Health Care General Committee

Wednesday, December 7, 2005
9:00 AM – 11:00 AM
306 HOB

COMMITTEE MEETING PACKET

Allan G. Bense
Speaker

Gayle B. Harrell
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Speaker Allan G. Bense

Health Care General Committee

Start Date and Time:	Wednesday, December 07, 2005 09:00 am
End Date and Time:	Wednesday, December 07, 2005 11:00 am
Location:	306 HOB
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 3 Florida Birth-Related Neurological Injury Compensation Plan by Berfield
HB 35 CS Abatement of Drug Paraphernalia by Peterman
HB 211 Area Health Education Center Network by Troutman

Presentation by the Department of Health on the "Emergency Operations Plan, Biological Incident Annex, Influenza Pandemic Appendix"

Presentation by the Agency for Health Care Administration on the development of the Florida Health Information Infrastructure

NOTICE FINALIZED on 11/22/2005 14:48 by RANDOLPH.CHERYL

HB 3

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 3 Florida Birth-Related Neurological Injury Compensation Plan
SPONSOR(S): Berfield; Goldstein
TIED BILLS: None **IDEN./SIM. BILLS:** SB 542

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Civil Justice Committee	5 Y, 0 N	Kruse	Bond
2) Health Care General Committee		Ciccone	Brown-Barrios
3) Finance & Tax Committee			
4) Justice Council			
5)			

SUMMARY ANALYSIS

The Florida Birth-Related Neurological Injury Compensation Plan (plan) is the alternative to medical malpractice claims for birth-related neurological injuries. The plan provides compensation and other services to persons with birth-related neurological injuries. The benefits are more restricted than the remedies that would be provided by tort law, but a claimant is not required to prove malpractice. One issue that arises in cases to determine whether a family is required to file for benefits under the plan is whether the mother was properly notified regarding the plan.

This bill provides that the Division of Administrative Hearings has the exclusive jurisdiction to decide whether the statutory notice provision has been met.

Additionally, the bill authorizes the Florida Birth-Related Neurological Injury Compensation Association (NICA), which administers the plan, to contract with the State Board of Administration to invest and reinvest plan funds. NICA currently has authority to invest plan funds, and the bill provides that the State Board of Administration is one of the entities with whom NICA may contract for this service.

This bill does not appear to have a fiscal impact on state or local governments.

This bill provides an effective date of upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

This bill does not appear to implicate any of the House Principles.

B. EFFECT OF PROPOSED CHANGES:

Florida Birth-Related Neurological Injury Compensation Plan

The Florida Birth-Related Neurological Injury Compensation Plan (the "plan") was enacted by the Legislature in 1988.[1] Currently, Virginia is the only other state in the nation that has a no-fault coverage plan that is similar to Florida's plan.[2] The plan was created to provide compensation, long-term medical care, and other services to persons with birth-related neurological injuries. Although the benefits paid under the plan are more restricted than the remedies provided by tort law, the plan does not require the claimant to prove malpractice and provides a streamlined administrative hearing to resolve the claim.[3]

A "birth-related neurological injury" as defined in s. 766.302(2), F.S., is an injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or by mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital. The injury must render the infant permanently and substantially mentally and physically impaired.

Florida Birth-Related Neurological Injury Compensation Association (NICA)

The entity charged with administering the plan is the Florida Birth-Related Neurological Injury Compensation Association (NICA or association). Under s. 766.315(4), F.S., NICA's duties include:

- Administering the plan;
- Administering the funds collected;
- Reviewing and paying claims;
- Directing the investment and reinvestment of any surplus funds over losses and expenses;
- Reinsuring the risks of the plan in whole or in part;
- Suing and being sued, appearing and defending, in all actions and proceedings in its name; and
- Taking such legal action as may be necessary to avoid payment of improper claims.[4]

The funding for the plan is derived from an appropriation by the Legislature when the plan was created and annual fees paid by physicians and hospitals.[5]

The plan pays, on behalf of a qualifying infant:

- Necessary and reasonable care, services, drugs, equipment, facilities, and travel;[6]

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[1] Chapter 88-1, ss. 60-75, L.O.F., was enacted by the Legislature in an attempt to stabilize and reduce malpractice insurance premiums for physicians practicing obstetrics, according to the legislative findings and intent cited in s. 766.301(1)(c), F.S.

[2] Governor's Select Task Force on Healthcare Professional Liability Insurance, *Report and Recommendations*, p. 307 (2003).

[3] See *Florida Birth-Related Neurological Injury Compensation Ass'n v. McKaughan*, 668 So.2d 974, 977 (Fla. 1996).

[4] Section 766.315(4), F.S.

[5] Section 766.314, F.S., requires non-participating physicians to pay $250 per year, participating physicians to pay $5,000 per year, and hospitals to pay $50 per infant delivered during the prior year.

- One-time cash award, not to exceed $100,000, to the infant's parents or guardians;[7]
- Death benefit of $10,000 for the infant; and
- Reasonable expenses for filing the claim, including attorney's fees.

Filing a Claim for Benefits

A claim for benefits under the plan must be filed within five years of the birth of the infant alleged to be injured.[8] The parents or guardian of the infant files a petition with the Division of Administrative Hearings (DOAH). DOAH serves a copy of the petition upon NICA, the physician(s) and hospital named in the petition, and the Division of Medical Quality Assurance.[9] Within ten days of filing the petition, the parents or guardian must provide NICA all medical records, assessments, evaluations and prognoses, documentation of expenses, and documentation of any private or governmental source of services or reimbursement relative to the impairments. An administrative law judge (ALJ) from DOAH will set a hearing on the claim to be conducted 60-120 days from the petition filing date.

The issue of whether the claim for compensation is covered by the plan is determined exclusively in an administrative proceeding.[10] The ALJ presiding over the hearing makes the following determinations:

- Whether the injury claimed is a birth-related neurological injury;
- Whether obstetrical services were delivered by a participating physician; and
- How much compensation, if any, is awardable under s. 766.31, F.S.[11]

If the ALJ determines that an injury meets the definition of a birth-related neurological injury, compensation from the plan is the exclusive legal remedy.[12] If the ALJ determines that the injury alleged is not a birth-related neurological injury or that the obstetrical services were not delivered by a participating physician, the ALJ will enter an order to that effect. The ALJ may also bifurcate the proceeding and address compensability and notice first, and address an award, if any, in a separate proceeding.[13] If any party chooses to appeal the ALJ's order under s. 766.309, F.S., the appeal must be filed in the District Court of Appeal.[14]

Notice Requirement

Section 766.316, F.S., requires any hospital with a participating physician on its staff, and each participating physician under the plan to provide notice to an obstetrical patient as to the limited no-fault alternative for birth-related neurological injuries. The notice must:

- be provided on forms furnished by the association; and
- include a clear and concise explanation of a patient's rights and limitations under the plan.

This section also provides that notice does not need to be provided to a patient when the patient has an emergency medical condition or when notice is not practicable. This section does not specifically address the effect of failure to provide notice to the obstetrical patient.

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[6] Expenses that can be compensated by state or federal governments, or by private insurers, are not covered by the plan.
[7] Often the award is paid out over time to assist the parents or guardians in making necessary modifications to living quarters to accommodate a disabled child.
[8] Section 766.313, F.S.
[9] Only infants born in a hospital are covered by the plan.
[10] Section 766.301(1)(d), F.S.
[11] Section 766.309(1), F.S. The determination of notice is not explicitly provided for in this section.
[12] Section 766.303(2), F.S., only allows a civil action in place of a claim under the plan where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property.
[13] Section 766.309(4), F.S.
[14] Section 766.311(1), F.S.

Courts have addressed the issue of who determines whether notice has been properly provided. Four of the five District Courts of Appeal have held that the ALJ has the exclusive jurisdiction to determine whether notice has been properly provided. However, in the Second District Court of Appeal, in *Bayfront Medical Center, Inc. v. NICA*, 893 So. 2d 636 (Fla. 2nd DCA 2005), the court affirmed its approach that the ALJ's jurisdiction extends only to the determination of whether the child suffered a neurological injury that was compensable under the plan. The court recognized the conflict with the other district courts of appeal, but declined to recede from its holding and certified the conflict to the Florida Supreme Court.[15] In *Tabb v. Florida Birth-Related Neurological Injury Compensation Association*, 880 So. 2d 1253, 1256 (Fla. 1st DCA 2004), the First District Court of Appeal reasoned that "[i]n order to 'hear and determine' a claim, an ALJ must, almost of necessity, decide whether notice was given, because if no notice was given, the exclusivity provision of the statute does not apply." In addition, the court pointed to recent amendments to the statute that implicitly acknowledge the existing case law indicating that an ALJ has jurisdiction to determine whether notice was provided.

