

Professions and Public Health Subcommittee

Wednesday, January 19, 2022
1:00 PM – 3:00 PM
Webster Hall (212 Knott)

Meeting Packet

Chris Sprowls
Speaker

Will Robinson
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Professions & Public Health Subcommittee

Start Date and Time: Wednesday, January 19, 2022 01:00 pm

End Date and Time: Wednesday, January 19, 2022 03:00 pm

Location: Webster Hall (212 Knott)

Duration: 2.00 hrs

Consideration of the following bill(s):

HB 5 Reducing Fetal and Infant Mortality by Grall, Persons-Mulicka
CS/HB 469 Patient Care in Health Care Facilities by Finance & Facilities Subcommittee, Trabulsy
HB 817 Emergency Medical Care and Treatment to Minors Without Parental Consent by Massullo
HB 847 Occupational Therapy by Koster

Consideration of the following proposed committee substitute(s):

HB 731 Drug-related Overdose Prevention by Caruso

For information about attending or testifying at a committee meeting, please see the "Visiting the House" tab at www.myfloridahouse.gov.

NOTICE FINALIZED on 01/14/2022 4:03PM by Osborne.Erin

HB 5

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 5 Reducing Fetal and Infant Mortality
SPONSOR(S): Grall and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 146

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

SUMMARY ANALYSIS

Infant mortality is the death of an infant before the first birthday. The infant mortality rate in the United States is 5.6 deaths per 1,000 live births and Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births. Abortion is the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus. The bill addresses fetal and infant mortality reduction related to fetal and infant mortality reviews (FIMR), hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and infant mortality review (FIMR) is a community-based fetal and infant mortality review process to identify and address factors that affect infant mortality and morbidity. The Department of Health (DOH) contracts with Healthy Start Coalitions around the state for FIMR programs; however, FIMR programs are not available statewide. The bill requires DOH to contract for additional FIMR committees in all regions of the state. Each Coalition must report FIMR committee findings and recommendations to DOH annually and DOH must submit such in a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

The Florida Perinatal Quality Collaborative (FPQC) partners with stakeholders and partners across the state to develop and implement quality initiatives to reduce maternal and infant mortality. FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with implementing process changes to carry out quality improvement initiatives. While many hospitals participate in FPQC initiatives, participation is voluntary and many do not. The bill requires hospitals that provide birthing services (labor and delivery) to participate in at least two quality improvement initiatives developed in collaboration with the FPQC.

The Comprehensive Statewide Tobacco Education and Use Prevention Program (Program) is a program based on best practices from the U.S. Centers for Disease Control and Prevention. The Program educates Floridians, particularly youth and their parents, about the hazards of tobacco and preventing use. The bill requires the Program to include a focus on pregnant women and women who may become pregnant.

Florida law prohibits abortions during the third trimester with certain medical exceptions. Current law also requires the physician performing the abortion to determine, by ultrasound, the gestational age of the fetus at the time the abortion is to be performed.

HB 5 prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, based on the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester. The bill retains the current medical exception to prohibited abortions and, adds an exception for fatal fetal abnormalities.

Current law requires abortion providers to submit a monthly report to AHCA. Abortion providers are not currently required to report whether the abortion was due to human trafficking or the number of medication abortion regimens prescribed or dispensed by abortion providers.

HB 5 enhances and clarifies current abortion reporting requirements. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by clarifying that both surgical and medication-induced abortions must be reported and to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA, the Board of Medicine and the Board of Osteopathic Medicine to adopt an electronic reporting form.
The bill has a significant, negative fiscal impact to the Department of Health and no fiscal impact to local governments. The bill appropriates $260,000 in recurring General Revenue to DOH for these costs.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

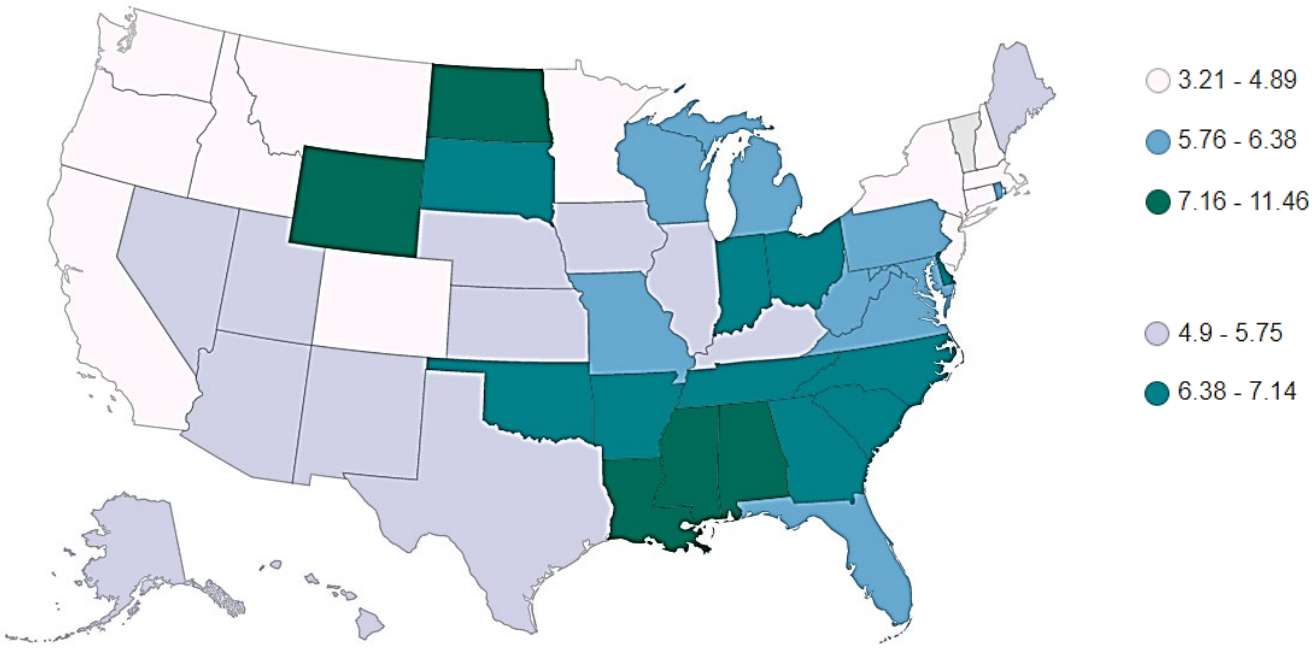
A. EFFECT OF PROPOSED CHANGES:

Background

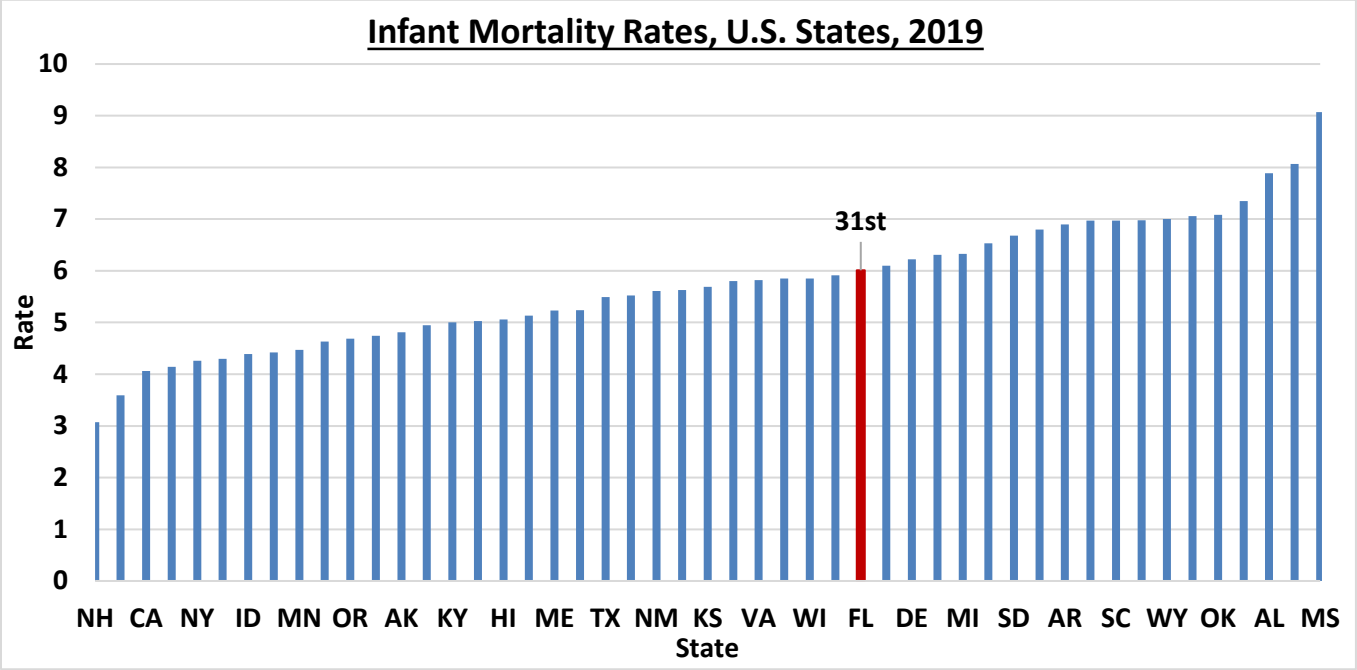
Infant Mortality

Infant mortality is the death of an infant before the first birthday. The infant mortality rate is the number of infant deaths for every 1,000 live births. In addition to giving key information about maternal and infant health, the infant mortality rate is a marker of the overall health of a society. In 2019, the infant mortality rate in the United States was 5.6 deaths per 1,000 live births.[1]

Infant Mortality Rates by State – 2019[2]



[1] Centers for Disease Control and Prevention, *Infant Mortality,* https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm (last visited Jan. 12, 2022).
[2] Centers for Disease Control and Prevention, *Infant Mortality Rates by State,* https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 12, 2022).



[3]

Infant Mortality in Florida

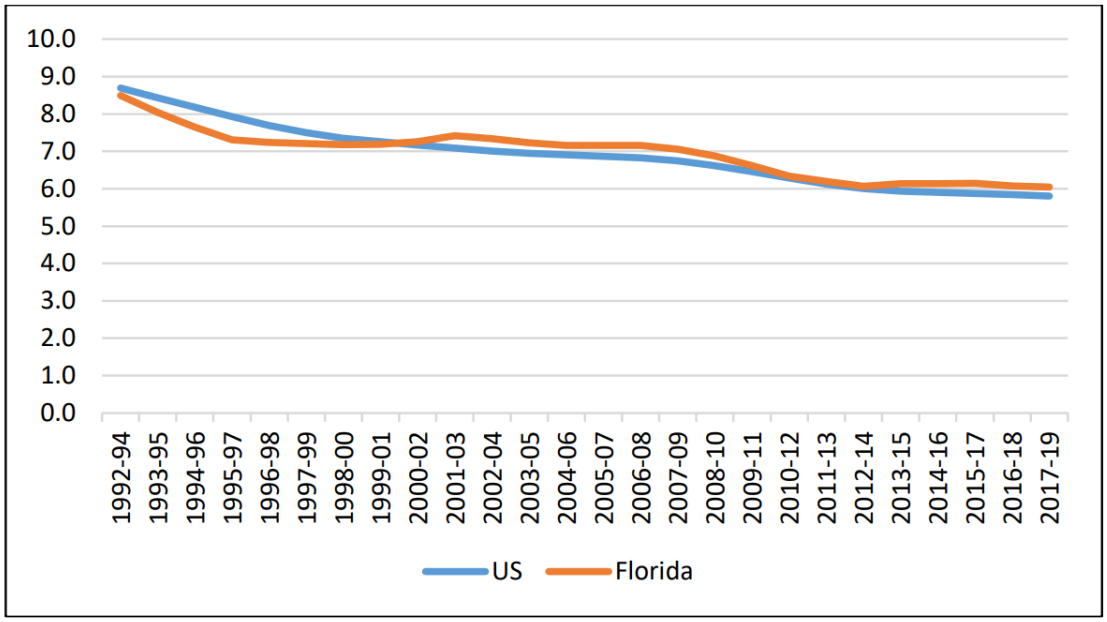
The Department of Health (DOH) reports annually on fetal and infant deaths through the Florida Vital Statistics Annual Report.[4] This report provides the number of fetal deaths per 1,000 live births, the number of deaths by race, and compares that data to national figures. Florida ranks 18th in the nation in infant mortality with a rate of six deaths per 1,000 live births (1,213 in 2020).[5]

In Florida, the leading causes of infant mortality, per 1,000 live births, are:[6]

- Birth defects (1.1);
- Preterm and low birth weight (0.9);
- Unintentional injuries (0.5);
- Maternal complications of pregnancy (0.4);
- Complications of placenta, cord, and membranes (0.3); and
- Sudden Infant Death Syndrome (0.3).

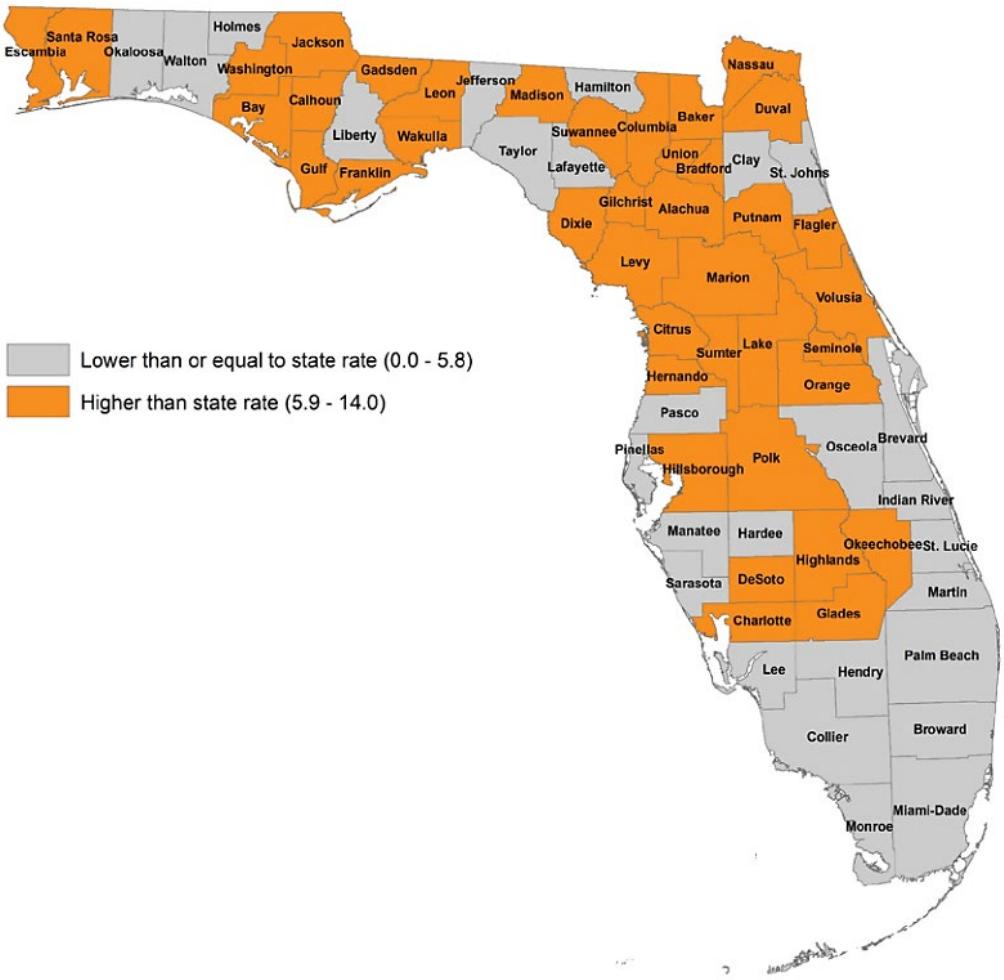
[3] Centers for Disease Control and Prevention, Reproductive Health – Infant Mortality Rates by State, 2019, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/infantmortality.htm#infant (last visited Jan. 12, 2022). Note that Vermont's rate was determined unreliable for 2019 by the CDC and is not included in this chart.
[4] Florida Vital Statistics Annual Report 2020, http://www.flpublichealth.com/VSbook/PDF/2020/Fetal.pdf (last visited Jan. 12, 2022).
[5] Id. *See also* Centers for Disease Control and Prevention, Infant Mortality Rates by State (2019), https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm (last visited Jan. 12, 2022).
[6] Presentation by Shay Chapman, BSN, MBA, Deputy Division Director, Community Health Promotion, Sept. 21, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+9-21-21.pdf (last visited Jan. 12, 2022).

Infant Mortality Rates, 1992-2019, Florida vs. the United States



Source: Florida CHARTS, www.flhealthcharts.com.

Florida Infant Mortality Rates by County[7]



[7] Id.

Fetal and Infant Mortality Review

Fetal and infant mortality review (FIMR) is a process of community-based fetal and infant mortality reviews aimed at addressing factors and issues that affect infant mortality and morbidity. FIMR committees aim to gain knowledge through the reviews to empower communities to enhance services, influence policy, and direct planning efforts that will ultimately lower infant mortality rates. The process is based on the National FIMR model which supports case review and interventions at the local level.[8]

FIMR Process

In Florida, FIMR committees operate in a two-tier structure consisting of Healthy Start Coalitions (Coalition) and Case Review Teams (CRT). The FIMR process begins when infant death cases are selected for review by a committee within the Healthy Start Coalition (Coalition) based on specific criteria, including type of death, residence and race. Information is abstracted from birth, death, medical, hospital and autopsy records. Efforts are also made to interview the family. No information which identifies the family or medical providers is included on the abstraction form.[9]

Case summaries are developed by the Coalition committee and presented to the CRT, a multidisciplinary group of community medical and social service professionals. This group usually includes a district and local health officer, obstetrician, pediatrician, social worker, nurse-midwife, a hospital and community nurse, coroner or medical examiner, interviewer, abstractor, community outreach worker, mental health counselor, and other people important to the individual reviews. The CRT examines each case to determine medical, social, financial and other issues that may have impacted the poor birth outcome. Recommendations for community action are crafted by the CRT based on review findings. These recommendations are shared with the Community Action Group, a group of volunteers working with at-risk families and other partner agencies[10] in the region to implement and develop street-level outreach activities.[11]

FIMR work has several benefits, such as including the perspective of the family, identifying issues unique to a community, allowing for targeted initiatives, and engaging community leaders to identify and implement solutions.[12]

FIMR in Florida

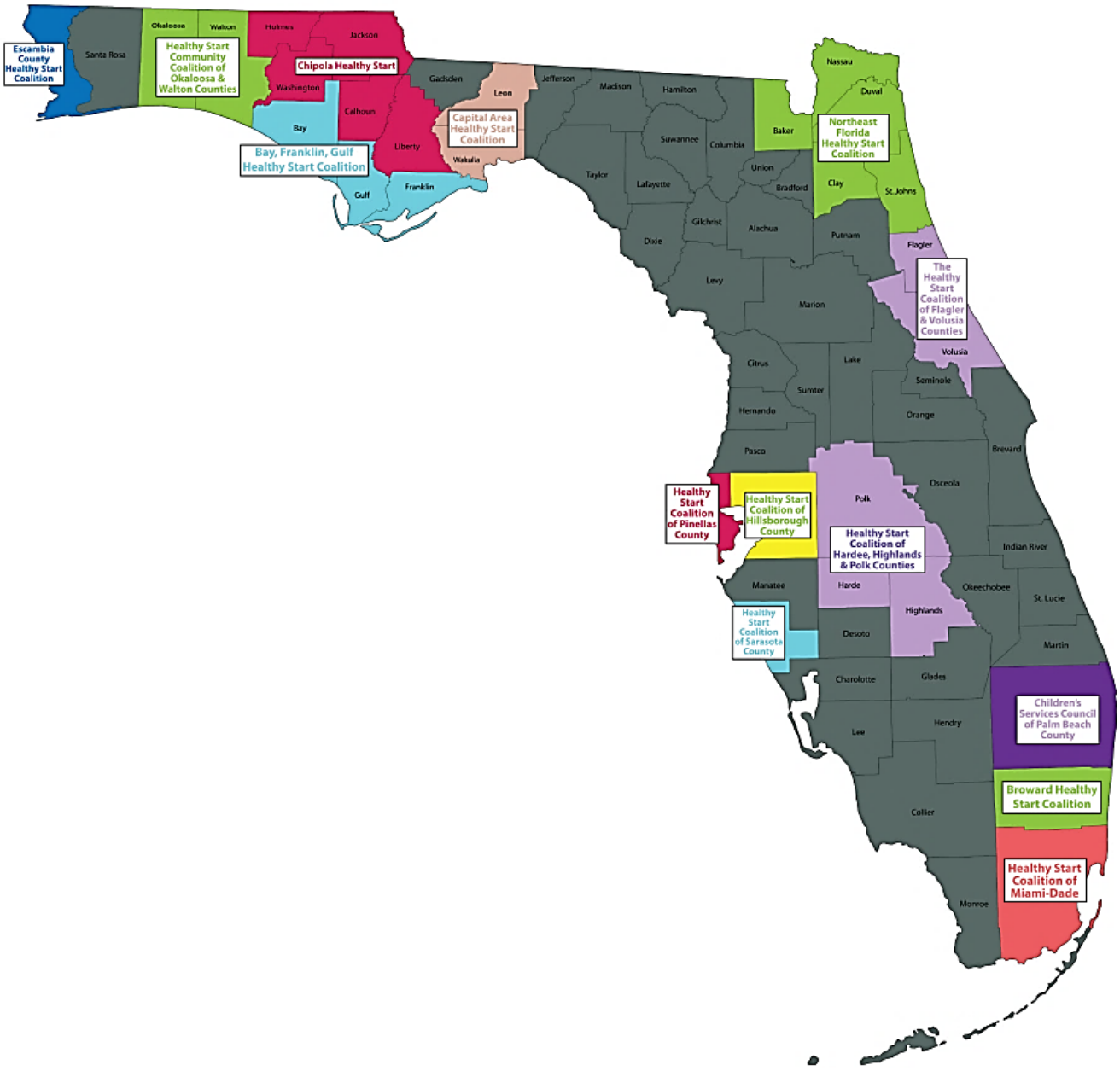
DOH contracts with Healthy Start Coalitions around the state for FIMR programs.[13] Rather, FIMIR is not a statewide program and there is no statutory directive for the FIMR process; programs are authorized in the General Appropriations Act. Approximately half of the counties in the state participate in a FIMR program.[14] Currently, Florida has:[15]

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[8] Florida Department of Health. *FIMR, available at* http://www.doh.state.fl.us/family/mch/FIMR/fimr_facts.html (last visited Jan. 12, 2022).
[9] Id.
[10] Partner agencies may include health departments, hospitals, medical societies, schools, community and business leaders, and consumers
[11] *Supra*, note 8.
[12] National Fetal and Infant Mortality Review Program, *A Guide for Communities: Fetal and Infant Mortality Review Manual, 2nd Edition (2008),* https://ncfrp.org/wp-content/uploads/NCRPCD-Docs/FIMRManual.pdf (last visited Jan 12, 2022).
[13] Email from Andrew Love, Director of Legislative Planning, Department of Health, Infant Mortality Policy Recommendations (Sept. 2, 2021) and
[14] Email from Andrew Love, Director of Legislative Planning, Department of Health, Follow Up Documents (July 26, 2021). *See also* Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited Jan., 12, 2022).
[15] Id.

