medicare will pay for some services during every stage of Alzheimer's disease and dementia care, such as:[25]

- Cognitive assessments;
- Home safety evaluations

[22] Alzheimer's Disease Advisory Committee, *2009-2016 Summary of Accomplishments*, http://elderaffairs.state.fl.us/doea/alz/ADI_Accomplishments.pdf (last accessed March 18, 2021).
[23] Department of Elder Affairs, *Dementia Care and Cure Initiative*, http://elderaffairs.state.fl.us/doea/dcci.php (last accessed March 18, 2021).
[24] Medicare.gov, *What's Medicare*, https://www.medicare.gov/what-medicare-covers/your-medicare-coverage-choices/whats-medicare (last accessed March 3, 2021).
[25] Centers for Medicare and Medicaid Services, *Medicare and Medicaid Benefits for People with Dementia*, August 2017, https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/Downloads/Medicare-and-Medicaid-Benefits-for-People-with-Dementia.pdf (last accessed March 18, 2021).

- Planning for care;
- Hospital stays; and,
- Prescription drugs — Medicare Part D pays a portion of drug costs for individuals diagnosed with dementia.

Effect of Proposed Changes

The bill requires the DOH, in collaboration with the DOEA and the Alzheimer's Association, to use existing resources to educate physicians and nursing professionals on a range of topics related to the diagnosis and treatment of Alzheimer's disease and dementia-related disorders. The information provided to practitioners must include education on:

- The importance of early detection and timely diagnosis of cognitive impairment;
- Utilization of a validated cognitive assessment tool;
- The value of Medicare annual wellness visits for cognitive health;
- The use of the Medicare billing code for care planning for individuals with cognitive impairment;
- Methods to detect early warning signs of Alzheimer's disease and other types of dementia; and,
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and other types of dementia.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.825, F.S.; relating to Alzheimer's disease and dementia-related disorders education.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No rule-making authority is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to Alzheimer's disease and dementia-related disorders education; creating s. 381.825, F.S.; requiring the Department of Health, in partnership with the Department of Elderly Affairs and the Alzheimer's Association, to provide specified information relating to creating awareness about Alzheimer's disease and dementia-related disorders to certain licensed health care providers; providing an effective date.

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

Section 1. Section 381.825, Florida Statutes, is created to read:

381.825 Alzheimer's disease and dementia-related disorders education.—The Department of Health, in partnership with the Department of Elderly Affairs and the Alzheimer's Association, shall provide, through existing, relevant public health and community outreach programs, information to educate health care providers licensed under chapter 458, chapter 459, or chapter 464 on the following:

(1) The importance of early detection and timely diagnosis of cognitive impairment.

(2) Use of a validated cognitive assessment tool.

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

(3) The value of a Medicare annual wellness visit for cognitive health.

(4) Use of the Medicare advance care planning billing code for persons with cognitive impairment.

(5) An increased understanding and awareness of early warning signs of Alzheimer's disease and dementia-related disorders.

(6) Reducing the risk of cognitive decline, particularly among persons in diverse communities who are at greater risk of developing Alzheimer's disease and dementia-related disorders.

Section 2. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 631 Optometry
SPONSOR(S): Rizo
TIED BILLS: **IDEN./SIM. BILLS:** SB 876

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Health & Human Services Committee			

SUMMARY ANALYSIS

Optometrists examine, diagnose, treat, and manage diseases and injuries of the visual system as well as identify systemic conditions which affect visual health. Optometrists are regulated under ch. 463, F.S., by the Board of Optometry (Board) within the Department of Health (DOH). Optometrists may prescribe certain ocular medications listed in law or established in a formulary by the Board, but may not perform certain surgical procedures using an instrument, including a laser, scalpel, or needle.

HB 613 creates a new category for certification of licensed optometrists, "optometrist certified in ophthalmic procedures," which authorizes the performance of board-approved laser and non-laser ophthalmic procedures and therapy.

The bill repeals the statutory formulary that specifies the oral ocular pharmaceutical agents a certified optometrist may administer or prescribe and the prohibition on administering or prescribing certain drugs for more than 72 hours, expanding the types of drugs certified optometrist may administer or prescribe. Instead, the Board is required to create a negative formulary consisting of ocular pharmaceutical agents that a certified optometrist may not administer or prescribe. The bill also repeals the requirement that certified optometrists complete a board-approved course and examination in order to administer and prescribe oral ocular pharmaceutical agents.

The bill prohibits a certified optometrist from administering or prescribing Schedule II controlled substances except for oral analgesics for pain relief of the eye and its appendages. Current law allows this exception for Schedule III, IV, and V controlled substances.

The bill requires the Board to adopt rules relating to the performance of laser and non-laser ophthalmic procedures and therapies, the scope of the practice of optometry, and the required content, grading criteria, and passing scores for the optometry licensure examination.

The bill has an insignificant, negative fiscal impact to DOH which can be absorbed within current resources.

The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Optometrists and Ophthalmologists

Optometrists examine, diagnose, treat, and manage diseases and injuries of the visual system as well as identify systemic conditions which affect visual health. Optometrists are regulated under ch. 463, F.S., by the Board of Optometry (Board) within DOH. The Board is composed of seven members appointed by the Governor and confirmed by the Senate. Five members must be licensed practitioners actively participating in this state and the two reaming members must be citizens of the state that are not and have never been licensed practitioners.[1]

Optometrist training involves an undergraduate degree and completion of a 4-year program at a college of optometry. Some optometrists complete residencies to gain more specialized knowledge, but residency training is not required for licensure or practice.[2]

Ophthalmologists are medical doctors who specialize in diseases of the eye. Ophthalmologists provide a full spectrum of eye care, from prescribing corrective lenses and medications to performing eye surgery. Ophthalmologists also care for patients with more advanced and complicated diseases than optometrists. Ophthalmologists are regulated under ch. 458 and 459, F.S., by the Board of Medicine and the Board of Osteopathic Medicine within DOH. Ophthalmologist training involves an undergraduate degree, 4 years of medical school, and completion of at least 4 years of residency training in ophthalmology.[3]

The American Council for Graduate Medical Education (ACGME)[4] requires each opthamologist resident to perform a minimum number of certain surgeries before he or she may graduate from the program. Residents must perform the following minimum number of surgeries:[5]

Cataract	86
Laser Surgery- YAG Capsulotomy	5
Laser Surgery - Laser Trabeculoplasty	5
Laser Surgery – Laser Iridotomy	4
Laser Surgery – Panretinal Laser Photocoagulation	10
Keratoplasty	5
Pterygium/Conjunctival and other cornea	3
Keratorefractive Surgery	6
Strabismus	10
Glaucoma – Filtering/Shunting Procedures	5
Retinal Vitreous	10
Intravitreal Injection	10
Oculoplastic and orbit– Total	28
Oculoplastic and orbit – Eyelid Laceration	3
Oculoplastic and orbit – Chalazia Excision	3
Oculoplastic and orbit – Ptosis/Blepharoplasty	3

[1] Section 463.003, F.S.
[2] American Optometric Association, *What is a Doctor of Optometry?*, http://www.aoa.org/about-the-aoa/what-is-a-doctor-of-optometry?sso=y (last visited March 17, 2021).
[3] American Academy of Ophthalmology, *What is an Ophthalmologist?*, https://www.aao.org/eye-health/tips-prevention/what-is-ophthalmologist (last visited March 17, 2021).
[4] ACGME sets standards for and accredits US graduate medical education (residency and fellowship) programs. Available at: http://www.acgme.org/What-We-Do/Overview (last visited March 17, 2021).
[5] ACGME Review Committee for Ophthalmology, *Frequently Asked Questions,* https://www.acgme.org/Portals/0/PDFs/FAQ/240_ophthalmology_FAQs.pdf (last visited March 17, 2021).

ACGME resident case logs between 2015 and 2016 showed that the average resident performed 183 cataract surgeries, 13.4 glaucoma surgeries, and 107.6 laser surgeries.

Florida law requires optometrists diagnosing a patient with certain diseases to refer such patients to "physician skilled in the diseases of the eye" (ophthalmologists) for further treatment.[6] Additionally, an optometrist must promptly advise a patient to seek an evaluation by an ophthalmologist for diagnosis and possible treatment whenever the optometrist is informed by the patient of the sudden onset of spots or "floaters" with loss of all or part of the visual field.[7] Optometrists must maintain the names of at least three physicians, clinics, or hospitals to which they may refer patients who experience adverse drug reactions.[8]

Five states, Alaska, Arkansas, Kentucky, Louisiana, and Oklahoma allow optometrists to perform surgical procedures.[9] Oklahoma has allowed optometrists to perform surgical procedures since 1988.[10] Oklahoma requires passage of the Laser Therapy for the Anterior Segment Course offered by Northeastern State University to become a licensed optometrist.[11] The course consists of 9 hours of lectures and 4 hours of laboratory sessions with hands-on training.[12]

Between 1988 and 1998, 5,000 laser surgeries were performed by optometrists in Oklahoma.[13] A review by the Oklahoma Board of Examiners in Optometry of the outcomes of those surgeries found that negative outcome rates ranged between 0.5%-1.5% and were the same as those of surgeries performed by ophthalmologists in Oklahoma.[14] Since 1998, 25,000 anterior laser surgeries have been performed by optometrists in Oklahoma and the Oklahoma Board of Examiners in Optometry has not received any complaints regarding those surgeries.[15]

A 2016 peer-reviewed study that analyzed the outcomes for laser glaucoma surgeries between 2008 and 2013 in Oklahoma found that patients were nearly twice as likely to need additional treatment when the procedure was performed by an optometrist as compared to an ophthalmologist.[16] The study also found there was a 189% increased risk of needing additional treatment in the eye that had been treated when the procedure was performed by an optometrist as compared to an ophthalmologist.[17]

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[6] Diagnoses which mandate a referral to an ophthalmologist include angle closure glaucoma, congenital or infantile glaucoma, and infectious corneal diseases that are unresponsive to standard treatment. Section 463.0135, F.S.
[7] Section 463.0135(4), F.S.
[8] Section 463.0135(8), F.S.
[9] National Conference of State Legislatures, *Optometrist Scope of Practice,* https://www.ncsl.org/research/health/optometrist-scope-of-practice.aspx (last visited on March 17, 2021). In September 2020, the Arkansas Supreme Court ruled to disqualify Arkansas Issue 6, the Practice of Optometry Referendum, from the 2020 general election ballot, allowing optometrists to continue to perform a range of surgeries. *See* Arkansas Democrat Gazette, *Ruling Keeps Question on Eye Surgery off State Ballot,* https://www.arkansasonline.com/news/2020/sep/18/ruling-keeps-question-on-eye-surgery-off-ballot/ (last visited March 17, 2021).
[10] Testimony of Dr. April Jasper, former President of the Florida Optometric Association, on file with Professions and Public Health Subcommittee staff.
[11] Oklahoma Board of Examiners, *Licensing,* https://optometry.ok.gov/licensing.htm (last visited March 17, 2021).
[12] Stein, J.D., et. al. *Comparison of Outcomes of Laser Trabeculoplasty Performed by Optometrists vs. Ophthalmologists in Oklahoma*. JAMA Ophthalmol. 2016;134(10):1095-1101.
[13] *Supra*, note 10.
[14] Id.
[15] Id.
[16] *Supra*, note 12.
[17] Id.
[18] Id.

Provider	Number of eyes that received laser surgery	Number of eyes that received 1 or more additional surgeries	Probability of 1 or more additional surgeries performed during 10 days after initial surgery	Probability of 1 or more additional surgeries performed 11-30 days after initial surgery
Ophthalmologist	1150	174 (15%)	0	1.1%
Optometrist	234	84 (35.9%)	0.4%	10.3%

Optometrist Prescribing Authority in Florida

Currently, Florida law allows licensed optometrists to administer and prescribe drugs under limited circumstances. Licensed optometrists may only use topical anesthetics for glaucoma examinations, unless the licensed optometrist is also a certified optometrist.[19] Certified optometrists may administer and prescribe topical or oral ocular pharmaceutical agents for the diagnosis and treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques.[20]

To be certified by the board to administer and prescribe topical ocular pharmaceuticals, a licensed optometrist must be complete at least 110 hours of board approved coursework and training and one year of supervised experience in differential diagnosis of eye diseases or disorders.[21] Certified optometrists that also wish to administer and prescribe oral ocular pharmaceutical agents must also complete a board-approved 20-hour course and examination on general and ocular pharmaceutical agents and their side effects.[22] If a certified optometrist does not complete the course and examination, he or she may only administer or prescribe topical ocular pharmaceutical agents as established by board rule.[23]

The oral ocular pharmaceutical agents a certified optometrist may administer or prescribe are specified in a statutory formulary.[24] The agents include seven antibiotics and three antivirals:[25]

- Amoxicillin with or without clavulanic acid;
- Azithromycin;
- Erythromycin;
- Dicloxacillin;
- Doxycycline/Tetracycline;
- Keflex; and
- Minocycline.
- Acyclovir;
- Famciclovir; and
- Valacyclovir.

Current law prohibits a certified optometrist from administering or prescribing certain drugs for more than 72 hours, including two analgesics and two anti-glaucoma agents:[26]

- Tramadol hydrochloride; and

[19] Section 453.0055(1)(a), F.S.; Chapter No. 2013-26,L.O.F.
[20] Ss. 463.0055(1)(a) and 463.002(4), F.S.
[21] Rule 64B13-10.001, F.A.C.
[22] Section 463.0055, F.S.
[23] Rule 64B13-18.002, F.A.C.
[24] Section 463.0055(3), F.S.
[25] Section 463.0055(3)(b), F.S.
[26] Section 463.0055(3)(a), (c), (d) F.S.

- Acetaminophen 300 mg with No. 3 codeine phosphate 30 mg.
- Acetazolamide; and
- Methazolamide.

Any oral ocular pharmaceutical agent listed in the statutory formulary which is subsequently determined by the U.S. Food and Drug Administration to be unsafe for the administration or prescription is considered to have been deleted from the statutory formulary.[27]

The statutory formulary prohibits the administration or prescription of a controlled substance listed in Schedule III[28], Schedule IV[29], or Schedule V[30] of s. 893.03, F.S., except for the oral analgesics specified in the statutory formulary for the relief of pain due to ocular conditions of the eye and its appendages, or a controlled substance for the treatment of chronic nonmalignant pain.[31]

As of February 2021, there are 3,855 licensed certified optometrists and 91 non-certified optometrists in this state.[32] Since July 1, 1993, graduates of accredited schools of optometry have been considered certified optometrists as the curriculum changed to include specific training on administering and prescribing ocular pharmaceutical agents.[33] There are currently 51 optometrists in this state licensed before July 1, 1993 that are not certified.[34]

Optometrist Scope of Practice in Florida

Optometrists may prescribe certain medications, vision therapy, and corrective lenses, but may not perform surgical procedures in Florida.[35] Florida law defines surgery as a procedure using an instrument, including a laser, scalpel, or needle, in which human tissue is cut, burned, scraped, or vaporized by incision, injection, ultrasound, laser, infusion, cryotherapy, or radiation and also includes a procedure using an instrument which requires the closure of human tissue by suture, clamp, or a similar device.[36] However, certified optometrists that are authorized to administer or prescribe certain medication, may perform the following optometric practices[37]:

- Performing an eye examination, including a dilated examination, if required or authorized under laws related to pugilistic exhibitions;[38]
- Removing an eyelash by epilation;
- Probing an uninflamed tear duct in a patient 18 years of age or older;
- Blocking the puncta by plug;
- Performing a superficial scraping to remove damaged epithelial tissue or superficial foreign bodies or take a culture of the surface of the cornea or conjunctiva; and
- Using commonly accepted means or methods to immediately address incidents of anaphylaxis.

Effect of Proposed Changes

[27] Id.
[28] Section 893.03(3), F.S. defines a Schedule II substance as a substance that has a potential for abuse less than the substances contained in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage.
[29] Section 893.03(4) defines a Schedule IV substance as a substance that has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.
[30] Section 893.03(5), F.S. defines a Schedule V substance, compound, mixture or preparation that has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.
[31] Chronic nonmalignant pain is defined in section 456.44, F.S., as pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 day after surgery.
[32] Department of Health, Agency Analysis of 2021 House Bill 631, p. 2 (March 5, 2021).
[33] Id at p. 2.
[34] Id.
[35] Section 463.014(4), F.S.
[36] Section 463.002(6), F.S.
[37] Section 463.014(4), F.S.
[38] Ch. 548, F.S.

HB 613 repeals the prohibition on performing surgery, authorizes certified optometrists to perform laser and non-laser ophthalmic procedures, and expands the prescriptive authority of certified optometrists. The bill creates a new category for certification of licensed optometrists, "optometrist certified in ophthalmic procedures," which authorizes the performance of board-approved laser and non-laser ophthalmic procedures and therapy.

Optometrist Prescribing Authority

The bill repeals the requirement that certified optometrists complete a board-approved 20-hour course and examination on general and ocular pharmaceutical agents and their side effects in order to administer and prescribe oral ocular pharmaceutical agents, allowing certified optometrists to administer and prescribe such agents without completing board-approved courses.

The bill prohibits a certified optometrist from administering or prescribing Schedule II controlled substances except for oral analgesics for pain relief of the eye and its appendages. The bill also repeals the statutory formulary that specifies the oral ocular pharmaceutical agents a certified optometrist may administer or prescribe and the prohibition on administering or prescribing certain drugs for more than 72 hours. Instead, the bill requires the Board to create a negative formulary consisting of ocular pharmaceutical agents that a certified optometrist may not administer or prescribe. This expands the types of drugs certified optometrist may administer or prescribe.

Optometrist Scope of Practice

The bill repeals the prohibition on performing surgery, allowing optometrists to perform surgical procedures.

The bill creates a new certification category for licensed optometrists, "optometrist in ophthalmic procedures." The bill requires a licensed optometrist successfully complete a board-approved course and examination to become an optometrist certified in ophthalmic procedures. The bill allows optometrists certified in ophthalmic procedures to perform board-authorized laser and non-laser ophthalmic procedures. The bill prohibits such optometrists from performing ophthalmic procedures or therapy that requires preoperative medication or drug-induced alteration of consciousness. However, an optometrist certified in ophthalmic procedures may use medication for minimal tranquilization of the patient and local or topical anesthesia if the chances of complications requiring hospitalization of the patient are remote.

The bill also specifies certain ophthalmic procedures that optometrists certified in ophthalmic procedures are prohibited from performing, including:

- Laser vision correction, penetrating keratoplasty, and corneal or lamellar keratoplasty;
- Laser of the vitreous chamber or retina of the eye to treat any vitreomacular or retinal disease;
- Surgery of the eyelid for suspected eyelid malignancies or for incisional cosmetic or mechanical repair of blepharochalasis, ptosis, or tarsorrhaphy;
- Surgery of the boney orbit, including, but not limited to, orbital implants or removal of the human eye;
- Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures;
- Surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of elevated pressure inside the eye;
- Surgery requiring incision or excision by scalpel of the iris and ciliary body, including, but not limited to, iris diathermy or cryotherapy;
- Surgery requiring incision or excision of the vitreous or retina;
- Surgery requiring incision or excision of the crystalline lens or an intraocular prosthetic implant;
- Surgery involving incision or excision of the extraocular muscles;
- Surgery requiring full thickness conjunctivoplasty with graft or flap;

- Pterygium surgery; and
- Any other procedure or therapy the board deems appropriate.

Board Authority

The bill requires the Board of Optometry to adopt rules relating to:

- Laser and non-laser ophthalmic procedures and therapies an optometrist certified in ophthalmic procedures may perform;
- The scope of the practice of optometry consistent with its practice act; and
- The required content, grading criteria, and passing scores for the optometry licensure examination.

The bill requires five members of the Board to be certified optometrists or optometrists certified in ophthalmic procedures. This may require new appointments to the Board if the current members do not meet such requirements.

The bill makes conforming changes.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 463.002, F.S., relating to definitions.
Section 2: Amends s. 463.003, F.S., relating to board of optometry.
Section 3: Amends s. 463.005, F.S., relating to authority of the board.
Section 4: Amends s. 463.0055, F.S., relating to administration and prescription of ocular pharmaceutical agents.
Section 5: Creates s. 463.0056, F.S., relating to ophthalmic procedures.
Section 6: Amends s. 463.0057, F.S., relating to optometric faculty certificate.
Section 7: Amends s. 463.006, F.S., relating to licensure and certification by examination.
Section 8: Amends s. 463.0135, F.S., relating to standards of practice.
Section 9: Amends s. 463.014, F.S., relating to certain acts prohibited.
Section 10: Amends s. 463.009, F.S., relating to supporting personnel.
Section 11: Amends s. 641.31, F.S., relating to health maintenance contracts.
Section 12: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will experience an increase in workload relating to rulemaking and technology updates to implement the bill, which current resources are adequate to absorb.[39]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[39] *Supra,* note 32 at p. 6.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

An optometrist may experience an increase in expenditures if he or she enrolls in the required board-approved course and sits for the examination in order to become certified in ophthalmic procedures.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

The bill requires the Board of Optometry to adopt rules relating to the scope of practice of optometry consistent with ch. 463, F.S., which is potentially an unlawful delegation of legislative authority.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to optometry; reordering and amending s. 463.002, F.S.; revising and defining terms; amending s. 463.003, F.S.; revising the member composition requirements for the Board of Optometry; revising applicability; amending s. 463.005, F.S.; revising specified rules the board must adopt; amending s. 463.0055, F.S.; revising circumstances under which a certified optometrist may administer or prescribe ocular pharmaceutical agents; deleting requirements a certified optometrist must satisfy to administer or prescribe ocular pharmaceutical agents; requiring the board to adopt a negative formulary of ocular pharmaceutical agents certified optometrists are prohibited from administering or prescribing; deleting provisions relating to the topical and oral ocular pharmaceutical agent formularies established by the board; requiring the board to mail a copy of the negative formulary to all certified optometrists and licensed pharmacies under certain circumstances; revising the controlled substances that certified optometrists are prohibited from administering or prescribing; creating s. 463.0056, F.S.; authorizing certain certified optometrists to perform laser and non-laser ophthalmic procedures and therapies under

certain circumstances; providing certification requirements certified optometrists must satisfy to perform such procedures and therapies; requiring the board to approve the courses and examinations to be used for certification if certain conditions are met; requiring the board to review and approve the examination annually if certain conditions are met; authorizing certified optometrists to use the board-approved course and examination to satisfy their continuing education requirements under certain circumstances; prohibiting a certified optometrist who does not complete such course and examination from performing certain ophthalmic procedures; specifying ophthalmic procedures that are excluded from the scope of practice of optometry, with an exception; amending s. 463.0057, F.S.; conforming a provision to changes made by the act; amending s. 463.006, F.S.; conforming provisions to changes made by the act; requiring the board to determine the required content, grading criteria, and passing score for the licensure examination for certified optometrists; making technical changes; amending s. 463.0135, F.S.; authorizing certified optometrists to remove superficial foreign bodies; defining the term "superficial foreign bodies"; specifying circumstances

under which optometrists may perform procedures within the practice of optometry which may otherwise be considered surgery; requiring licensed practitioners who are not certified optometrists to display in their practices a sign containing specified information; amending s. 463.014, F.S.; deleting a prohibition on surgery performed by certified optometrists to conform to changes made by the act; amending ss. 463.009 and 641.31, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 463.002, Florida Statutes, is reordered and amended to read:

463.002 Definitions.—As used in this chapter, the term:

(2)~~(1)~~ "Board" means the Board of Optometry.