Effect of Bill

Notice

This bill amends s. 766.309(1), F.S., to provide that it is the exclusive jurisdiction of an administrative law judge of DOAH to determine whether the notice requirement in s. 766.316, F.S., has been met.

The bill also states that it is the intent of the Legislature that the amendment contained in this act clarifies that since July 1, 1998, the administrative law judge has had the exclusive jurisdiction to make factual determinations as to whether the notice requirements in s. 766.31, F.S., are satisfied.

Contracts for Investment

This bill also authorizes NICA, which administers the plan, to contract with the State Board of Administration[16] to invest and reinvest plan funds. NICA currently has the authority to invest plan funds, and this bill authorizes NICA to utilize the State Board of Administration to provide NICA an additional source for managing investments at no cost to the state.

C. SECTION DIRECTORY:

Section 1. Amends s. 766.309, F.S., to provide that an administrative law judge of DOAH has the exclusive jurisdiction to determine whether the notice requirement in s. 766.316, F.S., has been met.

Section 2. Provides that it is the intent of the Legislature that the amendment contained in this act clarifies that since July 1, 1998, an administrative law judge of DOAH has had the exclusive jurisdiction to make factual determinations as to whether the notice requirements in s. 766.31, F.S., are satisfied.

Section 3. Amends s. 766.315, F.S., to authorize the State Board of Administration to invest and reinvest funds for NICA.

Section 4. Provides an effective date of upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

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[15] *Bayfront* at 637, 638.

[16] The State Board of Administration (SBA) is the professional investment organization for Florida. The SBA manages 25 funds, comprising more than $130 billion in assets under management at the end of fiscal year 2004.

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:

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

2. Other:

Florida courts have found that the Legislature has the authority to apply law retroactively as long as the new law does not impair a vested right.[17] Courts have used a weighing process to decide whether to sustain the retroactive application of a statute that has three considerations: the strength of the public interest served by the statute, the extent to which the right affected is abrogated, and the nature of the right affected.[18] In this instance, the bill does not appear to impair a vested right of a claimant or defendant, but may rather seek to serve the public interest. The bill provides that an administrative law judge (ALJ) of DOAH has exclusive jurisdiction to determine if the notice requirements were met.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

None.

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[17] *Dept. of Transportation v. Knowles*, 402 So. 2d 1155, 1157 (Fla. 1981). *Village of El Portal v. City of Miami Shores*, 362 So. 2d 275, 277 (Fla. 1978); *McCord v. Smith*, 43 So. 2d 704, 708-709 (Fla. 1949).

[18] Supra *Knowles* at 1158.

1 A bill to be entitled
2 An act relating to the Florida Birth-Related Neurological
3 Injury Compensation Plan; amending s. 766.309, F.S.;
4 requiring the administrative law judge to determine
5 whether factual determinations regarding required notice
6 to obstetrical patients of participation in the plan are
7 satisfied; providing exclusive jurisdiction to make such
8 determinations; providing legislative intent; amending s.
9 766.315, F.S.; authorizing the State Board of
10 Administration to invest and reinvest funds held on behalf
11 of the plan pursuant to certain requirements; providing an
12 effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Paragraph (d) is added to subsection (1) of
17 section 766.309, Florida Statutes, to read:
18 766.309 Determination of claims; presumption; findings of
19 administrative law judge binding on participants.--
20 (1) The administrative law judge shall make the following
21 determinations based upon all available evidence:
22 (d) Whether, if raised by the claimant or other party, the
23 factual determinations regarding the notice requirements in s.
24 766.316 are satisfied. The administrative law judge has the
25 exclusive jurisdiction to make these factual determinations.
26 Section 2. It is the intent of the Legislature that the
27 amendment to s. 766.309, Florida Statutes, contained in this
28 act, clarifies that since July 1, 1998, the administrative law

29 judge has had the exclusive jurisdiction to make factual
30 determinations as to whether the notice requirements in s.
31 766.316, Florida Statutes, are satisfied.
32 Section 3. Paragraph (e) of subsection (5) of section
33 766.315, Florida Statutes, is amended to read:
34 766.315 Florida Birth-Related Neurological Injury
35 Compensation Association; board of directors.--
36 (5)
37 (e) Funds held on behalf of the plan are funds of the
38 State of Florida. The association may only invest plan funds in
39 the investments and securities described in s. 215.47, and shall
40 be subject to the limitations on investments contained in that
41 section. All income derived from such investments will be
42 credited to the plan. The State Board of Administration may
43 invest and reinvest funds held on behalf of the plan in
44 accordance with the trust agreement approved by the association
45 and the State Board of Administration and within the provisions
46 of ss. 215.44-215.53.
47 Section 4. This act shall take effect upon becoming a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 35 CS Abatement of Drug Paraphernalia
SPONSOR(S): Peterman
TIED BILLS: **IDEN./SIM. BILLS:** SB 100

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Criminal Justice Committee	7 Y, 0 N, w/CS	Kramer	Kramer
2) Health Care General Committee		Ciccone	Brown-Barrios
3) Transportation & Economic Development Appropriations Committee			
4) Justice Council			
5)			

SUMMARY ANALYSIS

HB 35 CS creates an eight member task force within the Executive Office of the Governor to recommend strategies for reducing the availability and use of drug paraphernalia. The bill specifies the members and their appointment, the chair's selection, the minimum number and location of meetings, public access to meetings and records, reimbursement for per diem and travel expenses, topics for task force review, and deadlines for submitting reports of findings and recommendations. The task force must hold its first meeting by July 15, 2006. The Office of Drug Control is to provide staff support within existing resources. The bill abolishes the task force on July 1, 2007.

This bill appears to have a minimal fiscal impact on the state. This bill does not appear to have a fiscal impact on local governments.

The bill provides an effective date of upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government--this bill creates an eight member task force that sunsets on July 1, 2006.

B. EFFECT OF PROPOSED CHANGES:

Current situation

Florida law provides a three-part definition of the term "drug paraphernalia." First, s. 893.145, F.S., defines the term's general meeting. Second, this section provides a non-exclusive list of items that meet the term's definition. Third, s. 893.146, F.S., provides a non-exclusive list of factors for determining whether an item or object is drug paraphernalia.

Section 893.145, F.S., defines "drug paraphernalia" as all equipment, products, and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing, processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body a controlled substance in violation of ch. 893, F.S., (the "Florida Comprehensive Drug Abuse Prevention and Control Act") or s. 877.111, F.S., (proscribing the inhalation, ingestion, possession, sale, purchase, or transfer of harmful chemical substances).

Further, s. 893.145, F.S., provides the following non-exclusive list of items that fall within the statutory definition of "drug paraphernalia":

- Kits used, intended for use, or designed for use in the planting, propagating, cultivating, growing, or harvesting of any species of plant which is a controlled substance or from which a controlled substance can be derived.
- Kits used, intended for use, or designed for use in manufacturing, compounding, converting, producing, processing, or preparing controlled substances.
- Isomerization devices used, intended for use, or designed for use in increasing the potency of any species of plant which is a controlled substance.
- Testing equipment used, intended for use, or designed for use in identifying, or in analyzing the strength, effectiveness, or purity of, controlled substances.
- Scales and balances used, intended for use, or designed for use in weighing or measuring controlled substances.
- Diluents and adulterants, such as quinine hydrochloride, mannitol, mannite, dextrose, and lactose, used, intended for use, or designed for use in cutting controlled substances.
- Separation gins and sifters used, intended for use, or designed for use in removing twigs and seeds from, or in otherwise cleaning or refining, cannabis.
- Blenders, bowls, containers, spoons, and mixing devices used, intended for use, or designed for use in compounding controlled substances.

- Capsules, balloons, envelopes, and other containers used, intended for use, or designed for use in packaging small quantities of controlled substances.

- Containers and other objects used, intended for use, or designed for use in storing, concealing, or transporting controlled substances.

- Hypodermic syringes, needles, and other objects used, intended for use, or designed for use in parenterally injecting controlled substances into the human body.