- 11 state-funded FIMR programs though contracts with Healthy Start;
- 3 FIMRs funded through the County Health Departments (Orange, Osceola, and Palm Beach counties); and
- 2 FIMRs independently funded (Hillsborough and Indian River counties); and
- 1 inactive FIMR (St. Lucie County).

Healthy Start Coalition FIMR Programs[16]



[16] Presentation by Cathy Timuta, CEO, Florida Association of Healthy Start Coalitions, Inc., and Faye Johnson, CEO, Northeast Florida Healthy Start Coalition, Inc., Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited Jan., 12, 2022).

Comprehensive Statewide Tobacco Education and Use Prevention

On November 7, 2006, the voters in the State of Florida adopted Amendment 4, creating the Comprehensive Statewide Tobacco Education and Prevention Program.[17] Pursuant to the amendment, the state is required to create a comprehensive, statewide program consistent with the United States Department of Health and Human Services, Centers for Disease Control and Prevention 1999 best practices, as periodically amended. The program must consist, at a minimum, of the following components:[18]

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

The Constitution specifies that the Legislature must appropriate 15 percent of the total gross funds that tobacco companies paid to the State of Florida in 2005 under the Tobacco Settlement. This amount must be adjusted annually for inflation using the Consumer Price Index. For Fiscal Year 2021-2022, the mandated appropriation is $73.9 million.[19]

In 2007, the Legislature created section 381.84, Florida Statutes, the Comprehensive Statewide Tobacco Education and Use Prevention Program (Program), to implement the constitutional amendment. The Program consists of nine components:[20]

- Counter-marketing and advertising;
- Cessation programs, counseling and treatment;
- Surveillance and education;
- Youth and school programs;
- Community programs and chronic disease prevention;
- Training of health care practitioners, tobacco-use cessation counselors and teachers;
- Administration and management;
- Enforcement and awareness of related laws; and
- The area health education centers (AHEC) tobacco-use cessation initiative.

The Program requires each component to focus on educating people, particularly youth and their parents, about the hazards of tobacco and discouraging the use of tobacco. The Program does not specifically address pregnant women and women who may become pregnant.

Hospitals and Infant Mortality

Hospitals are regulated by the Agency for Health Care Administration (AHCA) under chapter 395, F.S., and the general licensure provisions of part II, of chapter 408, F.S. Hospitals offer a range of health care services with beds for use beyond 24 hours by individuals requiring diagnosis, treatment, or care.[21] Hospitals must make regularly available at least clinical laboratory services, diagnostic X-ray services, and treatment facilities for surgery or obstetrical care, or other definitive medical treatment.[22]

[17] Art. X, s. 27, Fla. Const.
[18] Id.
[19] Fla. General Appropriation Act Fiscal Year 2021-2022, SB 2500 item 458.
[20] S. 381.84(3), F.S.
[21] S. 395.002(12), F.S.
[22] Id.

Currently, hospitals that provide birthing services must incorporate information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death into postpartum instruction on the care of newborns. Hospitals must also provide parents with an informational pamphlet on infant and childhood eye and vision disorders.[23]

Florida Perinatal Quality Collaborative

The Florida Perinatal Quality Collaborative (FPQC) was established in 2010 and housed in the Chiles Center at the University of South Florida College of Public Health. FPQC aims to improve Florida's maternal and infant health outcomes through evidence-based perinatal care. FPQC partners with stakeholders, such as perinatal-related organizations, individuals, families, health professionals, hospitals, and payers to develop and implement quality improvement initiatives at partner hospitals that provide birthing services (labor and delivery) to address maternal and infant mortality.[24] FPQC's initiatives provide quality improvement data reports, toolkits, online toolboxes, and technical assistance to hospitals to assist with implementing process changes to carry out quality improvement initiatives.

Hospital participation in FPQC initiatives is voluntary.

Currently, FPQC has four active initiatives:[25]

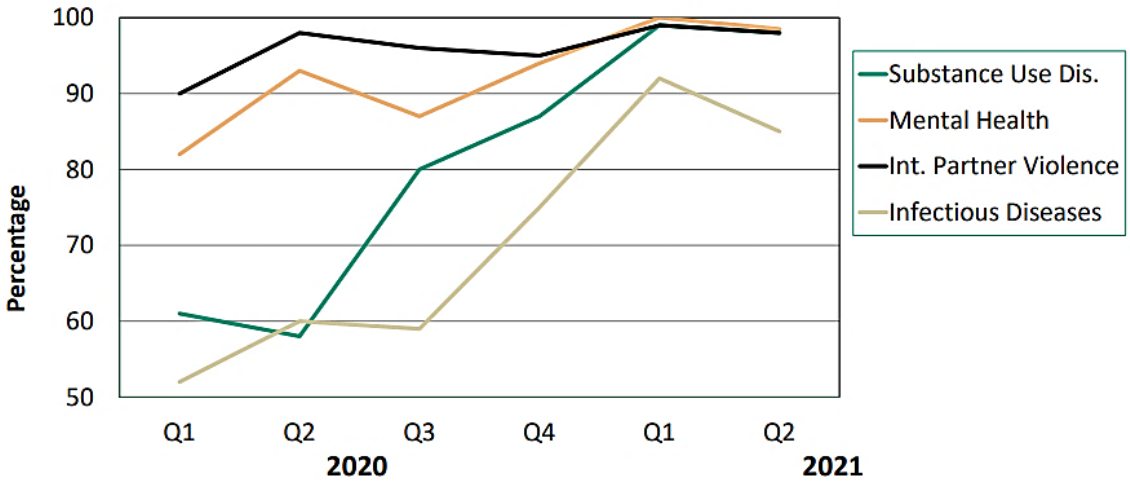
- **Promoting Primary Vaginal Deliveries (PROVIDE):**[26] The goal of the PROVIDE Initiative is to improve maternal and newborn outcomes by applying evidence-based interventions to promote primary vaginal deliveries at Florida delivery hospitals and ultimately reduce Nulliparous, Term, Singleton, Vertex cesareans.[27] Seventy-five hospitals currently participate in PROVIDE.
- **Family-Centered Care in the NICU (PAIRED):**[28] PAIRED helps hospital neonatal intensive care units (NICU) develop and implement unit-specific strategies to improve how a family engages with the NICU staff to assist in the care of their infant in a way that provides value to the family and to the NICU team. As its centerpiece project, this initiative facilitates adoption or expansion of safe skin-to-skin care**,** which has a growing evidence base for achieving better infant and family outcomes. Sixteen hospitals currently participate in PAIRED.
- **Perinatal Quality Indicators System (PQI):**[29] The PQI initiative supports hospital quality improvement efforts by providing hospital-specific semi-annual or quarterly reports of perinatal indicators and related reports. PQI is offered to all Florida delivery hospitals at no charge and hospitals can enroll at any time. Fifty-six hospitals currently participate in PQI.
- **Maternal Opioid Recovery Effort (MORE):**[30] MORE works with providers, hospitals, and other stakeholders to improve identification, clinical care, and coordinated treatment and support for pregnant women with opioid use disorder (OUD) and their infants. MORE focuses on standardization related to OUD screening, prevention, treatment, and comprehensive discharge planning. Thirty-one hospitals are currently participating in MORE.

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[23] S. 395.1053, F.S.
[24] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – About the FPQC,* https://health.usf.edu/publichealth/chiles/fpqc/about (last visited Jan. 12, 2022).
[25] USF Health College of Public Health, *Florida Perinatal Quality Collaborative,* https://health.usf.edu/publichealth/chiles/fpqc (last visited Jan. 12, 2022).
[26] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Promoting Vaginal Deliveries,* https://health.usf.edu/publichealth/chiles/fpqc/provide (last visited Jan. 12, 2022).
[27] Nulliparous, Term, Singleton, Vertex (NTSV) Cesareans are cesarean births where babies are at or beyond 37.0 weeks gestation to women in their first pregnancy, that are singleton (no twins or beyond) and in the vertex presentation (no breech or transverse positions).
[28] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – PAIRED Initiative,* https://health.usf.edu/publichealth/chiles/fpqc/paired (last visited Jan. 12, 2022).
[29] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Perinatal Quality Indicators System,* https://health.usf.edu/publichealth/chiles/fpqc/indicators (last visited Jan. 12, 2022).
[30] USF Health College of Public Health, *Florida Perinatal Quality Collaborative – Maternal Opioid Recovery Effort (MORE),* https://health.usf.edu/publichealth/chiles/fpqc/MORE (last visited Jan. 12, 2022).

Since the MORE initiative began in November 2019, participating hospitals have substantially increased screening for substance use disorder, mental health, intimate partner violence, and infectious diseases, as indicated by the graph below.[31]

Maternal Screening in MORE Participating Hospitals[32]



Federal Law on Abortion

In 1973, the foundation of modern abortion jurisprudence, *Roe v. Wade*[33], was decided by the U.S. Supreme Court (Supreme Court). The Supreme Court determined that a woman's right to an abortion is part of a fundamental right to privacy guaranteed under the Due Process Clause of the Fourteenth Amendment of the U.S. Constitution. Further, the Court reasoned that state regulation limiting the exercise of this right is subject to strict scrutiny: it must be justified by a compelling state interest, and must be narrowly drawn.[34] In 1992, the fundamental holding of *Roe* was upheld by the U.S. Supreme Court in *Planned Parenthood v. Casey*.[35]

The Viability Standard

In *Roe v. Wade*, the Supreme Court established a rigid trimester framework dictating when, if ever, states can regulate abortion.[36] The Court held that states could not regulate abortions during the first trimester of pregnancy.[37] With respect to the second trimester, the Court held that states could only enact regulations aimed at protecting the mother's health, not the fetus's life. Therefore, no ban on abortions is permitted during the second trimester. The state's interest in the life of the fetus becomes sufficiently compelling only at the beginning of the third trimester, allowing it to prohibit abortions. Even then, the Court requires states to permit an abortion in circumstances necessary to preserve the health or life of the mother.[38]

[31] Presentation by William Sappenfield, MD, MPH, CPH, Professor, Director of Chiles Center, University of South Florida, Oct. 13, 2021 meeting of the Professions and Public Health Subcommittee, available at: https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3093&Session=2022&DocumentType=Meeting+Packets&FileName=pph+10-13-21.pdf (last visited Jan. 12, 2022).
[32] Id.
[33] *Roe v. Wade*, 410 U.S. 113 (1973).
[34] Id.
[35] *Casey*, 505 U.S. 833 (1992).
[36] *Roe*, 410 U.S. 113 (1973).
[37] *Id.* at 163-64.
[38] *Id.* at 164-165.

The current viability standard is set forth in *Planned Parenthood v. Casey*.[39] Recognizing that medical advancements in neonatal care can advance viability to a point somewhat earlier than the third trimester, the Supreme Court rejected the trimester framework and, instead, limited the states' ability to regulate abortion pre-viability. Thus, while upholding the underlying holding in *Roe*, which authorizes states to "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother[,]"[40] the Court determined that the line for this authority should be drawn at "viability," because "there may be some medical developments that affect the precise point of viability . . . but this is an imprecision within tolerable limits given that the medical community and all those who must apply its discoveries will continue to explore the matter."[41] Furthermore, the Court recognized that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child."[42]

The Undue Burden Standard

In *Planned Parenthood v. Casey*, the Supreme Court established the undue burden standard for determining whether a law places an impermissible obstacle to a woman's right to an abortion. The Court held that health regulations which impose undue burdens on the right to abortion are invalid.[43] State regulation imposes an "undue burden" on a woman's decision to have an abortion if it has the purpose or effect of placing a substantial obstacle in the path of the woman who seeks the abortion of a nonviable fetus.[44] However, the court opined, not every law which makes the right to an abortion more difficult to exercise is an infringement of that right.[45]

The Medical Emergency Exception

In *Doe v. Bolton*, the U.S. Supreme Court was faced with determining, among other things, whether a Georgia statute criminalizing abortions (pre- and post-viability), except when determined to be necessary based upon a physician's "best clinical judgment," was unconstitutionally void for vagueness for inadequately warning a physician under what circumstances an abortion could be performed.[46] In its reasoning, the Court agreed with the district court decision that the exception was not unconstitutionally vague, by recognizing that:

> [T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age-relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.[47]

This broad interpretation of what constitutes a medical emergency was later tested in *Casey*[48], albeit in a different context. One question before the Supreme Court in *Casey* was whether the medical emergency exception to a 24-hour waiting period for an abortion was too narrow in that there were some potentially significant health risks that would not be considered "immediate."[49] The exception in question provided that a medical emergency is:

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[39] *Planned Parenthood of SE Pa. v. Casey*, 505 U.S. 833 (1992).
[40] *See Roe*, 410 U.S. at 164-65.
[41] *See Casey*, 505 U.S. at 870.
[42] *Id.*
[43] Id. at 878.
[44] Id. at 877
[45] Id. at 873.
[46] *Doe*, 410 U.S. at 179 (1973). Other exceptions, such as in cases of rape and when, "[t]he fetus would very likely be born with a grave, permanent, and irremediable mental or physical defect." *Id.* at 183. *See also, U.S. v. Vuitich*, 402 U.S. 62, 71-72 (1971) (determining that a medical emergency exception to a criminal statute banning abortions would include consideration of the mental health of the pregnant woman).
[47] *Doe*, 410 U.S. at 192.
[48] *Casey*, 505. U.S. 833 (1992).
[49] *Id.* at 880.

> [T]hat condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.[50]

In evaluating the more objective standard under which a physician is to determine the existence of a medical emergency, the Court in *Casey* determined that the exception would not significantly threaten the life and health of a woman and imposed no undue burden on the woman's right to have an abortion.[51]

Jackson Women's Health Organization v. Dobbs

In 2018, Mississippi enacted the Gestational Age Act (Act) which prohibited a person from performing an abortion if the probable gestational age of the fetus is greater than 15 weeks. Jackson Women's Health Organization filed a lawsuit challenging the Act alleging that it was an unconstitutional pre-viability ban on abortion. The state argued the Act was a constitutional restriction on abortion. The federal trial court ruled in favor of Jackson Women's Health Organization, which was upheld by the Fifth Circuit of Appeals.[52]

The lawsuit matter is currently pending before the U.S. Supreme Court, which held oral arguments on December 1, 2021.[53]

Florida Abortion Law

Right to Abortion

The Florida Constitution, as interpreted by Florida courts, affords greater privacy rights than those provided by the U.S. Constitution. While the federal Constitution traditionally shields enumerated and implied individual liberties from state or federal intrusion, the U.S. Supreme Court has noted that state constitutions may provide greater protections.[54] Unlike the U.S. Constitution, Article I, s. 23 of the Florida Constitution contains an express right to privacy:

> Every natural person has the right to be let alone and free from governmental intrusion into the person's private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law.

The Florida Supreme Court opined in *In re T.W.* that this section provides greater privacy rights than those implied by the U.S. Constitution.[55]

The Florida Supreme Court has recognized Florida's constitutional right to privacy "is clearly implicated in a woman's decision whether or not to continue her pregnancy."[56] In *In re T.W.,* the Florida Supreme Court ruled that:[57]

> [P]rior to the end of the first trimester, the abortion decision must be left to the woman and may not be significantly restricted by the state. Following this point, the state may impose significant restrictions only in the least

[50] *Id.* at 879 (quoting 18 Pa. Cons. Stat. § 3203 (1990)).
[51] *Id.* at 880.
[52] See *Jackson Women's Health Organization v. Dobbs,* 945 F.3d 265 (5th Cir. 2019).
[53] *See Dobbs v. Jackson Women's Health Organization*, Case No. 19-1932, available at https://www.supremecourt.gov/search.aspx?filename=/docket/docketfiles/html/public/19-1392.html (last visited January 16, 2022).
[54] *Pruneyard Shopping Center v. Robins*, 100 S.Ct. 2035, 2040 (1980), cited in *In re T.W.*, 551 So.2d 1186, 1191 (Fla. 1989).
[55] Id. at 1191-1192.
[56] Id. at 1192.
[57] Id. at 1193.

> intrusive manner designed to safeguard the health of the mother. Insignificant burdens during either period must substantially further important state interests….Under our Florida Constitution, the state's interest becomes compelling upon viability….Viability under Florida law occurs at that point in time when the fetus becomes capable of meaningful life outside the womb through standard medical procedures.

The court recognized that after viability, the state can regulate abortion in the interest of the unborn child if the mother's health is not in jeopardy.[58]

The state may regulate abortion pre-viability based upon its interest in maternal health beginning in the second trimester. In *Fla. Women's Medical Clinic, Inc. v. Smith,* the court held that the state has an interest in maternal health only after the first trimester, not before, and may not impose substantive clinical standards in the first trimester.[59]

Abortion Regulation

Abortion clinics are regulated by the Agency for Health Care Administration (AHCA) under ch. 390, F.S. Physicians performing abortions (which may take place in abortion clinics, hospitals, physician offices or other physician settings) are regulated by the Department of Health (DOH) under chs. 458 and 459 F.S.

In Florida, abortion is defined as the termination of a human pregnancy with an intention other than to produce a live birth or to remove a dead fetus.[60] An abortion must be performed by a physician[61] licensed under ch. 458, F.S., or ch. 459, F.S., or a physician practicing medicine or osteopathic medicine in the employment of the United States.[62]

Florida law prohibits abortions after viability, as well as during the third trimester, unless a medical exception exists. Section 390.01112(1), F.S., prohibits an abortion from being performed if a physician determines that, in reasonable medical judgment, the fetus has achieved viability.[63] Section 390.0111, F.S., prohibits an abortion from being performed during the third trimester.[64] Exceptions to both of these prohibitions exist if:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.[65]

[58] Id. at 1194.
[59] Fla. Women's Medical Clinic, Inc. v. Smith, 478 F.Supp. 233 (S.D. Fla. 1979); Fla. Women's Medical Clinic, Inc. v. Smith, 536 F.Supp. 1048 (S.D. Fla. 1982).
[60] Section 390.011(1), F.S.
[61] Section 390.0111(2), F.S.
[62] Section 390.011(8), F.S.
[63] Viability is defined as the stage of fetal development when the life of a fetus is sustainable outside the womb through standard medical measures. Section 390.011(13), F.S.
[64] Section 390.011(11), F.S., defines the third trimester to mean the weeks of pregnancy after the 24th week of pregnancy.
[65] Sections 390.0111(1)(a) and (b) and 390.01112(1)(a) and (b), F.S.

