Health Care Regulation Committee

Tuesday, March 28, 2006
10:30 AM - 12:00 PM
212 Knott Building

Allan G. Bense
Speaker

Rene Garcia
Chair

House of Representatives

Committee on Health Care Regulation

AGENDA

March 28, 2006
10:30 AM - 12:00 PM
212 Knott Building

I. Opening Remarks by Chair Garcia

II. Consideration of the following bills:

HB 485 – Specialty Nursing by Rep. Farkas

HB 569 – Athletic Trainers by Rep. Kreegel

HB 575 – Practice of Podiatric Medicine by Rep. Garcia

HB 819 – Radiologist Assistants by Rep. Grant

HB 1111 – Financial Responsibility of Advanced Registered Nurse Practitioners by Rep. Proctor

HB 1177 – Patient Handling and Moving Practices by Rep. Roberson

HB 1213 – Exceptional Student Evaluation by Rep. Barreiro

HB 1265 – Small Business Health Care Insurance Assistance by Rep. Hukill

HB 1319 – Certification of Swimming Instructors by Rep. Goldstein

III. Consideration of the following proposed committee bills:

PCB HCR 06-06 – Rural Health Care

PCB HCR 06-07 – Obesity

IV. Closing Remarks

V. Adjournment

HB 485

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 485 Specialty Nursing
SPONSOR(S): Farkas
TIED BILLS: **IDEN./SIM. BILLS:** SB 602

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Health & Families Council			
3)			
4)			
5)			

SUMMARY ANALYSIS

HB 485 provides a definition of "clinical nurse specialist" to mean nurses with advanced degrees and expertise in specialized areas of nursing care. It provides for state certification and title protection for Clinical Nurse Specialists (CNS) who are already nationally certified. The bill provides title protection for Certified Registered Nurse Anesthetists (CRNA) and Certified Nurse Midwives (CNM). The provisions in the bill establish that a person can not present themselves as being a clinical specialist, anesthetist, or midwife unless they have the required training and certification to do so. The Department of Health estimates that 2,065 nurses will apply for CNS certification, based on data from comparable states and the National Council of State Boards of Nursing. Currently the only specialized nursing certification that is licensed in Florida is the advanced registered nurse practitioner.

The bill provides for the registration of advanced registered nurse practitioners (ARNPs) to prescribe medicinal drugs and controlled substances. Currently, ARNPs are authorized to prescribe prescription medications, except controlled substances, under the standards of a protocol agreement with a physician. The bill stipulates that the protocol identify the categories of drugs an ARNP may prescribe under the general supervision of a physician. The protocol must be submitted to the Board of Nursing and include a quality assurance procedure. The supervising physician must be available at all times by phone or other electronic means. It provides for continuing education, fees for registration and provides ARNPs the ability to receive a valid mid-level federal Drug Enforcement Administration number. It redefines the term "practitioner" under the "Florida Comprehensive Drug Abuse Prevention and Control Act" to include ARNPs who hold federal controlled substance registry numbers and are registered with the state to prescribe controlled substances.

Fiscal Impact: According to the Department of Health, the revenue from registration of ARNP's to prescribe medicinal and controlled substances for the first year will be approximately $1,009,125. According to DOH, the long-term fiscal impact will be negative unless renewal fees are increased from the $25 for the certification of clinical nurse specialists established in the bill.

The bill takes effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government-The bill enables ARNPs to prescribe controlled and medicinal drugs, which will allow ARNPs to practice within the scope of their profession to provide greater access to health care. The bill will impact the Department of Health's responsibilities of administration and monitoring of protocol agreements.

Promote personal responsibility-The bill requires only nurses who are certified as clinical specialists by a nationally recognized body to be able to hold themselves out as a certified specialist. The bill provides fees such that the beneficiaries of the legislation will pay a large portion of the cost for implementation.

Empower families-The bill may enable advanced registered nurse practitioners (ARNPs) to provide more services to individuals in underserved and under funded clinics.