- Objects used, intended for use, or designed for use in ingesting, inhaling, or otherwise introducing cannabis, cocaine, hashish, hashish oil, or nitrous oxide into the human body, such as:

    - Metal, wooden, acrylic, glass, stone, plastic, or ceramic pipes, with or without screens, permanent screens, hashish heads, or punctured metal bowls.
    - Water pipes.
    - Carburetion tubes and devices.
    - Smoking and carburetion masks.
    - Roach clips: meaning objects used to hold burning material, such as a cannabis cigarette, that has become too small or too short to be held in the hand.
    - Miniature cocaine spoons, and cocaine vials.
    - Chamber pipes.
    - Carburetor pipes.
    - Electric pipes.
    - Air-driven pipes.
    - Chillums.
    - Bongs.
    - Ice pipes or chillers.
    - A cartridge or canister, which means a small metal device used to contain nitrous oxide.
    - A charger, sometimes referred to as a "cracker," which means a small metal or plastic device that contains an interior pin that may be used to expel nitrous oxide from a cartridge or container.
    - A charging bottle, which means a device that may be used to expel nitrous oxide from a cartridge or canister.
    - A whip-it, which means a device that may be used to expel nitrous oxide.
    - A tank.
    - A balloon.
    - A hose or tube.
    - A 2-liter-type soda bottle.
    - Duct tape.[1]

Section 893.146, F.S., provides that, in determining whether an object is drug paraphernalia, a court or other authority or jury must consider, in addition to all other logically relevant factors, the following factors:

- Statements by an owner or by anyone in control of the object concerning its use.

- The proximity of the object, in time and space, to a direct violation of this act.

- The proximity of the object to controlled substances.

- The existence of any residue of controlled substances on the object.

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[1] This section further provides that drug paraphernalia is contraband and is subject to civil forfeiture.

- Direct or circumstantial evidence of the intent of an owner, or of anyone in control of the object, to deliver it to persons who he or she knows, or should reasonably know, intend to use the object to facilitate a violation of this act. The innocence of an owner, or of anyone in control of the object, as to a direct violation of this act shall not prevent a finding that the object is intended for use, or designed for use, as drug paraphernalia.

- Instructions, oral or written, provided with the object concerning its use.

- Descriptive materials accompanying the object which explain or depict its use.

- Any advertising concerning its use.

- The manner in which the object is displayed for sale.

- Whether the owner, or anyone in control of the object, is a legitimate supplier of like or related items to the community, such as a licensed distributor of or dealer in tobacco products.

- Direct or circumstantial evidence of the ratio of sales of the object or objects to the total sales of the business enterprise.

- The existence and scope of legitimate uses for the object in the community.

- Expert testimony concerning its use.

Section 893.147, F.S., proscribes the possession, use, manufacture, delivery, transportation, and advertisement of drug paraphernalia. It is a first degree misdemeanor to use or possess with intent to use drug paraphernalia:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of ch. 893, F.S.; or

- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of ch. 893, F.S.[2]

It is a third degree felony to deliver, possess with intent to deliver, or manufacture with intent to deliver drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of ch. 893, F.S.; or

- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of ch. 893, F.S. [3]

If the person committing the delivery and manufacturing offense delivered the drug paraphernalia to a minor, the person commits a second degree felony. It is a first degree misdemeanor to sell or otherwise

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[2] "To prove possession of drug paraphernalia, the state must show that the appellant had in his possession drug paraphernalia and that he had knowledge of its presence." *Lawson v. State*, 666 So.2d 193, 194 (Fla. 2d DCA 1995).
[3] "The statute does not require that a person unequivocally know that the paraphernalia will be used for an illicit purpose; rather the state must only show that the defendant knew or reasonably should have known that the drug paraphernalia would be used for such purposes. It is important to note that the intent at issue in the statute is that of the seller/defendant, not that of the buyer." *Baldwin v. State*, 498 So.2d 1385, 1386 (Fla. 5th DCA 1986).

deliver hypodermic syringes, needles, or other such objects to a minor, with some lawful dispensing exceptions.

It is a third degree felony to use, possess with the intent to use, or manufacture with the intent to use drug paraphernalia, knowing or under circumstances in which one reasonably should know that it will be used to transport a controlled substance in violation of ch. 893, F.S., or contraband, as defined in s. 932.701(2)(a)1., F.S.

It is a first degree misdemeanor to place in any newspaper, magazine, handbill, or other publication any advertisement, knowing, or under circumstances where one reasonably should know, that the purpose of the advertisement, in whole or in part, is to promote the sale of objects designed or intended for use as drug paraphernalia.

Proving requisite intent is often difficult because some items sold have multiple and legal uses[4] or contain features that may suggest a use other than an illegal use or support a claim that the item is not being sold for an illegal use.[5]

A "head shop" is a term defining a type of establishment allegedly specializing in selling drug paraphernalia. There has been a longstanding tension between "head shop" owners and law enforcement, prosecutors, and some communities over the sale of such items. Head shop owners argue that they only engage in legitimate business activities and that they only sell such items for legitimate uses, such as for use in smoking tobacco. They contend that possession, sale, and purchase of such items are not per se illegal. They further contend that many of the same items they sell in their shops are also sold in convenience stores and general retail stores and over the Internet.

Law enforcement, prosecutors, and opponents of head shops argue that, despite the claims of head shop owners that they sell such items only for legitimate uses, the owners are really engaged in selling drug paraphernalia to illicit substance users and producers. They contend that some of the items sold by head shop owners have little or no real use to the general public outside of the illicit drug trade. Further, they contend that the prevalence or number of such items within one establishment and as part of the establishment's total inventory indicate that the true motive of head shop owners is to profit from the illicit drug trade under the pretext of engaging in a legitimate business.

Some communities have raised concerns that head shops adversely affect quality of life, increase accessibility to drug paraphernalia, and attract or engage in criminal activity. Communities throughout the nation have taken different approaches to address concerns about head shops, including outright prohibition; moratoriums on new licenses; special business classifications; nuisance abatement; fees and compliance checks on head shops that sell tobacco paraphernalia; limitations on hours of operation, window displays, and signage; lighting or security requirements; zoning; annexation of commercial properties; development standards; separation buffers; public education campaigns; media

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[4] In *Subuh v. State*, 732 So.2d 40, 44 (Fla. 2d DCA 1999), the court noted that a glass pipe sold by the defendant and which police claimed was a crack pipe was "very similar to the 'glass tube' or 'pipette' commonly found in any chemistry laboratory or glass 'straw' formerly used in hospitals for patients to drink liquids, except this one was shorter." In reversing the conviction, the court stated that "[a]lthough we are hard pressed to think of a probable lawful use for this tube when purchased from this location, there are many lawful uses for glass tubing."

[5] For example, store owners arrested in a drug paraphernalia sting claim that they are selling glass tubes with miniature roses as "ornamental novelty items"; the police claim the tubes are "nothing but ready-made crack pipes." Stores accused of selling glass tubes for crack pipes. *St. Petersburg Times* (December 31, 1998). Reporting on a 2004 U.S. Customs seizure of items in a Miami-Dade County warehouse, the South Florida Sun-Sentinel noted that the items included bongs "shaped as guns," "disguised as lipstick tubes," and "decorated with cartoon characters such as Cat in the Hat." One bong, which was "disguised as a thermos, was placed inside a Simpsons lunchbox." Customs agents raid drug warehouse. *South Florida Sun-Sentinel* (May 4, 2004). Similarly, reporting on a 2005 drug paraphernalia sting of head shops in Palm Beach County, the Palm Beach Post quoted one federal official as stating that bong and other drug paraphernalia seized were "disguised as cartoon characters." Alleged drug items seized at 3 shops. *Palm Beach Post* (February 17, 2005).

advisories of enforcement actions; and enforcement actions relating to violations of local ordinances or state laws.

Proposed changes

This bill creates an eight member Drug Paraphernalia Abatement Task Force within the Executive Office of the Governor. The task force is to recommend strategies and actions for abating access to and the use and proliferation of drug paraphernalia, as that term is defined in s. 893.145, F.S.

The task force consists of six members appointed by the Governor:

- A representative of a corporation that is licensed to do business in this state and that sells any of the items described in s. 893.145, F.S.;
- A local law enforcement official or officer;
- A member of a faith-based community;
- A superintendent of a school district or a principal of a secondary school;
- A member of a community organization concerned about issues relating to illicit activities involving controlled substances; and
- A former or recovering drug addict.

These members must be representative of the geographic regions and ethnic and gender diversity of this state.

Other members include the Secretary of Business and Professional Regulation or his or her designee and the director of the Office of Drug Control within the Executive Office of the Governor.

The first meeting of the task force must be held by July 15, 2006, at which time the members must select by majority vote a chairperson from among the task force members. All recommendations of the task force are by majority vote. The task force meets at the call of the chairperson as approved by the Governor and must conduct at least three public meetings in localities throughout this state which have a significant urban business district or have experienced problems with illicit controlled-substance activity resulting, in part, from access to and the use and proliferation of drug paraphernalia.

Meetings of the task force are open to the public and are subject to the requirements of ch. 286, F.S. Records of the task force are public records and subject to the requirements of ch. 119, F.S., except to the extent that public access to any of those records may be restricted pursuant to that chapter.

Members of the task force serve without compensation, but are entitled to reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S. The task force is staffed by the Office of Drug Control within existing appropriations.