Current law requires the physician performing the abortion to verify the probable gestational age of the fetus, by ultrasound, at the time the abortion is performed.[66] The physician performing the abortion, or person qualified to operate an ultrasound who is working with in conjunction with the physician, must perform the ultrasound.[67]

Any person who willfully performs, or actively participates in, an abortion in violation of these statutory requirements commits a third degree felony and commits a second-degree felony if the woman dies.[68]

Abortion Data Reporting

Section 390.0112, F.S., requires the medical director of medical facilities where abortions are performed to submit a monthly report to AHCA that must contain information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention (CDC).[69] If the abortion is performed in a location other than a medical facility, the physician who performed the abortion is responsible for reporting the information to AHCA.[70]

In 2020, there were 209,645 live births in Florida.[71] In the same year, there were 72,073 abortion procedures performed in the state. Of those: [72]

- 70,594 were performed in the first trimester (12 weeks and under);
- 4,274 were performed in the second trimester (13 to 24 weeks); and
- None were performed in the third trimester (25 weeks and over).

The majority of the procedures (65,210) were elective.[73] The remainder of the abortions were performed due to: [74]

- Emotional or psychological health of the mother (1,409);
- Physical health of the mother that was not life endangering (1,111);
- Life endangering physical condition (146);
- Rape (112);
- Incest (9)
- Serious fetal genetic defect, deformity, or abnormality (734); and
- Social or economic reasons (15,271).

[66] Section 390.0111(3)(a)1.b.II, F.S.
[67] Section 390.0111(3), F.S.
[68] Section 390.0111(10), F.S. Such regulations include basic clinical standards for abortion clinics performing abortions after the first trimester and informed consent.
[69] The CDC requests the following information from states for the U.S. Standard Report of Induced Termination of Pregnancy: facility name (clinic or hospital); city, town or location; county; hospital or clinic's patient identification number (used for querying for missing information without identifying the patient); age; marital status; date of termination; residence of patient; ethnicity; race; education attainment; date of last menses; clinical estimate of gestation; previous pregnancy history; previous abortion history; type of abortion procedure; and name of attending physician and name of person completing report. Centers for Disease Control, Handbook on the Reporting of Induced Termination of Pregnancy, www.cdc.gov/nchs/data/misc/hb_itop.pdf (last visited on January 6, 2022).
[70] Section 390.0112(2), F.S.
[71] Total Resident Live Births, Department of Health, available at https://www.flhealthcharts.gov/ChartsReports/rdPage.aspx?rdReport=Birth.DataViewer&cid=25 (last viewed January 8, 2022).
[72] Reported Induced Terminations of Pregnancy by Reason, by Trimester, Agency for Health Care Administration, available at https://ahca.myflorida.com/mchq/central_services/training_support/docs/TrimesterByReason_2020.pdf (last viewed January 8, 2022).
[73] Id.
[74] Id.

AHCA must keep this information in a central location from which statistical data can be drawn and must provide this information to the CDC upon request.[75] The reports are confidential and exempt from public records requirements.[76] AHCA may impose fines for violations of the reporting requirements.[77]

Abortion providers report abortions due to rape or incest, but are not currently required to report whether the abortion was due to human trafficking.

Additionally, potential gaps in abortion date may exist. If an abortion is performed outside of a medical facility, the physician performing the abortion must submit a monthly report to AHCA. Because AHCA has no regulatory oversight of physicians (this authority rests with the Boards), it is unclear whether all physicians performing abortions outside of medical facilities are reporting. It is equally unclear if all medication abortions are being reported as abortion providers are not currently required to report the number of medication abortion regimens[78] prescribed or dispensed.

Effect of the Bill

The bill addresses fetal and infant mortality reduction related to FIMR, hospital quality initiatives, comprehensive statewide tobacco education and use prevention, and abortion policy.

Fetal and Infant Mortality Review

The bill requires DOH to contract with local Healthy Start Coalitions to establish fetal and infant mortality review committees in all regions of the state, to improve fetal and infant mortality in each region. Each committee must:

- Review and analyze the geographic area's fetal and infant mortality rates, trends, causes, and other data;
- Develop findings and recommendations for interventions and policy changes to reduce rates; and
- Engage with local communities and stakeholders to implement recommended policies and procedures.

Each Coalition must report FIMR committee findings and recommendations to DOH annually. Beginning on October 1, 2023, DOH must compile FIMR committee findings and submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives.

Comprehensive Statewide Tobacco Education and Use Prevention

The bill requires the Comprehensive Statewide Tobacco Education and Use Prevention Program to include a focus on pregnant women and women who may become pregnant in the program's components.

Hospitals and Infant Mortality

[75] Id. The CDC compiles statistics voluntarily reported by the 50 states, the District of Columbia and New York City, related to termination of pregnancies to produce a national data report. *Abortion Surveillance- United States, 2019*, Surveillance Summaries, Centers for Disease Control and Prevention, November 26, 2021 / 70(9);1–29 https://www.cdc.gov/mmwr/volumes/70/ss/ss7009a1.htm (last visited on January 6, 2022).
[76] Section 390.0112(3), F.S.
[77] Section 390.0112(4), F.S.
[78] The FDA approved medication abortion regimen consists of mifepristone and misoprostol which may be taken through 70 days gestation (70 days or less since the first day of a woman's last menstrual period) to end a pregnancy. *Mifeprex (mifepristone) Information*, U.S. Food and Drug Administration, available at https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/mifeprex-mifepristone-information (last visited on January 15, 2022).

The bill requires hospitals that provide birthing services (labor and delivery) to participate in at least two quality improvement initiatives developed in collaboration with the FPQC at all times.

Abortion Regulation

HB 5 prohibits abortions if the physician performing abortion determines the gestational age of the fetus is more than 15 weeks, as calculated from the first day of the woman's last menstrual period. This replaces the current prohibition against abortions during the third trimester.

The bill retains the same medical exception to prohibited abortions in existing law:

- Two physicians certify in writing that, in reasonable medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition; or
- One physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

The bill adds an exception for fatal fetal abnormalities if two physicians certify in writing that, in reasonable medical judgment, the fetus has a fatal fetal abnormality. Because current law prohibits abortions past the gestational stage of viability, with no exceptions for fatal fetal abnormalities, this exception applies until the fetus reaches the gestational stage of viability. A fetal anomaly is a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

Abortion Reporting

HB 5 enhances and clarifies current abortion reporting requirements. The bill requires abortion providers to report whether abortions were due to human trafficking. The bill addresses potential data reporting gaps by requiring abortion providers to report both surgical and medication-induced abortions and to report the number of medication abortion regimens prescribed and dispensed. The bill also requires AHCA and the Boards to adopt an electronic reporting form. This provides greater regulatory oversight over the reporting requirement for physicians performing abortions outside of a medical facility.

B. SECTION DIRECTORY:

Section 1: Amends s. 381.84, F.S., relating to Comprehensive Statewide Tobacco Education and Use Prevention Program.
Section 2: Creates s. 383.21625, F.S., relating to fetal and infant mortality review committees.
Section 3: Amends s. 390.011, F.S., relating to definitions.
Section 4: Amends s. 390.0111, F.S., relating to termination of pregnancies.
Section 5: Amends s. 390.0112, F.S., relating to termination of pregnancies; reporting.
Section 6: Creates s. 395.0154, F.S., relating to birthing quality improvement initiatives.
Section 7: Appropriates funds to DOH to establish fetal and infant mortality review committees.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill appropriates $260,000 in recurring General Revenue funds to DOH for the purpose of establishing FIMR committees in areas of the state where no state-funded FIMIR committees exist. According to DOH, each FIMR committee contract is approximately $22,000 annually, allowing DOH to contract with local Healthy Start Coalitions to establish 10 new FIMR committees and fund the 11 existing state-funded FIMR programs with Healthy Start, the three FIMR committees funded through local county health departments, and the two independently funded FIMR committees.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Some local governments may experience an increase in revenues associated with state-funded FIMR programs as such counties may no longer need to fund local FIMR programs.

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:

   See main analysis.

B. RULE-MAKING AUTHORITY:

Current law and the bill provide sufficient rule-making authority 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 reducing fetal and infant mortality; amending s. 381.84, F.S.; revising the purpose and requirements for the Comprehensive Statewide Tobacco Education and Use Prevention Program; revising a provision relating to a certain report to conform to changes made by the act; creating s. 383.21625, F.S.; providing a definition; requiring the Department of Health to contract with local healthy start coalitions for the creation of fetal and infant mortality review committees in all regions of the state; providing requirements for such committees; requiring local healthy start coalitions to report the findings and recommendations developed by the committees to the department annually; requiring the department to compile such findings and recommendations in a report and submit such report to the Governor and Legislature by a specified date and annually; authorizing the department to adopt rules; amending s. 390.011, F.S.; revising and providing definitions; amending s. 390.0111, F.S.; prohibiting a physician from performing a termination of pregnancy if the physician determines the gestational age of a fetus is more than a specified number of weeks; providing an exception; amending s. 390.0112, F.S.;

revising a requirement that the directors of certain medical facilities submit a monthly report to the Agency for Health Care Administration; requiring certain physicians to submit such report to the agency; requiring the report to be submitted electronically on a form adopted by the agency, the Board of Medicine, and the Board of Osteopathic Medicine; requiring the report to include certain additional information; removing obsolete language; creating s. 395.1054, F.S.; requiring that certain hospitals participate in a minimum number of quality improvement initiatives developed in collaboration with the Florida Perinatal Quality Collaborative within the University of South Florida College of Public Health; providing an appropriation; providing an effective date.

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

Section 1. Subsections (2), (3), and (7) of section 381.84, Florida Statutes, are amended to read:

381.84 Comprehensive Statewide Tobacco Education and Use Prevention Program.—

(2) PURPOSE, FINDINGS, AND INTENT.—It is the purpose of this section to implement s. 27, Art. X of the State

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

Constitution. The Legislature finds that s. 27, Art. X of the State Constitution requires the funding of a statewide tobacco education and use prevention program that focuses on tobacco use by youth. The Legislature further finds that the primary goals of the program are to reduce the prevalence of tobacco use among youth, adults, ~~and~~ pregnant women, and women who may become pregnant; reduce per capita tobacco consumption; and reduce exposure to environmental tobacco smoke. Further, it is the intent of the Legislature to base increases in funding for individual components of the program on the results of assessments and evaluations. Recognizing that some components will need to grow faster than inflation, it is the intent of the Legislature to fund portions of the program on a nonrecurring basis in the early years so that those components that are most effective can be supported as the program matures.

(3) PROGRAM COMPONENTS AND REQUIREMENTS.—The department shall conduct a comprehensive, statewide tobacco education and use prevention program consistent with the recommendations for effective program components contained in the 1999 Best Practices for Comprehensive Tobacco Control Programs of the CDC, as amended by the CDC. The program shall include the following components, each of which shall focus on educating people, particularly pregnant women, women who may become pregnant, and youth and their parents, about the health hazards of tobacco and discouraging the use of tobacco:

(a) Counter-marketing and advertising; Internet resource center.—The counter-marketing and advertising campaign shall include, at a minimum, Internet, print, radio, and television advertising and shall be funded with a minimum of one-third of the total annual appropriation required by s. 27, Art. X of the State Constitution.

1. The campaign shall include an Internet resource center for copyrighted materials and information concerning tobacco education and use prevention, including cessation. The Internet resource center must be accessible to the public, including parents, teachers, and students, at each level of public and private schools, universities, and colleges in the state and shall provide links to other relevant resources. The Internet address for the resource center must be incorporated in all advertising. The information maintained in the resource center shall be used by the other components of the program.

2. The campaign shall use innovative communication strategies, such as targeting specific audiences who use personal communication devices and frequent social networking websites.

(b) Cessation programs, counseling, and treatment.—This program component shall include two subcomponents:

1. A statewide toll-free cessation service, which may include counseling, referrals to other local resources and support services, and treatment to the extent funds are

available for treatment services; and

2. A local community-based program to disseminate information about tobacco-use cessation, how tobacco-use cessation relates to prenatal care and obesity prevention, and other chronic tobacco-related diseases.

(c) Surveillance and evaluation.—The program shall conduct ongoing epidemiological surveillance and shall contract for annual independent evaluations of the effectiveness of the various components of the program in meeting the goals as set forth in subsection (2).

(d) Youth school programs.—School and after-school programs shall use current evidence-based curricula and programs that involve youth to educate youth about the health hazards of tobacco, help youth develop skills to refuse tobacco, and demonstrate to youth how to stop using tobacco.

(e) Community programs and chronic disease prevention.—The department shall promote and support local community-based partnerships that emphasize programs involving youth, pregnant women, and women who may become pregnant, including programs for the prevention, detection, and early intervention of tobacco-related chronic diseases.

(f) Training.—The program shall include the training of health care practitioners, tobacco-use cessation counselors, and teachers by health professional students and other tobacco-use prevention specialists who are trained in preventing tobacco use

and health education. Tobacco-use cessation counselors shall be trained by specialists who are certified in tobacco-use cessation.

(g) Administration and management, statewide programs, and county health departments.—The department shall administer the program within the expenditure limit established in subsection (8). Each county health department is eligible to receive a portion of the annual appropriation, on a per capita basis, for coordinating tobacco education and use prevention programs within that county. Appropriated funds may be used to improve the infrastructure of the county health department to implement the comprehensive, statewide tobacco education and use prevention program. Each county health department shall prominently display in all treatment rooms and waiting rooms counter-marketing and advertisement materials in the form of wall posters, brochures, television advertising if televisions are used in the lobby or waiting room, and screensavers and Internet advertising if computer kiosks are available for use or viewing by people at the county health department.

(h) Enforcement and awareness of related laws.—In coordination with the Department of Business and Professional Regulation, the program shall monitor the enforcement of laws, rules, and policies prohibiting the sale or other provision of tobacco to minors, as well as the continued enforcement of the Clean Indoor Air Act prescribed in chapter 386. The

advertisements produced in accordance with paragraph (a) may also include information designed to make the public aware of these related laws and rules. The departments may enter into interagency agreements to carry out this program component.

(i) AHEC tobacco-use cessation initiative.—The AHEC network may administer the AHEC tobacco-use cessation initiative in each county within the state and perform other activities as determined by the department.

(7) ANNUAL REPORT REQUIRED.—By January 31 of each year, the department shall provide to the Governor, the President of the Senate, and the Speaker of the House of Representatives a report that evaluates the program's effectiveness in reducing and preventing tobacco use and that recommends improvements to enhance the program's effectiveness. The report must contain, at a minimum, an annual survey of youth attitudes and behavior toward tobacco, as well as a description of the progress in reducing the prevalence of tobacco use among youth, adults, ~~and~~ pregnant women, and women who may become pregnant; reducing per capita tobacco consumption; and reducing exposure to environmental tobacco smoke.

Section 2. Section 383.21625, Florida Statutes, is created to read:

383.21625 Fetal and infant mortality review committees.—

(1) As used in this section, the term "department" means the Department of Health.

(2) The department shall contract with local healthy start coalitions for the creation of fetal and infant mortality review committees in all regions of the state to improve fetal and infant mortality and morbidity in each region. Each committee shall:

(a) Review and analyze rates, trends, causes, and other data related to fetal and infant mortality and morbidity in a geographic area.

(b) Develop findings and recommendations for interventions and policy changes to reduce fetal and infant mortality and morbidity rates.

(c) Engage with local communities and stakeholders to implement recommended policies and procedures to reduce fetal and infant mortality and morbidity.

(3) Each local healthy start coalition shall report the findings and recommendations developed by each fetal and infant mortality review committee to the department annually. Beginning October 1, 2023, the department shall compile such findings and recommendations in an annual report, which must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

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

Section 3. Subsections (6) and (7) of section 390.011, Florida Statutes, are renumbered as subsections (7) and (8),

respectively, present subsections (8) through (13) are renumbered as subsections (10) through (15), respectively, present subsection (6) is amended, and new subsections (6) and (9) are added to that section, to read:

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

(6) "Fatal fetal abnormality" means a terminal condition that, in reasonable medical judgment, regardless of the provision of life-saving medical treatment, is incompatible with life outside the womb and will result in death upon birth or imminently thereafter.

(7) ~~(6)~~ "Gestation" means the development of a human embryo or fetus as calculated from the first day of the pregnant woman's last menstrual period ~~between fertilization and birth~~.

(9) "Medical abortion" means the administration or use of an abortion-inducing drug to induce an abortion.

Section 4. Subsection (1) of section 390.0111, Florida Statutes, is amended to read:

390.0111 Termination of pregnancies.—

(1) TERMINATION AFTER GESTATIONAL AGE OF 15 WEEKS ~~IN THIRD TRIMESTER~~; WHEN ALLOWED.—A physician may not perform a ~~No~~ termination of pregnancy if the physician determines the gestational age of the fetus is more than 15 weeks ~~shall be performed on any human being in the third trimester of pregnancy~~ unless one of the following conditions is met:

(a) Two physicians certify in writing that, in reasonable

medical judgment, the termination of the pregnancy is necessary to save the pregnant woman's life or avert a serious risk of substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition.

(b) The physician certifies in writing that, in reasonable medical judgment, there is a medical necessity for legitimate emergency medical procedures for termination of the pregnancy to save the pregnant woman's life or avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the pregnant woman other than a psychological condition, and another physician is not available for consultation.

(c) The fetus has not achieved viability under s. 390.01112 and two physicians certify in writing that, in reasonable medical judgement, the fetus has a fatal fetal abnormality.

Section 5. Section 390.0112, Florida Statutes, is amended to read:

390.0112 Termination of pregnancies; reporting.—

(1) The director of any medical facility in which abortions are performed, including surgical procedures and medical abortions, ~~including a physician's office,~~ shall submit a report each month to the agency. If the abortion is not performed in a medical facility, the physician performing the

abortion shall submit the monthly report. The report must ~~may~~ be submitted electronically on a form adopted by the agency, the Board of Medicine, and the Board of Osteopathic Medicine which~~,~~ may not include personal identifying information~~,~~ and must include:

(a) ~~Until the agency begins collecting data under paragraph (e),~~ The number of abortions performed.

(b) The reasons such abortions were performed. If a woman upon whom an abortion is performed has provided evidence that she is a victim of human trafficking pursuant to s. 390.0111(3)(a)1.b.(IV), such reason must be included in the information reported under this section.

(c) For each abortion, the period of gestation at the time the abortion was performed.

(d) The number of infants born alive or alive immediately after an attempted abortion.

(e) ~~Beginning no later than January 1, 2017,~~ Information consistent with the United States Standard Report of Induced Termination of Pregnancy adopted by the Centers for Disease Control and Prevention.

(f) The number of medication abortion regimens prescribed or dispensed.

(2) The agency shall keep such reports in a central location for the purpose of compiling and analyzing statistical data and shall submit data reported pursuant to paragraph (1)(e)

to the Division of Reproductive Health within the Centers for Disease Control and Prevention, as requested by the Centers for Disease Control and Prevention.

~~(3) If the termination of pregnancy is not performed in a medical facility, the physician performing the procedure shall be responsible for reporting such information as required in subsection (1).~~

(3)~~(4)~~ Reports submitted pursuant to this section shall be confidential and exempt from the provisions of s. 119.07(1) and shall not be revealed except upon the order of a court of competent jurisdiction in a civil or criminal proceeding.

(4)~~(5)~~ Any person required under this section to file a report or keep any records who willfully fails to file such report or keep such records may be subject to a $200 fine for each violation. The agency shall be required to impose such fines when reports or records required under this section have not been timely received. For purposes of this section, timely received is defined as 30 days following the preceding month.

Section 6. Section 395.1054, Florida Statutes, is created to read:

395.1054 Birthing quality improvement initiatives.—A hospital that provides birthing services shall at all times participate in at least two quality improvement initiatives developed in collaboration with the Florida Perinatal Quality Collaborative within the University of South Florida College of

Public Health.

Section 7. For the 2022-2023 fiscal year, the sum of $260,000 in recurring funds from the General Revenue Fund is appropriated to the Department of Health for the purpose of establishing fetal and infant mortality review committees under s. 383.21625, Florida Statutes, in areas of the state in which such state-funded fetal and infant mortality review committees do not exist.

Section 8. This act shall take effect July 1, 2022.

HB 469

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 469 Patient Care in Health Care Facilities
SPONSOR(S): Finance & Facilities Subcommittee, Trabulsy
TIED BILLS: **IDEN./SIM. BILLS:** SB 718

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Finance & Facilities Subcommittee	15 Y, 0 N, As CS	Guzzo	Lloyd
2) Professions & Public Health Subcommittee		Guzzo	McElroy
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Under current law, home health aides and certified nursing assistants (CNAs) may assist a patient of a home health agency with self-administration of certain medications after completion of prescribed training.

Current law authorizes home health aides and CNAs to perform certain tasks in providing assistance to assisted living facility (ALF) residents with self-administration of medication that home health aides and CNAs are not currently authorized to provide if they work for a home health agency. Current law also authorizes an ALF to contract with a home health agency to employ home health aides and CNAs, which can cause confusion as to which tasks a home health aide or CNA may provide when they are employed by a home health agency but they are working in an ALF. The bill revises home health agency statutes to allow home health aides and CNAs to perform additional tasks in providing assistance to patients with self-administration of medication to create consistency.