(5)~~(2)~~ "Department" means the Department of Health.

(8)~~(3)(a)~~ "Licensed practitioner" means a person who is a primary health care provider licensed to engage in the practice of optometry under the authority of this chapter. With respect to persons initially licensed under this chapter after July 1, 1993, the term includes only certified optometrists.

~~(b) A licensed practitioner who is not a certified optometrist shall be required to display at her or his place of~~

~~practice a sign which states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ocular pharmaceutical agents."~~

~~(c) All practitioners initially licensed after July 1, 1993, must be certified optometrists.~~

(3)~~(4)~~ "Certified optometrist" or "certified optometric physician" means a licensed practitioner authorized by the board to administer and prescribe ocular pharmaceutical agents.

(9)~~(5)~~ "Ocular pharmaceutical agent" means a pharmaceutical agent that is administered or prescribed ~~topically or orally~~ for the diagnosis or treatment of ocular conditions of the human eye and its appendages ~~without the use of surgery or other invasive techniques~~.

(13)~~(6)~~ "Surgery" means a procedure using an instrument, including a laser, scalpel, or needle, in which human tissue is cut, burned, scraped except as provided in s. 463.0135(12) ~~s. 463.014(4)~~, or vaporized, by incision, injection, ultrasound, laser, infusion, cryotherapy, or radiation. The term includes a procedure using an instrument which requires the closure of human tissue by suture, clamp, or other such device.

(11)~~(7)~~ "Optometry" means the diagnosis, evaluation, treatment, and management of conditions of the human eye and its appendages, including any visual, muscular, neurological, or anatomical anomalies and chronic systemic conditions relating to the eye; the determination of the refractive powers of the human

eye; and the prescribing and employment of any ~~objective or subjective~~ means or methods, including ~~the administration of~~ ocular pharmaceutical agents, contact lenses, spectacle lenses, magnification lenses, vision therapy, low vision rehabilitation devices, and ophthalmic procedures and therapy, for the diagnosis, evaluation, correction, remedy, treatment, management, or relief of any insufficiency, anomaly, abnormality, or disease condition relating to the human eye or its appendages ~~for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and any other means or methods, including ocular pharmaceutical agents, for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages~~.

(6) ~~(8)~~ "Direct supervision" means supervision to an extent that the licensee remains on the premises while all procedures are being done and gives final approval to any procedures performed by an employee.

(7) ~~(9)~~ "General supervision" means the responsible supervision of supportive personnel by a licensee who need not be present when such procedures are performed, but who assumes legal liability therefor. Except in cases of emergency, "general

supervision" shall require the easy availability or physical presence of the licensee for consultation with and direction of the supportive personnel.

(1) ~~(10)~~ "Appendages" means the eyelids, the eyebrows, the conjunctiva, and the lacrimal apparatus.

(14) ~~(11)~~ "Transcript-quality" means a course that ~~which~~ is in conjunction with or sponsored by a school or college of optometry or equivalent educational entity, which course is approved by the board and requires a test and passing grade.

(4) ~~(12)~~ "Clock hours" means the actual time engaged in approved coursework and clinical training.

(10) "Optometrist certified in ophthalmic procedures" means a certified optometrist who is authorized under s. 463.0056 to perform board-approved laser and non-laser ophthalmic procedures and therapy in accordance with that section.

(12) "Refraction" means the use of lenses and ocular pharmaceutical agents during the course of a comprehensive medical eye examination to determine a patient's visual, neurological, and physical requirements to attain optimal visual and perceptual performance.

Section 2. Subsections (2) and (4) of section 463.003, Florida Statutes, are amended to read:

463.003 Board of Optometry.—

(2) Five members of the board must be certified

optometrists or optometrists certified in ophthalmic procedures ~~licensed practitioners~~ actively practicing in this state. The remaining two members must be citizens of this ~~the~~ state who are not, and have never been, licensed practitioners and who are in no way connected with the practice of optometry or with any vision-oriented profession or business. At least one member of the board must be 60 years of age or older.

(4) All applicable provisions of chapter 456 relating to activities of regulatory boards which do not conflict with this chapter shall apply.

Section 3. Subsection (1) of section 463.005, Florida Statutes, is amended to read:

463.005 Authority of the board.—

(1) The Board of Optometry shall ~~has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it. Such rules must ~~shall~~ include, but need not be limited to, rules relating to all of the following:

(a) Standards of practice, including, but not limited to, those provided ~~for~~ in s. 463.0135.

(b) Minimum equipment that ~~which~~ a licensed practitioner must ~~shall~~ at all times possess to engage in the practice of optometry.

(c) Minimum procedures that ~~which shall~~ constitute a visual examination.

(d) Procedures for the safekeeping and transfer of prescription files or case records ~~upon the discontinuance of practice~~.

(e) Supervision of supportive personnel.

(f) Courses and procedures for continuing education.

(g) Practices and procedures for the administration and prescription of ocular pharmaceutical agents.

(h) Laser and non-laser ophthalmic procedures and therapies an optometrist certified in ophthalmic procedures may perform, including, but not limited to, the standards of practice for such ophthalmic procedures and therapies.

(i) The scope of practice of optometry consistent with this chapter.

(j) Required content, grading criteria, and passing scores for the licensure examinations set forth in s. 463.006.

Section 4. Section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ocular pharmaceutical agents.—

(1)~~(a)~~ Certified optometrists may administer and prescribe ocular pharmaceutical agents as provided in this section for the diagnosis and treatment of ocular conditions of the human eye and its appendages ~~without the use of surgery or other invasive techniques~~. However, a licensed practitioner who is not certified may use topically applied anesthetics solely for the

purpose of glaucoma examinations, but is otherwise prohibited from administering or prescribing ocular pharmaceutical agents.

~~(b) Before a certified optometrist may administer or prescribe oral ocular pharmaceutical agents, the certified optometrist must provide proof to the department of successful completion of a course and subsequent examination, approved by the board, on general and ocular pharmaceutical agents and the side effects of those agents. The course shall consist of 20 contact hours, all of which may be web-based. The first course and examination shall be presented by October 1, 2013, and shall be administered at least annually thereafter. The course and examination shall be developed and offered jointly by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award (AMA PRA) Category 1 credit and a statewide professional association of licensed practitioners which provides board-approved continuing education on an annual basis. The board shall review and approve the content of the initial course and examination if the board determines that the course and examination adequately and reliably satisfy the criteria set forth in this section. The board shall thereafter annually review and approve the course and examination if the board determines that the content continues to adequately and reliably satisfy the criteria set forth in this section. Successful completion of the board-~~

~~approved course and examination may be used by a certified optometrist to satisfy 20 hours of the continuing education requirements in s. 463.007(3), only for the biennial period in which the board-approved course and examination are taken. If a certified optometrist does not complete a board-approved course and examination under this section, the certified optometrist is only authorized to administer and prescribe topical ocular pharmaceutical agents.~~

(2)~~(a)~~ The board shall establish a negative formulary of ~~topical~~ ocular pharmaceutical agents that a certified optometrist may not administer or prescribe ~~be prescribed and administered by a certified optometrist~~. ~~The formulary shall consist of those topical ocular pharmaceutical agents that are appropriate to treat or diagnose ocular diseases and disorders and that the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the topical formulary by rule. Notwithstanding any provision of chapter 120 to the contrary, the topical formulary rule becomes effective 60 days from the date it is filed with the Secretary of State.~~

~~(b) The formulary may be added to, deleted from, or modified according to the procedure described in paragraph (a). Any person who requests an addition, deletion, or modification of an authorized topical ocular pharmaceutical agent shall have the burden of proof to show cause why such addition, deletion,~~

~~or modification should be made.~~

~~(c) The State Surgeon General shall have standing to challenge any rule or proposed rule of the board pursuant to s. 120.56. In addition to challenges for any invalid exercise of delegated legislative authority, the administrative law judge, upon such a challenge by the State Surgeon General, may declare all or part of a rule or proposed rule invalid if it:~~

~~1. Does not protect the public from any significant and discernible harm or damages;~~

~~2. Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or~~

~~3. Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.~~

~~However, there shall not be created a presumption of the existence of any of the conditions cited in this subsection in the event that the rule or proposed rule is challenged.~~

~~(d)~~ Upon adoption of the negative formulary ~~required by this section~~, and upon each addition, deletion, or modification to the formulary, the board shall mail a copy of the amended formulary to each certified optometrist and to each pharmacy licensed by the state.

~~(3) In addition to the formulary of topical ocular pharmaceutical agents established by rule of the board, there is~~

~~created a statutory formulary of oral ocular pharmaceutical agents, which includes the following agents:~~

~~(a) The following analgesics or their generic or therapeutic equivalents, which may not be administered or prescribed for more than 72 hours without consultation with a physician licensed under chapter 458 or chapter 459 who is skilled in diseases of the eye:~~

~~1. Tramadol hydrochloride.~~

~~2. Acetaminophen 300 mg with No. 3 codeine phosphate 30 mg.~~

~~(b) The following antibiotics or their generic or therapeutic equivalents:~~

~~1. Amoxicillin with or without clavulanic acid.~~

~~2. Azithromycin.~~

~~3. Erythromycin.~~

~~4. Dicloxacillin.~~

~~5. Doxycycline/Tetracycline.~~

~~6. Keflex.~~

~~7. Minocycline.~~

~~(c) The following antivirals or their generic or therapeutic equivalents:~~

~~1. Acyclovir.~~

~~2. Famciclovir.~~

~~3. Valacyclovir.~~

~~(d) The following oral anti-glaucoma agents or their~~

~~generic or therapeutic equivalents, which may not be administered or prescribed for more than 72 hours:~~

~~1. Acetazolamide.~~

~~2. Methazolamide.~~

~~Any oral ocular pharmaceutical agent that is listed in the statutory formulary set forth in this subsection and that is subsequently determined by the United States Food and Drug Administration to be unsafe for administration or prescription shall be considered to have been deleted from the formulary of oral ocular pharmaceutical agents. The oral ocular pharmaceutical agents on the statutory formulary set forth in this subsection may not otherwise be deleted by the board, the department, or the State Surgeon General.~~

(3)~~(4)~~ A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon. A certified optometrist may not administer or prescribe any of the following:

(a) A controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, except for an oral analgesic ~~placed on the formulary pursuant to this section~~ for the relief of pain due to ocular conditions of the eye and its appendages.

(b) A controlled substance for the treatment of chronic nonmalignant pain as defined in s. 456.44(1)(f).

Section 5. Section 463.0056, Florida Statutes, is created to read:

463.0056 Ophthalmic Procedures.—

(1)(a) An optometrist certified in ophthalmic procedures may perform laser and non-laser ophthalmic procedures and therapies as authorized by the board but may not perform an ophthalmic procedure or therapy that requires preoperative medications or drug-induced alteration of consciousness. However, an optometrist certified in ophthalmic procedures may use medication for minimal tranquilization of the patient and local or topical anesthesia if the chances of complications requiring hospitalization of the patient as a result are remote.

(b) To be certified to perform ophthalmic procedures, a certified optometrist must first provide proof to the department of successful completion of a course and subsequent examination, approved by the board, on laser and non-laser ophthalmic procedures and therapy. The course and examination shall be developed and offered jointly by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit and a statewide professional association of licensed practitioners which provides board-approved continuing education on an annual

basis. The board shall review and approve the content of the initial course and examination if the board determines that the course and examination adequately and reliably satisfy the criteria set forth in this section. The board shall thereafter annually review and approve the examination if the board determines that the content continues to adequately and reliably satisfy the criteria set forth in this section. Successful completion of the board-approved course and examination may be used by a certified optometrist to satisfy the continuing education requirements in s. 463.007(3) only for the biennial period in which the board-approved course and examination are taken. If a certified optometrist does not complete a board-approved course and examination under this section, the certified optometrist may not perform ophthalmic procedures described in paragraph (a).

(2) The following ophthalmic procedures are excluded from the scope of practice of optometry, except for the preoperative and postoperative care of these procedures:

(a) Laser vision correction, penetrating keratoplasty, and corneal or lamellar keratoplasty.

(b) Laser of the vitreous chamber or retina of the eye to treat any vitreomacular or retinal disease.

(c) Surgery of the eyelid for suspected eyelid malignancies or for incisional cosmetic or mechanical repair of blepharochalasis, ptosis, or tarsorrhaphy.

(d) Surgery of the boney orbit, including, but not limited to, orbital implants or removal of the human eye.

(e) Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures.

(f) Surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of elevated pressure inside the eye.

(g) Surgery requiring incision or excision by scalpel of the iris and ciliary body, including, but not limited to, iris diathermy or cryotherapy.

(h) Surgery requiring incision or excision of the vitreous or retina.

(i) Surgery requiring incision or excision of the crystalline lens or an intraocular prosthetic implant.

(j) Surgery involving incision or excision of the extraocular muscles.

(k) Surgery requiring full thickness conjunctivoplasty with graft or flap.

(l) Pterygium surgery.

(m) Any other procedure or therapy the board deems appropriate.

Section 6. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section but may not administer or prescribe topical ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of s. 463.006(1)(e) and (f). ~~If a certificateholder wishes to administer or prescribe oral ocular pharmaceutical agents, the certificateholder must also satisfy the requirements of s. 463.0055(1)(b).~~

Section 7. Section 463.006, Florida Statutes, is amended to read:

463.006 Licensure and certification by examination.—

(1) Any person desiring to be a certified optometrist ~~licensed practitioner~~ pursuant to this chapter must apply to the department and must submit proof to the department that she or he:

(a) Has completed the application forms as required by the board, remitted an application fee for certification not to exceed $250, remitted an examination fee for certification not to exceed $250, and remitted an examination fee for licensure not to exceed $325, all as set by the board.

(b) Is at least 18 years of age.

(c) Has graduated from an accredited school or college of optometry approved by rule of the board.

(d) Is of good moral character.

(e) Has successfully completed at least 110 hours of

transcript-quality coursework and clinical training in general and ocular pharmacology as determined by the board, at an institution that:

1. Has facilities for both didactic and clinical instructions in pharmacology; and

2. Is accredited by a regional or professional accrediting organization that is recognized and approved by the Commission on Recognition of Postsecondary Accreditation or the United States Department of Education.

(f) Has completed at least 1 year of supervised experience in differential diagnosis of eye disease or disorders as part of the optometric training or in a clinical setting as part of the optometric experience.

(2) The board shall approve a licensure examination consisting of the appropriate subjects and including applicable state laws and rules and general and ocular pharmacology with emphasis on the use and side effects of ocular pharmaceutical agents. The board may by rule substitute a national examination as part or all of the examination and, notwithstanding chapter 456, may by rule offer a practical examination in addition to a written examination. The board shall determine the required content, grading criteria, and passing score for the licensure examination.

(3) Each applicant who submits proof satisfactory to the board that he or she has met the requirements of subsection (1),

who successfully passes the licensure examination within 3 years before the date of application or within 3 years after the submission of an application, and who otherwise meets the requirements of this chapter is entitled to be licensed as a certified optometrist ~~practitioner and to be certified to administer and prescribe ocular pharmaceutical agents in the diagnosis and treatment of ocular conditions~~.

Section 8. Subsections (12) and (13) are added to section 463.0135, Florida Statutes, to read:

463.0135 Standards of practice.—

(12) Certified optometrists may remove superficial foreign bodies. For the purpose of this subsection, the term "superficial foreign bodies" means any foreign matter that is embedded in the conjunctiva or cornea but that has not penetrated the globe. Notwithstanding the definition of surgery in s. 463.002, a certified optometrist may provide any optometric care within the practice of optometry as defined in s. 463.002, including, but not limited to, removing an eyelash by epilation, probing an uninflamed tear duct in a patient 18 years of age or older, blocking the puncta by plug, or superficial scraping for the purpose of removing damaged epithelial tissue or superficial foreign bodies or taking a culture of the surface of the cornea or conjunctiva.

(13) A licensed practitioner who is not a certified optometrist is required to display at her or his place of

practice a sign that states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ocular pharmaceutical agents or perform ophthalmic procedures."

Section 9. Subsection (4) of section 463.014, Florida Statutes, is amended to read:

463.014 Certain acts prohibited.—

~~(4) Surgery of any kind is expressly prohibited. Certified optometrists may remove superficial foreign bodies. For the purposes of this subsection, the term "superficial foreign bodies" means any foreign matter that is embedded in the conjunctiva or cornea but that has not penetrated the globe. Notwithstanding the definition of surgery as provided in s. 463.002(6), a certified optometrist is not prohibited from providing any optometric care within the practice of optometry as defined in s. 463.002(7), such as removing an eyelash by epilation, probing an uninflamed tear duct in a patient 18 years of age or older, blocking the puncta by plug, or superficial scraping for the purpose of removing damaged epithelial tissue or superficial foreign bodies or taking a culture of the surface of the cornea or conjunctiva.~~

Section 10. Section 463.009, Florida Statutes, is amended to read:

463.009 Supportive personnel.—No person other than a licensed practitioner may engage in the practice of optometry as defined in s. 463.002 ~~s. 463.002(7)~~. Except as provided in this

section, under no circumstances shall nonlicensed supportive personnel be delegated diagnosis or treatment duties; however, such personnel may perform data gathering, preliminary testing, prescribed visual therapy, and related duties under the direct supervision of the licensed practitioner. Nonlicensed personnel, who need not be employees of the licensed practitioner, may perform ministerial duties, tasks, and functions assigned to them by and performed under the general supervision of a licensed practitioner, including obtaining information from consumers for the purpose of making appointments for the licensed practitioner. The licensed practitioner shall be responsible for all delegated acts performed by persons under her or his direct and general supervision.

Section 11. Subsection (19) of section 641.31, Florida Statutes, is amended to read:

641.31 Health maintenance contracts.—

(19) Notwithstanding any other provision of law, health maintenance policies or contracts which provide coverage, benefits, or services as described in s. 463.002 ~~s. 463.002(7),~~ shall offer to the subscriber the services of an optometrist licensed pursuant to chapter 463.

Section 12. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee
Representative Rizo offered the following:

Amendment (with title amendment)

Remove lines 315-495 and insert:

(3) Controlled substances for acute pain shall not be administered or prescribed for more than 72 hours without consultation with a physician licensed under chapter 458 or chapter 459 who is skilled in diseases of the eye.

(3)~~(4)~~ A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ocular pharmaceutical agent pursuant to this section shall have the prescriber number printed thereon. A certified optometrist may not administer or prescribe any of the following:

(a) A controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03, except for an oral analgesic ~~placed on the formulary pursuant to this section~~ for the relief of pain due to ocular conditions of the eye and its appendages.

(b) A controlled substance for the treatment of chronic nonmalignant pain as defined in s. 456.44(1)(f).

Section 5. Section 463.0056, Florida Statutes, is created to read:

463.0056 Ophthalmic Procedures.—

(1)(a) An optometrist certified in ophthalmic procedures may perform laser and non-laser ophthalmic procedures and therapies as authorized by the board but may not perform an ophthalmic procedure or therapy that requires drug-induced alteration of consciousness or that burns, cuts, or incises the globe of the eye. However, an optometrist certified in ophthalmic procedures may use medication for minimal tranquilization of the patient and local or topical anesthesia if the chances of complications requiring hospitalization of the patient as a result are remote.

(b) To be certified to perform ophthalmic procedures, a certified optometrist must first provide proof to the department of successful completion of a course and subsequent examination, approved by the board, on laser and non-laser ophthalmic procedures and therapy. The course and examination shall be

developed and offered jointly by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit and a statewide professional association of licensed practitioners which provides board-approved continuing education on an annual basis. The board shall review and approve the content of the initial course and examination if the board determines that the course and examination adequately and reliably satisfy the criteria set forth in this section. The board shall thereafter annually review and approve the examination if the board determines that the content continues to adequately and reliably satisfy the criteria set forth in this section. Successful completion of the board-approved course and examination may be used by a certified optometrist to satisfy the continuing education requirements in s. 463.007(3) only for the biennial period in which the board-approved course and examination are taken. If a certified optometrist does not complete a board-approved course and examination under this section, the certified optometrist may not perform ophthalmic procedures described in paragraph (a).