The task force is required to study and take testimony regarding:

- The problem of access to and the use and proliferation of drug paraphernalia in this state;
- Businesses that sell items that may be used as drug paraphernalia;
- Current laws and rules and current efforts by regulatory agencies and law enforcement agencies to abate access to, use and proliferation of drug paraphernalia, including, whether new or amended laws and rules are needed; and
- Approaches to abate access to and the use and proliferation of drug paraphernalia.

The task force must submit a preliminary draft report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives at least 45 days before the first day of the 2007 Regular Session of the Legislature and must submit its final report 15 days later. In addition to findings and recommendations, the report must include any proposed legislation or rules necessary to implement recommendations.

The task force is abolished July 1, 2007.

C. SECTION DIRECTORY:

Section 1. Creates the Drug Paraphernalia Abatement Task Force and provides for its membership and responsibilities.

Section 2. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Minimal. Task force members are entitled to per diem.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Members of the task force serve without compensation but are entitled to reimbursement for per diem and travel expenses in accordance with s. 112.061, F.S. The task force is staffed by the Office of Drug Control within existing appropriations.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   Not applicable because this bill does not appear to: require the counties or cities to spend funds or take an action requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

The Criminal Justice Committee adopted one amendment which clarified that the chair of the task force will call meetings of the task force *at the approval of the Governor.*

The analysis reflects the bill as amended.

CHAMBER ACTION

1 The Criminal Justice Committee recommends the following:
2
3 **Council/Committee Substitute**
4 Remove the entire bill and insert:
5 A bill to be entitled
6 An act relating to the abatement of drug paraphernalia;
7 creating the Drug Paraphernalia Abatement Task Force
8 within the Executive Office of the Governor; prescribing
9 task force membership; providing for meetings and duties
10 of the task force; providing that meetings and records of
11 the task force are subject to statutory public meetings
12 and records requirements; providing for members of the
13 task force to be reimbursed for per diem and travel
14 expenses; requiring the Office of Drug Control within the
15 Executive Office of the Governor to provide staff support;
16 requiring reports; requiring cooperation by state
17 agencies; abolishing the task force on a specified date;
18 providing an effective date.
19
20 Be It Enacted by the Legislature of the State of Florida:
21
22 Section 1. Drug Paraphernalia Abatement Task Force.--

23 (1)(a) There is created within the Executive Office of the
24 Governor the Drug Paraphernalia Abatement Task Force for the
25 purpose of recommending strategies and actions for abating
26 access to and the use and proliferation of drug paraphernalia,
27 as that term is defined in s. 893.145, Florida Statutes.
28 (b) The task force shall consist of the following eight
29 members:
30 1. The Secretary of Business and Professional Regulation
31 or his or her designee.
32 2. The director of the Office of Drug Control within the
33 Executive Office of the Governor.
34 3. A representative from a corporation that is licensed to
35 do business in this state and that sells any of the items
36 described in s. 893.145, Florida Statutes, that may be used as
37 drug paraphernalia.
38 4. A local law enforcement official or officer.
39 5. A member of a faith-based community.
40 6. A superintendent of a school district or a principal of
41 a secondary school.
42 7. A member of a community organization concerned about
43 issues relating to illicit activities involving controlled
44 substances, including access to and the use and proliferation of
45 drug paraphernalia.
46 8. A former or recovering drug addict.
47 (c) Members of the task force shall be appointed by the
48 Governor by July 1, 2006, and shall be representative of the
49 geographic regions and ethnic and gender diversity of this
50 state. The first meeting of the task force shall be held by July

51 15, 2006, at which time the members shall select by majority
52 vote a chairperson from among the task force members. All
53 recommendations of the task force shall be by majority vote.
54 (d) The task force shall meet at the call of the
55 chairperson, as approved by the Governor, and shall conduct at
56 least three public meetings, which shall be held in localities
57 throughout this state that have a significant urban business
58 district or have experienced problems with illicit controlled-
59 substance activity resulting, in part, from access to and the
60 use and proliferation of drug paraphernalia.
61 (e) Meetings of the task force shall be open to the public
62 and are subject to the requirements of chapter 286, Florida
63 Statutes. Records of the task force are public records and
64 subject to the requirements of chapter 119, Florida Statutes,
65 except to the extent that public access to any of those records
66 may be restricted pursuant to that chapter.
67 (f) Members of the task force shall serve without
68 compensation but are entitled to reimbursement for per diem and
69 travel expenses in accordance with s. 112.061, Florida Statutes.
70 (g) The Office of Drug Control within the Executive Office
71 of the Governor shall provide staff support for the task force
72 within existing appropriations.
73 (2)(a) The task force shall study and take testimony
74 regarding:
75 1. The nature and extent of the problem of access to and
76 the use and proliferation of drug paraphernalia in this state,
77 including the extent to which the marketing, selling, or

78 purchasing of items that may be used as drug paraphernalia may
79 contribute to that problem.
80 2. Businesses that sell items that may be used as drug
81 paraphernalia, including, but not limited to, consideration of:
82 a. The types, ownership, organization, and operation of
83 those businesses.
84 b. The regulation of those businesses and the state and
85 federal laws applicable to them.
86 c. The marketing or selling of those items by those
87 businesses.
88 d. The inventory and sale of those items relative to the
89 total inventory and total sales of those businesses.
90 e. Measures taken by those businesses to restrict
91 purchases of those items by minors or otherwise restrict
92 purchases of those items.
93 f. The clientele of those businesses.
94 g. The prevalence of civil or criminal enforcement actions
95 taken against those businesses for violations of state or
96 federal rules or laws that are relevant to prohibited activities
97 involving drug paraphernalia.
98 h. The location of those businesses relative to the
99 location of schools; churches or places of worship;
100 neighborhoods; and buildings, facilities, and areas where
101 children may regularly congregate.
102 i. The opinions and concerns of local residents, community
103 and neighborhood activists and leaders, faith-based community
104 members and leaders, school personnel and students, businesses,

105 service providers, local law enforcement officials and officers,
106 and local government officials regarding those businesses.
107 j. Local or community efforts to restrict or regulate
108 those businesses.
109 3. Current rules and laws and current efforts by
110 regulatory agencies and law enforcement agencies to abate access
111 to and the use and proliferation of drug paraphernalia in this
112 state, including, but not limited to, consideration of whether
113 it is necessary to amend those rules or laws or propose new
114 rules or new legislation.
115 4. Approaches to abate access to and the use and
116 proliferation of drug paraphernalia, including, but not limited
117 to:
118 a. Conforming the rules or laws of this state to federal
119 rules or laws that are relevant to abating access to and the use
120 and proliferation of drug paraphernalia.
121 b. Restricting the marketing, selling, or purchasing of
122 any item that may be used as drug paraphernalia and legal
123 concerns relevant to that restriction.
124 c. Adopting provisions of rules or laws of other states
125 that are relevant to abating access to and the use and
126 proliferation of drug paraphernalia.
127 5. Any other subject that is relevant to abating access to
128 and the use and proliferation of drug paraphernalia.
129 (b) The task force shall submit a preliminary draft report
130 of its findings and recommendations to the Governor, the
131 President of the Senate, and the Speaker of the House of
132 Representatives at least 45 days before the first day of the

133 2007 Regular Session of the Legislature. The final report shall
134 be filed with the Governor, the President of the Senate, and the
135 Speaker of the House of Representatives at least 30 days before
136 the first day of the 2007 Regular Session. In addition to the
137 findings and recommendations included in the final report, the
138 report must include a draft of proposed rules and proposed
139 legislation for any recommendations requiring proposed rules and
140 proposed legislation.
141 (c) Each state agency shall fully cooperate with the task
142 force in the performance of its duties.
143 (3)(a) All meetings of the task force and all business of
144 the task force for which reimbursement may be requested shall be
145 concluded before the final report is filed.
146 (b) The task force is abolished July 1, 2007.
147 Section 2. This act shall take effect upon becoming a law.

HB 211

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 211 Area Health Education Center Network
SPONSOR(S): Troutman
TIED BILLS: **IDEN./SIM. BILLS:** SB 374

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care General Committee		Ciccone	Brown-Barrios
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 211 amends section 381.0402, F.S., and revises the Department of Health's duties regarding Area Health Education Center (AHEC) networks in Florida. The bill specifies that the department maintain AHEC networks focused increasing training opportunities, increasing access to primary care services, providing health workforce recruitment, enhancing health care quality and addressing public health issues in medically underserved areas.

The bill amends section 381.0405, F.S., to reflect current practices and removes obsolete language regarding grant programs no longer in existence.

The bill amends section 381.0409, F.S., and establishes requirements for the AHEC network relating to students in the health care professions and health care providers serving medically underserved populations.

The bill provides an effective date of July 1, 2006.