B. EFFECT OF PROPOSED CHANGES:

Title Protection for Clinical Nurse Specialists, Registered Nurse Anesthetists, and Certified Nurse Midwives

The bill provides a definition of "clinical nurse specialist" to mean nurses with advanced degrees and expertise in specialized areas of nursing care. It provides for state certification and title protection for Clinical Nurse Specialists (CNS) who are already certified nationally. The bill provides title protection for Certified Registered Nurse Anesthetists (CRNA) and Certified Nurse Midwives (CNM). The Department of Health estimates that 2,065 nurses would apply for CNS certification, based on data from comparable states and the National Council of State Boards of Nursing.

The provisions in the bill will establish that a person can not present themselves as being a clinical specialist, anesthetist, or midwife unless they have the required training and certification to do so. Currently the only specialized nursing licensure certification is the ARNP. CNSs are licensed in 23 states, but not in Florida. A CNS is prepared at master's level by several nursing programs in Florida, but since there is no title protection, any nurse can use the CNS title.

Prescribing Authority for Medicinal Drugs and Controlled Substances by Advanced Registered Nurse Practitioners

The bill also provides for registration of Advanced Registered Nurse Practitioners (ARNPs) to prescribe medicinal drugs and to prescribe controlled substances. The provisions for ARNPs will assist their patients in receiving their medication. As the number and use of advanced registered nurse practitioners has increased in primary care, patients are not able to receive prescriptions for all of their drugs from one practitioner, requiring some patients to have second appointments, delays in treatment, and increased expense for consultations. The bill establishes requirements for protocols with the supervising physician, continuing education, and fees for registration. Additional requirements for prescribing controlled substances include possession of a valid mid-level federal Drug Enforcement Administration registration and continuing education. The bill provides for disciplinary sanctions and criminal penalties. It redefines the term "practitioner" under the "Florida Comprehensive Drug Abuse Prevention and Control Act" to include ARNPs who hold federal controlled substance registry numbers and are registered with the state to prescribe controlled substances. According to the Department of Health, the number of ARNPs in Florida is 11,471. The department estimates that 80% will apply for the medicinal drug registration and of those 50% will apply for the controlled substance registration.

The bill requires an ARNP who prescribes medicinal drugs to: register with the Board of Nursing; complete at least 16 hours of continuing education in pharmacology biennially; and submit a copy of

the protocol between the ARNP and the supervising physician prior to their license renewal. The bill requires general supervision by the physician, and requires the nurse to maintain medical records for each prescription. The Board of Nursing is required to review new applications and documents related to continuing education and protocols, and establish a registration process for prescribing medicinal drugs. The bill provides for the board to adopt rules.

Currently, ARNPs may prescribe drugs, but not controlled substances, upon licensure and establishment of a protocol with a physician. ARNPs are not included on the list of practitioners able to prescribe controlled substances under the Florida Comprehensive Drug Abuse Prevention and Control Act. As a result, ARNPs are not authorized by state statute to be able to obtain a federal Drug Enforcement Administration (DEA) number required by pharmacies to fill their patients' prescriptions. Some insurance companies require pharmacies, when submitting claims for prescriptions, to include a DEA number as an identifier for each prescription submitted, regardless of whether or not it is for a controlled substance.

BACKGROUND

Three General Types of Professional Regulation: Licensure, Certification, and Registration

The bill provides for the certification of clinical nurse specialists. There are three primary forms of regulation used to grant individuals the right or privilege to perform certain activities. They are licensure, certification, and registration. Although these terms are often used interchangeably, the literature on professional regulation makes the following distinctions:

- Licensure is the most restrictive mechanism and entails the creation of a monopoly on the regulated activity of a profession through enactment of profession-specific Practice Acts. Licensed practitioners gain an exclusive right to deliver services, and the profession enjoys protection of its title.

- Certification is less restrictive than licensure. It is achieved through the use of title protection acts that give a designated "recognition" to individuals who meet qualifications set by a regulatory agency. Non-certified individuals may still offer services, but they are prohibited from using the term "certified" or the designated title. Certification is also used in the context of licensure, as in the American Medical Association's scheme of specialty boards which certify physicians specializing in different practice areas. In this context, certification denotes that a licensed practitioner has met certain professional standards.