Specifically, the bill allows a home health aide or CNA to provide assistance with:

- Transdermal patches;
- Insulin syringes that are prefilled with the proper dosage by a pharmacist and insulin pens that are prefilled by the manufacturer;
- Glucometers to perform blood-glucose level checks;
- Antiembolism stockings;
- Applying and removing oxygen cannulas;
- Using continuous positive airway pressure devices;
- Measuring vital signs; and
- Colostomy bags.

Current law authorizes a registered nurse to delegate to a home health aide or CNA the authority to administer certain medications. The bill expands the duties a nurse may delegate to a home health aide or CNA to include administering an insulin syringe that is prefilled with the proper dosage by a pharmacist or an insulin pen that is prefilled by the manufacturer.

An advanced life support ambulance transporting a patient between two facilities is required to be occupied by two people, including one patient attendant who may be a paramedic, registered nurse, or a physician, and one qualified ambulance driver who is an EMT, paramedic, registered nurse, or physician. The bill removes the requirement for the driver to be an EMT, paramedic, registered nurse, or physician.

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

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Home Health Agencies

A "home health agency" is an organization that provides home health services.[1] Home health services are health and medical services and supplies furnished to an individual in the individual's home or place of residence.[2]

Home health aides[3] and certified nursing assistants[4] (CNAs) are unlicensed health care workers employed by a home health agency to provide personal care[5] to patients and assist them with the following activities of daily living:

- Ambulation;
- Bathing;
- Dressing;
- Eating;
- Personal hygiene;
- Toileting;
- Physical transferring;
- Assistance with self-administered medication; and
- Administering medications.[6]

Medication Administration and Assistance with Self-Administration

Medication Administration

Under certain conditions, home health aides and CNAs are authorized to administer certain types of medication to a patient of a home health agency, including oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications. Specifically, the home health aide or CNA must:

- Be delegated such task by a registered nurse;
- Complete an initial 6-hour training course approved by the Board of Nursing (Board) or the Agency for Health Care Administration (AHCA);
- Be found competent to administer medication to a patient in a safe and sanitary manner; and
- Complete two hours of annual inservice training in medication administration and medication error prevention approved by the Board.[7]

[1] S. 400.462(12), F.S.
[2] S. 400.462(15), F.S., home health services include the following: nursing care; physical, occupational, respiratory, or speech therapy; home health aide services; dietetics and nutrition practice and nutrition counseling; and medical supplies, restricted to drugs and biologics prescribed by a physician.
[3] S. 400.462(14), F.S., a home health aide is a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, assists in administering medications as permitted in rule and for which the person has received training established by the agency, or performs tasks delegated to him or her under ch. 464, F.S.
[4] S. 464.201(3), F.S., a CNA is a person who meets the qualifications of part II of ch. 464, F.S., and who is certified by the Board of Nursing as a certified nursing assistant.
[5] S. 400.462(23), F.S., defines "personal care" as assistance to a patient in the activities of daily living, such as dressing, bathing, eating, or personal hygiene, and assistance in physical transfer, ambulation, and in administering medications as permitted by rule.
[6] Rule 59A-8.002(3), F.A.C.
[7] S. 464.2035, F.S., and s. 400.489, F.S.

Section 464.0156, F.S., prohibits a registered nurse from delegating to a home health aide or CNA the administration of a controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03, F.S., or 21 U.S.C., s. 812. Controlled substances are classified by their acceptable medical use and propensity for abuse and dependency.[8] Insulin is not a schedule II, III, or IV controlled substance.

As of 2018, 34.2 million Americans, or 10.5 percent of the population, had diabetes,[9] and 8.3 million of those people required insulin to regulate blood glucose levels.[10] There are different types of insulin that vary by how quickly they work, when they peak, and how long they last.[11] All insulin available in the United States is manufactured in a laboratory.[12]

Assistance with Self-Administration

Patients are often capable of administering their own medication, but need assistance to ensure that they are taking the correct medication, at the proper dosage, and at the correct time. Under current law, home health aides and CNAs may assist with self-administration of medication after completion of required training.[13]

Home health aides and CNAs must complete two hours of training to assist with self-administration of medication.[14] The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.[15] The training may be provided by a licensed home health agency or a vocational school approved by the Department of Education.[16]

Current law authorizes home health aides and CNAs to perform certain tasks in providing assistance to assisted living facility (ALF) residents with self-administration of medication that home health aides and CNAs are not currently authorized to provide if they work for a home health agency. Current law also authorizes an ALF to contract with a home health agency to employ home health aides and CNAs,[17] which can cause confusion as to which tasks a home health aide or CNA may provide when they are employed by a home health agency but they are working in an ALF.

[8] U.S. Drug Enforcement Administration, *Drug Scheduling*, available at https://www.dea.gov/drug-information/drug-scheduling (last visited November 23, 2021).
[9] U.S. Department of Health and Human Services Centers for Disease Control and Prevention, *National Diabetes Statistics Report 2020 Estimates of Diabetes and its Burden in the United States*, available at https://www.cdc.gov/diabetes/pdfs/data/statistics/national-diabetes-statistics-report.pdf (last visited November 23, 2021).
[10] Tara O'Neill Hayes, *Understanding the Insulin Market*, American Action Forum (March 3, 2020), available at https://www.americanactionforum.org/research/understanding-the-insulin-market/ (last visited November 23, 2021).
[11] American Diabetes Association, *Insulin & Other Injectables, Insulin Basics*, available at https://www.diabetes.org/healthy-living/medication-treatments/insulin-other-injectables/insulin-basics (last visited November 23, 2021). "Rapid-acting insulin" begins to work about 15 minutes after injection, peaks within one or two hours, and lasts between two to four hours. "Regular or short-acting insulin" usually reaches the bloodstream within 30 minutes after injection, peaks within two to three hours, and lasts for three to six hours. "Intermediate-acting insulin" reaches the bloodstream two to four hours after injection, peaks within four to 12 hours, and lasts for 12 to 18 hours.
[12] Id.
[13] S. 400.488(1)(b), F.S.
[14] Rule 59A-8.0095(5), F.A.C.
[15] Id.
[16] Rule 59A-8.0095(5)(e)-(f), F.A.C.
[17] S. 429.256(1)(b), F.S.

The table below lists the tasks that a home health aide and a CNA in a home health agency[18] may assist a patient with compared to when they work in an ALF[19].

Task	Home Health Agency	ALF
Bringing to the patient, an insulin syringe that is prefilled with the proper dosage by a pharmacist or an insulin pen that is prefilled by the manufacturer.	☐	☑
Using a glucometer to perform blood-glucose level checks.	☐	☑
Assisting with putting on and taking off antiembolism stockings.	☐	☑
Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.	☐	☑
Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.	☐	☑
Assisting with measuring vital signs.	☐	☑
Assisting with colostomy bags.	☐	☑
Taking the medication, in its properly labeled container, from where it is stored to the patient.	☑	☑
Confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing a prescribed amount of medication from the container, and closing the container.	☑	☑
Placing an oral dose in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.	☑	☑
Returning the medication container to proper storage.	☑	☑
Keeping a record of when a patient receives assistance.	☑	☑
Applying topical medications, including routine preventative skin care and applying and replacing bandages for minor cuts and abrasions	☑	☑
Assisting with nebulizer treatments.	☑	☑

Assistance with self-administration of medication does not include, and a home health aide or CNA with the authority to assist with self-administration of medication may not perform the following tasks in a home health agency[20] or an ALF:[21]

- Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed;
- Preparing syringes for injection or administering medications by any injectable route;
- Administering medications by way of a tube inserted in a cavity of the body;
- Administering parenteral preparations;[22]

[18] S. 400.488(3), F.S.
[19] S. 429.256(3), F.S.
[20] S. 400.488(4), F.S.
[21] S. 429.256(4), F.S.

- Irrigating or using debriding agents to treat a skin condition;
- Preparing rectal, urethral, or vaginal medications;
- Administering medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the home health aide or CNA, and at the request of a competent patient; or
- Administering medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

Emergency Medical Transport Services

Basic Life Support and Advanced Life Support Ambulance Services

Ambulances[23] are used to transport sick or injured people to or between medical facilities. Ambulances provide two types of services; basic life support services (BLS) and advanced life support services (ALS).

BLS ambulance services use only basic life support techniques[24] and transport patients who only require basic medical monitoring.[25] 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.[26] The term includes the administration of oxygen and other techniques that have been approved and are performed under specific conditions.[27] BLS services are usually performed by emergency medical technicians[28] (EMTs).[29]

ALS ambulance services transport patients who require a higher level of medical monitoring.[30] 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.[31] ALS services are usually provided by paramedics.[32]

Staffing Requirements

Staffing requirements differ between BLS and ALS ambulance services. They also differ depending on whether the ambulance is transporting a patient to the hospital in an emergency situation or if the ambulance is transferring a patient who is in stable condition to another facility.

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[22] Parenteral means administration of a medication by injection, infusion, or implantation. U.S. Food & Drug Administration, *Route of Administration*, available at https://www.fda.gov/drugs/data-standards-manual-monographs/route-administration (last visited November 29, 2021).
[23] S. 401.23(5), F.S., defines "ambulance" or "emergency medical services vehicle" as any privately or publicly owned land or water vehicle that is designed, constructed, reconstructed, maintained, equipped, or operated for, and is used for, or intended to be used for, land or water transportation of sick or injured persons requiring or likely to require medical attention during transport.
[24] S. 401.23(8), F.S.
[25] Johns Hopkins Medicine, *Lifeline: Basic and Advanced Life Support,* available at https://www.hopkinsmedicine.org/lifeline/trans_services/life_support.html (last visited November 23, 2021).
[26] 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 November 19, 2021).
[27] S. 401.23(7) and (8), F.S.
[28] Ss. 401.23(11) and 401.27, F.S. EMTs are licensed by DOH.
[29] 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 November 19, 2021).
[30] *Supra* note 25.
[31] Ss. 401.23(1) and (2), F.S.
[32] Ryynanen, et. al, supra note 29.

A BLS ambulance transporting a patient to a hospital in an emergency situation must be occupied by at least two people, including one patient attendant who may be an EMT, paramedic, or physician, and one qualified ambulance driver.[33] The staffing requirements are the same, with one exception, for a BLS ambulance transporting a patient who is in stable condition between two facilities. The BLS ambulance transporting a patient who is in stable condition between two facilities can use a registered nurse in place of the EMT or paramedic.[34]

An ALS ambulance transporting a patient to a hospital in an emergency situation must be occupied by at least two people, including one patient attendant who may be a paramedic or a physician, and one qualified ambulance driver who may be an EMT, paramedic, or physician.[35] An ALS ambulance transporting a stable patient between two facilities can use a registered nurse in place of the EMT or paramedic.[36]

Effect of the Bill

The bill revises home health agency statutes to allow home health aides and CNAs to perform additional tasks in providing assistance to patients with self-administration of medication. This allows home health aides and CNAs to perform the same functions in home health settings as they can in ALF settings. Specifically, the bill allows a home health aide or CNA to provide assistance with transdermal patches, insulin syringes that are prefilled with the proper dosage by a pharmacist, and insulin pens that are prefilled by the manufacturer.

The bill also allows home health aides and CNAs in a home health setting to assist with the following tasks:

- Using glucometers to perform blood-glucose level checks;
- Putting on and taking off antiembolism stockings;
- Applying and removing oxygen cannulas;
- Using continuous positive airway pressure devices;
- Measuring vital signs; and
- Assisting with colostomy bags.

The bill makes conforming changes to the ALF statute to separate assistance with medications from assistance with tasks that do not involve medication.

In 2020, the Legislature authorized home health aides and CNAs to provide assistance to patients of home health agencies with the use of a nebulizer.[37] However, the 2020 bill did not remove a provision prohibiting home health aides and CNAs from providing assistance with the administration of medications through nebulizers.[38] The bill removes this provision.

Current law prohibits a registered nurse from delegating to a home health aide or CNA the administration of a controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03,

[33] S. 401.25(7)(a), F.S. S. 401.281, F.S., requires drivers to: be at least 18 years of age; certify under oath that they are not addicted to alcohol or any controlled substance; certify under oath that they are free from any physical or mental defect or disease that might impair their ability to drive an ambulance; not have been convicted, within the past three years, of driving under the influence of alcohol or controlled substances, and not had their driver license suspended due to excessive points; possess a valid driver license; be trained in the safe operation of emergency vehicles and complete an emergency vehicle operator's course; possess a valid American Red Cross or National Safety Council standard first aid course card or its equivalent; and possess a valid American Red Cross or American Heart Association cardiopulmonary resuscitation card.
[34] S. 401.252(1), F.S., authorizes a BLS or an ALS ambulance service to conduct an interfacility transfer using a registered nurse in place of an EMT or a paramedic, if: the registered nurse holds a current certificate of successful course completion in advanced cardiac life support; the physician in charge has granted permission for such a transfer, has designated the level of service required for such transfer, and has deemed the patient to be in such a condition appropriate for this type of ambulance staffing; and the registered nurse operates within the scope of part I of ch. 464, F.S.
[35] S. 401.25(7)(b), F.S.
[36] *Supra* note 34.
[37] Ch. 2020-9, Laws of Fla.
[38] S. 400.488(4)(c), F.S.

F.S., or 21 U.S.C., s. 812.[39] The bill amends s. 464.0156(2), F.S., to authorize a registered nurse to delegate to a home health aide or CNA the administration of an insulin syringe that is prefilled with the proper dosage by a pharmacist or an insulin pen that is prefilled by the manufacturer.

An ALS ambulance transporting a patient between two facilities must be occupied by two people, including one patient attendant who may be a paramedic, registered nurse, or a physician, and one EMT, paramedic, registered nurse, or physician if they meet the requirements to be a driver. The bill retains the requirement for the patient attendant to be a paramedic, registered nurse, or a physician, but it removes the requirement for the driver to be an EMT, paramedic, registered nurse, or physician. This change aligns the staffing requirements for interfacility transfer by an ALS ambulance with the staffing requirements for an interfacility transfer by a BLS ambulance.

Current law authorizes CNAs to provide assistance to ALF residents with insulin syringes and pens. The bill amends s. 429.256, F.S., to provide consistency with provisions of the bill that provide the same authority for home health aides and CNAs employed by home health agencies.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.488, F.S., relating to assistance with self-administration of medication.
Section 2: Amends s. 401.252, F.S., relating to interfacility transfer.
Section 3: Amends s. 464.0156, F.S., relating to delegation of duties.
Section 4: Amends s. 401.25, F.S., relating to licensure as a basic life support or an advanced life support service.
Section 5: Amends s. 401.27, F.S., relating to personnel; standards and certification.
Section 6: Amends s. 429.256, F.S., relating to assistance with self-administration of medication.
Section 7: Provides an effective date of July 1, 2022.

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:

The bill creates staffing efficiencies for home health agencies and ALS ambulance services, which could have a positive, but indeterminate, fiscal impact on these providers.

D. FISCAL COMMENTS:

[39] S. 464.0156(2), F.S.

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:

Sufficient rule-making authority exists for AHCA to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 2, 2021, the Finance & Facilities Subcommittee adopted two amendments and reported the bill favorably as a committee substitute. The amendments restructure the proposed change to the home health agency statute and the current ALF statute to separate assisting with the administration of medication from assisting with the performance of tasks that do not involve medication.

This analysis is drafted to the committee substitute as passed by the Finance & Facilities Subcommittee.

A bill to be entitled

An act relating to patient care in health care facilities; amending s. 400.488, F.S.; revising the definitions of the terms "informed consent" and "unlicensed person"; authorizing unlicensed persons to assist patients with other specified tasks; revising provisions relating to medications and devices with which unlicensed persons may assist patients in self-administration under certain circumstances; amending s. 401.252, F.S.; specifying staffing requirements for advanced life support ambulances during interfacility transfers; providing that the person occupying the ambulance who has the highest medical certification in this state is in charge of patient care during the transfer; amending s. 464.0156, F.S.; revising the list of medications that a registered nurse may delegate the administration of to a certified nursing assistant or home health aide; amending ss. 401.25, 401.27, and 429.256, F.S.; conforming provisions to changes made by the act; providing an effective date.

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

Section 1. Section 400.488, Florida Statutes, is amended to read:

400.488 Assistance with self-administration of medication and with other tasks.—

(1) For purposes of this section, the term:

(a) "Informed consent" means advising the patient, or the patient's surrogate, guardian, or attorney in fact, that the patient may be receiving assistance with self-administration of medication or other tasks from an unlicensed person.

(b) "Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by or under contract to a home health agency and who has received training with respect to assisting with the self-administration of medication or other tasks as provided by agency rule.

(2) Patients who are capable of self-administering their own medications and performing other tasks without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a patient whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. An unlicensed person may also provide assistance with other tasks specified in subsection (6). Assistance with self-administration of medication or such other tasks ~~self-medication~~ by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a patient or the patient's surrogate, guardian, or

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

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

(a) Taking the medication, in its previously dispensed, properly labeled container, from where it is stored and bringing it to the patient. For purposes of this paragraph, an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.

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

(c) Placing an oral dosage in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth.

(d) Applying topical medications~~, including routine preventive skin care and applying and replacing bandages for minor cuts and abrasions as provided by the agency in rule~~.

(e) Returning the medication container to proper storage.

~~(f) For nebulizer treatments, assisting with setting up and cleaning the device in the presence of the patient, confirming that the medication is intended for that patient, orally advising the patient of the medication name and purpose, opening the container, removing the prescribed amount for a single treatment dose from a properly labeled container, and assisting the patient with placing the dose into the medicine receptacle or mouthpiece.~~

(f)~~(g)~~ Keeping a record of when a patient receives assistance with self-administration under this section.

(g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solutions, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer.

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

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

~~(c) Administration of medications through intermittent positive pressure breathing machines or a nebulizer.~~

(c) ~~(d)~~ Administration of medications by way of a tube inserted in a cavity of the body.

(d) ~~(e)~~ Administration of parenteral preparations.

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

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

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

(h) ~~(i)~~ Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

(5) Assistance with the self-administration of medication by an unlicensed person as described in this section does not constitute administration as defined in s. 465.003.

(6) Assistance with other tasks includes:

(a) Assisting with the use of a glucometer to perform blood-glucose level checks.

(b) Assisting with putting on and taking off antiembolism stockings.

(c) Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.

(d) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.

(e) Assisting with measuring vital signs.

(f) Assisting with colostomy bags.

(7) ~~(6)~~ The agency may by rule establish procedures and interpret terms as necessary to administer this section.

Section 2. Section 401.252, Florida Statutes, is amended to read:

401.252 Interfacility transfer.—

(1) When conducting an interfacility transfer, a permitted advanced life support ambulance must be occupied by at least two persons: one patient attendant who is a certified paramedic, a registered nurse authorized under subsection (2), or a licensed physician; and one who is a certified emergency medical technician, a certified paramedic, a licensed physician, or an ambulance driver who meets the driver requirements of s. 401.281. The person occupying the ambulance who has the highest medical certification in this state is in charge of patient care

during the interfacility transfer.

(2) A licensed basic or advanced life support ambulance service may conduct interfacility transfers in a permitted ambulance~~,~~ using a registered nurse in place of an emergency medical technician or paramedic~~,~~ if:

(a) The registered nurse holds a current certificate of successful course completion in advanced cardiac life support;

(b) The physician in charge has granted permission for such a transfer, has designated the level of service required for such transfer, and has deemed the patient to be in such a condition appropriate to this type of ambulance staffing; and

(c) The registered nurse operates within the scope of part I of chapter 464.

(3)~~(2)~~ A licensed basic or advanced life support service may conduct interfacility transfers in a permitted ambulance if the patient's treating physician certifies that the transfer is medically appropriate and the physician provides reasonable transfer orders. An interfacility transfer must be conducted in a permitted ambulance if it is determined that the patient needs, or is likely to need, medical attention during transport. If the emergency medical technician or paramedic believes the level of patient care required during the transfer is beyond his or her capability, the medical director, or his or her designee, must be contacted for clearance prior to conducting the transfer. If necessary, the medical director, or his or her

designee, shall attempt to contact the treating physician for consultation to determine the appropriateness of the transfer.

(4) ~~(3)~~ Infants younger ~~less~~ than 28 days old or ~~infants~~ weighing less than 5 kilograms~~,~~ who require critical care interfacility transport to a neonatal intensive care unit must~~,~~ ~~shall~~ be transported in a permitted advanced life support or basic life support transport ambulance, or in a permitted advanced life support or basic life support ambulance that is recognized by the department as meeting designated criteria for neonatal interfacility critical care transport.