There is no fiscal impact with this bill.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote personal responsibility – The bill provides an opportunity for health professionals to train in medically underserved areas, thereby increasing access to primary care services and enhancing the quality of health care. As a result, individuals and families should have greater incentive to use health care services.

B. EFFECT OF PROPOSED CHANGES:

The bill revises the Department of Health's duties relating to the Area Health Education Centers (AHEC) in Florida to reflect current practices. The bill clarifies existing law regarding the multidisciplinary approach that AHEC networks use to recruit and retain health profession students to improve health care services to medically underserved persons. New language is created in s. 381.0402, F.S., to provide that AHEC programs work to strengthen the health care safety net by enhancing services and that AHECs provide library and other informational services.

Background

Area Health Education Centers link the resources of university health science centers with local planning, educational and clinical resources. An AHEC network of health-related institutions provides multidisciplinary educational services to students, faculty and local practitioners, ultimately improving health care delivery in medically underserved areas.

The AHEC program is a long-term initiative, requiring major changes in the traditional method of training medical and other health profession students and in the relationship between university health science centers and community health service delivery systems. The Basic AHEC Program was initiated in 1972 and the Model State Supported AHEC Program was initiated in 1992.

The Florida AHEC Network is an extensive, statewide system for health professional education and support founded on 10 regional AHECs. Each AHEC is supported by an AHEC Program at one of the state's five medical schools. The organization of the network allows the AHECs to draw on the resources of the academic health centers to address local health care issues. The Florida AHEC Network has addressed the primary health care needs of Florida's underserved populations by:

- Extending academic health resources;
- Providing information and support to community health care providers;
- Emphasizing the primary care needs of medically underserved populations;
- Encouraging health profession education programs to enhance their curricula with community-based clinical experiences, interdisciplinary training, distance education and other programs vital to students' learning; and
- Influencing the future health professional workforce by development programs to general interest in health careers among minority and disadvantaged youth.

Under section 381.0402, F.S., the Department of Health, in cooperation with the state-approved medical schools in Florida must organize an AHEC network based on earlier medically indigent demonstration projects and must evaluate the impact of each network on improving access to services by persons who are medically underserved. The network must be a catalyst for the primary care training of health professionals through increased opportunities to train in medically underserved areas.

An AHEC network must:

- Be coordinated and under contract with a state-approved medical school, which is responsible for clinical training and supervision;
- Divide the state into service areas with each medical school coordinating recruitment, training and retention of medical students within an assigned area;
- Use a multidisciplinary approach with medical supervision;
- Use community resources, such as county health departments, federally funded primary care centers, or other primary health care providers, as community-based sites to train medical students, interns and residents;
- Assist providers in medically underserved areas and other safety net providers to remain current in their fields through a variety of community resource initiatives;
- Strengthen the state's health care safety net by enhancing services and increasing access to care in medically underserved areas; and
- Provide other services, such as library and information resources, continuing professional education, technical assistance, and other support services, for providers who serve in medically underserved areas.

The Department of Health must establish criteria and procedures for quality assurance, performance evaluations, periodic audits, and other network safeguards. The department must make every effort to assure that participating medical schools do not discriminate among enrollees with respect to age, race, sex, or health status. Participating medical schools may target high-risk medically needy population groups.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0402, F.S., to clarify the Department of Health's responsibilities regarding the development and approval of Area Health Education Center (AHEC) networks.

Section 2. Amends s. 381.0405, F.S., regarding the Office of Rural Health grant process.

Section 3. Creates s. 381.0409, F.S., and provides new language regarding coordination with federal health professional recruitment and placement programs.

Section 4. Provides an effective date of July 1, 2006.

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:

   None applicable because this bill does not: require counties or municipalities to spend funds or to take actions requiring the expenditure of funds; reduce the authority that cities or counties have to raise revenues in the aggregate; or reduce the percentage of a state tax shared with cities or counties.

2. Other: None

B. RULE-MAKING AUTHORITY:

The Department of Health has sufficient rulemaking authority to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to the area health education center
3 network; amending s. 381.0402, F.S.; requiring the
4 Department of Health to cooperate with specified medical
5 schools in maintaining and evaluating the network;
6 expanding the purposes of the network; requiring the
7 department to contract with the medical schools to provide
8 funds to the network; providing that the persons to be
9 served by the network are "medically underserved
10 populations" rather than "low-income persons"; requiring
11 that the network link the provision of primary care
12 services to medically underserved populations with the
13 education of medical students, interns, and residents,
14 students in the health care professions, and health care
15 providers serving medically underserved populations;
16 amending s. 381.0405, F.S.; providing that the Office of
17 Rural Health assume responsibility for state coordination
18 of federal rural hospital and rural health care grant
19 programs; deleting obsolete provisions; creating s.
20 381.0409, F.S.; authorizing the department to coordinate
21 with the Federal Government in carrying out certain
22 activities relating to the recruitment and placement of
23 health practitioners in medically underserved areas;
24 providing an effective date.
25
26 Be It Enacted by the Legislature of the State of Florida:
27

28 Section 1. Section 381.0402, Florida Statutes, is amended
29 to read:
30 381.0402 Area health education center network.--The
31 department, in cooperation with ~~the state-approved~~ medical
32 schools located in this state which form the area health
33 education center network ~~in this state~~, shall maintain and
34 evaluate ~~organize~~ an area health education center network
35 focused ~~based on earlier medically indigent demonstration~~
36 ~~projects and shall evaluate the impact of each network~~ on
37 improving access to health services by persons who are medically
38 underserved. The network shall serve as ~~be~~ a catalyst for the
39 primary care training of health professionals by increasing
40 ~~through increased~~ opportunities for training in medically
41 underserved areas, increasing access to primary care services,
42 providing health workforce recruitment, enhancing the quality of
43 health care, and addressing current and emerging public health
44 issues.
45 (1) The department shall contract with the medical schools
46 to assist in funding the ~~an~~ area health education center
47 network, which links the provision of primary care services to
48 medically underserved populations ~~low-income persons~~ with the
49 education of:
50 (a) Medical students, interns, and residents. The network
51 shall:
52 ~~(a) Be coordinated with and under contract with the state-~~
53 ~~approved medical schools, which shall be responsible for the~~
54 ~~clinical training and supervision.~~

55 1. ~~(b)~~ Divide the state into service areas within the
56 network for ~~with each state-approved medical school~~ coordinating
57 the recruitment ~~recruiting~~, training, and retention of medical
58 students within its assigned area.
59 ~~(c) Use a multidisciplinary approach with appropriate~~
60 ~~medical supervision.~~
61 2. ~~(d)~~ Use ~~current~~ community resources, such as county
62 health departments, federally funded community or migrant health
63 ~~primary care~~ centers, and ~~or~~ other primary health care
64 providers, as ~~community-based~~ sites for training medical
65 students, interns, and residents.
66 3. Use a multidisciplinary approach with appropriate
67 medical supervision.
68 (b) Students in the health care professions. The network
69 shall:
70 1. Facilitate the recruitment, training, and retention of
71 students in the health care professions within service areas.
72 2. Use community resources, such as county health
73 departments, federally funded community or migrant health
74 centers, and other primary health care providers, as sites for
75 training students in the health care professions.
76 3. Use a multidisciplinary approach with appropriate
77 medical supervision.
78 (c) Health care providers serving medically underserved
79 populations. The network shall:
80 1. Assist providers in medically underserved areas and
81 other safety net providers in remaining current in their fields
82 through a variety of community resource initiatives.

83 2. Strengthen the health care safety net in this state by
84 enhancing services and increasing access to care in medically
85 underserved areas.
86 3. Provide other services, such as library and information
87 resources, continuing professional education, technical
88 assistance, and other support services, for providers who serve
89 in medically underserved areas.
90 (2) The department shall establish criteria and procedures
91 for quality assurance, performance evaluations, periodic audits,
92 and other appropriate safeguards for the network.
93 (3) The department shall make every effort to assure that
94 the network does ~~participating medical schools do~~ not
95 discriminate among enrollees with respect to age, race, sex, or
96 health status. However, the network ~~such schools~~ may target
97 high-risk medically needy population groups.
98 (4) The department may use no more than 5 percent of the
99 annual appropriation for administering and evaluating the
100 network.
101 Section 2. Paragraph (f) of subsection (4) of section
102 381.0405, Florida Statutes, is amended to read:
103 381.0405 Office of Rural Health.--
104 (4) COORDINATION.--The office shall:
105 (f) Assume responsibility for state coordination of ~~the~~
106 ~~Rural Hospital Transition Grant Program, the Essential Access~~
107 ~~Community Hospital Program, and other~~ federal rural hospital and
108 rural health care grant programs.
109 Section 3. Section 381.0409, Florida Statutes, is created
110 to read:

111 381.0409 Coordination with federal health professional
112 recruitment and placement programs.--The department may
113 coordinate with the Federal Government to designate health
114 professional shortage areas and medically underserved areas, to
115 recommend foreign physicians for visa waivers, to document
116 health professionals working in the public interest, and to
117 place health care professionals in medically underserved areas
118 using federally funded recruitment incentive programs.
119 Section 4. This act shall take effect July 1, 2006.