- Registration is the least restrictive regulatory mechanism and is achieved through registration requirement acts. Registration requires an individual to file his or her name and address with a designated agency. Unlike licensure, registration does not require complex or onerous pre-entry screening requirements, nor is a registration regime exclusionary. It does little more than provide a roster of practitioners.

Specialized Nursing Certification and Advanced Registered Nurse Practitioners

Currently the only specialized nursing licensure certification in Florida is the Advanced Registered Nurse. Section 464.012, F.S., provides for certification of Advanced Registered Nurse Practitioners that have met one or more of the following requirements:

- Completed a post basic education program that prepares nurses for advanced or specialized practice;
- Are certified by a specialty board, such as a registered nurse anesthetist or nurse midwife; or
- Have graduated with a master degree in a nursing clinical specialty area.

Who are Clinical Nurse Specialists?

Clinical Nurse Specialists (CNSs) are licensed registered nurses who have graduate preparation (Master's or Doctorate) in nursing as a Clinical Nurse Specialist. According to the National Association of Clinical Nurse Specialists, they are trained to be expert clinicians in a specialized area of nursing

practice. They can provide direct care, expert consultation to nursing staffs, and implement improvements in health care delivery systems. Their specialty may be identified in terms of:

- A Population (e.g. pediatrics, geriatrics, women's health);
- A Setting (e.g. critical care, emergency room);
- A Disease or Medical Subspecialty (e.g. diabetes, oncology);
- A Type of Care (e.g. psychiatric, rehabilitation); or
- A Type of Problem (e.g. pain, wounds, stress).

Authorization of Advanced Registered Nurse Practitioners to Prescribe Medications
Advanced Registered Nurse Practitioners are authorized to prescribe prescription medications, excluding controlled substances, under standards of a protocol agreement with a physician, as provided by s. 464.003(3)(c), F.S., and Rule 64B9-4.010, Florida Administrative Code.

All medications that the supervising physician has agreed for the ARNP to prescribe must be listed in the protocol. The writing of the protocols and approval of the collaborative practice physician gives the ARNP prescriptive privileges. Nurse practitioners have their own prescription pads.

A nurse practitioner can not write prescriptions for controlled substances. Federal law requires that anyone prescribing controlled substances have a DEA license number. All prescriptions for controlled substances must be written and signed by a licensed physician.

A Drug Enforcement Administration (DEA) Number is Required to Prescribe Controlled Substances
Federal regulation, Title 21, section 1306.5, CFR requires prescriptions for controlled substances to indicate the federal registration number, which is the Drug Enforcement Administration (DEA) number that is issued to physicians, veterinarians, dentists, and podiatrists authorized to prescribe controlled substances.

The federal Controlled Substances Act (CSA), Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 regulates the manufacture and distribution of narcotics, stimulants, depressants, hallucinogens, anabolic steroids, and chemicals used in the illegal production of controlled substances. It places all substances regulated under existing federal law, in one of five schedules based on the substance's medicinal value, harmfulness, and potential for abuse or addiction. Schedule I is reserved for the most dangerous drugs that have no recognized medical use, while Schedule V is the classification used for the least dangerous drugs.

Through the registration of all those authorized by the DEA to handle controlled substances the Controlled Substances Act creates a closed distribution system for controlled substances. All individuals and firms that are registered are required to maintain complete and accurate inventories and records of all transactions involving controlled substances, as well as security for the storage of controlled substances.

Chapter 893, F.S., sets forth the *Florida Comprehensive Drug Abuse Prevention and Control Act*. It classifies controlled substances into five schedules based on federal law in order to regulate the manufacture, distribution, preparation, and dispensing of the substances.

- Substances in Schedule I have a high potential for abuse and have no currently accepted medical use in the United States.
- Schedule II drugs have a high potential for abuse and a severely restricted medical use. Cocaine and morphine are examples of Schedule II drugs.
- Schedule III controlled substances have less potential for abuse than Schedule I or Schedule II substances and have some accepted medical use. Substances listed in Schedule III include anabolic steroids, codeine, and derivatives of barbituric acid.