Section 3. Subsection (2) of section 464.0156, Florida Statutes, is amended to read:

464.0156 Delegation of duties.—

(2) A registered nurse may delegate to a certified nursing assistant or a home health aide the administration of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a patient of a home health agency, if the certified nursing assistant or home health aide meets the requirements of s. 464.2035 or s. 400.489, respectively. A registered nurse may not delegate the administration of any controlled substance listed in Schedule II, Schedule III, or Schedule IV of s. 893.03 or 21 U.S.C. s. 812, except for the administration of an insulin syringe that is prefilled with the proper dosage by a pharmacist or an insulin pen that is prefilled by the manufacturer.

Section 4. Subsection (7) of section 401.25, Florida Statutes, is amended to read:

401.25 Licensure as a basic life support or an advanced life support service.—

(7)(a) Each permitted basic life support ambulance not specifically exempted from this part, when transporting a person who is sick, injured, wounded, incapacitated, or helpless, must be occupied by at least two persons: one patient attendant who is a certified emergency medical technician, certified paramedic, or licensed physician; and one ambulance driver who meets the requirements of s. 401.281. This paragraph does not apply to interfacility transfers governed by s. 401.252 ~~s. 401.252(1)~~.

(b) Each permitted advanced life support ambulance not specifically exempted from this part, when transporting a person who is sick, injured, wounded, incapacitated, or helpless, must be occupied by at least two persons: one who is a certified paramedic or licensed physician; and one who is a certified emergency medical technician, certified paramedic, or licensed physician who also meets the requirements of s. 401.281 for drivers. The person with the highest medical certifications shall be in charge of patient care. This paragraph does not apply to interfacility transfers governed by s. 401.252 ~~s. 401.252(1)~~.

Section 5. Subsection (1) of section 401.27, Florida

Statutes, is amended to read:

401.27 Personnel; standards and certification.—

(1) Each permitted ambulance not specifically exempted from this part, when transporting a person who is sick, injured, wounded, incapacitated, or helpless, must be occupied by at least two persons, one of whom must be a certified emergency medical technician, certified paramedic, or licensed physician and one of whom must be a driver who meets the requirements for ambulance drivers. This subsection does not apply to interfacility transfers governed by s. 401.252 ~~s. 401.252(1)~~.

Section 6. Section 429.256, Florida Statutes, is amended to read:

429.256 Assistance with self-administration of medication and with other tasks.—

(1) For the purposes of this section, the term:

(a) "Informed consent" means advising the resident, or the resident's surrogate, guardian, or attorney in fact, that an assisted living facility is not required to have a licensed nurse on staff, that the resident may be receiving assistance with self-administration of medication or other tasks from an unlicensed person, and that such assistance, if provided by an unlicensed person, will or will not be overseen by a licensed nurse.

(b) "Unlicensed person" means an individual not currently licensed to practice nursing or medicine who is employed by or

under contract to an assisted living facility and who has received training with respect to assisting with the self-administration of medication or other tasks in an assisted living facility as provided under s. 429.52 prior to providing such assistance as described in this section.

(2) Residents who are capable of self-administering their own medications and performing other tasks without assistance shall be encouraged and allowed to do so. However, an unlicensed person may, consistent with a dispensed prescription's label or the package directions of an over-the-counter medication, assist a resident whose condition is medically stable with the self-administration of routine, regularly scheduled medications that are intended to be self-administered. An unlicensed person may also provide assistance with other tasks specified in subsection (6). Assistance with self-administration of medication or such other tasks ~~self-medication~~ by an unlicensed person may occur only upon a documented request by, and the written informed consent of, a resident or the resident's surrogate, guardian, or attorney in fact. For the purposes of this section, self-administered medications include both legend and over-the-counter oral dosage forms, topical dosage forms, transdermal patches, and topical ophthalmic, otic, and nasal dosage forms including solutions, suspensions, sprays, and inhalers.

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

(a) Taking the medication, in its previously dispensed, properly labeled container, ~~including an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer,~~ from where it is stored~~,~~ and bringing it to the resident. For purposes of this paragraph, an insulin syringe that is prefilled with the proper dosage by a pharmacist and an insulin pen that is prefilled by the manufacturer are considered medications in previously dispensed, properly labeled containers.

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

(c) Placing an oral dosage in the resident's hand or placing the dosage in another container and helping the resident by lifting the container to his or her mouth.

(d) Applying topical medications.

(e) Returning the medication container to proper storage.

(f) Keeping a record of when a resident receives assistance with self-administration under this section.

(g) Assisting with the use of a nebulizer, including removing the cap of a nebulizer, opening the unit dose of nebulizer solution, and pouring the prescribed premeasured dose of medication into the dispensing cup of the nebulizer.

~~(h) Using a glucometer to perform blood-glucose level checks.~~

~~(i) Assisting with putting on and taking off antiembolism stockings.~~

~~(j) Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.~~

~~(k) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.~~

~~(l) Assisting with measuring vital signs.~~

~~(m) Assisting with colostomy bags.~~

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

(a) Mixing, compounding, converting, or calculating medication doses, except for measuring a prescribed amount of liquid medication or breaking a scored tablet or crushing a tablet as prescribed.

(b) The preparation of syringes for injection or the administration of medications by any injectable route.

(c) Administration of medications by way of a tube inserted in a cavity of the body.

(d) Administration of parenteral preparations.

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

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

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

(h) Medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

(5) Assistance with the self-administration of medication by an unlicensed person as described in this section shall not be considered administration as defined in s. 465.003.

(6) Assistance with other tasks includes:

(a) Assisting with the use of a glucometer to perform blood-glucose level checks.

(b) Assisting with putting on and taking off antiembolism stockings.

(c) Assisting with applying and removing an oxygen cannula but not with titrating the prescribed oxygen settings.

(d) Assisting with the use of a continuous positive airway pressure device but not with titrating the prescribed setting of the device.

(e) Assisting with measuring vital signs.

(f) Assisting with colostomy bags.

(7)~~(6)~~ The agency may by rule establish facility procedures and interpret terms as necessary to implement this section.

Section 7. This act shall take effect July 1, 2022.

PCS for HB 731

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCS for HB 731 Drug-related Overdose Prevention
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		Woodruff	McElroy

SUMMARY ANALYSIS

An overabundance of opioids in the body can lead to a fatal overdose. Opioid antagonists are used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.

Current law authorizes health care practitioner to prescribe and dispense an emergency opioid antagonist to a patient or caregiver, and pharmacists may dispense an emergency opioid antagonist pursuant to a prescription or non-patient-specific standing order. A patient or caregiver can store and possess approved emergency opioid antagonists and, in an emergency, when a physician is not immediately available, administer the emergency opioid antagonists to a person believed in good faith to be experiencing an opioid overdose, regardless of whether the person has a prescription for an emergency opioid antagonist. Emergency responders and crime laboratory personnel are authorized to possess, store, and administer emergency opioid antagonists. Current law affords civil liability immunity to anyone who possesses, administers, prescribes, dispenses, or stores an approved emergency opioid antagonist.

Current law allows emergency medical technicians and paramedics who provide basic and advanced life support services to report controlled substances overdoses to the Department of Health (DOH). Hospital emergency departments and urgent care centers that treat suspected or actual overdoses are not required to report such information. This creates a potential gap in the data related to any person that was not transported by a basic life support service or an advanced life support service to a hospital or urgent care center.

The Florida Public Health Institute (Institute) is a not-for-profit corporation established by s. 381.98, F.S., with the purpose of advancing the knowledge and practice of public health, including promoting health awareness in Florida. The law requires the Institute to, in consultation with DOH, coordinate monthly health awareness campaigns with national, state, and local health care organizations and government entities on numerous topics, including substance abuse.

HB 731 amends s. 381.887, F.S., to reflect that the purpose of the section is for the prescribing, ordering, and dispensing of emergency opioid antagonists. The bill requires the Institute, in consultation with DOH, to educate the public regarding the use of emergency opioid antagonist. Further, the bill allows pharmacist to order and dispense an emergency opioid antagonist to a patient or caregiver.

The bill expressly authorizes personnel of a law enforcement agency or other agency, including, correctional probation officers and child protective investigators to possess, store, and administer emergency opioid antagonists. The bill also amends s. 395.1041, F.S., to require hospital emergency departments and urgent care centers to report the treatment of suspected or actual overdose victims under certain circumstances.

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

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Opioids

Opioids are psychoactive substances derived from the opium poppy, or their synthetic analogues.[1] They are commonly used as pain relievers to treat acute and chronic pain. An individual experiences pain because of a series of electrical and chemical exchanges among the individual's peripheral nerves, spinal cord, and brain.[2] Opioid receptors occur naturally and are distributed widely throughout the central nervous system and in peripheral sensory and autonomic nerves. [3] When an individual experiences pain, the body releases hormones, such as endorphins, which bind with targeted opioid receptors.[4] This disrupts the transmission of pain signals through the central nervous system and reduces the perception of pain.[5] Opioids function in the same way by binding to specific opioid receptors in the brain, spinal cord and gastrointestinal tract, thereby reducing the perception of pain.[6]

Opioids include prescription medications used to treat pain, as well as illegal drugs. Opioids include[7]:

- Buprenorphine (Subutex, Suboxone)
- Codeine
- Fentanyl (Duragesic, Fentora)
- Heroin
- Hydrocodone (Vicodin, Lortab, Norco)
- Hydromorphone (Dilaudid, Exalgo)
- Meperidine
- Methadone
- Morphine
- Oxycodone (OxyContin, Percodan, Percocet)
- Oxymorphone
- Tramadol
- U-47700

In 2019, an estimated 62 million people used opioids for non-medical reasons worldwide.[8] Opioids are commonly abused, with an estimated 36.3 million people worldwide suffering from drug use disorders.[9] Opioids can create a euphoric feeling because they affect the regions of the brain involved with pleasure and reward, which can lead to abuse.[10] Continued use of these drugs can lead to the development of tolerance and psychological and physical dependence.[11] This dependence is characterized by a strong desire to take opioids, impaired control over opioid use, persistent opioid use

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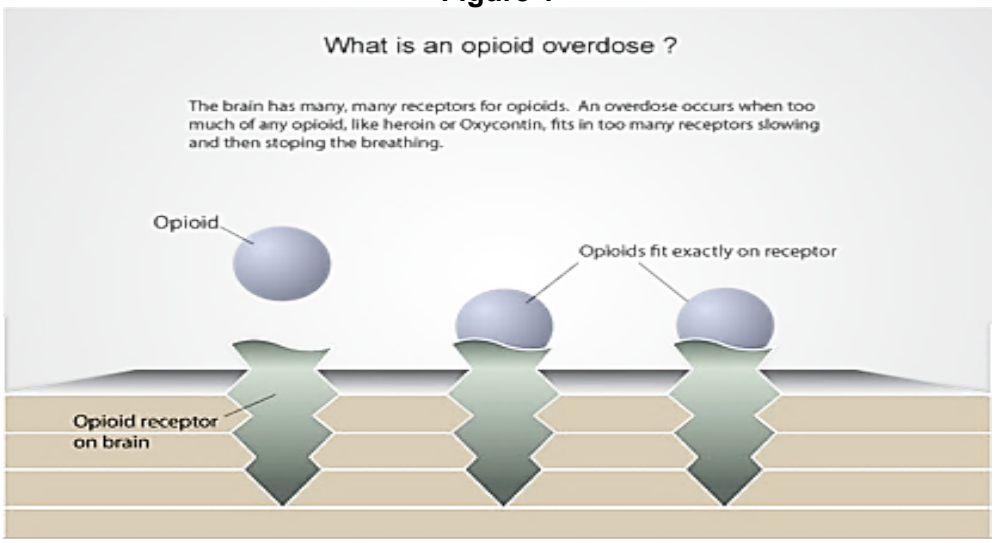
[1] World Health Organization, *Opioid Overdose*, https://www.who.int/news-room/fact-sheets/detail/opioid-overdose (last visited Jan. 4, 2022).
[2] Medical News Today, *What is pain, and how do you treat it?* (Sept. 7, 2020), https://www.medicalnewstoday.com/articles/145750#:~:text=People%20feel%20pain%20when%20specific,immediate%20contraction%20of%20the%20muscles (last visited Jan. 4, 2022).
[3] Gjermund Henriksen, Frode Willoch*, Imaging of Opioid Receptors in the Central Nervous System,* Brain (2008) 131 (5): 1171-1196.
[4] *Id*.
[5] *Id*.
[6] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *SAMHSA Opioid Overdose Toolkit: Facts for Community Members* (2018).
[7] Florida Department of Law Enforcement, *Drugs Identified in Deceased Persons by Florida Medical Examiners 2019 Report,* (Nov. 2020).
[8] United Nations Office on Drugs and Crime, World Drug Report 2021, *Global Overview: Drug Demand and Drug Supply* (Jun. 2021), WDR21_Booklet_2.pdf (unodc.org) (last visited Jan. 4, 2022).
[9] *Id*.
[10] National Institute on Drug Abuse, *How Do Opioids Affect the Brain and Body?,* (June 2020) http://www.drugabuse.gov/publications/research-reports/prescription-drugs/opioids/how-do-opioids-affect-brain-body (last visited Jan. 4, 2022).
[11] *Supra* note 6.

despite harmful consequences, a higher priority given to opioid use than to other activities and obligations, and a physical withdrawal reaction when opioids are discontinued.[12]

An overabundance of opioids in the body can lead to a fatal overdose. In addition to their presence in major pain pathways, opioid receptors are also located in the respiratory control centers of the brain.[13] Opioids disrupt the transmission of signals for respiration in the identical manner that they disrupt the transmission of pain signals (figure 1). This leads to a reduction, and potentially cessation, of an individual's respiration. Oxygen starvation will eventually stop vital organs like the heart, then the brain, and can lead to unconsciousness, coma, and possible death.[14] Within 3-5 minutes without oxygen, brain damage starts to occur, soon followed by death.[15] However, this does not occur instantaneously as people will commonly stop breathing slowly, minutes to hours after the drug or drugs were used.[16] An opioid overdose can be identified by a combination of three signs and symptoms referred to as the "opioid overdose triad":[17]

- Pinpoint pupils.
- Unconsciousness.
- Respiratory depression.

Figure 1



Source: Maya Doe-Simkins, MPH, Boston Medical Center.

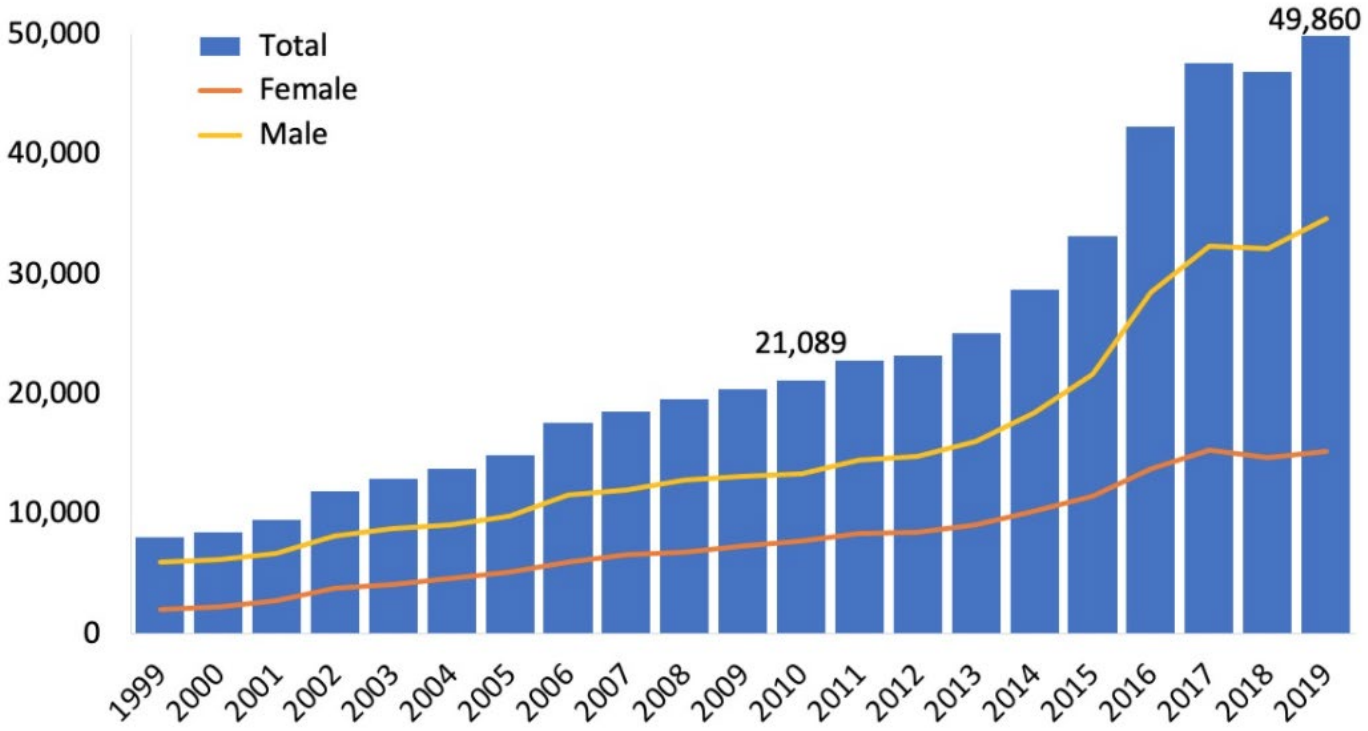
The rise in opioid overdose deaths can be outlined in three distinct waves:

1. The first wave began with increase prescribing of opioids in the 1990s, with overdose deaths involving prescription opioids increasing since at least 1999.
2. The second wave began in 2010, with rapid increase in overdose deaths involving heroin.
3. The third wave began in 2013 with significant increases in overdose deaths involving synthetic opioids, particularly those involving illicitly manufactured fentanyl. The market for illicitly manufactured fentanyl continues to change, and it can be found in combination with heroin, counterfeit pills, and cocaine.[18]

More than 70,000 Americans died from drug-involved overdose in 2019, including illicit drugs and prescription opioids.[19] Overall, drug overdose deaths increased from 2018 to 2019 with 70,630 drug

[12] *Supra* note 1.
[13] Pattinson, K.T.S., *Opioids and the Control of Respiration*, BJA, Vol. 100, Issue 6, Pages 747-758. https://doi.org/10.1093/bja/aen094.
[14] Harm Reduction Coalition, *Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects*, (Aug. 31, 2020) http://harmreduction.org/our-work/overdose-prevention/ (last visited Jan. 4, 2022).
[15] *Id*.
[16] *Id*.
[17] *Supra* note 1.
[18] Centers for Disease Control and Prevention, *Understanding the Epidemic*, https://www.cdc.gov/drugoverdose/epidemic/index.html (last visited Jan. 4, 2022).
[19] National institute on Drug Abuse, *Overdose Death Rates*, https://www.drugabuse.gov/drug-topics/trends-statistics/overdose-death-rates (last visited Jan. 4, 2022).

overdoses reported in 2019.[20] The following graph provides information on the total number of U.S. overdose deaths involving any opioid[21] from 1999 to 2019.[22] Opioid-involved overdose deaths increased from 21,088 in 2010 to 47,600 in 2017, and remained steady in 2018 with 46,802.[23] This was following by a significant increase in 2019 to 49,860 overdose deaths.[24]



In 2019, Florida reported 5,268 opioid overdose deaths.[25] This was an 11.9 percent increase from 2018.[26] Florida also experienced 4,152 opioid and 10,464 all drug non-fatal overdoses between July and September 2019.[27]

With the onset of the COVID-19 pandemic, the incidence of opioid use disorder and resulting overdose deaths has once again risen. A report from Project Opioid details provisional data from the Florida Department of Health (DOH) showing that deaths from drug overdoses have increased by 43 percent between 2019 and 2020, from 56 deaths per 100,000 in 2019 to 94 deaths per 100,000 in 2020.[28] Additionally, fentanyl, an extremely potent opioid drug, is the leading cause of overdose deaths in Florida, and the incidence of fentanyl overdose deaths increased by 38 percent from 2,348 in 2019 to 3,244 in 2020.[29]