(2) The following ophthalmic procedures are excluded from the scope of practice of optometry, except for the preoperative and postoperative care of these procedures:

(a) Any procedure that burns, cuts, or incises the globe of the eye.

(b) Laser vision correction, penetrating keratoplasty, and corneal or lamellar keratoplasty.

(c) Laser of the vitreous chamber or retina of the eye to treat any vitreomacular or retinal disease.

(d) Surgery of the eyelid for suspected eyelid malignancies or for incisional cosmetic or mechanical repair of blepharochalasis, ptosis, or tarsorrhaphy.

(e) Surgery of the boney orbit, including, but not limited to, orbital implants or removal of the human eye.

(f) Incisional or excisional surgery of the lacrimal system other than lacrimal probing or related procedures.

(g) Surgery requiring full thickness incision or excision of the cornea or sclera other than paracentesis in an emergency situation requiring immediate reduction of elevated pressure inside the eye.

(h) Surgery requiring incision or excision by scalpel of the iris and ciliary body, including, but not limited to, iris diathermy or cryotherapy.

(i) Surgery requiring incision or excision of the vitreous or retina.

(j) Surgery requiring incision or excision of the crystalline lens or an intraocular prosthetic implant.

(k) Surgery involving incision or excision of the extraocular muscles.

(l) Surgery requiring full thickness conjunctivoplasty with graft or flap.

(m) Pterygium surgery.

(n) Any other procedure or therapy the board deems appropriate.

Section 6. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section but may not administer or prescribe topical ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of s. 463.006(1)(e) and (f). ~~If a certificateholder wishes to administer or prescribe oral ocular pharmaceutical agents, the certificateholder must also satisfy the requirements of s. 463.0055(1)(b).~~

Section 7. Section 463.006, Florida Statutes, is amended to read:

463.006 Licensure and certification by examination.—

(1) Any person desiring to be a certified optometrist ~~licensed practitioner~~ pursuant to this chapter must apply to the department and must submit proof to the department that she or he:

(a) Has completed the application forms as required by the board, remitted an application fee for certification not to exceed $250, remitted an examination fee for certification not to exceed $250, and remitted an examination fee for licensure not to exceed $325, all as set by the board.

(b) Is at least 18 years of age.

(c) Has graduated from an accredited school or college of optometry approved by rule of the board.

(d) Is of good moral character.

(e) Has successfully completed at least 110 hours of transcript-quality coursework and clinical training in general and ocular pharmacology as determined by the board, at an institution that:

1. Has facilities for both didactic and clinical instructions in pharmacology; and

2. Is accredited by a regional or professional accrediting organization that is recognized and approved by the Commission on Recognition of Postsecondary Accreditation or the United States Department of Education.

(f) Has completed at least 1 year of supervised experience in differential diagnosis of eye disease or disorders as part of the optometric training or in a clinical setting as part of the optometric experience.

(2) The board shall approve a licensure examination consisting of the appropriate subjects and including applicable

state laws and rules and general and ocular pharmacology with emphasis on the use and side effects of ocular pharmaceutical agents. The board may by rule substitute a national examination as part or all of the examination and, notwithstanding chapter 456, may by rule offer a practical examination in addition to a written examination. The board shall determine the required content, grading criteria, and passing score for the licensure examination.

(3) Each applicant who submits proof satisfactory to the board that he or she has met the requirements of subsection (1), who successfully passes the licensure examination within 3 years before the date of application or within 3 years after the submission of an application, and who otherwise meets the requirements of this chapter is entitled to be licensed as a certified optometrist ~~practitioner and to be certified to administer and prescribe ocular pharmaceutical agents in the diagnosis and treatment of ocular conditions~~.

Section 8. Subsection (12) is added to section 463.0135, Florida Statutes, to read:

463.0135 Standards of practice.—

(12) A licensed practitioner who is not a certified optometrist is required to display at her or his place of practice a sign that states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ocular pharmaceutical agents or perform ophthalmic procedures."

Section 9. Subsection (4) of section 463.014, Florida Statutes, is amended to read:

463.014 Certain acts prohibited.—

(4) Surgery, except as otherwise provided in this chapter, is ~~of any kind is expressly~~ prohibited. Certified optometrists may remove superficial foreign bodies. For the purposes of this subsection, the term "superficial foreign bodies" means any foreign matter that is embedded in the conjunctiva or cornea but that has not penetrated the globe. Notwithstanding the definition of surgery as provided in s. 463.002~~(6)~~, a certified optometrist may provide ~~is not prohibited from providing~~ any optometric care within the practice of optometry as defined in s. 463.002~~(7)~~, including, but not limited to, ~~such as~~ removing an eyelash by epilation, probing an uninflamed tear duct in a patient 18 years of age or older, blocking the puncta by plug, or superficial scraping for the purpose of removing damaged epithelial tissue or superficial foreign bodies or taking a culture of the surface of the cornea or conjunctiva.

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

Remove lines 48-56 and insert:
requiring licensed practitioners who are not certified optometrists to display in their practices a sign containing

specified information; amending s. 463.014, F.S.; revising a prohibition on

HB 805

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 805 Volunteer Ambulance Services
SPONSOR(S): Caruso and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1084

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Guzzo	McElroy
2) Local Administration & Veterans Affairs Subcommittee			
3) Tourism, Infrastructure & Energy Subcommittee			
4) Health & Human Services Committee			

SUMMARY ANALYSIS

Prehospital life support transport services fall into two general categories – basic life support services (BLS) and advanced life support services (ALS). The Department of Health (DOH) licenses basic life support (BLS) service providers, advanced life support (ALS) service providers and air ambulances. To obtain a transport vehicle permit to provide BLS or ALS services, an applicant must meet the minimum standards regarding equipment, vehicles, personnel, services, and insurance established by the DOH. However, BLS and ALS service providers must also obtain a Certificate of Public Convenience and Necessity (COPCN) from the governing board of each county in which the provider plans to operate.

The "Florida Uniform Traffic Control Law" permits the drivers of certain authorized emergency vehicles to disregard specified traffic laws and ordinances and use emergency lights and sirens while responding to an emergency. The authorized emergency vehicles include vehicles of a fire department, police department, and ambulance and emergency vehicles of municipal and county departments, public service corporations operated by private corporations, and certain state agencies. Current law does not recognize an ambulance providing volunteer ambulance services as an authorized emergency vehicle.

HB 805 exempts certain faith-based volunteer first responder agencies that have operated for at least 10 consecutive years from the certificate of public convenience and necessity requirements. The bill prohibits a county or municipal government from limiting, prohibiting, or preventing a volunteer ambulance service from responding to an emergency or providing emergency medical services or transport within its jurisdiction. The bill also prohibits a county or municipal government from requiring a volunteer ambulance service to obtain a license or certificate or pay a fee to provide ambulance or air ambulance services within its jurisdiction.

The bill allows a volunteer ambulance services vehicle that qualifies as an authorized emergency vehicle to disregard specified traffic laws and ordinances and use emergency lights and sirens while responding to an emergency. The bill also allows a medical staff physician or technician of a volunteer ambulance service to disregard specified traffic laws and ordinances and use red lights in their privately owned vehicles when responding to an emergency in the line of duty.

The bill declares that it is in the public interest to foster the development of emergency medical services that address religious sensitivities and to recognize the value of augmenting existing county and municipal emergency medical services with those provided by volunteer service organizations.

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

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Emergency Medical Transport Services

Prehospital life support transport services fall into two general categories – basic life support services (BLS) and advanced life support services (ALS).

BLS services include the assessment or treatment by a person qualified under part III of ch. 401, F.S., through the use of techniques described in the EMT-Basic National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards of the U.S. Department of Transportation.[1] The term includes the administration of oxygen and other techniques that have been approved and are performed under specific conditions.[2] BLS services are usually performed by EMTs.[3]

ALS services include patient assessment or treatment including the implementation of advanced medical skills such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards.[4] ALS services can be performed on site and are usually provided by physicians or paramedics.[5]

To obtain a transport vehicle permit to provide BLS or ALS services, an applicant must provide to the Department of Health the following:

- An application and required fees; and
- Documentation that the vehicle qualifies as follows:
  - Is furnished with essential medical supplies and equipment which is in good working order;
  - Meets appropriate standards for design and construction;
  - Is equipped with an appropriate communication system;
  - Meets appropriate safety standards;
  - Meets sanitation and maintenance standards;
  - Is insured for a minimum of $100,000/$300,000 against injuries to or the death of any person arising out of an accident; and
  - Has been awarded a Certificate of Public Convenience and Necessity (COPCN).[6]

Certificate of Public Convenience and Necessity

A Certificate of Public Convenience and Necessity (COPCN) is a written statement, issued by the governing board of a county, granting permission for an emergency medical service provider to provide authorized services for the benefit of the population of that county or the benefit of the population of some geographic area of that county.[7] At the time of licensure, each provider of life support transportation services must have a COPCN from each county in which the provider intends to

[1] United States Department of Transportation, National Highway Traffic Safety Administration, *National Emergency Medical Services Education Standards*, (January 2009), *available at* https://www.ems.gov/pdf/National-EMS-Education-Standards-FINAL-Jan-2009.pdf (last visited March 11, 2021).
[2] Sections 401.23(7) and (8), F.S.
[3] Ryynanen, et. al, *Is advanced life support better than basic life support in prehospital care? A systematic review*, Scand J Trauma Resusc. Emerg. Med. 2010; 18: 62, (November 23, 2010), *available at* http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001418/ (last visited March 11, 2021).
[4] Sections 401.23(1) and (2), F.S.
[5] Ryynanen, et. al, supra note 18.
[6] Section 401.26(2), F.S., and Fla. Admin. Code R. 64J-1.002 and 64J-1.003 (2019).
[7] Rule 64J-1.001(2), F.A.C.

operate.[8] Section 401.25(6), F.S., authorizes, but does not require, counties to adopt ordinances establishing standards for issuing a COPCN.

Emergency Vehicles

Chapter 316, F.S., provides uniform traffic laws and ordinances applicable throughout the state and is titled the "Florida Uniform Traffic Control Law". The law permits the drivers of certain authorized emergency vehicles to disregard specified traffic laws and ordinances and use emergency lights and sirens while responding to an emergency. The authorized emergency vehicles include vehicles of a fire department, police department, and ambulance and emergency vehicles of: [9]

- Municipal and county departments;
- Public service corporations operated by private corporations;
- The Fish and Wildlife Conservation Commission;
- The Department of Environmental Protection;
- The Department of Health;
- The Department of Transportation; and
- The Department of Corrections.

Red or red and white lights may be shown or displayed by vehicles of the fire department and fire patrol, and by a privately owned vehicle belonging to a member of a regularly organized volunteer firefighting company or association, while on their way to the scene of a fire or other emergency in the line of duty.[10]

Red lights may be shown or displayed by privately owned vehicles of medical staff physicians or technicians of medical facilities licensed by the state while responding to an emergency in the line of duty, certain ambulances, and certain buses and taxicabs.[11]

Section 316.072(5), F.S., permits the drivers of certain vehicles to disregard specified traffic laws and ordinances while responding to an emergency, including:

- The driver of an authorized emergency vehicle when responding to an emergency call, when in the pursuit of an actual or suspected violator of the law, or when responding to a fire alarm, but not upon returning from a fire;
- A medical staff physician or technician of a licensed medical facility when responding to an emergency in the line of duty in his or her privately owned vehicle, using red lights;
- The driver of an authorized law enforcement vehicle, when conducting a nonemergency escort, to warn the public of an approaching motorcade.

The driver of a vehicle described above, unless otherwise directed by a police officer may:

- Park or stand, regardless of traffic laws and ordinances;
- Proceed past a red light or stop sign, but only after slowing down as may be necessary for safe operation;
- Exceed the maximum speed limits so long as the driver does not endanger life or property; and
- Disregard regulations governing direction or movement or turning in specified directions, as long as the driver does not endanger life or property.

Current law does not recognize an ambulance providing volunteer ambulance services as an authorized emergency vehicle.

Effect of the Bill

[8] Section 401.25(2)(d), F.S.
[9] Section 316.003(1), F.S.
[10] Section 316.2398(1), F.S.
[11] *Id.*

HB 805 exempts certain faith-based volunteer first responder agencies that have operated for at least 10 consecutive years from the certificate of public convenience and necessity requirements. The bill prohibits a county or municipal government from limiting, prohibiting, or preventing a volunteer ambulance service from responding to an emergency or providing emergency medical services or transport within its jurisdiction. The bill also prohibits a county or municipal government from requiring a volunteer ambulance service to obtain a license or certificate or pay a fee to provide ambulance or air ambulance services within its jurisdiction.

The bill allows a volunteer ambulance services vehicle that qualifies as an authorized emergency vehicle to disregard specified traffic laws and ordinances and use emergency lights and sirens while responding to an emergency. The bill also allows a medical staff physician or technician of a volunteer ambulance service to disregard specified traffic laws and ordinances and use red lights in their privately owned vehicles when responding to an emergency in the line of duty.

The bill declares that it is in the public interest to foster the development of emergency medical services that address religious sensitivities and to recognize the value of augmenting existing county and municipal emergency medical services with those provided by volunteer service organizations.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 316.003, F.S., relating to definitions.
Section 2: Amends s. 316.072, F.S., relating to obedience to and effect of traffic laws.
Section 3: Amends s. 316.2397, F.S., relating to certain lights prohibited; exceptions.
Section 4: Amends s. 316.2398, F.S., relating to display or use of red or red and white warning signals; motor vehicles of volunteer firefighters or medical staff.
Section 5: Amends s. 401.211, F.S., relating to legislative intent.
Section 6: Amends s. 401.23, F.S., relating to definitions.
Section 7: Amends s. 401.25, F.S., relating to licensure as a basic life support or an advanced life support service.
Section 8: Amends s. 316.306, F.S., relating to school and work zones; prohibition on the use of a wireless communications device in a handheld manner.
Section 9: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rule-making authority is necessary to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill may present challenges for a county or municipal government (especially during a disaster or mass casualty event) because a volunteer ambulance service is not required to report to or communicate with the county or municipal government. The county or municipal government would have no ability to respond or control the scene in terms of traffic management and staging areas.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to volunteer ambulance services; amending s. 316.003, F.S.; revising the definition of the term "authorized emergency vehicles" and defining the term "volunteer ambulance service"; amending s. 316.072, F.S.; authorizing certain medical staff of a volunteer ambulance service to use red lights on a privately owned vehicle under certain circumstances; amending s. 316.2397, F.S.; authorizing vehicles of volunteer ambulance services to show or display red lights and operate emergency lights and sirens under certain circumstances; amending s. 316.2398, F.S.; authorizing privately owned vehicles belonging to certain medical staff of a volunteer ambulance service to display or use red warning signals under certain circumstances; conforming a provision to changes made by the act; prohibiting certain medical staff of volunteer ambulance services from operating red warning signals when not responding to an emergency in the line of duty; amending s. 401.211, F.S.; revising legislative intent; amending s. 401.23, F.S.; defining the terms "volunteer ambulance service" and "volunteer first responder agency"; amending s. 401.25, F.S.; exempting volunteer first responder agencies from certificate of public convenience and necessity

requirements; providing that county and municipal governments may not limit, prohibit, or prevent volunteer ambulance services from responding to emergencies or providing emergency medical services or transport within their respective jurisdictions; prohibiting county and municipal governments from requiring volunteer ambulance services to obtain a license or certificate or pay a fee to provide ambulance or air ambulance services within their respective jurisdictions, with an exception; amending s. 316.306, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Present subsection (105) of section 316.003, Florida Statutes, is redesignated as subsection (106), a new subsection (105) is added to that section, and subsection (1) of that section is amended, to read:

316.003 Definitions.—The following words and phrases, when used in this chapter, shall have the meanings respectively ascribed to them in this section, except where the context otherwise requires:

(1) AUTHORIZED EMERGENCY VEHICLES.—Vehicles of the fire department (fire patrol), police vehicles, and such ambulances

and emergency vehicles of municipal departments, volunteer ambulance services, public service corporations operated by private corporations, the Fish and Wildlife Conservation Commission, the Department of Environmental Protection, the Department of Health, the Department of Transportation, and the Department of Corrections as are designated or authorized by their respective departments ~~department~~ or the chief of police of an incorporated city or any sheriff of any of the various counties.

(105) VOLUNTEER AMBULANCE SERVICE.—A faith-based, not-for-profit corporation registered under chapter 617 which is licensed by the department as a basic life support service or an advanced life support service and which has no for-profit subsidiaries, uses volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, members, or officers any part of its assets or income.

Section 2. Paragraph (a) of subsection (5) of section 316.072, Florida Statutes, is amended to read:

316.072 Obedience to and effect of traffic laws.—

(5) AUTHORIZED EMERGENCY VEHICLES.—

(a)1. The driver of an authorized emergency vehicle, when responding to an emergency call, when in the pursuit of an actual or suspected violator of the law, or when responding to a fire alarm, but not upon returning from a fire;

2. A medical staff physician or technician of a medical facility or a volunteer ambulance service licensed by the state when responding to an emergency in the line of duty in his or her privately owned vehicle, using red lights as authorized in s. 316.2398; or

3. The driver of an authorized law enforcement vehicle, when conducting a nonemergency escort, to warn the public of an approaching motorcade;

may exercise the privileges set forth in this section, but subject to the conditions herein stated.

Section 3. Subsection (3) of section 316.2397, Florida Statutes, is amended to read:

316.2397 Certain lights prohibited; exceptions.—

(3) Vehicles of the fire department and fire patrol, including vehicles of volunteer firefighters as permitted under s. 316.2398, may show or display red or red and white lights. Vehicles of medical staff physicians or technicians of medical facilities or volunteer ambulance services licensed by the state as authorized under s. 316.2398, ambulances as authorized under this chapter, and buses and taxicabs as authorized under s. 316.2399 may show or display red lights. Vehicles of the fire department, fire patrol, police vehicles, and such ambulances and emergency vehicles of municipal and county departments, volunteer ambulance services, public service corporations

operated by private corporations, the Fish and Wildlife Conservation Commission, the Department of Environmental Protection, the Department of Transportation, the Department of Agriculture and Consumer Services, and the Department of Corrections as are designated or authorized by their respective department or the chief of police of an incorporated city or any sheriff of any county may operate emergency lights and sirens in an emergency. Wreckers, mosquito control fog and spray vehicles, and emergency vehicles of governmental departments or public service corporations may show or display amber lights when in actual operation or when a hazard exists provided they are not used going to and from the scene of operation or hazard without specific authorization of a law enforcement officer or law enforcement agency. Wreckers must use amber rotating or flashing lights while performing recoveries and loading on the roadside day or night, and may use such lights while towing a vehicle on wheel lifts, slings, or under reach if the operator of the wrecker deems such lights necessary. A flatbed, car carrier, or rollback may not use amber rotating or flashing lights when hauling a vehicle on the bed unless it creates a hazard to other motorists because of protruding objects. Further, escort vehicles may show or display amber lights when in the actual process of escorting overdimensioned equipment, material, or buildings as authorized by law. Vehicles owned or leased by private security agencies may show or display green and amber

lights, with either color being no greater than 50 percent of the lights displayed, while the security personnel are engaged in security duties on private or public property.

Section 4. Subsections (1), (2), and (4) of section 316.2398, Florida Statutes, are amended to read:

316.2398 Display or use of red or red and white warning signals; motor vehicles of volunteer firefighters or medical staff.—

(1) A privately owned vehicle belonging to an active firefighter member of a regularly organized volunteer firefighting company or association, while en route to the fire station for the purpose of proceeding to the scene of a fire or other emergency or while en route to the scene of a fire or other emergency in the line of duty as an active firefighter member of a regularly organized firefighting company or association, may display or use red or red and white warning signals. A privately owned vehicle belonging to a medical staff physician or technician of a medical facility or a volunteer ambulance service licensed by the state, while responding to an emergency in the line of duty, may display or use red warning signals. Warning signals must be visible from the front and from the rear of such vehicle, subject to the following restrictions and conditions:

(a) No more than two red or red and white warning signals may be displayed.

(b) No inscription of any kind may appear across the face of the lens of the red or red and white warning signal.

(c) In order for an active volunteer firefighter to display such red or red and white warning signals on his or her vehicle, the volunteer firefighter must first secure a written permit from the chief executive officers of the firefighting organization to use the red or red and white warning signals, and this permit must be carried by the volunteer firefighter at all times while the red or red and white warning signals are displayed.

(2) A person who is not an active firefighter member of a regularly organized volunteer firefighting company or association or a physician or technician of the medical staff of a medical facility or a volunteer ambulance service licensed by the state may not display on any motor vehicle owned by him or her, at any time, any red or red and white warning signals as described in subsection (1).

(4) A physician or technician of the medical staff of a medical facility or a volunteer ambulance service may not operate any red warning signals as authorized in subsection (1), except when responding to an emergency in the line of duty.

Section 5. Section 401.211, Florida Statutes, is amended to read:

401.211 Legislative intent.—The Legislature recognizes that the systematic provision of emergency medical services

saves lives and reduces disability associated with illness and injury. In addition, that system of care must be equally capable of assessing, treating, and transporting children, adults, and frail elderly persons. Further, it is the intent of the Legislature to encourage the development and maintenance of emergency medical services because such services are essential to the health and well-being of all citizens of the state. The Legislature finds that it is in the public interest to foster the development of emergency medical services that address religious sensitivities. In accordance with the Florida Volunteer and Community Service Act of 2001, the Legislature further recognizes the value of augmenting existing county and municipal emergency medical services with those provided by volunteer service organizations. The Legislature also recognizes that the establishment of a comprehensive statewide injury-prevention program supports state and community health systems by further enhancing the total delivery system of emergency medical services and reduces injuries for all persons. The purpose of this part is to protect and enhance the public health, welfare, and safety through the establishment of an emergency medical services state plan, an advisory council, a comprehensive statewide injury-prevention program, minimum standards for emergency medical services personnel, vehicles, services and medical direction, and the establishment of a statewide inspection program created to monitor the quality of

patient care delivered by each licensed service and appropriately certified personnel.