Emergency Operations Plan
Biological Incident Annex
Influenza Pandemic Appendix

Florida Strategy for Pandemic Influenza

Health Care Committee

December 7, 2005

Promote and protect the health and safety of all people in Florida

Emergency Management System

All Disasters are Local

- **County Emergency Management System**
- **State Emergency Response Team**
  - ✓ **Emergency Support Functions**
- **Federal Emergency Management System**

Chapter 252, F.S.

Emergency Support Functions

- ESF1 – Transportation
- ESF2 – Communications
- ESF3 – Public Works and Engineering
- ESF4 – Fire Fighting
- ESF5 – Information & Planning
- ESF6 – Mass Care
- ESF7 – Resources
- ESF8 – **Health and Medical**
- ESF9 – Search & Rescue

Emergency Support Functions

- ESF10 – Hazmat
- ESF11 – Food & Water
- ESF12 – Energy
- ESF13 – Military Support
- ESF14 – Public Information
- ESF15 – Volunteers & Donations
- ESF16 – Law Enforcement & Security
- ESF17 – Animal Protection & Agriculture

All-Hazards Emergency Management Phases

- **Preparedness** — Pandemic Influenza and Terrorism
- **Response**
- **Recovery** — 2005 Hurricanes
- **Mitigation** — 2004 Hurricanes

Approach to Pan Flu Preparedness

- ESF8 Emerging Event Planning Team
- Develop *Florida Strategy for Pandemic Influenza*
- Engage entire emergency management system
- Prepare gap analysis with HHS & WHO Plans
- Review and update existing all-hazards plans
- Develop communications strategy for phases of disease to all stakeholder groups and the public

All-Hazards Preparedness Process

- Identify hazard, possible scenarios, threats and vulnerabilities
- Articulate planning goals
- Develop planning considerations and contingencies
- Define roles and responsibilities
- Document “how to” for responsibilities
- Train responders to the plan
- Exercise the plan
- Update the plan based on exercise or actual event

Pandemic Influenza Planning Goals

1. **Control the spread of disease**
2. **Care for victims of disease**
3. **Protect state infrastructure and economy**

Roles and Responsibilities

- **Federal Government**
- **State Government**
- **Local Communities**
- **Individual Citizens**

Pandemic Influenza Goal 1: Control Spread of Disease

- **Planning considerations**
- **A likely severe scenario**
- **Disease intervals**
- **Disease control challenges**

Planning Considerations

- Influenza viruses can spread rapidly worldwide;
- The biology of the virus makes control hard;
- The whole country will likely be affected at the same time;
- Enormous demands on all parts of the health care system at the same time;
- Widespread illness would disrupt national and community infrastructure -- transportation, commerce, utility and public safety.

Planning Considerations
Disease Control

1. Currently, avian influenza H5N1 is a disease of birds with occasional spillover into people
2. A worldwide pandemic of influenza could result from this or some other virus
3. Antivirals may be in short supply
4. Vaccine won't be available for at least six months into the epidemic
5. Initial disease control will be difficult, disruptive and expensive
6. Widespread cooperation by all sectors of society, and a little luck, may make them less so

A Likely Severe Scenario

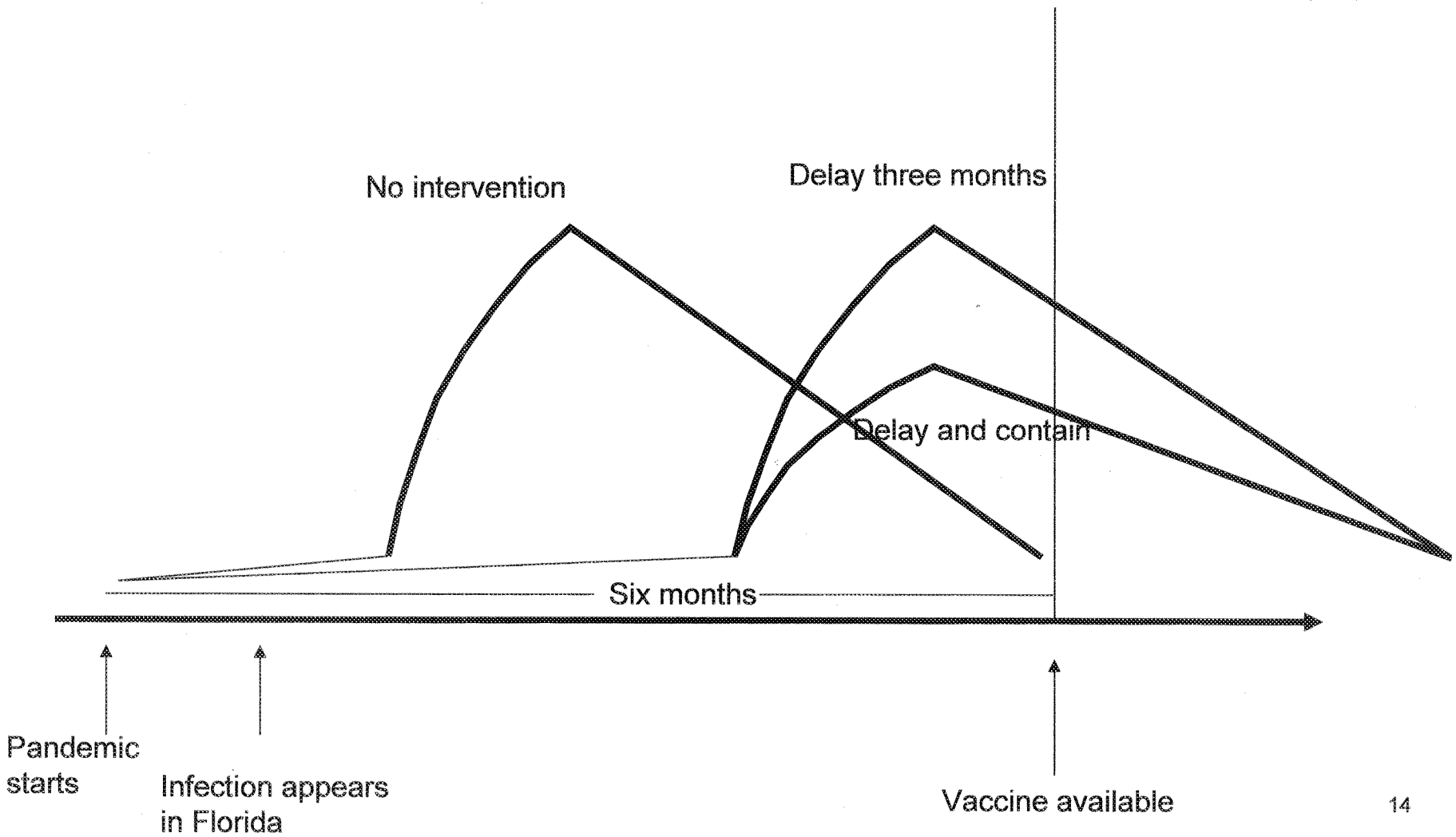
A: Single cases and clusters -- no vaccine

B: Widespread disease -- no vaccine

C: Widespread disease – vaccine

D: Recovery, monitor for next wave

Effect of delaying the onset of the epidemic



A: Single cases and clusters

Duration: A few weeks to months

Goal: Try to stamp out the disease locally:

- ✓ County Health Departments find individual cases and small clusters (airports, ED's, labs), using standard protocols
- ✓ CHDs control spread around each case using following procedures established by ESF8:
  - ◆ targeted Antivirals,
  - ◆ case isolation,
  - ◆ contact tracing and quarantine, and
  - ◆ local 'social distancing'

A. Single cases and clusters

Other Key Activities:

- State ESF8 Planning Section monitors situation daily, Incident Commander moves resources as needed
- Large role for public health laboratory
- Large public communication effort

B: Widespread disease No Vaccine Available

Duration: Likely to last several months in any one locality -- each community mostly on its own

Goal: voluntary compliance with public health recommendations

- ✓ Self-isolation ("Stay home if you are sick")
- ✓ Self-quarantine ("Stay home if you have been exposed")
- ✓ Social distancing measures (close schools, cancel events)
- ✓ Selective use of available antiviral medications
- ✓ Social and community support needed

B: Widespread Disease No Vaccine Available

Key Activities:

- Strong community and interagency partnerships needed everywhere to support disease prevention and patient care

- ESF 8 Planning Section documents impact of disease, assesses control measures and threats, adjusts control strategies

C: Widespread Disease Vaccine Available

- New interval starts when an effective vaccine becomes available in quantity and can start to be delivered to the population
- Two periods, each with its own challenges:
  - ✓ distribution to high-priority groups
  - ✓ vaccine for all

D: Recovery

- Long-term care needs for some
- Assessment and after-action reports
- Watch for new wave of influenza
- Rebuild core health services
- Individual case surveillance and laboratory become important again.