Opioid Antagonist

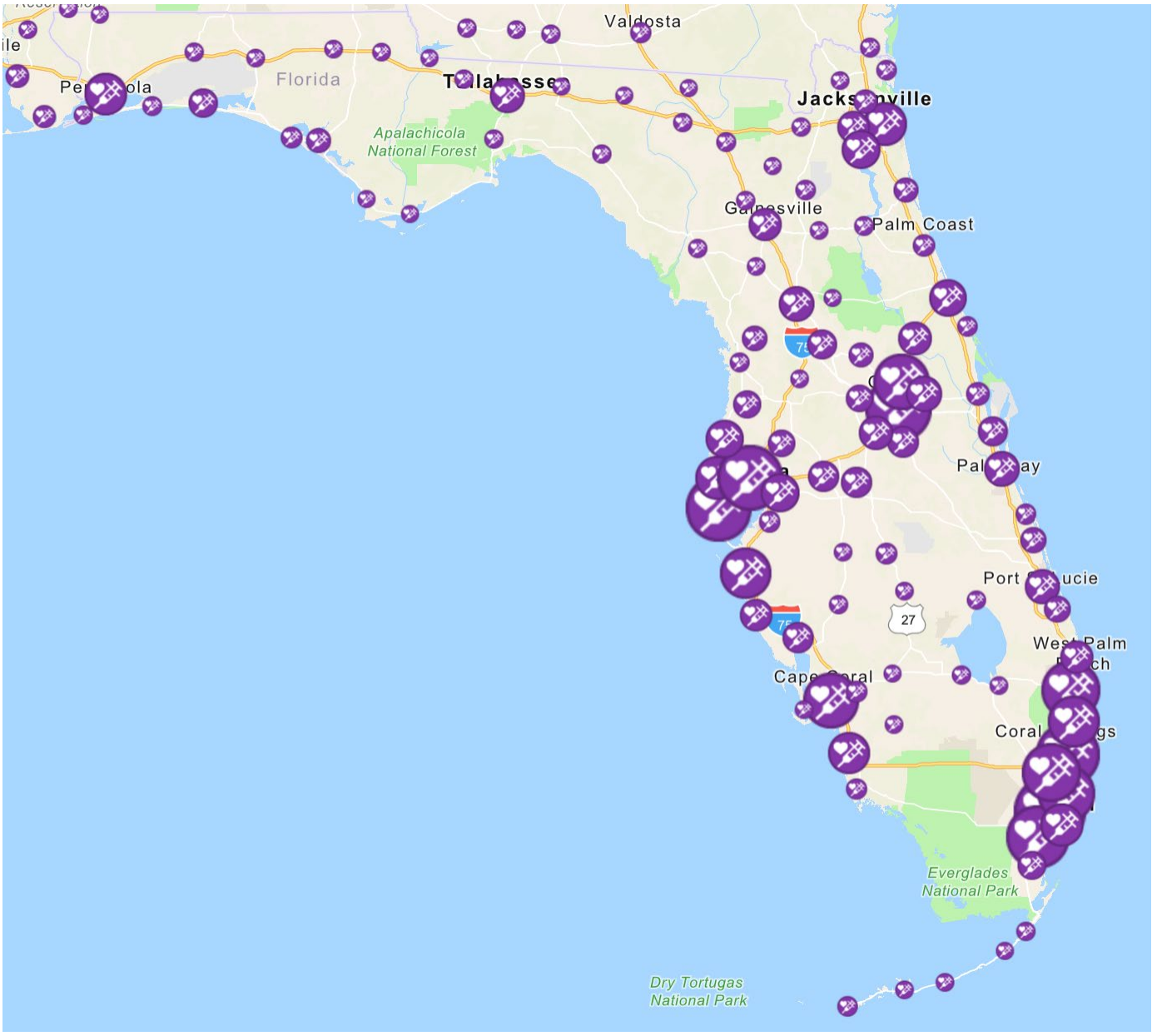
An opioid antagonist, such as Narcan or Naloxone, is a drug that blocks the effects of exogenously administered opioids. Opioid antagonists are used in opioid overdoses to counteract life-threatening

[20] *Id*.
[21] Any opioid includes prescription opioids (natural and semi-synthetic opioids and methadone), heroin and synthetic opioids other than methadone (primarily fentanyl).
[22] *Supra* note 19.
[23] *Id*.
[24] *Id*.
[25] Center for Disease Control and Prevention, *Drug Overdose Deaths*, https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2019.html (last visited Jan. 4, 2022).
[26] Center for Disease Control and Prevention, *2018-2019 Drug Overdose Death Rate Increase*, https://www.cdc.gov/drugoverdose/data/statedeaths/drug-overdose-death-2019.html (last visited Jan. 17, 2022).
[27] Florida Department of Health, *Non-Fatal Opioid and All Drug Overdose Surveillance Report, Florida Q4-2019*, http://www.floridahealth.gov/statistics-and-data/fl-dose/_documents/non-fatal-od-2019-q4.pdf
[28] Project Opioid, A Pandemic Fueling an Epidemic in Florida in 2020, https://projectopioid.org/wp-content/uploads/2020/12/PO-2020-Data-Study-Final_New-Section.pdf (last visited Jan. 4, 2022).
[29] *Id*.

depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally.[30] This occurs because opioid antagonists create a stronger bond with opioid receptors than opioids. This forces the opioids from the opioid receptors and allows the transmission of signals for respiration to resume.[31] This effect lasts only for a short period of time[32] with the narcotic effect of the opioids returning if still present in large quantities in the body. In this scenario, additional doses of an opioid antagonist would be required and it is why it is generally recommended that anyone who has experienced an overdose seek medical attention.

In February 2019, Florida issued a statewide Standing Order for Naloxone. The Standing Order authorizes pharmacists to dispense certain naloxone formulations to emergency responders for administration to persons exhibiting signs of opioid overdose.[33] Under the Standing Order, emergency responders, including law enforcement, firefighters, paramedics, and emergency medical technicians, can go to a pharmacy or community-based program for training on opioid antagonist administration and receive an opioid antagonist without a patient-specific prescription. Access to naloxone is available at most pharmacies in Florida. The following map provides information on pharmacy locations where naloxone is available a prescription.[34]

[30] Harm Reduction Coalition, *Understanding Naloxone,* (Sept. 8, 2020) http://harmreduction.org/issues/overdose-prevention/overview/overdose-basics/understanding-naloxone/ (last visited Jan. 4, 2022).
[31] *Supra* note 13.
[32] The half-life for a common opioid antagonist in adults ranged from 30 to 81 minutes. Acute opiate withdrawal is a potential side-effect of naloxone; however, this would be time limited to the half-life of naloxone.
[33] Florida Department of Health, State of Florida, *Statewide Standing Order for Naloxone* (Feb. 25, 2019), http://www.floridahealth.gov/licensing-and-regulation/ems-system/_documents/standing-order-naloxone.pdf (last visited Jan. 4, 2022).
[34] New America, *National Naloxone Access Map*, https://opioidepidemic.maps.arcgis.com/home/item.html?id=153b0c32fefc432eae6a0e8439b9f56b (last visited Jan. 4, 2022). The National Naloxone Map accumulates data from many difference sources, with participation from thousands of CVS, Walmart, and Walgreens pharmacies, along with other independent distributors. The map is meant to be a community effort, and contributing locations is encouraged to participate, to make it the best possible representation of resources. The map is not complete, and naloxone prescription needs and costs vary by state, but this effort represents over 25,000 locations to obtain naloxone.



Florida law allows an authorized health care practitioner to prescribe and dispense an emergency opioid antagonist to a patient or caregiver, and pharmacists may dispense an emergency opioid antagonist pursuant to a prescription or to a non-patient-specific standing order.[35] Current law defines a "caregiver" as a family member, friend, or person that has recurring contact with a person at risk of experiencing an opioid overdose.[36] Current law broadly defines a "person" to include individuals and children.[37] Therefore, an authorized health care practitioner may prescribed any person falling under the definition an emergency opioid antagonist.

Any person prescribed an opioid antagonist, or distributed an emergency opioid antagonist pursuant to a non-patient-specific standing order, may store and possess approved emergency opioid antagonists. In an emergency, when a physician is not immediately available, that person may administer the emergency opioid antagonists to an individual believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist.[38]

[35] S. 381.887, F.S.
[36] S. 381.887(1)(c), F.S.
[37] S. 1.01 (3), F.S.
[38] S. 381.887(3), F.S.

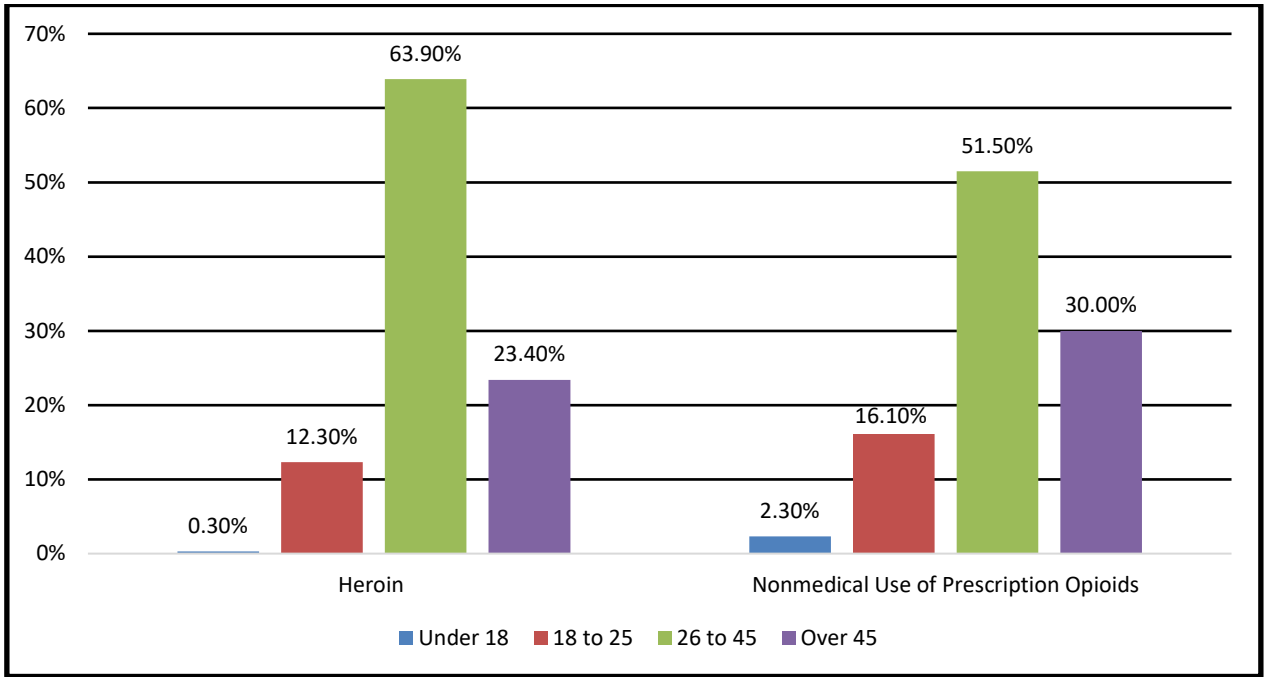
Current law also allows emergency responders and crime laboratory personnel to possess, store, and administer emergency opioid antagonists.[39]

A person who possesses, administers, prescribes, dispenses, or stores an approved emergency opioid antagonist is afforded the civil liability immunity protections under s. 768.13, F.S. (Good Samaritan Act).[40]

Emergency Response to Overdose

In 2017, U.S. drug overdose deaths increased 9.6% from 2016. Emergency departments treated 967,615 nonfatal drug overdoses in 2017.[41] From 2016 to 2017, rates for nonfatal overdoses increased for those involving all drugs (4.3%), all opioids (3.1%), nonheroin opioids (3.6%), heroin (3.6%), and cocaine (32.9%).[42]

The following table provides information on emergency department visits related to heroin and nonmedical use of prescription opioids by age from April 2019 to December 2020.[43] Patients aged 26 to 45 accounted for more than half (52%) of emergency department visits related to non-medical use of prescription opioids.[44]



Florida Emergency Response to Overdoses Reporting Requirements

Current law allows emergency medical technicians[45] (EMT) and paramedics[46] who provide basic and advanced life support services to report controlled substances overdoses to DOH. A report must contain:

[39] S. 381.887(4), F.S.
[40] S. 381.887(5), F.S.
[41] Centers for Disease Control and Prevention, *Nonfatal Drug Overdoses Treated in Emergency Departments – United States, 2016-2017,* (Apr. 3, 2020), https://www.cdc.gov/mmwr/volumes/69/wr/mm6913a3.htm (last visited Jan. 10, 2022).
[42] *Id.*
[43] U.S. Department of Health, Substance Abuse and Mental Health services Administration, *DAWN: Heroin and Nonmedical Use of Prescription Opioids,* https://www.samhsa.gov/data/sites/default/files/reports/rpt32814/DAWN%20Opioids%20Profile.pdf (last visited Jan. 4, 2022).
[44] *Id.*
[45] S. 401.23(11), F.S., defines an EMT as a person who is certified by DOH to perform basic life support.
[46] S. 401.23(17), F.S., defines a paramedic as a person who is certified by DOH to perform basic and advanced life support.

- The date and time of the overdose.
- The address of where the patient was picked up or where the overdose took place.
- Whether an emergency opioid antagonist was administered.
- Whether the overdose was fatal or non-fatal.

Additionally, the report must include the approximate age and gender of the patient and the suspected controlled substance involved in the overdose, if permitted by its reporting mechanism. Reporters must attempt to make the report within 120 hours.

A report must be filed with DOH using the Emergency Medical Tracking and Reporting System (EMSTARS),[47] the Washington/Baltimore High Intensity Drug Tracking Overdoes Detection Mapping Application Program,[48] or other program identified by DOH in rule.

Section 395.1041(6))(b), F.S., requires hospitals with an emergency department to develop a best practices policy to promote the prevention of unintentional drug overdoses. The policy may include, but is not limited to:

- A process to obtain a patient's consent to notify next of kin, and each physician or health care practitioner who prescribes a controlled substance to the patient, regarding the patient's overdose, the patient's location, and the nature of the substance or controlled substance involved in the overdose.
- A process for providing the patient or the patient's next of kin with information about licensed substance abuse treatment services.
- Guidelines for emergency department health care practitioners authorized to prescribe controlled substances to reduce the risk of opioid use, misuse, and addiction.
- The use of licensed or certified behavioral health professionals or peer specialists in the emergency department to encourage the patient to seek substance abuse treatment.
- The use of screening, brief intervention, and referral to treatment protocols in the emergency department.

Hospital emergency departments and urgent care centers that treat suspected or actual overdoses are not required to report such information. This creates a potential gap in the data related to any person that was not transported by a basic life support service or an advanced life support service to a hospital or urgent care center.

The Florida Public Health Institute, Inc.

The Florida Public Health Institute (Institute) is a not-for-profit corporation established by s. 381.98, F.S., with the purpose of advancing the knowledge and practice of public health, including promoting health awareness in Florida. The Institute is tasked with procuring funds to complement, supplement, and enhance the missions of the various organizations, entities, and departments that provide public health initiatives by serving as the lead corporation in the state for promoting public health awareness. The Institute is required to enter into partnerships with providers of continuing education for health care practitioners, including, but not limited to, hospitals and state and local medical organizations, to ensure that practitioners are aware of the most recent and complete diagnostic and treatment tools.

Additionally, s. 381.981, F.S., requires the Institute to, in consultation with DOH, coordinate monthly health awareness campaigns, with national, state, and local health care organizations and government

[47] DOH maintains the EMSTARS to collect data and analyze the incident level data from EMS agencies for benchmarking and quality improvement initiatives. The electronic patient care records submitted by licensed EMS agencies to EMSTARS are confidential and exempt pursuant to s. 401.30(4), F.S.

[48] The Washington/Baltimore High Intensity Drug Trafficking Area (HIDTA) is a federal grant program administered by the White House Office of National Drug Control Policy which provides resources to assist federal, state, local, and tribal agencies coordinate activities that address drug trafficking. HIDTA created an app, known as the Overdose Detection Mapping Application Program, which allows EMS agencies to report overdose incidents that are then transmitted in real time with electronic map showing the location, date, time, and incident type. The app does not allow EMS agencies to report on the patient's age or gender or suspected controlled substance involved in the overdose.

entities, targeting a wide range of the public, including parents, teachers, other school employees, students in 4th through 12th grade, colleges, universities, state agency employees, county and local government employees, patents of county health departments, Medicaid recipients, health care professionals and providers, and the public in general. The health awareness campaigns must include the following diseases in at least one monthly campaign every 24 months:

- Cancer, including breast, prostate, cervical, ovarian, colorectal, and skin cancer, and leukemia.
- Heart Disease.
- Stroke.
- Lung disease, including asthma and smoking-related disease.
- Neurological disorders and disease, including Alzheimer's disease, Parkinson's disease, and epilepsy.
- Gastrointestinal disease.
- Kidney disease.
- Diabetes.
- Liver disease.
- Autoimmune disorders.
- Birth defects and prenatal care.
- Obesity and malnutrition.
- Sexually transmissible disease.
- Hepatitis A, hepatitis B, and hepatitis C.
- Arthritis.
- Vaccine-preventable disease.
- Infectious diseases, including HIV/AIDS.
- Substance abuse.
- Mental illness.
- Lupus.
- Osteoporosis.

Effect of Proposed Changes

HB 731 amends s. 381.887, F.S., to specify that the purpose of the section is for the prescribing, ordering, and dispensing of emergency opioid antagonists. It requires the Institute, in consultation with DOH, to educate the public regarding the use of emergency opioid antagonists.

The bill allows a pharmacist to order an emergency opioid antagonist with an autoinjection delivery system or intranasal application delivery system for a patient or caregiver for use in accordance with s. 381.887, F.S. It further allows a pharmacist to dispense an emergency opioid antagonist pursuant to a prescription by an authorized health care practitioner. Pharmacists may dispense an emergency opioid antagonist with an autoinjection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use, pursuant to a pharmacist's order or pursuant to a non-patient standing order.

The bill expressly authorizes personnel of a law enforcement agency or other agency, including, but not limited to, correctional probation officers and child protective investigators to possess, store, and administer emergency opioid antagonists. Personnel of a law enforcement agency or other agency are immune from civil liability or criminal liability as a result of administering an emergency opioid antagonist.

Further, the bill amends s. 395.1041, F.S., to require hospital emergency departments or urgent care centers that treat and release a person in response to a suspected or actual overdose of a controlled substance to report such information to DOH, if that person was not transported by a basic life support service or an advanced life support service. When making such a report, hospital emergency departments and urgent care centers must use best efforts to make the report to DOH within 120 hours after discovering an incident. The bill requires reports to be made using an appropriate method with

secure access, including, but not limited to, the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping Application Program or other program identified by DOH through rule.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amending s. 381.887, F.S., relating to emergency treatment for suspected opioid overdose.
Section 2: Amending s. 381.981, F.S., relating to health awareness campaigns.
Section 3: Amending s. 395.1041, F.S., relating to access to emergency services and care.
Section 4: Providing an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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 rulemaking authority 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 drug-related overdose prevention; amending s. 381.887, F.S.; revising the purpose of specified provisions relating to the prescribing, ordering, and dispensing of emergency opioid antagonists to certain persons by authorized health care practitioners; authorizing pharmacists to order certain emergency opioid antagonists; providing certain authorized persons immunity from civil or criminal liability for administering emergency opioid antagonists under certain circumstances; authorizing personnel of law enforcement agencies to administer emergency opioid antagonists under certain circumstances; amending s. 381.981, F.S.; requiring a health awareness campaign; amending s. 395.1041, F.S.; requiring a hospital emergency room and urgent care facility to report incidents involving a suspected or actual overdose to the department under certain circumstances; providing requirements for the report; requiring hospital emergency rooms and urgent care facilities to use best efforts to report such incidents to the department within a specified timeframe; providing an effective date.

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

Section 1. Subsections (2), (3), and (4) of section 381.887, Florida Statutes, are amended to read:

381.887 Emergency treatment for suspected opioid overdose.—

(2) The purpose of this section is to provide for the prescribing, ordering, and dispensing ~~prescription~~ of emergency opioid antagonists ~~an emergency opioid antagonist~~ to patients and caregivers and to encourage the prescribing, ordering, and dispensing ~~prescription~~ of emergency opioid antagonists by authorized health care practitioners.

(3)(a) An authorized health care practitioner may prescribe and dispense an emergency opioid antagonist to, and a pharmacist may order an emergency opioid antagonist with an autoinjection delivery system or intranasal application delivery system for, a patient or caregiver for use in accordance with this section.~~, and~~

(b) A pharmacist ~~pharmacists~~ may dispense an emergency opioid antagonist pursuant to a prescription by an authorized health care practitioner. A pharmacist may dispense an emergency opioid antagonist with ~~such a prescription or pursuant to a non-patient-specific standing order for~~ an autoinjection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use, pursuant to a pharmacist's order or pursuant to a nonpatient-specific standing order.

(c) A ~~such~~ patient or caregiver is authorized to store and possess approved emergency opioid antagonists and, in an emergency situation when a physician is not immediately available, administer the emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist.

(4) The following persons are authorized to possess, store, and administer emergency opioid antagonists as clinically indicated and are immune from any civil liability or criminal liability as a result of administering an emergency opioid antagonist:

(a) Emergency responders, including, but not limited to, law enforcement officers, paramedics, and emergency medical technicians.

(b) Crime laboratory personnel for the statewide criminal analysis laboratory system as described in s. 943.32, including, but not limited to, analysts, evidence intake personnel, and their supervisors.

(c) Personnel of a law enforcement agency or other agency, including, but not limited to, correctional probation officers and child protective investigators who, while acting within the scope or course of employment, come into contact with a controlled substance or persons at risk of experiencing an opioid overdose.