- Schedule IV and Schedule V substances have a low potential for abuse, compared to substances in Schedules I, II, and III, and currently have accepted medical use. Substances in Schedule IV include phenobarbital, librium, and valium. Substances in Schedule V include certain stimulants and narcotic compounds.

Section 893.04 (1)(c)2., F.S., prohibits pharmacists from filling prescriptions for controlled substances without a DEA number indicated on the prescription.

Advanced Registered Nurse Practitioners and DEA Numbers in Florida and Other States
Because ARNPs cannot prescribe controlled substances by statute or rule, they cannot obtain a DEA number. Nurse Practitioners in Florida cannot receive a DEA number because there is no statutory authority for these practitioners to prescribe controlled substances.

The Drug Enforcement Agency does issue Mid-Level Practitioner DEA numbers to ARNPs in 44 states and the District of Columbia where these practitioners are authorized to prescribe controlled substances.

Supervising Physicians DEA Numbers are used by Pharmacist for Prescriptions Written by Advanced Registered Nurse Practitioners
It has become common procedure for pharmacies to use the federal DEA number as a unique identifier for billing reimbursement from insurance companies and managed care companies.

Because ARNPs can not obtain DEA numbers, Florida pharmacists use the DEA number of the physician who supervises the ARNP to bill insurers and managed care companies for prescriptions written by ARNPs.

By using the DEA number to bill insurers the pharmacist labels the prescription with the name of the physician rather than the name of the ARNP who actually wrote the prescription. This practice is a violation of the rules of the Florida Board of Pharmacy that requires that the name of the actual prescribing practitioner be on each prescription label.

C. SECTION DIRECTORY:

Section 1. Amends s. 464.003, F.S., to define the scope of practice of a clinical nurse specialist and amends the definition of advanced registered nurse practitioner.
Section 2. Creates s. 464.0115, F.S., to establish certification criteria for clinical nurse specialists, fees for application and renewal, and rulemaking authority.
Section 3. Amends s. 464.012, F.S., to include clinical nurse specialists within the specializations of advanced registered nurse practitioners.
Section 4. Creates s. 464.0125, F.S., to establish registration requirements for an advanced registered nurse practitioner who prescribes medicinal drugs and who prescribe controlled substances.
Section 5. Amends s. 464.015, F.S., to provide title protection for "Clinical Nurse Specialist" and the abbreviation "C.N.S."; "Certified Registered Nurse Anesthetist" and the abbreviation "C.R.N.A."; and "Certified Nurse Midwife" and the abbreviation "C.N.M."
Section 6. Amends s. 464.016, F.S., to prohibit a clinical nurse specialist, certified registered nurse anesthetist, or certified nurse midwife to practice without an active license or certification and the use of the title unless the person is duly licensed or certified.
Section 7. Amends s. 893.02, F.S., to include advanced registered nurse practitioners in the list of practitioners authorized to prescribe controlled substances.
Section 8. Reenacts s. 921.0022, F.S., to incorporate changes in s. 464.016, F.S., by reference.
Section 9. Amends s. 458.348, F.S., to correct a cross-reference.
Section 10. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:
According to the Department of Health, 2,065 nurses are expected to apply for Clinical Nurse Specialist certification. This is based on data from comparable states and the National Council of State Boards of Nursing. The number of advanced registered nurse practitioners (ARNPs) in Florida is 11,471. It is expected that 80% will apply for the medicinal drug registration and of those 50% will apply for the controlled substances registration.

1. Revenues:

According to the Department of Health, due to the renewal cycle, it is estimated 6,100 will renew their registration in year 1 and 3,100 will renew in year 2 at $25 each.

Estimated Revenue	1st Year	2nd Year	3rd Year	4th Year
CNS Certification	$51,625	$5,000	$5,000	$5,000
CNS Renewal	$0	$0	$7,000	$13,650
Registration-Medicinal Drugs	$690,000	$15,000	$15,000	$15,000
Registration-Controlled Substance	$115,000	$5,000	$5,000	$5,000
Renewal-Registration	$152,500	$77,500	$152,000	$77,000
Total Estimated Revenues	**$1,009,125**	**$102,500**	**$184,500**	**$116,150**

2. Expenditures:

According to the Department of Health, the Division of MQA would require 1 additional FTE for the Clinical Nurse Specialist portion of this bill and 3 additional FTEs for the prescribing portion.