Section 6. Subsections (22) and (23) are added to section 401.23, Florida Statutes, to read:

401.23 Definitions.—As used in this part, the term:

(22) "Volunteer ambulance service" means a faith-based, not-for-profit corporation registered under chapter 617 which is licensed by the department as a basic life support service or an advanced life support service and which has no for-profit subsidiaries, uses volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, members, or officers any part of its assets or income.

(23) "Volunteer first responder agency" means a first responder agency as defined in s. 401.435(2) which is a faith-based, not-for-profit corporation registered under chapter 617, has been operating in this state for at least 10 consecutive years, has no for-profit subsidiaries, uses volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, members, or officers any part of its assets or income.

Section 7. Paragraph (d) of subsection (2) and subsection (6) of section 401.25, Florida Statutes, are amended to read:

401.25 Licensure as a basic life support or an advanced

life support service.—

(2) The department shall issue a license for operation to any applicant who complies with the following requirements:

(d) The applicant has obtained a certificate of public convenience and necessity from each county in which the applicant will operate. In issuing the certificate of public convenience and necessity, the governing body of each county shall consider the recommendations of municipalities within its jurisdiction. An applicant that is a volunteer first responder agency is exempt from this requirement.

(6)(a) The governing body of each county may adopt ordinances that provide reasonable standards for certificates of public convenience and necessity for basic or advanced life support services and air ambulance services. In developing standards for certificates of public convenience and necessity, the governing body of each county must consider state guidelines, recommendations of the local or regional trauma agency created under chapter 395, and the recommendations of municipalities within its jurisdiction.

(b) A county or municipal government may not limit, prohibit, or prevent a volunteer ambulance service from responding to an emergency or from providing emergency medical services or transport within its jurisdiction.

(c) A county or municipal government may not require a volunteer ambulance service to obtain a license or certificate

or pay a fee to provide ambulance or air ambulance services within its jurisdiction, except that a county or municipal government may impose, collect, or enforce payment of any occupational license tax authorized by law.

Section 8. Paragraph (a) of subsection (3) of section 316.306, Florida Statutes, is amended to read:

316.306 School and work zones; prohibition on the use of a wireless communications device in a handheld manner.—

(3)(a)1. A person may not operate a motor vehicle while using a wireless communications device in a handheld manner in a designated school crossing, school zone, or work zone area as defined in s. 316.003(106) ~~s. 316.003(105)~~. This subparagraph shall only be applicable to work zone areas if construction personnel are present or are operating equipment on the road or immediately adjacent to the work zone area. For the purposes of this paragraph, a motor vehicle that is stationary is not being operated and is not subject to the prohibition in this paragraph.

2.a. During the period from October 1, 2019, through December 31, 2019, a law enforcement officer may stop motor vehicles to issue verbal or written warnings to persons who are in violation of subparagraph 1. for the purposes of informing and educating such persons of this section. This sub-subparagraph shall stand repealed on October 1, 2020.

b. Effective January 1, 2020, a law enforcement officer

may stop motor vehicles and issue citations to persons who are driving while using a wireless communications device in a handheld manner in violation of subparagraph 1.

Section 9. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Caruso offered the following:

Amendment

Remove lines 62-235 and insert:

licensed under part III of chapter 401 as a basic life support service or an advanced life support service and which has no for-profit subsidiaries, uses volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, members, or officers any part of its assets or income.

Section 2. Paragraph (a) of subsection (5) of section 316.072, Florida Statutes, is amended to read:

316.072 Obedience to and effect of traffic laws.—

(5) AUTHORIZED EMERGENCY VEHICLES.—

(a)1. The driver of an authorized emergency vehicle, when responding to an emergency call, when in the pursuit of an actual or suspected violator of the law, or when responding to a fire alarm, but not upon returning from a fire;

2. A medical staff physician or technician of a medical facility licensed by the state or of a volunteer ambulance service when responding to an emergency in the line of duty in his or her privately owned vehicle, using red lights as authorized in s. 316.2398; or

3. The driver of an authorized law enforcement vehicle, when conducting a nonemergency escort, to warn the public of an approaching motorcade;

may exercise the privileges set forth in this section, but subject to the conditions herein stated.

Section 3. Subsection (3) of section 316.2397, Florida Statutes, is amended to read:

316.2397 Certain lights prohibited; exceptions.—

(3) Vehicles of the fire department and fire patrol, including vehicles of volunteer firefighters as permitted under s. 316.2398, may show or display red or red and white lights. Vehicles of medical staff physicians or technicians of medical facilities licensed by the state or of volunteer ambulance services as authorized under s. 316.2398, ambulances as authorized under this chapter, and buses and taxicabs as

authorized under s. 316.2399 may show or display red lights. Vehicles of the fire department, fire patrol, police vehicles, and such ambulances and emergency vehicles of municipal and county departments, volunteer ambulance services, public service corporations operated by private corporations, the Fish and Wildlife Conservation Commission, the Department of Environmental Protection, the Department of Transportation, the Department of Agriculture and Consumer Services, and the Department of Corrections as are designated or authorized by their respective department or the chief of police of an incorporated city or any sheriff of any county may operate emergency lights and sirens in an emergency. Wreckers, mosquito control fog and spray vehicles, and emergency vehicles of governmental departments or public service corporations may show or display amber lights when in actual operation or when a hazard exists provided they are not used going to and from the scene of operation or hazard without specific authorization of a law enforcement officer or law enforcement agency. Wreckers must use amber rotating or flashing lights while performing recoveries and loading on the roadside day or night, and may use such lights while towing a vehicle on wheel lifts, slings, or under reach if the operator of the wrecker deems such lights necessary. A flatbed, car carrier, or rollback may not use amber rotating or flashing lights when hauling a vehicle on the bed unless it creates a hazard to other motorists because of

protruding objects. Further, escort vehicles may show or display amber lights when in the actual process of escorting overdimensioned equipment, material, or buildings as authorized by law. Vehicles owned or leased by private security agencies may show or display green and amber lights, with either color being no greater than 50 percent of the lights displayed, while the security personnel are engaged in security duties on private or public property.

Section 4. Subsections (1), (2), and (4) of section 316.2398, Florida Statutes, are amended to read:

316.2398 Display or use of red or red and white warning signals; motor vehicles of volunteer firefighters or medical staff.—

(1) A privately owned vehicle belonging to an active firefighter member of a regularly organized volunteer firefighting company or association, while en route to the fire station for the purpose of proceeding to the scene of a fire or other emergency or while en route to the scene of a fire or other emergency in the line of duty as an active firefighter member of a regularly organized firefighting company or association, may display or use red or red and white warning signals. A privately owned vehicle belonging to a medical staff physician or technician of a medical facility licensed by the state or of a volunteer ambulance service, while responding to an emergency in the line of duty, may display or use red warning

signals. Warning signals must be visible from the front and from the rear of such vehicle, subject to the following restrictions and conditions:

(a) No more than two red or red and white warning signals may be displayed.

(b) No inscription of any kind may appear across the face of the lens of the red or red and white warning signal.

(c) In order for an active volunteer firefighter to display such red or red and white warning signals on his or her vehicle, the volunteer firefighter must first secure a written permit from the chief executive officers of the firefighting organization to use the red or red and white warning signals, and this permit must be carried by the volunteer firefighter at all times while the red or red and white warning signals are displayed.

(2) A person who is not an active firefighter member of a regularly organized volunteer firefighting company or association or a physician or technician of the medical staff of a medical facility licensed by the state or of a volunteer ambulance service may not display on any motor vehicle owned by him or her, at any time, any red or red and white warning signals as described in subsection (1).

(4) A physician or technician of the medical staff of a medical facility licensed by the state or of a volunteer ambulance service may not operate any red warning signals as

authorized in subsection (1), except when responding to an emergency in the line of duty.

Section 5. Section 401.211, Florida Statutes, is amended to read:

401.211 Legislative intent.—The Legislature recognizes that the systematic provision of emergency medical services saves lives and reduces disability associated with illness and injury. In addition, that system of care must be equally capable of assessing, treating, and transporting children, adults, and frail elderly persons. Further, it is the intent of the Legislature to encourage the development and maintenance of emergency medical services because such services are essential to the health and well-being of all citizens of the state. The Legislature finds that it is in the public interest to foster the development of emergency medical services that address religious sensitivities. In accordance with the Florida Volunteer and Community Service Act of 2001, the Legislature further recognizes the value of augmenting existing county and municipal emergency medical services with those provided by volunteer service organizations. The Legislature also recognizes that the establishment of a comprehensive statewide injury-prevention program supports state and community health systems by further enhancing the total delivery system of emergency medical services and reduces injuries for all persons. The purpose of this part is to protect and enhance the public

health, welfare, and safety through the establishment of an emergency medical services state plan, an advisory council, a comprehensive statewide injury-prevention program, minimum standards for emergency medical services personnel, vehicles, services and medical direction, and the establishment of a statewide inspection program created to monitor the quality of patient care delivered by each licensed service and appropriately certified personnel.

Section 6. Subsection (22) is added to section 401.23, Florida Statutes, to read:

401.23 Definitions.—As used in this part, the term:

(22) "Volunteer ambulance service" means a faith-based, not-for-profit corporation registered under chapter 617 which is licensed by the department as a basic life support service or an advanced life support service, is not a parent, subsidiary or affiliate of, or related to any for-profit entity, and which uses only unpaid volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, volunteers, members, or officers, any part of its assets or income.

Section 7. Paragraph (d) of subsection (2) and subsection (6) of section 401.25, Florida Statutes, are amended to read:

401.25 Licensure as a basic life support or an advanced life support service.—

(2) The department shall issue a license for operation to any applicant who complies with the following requirements:

(d) The applicant has obtained a certificate of public convenience and necessity from each county in which the applicant will operate. In issuing the certificate of public convenience and necessity, the governing body of each county shall consider the recommendations of municipalities within its jurisdiction. An applicant that is a first responder agency is exempt from this requirement if it is a faith-based, not-for-profit corporation registered under chapter 617 which has been operating in this state for at least 10 consecutive years, has no for-profit subsidiaries, uses volunteers to provide services, is not operating for pecuniary profit or financial gain, and does not distribute to or inure to the benefit of its directors, members, or officers any part of its assets or income.

(6)(a) The governing body of each county may adopt ordinances that provide reasonable standards for certificates of public convenience and necessity for basic or advanced life support services and air ambulance services. In developing standards for certificates of public convenience and necessity, the governing body of each county must consider state guidelines, recommendations of the local or regional trauma agency created under chapter 395, and the recommendations of municipalities within its jurisdiction.

HB 1373

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1373 Rare Disease Advisory Council
SPONSOR(S): DuBose
TIED BILLS: **IDEN./SIM. BILLS:** CS/HB 1373

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Rahming	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In the United States (U.S), a rare disease is any condition that nationally affects fewer than 200,000 people. There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families. This estimate has been used by the rare disease community for several decades to highlight that while individual diseases may be rare, the total number of people with a rare disease is large.

The National Organization for Rare Disorders, a non-profit patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them, is working to establish a Rare Disease Advisory Council (RDAC) in every state. Currently, 16 states have successfully established RDACs, but Florida is not one of them.

HB 1373 creates the Rare Disease Advisory Council (Council) adjunct to the Department of Health (DOH). The bill establishes the membership of the Council as well as the length of the members' terms. The Council is required to:

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in this state.
- Develop recommended strategies for academic research institutions in this state to facilitate continued research on rare diseases.
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients.
- Provide written input and feedback to the DOH, the Medicaid program, and other state agencies on specified matters.

HB 1373 requires the Council to first meet on October 1, 2021, and provide its recommendations to the Governor and the State Surgeon General by July 1 of each year, beginning in 2022.

The bill has a significant, negative fiscal impact on the DOH. See Fiscal Comments.

The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Rare Disease

In the United States (U.S), a rare disease is any condition that nationally affects fewer than 200,000 people.[1] There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families.[2] This estimate has been used by the rare disease community for several decades to highlight that while individual diseases may be rare, the total number of people with a rare disease is large.[3]

Nationally, only a few types of rare diseases are tracked when a person is diagnosed.[4] These include certain infectious diseases, birth defects, and cancers. It also includes the diseases on state newborn screening tests.[5] Because most rare diseases are not tracked, it is difficult to determine the exact number of rare diseases or how many people are affected. Researchers have made progress in learning how to diagnose, treat, and even prevent a variety of rare diseases, however, most rare diseases have no treatments. [6]

The National Institutes of Health (NIH) supports research to improve the health of people with rare diseases.[7] Many of the 27 Institutes and Centers at the NIH fund medical research for rare diseases, such as the National Center for Advancing Translational Sciences (NCATS), which focuses on getting new cures and treatments to all patients more quickly.[8] NCATS supports research through collaborative projects to study common themes and causes of related diseases.[9] This approach aims to speed the development of treatments that will eventually serve both rare and common diseases.[10]

Efforts to improve and bring to market treatments for rare diseases are coordinated by the Food and Drug Administration.[11] The Office of Orphan Products Development (OOPD) provides incentives for drug companies to develop treatments for rare diseases.[12] Between 1973 and 1983, fewer than 10 treatments for rare diseases were approved.[13] Since 1983, the OOPD program has helped develop and bring to market more than 400 drugs and biologic products for rare diseases.[14]

Rare Disease Advisory Council

The National Organization for Rare Disorders (NORD), a non-profit patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them, is working to establish a Rare Disease Advisory Council (RDAC) in every state. An RDAC is an advisory body providing a platform for the rare disease community to have a stronger voice in state government.[15]

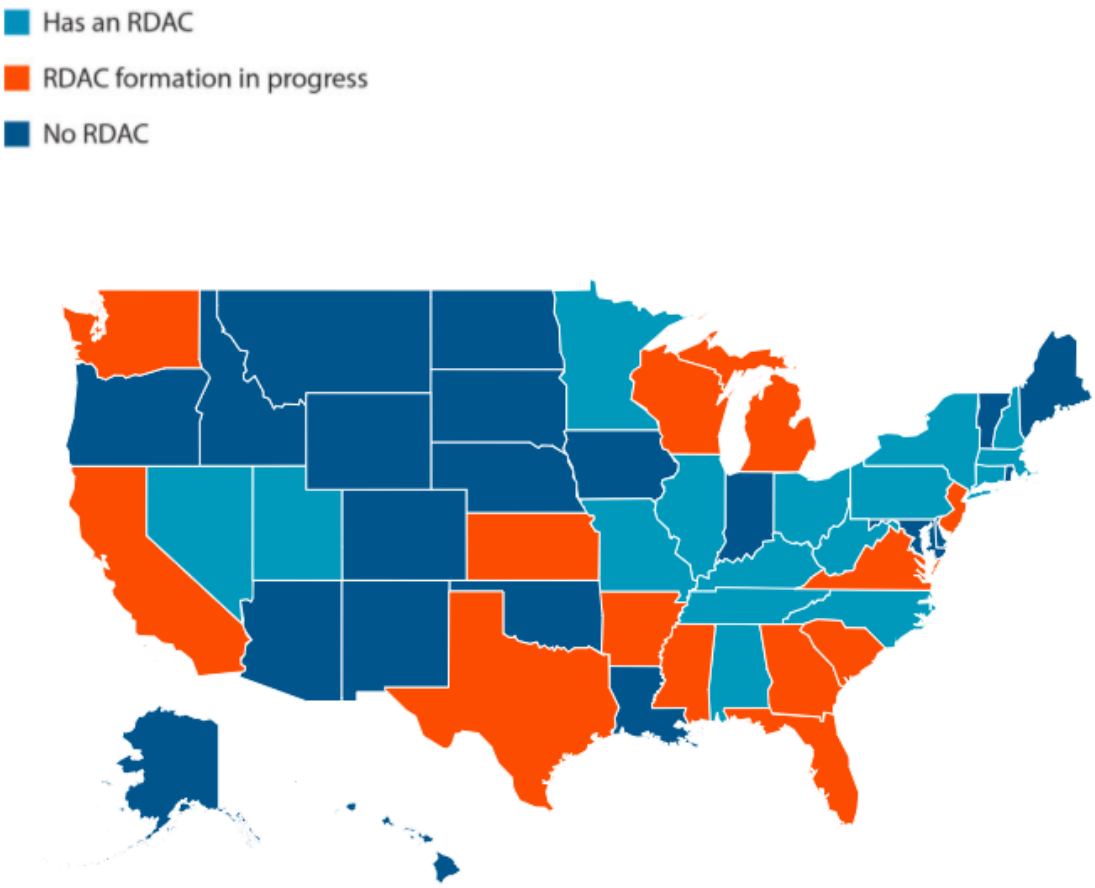
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[1] U.S. Department of Health & Human Services, National Institutes of Health (NIH), *FAQs About Rare Diseases*, https://rarediseases.info.nih.gov/diseases/pages/31/faqs-about-rare-diseases#:~:text=In%20the%20United%20States%2C%20only,on%20state%20newborn%20screening%20tests. (last visited Mar. 18, 2021).
[2] *Id*.
[3] *Id*.
[4] *Id.*
[5] *Id*.
[6] *Id*.
[7] *National Organization for Rare Diseases (NORD), Rare Disease Advisory Councils (RDACs): Project RDAC, https://rarediseases.org/rdac-overview/ (last visited Mar. 18, 2021).*
[8] *Id*.
[9] *Id*.
[10] *Id*.
[11] *Id*.
[12] *Id*.
[13] *Id*.
[14] *Id*.
[15] National Organization for Rare Diseases (NORD), Rare Disease Advisory Councils (RDACs): Project RDAC, https://rarediseases.org/rdac-overview/ (last visited Mar. 18, 2021).

RDACs address the needs of affected patients and families by giving stakeholders an opportunity to make recommendations to state leaders on critical issues including the need for increased awareness, diagnostic tools and access to affordable treatments and cures.[16] These councils are housed by a variety of organizations including departments of health, outside nonprofits, universities or grantees from departments of health. The types of RDACs include councils, task forces, advisory commissions, or work groups.

Through the support of the NORD, alongside patient organizations and the other members of the rare disease community, momentum around RDACs is growing. In 2015, the first RDAC was created in North Carolina by patients, caregivers, families and providers.[17] Currently, there are 16 states with RDACs and 13 states with RDAC formation in progress:[18]

RDACs by State



Advisory Councils in Florida

In Florida, a statutorily created advisory council is appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives[19]. An advisory council specifically created as an adjunct to an executive agency is created only after being found to be necessary and beneficial to the furtherance of a public purpose and must be terminated by the Legislature when it is no longer necessary.[20]

[16] *Id.*
[17] *Id.*
[18] NORD, *RDACs by State*, https://rarediseases.org/rdac-overview/rdacs-by-state/ (last visited Mar. 18, 2021).
[19] S. 20.03(7), F.S.
[20] S. 20.052, F.S.

Under current law, an advisory body may not be created unless:[21]

- It meets a statutorily defined purpose;
- Its powers and responsibilities conform with the definitions for specified governmental units;
- Its members, unless expressly provided otherwise in the State Constitution, are appointed for four-year staggered terms; and
- Its members, unless expressly provided otherwise by specific statutory enactment, serve without additional compensation or honorarium, and are authorized to receive only per diem and reimbursement for travel expenses as provided in s. 112.061, F.S.

Private citizen members of an advisory body that is adjunct to an executive agency must be appointed by the Governor, the head of the department, the executive director of the department, or a Cabinet officer.[22] Unless exempt under law, all advisory council meetings are open to the public under s. 286.011, F.S., and minutes, including a record of all votes cast, must be maintained for all meetings.[23]

If an advisory council adjunct to an executive agency is abolished, its records must be appropriately stored, within 30 days after the effective date of its abolition, by the executive agency to which it was adjunct, and any property assigned to it must be reclaimed by the executive agency.[24] An advisory council is prohibited from performing any activities after the effective date of its abolition.[25]

Florida currently does not have an RDAC. However, the Department of Health (DOH) supports existing councils to promote engagement with stakeholders regarding disabilities and development delays:[26]

- The Genetics and Newborn Screening Advisory Council.
    - This council includes a large array of expertise ranging from pediatricians, audiologists, representatives from each of the four medical schools in this state, pediatric hematologist, the Florida Hospital Association, as well as executive representation from the DOH.
- The Florida Interagency Coordinating Council for Infants and Toddlers.
    - This council advises and assists the Early Steps program with its implementation of the Individuals with Disabilities Education Act, Part C, and includes representation from public and private providers, the Agency for Health Care Administration, the Department of Education, and parents.
- The Information Clearinghouse on Developmental Disabilities Advisory Council.
    - This council provides resources to parents with children with developmental disabilities via the Bright Expectations website.

Effect of Proposed Changes

HB 1373 creates s. 381.99, F.S., to establish the Rare Disease Advisory Council (Council). The Council is created as an adjunct to the DOH for the purpose of providing recommendations on ways to improve health outcomes for individuals with rare diseases, conditions that affect fewer than 200,000 people in the United States.

The bill requires the Governor to appoint the following members to the Council:

- A representative of the Department of Health.
- A representative of the Agency for Health Care Administration.
- A representative of the Office of Insurance Regulation.
- A representative of the Department of Education.

[21] S. 20.052(4), F.S.
[22] S. 20.052(5)(a), F.S.
[23] S. 20.052(5)(c), F.S.
[24] S. 20.052(5)(d), F.S.
[25] *Id*.
[26] Florida Department of Health (DOH), 2021 Agency Legislative Bill Analysis for House Bill 1373, p. 2 (Mar. 1, 2021).