Section 2. Subsection (2) of section 381.981, Florida Statutes, is amended to read:

381.981 Health awareness campaigns.—

(2) The awareness campaigns shall include the provision of educational information about preventing, detecting, treating, and curing the following diseases or conditions. Additional diseases and conditions that impact the public health may be added by the board of directors of the Florida Public Health Institute, Inc.; however, each of the following diseases or conditions must be included in an awareness campaign during at least 1 month in any 24-month period:

(a) Cancer, including breast, prostate, cervical, ovarian, colorectal, and skin cancer and leukemia.

(b) Heart disease.

(c) Stroke.

(d) Lung disease, including asthma and smoking-relating disease.

(e) Neurological disorders and disease, including Alzheimer's disease, Parkinson's disease, and epilepsy.

(f) Gastrointestinal disease.

(g) Kidney disease.

(h) Diabetes.

(i) Liver disease.

(j) Autoimmune disorders.

(k) Birth defects and prenatal care.

(l) Obesity and malnutrition.

(m) Sexually transmissible disease.

(n) Hepatitis A, hepatitis B, and hepatitis C.

(o) Arthritis.

(p) Vaccine-preventable diseases.

(q) Infectious diseases, including HIV/AIDS.

(r) Substance abuse, including, but not limited to, emergency opioid antagonists.

(s) Mental illness.

(t) Lupus.

(u) Osteoporosis.

Section 3. Subsection (8) is added to section 395.1041, Florida Statutes, to read:

395.1041 Access to emergency services and care.—

(8) REPORTING OF CONTROLLED SUBSTANCE OVERDOSES.—A hospital emergency room or urgent care center that treats and releases a person in response to a suspected or actual overdose of a controlled substance must report such incident to the department if the patient was not transported by a transport service as defined in s. 401.23. Such reports must be made using an appropriate method with secure access, including, but not limited to, the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping Application Program, EMSTARS, or other program identified by department rule. If a hospital emergency room or urgent care center reports such

incidents, it must make its best efforts to make the report to the department within 120 hours after knowledge of the incident.

Section 4. This act shall take effect July 1, 2022.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 817 Emergency Medical Care and Treatment to Minors Without Parental Consent
SPONSOR(S): Massullo
TIED BILLS: **IDEN./SIM. BILLS:** SB 1114

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

SUMMARY ANALYSIS

It is well settled that the interest of parents in the care, custody, and control of their children is perhaps the oldest of the recognized fundamental liberty interests protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution. The Florida Supreme Court has likewise recognized that parents have a fundamental liberty interest in determining the care and upbringing of their children. Parents generally have the right to be informed about, and give consent for, proposed medical procedures on their children. However, the state also has an obligation to ensure that children receive reasonable medical treatment that is necessary for the preservation of life.

Current Florida law requires a health care practitioner, or his or her employees, to obtain written parental consent before performing health care services on a minor child. Physicians licensed under chapters 458 and 459, F.S., may provide emergency medical care or treatment to a minor without parental consent when a child has been injured in an accident or is suffering from an acute illness, disease, or condition and delaying treatment would endanger the health or physical well-being of the minor. This is limited to care or treatment that is administered in either a hospital or college health service. Paramedics, emergency medical technicians (EMTs), and other emergency medical services personnel may provide emergency care or treatment in a prehospital setting, such as an ambulance or roadside.

Health care practitioners and health care facilities that violate parental consent requirements are subject to disciplinary action under their respective practice acts and may be subject to criminal penalties.

The bill authorizes physicians licensed under chapters 458 and 459, F.S., to provide emergency medical care or treatment to a minor without parental consent. This allows physicians to provide such care in prehospital settings, similar to EMTs and paramedics, or in hospital settings.

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

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Constitutional Principles

It is well settled that the interest of parents in the care, custody, and control of their children is perhaps the oldest of the recognized fundamental liberty interests protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[1] This fundamental liberty interest is rooted in the fundamental right of privacy from interference in making important decisions relating to marriage, family relationships, and child rearing and education.[2] The United States Supreme Court has explained the fundamental nature of this right is rooted in history and tradition:[3]

> The history and culture of Western civilization reflect a strong tradition of parental concern for the nurture and upbringing of their children. This primary role of the parents in the upbringing of their children is now established beyond debate as an enduring American tradition.

The Florida Supreme Court has likewise recognized that parents have a fundamental liberty interest in determining the care and upbringing of their children.[4] These rights may not be intruded upon absent a compelling state interest.[5] According to the Florida Supreme Court, when analyzing a statute that infringes on the fundamental right of privacy, the applicable standard of review requires that the statute survive the highest level of scrutiny:[6]

> The right of privacy is a fundamental right which we believe demands the compelling state interest standard. This test shifts the burden of proof to the state to justify an intrusion on privacy. The burden can be met by demonstrating that the challenged regulation serves a compelling state interest and accomplishes its goal through the use of the least intrusive means.

Health Care

Parental Consent for Medical Treatment

Parents generally have the right to be informed about, and give consent for, proposed medical procedures on their children. However, the state also has an obligation to ensure that children receive

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[1] *Santosky v. Kramer*, 455 U.S. 745, 748 and 753 (1982) (holding the fundamental liberty interest of natural parents in the care custody, and management of their child is protected by the Fourteenth Amendment, and termination of any parental rights requires due process proceedings); *Troxel v. Granville,* 530 U.S. 57, 66 (2000) (holding there is a fundamental right under the Fourteenth Amendment for parents to oversee the care, custody, and control of their children).

[2] *Carey v. Population Svcs. Int'l*, 431 US 678, 684-685 (1977) (recognizing the right of privacy in personal decisions relating to marriage, family relationships, child rearing, and education); *See Wisconsin v. Yoder*, 406, U.S. 205, 232-33 (1972) (holding a state law requiring that children attend school past eight grade violates the parents' constitutional right to direct the religious upbringing of their children); See *Parham v. J.R.*, 442 U.S. 584, 602 (1979) (recognizing the presumption that parents act in their children's best interest); *Meyer v. Nebraska,* 262 U.S. 390, 400-01 (1923) (affirming that the Constitution protects the preferences of the parent in education over those of the state)*; Pierce v. Society of Sisters,* 268 U.S. 510, 534-35 (1925) (recognizing the right of parents to direct the upbringing of and education of their children).

[3] *Wisconsin v. Yoder*, 406, U.S. 205, 232 (1972).

[4] *Beagle v. Beagle*, 678 So. 2d 1271, 1272 (Fla. 1996) (holding a state law violated a parent's constitutional right to privacy by imposing grandparent visitation rights over objection of the parent without evidence of harm to the child or other compelling state interest).

[5] *Id*. *See, e.g., Shevin v. Byron, Harless, Schaffer, Reid & Assocs., Inc*., 379 So. 2d 633, 637 (Fla. 1980) and *Belair v. Drew*, 776 So. 2d 1105, 1107 (Fla. 5th DCA 2001).

[6] *Winfield v. Division of Pari-Mutuel Wagering, Dept. of Bus. Regulation*, 477 So. 2d 544, 547 (Fla. 1985).

reasonable medical treatment that is necessary for the preservation of life.[7] The state's interest diminishes as the severity of an affliction and the likelihood of death increase:[8]

> There is a substantial distinction in the State's insistence that human life be saved where the affliction is curable, as opposed to the State interest where . . . the issue is not whether, but when, for how long and at what cost to the individual . . . life may be briefly extended.

Current law establishes parental consent requirements for health care services. Specifically, unless otherwise permitted by law, without written, parental consent:[9]

- A health care practitioner,[10] or an individual employed by such health care practitioner, may not provide or solicit or arrange to provide health care services or prescribe medicinal drugs to a minor.
- A provider, as defined in s. 408.803, F.S.,[11] may not allow a medical procedure to be performed on a minor child in its facility.

A parent may reject medical treatment for a child and the state may not interfere with such decision if the evidence is not sufficiently compelling to establish the primacy of the state's interest, or that the child's own welfare would be best served by such treatment.[12]

Medical Treatment without Parental Consent

Current Florida law provides exceptions for circumstances in which someone other than a parent may consent for medical care of a minor or provide medical care without parental consent.

Section 743.064, F.S., allows allopathic[13] and osteopathic[14] physicians to provide emergency medical care or treatment to a minor without parental consent when a child has been injured in an accident or is suffering from an acute illness, disease, or condition and delaying treatment would endanger the health or physical well-being of the minor. This is limited to care or treatment is administered in either a hospital or college health service. Paramedics, emergency medical technicians (EMTs), and other emergency medical services personnel may provide emergency care or treatment in a prehospital setting, such as an ambulance or roadside.[15]

Even in emergency situations, medical treatment can only be provided without parental consent if:[16]

- The child's condition has rendered him or her unable to reveal the identity of his or her parents, guardian, or legal custodian, and such information is unknown to any person who accompanied the child to the hospital.
- The parents, guardian, or legal custodian cannot be immediately located by telephone at their place of residence or business.

The hospital must notify the parent or legal guardian as soon as possible after the emergency medical care or treatment is administered and document in the hospital records the reason parental consent was not initially obtained. This must include a statement from the attending physician that immediate emergency medical care or treatment was necessary for the child's health or physical well-being.[17]

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[7] *Von Eiff v. Azicri*, 720 So. 2d 510, 515 (Fla. 1998).
[8] *M.N. v. S. Baptist Hosp.*, 648 So. 2d 769, 771 (Fla. 1st DCA 1994).
[9] S. 1014.06, F.S.
[10] S. 456.001, F.S.
[11] "Provider" means any activity, service, agency, or facility regulated by the agency and listed in s. 408.802, F.S.
[12] *Id*.
[13] Physicians licensed under ch. 458, F.S.
[14] Physicians licensed under ch. 459, F.S.
[15] For example, an ambulance or roadside.
[16] S. 743.064(2), F.S.
[17] S. 743.064(3), F.S.

Section 743.0645, F.S., establishes a list of people, by priority, who may consent to the medical care or treatment of a minor in instances where the treatment provider is unable to contact the parent or legal guardian and the provider has not been given contrary instructions. Specifically, the following people may consent, in this order:

- A health care surrogate or a person with power of attorney to provide medical consent for the minor;[18]
- The stepparent;
- The grandparent of the minor;
- An adult brother or sister of the minor; or
- An adult aunt or uncle of the minor.

If a parent or legal guardian cannot be reached while the child is committed to the Department of Children Families or the Department of Juvenile Justice,[19] then the following individuals may consent to the medical care or treatment of a minor, unless the parent or legal guardian has expressly stated otherwise:[20]

- The caseworker, juvenile probation officer, or person primarily responsible for the case management of the child.
- The administrator of the state-licensed facility[21] or state-contracted or state-operated delinquency residential treatment facility where the child is committed.

In both of these instances, the treatment provider must document the reasonable attempts made to contact the parent or legal guardian in the minor's treatment records, and must notify the parent or legal guardian as soon as possible after the medical care or treatment is administered.[22]

Health care practitioners and health care facilities that violate parental consent requirements are subject to disciplinary action[23] under their respective practice acts and may be subject to criminal penalties.[24]

Effect of Proposed Changes

The bill authorizes physicians licensed under chapters 458 and 459, F.S., to provide emergency medical care or treatment to a minor without parental consent. This allows physicians to provide such care in prehospital settings, similar to EMTs and paramedics, or in hospital settings.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s, 743.064, F.S., relating to emergency medical care or treatment to minors without parental consent.
Section 2: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

[18] A health care surrogate designation under s. 765.2035, F.S., executed after September 30, 2015, or a power of attorney executed after July 1, 2001, to provide medical consent for a minor includes the power to consent to medically necessary surgical and general anesthesia services for the minor unless such services are excluded by the individual who executes the health care surrogate for a minor or power of attorney, s. 743.0645(2)(a), F.S.
[19] Specifically, under chs. 39, 984, or 985, F.S.
[20] S. 743.0645, F.S.
[21] S. 393.067, F.S., licensed facilities for individuals with developmental disabilities; s. 394.875, F.S., licensed mental health facilities for children and adolescents; s. 409.175, F.S., licensed family foster homes, residential child-caring agencies, and child-placing agencies.
[22] S. 743.0645(2)-(4), F.S.
[23] S. 456.072(1), F.S., provides grounds for disciplinary action against health care practitioners. S. 408.813, F.S., authorizes the Agency for Health Care Administration to impose administrative fines against providers for violations of its regulations.
[24] Violators commit a first-degree misdemeanor, which is punishable by a fine of up to $1,000 and imprisonment of up to one year S. 1014(5), F.S.

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:

   None. The bill does not appear to affect county or municipal governments.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to emergency medical care and treatment to minors without parental consent; amending s. 743.064, F.S.; removing the requirement that emergency medical care or treatment to a minor without parental consent be administered in a hospital or college health service; providing an effective date.

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

Section 1. Subsection (1) of section 743.064, Florida Statutes, is amended to read:

743.064 Emergency medical care or treatment to minors without parental consent.—

(1) The absence of parental consent notwithstanding, a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 may render emergency medical care or treatment to any minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition if, within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical well-being of the minor~~,~~ ~~and provided such emergency medical care or treatment is administered in a hospital licensed by the state under chapter 395 or in a college health service~~. Emergency medical care or

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

treatment may ~~also~~ be rendered in the prehospital setting by paramedics, emergency medical technicians, and other emergency medical services personnel, provided such care is rendered consistent with ~~the provisions of~~ chapter 401. These persons shall follow the general guidelines and notification provisions of this section.

Section 2. This act shall take effect July 1, 2022.

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

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 847 Occupational Therapy
SPONSOR(S): Koster
TIED BILLS: **IDEN./SIM. BILLS:** CS/SB 632

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

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, including occupational therapy.

Occupations are all the activities or tasks a person performs each day. Occupational therapy is the use of purposeful activity or interventions to maximize independence and maintain health. The bill amends the statutes that regulate the practice of occupational therapy. The bill revises the practice of occupational therapy by including:

- Assessment, treatment, education of, and consultation with individuals whose abilities to participate safely in occupations are impaired or at risk for impairment;
- Methods to determine abilities and limitations related to the performance of occupations; and
- Specific occupational therapy techniques used for treatment.

The bill authorizes licensed occupational therapists to use the title “occupational therapist doctorate” or the initials “O.T.D.” in connection with his or her name or business, and prohibits the use of that title or initials by individuals not licensed as an occupational therapist.

The bill clarifies the fieldwork experience time requirement for licensure as an occupational therapist by referencing it in weeks, not months.

It is not uncommon for licensed health care practitioners’ scopes of practice to overlap with other licensed health care practitioners’ scopes of practice. Numerous professions’ practice acts have exemptions to avoid unlicensed practice allegations when the scope of two or more practices overlap. The bill provides an exemption from the application of the Occupational Therapy Practice Act to licensed mental health counselors, marriage and family therapists, and clinical social workers. The bill also provides an exemption to licensed occupational therapists and occupational therapy assistants from the application of the Psychological Services Act and the Clinical, Counseling, and Psychotherapy Act.

The bill has an indeterminate, insignificant, negative fiscal impact on DOH. The bill does not have a fiscal impact on local governments.

The bill provides an effective date of July 1, 2022.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Department of Health

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[1] 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.[2] Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA.

Occupational Therapy

Occupations are all the activities or tasks a person performs each day. Getting dressed, playing sports, taking a class, cooking, and working at a job are examples of occupations.[3]

Occupational therapy is the use of purposeful activity or interventions to achieve functional outcomes, meaning maximizing independence and maintaining health.[4] Occupational therapy may be used by individuals with a limiting physical injury or illness, cognitive impairment, psychosocial dysfunction, mental illness, developmental or learning disability, or adverse environmental condition.[5] Occupational therapy services routinely include:[6]

- An evaluation to determine the patient's goals;
- Intervention to improve the patient's ability to perform needed activities and reach goals; and
- An evaluation of outcomes to determine if goals are being achieved, and changing plans as necessary.

Occupational therapy is performed by licensed occupational therapists (OT), licensed occupational therapy assistants (OTA) who work under the responsible supervision and control[7] of a licensed OT, and occupational therapy aides who are not licensed but assist in the practice of occupational therapy under the direct supervision of a licensed OT or occupational therapy assistant.[8] However, physicians, physician assistants, nurses, physical therapists, osteopathic physicians or surgeons, clinical psychologists, speech-language pathologists, and audiologists are permitted to use occupational

[1] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.
[2] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2019-2020*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2019-2020-annual-report.pdf (last visited Jan. 13, 2022).
[3] Britannica, *Occupational Therapy,* https://www.britannica.com/science/occupational-therapy (last visited Jan. 13, 2022).
[4] Section 468.203(4), F.S.
[5] Id.
[6] American Occupational Therapy Association, *About Occupational Therapy – What is Occupational Therapy?,* https://www.aota.org/about-occupational-therapy.aspx (last visited Jan. 13, 2022).
[7] Section 468.203(8), F.S. Responsible supervision and control by the licensed OT includes providing both the initial direction in developing a plan of treatment and periodic inspection of the actual implementation of the plan. The plan of treatment must not be changed by the supervised individual without prior consultation and approval of the supervising OT. The supervising OT is not always required to be physically present or on the premises when the occupational therapy assistant is performing services; but, supervision requires the availability of the supervising occupational therapist for consultation with and direction of the supervised individual.
[8] Section 468.203, F.S.

therapy skills and techniques as part of their professions, when they practice their profession under their own practice acts.[9]

Occupational therapy services include, but are not limited to: [10]

- The assessment, treatment, and education of, or consultation with, the individual, family, or other persons;
- Interventions directed toward developing daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills;
- Providing for the development of:
    - Sensory-motor, perceptual, or neuromuscular functioning;
    - Range of motion; or
    - Emotional, motivational, cognitive, or psychosocial components of performance.

These services require skilled assessment to determine the need for use of interventions, including: [11]

- The design, development, adaptation, application, or training needed to use the assistive devices;
- The design, fabrication, or application of rehabilitative technology such as selected orthotic devices;
- Training in the use of assistive technology;
- Orthotic or prosthetic devices;
- The application of physical modalities as an adjunct to or in preparation for activity;
- The use of ergonomic principles;
- The adaptation of environments and processes to enhance functional performance; or
- The promotion of health and wellness.

Education

There are four degree level programs available to individuals seeking to enter the profession of occupational therapy: [12]

- Doctoral-Degree-Level Occupational Therapist (Ph.D.);
- Master's-Degree-Level Occupational Therapist (O.T.R.);
- Baccalaureate-Degree-Level Occupational Therapy Assistant (certified occupational therapy assistant or C.O.T.A.); and
- Associate-Degree-Level Occupational Therapy Assistant (also a C.O.T.A.).

Such programs are available through institutions accredited by the Accreditation Council for Occupational Therapy Education (ACOTE), which is the certifying arm of the American Occupational Therapy Association (AOTA). ACOTE requirements for accreditation for occupational therapy curriculum vary by degree levels, but all levels must include theory, basic tenets of occupational therapy, and supervised educational fieldwork for accreditation.

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[9] Section 468.225, F.S.
[10] Section 468.203(4)(b), F.S.
[11] Section 468.203(4)a.2.,F.S. "Assessment" means the use of skilled observation or the administration and interpretation of standardized or non-standardized tests and measurements to identify areas for occupational therapy services.
[12] National Board of Certification in Occupational Therapy, 2018 Accreditation Council for Occupational Therapy Education (ACOTE®) *Standards and Interpretive Guide (effective July 31, 2020) August 2020 Interpretive Guide Version,* at pp. 20 and 49, https://acoteonline.org/wp-content/uploads/2020/10/2018-ACOTE-Standards.pdf (last visited Jan. 13, 2022). The Ph.D. in occupational therapy requires a minimum of six years of full time academic education and a Doctorial Capstone which is an in-depth exposure to a concentrated area, which is an integral part of the program's curriculum design. This in-depth exposure may be in one or more of the following areas: clinical practice skills, research skills, scholarship, administration, leadership, program and policy development, advocacy, education, and theory development. The doctoral capstone consists of two parts: the capstone experience and the capstone project.

Occupational therapy candidates are required to complete two levels of fieldwork, the second of which depends on the degree level sought.[13] Level I fieldwork required for Ph.D., O.T.R., and C.O.T.A. candidates can be met through one or more of the following instructional methods:[14]

- Simulated environments;
- Standardized patients;
- Faculty practice;
- Faculty-led site visits; and
- Supervision by a fieldwork instructor.

Level II fieldwork required for Doctorate level and Master's level candidates includes a minimum of 24 weeks of full-time level II fieldwork which may be completed in one setting if reflective of more than one practice area, or in a maximum of four different settings.[15] Baccalaureate level and Associate degree level candidates are required to complete a minimum of 16 weeks full-time level II fieldwork which may be completed in one setting if reflective of more than one practice area, or in a maximum of three different settings.[16]

Licensure

To be licensed as an occupational therapist, or occupational therapy assistant, an individual must:[17]

- Submit the licensure application and required application fee of $100;
- Be of good moral character;
- Have graduated from an ACOTE/AOTA accredited occupational therapy program or occupational therapy assistant program;
- Have completed a minimum of six months of supervised fieldwork experience for occupational therapists, and a minimum of two months for occupational therapy assistants, at a recognized educational institution or a training program approved by the education institution where you met the academic requirements; and
- Have passed an examination approved by the National Board of Certification in Occupational Therapy (NBCOT).