Disease control challenges

- Find 100% of introduced cases
- Keep public support for isolation and quarantine
- Reach near-universal voluntary compliance with public health directives
- Obtain adequate supplies of antiviral medications
- Keep public support for priority groups for antivirals
- Manage very high load for treatment facilities
- Keep public support for priority groups for the first vaccine
- Vaccinate up to 17 million people all at once

Shared responsibility

- Everyone will share in responsibility:
  - ✓ Individual responsibility to avoid infecting others
  - ✓ Organizational responsibility to adopt policies supporting public health actions – in all sectors of society

Pandemic Influenza

"No one in the world today is fully prepared for a pandemic—but we are better prepared today than we were yesterday—and we will be better prepared tomorrow than we are today."

Secretary Michael Leavitt, DHHS
HHS Pandemic Influenza Plan, November 2005.

Resources

- http://www.hhs.gov/pandemicflu/plan/
- http://www.pandemicflu.gov
- http://www.doh.state.fl.us/disease_ctrl/epi/htopics/flu/panflu.htm -- DOH Pandemic Influenza plan
- http://www.doh.state.fl.us/disease_ctrl/epi/htopics/BirdFlu.htm -- DOH information on pandemic influenza
- http://www.who.int/csr/disease/avian_influenza/en/ -- WHO site on avian influenza

Florida's Health Information Infrastructure

The Florida Health Information Network: A Progress Report

Presentation to the House Health Care General Committee

December 7, 2005

Secretary Alan Levine

Agency for Health Care Administration

The Vision:

A comprehensive integrated network of health privacy-protected record systems among the state's health care stakeholders.

- **Capable of providing medical information at the point of care, whenever and wherever that may be;**
- **Computerized "decision support" programs – built-in clinical logic that automatically analyzes all available health information to assist providers in making sound clinical decisions based on current medical science;**
- **State of the art public health functionality to permit real-time outbreak monitoring and disease reporting.**

The Governor's Health Information Infrastructure Advisory Board

- **Appointed by Governor Jeb Bush in June 2004**
- **Mission:**
  - Advise Governor and Agency for Healthcare Administration on the development of the Florida Health Information Network – "FHIN"
  - Identify obstacles to the implementation of FHIN and provide policy recommendations to remove or minimize those obstacles
  - Assist in ensuring the privacy and security of personal health information on the network

Conclusions of GHIIAB after one year on the job . . . .

1. The goals of the GHIIAB and the Florida Health information Network will not be accomplished without strategic partners. Stakeholders in the state are generally supportive of the FHIN, but more providers need to come to the table to learn and communicate.

2. Launch and learn.

3. We should foster pilot projects which are modest in scope and scale to progress deliberately.

   - Start modestly, refine model, scale up and out, and develop FHIN cumulatively.

   - Be a good steward of invested funds ~ prove concepts on modest scale before seeking substantial commitment of resources.

More conclusions . . .

4. Implementation of FHIN can be accelerated by sharing resources and lessons learned among states – don't reinvent the wheel (same thing within the state).

5. We need effective stakeholder information and education efforts to "pull" FHIN through the challenges that it will face; FHIN must be marketed like any other product or new idea.

6. Educating stakeholders on HIPAA and other privacy laws as they relate to operation of a health information network is a must.

7. **State medical records laws across the nation need to be updated and harmonized with each other. Areas where some states laws differ include**

- Mental Health
- HIV/AIDS
- Patient consent requirements
- Medicaid State Plan Administration
- Special program restrictions
- Physician self-referral laws/regulations

. . . and more . . .

8. The challenges we face are not so much technical as "human" challenges.

9. FHIN must be financed through a diversity of funding sources – need to receive federal, state and local governmental support, but also private funds.

Recommended Strategic Framework

- Promote adoption of effective EHR systems among Florida providers
- Develop the Florida Health Information Network
- Organization of the Florida Health Information Network – Governmental at inception, public/private partnership at maturity

Only about 20% of Florida physicians are using EHR's, and not many more hospitals are, so where will the electronic health information come from?

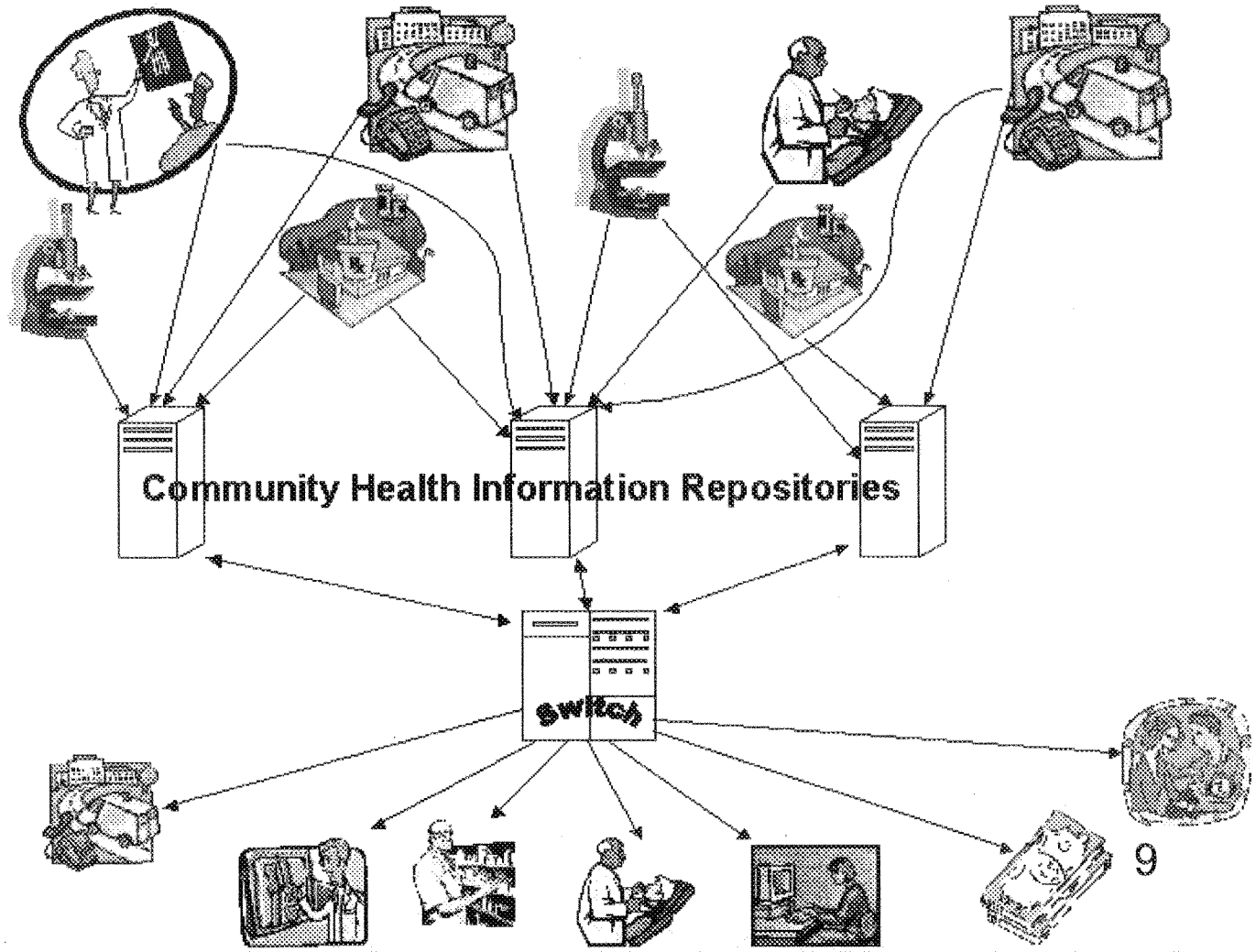
In order to have an interoperable network, health information must be electronically:

Captured >>>

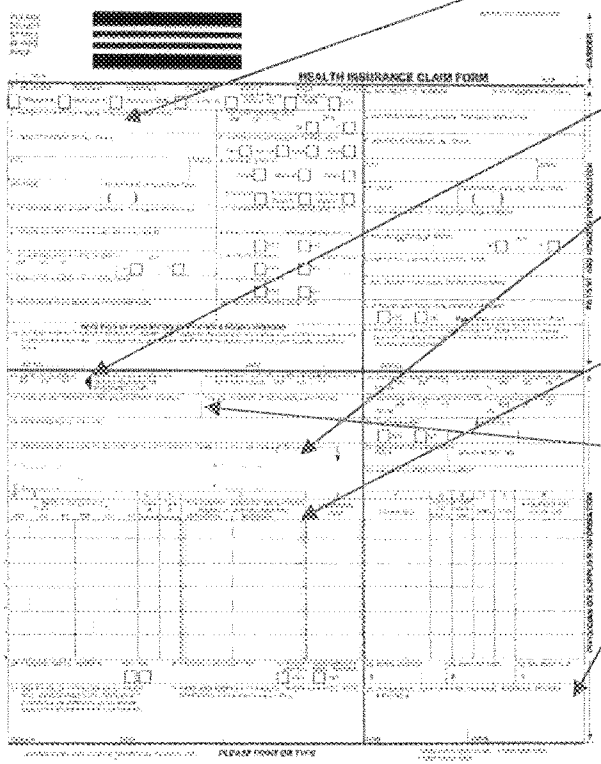
Stored >>>

and . . .