- Two representatives from academic research institutions in this state which receive any grant funding for research regarding rare diseases.
- One geneticist practicing in this state.
- One registered nurse or advanced practice registered nurse who is licensed and practicing in this state with experience treating rare diseases.
- Two physicians who are licensed and practicing in this state with experience treating rare diseases.
- One hospital administrator from a hospital in this state which provides care to individuals diagnosed with rare diseases.
- Two individuals who are 18 years of age or older who have a rare disease.
- Two individuals who are caregivers of an individual with a rare disease.
- Two representatives of organizations operating in this state which provide care or other support for individuals with rare diseases.
- A pharmacist who is licensed and practicing in this state who has experience with drugs that are used to treat rare diseases.
- A representative of the biotechnology industry.
- A representative of health insurance companies.

Members of the Council must be appointed by September 1, 2021, and are appointed for four-year terms except that specified members are initially appointed to two-year terms to stagger the appointments. The Council is required to hold its initial meeting by October 1, 2021, and may meet upon the call of the chair or upon the request of the majority of its members thereafter. The Council is authorized to meet electronically.

The bill requires the Council to:

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in this state.
- Develop recommended strategies for academic research institutions in this state to facilitate continued research on rare diseases.
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients. The advisory council shall provide such strategies to the DOH for publication on the department's website.
- Provide written input and feedback to the DOH, the Medicaid program, and other state agencies on specified matters.

The DOH must provide staff and administrative support to the Council. The Council is required to submit a report to the DOH and the State Surgeon General by July 1 of each year, beginning in 2022, which describes the activities of the Council in the most recent year and its findings and recommendations regarding rare disease research and care.

The bill provides an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 381.99, F.S., relating to the Rare Disease Advisory Council.
Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The DOH will incur costs associated with staffing and supporting the Rare Disease Advisory Council. The DOH estimates one FTE will be required and requests $122,888 in recurring funds and $4,429 in nonrecurring funds for Fiscal Year 2021-2022.[27]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. The bill does not require rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[27] DOH, *supra* note 26, at 5.

A bill to be entitled

An act relating to the Rare Disease Advisory Council; creating s. 381.99, F.S.; creating the advisory council adjunct to the Department of Health; specifying the purpose of the advisory council; providing for staff and administrative support; defining the term "rare disease"; specifying application of state law governing the establishment of advisory councils; prescribing the composition of the advisory council; providing for initial appointments to the advisory council by a specified date; providing organizational and other meeting requirements for the advisory council; prescribing duties and responsibilities of the advisory council; providing an effective date.

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

Section 1. Section 381.99, Florida Statutes, is created to read:

381.99 Rare Disease Advisory Council.—

(1) The Rare Disease Advisory Council, an advisory council as defined in s. 20.03(7), is created adjunct to the Department of Health for the purpose of providing recommendations on ways to improve health outcomes for individuals residing in this

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

state who have a rare disease. The department shall provide staff and administrative support for the advisory council in the carrying out of its duties and responsibilities. For purposes of this section, the term "rare disease" means a condition that affects fewer than 200,000 people in the United States. Except as otherwise provided in this section, the advisory council shall operate in a manner consistent with s. 20.052.

(2) The advisory council is composed of the following members appointed by the Governor:

(a) A representative of the Department of Health.

(b) A representative of the Agency for Health Care Administration.

(c) A representative of the Office of Insurance Regulation.

(d) A representative of the Department of Education.

(e) Two representatives from academic research institutions in this state which receive any grant funding for research regarding rare diseases.

(f) One geneticist practicing in this state.

(g) One registered nurse or advanced practice registered nurse who is licensed and practicing in this state with experience treating rare diseases.

(h) Two physicians who are licensed and practicing in this state with experience treating rare diseases.

(i) One hospital administrator from a hospital in this

state which provides care to individuals diagnosed with rare diseases.

(j) Two individuals who are 18 years of age or older who have a rare disease.

(k) Two individuals who are caregivers of an individual with a rare disease.

(l) Two representatives of organizations operating in this state which provide care or other support for individuals with rare diseases.

(m) A pharmacist who is licensed and practicing in this state who has experience with drugs that are used to treat rare diseases.

(n) A representative of the biotechnology industry.

(o) A representative of health insurance companies.

Any vacancy on the advisory council shall be filled in the same manner as the original appointment.

(3) The initial members of the advisory council shall be appointed by September 1, 2021. Each member shall be appointed to a 4-year term of office. However, in order to achieve staggered terms, the initial members appointed pursuant to paragraphs (2)(a)-(i) shall be appointed to a 2-year term. The Governor shall designate a chair and vice chair of the advisory council from among its membership. The advisory council shall meet for its initial meeting by October 1, 2021. Thereafter, the

advisory council may meet upon the call of the chair or upon the request of a majority of its members. The advisory council may meet via teleconferencing or other electronic means. Notices for any scheduled meetings of the advisory council must be published in advance on the department's website.

(4) The advisory council shall:

(a) Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in this state.

(b) Develop recommended strategies for academic research institutions in this state to facilitate continued research on rare diseases.

(c) Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients. The advisory council shall provide such strategies to the Department of Health for publication on the department's website.

(d) Provide input and feedback in writing to the department, the Medicaid program, and other state agencies on matters that affect people who have been diagnosed with rare diseases, including, but not limited to, pandemic or natural disaster preparedness and response.

(e) By July 1 of each year, beginning in 2022, submit a report to the Governor and the State Surgeon General which

describes the activities of the advisory council in the past year and its findings and recommendations regarding rare disease research and care. Additionally, the report must be made available on the department's website.

Section 2. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Plakon offered the following:

Amendment

Remove lines 34-72 and insert:

members:

(a) As appointed by the Governor:

1. A representative of the Department of Health.

2. A representative of the Agency for Health Care Administration.

3. A representative of the Office of Insurance Regulation.

4. A representative of the Department of Education.

5. One geneticist practicing in this state.

6. One registered nurse or advanced practice registered nurse who is licensed and practicing in this state with experience in treating rare diseases.

7. One hospital administrator from a hospital in this state which provides care to individuals diagnosed with rare diseases.

8. A pharmacist who is licensed and practicing in this state who has experience with drugs that are used in the treatment of rare diseases.

9. A representative of the biotechnology industry.

10. A representative of health insurance companies.

(b) As appointed by the President of the Senate:

1. A representative from an academic research institution in this state which receives grant funding for research regarding rare diseases.

2. A physician who is licensed under chapter 458 or chapter 459 and practicing in this state with experience in treating rare diseases.

3. An individual who is 18 years of age or older who has a rare disease.

4. An individual who is a caregiver of an individual with a rare disease.

5. A representative of an organization operating in this state which provides care or other support to individuals with rare diseases.

(c) As appointed by the Speaker of the House of Representatives:

1. A representative from an academic research institution in this state which receives grant funding for research regarding rare diseases.

2. A physician who is licensed under chapter 458 or chapter 459 and practicing in this state with experience in treating rare diseases.

3. An individual who is 18 years of age or older who has a rare disease.

4. An individual who is a caregiver of an individual with a rare disease.

5. A representative of organizations in this state which provide care or other support to individuals with rare diseases. Any vacancy on the advisory council must be filled in the same manner as the original appointment.

(3) The initial members of the advisory council must be appointed by September 1, 2021. Each member must be appointed to a 4-year term of office. However, in order to achieve staggered terms, each of the initial members appointed pursuant to paragraph (2)(a) must be appointed to a 2-year term. The

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1381 Maternal Health Outcomes
SPONSOR(S): Brown
TIED BILLS: **IDEN./SIM. BILLS:** SB 1540

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Rahming	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Department of Health Office of Minority Health and Health Equity administers multiple health promotion programs including the "Closing the Gap" (CTG) grant program. The grant program was created by the Legislature in 2000 to improve health outcomes and eliminate racial and ethnic health disparities in Florida by providing grants to increase community-based health and disease prevention activities.

Grants are awarded for one year through a proposal process, and may be renewed annually subject to the availability of funds and the grantee's achievement of quality standards, objectives, and outcomes. Projects funded through the CTG grant program must address racial and ethnic disparities associated with one or more of the following priority areas:

- Increasing adult and child immunization rates in certain racial and ethnic populations.
- Improving neighborhood social determinates of health, such as transportation, safety, and food access.
- Decreasing racial and ethnic disparities in maternal and infant mortality rates, oral health care, or morbidity and mortality rates related to cancer, HIV/AIDS, cardiovascular disease, diabetes, Alzheimer's disease and related dementia, sickle cell disease, and Lupus.

HB 1381 allows the CTG grant program to fund projects directed at decreasing racial and ethnic disparities in severe maternal morbidity and other maternal outcomes. The bill also adds maternal health programs to existing community-based programs the DOH is required to coordinate with to avoid duplicative efforts and promote consistency.

The bill creates telehealth minority maternity care pilot programs in Duval and Orange Counties, Florida, to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations. The bill expands the definition of telehealth to include audio-only telephone calls, e-mail messages, and facsimiles transmission for the purpose of the pilot programs. The pilot programs are required to use telehealth to provide specified services and education to eligible pregnant women up to the last day of their postpartum period and provide specified training to participating health care practitioners and other perinatal professionals.

The bill requires that legislative appropriated funds for the CTG grant program be used to fund the pilot programs. The bill also requires that the DOH's Division of Community Health Promotion and Office of Minority Health and Health Equity work together to apply for available federal funds to assist in the implementation of the bill.

The bill grants rulemaking authority to the DOH to implement the bill's provisions.

The bill has an indeterminate, negative, significant impact on the DOH.

The bill has no fiscal impact on local governments.

The bill has an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Closing the Gap Program

The Department of Health (DOH) Office of Minority Health and Health Equity (Office) is the coordinating office for consultative services in the areas of cultural and linguistic competency, partnership building, and program development and implementation to address the heath needs of Florida's minority and underrepresented populations statewide. The Office administers multiple health promotion programs including the "Closing the Gap" (CTG) grant program.[1] In 2000, the Legislature created the CTG grant program to improve health outcomes and eliminate racial and ethnic health disparities in Florida by providing grants to increase community-based health and disease prevention activities.[2]

Currently, the DOH is required to coordinate with existing community-based programs to avoid duplicative efforts and promote consistency, such as:[3]

- Chronic disease intervention programs;
- Cancer prevention ad control programs;
- Diabetes control programs;
- The Healthy Start program;
- The Florida Kidcare Program;
- The HIV/AIDS program;
- Immunization programs; and
- Other related programs at the state and local levels.

Grant Proposals

Grants are awarded for one year through a proposal process, and may be renewed annually subject to the availability of funds and the grantee's achievement of quality standards, objectives, and outcomes.[4] Proposals for grants must identify:[5]

- The purpose and objectives of the proposed project, including the particular racial or ethnic disparity the project will address from one or more of the following priority areas:
  - Increasing adult and child immunization rates in certain racial and ethnic populations;
  - Improving neighborhood social determinates of health, such as transportation, safety, and food access, as outlined by the Centers for Disease Control and Prevention (CDC), or
  - Decreasing racial and ethnic disparities in:
    - Maternal and infant mortality rates;
    - Morbidity and mortality rates relating to cancer;
    - Morbidity and mortality rates relating to HIV/AIDS;
    - Morbidity and mortality rates relating to cardiovascular disease;
    - Morbidity and mortality rates relating to diabetes;
    - Morbidity and mortality rates relating to sickle cell disease;
    - Morbidity and mortality rates relating to Lupus; or
    - Oral health care.
- The target population and its relevance;

[1] Florida Department of Health, *Minority Health*, http://www.floridahealth.gov/%5C/programs-and-services/minority-health/index.html (last visited Mar. 15, 2021).
[2] Ss. 381.7353–381.7356, F.S.
[3] S. 381.7353, F.S.
[4] S. 381.7356(4), F.S.
[5] S. 381.7355, F.S.

- Methods for obtaining baseline health status data and assessment of community health needs;
- Mechanisms for mobilizing community resources and gaining local commitment;
- Development and implementation of health promotion and disease prevention interventions;
- Mechanisms and strategies for evaluating the project's objectives, procedures, and outcomes;
- A proposed work plan, including a timeline for implementing the project; and
- The likelihood that project activities will occur and continue in the absence of funding. [6]

Grant Funding

The amount of award per applicant may vary, as awards are based on the merit of the grant application and there are no minimum or maximum amounts for grant awards.[7] Projects receiving grants are required to provide local matching funds of one dollar for every three dollars awarded.[8] In counties with populations greater than 50,000, up to 50 percent of the local matching funds may be in-kind in the form of free services or human resources.[9] In counties with populations of 50,000 or less, local matching funds may be provided entirely through in-kind contributions.[10]

Social Determinants of Health

Healthy People 2020 is an initiative of the U.S. Department of Health and Human Services that provides 10-year national objectives for improving the health of Americans.[11] This initiative highlights the importance of social determinants of health as one of its overarching goals.[12] Social determinants of health (SDOH) refer to the conditions in the places where people live, learn, and play that have an effect on health risks outcomes.[13] Examples of social determinants include access to health care services, public safety, social norms and attitudes, access to educational, economic, and job opportunities, residential segregation, and quality of education and job training.[14] Healthy People 2020's five key areas of SDOH are: [15]

- Economic stability;
- Education;
- Social and community context;
- Health and health care; and
- Neighborhood and built environment.

The CDC has also developed a web-based toolkit to help practitioners recognize the root causes that can affect the health of a population.[16]

Maternal Health Outcomes

The well-being of women, children, and families determines the health of future generations. Life events influence maternal and child health risks and outcomes. Racial and ethnic differences in maternal

[6] *Id*.
[7] S. 381.7356(4), F.S. *See also,* Florida Department of Health, *Application Guidelines FY 2021-2023*, *available at* http://www.floridahealth.gov/about/administrative-functions/purchasing/grant-funding-opportunities/RFA20-005.pdf (last visited Mar. 15, 2021).
[8] S. 381.7356(2), F.S.
[9] S. 381.7356(2)(a), F.S.
[10] S. 381.7356(2)(b), F.S.
[11] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *About Healthy People*, http://www.healthypeople.gov/2020/About-Healthy-People (last visited Mar. 15, 2021).
[12] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion, *Social Determinants of Health*, http://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-of-health (last visited on Mar. 15, 2021).
[13] Centers for Disease Control and Prevention (CDC), *Social Determinants of Health: Know What Affects Health* (rev. Mar. 9, 2021), http://www.cdc.gov/socialdeterminants/index.htm (last visited Mar. 15, 2019).
[14] *Supra* note 12.
[15] *Id*.
[16] CDC, *Tools for Putting Social Determinants of Health into Action*, (rev. Mar. 9, 2021), http://www.cdc.gov/socialdeterminants/tools/index.htm (last visited Mar. 15, 2019).

health outcomes, such as maternal and infant mortality and severe maternal morbidity, can predict future public health challenges for families, communities and the health care system.

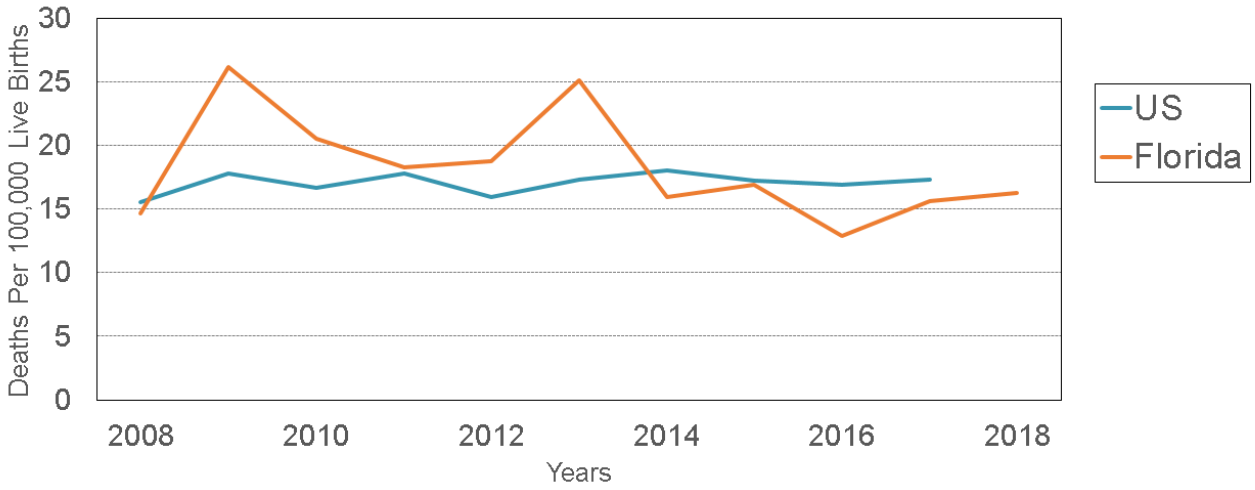
Maternal Mortality

Maternal mortality refers to deaths occurring during pregnancy or within 42 days of the end of pregnancy, regardless of the duration of the pregnancy, from any cause related to or aggravated by the pregnancy, but not from accidental or incidental causes.[17] Late maternal deaths (occurring between 43 days and 1 year of death) are not included as part of the World Heath Organization's (WHO) definition of maternal mortality.[18] Approximately 700 women die each year in the United States (U.S.) as a result of pregnancy or delivery complications.[19] The national maternal mortality rate is 17.4 deaths per 100,000 live births.[20] Racial and ethnic gaps exist between non-Hispanic black, non-Hispanic white, and Hispanic women. The maternal mortality rate of these groups is 37.3, 14.9, and 11.8 deaths per 100,000 live births, respectively.[21]

Maternal Mortality in Florida

Overall, Florida's maternal mortality rate has been decreasing and consistently below the national rate within recent years. As of 2018, the maternal mortality rate in Florida is 16.3 deaths per 100,000 live births, a decrease from a high of 26.2 per 100,000 live births in 2009:[22]

Pregnancy-Related Mortality Rates United States & Florida, 2008 – 2018



Severe Maternal Morbidity

A significant number of women in the U.S. experience severe maternal morbidity, or severe complications from labor and delivery that start after they leave the hospital.[23] Severe maternal

[17] U.S. Department of Health and Human Services, *The Surgeon General's Call to Action to Improve Maternal Health*, (Dec. 2020), https://www.hhs.gov/sites/default/files/call-to-action-maternal-health.pdf (last visited Mar. 16, 2021).
[18] *Id*.
[19] CDC, *Maternal Mortality,* https://www.cdc.gov/reproductivehealth/maternal-mortality/index.html (last visited Mar. 16, 2021).
[20] CDC, National Center for Health Statistics, *Maternal Mortality,* https://www.cdc.gov/nchs/maternal-mortality/index.htm (last visited Mar. 16, 2021).
[21] *Id*.
[22] Presentation by Dr. William M. Sappenfield, MD, MPH, CPH, Professor and Director, Florida Perinatal Quality Collaborative, Feb. 3, 2021 meeting of the House Health and Human Services Committee (on file with Finance and Facilities Subcommittee staff).
[23] CDC, *Severe Maternal Morbidity after Delivery Discharge among U.S. Women, 2010-2014*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/smm-after-delivery-discharge-among-us-women/index.htm (last visited Mar. 16, 2021).

morbidity (SMM), which includes unexpected outcomes of labor and delivery that result in significant short- or long-term consequences to a woman's health, affected more than 50,000 women in the U.S. in 2014 and has been steadily increasing in recent years.[24]

Although it is unclear why SMM rates are increasing, changes in the overall health of the population of women giving birth, including increases in maternal age, pre-pregnancy obesity, preexisting chronic medical conditions, and cesarean delivery, have been documented as possible contributors to increases in complications.[25] The consequences of the increasing SMM prevalence, in addition to the health effects for the woman, are wide-ranging and include increased medical costs and longer hospitalization stays.[26]

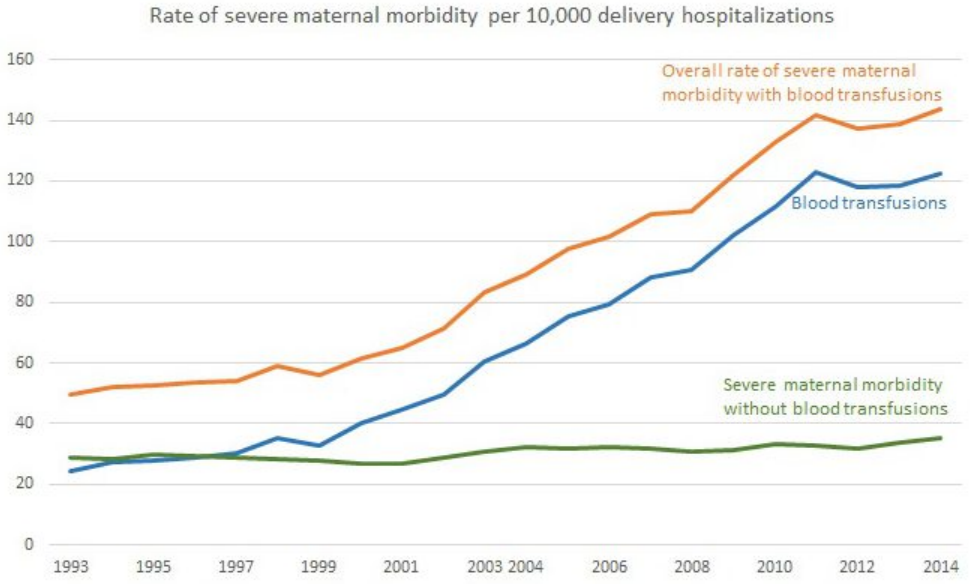
The most common SMM indicators after delivery discharge are:[27]

- Blood transfusion
- Pulmonary edema/ acute heart failure
- Sepsis
- Adult respiratory distress syndrome
- Air and thrombotic embolism
- Eclampsia
- Puerperal cerebrovascular disorders
- Acute Renal Failure

The overall SMM rate increased almost 200% over the years, from 49.5 in 1993 to 144.0 in 2014. This increase has been mostly driven by blood transfusions, which increased from 24.5 in 1993 to 122.3 in 2014. After excluding blood transfusions, the SMM rate increased by about 20% over time, from 28.6 in 1993 to 35.0 in 2014.