Current law allows applicants who have practiced as a state-licensed or AOTA-certified occupational therapy assistant for four years and who, prior to January 24, 1988, have completed a minimum of six months of supervised occupational-therapist-level fieldwork experience to obtain licensure. Such individuals may take the examination approved by the NBCOT to be licensed as an occupational therapist without meeting the educational requirements for occupational therapists to have graduated from a program accredited by the ACOTE/AOTA.[18] The NBCOT requires the same amount of fieldwork, but expresses it in weeks (24) not months, which may result in confusion.

Endorsement is another path to licensure for an occupational therapists, or occupational therapist assistants, in which the Board may waive the examination requirement and grant a license to any person who presents proof of: [19]

- A current certification as an occupational therapist or occupational therapy assistant by a national certifying organization if the Board determines the requirements for such certification to be equivalent to the requirements for Florida licensure; or

[13] *Supra* note 12, p. 39.
[14] Id.
[15] Id at p. 42.
[16] Id.
[17] Section 468.209, F.S. and ch. 64B-11.2003, F.A.C.
[18] Section 468.209(2), F.S.
[19] Section 468.213, F.S.

- A current licensure as an occupational therapist or occupational therapy assistant in another state, the District of Columbia, or any territory or jurisdiction of the United States or foreign national jurisdiction which requires standards for licensure determined by the Board to be equivalent to the requirements for Florida licensure.

In fiscal year 2020-2021, there were 9,298 active licensed occupational therapists and 6,247 active licensed occupational therapy assistants in Florida.[20]

Exemptions

It is not uncommon for licensed health care practitioners' scopes of practice to overlap with other licensed health care practitioners' scopes of practice. For example, the psychology practice act provides an exemption to the application of its provisions to licensed allopathic and osteopathic physicians so long as such physicians do not hold themselves out to the public as psychologists.[21] This is done to avoid unlicensed practice allegations when the scope of two or more practices overlap.

Currently, the provisions of the Occupational Therapy Practice Act do not apply to certain licensed health care practitioners, including:[22]

- Allopathic and osteopathic physicians;
- Physicians assistants;
- Nurses;
- Physical therapists;
- Clinical psychologists;
- Speech language pathologists; and
- Audiologists.

Health care professions not exempt from the provisions of the Occupational Therapy Practice Act include:

- School speech and language providers;
- Clinical social workers;
- Marriage and family therapists;
- Mental health counselors; and
- Orthotists and prosthetists.

Title Regulation

Current law prohibits a person from using the titles, "occupational therapist," "licensed occupational therapist," "occupational therapist registered," "occupational therapy assistant," "licensed occupational therapy assistant," "certified occupational therapy assistant;" or the letters "O.T.," "L.O.T.," "O.T.R.," "O.T.A.," "L.O.T.A.," or "C.O.T.A.;" or any other words, letters, abbreviations, or insignia indicating or implying the user is an occupational therapist or an occupational therapy assistant, unless the person holds a valid license. Any person who does so commits a second degree misdemeanor.[23]

[20] Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan for 2020-2021,* http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/2020-2021-annual-report.pdf (last visited Jan. 13, 2022).
[21] Section 490.014(1)(a), F.S.
[22] Section 468.225(2), F.S.
[23] Sections 468.215 and 468.223, F.S. A second degree misdemeanor is punishable by a fine of up to $500 and imprisonment of up to 60 days. *See* Sections 775.082(4) and 775.083(1)(e), F.S.

Effect of Proposed Changes

Occupational Therapy

The bill revises occupational therapy to include the therapeutic use of occupations with individuals, groups, or populations, along with their families or organizations to support participation, performance, and function in roles and situations in the home, school, workplace, community, and other settings. Under the bill, occupational therapy services are provided for clients who have or are at risk for developing an:

- Illness;
- Injury;
- Disease;
- Disorder;
- Condition;
- Impairment;
- Disability;
- Activity limitation; or
- Participation restriction.

The bill specifies that occupational therapy supports occupational performance in persons with, or at risk of experiencing, a range of disorders and disabilities.

The bill revises the practice of occupational therapy to include:

- Assessment, treatment, education of, and consultation with individuals whose abilities to participate safely in occupations are impaired or at risk for impairment due to developmental deficiencies, aging, learning disabilities, environment, injury, disease, cognitive impairment, and disability;
- Methods to determine abilities and limitations related to the performance of occupations; and
- Specific occupational therapy techniques used for treatment involving training in activities of daily living, environment modification, assessment of the need for orthotics or orthotic devices, use of assistive technology and adaptive devices, cognitive activities, therapeutic exercises, manual therapy techniques, physical agent modalities, and mental health services.

Title Regulation

The bill authorizes licensed occupational therapists to use the title “occupational therapist doctorate” or the initials “O.T.D.” in connection with his or her name or business. The bill also prohibits the use of the title “occupational therapist doctorate” or the initials “O.T.D.” by individuals not licensed as an occupational therapist.

Education

The bill clarifies the length of time required for fieldwork by occupational therapy applicants who have practiced as a state-licensed or AOTA-certified occupational therapy assistant. The bill expresses the time as 24 weeks, rather than 6 months, to align with phrasing used by NBCOT.

Licensure Exemptions

The bill exempts clinical social workers, marriage and family therapists, and mental health counselors from the application of the Occupational Therapy Practice Act. It also exempts occupational therapists and occupational therapy assistants from the application of the Psychological Services Act under ch. 490, F.S., and the Clinical, Counseling, and Psychotherapy Act under ch. 491, F.S.

The bill also exempts any person fulfilling an occupational therapy doctoral capstone experience that involves clinical practice or projects, from the application of the Occupational Therapy Practice Act if the person registers with the DOH before commencing the capstone experience. This will allow Ph.D. candidates in occupational therapy to commence capstone projects without being subject to occupational therapy licensure requirements.

The bill makes conforming changes.

The bill provides an effective date of July 1, 2022.

B. SECTION DIRECTORY:

Section 1: Amends s. 468.203, F.S., relating to definitions.
Section 2: Amends s. 468.209, F.S., relating to requirements for licensure.
Section 3: Amends s. 468.215, F.S., relating to issuance of license.
Section 4: Amends s. 468.223, F.S., relating to prohibitions; penalties.
Section 5: Amends s. 468.225, F.S., relating to exemptions.
Section 6: Amends s. 490.014, F.S., relating to exemptions.
Section 7: Amends s. 491.014, F.S., relating to exemptions.
Section 8: Amends s. 490.012, F.S., relating to violations; penalties; injunction.
Section 9: Amends s. 1002.394, F.S., relating to The Family Empowerment Scholarship Program.
Section 10: Reenacts s. 1002.66, F.S., relating to specialized instructional services for children with disabilities.
Section 11: Provides an effective date of July 1, 2022.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   The bill has an indeterminate, insignificant, negative fiscal impact on DOH. DOH may experience an increase in workload associated with additional complaints due to the bill's title and initial protection as well as scope expansion provisions, which current resources are adequate to absorb.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Board of Occupational Therapy has sufficient rule-making authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to occupational therapy; amending s. 468.203, F.S.; defining and revising terms; amending s. 468.209, F.S.; revising eligibility requirements for the occupational therapist licensure examination; amending s. 468.215, F.S.; authorizing certain licensed occupational therapists to use a specified title and the associated initials; amending s. 468.223, F.S.; prohibiting certain persons from using a specified title and the associated initials; providing criminal penalties; amending ss. 468.225, 490.014, and 491.014, F.S.; revising construction; reenacting s. 490.012(1)(c), F.S., relating to violations, penalties, and injunctions, to incorporate the amendment made to s. 490.014, F.S., in a reference thereto; amending s. 1002.394, F.S.; conforming a provision to changes made by the act; reenacting s. 1002.66(2)(c), F.S., relating to specialized instructional services for children with disabilities, to incorporate the amendments made to s. 468.203, F.S., in a reference thereto; providing an effective date.

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

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

Section 1. Subsection (4) of section 468.203, Florida Statutes, is amended to read:

468.203 Definitions.—As used in this act, the term:

(4) "Occupational therapy" means the therapeutic use of occupations through habilitation, rehabilitation, and the promotion of health and wellness with individuals, groups, or populations, along with their families or organizations, to support participation, performance, and function in the home, at school, in the workplace, in the community, and in other settings for clients who have, or who have been identified as being at risk of developing, an illness, an injury, a disease, a disorder, a condition, an impairment, a disability, an activity limitation, or a participation restriction ~~purposeful activity or interventions to achieve functional outcomes~~.

(a) For the purposes of this subsection:

1. "Activities of daily living" means functions and tasks for self-care which are performed on a daily or routine basis, including functional mobility, bathing, dressing, eating and swallowing, personal hygiene and grooming, toileting, and other similar tasks ~~"Achieving functional outcomes" means to maximize the independence and the maintenance of health of any individual who is limited by a physical injury or illness, a cognitive impairment, a psychosocial dysfunction, a mental illness, a developmental or a learning disability, or an adverse environmental condition~~.

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

2. "Assessment" means the use of skilled observation or the administration and interpretation of standardized or nonstandardized tests and measurements to identify areas for occupational therapy services.

3. "Health management" means therapeutic services designed to develop, manage, and maintain health and wellness routines, including self-management, performed with the goal of improving or maintaining health to support participation in occupations.

4. "Instrumental activities of daily living" means daily or routine activities a person must perform to live independently within the home and community.

5. "Occupational performance" means the ability to perceive, desire, recall, plan, and carry out roles, routines, tasks, and subtasks for the purpose of self-maintenance, self-preservation, productivity, leisure, and rest, for oneself or for others, in response to internal or external demands of occupations and contexts.

6. "Occupational therapy services in mental health" means occupation-based interventions and services for individuals, groups, populations, families, or communities to improve participation in daily occupations for individuals who are experiencing, are in recovery from, or are identified as being at risk of developing mental health conditions.

7. "Occupations" means meaningful and purposeful everyday activities performed and engaged in by individuals, groups,

populations, families, or communities which occur in contexts and over time, such as activities of daily living, instrumental activities of daily living, health management, rest and sleep, education, work, play, leisure, and social participation. The term includes more specific occupations and the execution of multiple activities that are influenced by performance patterns, performance skills, and client factors, and that result in varied outcomes.

(b) The practice of occupational therapy includes ~~services include~~, but is ~~are~~ not limited to, the following services:

1. ~~The~~ Assessment, treatment, and education of or consultation with individuals, groups, and populations whose abilities to participate safely in occupations, including activities of daily living, instrumental activities of daily living, rest and sleep, education, work, play, leisure, and social participation, are impaired or have been identified as being at risk of impairment due to issues related to, but not limited to, developmental deficiencies, the aging process, learning disabilities, physical environment and sociocultural context, physical injury or disease, cognitive impairments, or psychological and social disabilities ~~the individual, family, or other persons~~.

2. Methods or approaches used to determine abilities and limitations related to performance of occupations, including, but not limited to, the identification of physical, sensory,

cognitive, emotional, or social deficiencies ~~Interventions directed toward developing daily living skills, work readiness or work performance, play skills or leisure capacities, or enhancing educational performance skills~~.

3. Specific occupational therapy techniques used for treatment which include, but are not limited to, training in activities of daily living; environmental modification; assessment of the need for the use of interventions such as the design, fabrication, and application of orthotics or orthotic devices; selecting, applying, and training in the use of assistive technology and adaptive devices; sensory, motor, and cognitive activities; therapeutic exercises; manual techniques; physical agent modalities; and occupational therapy services in mental health ~~Providing for the development of: sensory-motor, perceptual, or neuromuscular functioning; range of motion; or emotional, motivational, cognitive, or psychosocial components of performance~~.

~~These services may require assessment of the need for use of interventions such as the design, development, adaptation, application, or training in the use of assistive technology devices; the design, fabrication, or application of rehabilitative technology such as selected orthotic devices; training in the use of assistive technology; orthotic or prosthetic devices; the application of physical agent modalities~~

~~as an adjunct to or in preparation for purposeful activity; the use of ergonomic principles; the adaptation of environments and processes to enhance functional performance; or the promotion of health and wellness.~~

(c) The use of devices subject to 21 C.F.R. s. 801.109 and identified by the board is expressly prohibited except by an occupational therapist or occupational therapy assistant who has received training as specified by the board. The board shall adopt rules to carry out the purpose of this provision.

Section 2. Subsection (2) of section 468.209, Florida Statutes, is amended to read:

468.209 Requirements for licensure.—

(2) An applicant who has practiced as a state-licensed or American Occupational Therapy Association-certified occupational therapy assistant for 4 years and who, before ~~prior to~~ January 24, 1988, completed a minimum of 24 weeks ~~6 months~~ of supervised occupational-therapist-level fieldwork experience may take the examination to be licensed as an occupational therapist without meeting the educational requirements for occupational therapists made otherwise applicable under paragraph (1)(b).

Section 3. Subsection (2) of section 468.215, Florida Statutes, is amended to read:

468.215 Issuance of license.—

(2)(a) Any person who is issued a license as an occupational therapist under the terms of this act may use the

words "occupational therapist," "licensed occupational therapist," or "occupational therapist registered," or ~~he or she~~ may use the letters "O.T.," "L.O.T.," or "O.T.R.," in connection with his or her name or place of business to denote his or her registration hereunder.

(b) Any person who is issued a license as an occupational therapist under the terms of this act and holds a doctorate degree in occupational therapy may also use the words "occupational therapist doctorate" and the letters "O.T.D." in connection with his or her name or place of business to denote his or her registration hereunder.

Section 4. Section 468.223, Florida Statutes, is amended to read:

468.223 Prohibitions; penalties.—

(1) A person may not:

(a) Practice occupational therapy unless such person is licensed pursuant to ss. 468.201-468.225;

(b) Use, in connection with his or her name or place of business, the words "occupational therapist," "licensed occupational therapist," "occupational therapist doctorate," "occupational therapist registered," "occupational therapy assistant," "licensed occupational therapy assistant," "certified occupational therapy assistant"; the letters "O.T.," "L.O.T.," "O.T.D.," "O.T.R.," "O.T.A.," "L.O.T.A.," or "C.O.T.A."; or any other words, letters, abbreviations, or

insignia indicating or implying that he or she is an occupational therapist or an occupational therapy assistant or, in any way, orally or in writing, in print or by sign, directly or by implication, to represent himself or herself as an occupational therapist or an occupational therapy assistant unless the person is a holder of a valid license issued pursuant to ss. 468.201-468.225;

(c) Present as his or her own the license of another;

(d) Knowingly give false or forged evidence to the board or a member thereof;

(e) Use or attempt to use a license that ~~which~~ has been suspended, revoked, or placed on inactive or delinquent status;

(f) Employ unlicensed persons to engage in the practice of occupational therapy; or

(g) Conceal information relative to any violation of ss. 468.201-468.225.

(2) Any person who violates any provision of this section commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 5. Subsection (2) of section 468.225, Florida Statutes, is amended, and paragraph (e) is added to subsection (1) of that section, to read:

468.225 Exemptions.—

(1) Nothing in this act shall be construed as preventing or restricting the practice, services, or activities of:

(e) Any person fulfilling an occupational therapy doctoral capstone experience that involves clinical practice or projects. To benefit from an exemption under this paragraph, a person must register with the department in a manner determined by department rule before commencing the capstone experience.

(2) No provision of this act shall be construed to prohibit physicians, physician assistants, nurses, physical therapists, osteopathic physicians or surgeons, clinical psychologists, clinical social workers, marriage and family therapists, mental health counselors, speech-language pathologists, or audiologists from using occupational therapy as a part of or incidental to their profession, when they practice their profession under the statutes applicable to their profession.

Section 6. Paragraph (b) of subsection (1) of section 490.014, Florida Statutes, is amended to read:

490.014 Exemptions.—

(1)

(b) No provision of this chapter shall be construed to limit the practice of nursing, clinical social work, marriage and family therapy, mental health counseling, occupational therapy, or other recognized businesses or professions, or to prevent qualified members of other professions from doing work of a nature consistent with their training, so long as they do not hold themselves out to the public as psychologists or use a

title or description protected by this chapter. Nothing in this subsection shall be construed to exempt any person from the provisions of s. 490.012.

Section 7. Subsection (2) of section 491.014, Florida Statutes, is amended to read:

491.014 Exemptions.—

(2) No provision of this chapter shall be construed to limit the practice of nursing, school psychology, ~~or~~ psychology, or occupational therapy, or to prevent qualified members of other professions from doing work of a nature consistent with their training and licensure, so long as they do not hold themselves out to the public as possessing a license, provisional license, registration, or certificate issued pursuant to this chapter or use a title protected by this chapter.

Section 8. For the purpose of incorporating the amendment made by this act to section 490.014, Florida Statutes, in a reference thereto, paragraph (c) of subsection (1) of section 490.012, Florida Statutes, is reenacted to read:

490.012 Violations; penalties; injunction.—

(1)

(c) No person shall hold herself or himself out by any title or description incorporating the words, or permutations of them, "psychology," "psychological," or "psychodiagnostic," or describe any test or report as psychological, unless such person

holds a valid, active license under this chapter or is exempt from the provisions of this chapter.

Section 9. Paragraph (b) of subsection (4) of section 1002.394, Florida Statutes, is amended to read:

1002.394 The Family Empowerment Scholarship Program.—

(4) AUTHORIZED USES OF PROGRAM FUNDS.—

(b) Program funds awarded to a student with a disability determined eligible pursuant to paragraph (3)(b) may be used for the following purposes:

1. Instructional materials, including digital devices, digital periphery devices, and assistive technology devices that allow a student to access instruction or instructional content and training on the use of and maintenance agreements for these devices.

2. Curriculum as defined in subsection (2).

3. Specialized services by approved providers or by a hospital in this state which are selected by the parent. These specialized services may include, but are not limited to:

a. Applied behavior analysis services as provided in ss. 627.6686 and 641.31098.

b. Services provided by speech-language pathologists as defined in s. 468.1125(8).

c. Occupational therapy ~~services~~ as defined in s. 468.203.

d. Services provided by physical therapists as defined in s. 486.021(8).

e. Services provided by listening and spoken language specialists and an appropriate acoustical environment for a child who has a hearing impairment, including deafness, and who has received an implant or assistive hearing device.

4. Tuition or fees associated with full-time or part-time enrollment in a home education program, an eligible private school, an eligible postsecondary educational institution or a program offered by the postsecondary educational institution, a private tutoring program authorized under s. 1002.43, a virtual program offered by a department-approved private online provider that meets the provider qualifications specified in s. 1002.45(2)(a), the Florida Virtual School as a private paying student, or an approved online course offered pursuant to s. 1003.499 or s. 1004.0961.

5. Fees for nationally standardized, norm-referenced achievement tests, Advanced Placement Examinations, industry certification examinations, assessments related to postsecondary education, or other assessments.

6. Contributions to the Stanley G. Tate Florida Prepaid College Program pursuant to s. 1009.98 or the Florida College Savings Program pursuant to s. 1009.981 for the benefit of the eligible student.

7. Contracted services provided by a public school or school district, including classes. A student who receives services under a contract under this paragraph is not considered

enrolled in a public school for eligibility purposes as specified in subsection (6).

8. Tuition and fees for part-time tutoring services provided by a person who holds a valid Florida educator's certificate pursuant to s. 1012.56, a person who holds an adjunct teaching certificate pursuant to s. 1012.57, a person who has a bachelor's degree or a graduate degree in the subject area in which instruction is given, a person who has demonstrated a mastery of subject area knowledge pursuant to s. 1012.56(5), or a person certified by a nationally or internationally recognized research-based training program as approved by the department. As used in this paragraph, the term "part-time tutoring services" does not qualify as regular school attendance as defined in s. 1003.01(13)(e).

9. Fees for specialized summer education programs.

10. Fees for specialized after-school education programs.

11. Transition services provided by job coaches.

12. Fees for an annual evaluation of educational progress by a state-certified teacher under s. 1002.41(1)(f), if this option is chosen for a home education student.

13. Tuition and fees associated with programs offered by Voluntary Prekindergarten Education Program providers approved pursuant to s. 1002.55 and school readiness providers approved pursuant to s. 1002.88.

14. Fees for services provided at a center that is a

member of the Professional Association of Therapeutic Horsemanship International.

15. Fees for services provided by a therapist who is certified by the Certification Board for Music Therapists or credentialed by the Art Therapy Credentials Board, Inc.

Section 10. For the purpose of incorporating the amendment made by this act to section 468.203, Florida Statutes, in a reference thereto, paragraph (c) of subsection (2) of section 1002.66, Florida Statutes, is reenacted to read:

1002.66 Specialized instructional services for children with disabilities.—

(2) The parent of a child who is eligible for the prekindergarten program for children with disabilities may select one or more specialized instructional services that are consistent with the child's individual educational plan. These specialized instructional services may include, but are not limited to:

(c) Occupational therapy as defined in s. 468.203.

Section 11. This act shall take effect July 1, 2022.