Retrieved >>>



In an environment of low EHR usage, what meaningful electronic health information is available to be shared?



Patient Demographic info

Date of treatment

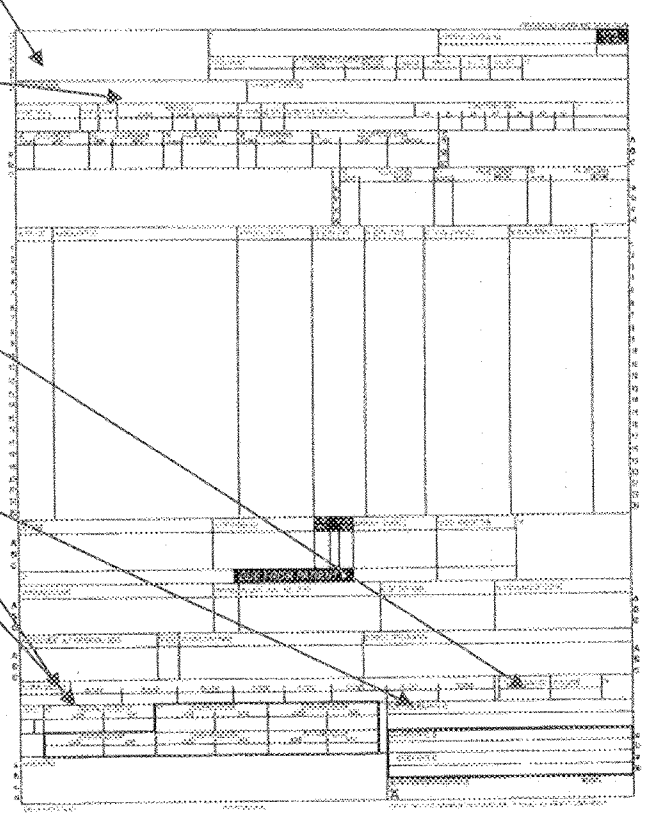
Diagnosis

Procedures

Identities of treating and referring providers and contact information

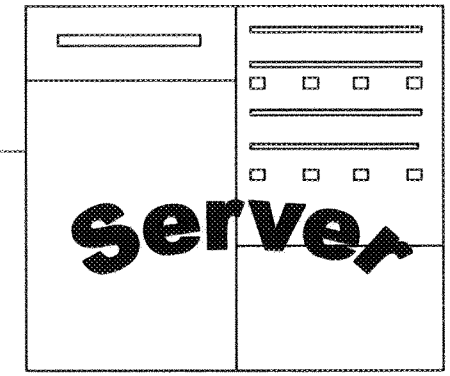
(Medications)

(Lab values)



FHIN Architecture

The Server maintains a Master Patient Index for patient records in Florida.



Web services will enable the transfer of Continuity of Care Records (CCR) for all patients.

Regional Health Information Organizations (RHIO) manage relations with health care providers to provide data.

FHIN

Tampa Bay RHIO

Miami RHIO

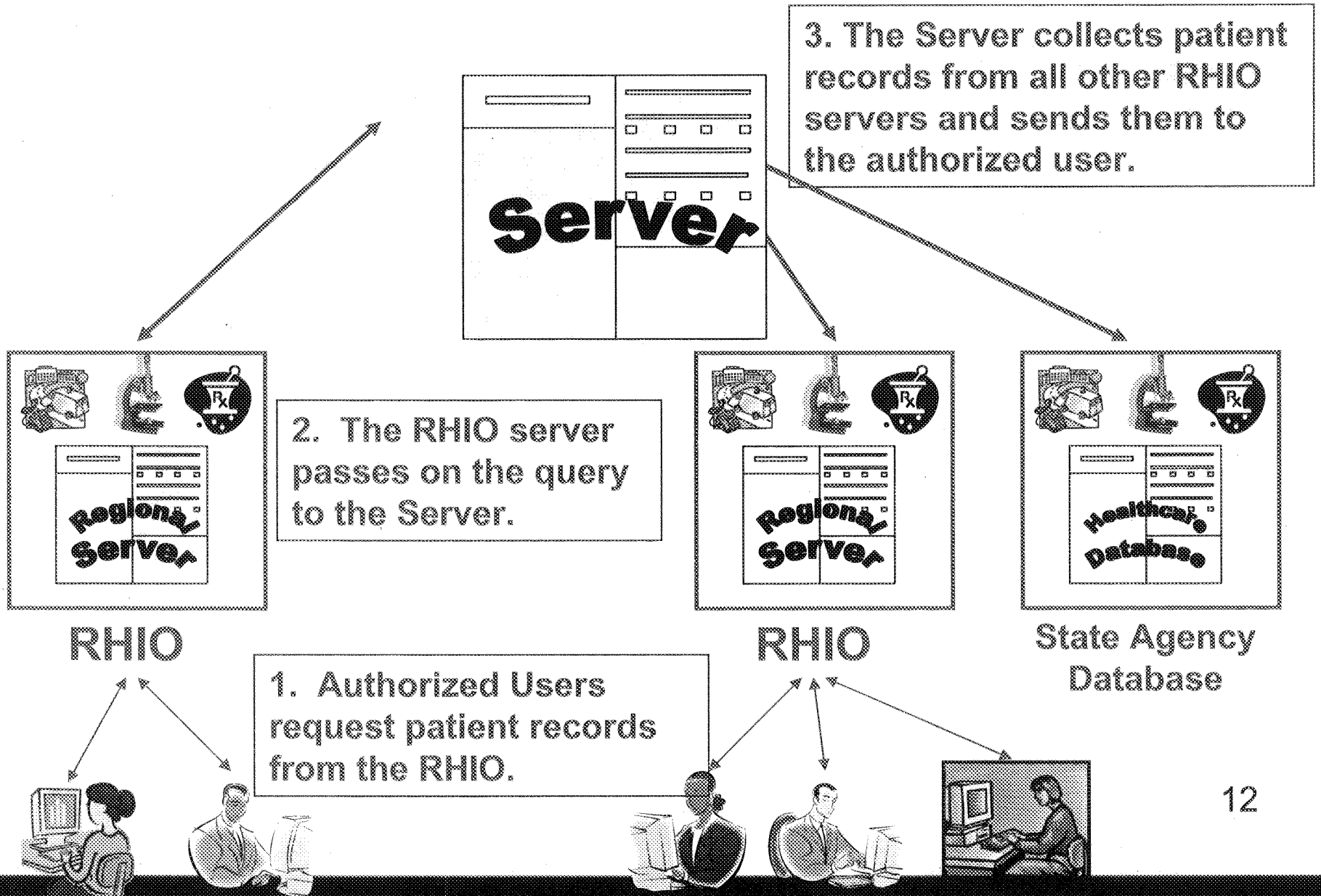
Big Bend RHIO

Pensacola RHIO

AHCA/DOH Databases

FQHC Databases

Potential Workflow



Florida Health Information Network – First Steps

- Incorporate FHIN, Inc.
- Conduct initial investment round
- Obtain tax status as a charity under Section 501(c)(3)
- Recruit organizational staff
- Promote participation in, and support for FHIN among Florida healthcare stakeholders
- Establish governance model – Board, advisors, etc.
- Develop and implement statewide infrastructure
- Nurture pilot projects – funding, management, etc.
- Conduct critical baseline studies and projects – stakeholder attitudes and opinions surveys, state coordinated health informatics initiative framework, etc.
- Execute information and education program