[24] CDC, *Severe Maternal Morbidity in the United States*, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html (last visited Mar. 16, 2021). 2014 is the most recent year for which data are available on a national level.
[25] *Id*.
[26] *Id*.
[27] CDC, *supra* note 23.

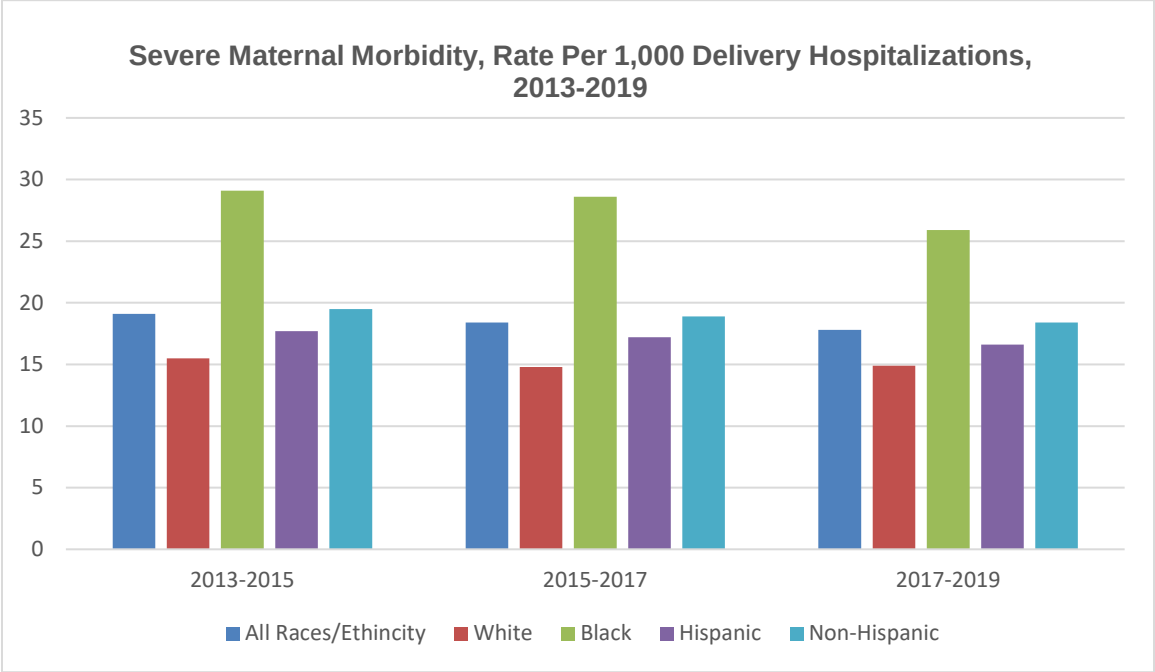
The following figure shows the trend over time for SMM rates in the U.S. per 10,000 delivery hospitalizations from 1993–2014:



Impact in Racial and Ethnic Minority Populations

Nationwide, racial disparities in SMM after delivery discharge persist. Among deliveries insured by Medicaid, the odds of SMM among Black women are about 1.7 times more likely than White women.[28]

In Florida, complications during pregnancy or delivery reveal similar racial and ethnic disparities in SMM:[29]



In 2013-2015, Black women in Florida were 1.9 times more likely than White women to have SMM, with their SMM rate being 29.1 per 1,000 delivery hospitalizations, compared to 15.5 for White women. Though the overall SMM rate decreased by 2019, Black women were still 1.7 times more likely than

[28] CDC, Reproductive Health, Severe Maternal Morbidity after Delivery Discharge among U.S. Women, 2010-2014, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/smm/smm-after-delivery-discharge-among-us-women/index.htm (last visited Mar. 16, 2021).

[29] Data compiled by Florida House of Representatives, Health & Human Services Committee staff, using information from the Florida Department of Health, *Severe Maternal Morbidity*, available at http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndDataViewer.aspx?cid=0867 (last visited Mar. 16, 2021).

White women to have SMM, with their SMM rate being 25.9 per 1,000 delivery hospitalizations, compared to 14.9 for White women.

Unlike decreasing racial and ethnic disparities in maternal and infant mortality rates, decreasing such disparities for severe maternal morbidity is currently not one of the CTG grant program's priority areas.

Telehealth

As of July 1, 2019, Florida licensed health care professionals, as well as those licensed under a multistate health care licensure compact of which Florida is a member, are authorized to use telehealth to deliver health care services within their respective scopes of practice.[30] Currently, telehealth does not include audio-only telephone calls, e-mail messages, or facsimile transmission.

Effect of Proposed Changes

HB 1381 adds decreasing racial and ethnic disparities in severe morbidity rates and other maternal health outcomes as a "Closing the Gap" grant program priority area, allowing the CTG grant program to fund projects directed at decreasing these disparities.

The bill adds maternal health programs to existing community-based programs the DOH is required to coordinate with to avoid duplicative efforts and promote consistency.

The bill also creates telehealth minority maternity care pilot programs in Duval and Orange Counties, Florida, to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations. The bill requires the DOH, by July 1, 2022, to direct and assist these two county health departments to implement the programs.

The pilot programs are required to use telehealth, which the bill expands to include audio-only telephone calls, e-mail messages, and facsimiles transmission, to provide the following services and education to eligible pregnant women up to the last day of their postpartum period, as applicable:

- Services and education addressing health social determinants;
- Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods;
- For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers; and
- Medical devices to conduct key components of maternal wellness checks.

The bill requires the pilot programs to provide specified training to participating health care practitioners and other perinatal professionals.

The bill grants discretionary rulemaking authority to the DOH to implement the bill's provisions.

The bill establishes an effective date of July 1, 2021.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.7353, F.S., relating to reducing racial and ethnic health disparities: Closing the Gap grant program; administration; department duties.
Section 2: Amends s. 381.7355, F.S., relating to project requirements; review criteria.
Section 3: Creates s. 383.2163, F.S., relating to telehealth minority care pilot programs.
Section 4: Provides an effective date of July 1, 2021.

[30] S. 456.47, F.S.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

None. SMM and other maternal health outcomes proposals will compete with other proposals for existing grant funds.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill requires that legislative appropriated funds for the Closing the Gap grant program be used to fund the pilot programs. The 2020-2021 GAA provided $4,850,354 in recurring GR for Minority Health Initiatives, which includes the CTG grant program. (Specific Appropriation 429).

The bill requires that the DOH's Division of Community Health Promotion and its Office of Minority Health and Health Equity work together to apply for available federal funds to assist in the implementation of the bill.

Adding severe maternal morbidity and other maternal health outcomes as a priority area may reduce awards for other areas.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to the DOH to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to maternal health outcomes; amending s. 381.7353, F.S.; revising the Department of Health's duties under the Closing the Gap grant program; amending s. 381.7355, F.S.; revising the requirements for Closing the Gap grant proposals; creating s. 383.2163, F.S.; requiring the department to establish telehealth minority maternity care pilot programs in Duval County and Orange County by a specified date; defining terms; providing program purposes; requiring the pilot programs to provide specified telehealth services to eligible pregnant women for a specified period; requiring pilot programs to train participating health care practitioners and perinatal professionals on specified topics; providing for funding for the pilot programs; requiring the department's Division of Community Health Promotion and Office of Minority Health and Health Equity to apply for certain federal funding; authorizing the department to adopt rules; providing an effective date.

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

Section 1. Paragraph (e) of subsection (2) of section

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

381.7353, Florida Statutes, is amended to read:

381.7353 Reducing Racial and Ethnic Health Disparities: Closing the Gap grant program; administration; department duties.—

(2) The department shall:

(e) Coordinate with existing community-based programs, such as chronic disease community intervention programs, cancer prevention and control programs, diabetes control programs, the Healthy Start program, the Florida Kidcare Program, the HIV/AIDS program, immunization programs, maternal health programs, and other related programs at the state and local levels, to avoid duplication of effort and promote consistency.

Section 2. Paragraph (a) of subsection (2) of section 381.7355, Florida Statutes, is amended to read:

381.7355 Project requirements; review criteria.—

(2) A proposal must include each of the following elements:

(a) The purpose and objectives of the proposal, including identification of the particular racial or ethnic disparity the project will address. The proposal must address one or more of the following priority areas:

1. Decreasing racial and ethnic disparities in maternal and infant mortality rates.

2. Decreasing racial and ethnic disparities in severe maternal morbidity rates and other maternal health outcomes.

3. Decreasing racial and ethnic disparities in morbidity and mortality rates relating to cancer.

4.~~3.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to HIV/AIDS.

5.~~4.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to cardiovascular disease.

6.~~5.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to diabetes.

7.~~6.~~ Increasing adult and child immunization rates in certain racial and ethnic populations.

8.~~7.~~ Decreasing racial and ethnic disparities in oral health care.

9.~~8.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to sickle cell disease.

10.~~9.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to Lupus.

11.~~10.~~ Decreasing racial and ethnic disparities in morbidity and mortality rates relating to Alzheimer's disease and dementia.

12.~~11.~~ Improving neighborhood social determinants of health, such as transportation, safety, and food access, as outlined by the Centers for Disease Control and Prevention's "Tools for Putting Social Determinants of Health into Action."

Section 3. Effective January 1, 2022, section 383.2163, Florida Statutes, is created to read:

383.2163 Telehealth minority maternity care pilot programs.—By July 1, 2022, the department shall establish a telehealth minority maternity care pilot program in Duval County and Orange County which uses telehealth to expand the capacity for positive maternal health outcomes in racial and ethnic minority populations. The department shall direct and assist the county health departments in Duval County and Orange County to implement the programs.

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

(a) "Department" means the Department of Health.

(b) "Eligible pregnant woman" means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or chapter 383.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

(d) "Health professional shortage 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.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act,

as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human Services as having a shortage of such services.

(h) "Perinatal professionals" means doulas, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through

simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(l) "Telehealth" has the same meaning as in s. 456.47 but includes audio-only telephone calls, e-mail messages, and facsimile transmissions.

(2) PURPOSE.—The purpose of the pilot programs is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other

cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The pilot programs shall adopt the use of telehealth to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(b) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(c) For women during their pregnancies through the postpartum periods, connection to support from doulas and other

perinatal health workers.

(d) Tools to conduct key components of maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary to ensure an accurate assessment of pregnant women participating in the program is conducted.

(4) TRAINING.—The pilot programs shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the pilot program;

2. Ensure access to and the quality of care;

3. Evaluate patient outcomes as a result of the pilot program;

4. Measure patient experience; and

5. Identify best practices for the future expansion of the pilot program.

(5) FUNDING.—The pilot programs shall be funded using funds appropriated by the Legislature for the Closing the Gap grant program. The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall also work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the pilot programs.

(6) RULES.—The department may adopt rules to implement

this section.

Section 4. This act shall take effect July 1, 2021.

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

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee
Representative Brown offered the following:

Amendment

Remove lines 111-191 and insert:

(h) "Perinatal professionals" means doulas, Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in

significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the pilot programs is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage,

infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The pilot programs shall adopt the use of telehealth or coordinate with prenatal home visiting programs for services to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1483 Solicitation of Non-medical Services
SPONSOR(S): Yarborough
TIED BILLS: **IDEN./SIM. BILLS:** SB 1992

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Criminal Justice & Public Safety Subcommittee	18 Y, 0 N	Padgett	Hall
2) Professions & Public Health Subcommittee		Guzzo	McElroy
3) Judiciary Committee			

SUMMARY ANALYSIS

In 2019, the Federal Trade Commission (FTC) noted that the Food and Drug Administration's Adverse Event Reporting System contained reports of consumers who had viewed advertisements by law firms and personal injury lead generating companies about the prescription drugs they were taking. Multiple consumers reported discontinuing taking such medications and suffering adverse consequences as a result. The FTC warned that advertisements that cause, or are likely to cause, viewers to discontinue prescription medications may constitute an unfair act or practice under Federal law.

HB 1483 prohibits as a deceptive and unfair trade practice a solicitation for a non-medical professional service from containing certain terminology and requires an advertisement to contain specified disclaimers. Specifically, the bill prohibits a person who submits or approves for submittal a non-medical solicitation for professional services for publication, broadcast, or dissemination, or who pays for or otherwise sponsors such solicitation for professional services from:

- Failing to clearly disclose the nature of the message as a paid advertisement for non-medical services at the outset of the advertisement.
- Failing to disclose the sponsor of the advertisement.
- Including terminology implying that the advertisement is a "medical alert," "health alert," "consumer alert," "public service announcement," or similar public alert or announcement.
- Displaying a federal or state government agency logo in a manner that implies affiliation with that agency.
- Implying that a product has been recalled when the product has not been recalled.
- Failing to clearly and conspicuously disclose the individual or entity that will provide professional services to a person responding to the advertisement or how such person will be otherwise referred.
- Failing to clearly warn a person taking a prescribed medication or using a medical device to not stop taking the medication or using the medical device without consulting his or her doctor.
- Failing to clearly disclose that a drug or medical device referenced in the advertisement remains approved by the Food and Drug Administration, unless the product is recalled or withdrawn.

A disclosure required under the bill must be presented in a manner that makes it plainly legible or audible and presented for sufficient time that it allows the viewer to read or discern the disclosure. The Department of Legal Affairs or a state attorney may bring an action to enjoin any person who commits a violation, or may bring an action on behalf of one or more consumers or governmental entities for actual damages caused by a violation.

The bill creates a first degree misdemeanor prohibiting a person from willfully or knowingly using, obtaining, selling, transferring, or disclosing another person's protected health information to solicit non-medical professional services without such person's written authorization. A person who violates the prohibition for financial gain commits a second degree felony.

The bill may have a positive indeterminate jail bed and prison bed impact due to the creation of new felony and misdemeanor offenses.

The effective date for advertising restrictions for a non-medical solicitation is July 1, 2021. The effective date for the prohibition against the solicitation of professional services by unauthorized use of PHI is October 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Drug Injury Advertising

In 2017, the U.S. Chamber Institute for Legal Reform (ILR) surveyed 1,335 adults, 500 of whom were currently taking or had taken one of 12 prescription drugs frequently targeted by personal injury lawyers, and asked how they would respond if they saw an advertisement about a lawsuit for injury caused by a medication they were taking.[1] Nearly half of the survey respondents said they would definitely or probably stop taking the drug immediately after seeing the advertisement.[2] When shown an actual television legal advertisement about a drug they had taken, more than half said they would reduce the dosage to below the prescribed amount.[3]

A 2018 survey found that 90 percent of jurors would be somewhat or very concerned if they saw an advertisement claiming that a company's product injured people.[4] Additionally, 72 percent of jurors agreed that if a lawsuit alleges a company's product has injured people, then there is probably truth to the claim.[5]

In 2019, the Federal Trade Commission (FTC) contacted seven law firms and lead generating companies expressing concern that some television advertisements that solicit clients for personal injury lawsuits against drug manufacturers may be considered deceptive or unfair under federal law.[6] The FTC also noted that the Food and Drug Administration's (FDA) Adverse Event Reporting System contained reports of consumers who had viewed advertisements about the prescription drugs they were taking, discontinued those medications, and suffered adverse consequences.[7] The FTC warned that advertisements that cause, or are likely to cause, viewers to discontinue their medications may constitute an unfair act or practice and recommended such advertisements include clear and prominent audio and visual disclosures stating that a consumer should not stop taking medication without first consulting a doctor.[8]

Legal Advertising

Until 1977, most states prohibited attorney advertising.[9] In *Bates v. State Bar of Arizona*, however, the U.S. Supreme Court held that commercial speech is protected by the First Amendment and cannot be prohibited.[10] The Supreme Court has distinguished advertising that is false, deceptive, or misleading, which may be prohibited. Moreover, non-misleading commercial speech may be regulated when:

- There is a substantial government interest;
- The regulation directly advances the government's interest; and
- The regulation is narrowly tailored.[11]

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[1] U.S. Chamber Institute for Legal Reform, *Bad for Your Health: Lawsuit Advertising Implications and Solutions* (Oct. 2017), https://www.instituteforlegalreform.com/uploads/sites/1/TLA_Advertising-Paper-WEB.pdf (last visited Mar. 20, 2021).
[2] *Id*.
[3] *Id*.
[4] American Tort Reform Association, Local Legal Services Advertising (Jan. 2020), http://www.atra.org/wp-content/uploads/2020/01/ATRA-Q3-Legal-Services-Ad-Report-FL.pdf (last visited Mar. 16, 2021).
[5] *Id*.
[6] Federal Trade Commission, *FTC Flags Potentially Unlawful TV Ads for Prescription Drug Lawsuits* (Sept. 24, 2019), https://www.ftc.gov/news-events/press-releases/2019/09/ftc-flags-potentially-unlawful-tv-ads-prescription-drug-lawsuits (last visited Mar. 20, 2021).
[7] *Id*.
[8] *Id*.
[9] JD Supra, *Remember When Lawyers Couldn't Advertise?* (Oct. 26, 2018), https://www.jdsupra.com/legalnews/remember-when-lawyers-couldn-t-advertise-11628/ (last visited Mar. 20, 2021).
[10] *Bates v. State Bar of Arizona*, 433 U.S. 350 (1977).
[11] *Central Hudson Gas & Elec. v. Public Service Commission*, 447 U.S. 557 (1980).

The U.S. Supreme Court has also recognized that states not only have an interest in protecting their citizens from misleading advertisements, but state bars also have an interest in protecting their image as a profession and the public's perception of the judicial system.[12]

Legal Advertisement Regulation

The Florida Bar is an extension of the Florida Supreme Court and approves lawyer advertising, issues advisory opinions interpreting the Bar rules, and investigates and prosecutes attorneys for alleged violations.[13] Florida's legal advertising rules apply to all forms of communication soliciting legal services in any print or electronic form, including but not limited to newspapers, magazines, brochures, flyers, television, radio, direct mail, electronic mail, and Internet, including banners, pop-ups, websites, social media, and video sharing platforms.[14] Advertisements in specified media must be submitted to the Legal Division of the Florida Bar at least 20 days prior to dissemination, including print, television, radio, direct mail, and Internet.[15]

The Legal Division reviews an advertisement to determine whether it complies with the Florida Bar's advertising rules. The Legal Division issues an opinion either approving or disapproving the advertisement. The Disciplinary Counsel of the Florida Bar investigates and prosecutes attorneys for alleged violations of the Bar's advertising rules.[16]

Florida Bar rules require legal advertising to include:

- The name of the lawyer or law firm;[17]
- The location of the law practice;[18] and
- Certain disclosures when relevant, including whether:
  - A case will be referred to another lawyer;[19]
  - A spokesperson in the advertisement is not an employee or member of the law firm;[20] or
  - A scene depicted is a dramatization and not an actual event.[21]

Such required information must be reasonably prominent and clearly legible if written and clearly audible if spoken aloud.[22]

Florida Deceptive and Unfair Trade Practices Act

The Florida Deceptive and Unfair Trade Practices Act (FDUTPA) prohibits unfair methods of competition, and unconscionable, unfair or deceptive acts or practices in the conduct of any trade or commerce.[23,24] FDUTPA operates for the purposes of:[25]

- Simplifying, clarifying, and modernizing the law governing consumer protection, unfair methods of competition, and unconscionable, deceptive, and unfair trade practices;
- Protecting the consuming public and legitimate business enterprises from those who engage in unfair methods of competition, or unconscionable, deceptive, or unfair acts or practices in the conduct of any trade or commerce; and

[12] *Florida Bar v. Went For It, Inc.*, 515 U.S. 618, 635 (1995).
[13] The Florida Bar, *Frequently Asked Questions About the Florida Bar*, https://www.floridabar.org/about/faq/ (last visited Mar. 20, 2021).
[14] Fla. Bar Code Prof. Resp. D. R. 4-7.11(a).
[15] Fla. Bar Code Prof. Resp. D. R. 4-7.11.
[16] Fla. Bar Code Prof. Resp. D. R. 4-7.19.
[17] Fla. Bar Code Prof. Resp. D. R. 4-7.12(a)(1).
[18] Fla. Bar Code Prof. Resp. D. R. 4-7.12(a)(2).
[19] Fla. Bar Code Prof. Resp. D. R. 4-7.12(b).
[20] Fla. Bar Code Prof. Resp. D. R. 4-7.13(b)(5).
[21] Fla. Bar Code Prof. Resp. D. R. 4-7.13(b)(6).
[22] Fla. Bar Code Prof. Resp. D. R. 4-7.12(d).
[23] The term "trade or commerce" is defined as "advertising, soliciting, providing, offering, or distributing, whether by sale, rental, or otherwise, of any good or service, or any property, whether tangible or intangible, or any other article, commodity, or thing of value, wherever situated. The term includes the conduct of any trade or commerce including any nonprofit or not-for-profit person or activity. S. 501.203(8), F.S.
[24] S. 501.204(1), F.S.
[25] S. 501.202, F.S.

- Making state consumer protection and enforcement consistent with established policies of federal law relating to consumer protection.

FDUTPA provides investigative and enforcement authority to a state attorney if a violation occurs in or affects the judicial circuit under the office's jurisdiction, and to the Department of Legal Affairs (DLA) if a violation occurs in or affects more than one judicial circuit, or if a state attorney defers to DLA.[26] An enforcing authority may, within four years after a violation occurs or within two years after the last payment in a transaction involved in a violation, bring an action:

- To obtain a declaratory judgment that an act or practice violates FDUTPA;
- To enjoin any person who has violated, is violating, or is otherwise likely to violate FDUTPA; or
- On behalf of one or more consumers or governmental entities for the actual damages caused by an act or practice in violation of FDUTPA.[27]

Additionally, an enforcing authority may collect a civil penalty of up to $10,000 per violation plus reasonable attorney fees and costs for a willful violation and up to a $15,000 penalty plus reasonable attorney fees and costs for a willful violation involving a senior citizen, a disabled person, a military servicemember, or the spouse or dependent child of a military servicemember.[28] DLA may also issue a cease and desist order if such order would be in the interest of the public.[29]

FDUTPA authorizes a private cause of action for any person aggrieved by a violation of FDUTPA to:

- Obtain a declaratory judgement that an act or practice violates FDUTPA;
- Enjoin a person who has violated, is violating, or is otherwise likely to violate this part; and
- Recover actual damages plus reasonable attorney fees and costs.[30]

The Health Insurance Portability and Accountability Act

The Federal Health Insurance Portability and Accountability Act (HIPAA), protects personal health information (PHI).[31] The U.S. Department of Health and Human Services privacy rules establish national standards to protect medical records and other PHI.[32] The rules address, among other things, the use and disclosure of a person's PHI. Only "covered entities" are subject to HIPAA's provisions, including:

- Health plans;
- Health care providers;
- Health care clearinghouses; and
- Business associates of any of the above.[33]

HIPAA requires the disclosure of a person's PHI to the person who is the subject of the PHI information or his or her personal representative, upon his or her request.[34] The punishment for a HIPAA violation can either be a civil or criminal penalty. A civil penalty varies based on the severity of the violation, the number of people affected, the nature of the data exposed, the length of time a violation was allowed to persist, the prior compliance history of the covered entity, and the knowledge the covered entity had of the violation.[35] Criminal penalties for a HIPAA violation are triggered when a person obtains PHI for

[26] Ss. 501.203(2), 501.206, and 501.207, F.S.
[27] S. 501.207(1) and (5), F.S.
[28] Ss. 501.2075, 501.2077, and 501.2105, F.S.
[29] S. 501.208(1), F.S.
[30] Ss. 501.2105 and 501.211, F.S.
[31] Protected health information includes all individually identifiable health information held or transmitted by a covered entity or its business associate. Pub. L. No. 104-191 (1996).
[32] U.S. Department of Health and Human Services, *Health Information Privacy*, https://www.hhs.gov/hipaa/for-professionals/privacy/index.html (last visited Mar. 20, 2021).
[33] U.S. Department of Health and Human Services, Office for Civil Rights, *Summary of the HIPAA Privacy Rule*, (last rev. May 2003), https://www.hhs.gov/sites/default/files/privacysummary.pdf. (last visited Mar. 20, 2021).
[34] *Id.*
[35] HIPAA Journal, *What are the penalties for HIPAA Violations?*, https://www.hipaajournal.com/what-are-the-penalties-for-hipaa-violations-7096/ (last visited Mar. 20, 2021).

financial gain or under false pretenses.[36] The criminal penalty for such HIPAA violations are punishable by up to 10 years imprisonment.[37]

Effect of Proposed Changes

HB 1483 prohibits a person who submits or approves the submittal of a non-medical solicitation for professional services which contains information about a drug or device,[38] for publication, broadcast, or dissemination, or who pays for or otherwise sponsors such non-medical solicitation from:

- Failing to clearly disclose, "This is a paid advertisement for non-medical services," at the outset of the advertisement.
- Including terminology implying that the advertisement is a “medical alert,” “health alert,” “consumer alert,” “public service announcement,” or similar public alert or announcement.
- Displaying a federal or state government agency logo in a manner that implies affiliation with such an agency.
- Including terminology that implies a product has been recalled when the product has not been recalled.
- Failing to clearly disclose the sponsor of the advertisement.
- Failing to clearly and conspicuously disclose the individual or entity that will provide professional services to a person who responds to the advertisement.
- Failing to clearly disclose that the drug or medical device remains approved by the Food and Drug Administration, unless the product has actually been recalled or withdrawn.
- If the advertisement solicits clients who may allege injury from a prescription drug, failing to clearly disclose the following warning:
    - "Do not stop taking a prescribed medication without first consulting your doctor. Discontinuing a prescribed medication without your doctor's advice can result in injury or death."

A disclosure required by the bill must be clearly legible, if written, and, if displayed electronically, displayed for sufficient time to enable the viewer to easily see and fully read the disclosure. A spoken disclosure must be plainly audible and clearly intelligible.

The bill defines “non-medical solicitation” as a paid solicitation for non-medical professional services which contains information about a drug or device as defined in s. 499.003, F.S., and which is directed to the public through television; radio; the Internet, including a domain name; a newspaper or other periodical; an outdoor advertising sign; or another written, electronic, or recorded communication.

Under the bill, a violation constitutes a deceptive and unfair trade practice. DLA or a state attorney may bring an action:

- To obtain a declaratory judgment that the non-medical solicitation violates FDUTPA;
- To enjoin any person who has violated these provisions from continuing to disseminate the non-medical solicitation; or
- For actual damages caused by a violation on behalf of consumers.

The bill creates a first degree misdemeanor offense prohibiting a person from willfully or knowingly using, obtaining, selling, transferring, or disclosing another person’s PHI to solicit non-medical professional services without such person’s written authorization. A person who violates the prohibition commits a deceptive and unfair trade practice subject to penalties and remedies under ch. 501, part II and:

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[36] *Id.*
[37] *Id.*
[38] The bill defines “device” in accordance with s. 499.003, F.S., as any instrument, apparatus, implement, machine, contrivance, implant, in vitro reagent, or other similar or related article, including its components, parts, or accessories, which is:
(a) Recognized in the current edition of the United States Pharmacopoeia and National Formulary, or any supplement thereof,
(b) Intended for use in the diagnosis, cure, mitigation, treatment, therapy, or prevention of disease in humans or other animals, or
(c) Intended to affect the structure or any function of the body of humans or other animals,
and that does not achieve any of its principal intended purposes through chemical action within or on the body of humans or other animals and which is not dependent upon being metabolized for the achievement of any of its principal intended purposes.

- A first degree misdemeanor for a willful and knowing violation.[39]
- A second degree felony for a willful and knowing violation with the intent to sell, transfer, or use PHI for financial gain,[40] except the term of imprisonment may not exceed 10 years and the fine may exceed $10,000 but may not exceed $250,000.

The provisions of the bill relating to advertising regulations for a non-medical solicitation are effective July 1, 2021. The provisions of the bill prohibiting the solicitation of professional services by the use, sale, transfer, or disclosure of PHI without a person's written authorization are effective October 1, 2021.

B. SECTION DIRECTORY:

Section 1: Creates s. 501.2106, F.S., related to non-medical solicitation; deceptive and unfair trade practices.
Section 2: Creates s. 877.025, F.S., related to solicitation of non-medical services; wrongful use or disclosure of protected health information.
Section 3: Provides an effective date of July 1, 2021, unless otherwise provided in the bill.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill may have a positive indeterminate prison bed impact due to the creation of a new felony offense.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

The bill may have a positive indeterminate jail bed impact due to the creation of a new misdemeanor offense.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

[39] A first degree misdemeanor, punishable by up to one year in county jail and a $1,000 fine. Ss. 775.082 and 775.083, F.S.
[40] A second degree felony is punishable by up to 15 years imprisonment, and a $10,000 fine. Ss. 775.082 and 775.083, F.S.

Although commercial speech enjoys protection under the First Amendment, courts have held that it is subject to greater restrictions than noncommercial speech.[41] As such, false or misleading advertising and other forms of fraudulent commercial speech are not protected under the First Amendment, and can be restricted by the government.[42] The restrictions on the solicitation of non-medical services in the bill are narrowly tailored to address a specific category of professional services on the limited subjects of drugs and medical devices. Furthermore, each advertising prohibition is a statement or omission that is intended to mislead a member of the public into believing the advertisement has been disseminated by the government, or with the approval of a government agency. Because the advertising restrictions in the bill are narrow in scope and focused on misleading statements which have no First Amendment protection, the bill likely complies with constitutional requirements.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[41] *Board of Trs. of State Univ. of N.Y. v. Fox*, 492 U.S. 469 (1989).
[42] *Friedman v. Rogers*, 440 U.S. 1 (1979).

A bill to be entitled

An act relating to the solicitation of non-medical services; creating s. 501.2106, F.S.; defining terms; providing that a person who submits or sponsors a non-medical solicitation that contains certain terminology or fails to include specified disclosures commits a deceptive and unfair trade practice, subject to the penalties and remedies of the Florida Deceptive and Unfair Trade Practices Act; creating s. 877.025, F.S.; defining terms; prohibiting the unauthorized use, sale, or transfer of protected health information for the purpose of soliciting professional services; providing that a person who willfully and knowingly violates such prohibition commits a deceptive and unfair trade practice, subject to the penalties and remedies of the Florida Deceptive and Unfair Trade Practices Act; providing criminal penalties for willful and knowing violations and enhanced criminal penalties for violations committed for financial gain; providing applicability; providing effective dates.

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

Section 1. Section 501.2106, Florida Statutes, is created

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

to read:

501.2106 Non-medical solicitation; deceptive and unfair trade practices.—

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

(a) "Client" means a prospective customer, client, or patron of non-medical professional services.

(b) "Non-medical solicitation" means a paid solicitation for non-medical professional services which contains information about a drug or device as defined in s. 499.003 and which is directed to the public through television; radio; the Internet, including a domain name; a newspaper or other periodical; an outdoor advertising sign; or another written, electronic, or recorded communication.

(c) "Person" has the same meaning as in s. 1.01(3).

(2) A person who submits or approves the submittal of a non-medical solicitation for publication, broadcast, or dissemination, or who pays for or otherwise sponsors a non-medical solicitation, commits a deceptive and unfair trade practice under this part if the solicitation, once published, broadcast, or disseminated, does any of the following:

(a) Fails to clearly and conspicuously disclose at the outset of the solicitation the phrase, "This is a paid advertisement for non-medical services."

(b) Includes terminology implying that the advertisement is a "medical alert," "health alert," "consumer alert," "public

service announcement," or similar public alert or announcement.

(c) Displays the logo, or a similar facsimile thereof, of a federal or state governmental agency in a manner implying affiliation with, or sponsorship by, a governmental agency.

(d) Includes terminology, including use of the term "recall" when referring to a product, implying that the product has been recalled when, in fact, the product has not been recalled by a governmental agency or through agreement between a manufacturer and a governmental agency.

(e) Fails to clearly and conspicuously disclose the sponsor of the advertisement.

(f) Fails to clearly and conspicuously disclose the individual or entity that will provide professional services to persons responding to the advertisement or how those persons will be referred to such individual or entity.

(g) Solicits clients who may allege injury from a prescription drug approved or cleared by, or which is the subject of a monograph authorized by, the United States Food and Drug Administration and fails to clearly and conspicuously disclose the following warning: "Do not stop taking a prescribed medication without first consulting with your doctor. Discontinuing a prescribed medication without your doctor's advice can result in injury or death."

(h) Solicits clients who may allege injury from a prescription drug or medical device approved or cleared by, or

which is the subject of a monograph authorized by, the United States Food and Drug Administration and fails to clearly and conspicuously disclose that the drug or medical device remains approved by the United States Food and Drug Administration, unless the product is recalled or withdrawn.

(i) Fails to present any disclosure required by this subsection such that:

1. A written disclosure is clearly legible and, if televised or displayed electronically, is displayed for sufficient time to enable the viewer to easily see and fully read the disclosure.

2. A spoken disclosure is plainly audible and clearly intelligible.

Section 2. Effective October 1, 2021, section 877.025, Florida Statutes, is created to read:

877.025 Solicitation of non-medical services; wrongful use or disclosure of protected health information.—

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

(a) "Person" has the same meaning as in s. 1.01(3).

(b) "Protected health information" has the same meaning as provided in 45 C.F.R. s. 106.103.

(c) "Solicit" means to offer to provide professional services by written, recorded, or electronic communication or by in-person, telephone, or real-time electronic contact.

(2) A person may not use, cause to be used, obtain, sell,

transfer, or disclose to another person an individual's protected health information, without that individual's written authorization, to solicit professional services.

(3)(a) A person who violates subsection (2) commits a deceptive and unfair trade practice subject to the penalties and remedies provided in part II of chapter 501.

(b) A person who willfully and knowingly violates subsection (2) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) A person who willfully and knowingly violates subsection (2) with intent to sell, transfer, or use protected health information for financial gain commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, except that the term of imprisonment may not exceed 10 years and the fine must be more than $10,000 but may not exceed $250,000.

(4) This section does not apply to the disclosure of protected health information to an attorney, or the attorney's use of such protected health information, in any judicial or administrative proceeding or any other use or disclosure otherwise authorized or required by law.

Section 3. Except as otherwise expressly provided in this act, this act shall take effect July 1, 2021.

PCS for HB 1579

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 1579 Health Care Practitioner Discipline
SPONSOR(S): Professions & Public Health Subcommittee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Professions & Public Health Subcommittee		Morris	McElroy

SUMMARY ANALYSIS

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions. Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory authority and licensure authority for MQA, including discipline of practitioners.

Under current law, DOH must issue an emergency order suspending the license of a licensed physician, chiropractor, podiatrist, naturopath, optometrist, nurse, nursing assistant, pharmacist, dentist, optician, or hearing aid specialist who pleads guilty to or is convicted of certain violations of federal law and offenses relating to Medicare, fraud, drug offenses, and reproductive battery. PCS for HB 1579 expands DOH's authority to issue an emergency suspension order to all licensed health care practitioners and adds homicide to the list of offenses that DOH must issue an emergency suspension order.

PCS for HB 1579 also requires DOH to issue an emergency order suspending the license if a health care practitioner is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of certain offenses in this state or similar offenses in another jurisdiction. The PCS also includes such offenses as acts that constitute grounds for discipline of a licensed health care practitioner.

The bill has a negative, indeterminate fiscal impact on DOH. The bill has no fiscal impacts on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Professional Licensure

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. MQA works in conjunction with 22 boards and 4 councils to license and regulate 7 types of health care facilities and more than 40 health care professions.[1] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA. MQA is statutorily responsible for the following boards and professions established within the division:[2]

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.;
- Medical physicists, as provided under part IV of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.;

Background Screening

[1] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2019-2020*, p. 6, http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2019-2020-annual-report.pdf (last visited on March 16, 2021).
[2] S. 456.001(4), F.S; Id.

Chapter 435, F.S., establishes standard procedures and requirements for criminal history background screening of prospective employees. 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,[3] and may include criminal records checks through local law enforcement agencies. A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[4]

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[5] Such information for a level 2 screening includes fingerprints, which are taken by a vendor that submits them electronically to FDLE.[6]

For both level 1 and 2 screenings, the employer must submit the information necessary for screening to FDLE within five working days after receiving it.[7] Additionally, for both levels of screening, FDLE must perform a criminal history record check of its records.[8] For a level 1 screening, this is the only information searched, and once complete, FDLE responds to the employer or agency, who must then inform the employee whether screening has revealed any disqualifying information.[9] For level 2 screening, FDLE also requests the FBI to conduct a national criminal history record check of its records for each employee for whom the request is made.[10] As with a level 1 screening, FDLE responds to the employer or agency, and the employer or agency must inform the employee whether screening has revealed disqualifying information. If the employer or agency finds that an individual has a history containing one of these offenses, it must disqualify that individual from employment.

The person whose background is being checked 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.[11]

Disqualifying Offenses

Regardless of whether the screening is level 1 or level 2, the screening employer or agency must make sure that the applicant has good moral character by ensuring that the employee has not been arrested for and is awaiting final disposition of, been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, or been adjudicated delinquent and the record has not been sealed or expunged for, certain offenses under Florida law, or similar law of another jurisdiction.[12]

Health Care Practitioner Background Screening Under Ch. 456, F.S.

Section 456.0135, F.S., requires physicians, physician assistants, chiropractic physicians, podiatric physicians, nurses, certified nursing assistants, pharmacy owners, athletic trainers, massage therapists, and massage establishment owners to undergo a Level 2 background screening as a part of the licensure process. The appropriate regulatory board reviews the background screening results of an applicant or licensee to determine if there is a disqualifying offense. The only automatic disqualifying offenses for licensure are the following offenses under federal law or Florida law, or similar law in another jurisdiction:[13]

[3] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited March 16, 2021).
[4] Section 435.04, F.S.
[5] Section 435.05(1)(a), F.S.
[6] Sections 435.03(1) and 435.04(1)(a), F.S.
[7] Section 435.05(1)(b)-(c), F.S.
[8] Id.
[9] Section 435.05(1)(b), F.S.
[10] Section 435.05(1)(c), F.S.
[11] Section 435.05(1)(d), F.S.
[12] Section 435.04(2), F.S.
[13] Section 456.0635, F.S.

- A felony under:
    - Chapter 409, related to social and economic assistance;
    - Chapter 817, relating to fraudulently practices; and
    - Chapter 893, relating to drug abuse prevention and control.
- A felony under 21 U.S.C. ss. 801-970, relating to controlled substances, or 42 U.S.C. ss. 1395-1396, relating to health insurance for the aged and disabled, if the sentence and any subsequent probation ended less than 15 years before the date of application.

Exemption from Disqualification

If an individual is disqualified due to a conviction, plea of nolo contendere, or adjudication of delinquency to one or more of the disqualifying offenses, s. 435.07, F.S., allows the Secretary of the appropriate agency to exempt applicants from that disqualification under certain circumstances:[14]

- Three years have elapsed since the individual has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by a court for a disqualifying felony; or
- The applicant has completed or been lawfully released from confinement, supervision, or nonmonetary condition imposed by a court for a misdemeanor or an offense that was a felony at the time of commission but is now a misdemeanor.

Only the appropriate regulatory board, or the DOH when there is no board, may grant an exemption from disqualification to a person under the licensing jurisdiction of that board or the DOH, as applicable.[15]

Receiving an exemption allows that individual to work despite the disqualifying crime in that person's past. However, an individual who is considered a sexual predator,[16] career offender,[17] or sexual offender (unless not required to register)[18] cannot be exempted from disqualification.[19]

Discipline

Section 456.072, F.S., authorizes a regulatory board or DOH, if there is no board, to discipline a health care practitioner's licensure for a number of offenses, including but not limited to:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession;
- Making deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession; or
- Engaging or attempting to engage in sexual misconduct as defined in s. 456.063, F.S.

Sexual misconduct involves a health care practitioner engaging, or attempting to engage, in verbal or physical sexual activity outside the scope of the professional practice of his or her health care profession with a patient or client, or an immediate family member, guardian, or representative of a patient or client.[20]

If the board or DOH finds that a licensee committed a violation, the board or DOH may:[21]

- Refuse to certify, or to certify with restrictions, an application for a license;

[14] Section 435.07(1), F.S.
[15] Section 456.36, F.S.
[16] Section 775.261, F.S.
[17] Section 775.261, F.S.
[18] Section 943.0435, F.S.
[19] Section 435.07(4)(b), F.S.
[20] Section 456.063, F.S. A person who commits such sexual misconduct is disqualified from licensure in this state.
[21] Section 456.072(2), F.S.

- Suspend or permanently revoke a license;
- Place a restriction on the licensee's practice or license;
- Impose an administrative fine not to exceed $10,000 for each count or separate offense; if the violation is for fraud or making a false representation, a fine of $10,000 must be imposed for each count or separate offense;
- Issue a reprimand or letter of concern;
- Place the licensee on probation;
- Require a corrective action plan;
- Refund fees billed and collected from the patient or third party on behalf of the patient; or
- Require the licensee to undergo remedial education.

Emergency Suspension of Practitioner Licenses

Under current law, DOH must issue an emergency order suspending the license of a licensed physician, chiropractor, podiatrist, naturopath, optometrist, nurse, nursing assistant, pharmacist, dentist, optician, or hearing aid specialist who pleads guilty to or is convicted of certain violations of federal law and offenses relating to Medicare, fraud, drug offenses, and reproductive battery. The PCS expands DOH's authority to issue an emergency suspension order to all licensed health care practitioners and adds homicide to the list of offenses that DOH must issue an emergency suspension order:[22]

- A felony under:
  - Chapter 409, related to social and economic assistance;
  - Chapter 817, relating to fraudulently practices; and
  - Chapter 893, relating to drug abuse prevention and control.
- A felony under 21 U.S.C. ss. 801-970, relating to controlled substances, or 42 U.S.C. ss. 1395-1396, relating to health insurance for the aged and disabled;
- A misdemeanor or felony under:
  - 18 U.S.C. s. 669, relating to theft or embezzlement in connection with health care;
  - 18 U.S.C. ss. 285-287, relating to taking or using papers relating to claims, conspiracy to defraud the government with respect to claims, and false, fictitious of fraudulent claims;
  - 18 U.S.C. s. 371, relating to conspiracy to commit offense or to defraud United States;
  - 18 U.S.C. s. 1001, relating to statements or entries generally;
  - 18 U.S.C. s. 1035, relating to false statements relating to health care matters;
  - 18 U.S.C. s. 1341, relating to frauds and swindles;
  - 18 U.S.C. s. 1343, relating to fraud by wire, radio, or television;
  - 18 U.S.C. s. 1347, relating to health care fraud;
  - 18 U.S.C. s. 1349, relating to attempt and conspiracy;
  - 18 U.S.C. s. 1518, relating to obstruction of criminal investigations of health care offenses; or
  - 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.
- A felony under s. 784.086, F.S., relating to a reproductive battery.

DOH is not currently authorized to suspend the license of a health care practitioner who is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication to a felony under ch. 782, F.S., relating to homicide. DOH is also not currently authorized to issue an emergency order suspending the license of a health care practitioner upon his or her arrest for any violation.

Effect of the Bill

The bill requires DOH to issue an emergency order suspending the license of a health care practitioner who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication to any offense under s. 456.074, F.S.

The bill adds a felony under ch. 782, F.S., relating to homicide, to the list of offenses in which case DOH must issue an emergency suspension order.

[22] Section 456.074(1), F.S.

The bill also requires DOH to issue an emergency order suspending the license of any health care practitioner who is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses in this state or similar offenses in another jurisdiction:

- Section 393.135(2), F.S., relating to sexual misconduct against an individual with a developmental disability;
- Section 394.4593(2), F.S., relating to sexual misconduct against a patient of a receiving or treatment facility or otherwise in the custody of the Department of Children and Families;
- Section 787.01, F.S., relating to kidnapping;
- Section 787.02, F.S., relating to false imprisonment;
- Section 787.025(2), F.S., relating to luring or enticing a child;
- Section 787.06(3)(b),(d), (f), or (g), F.S., relating to human trafficking for commercial sexual activity;
- Former s. 787.06(3)(h), F.S., relating to human trafficking of a child under the age of 15 for commercial sexual activity;
- Section 787.07, F.S., relating to human smuggling;
- Section 794.011, F.S., relating to sexual battery, excluding s. 794.011(10), F.S.;
- Section 794.05, F.S., relating to unlawful sexual activity with certain minors;
- Section 794.08, F.S., relating to female genital mutilation;
- Former s. 796.03, F.S., relating to procuring a person under the age of 18 for prostitution;
- Former s. 796.035, F.S., relating to the selling or buying of minors into prostitution;
- Section 796.04, F.S., relating to forcing, compelling, or coercing another to become a prostitute;
- Section 796.05, F.S., relating to deriving support from the proceeds of prostitution;
- Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, relating to prohibiting prostitution and related acts;
- Section 800.04, F.S., relating to lewd or lascivious offenses committed upon or in the presence of persons younger than 16 years of age;
- Section 810.145(8), F.S., relating to video voyeurism of a minor;
- Section 825.1025, F.S., relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled person;
- Section 827.071, F.S., relating to sexual performance by a child;
- Section 847.011, F.S., relating to prohibited acts in connection with obscene, lewd, etc., materials;
- Section 847.012, F.S., relating to materials harmful to minors;
- Section 847.013, F.S., relating to exposing minors to harmful motion pictures, exhibitions, shows, presentations, or representations;
- Section 847.0133, F.S., relating to the protection of minors from obscene materials;
- Section 847.0135, F.S., relating to computer pornography, prohibited computer usage, or traveling to meet minors, excluding s. 847.0135(6) F.S.;
- Section 847.0137, F.S., relating to transmission of child pornography by electronic device or equipment;
- Section 847.0138, F.S., relating to the transmission of material harmful to minors to a minor by electronic device or equipment;
- Section 847.0145, F.S., relating to the selling or buying of minors;
- Section 856.022, F.S., relating to loitering or prowling in close proximity to children;
- Section 895.03, F.S., relating to racketeering activity, if the court makes a written finding that the racketeering activity involved at least one sexual offense listed in this subsection or at least one offense listed in this subsection which was committed with sexual intent or motive;
- Section 916.1075(2), F.S., relating to sexual misconduct against a forensic client of a civil or forensic facility for defendants who have a mental illness or an intellectual disability;
- Section 985.701(1), F.S., relating to sexual misconduct against a juvenile offender; or
- Any similar offense committed in this state which has been redesignated from a former statute number to one of those listed in the bill.

Under the bill, being found guilty of, entering a plea of guilty or nolo contendere to, regardless of adjudication, or committing or attempting, soliciting, or conspiring to commit an act that would constitute a violation of any offense listed above, or a similar offense in another jurisdiction, as acts that constitute grounds for discipline of any licensed health care practitioner.

A licensed health care practitioner who has his or her license suspended by emergency order will not be able to practice for the duration of the suspension.

B. SECTION DIRECTORY:

Section 1 Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 2 Amends s. 456.074, F.S., relating to certain health care practitioners; immediate suspension of license.
Section 3 Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DOH may experience an increase in workload related to investigating complaints against a health care practitioner and issuing disciplinary actions or emergency suspension orders, the impact of which is likely negative, insignificant, and indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensed health care practitioners who are arrested for certain offenses may experience a decrease in revenue associated with the suspension of a professional license because he or she will not be able to practice his or her profession for the duration of the suspension.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Current law provides sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to health care practitioner discipline; amending s. 456.072, F.S.; subjecting health care practitioners to disciplinary action for specified offenses; amending s. 456.074, F.S.; revising provisions relating to immediate suspension of licensure to apply to all health care practitioners; requiring the Department of Health to issue emergency orders to suspend health care practitioner licenses if they enter a criminal plea to, or are convicted or found guilty of, a felony relating to homicide or are arrested for committing or attempting, soliciting, or conspiring to commit acts that would constitute violations of specified criminal offenses; providing an effective date; providing an effective date.

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

Section 1. Paragraph (rr) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(rr) Being convicted or found guilty of, entering a plea of guilty or nolo contendere to, regardless of adjudication, or committing or attempting, soliciting, or conspiring to commit an act that would constitute a violation of any of the offenses listed in s. 456.074(5) or a similar offense in another jurisdiction.

Section 2. Subsection (5) of section 456.074, Florida Statutes, is renumbered as subsection (6), respectively, and subsection (5) is added to that section, and subsection (1) of that section is amended, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(1) The department shall issue an emergency order suspending the license of any health care practitioner ~~person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, chapter 466, or chapter 484~~ who pleads guilty to, is convicted or found guilty of, or who enters a plea of nolo contendere to, regardless of adjudication, any of the following ~~to~~:

(a) A felony under chapter 409, chapter 817, or chapter 893 or under 21 U.S.C. ss. 801-970 or under 42 U.S.C. ss. 1395-1396.~~;~~

(b) A misdemeanor or felony under 18 U.S.C. s. 669, ss. 285-287, s. 371, s. 1001, s. 1035, s. 1341, s. 1343, s. 1347, s. 1349, or s. 1518 or 42 U.S.C. ss. 1320a-7b, relating to the Medicaid program.~~; or~~

(c) A felony under s. 784.086, relating to a reproductive battery.

(d) A felony under chapter 782, relating to homicide.

(5) The department shall issue an emergency order suspending the license of any health care practitioner who is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses in this state or similar offenses in another jurisdiction:

(a) Section 393.135(2), relating to sexual misconduct against an individual with a developmental disability.

(b) Section 394.4593(2), relating to sexual misconduct against a patient of a receiving or treatment facility or otherwise in the custody of the Department of Children and Families.

(c) Section 787.01, relating to kidnapping.

(d) Section 787.02, relating to false imprisonment.

(e) Section 787.025(2), relating to luring or enticing a child.

(f) Section 787.06(3)(b),(d), (f), or (g), relating to human trafficking for commercial sexual activity.

(g) Former s. 787.06(3)(h), relating to human trafficking of a child under the age of 15 for commercial sexual activity.

(h) Section 787.07, relating to human smuggling.

(i) Section 794.011, relating to sexual battery, excluding s. 794.011(10).

(j) Section 794.05, relating to unlawful sexual activity

with certain minors.

(k) Section 794.08, relating to female genital mutilation.

(l) Former s. 796.03, relating to procuring a person under the age of 18 for prostitution.

(m) Former s. 796.035, relating to the selling or buying of minors into prostitution.

(n) Section 796.04, relating to forcing, compelling, or coercing another to become a prostitute.

(o) Section 796.05, relating to deriving support from the proceeds of prostitution.

(p) Section 796.07(4)(a)3., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, relating to prohibiting prostitution and related acts.

(q) Section 800.04, relating to lewd or lascivious offenses committed upon or in the presence of persons younger than 16 years of age.

(r) Section 810.145(8), relating to video voyeurism of a minor.

(s) Section 825.1025, relating to lewd or lascivious offenses committed upon or in the presence of an elderly person or disabled person.

(t) Section 827.071, relating to sexual performance by a child.

(u) Section 847.011, relating to prohibited acts in connection with obscene, lewd, etc., materials.

(v) Section 847.012, relating to materials harmful to minors.

(w) Section 847.013, relating to exposing minors to harmful motion pictures, exhibitions, shows, presentations, or representations.

(x) Section 847.0133, relating to the protection of minors from obscene materials.

(y) Section 847.0135, relating to computer pornography, prohibited computer usage, or traveling to meet minors, excluding s. 847.0135(6).

(z) Section 847.0137, relating to transmission of child pornography by electronic device or equipment.

(aa) Section 847.0138, relating to the transmission of material harmful to minors to a minor by electronic device or equipment.

(bb) Section 847.0145, relating to the selling or buying of minors.

(cc) Section 856.022, relating to loitering or prowling in close proximity to children.

(dd) Section 895.03, relating to racketeering activity, if the court makes a written finding that the racketeering activity involved at least one sexual offense listed in this subsection or at least one offense listed in this subsection which was committed with sexual intent or motive.

(ee) Section 916.1075(2), relating to sexual misconduct against a forensic client of a civil or forensic facility for defendants who have a mental illness or an intellectual disability.

(ff) Section 985.701(1), relating to sexual misconduct

against a juvenile offender.

(gg) Any similar offense committed in this state which has been redesignated from a former statute number to one of those listed in this subsection.

Section 3. This act shall take effect July 1, 2021.

HB 1627

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1627 Continuing Chiropractic Education
SPONSOR(S): Maggard
TIED BILLS: **IDEN./SIM. BILLS:** SB 1676

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee		Morris	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Chapter 460, F.S., is the practice act for chiropractic medicine and sets the minimum requirements for safe practice in the state. The Board of Chiropractic Medicine (Board), under the Department of Health (DOH) enforces the practice act, including licensure, monitoring, and ensuring safe practice of chiropractic professionals.

Currently, chiropractic licensees are required to complete continuing education courses in a classroom setting. HB 1627 repeals that requirement and requires the Board to approve continuing education courses offered in a distance learning format.

The bill authorizes continuing education courses to be taught by:

- Current faculty members or postgraduate level instructions of a chiropractic college or school, or a medical or osteopathic college;
- A person who holds a terminal degree with a minimum of three years of related practice and experience in the subject matter taught; or
- A person who holds a doctoral degree in chiropractic medicine with a minimum of three years of chiropractic practice and experience in the subject matter taught.

The bill prohibits the Board from requiring licensees to enroll only in preapproved continuing education courses and limiting the number or type of continuing education hours that may be completed through distance learning. The bill also authorizes the Board to rescind continuing education course approval and impose disciplinary action, if appropriate.

Currently, the Board may provide exceptions to continuing education requirements in cases of emergency or hardship. The bill authorizes the Board to provide exceptions to such requirements during a declared state of emergency in this state.

The bill has a negative, insignificant fiscal impact on DOH, which can be absorbed within current resources. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2021.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation and Licensure of Chiropractic Physicians

Chapter 460, F.S., is the practice act for chiropractic medicine and sets the minimum requirements for safe practice in the state. The Board of Chiropractic Medicine (Board), under the Department of Health (DOH) enforces the practice act, including licensure, monitoring, and ensuring safe practice of chiropractic professionals.[1]

To obtain a chiropractic physician license by examination, one must:[2]

- Submit a complete application and pay an application fee;
- Be at least 18 years of age;
- Have graduated from a chiropractic college accredited by the Council on Chiropractic Education or its predecessor agency;
- Have completed at least 3 years of residence college work prior to graduation, consisting of a minimum of 90 semester hours leading up to a bachelor's degree from an accredited college or university;[3]
- Pass the National Board of Chiropractic Examiners certification exams I, II, III, and IV and physiotherapy exam;
- Pass the Florida Laws and Rules Exam;[4] and
- Submit to background screening for criminal history.

Students in an accredited chiropractic college may practice chiropractic medicine without a license as part of their clinical training or under the direct supervision of chiropractic physician as part of their course of study. Students in their final year of education at an accredited college may also apply for licensure and take all of the requisite exams, but must graduate before receiving their license.

Continuing Education

The board is tasked with approving continuing education courses.[5] The board is required to approve continuing education courses that are sponsored by chiropractic colleges whose graduates are eligible to take the national examination and the courses must build upon the basic courses required for the practice of chiropractic medicine.[6] The board is permitted to approve courses in adjunctive modalities. Furthermore, the board is directed to require licensees to periodically demonstrate their professional competence as a condition of license renewal by completing at least 40 classroom hours of continuing education every biennium.[7] The Board may provide exceptions to continuing education requirements in cases of emergency or hardship.[8]

Accreditation for Chiropractic Colleges

[1] Florida Department of Health, *Board of Chiropractic Medicine,* https://floridaschiropracticmedicine.gov/ (last visited March 16, 2021).
[2] S. 460.406, F.S.
[3] For applicants who graduated from a chiropractic college before July 2, 1990, only 2 years of residence college work from an accredited college or university are required. However, anyone who graduated from a chiropractic college after July 1, 1990, must have been granted a bachelor's degree based on 4 academic years of study from an accredited college.
[4] S. 456.017(6), F.S.; Rule 64B2-11.001(2), F.A.C.
[5] S. 460.408, F.S.
[6] S. 460.408(1), F.S.
[7] S.460.408(1), F.S. and 64B2-13.004, F.A.C.
[8] S. 460.408(2), F.S.

Chiropractic education generally includes a four-year doctoral graduate school program which includes classroom instruction and clinical training.[9] Licensure laws generally require chiropractic education from an accredited chiropractic college. Accreditation is a process for validating an educational program which involves an external peer review board developing evaluation criteria and evaluating a program's curriculum, faculty, services and operations, clinical competency, and research to determine if the program meets recognized standards.[10]

U.S. Department of Education

The U.S. Department of Education (USDE) does not accredit individual higher educational programs, but instead recognizes accreditation agencies to evaluate the individual educational programs for purposes of participating in USDE's federal student aid programs.[11] Accreditation agencies are not required to apply for recognition with the USDE, but if an educational institution wants to participate in federal student aid programs and offer public financial aid to its students, it must be accredited by an agency which the USDE has recognized. Therefore, many accreditation agencies choose to apply for recognition with the USDE.[12] The USDE currently recognizes approximately 67 accreditation agencies.[13]

Council on Higher Education Accreditation

The Council on Higher Education Accreditation (CHEA) is a nongovernmental organization that also evaluates and recognizes accrediting agencies to ensure the academic quality of institutions and programs for higher education in the United States.[14] There is significant overlap between accrediting agencies the USDE and CHEA recognize; however, the USDE limits its review to higher education related to federal student financial aid programs whereas the CHEA will consider accreditation of all higher education.[15] CHEA currently recognizes approximately 60 accrediting agencies for various higher education institutions and programs.[16]

Council on Chiropractic Education

The Council on Chiropractic Education (CCE) is the only national organization recognized by the federal DOE or CHEA to accredit chiropractic education programs for its federal programs.[17] There are currently approximately 20 chiropractic colleges accredited by the CCE, three of which are in Florida.[18]

Effect of Proposed Changes

Continuing Education

[9] U.S. Department of Labor, Bureau of Labor Statistics, *Chiropractors*, https://www.bls.gov/ooh/healthcare/chiropractors.htm#tab-4 (last visited March 19, 2021).
[10] U.S. Department of Education, *Overview of Accreditation in the United States,* https://www2.ed.gov/admins/finaid/accred/accreditation.html#Overview (last visited March 19, 2021).
[11] Id.
[12] Id.
[13] U.S. Department of Education, *Recognized Accrediting Agencies*, https://www2.ed.gov/admins/finaid/accred/accreditation_pg5.html#NationallyRecognized (last visited March 19, 2021).
[14] Council for Higher Education Accreditation, *Accreditation & Recognition in the United States, https://www.chea.org/accreditation-recognition-united-states*
[15] Id.
[16] Council for Higher Education Accreditation, *CHEA- and USDE-Recognized Accrediting Organizations,* (Apr. 18, 2018), https://www.chea.org/chea-and-usde-recognized-accrediting-organizations (last visited March 19, 2021).
[17] *Supra* notes 13 and 16.
[18] U.S. Department of Education, *Database of Accredited Postsecondary Institutions and Programs,* https://ope.ed.gov/dapip/#/search-results (last visited March 19, 2021); Council on Chiropractic Education, *Accredited Doctor of Chiropractic Programs/Institutions,* http://www.cce-usa.org/dcp-info.html (last visited March 19, 2021); The 3 FL accredited institutions are the National University of Health Sciences, Palmer College of Chiropractic, and Keiser University.

HB 1627 authorizes the Board to rescind continuing education course approval and impose disciplinary action, if appropriate. The bill repeals the requirement that chiropractic continuing education be completed in a classroom setting and requires the Board to approve continuing education courses offered in a distance learning format, which includes synchronous and asynchronous learning. The Board may not require licensees to enroll only in preapproved continuing education courses nor limit the number or type of continuing education hours that may be completed through distance learning.

The bill authorizes the Board to provide exceptions to continuing education requirements during a declared state of emergency in this state.

The bill authorizes continuing education courses to be taught by:

- A current faculty member of a:
  - Chiropractic college or school approved by the board; or
  - Medical or osteopathic college or university accredited by the CHEA or its successor or the USDE.
- A postgraduate level instructor of a:
  - Chiropractic college or school approved by the Board; or
  - Medical or osteopathic college or university accredited by the agency recognized by the CHEA or its successor or the USDE.
- A person who holds a terminal degree[19] with a minimum of three years of related practice and experience in the subject matter taught; or
- A person who holds a doctoral degree in chiropractic medicine with a minimum of three years of chiropractic practice and experience in the subject matter taught.

The bill requires, rather than authorizes, the Board to adopt rules to implement the changes under the bill.

B. SECTION DIRECTORY:

Section 1 Amends s. 460.408, F.S., relating to continuing chiropractic education.
Section 2 Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH will experience an increase in workload associated with any rulemaking needed to implement the bill and updating the Board's website, which current resources are adequate to absorb.[20]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

[19] A terminal degree is the highest degree that may be obtained in a course of study.
[20] Department of Health, Agency Analysis of 2021 House Bill 1627, p. 5 (March 16, 2021).

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Licensees may incur a reduction in expenses associated with travel to a classroom setting to complete continuing education hours required for license renewal.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority for implementation by the Board.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to continuing chiropractic education; amending s. 460.408, F.S.; deleting a requirement that chiropractic continuing education be completed in a classroom setting; authorizing the Board of Chiropractic Medicine to rescind approval for continuing education courses and impose disciplinary action, if appropriate; prohibiting the board from requiring licensees to enroll in only preapproved courses to satisfy continuing education requirements; requiring the board to approve distance learning courses to satisfy continuing education requirements; prohibiting the board from limiting the number of hours and type of continuing education courses a chiropractic physician may complete through distance learning; authorizing the board to make exceptions to continuing education requirements during a declared state of emergency in this state; specifying who may teach board-approved continuing education courses; requiring, rather than authorizing, the board to adopt rules; providing an effective date.

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

Section 1. Section 460.408, Florida Statutes, is amended

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

to read:

460.408 Continuing chiropractic education.—

(1) The board shall require licensees to periodically demonstrate their professional competence as a condition of renewal of a license by completing up to 40 ~~contact classroom~~ hours of continuing education.

(a) Continuing education courses sponsored by chiropractic colleges whose graduates are eligible for examination under any provision of this chapter may be approved upon review by the board if all other requirements of board rules setting forth criteria for course approval are met.

(b) The board shall approve those courses that build upon the basic courses required for the practice of chiropractic medicine, and the board may also approve courses in adjunctive modalities. Courses that consist of instruction in the use, application, prescription, recommendation, or administration of a specific company's brand of products or services are not eligible for approval. The board may rescind course approval and impose disciplinary action, if appropriate. However, the board may not require licensees to enroll in only those courses that have been preapproved by the board to satisfy continuing education requirements under this section.

(c) The board shall approve continuing education courses offered in a distance learning format, including synchronous and asynchronous forms of distance learning, as an alternative to

classroom courses which may be used to satisfy continuing education requirements under this section.

(d) The board may not limit the number or type of approved continuing education hours that may be completed through distance learning.

(2) The board may provide exceptions to ~~make exception from~~ the requirements of this section in emergency or hardship cases and during a declared state of emergency in this state.

(3) A course may be taught by any of the following:

(a) A person holding a doctoral degree in chiropractic medicine, with a minimum of 3 years of chiropractic practice and a minimum of 3 years' experience in the subject matter taught, or a person holding a terminal degree, with a minimum of 3 years of related practice and a minimum of 3 years' experience in the subject matter taught.

(b) A current faculty member of a chiropractic college or school approved by the board, or a current faculty member of a medical or osteopathic college or university accredited by an accrediting agency recognized by the Council for Higher Education Accreditation or its successor or the United States Department of Education.

(c) A postgraduate level instructor of a chiropractic college or school approved by the board, or a postgraduate level instructor of a medical or osteopathic college or university accredited by an accrediting agency recognized by the Council

for Higher Education Accreditation or its successor or the United States Department of Education.

(4) The board shall ~~may~~ adopt rules necessary to implement this section ~~within the requirements of this section that are necessary for its implementation~~.

Section 2. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE ACTION

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

Committee/Subcommittee hearing bill: Professions & Public Health Subcommittee

Representative Maggard offered the following:

Amendment (with title amendment)

Remove lines 56-58

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

Remove lines 16-18 and insert:

Learning; specifying who may