Estimated Expenditures	1st Year	2nd Year	3rd Year	4th Year
Salaries				
1- Nurse Consultant, PG 077 (CNS)	$40,829	$54,439	$54,439	$54,439
1Nurse Consultants, PG 077(registration)	$40,829	$54,439	$54,439	$54,439
1-RSII, PG 17 (registration)	$28,912	$38,550	$38,550	$38,550
1-RSI, PG 15 (registration)	$26,379	$35,172	$35,172	$35,172
Expense				
Non-recurring expense for 1 FTE (CNS)	$3,343			
Non-recurring expense for 2FTEs (registration)	$6,686			
Non-recurring expense for 1 FTE (registration)	$2,791			
Recurring expense for 1 Nurse Consultant w/ limited travel (CNS)	$10,390	$10,390	$10,390	$10,390
Recurring expense for 1 Nurse Consultants with limited travel (registration)	$10,390	$10,390	$10,390	$10,390
Recurring expense for 1 RSII (reg)	$6,403	$6,403	$6,403	$6,403
Recurring expense for 1 RSI (reg)	$5,195	$5,195	$5,195	$5,195

Operating Capital Outlay				
Standard OCO pkg for 1 FTE (CNS)	$1,900			
Standard OCO pkg for 2FTEs (registration)	$3,800			
Standard OCO pkg for 1 FTE (registration)	$2,100			
Human Resource Services				
1 FTE for CNS	$393	$393	$393	$393
3 FTEs for registration	$1,179	$1,179	$1.,179	$1,179
Total Estimated Expenditures	**$191,519**	**$216,550**	**$216,550**	**$216,550**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A broader prescribing authority may enable advanced registered nurse practitioners (ARNPs) to provide more services to individuals in underserved and under funded clinics.

Employers will have to revise job descriptions for Clinical Nurse Specialists to conform to the new certification requirements. Employees that are currently using the title of CNS may need additional education and/or certification to meet requirements or may not qualify to use the title at all.

D. FISCAL COMMENTS:

According to the Department of Health, the bill establishes a new licensing profession (CNS) and two new registrations for existing profession (ARNP). The CNS licensing profession is projected to operate in a deficit unless the application and renewal fee caps are raised above the $25 established in the bill. The first two year expenditures are projected at $122,077 with revenues for these two years to be $56,625.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides adequate rule-making authority to the Department of Health to implement the provisions of the bill. However, the Department of Health has stated that the effective date of the bill

does not allow sufficient time to the Board of Nursing to engage in rule-making to promulgate rules and develop procedures necessary to implement the provisions provided for in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The Board of Nursing reports that as the number of ARNPs has increased in primary care, patients are sometimes required to have second appointments, delays in treatment, and increased expenses for consultations because of the limitations on ARNP prescription writing.

Amendments have been proposed to test the expanding prescribing authority in a pilot project.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to specialty nursing; amending s. 464.003,
3 F.S.; defining the terms "clinical nurse specialist
4 practice" and "clinical nurse specialist"; creating s.
5 464.0115, F.S.; providing requirements for certification
6 as a clinical nurse specialist; providing fees;
7 authorizing the Board of Nursing to adopt rules; amending
8 s. 464.012, F.S.; adding clinical nurse specialist to the
9 classifications of advanced registered nurse
10 practitioners; creating s. 464.0125, F.S.; requiring
11 advanced registered nurse practitioners to register with
12 the Board of Nursing to prescribe medicinal drugs,
13 including controlled substances; providing requirements
14 for registration and renewal of registration, including
15 continuing education; providing fees; prohibiting
16 prescription of controlled substances for personal use or
17 the use of immediate family members; providing for
18 disciplinary actions; authorizing the board to adopt
19 rules; amending s. 464.015, F.S.; restricting the use of
20 professional titles and abbreviations relating to clinical
21 nurse specialist, certified registered nurse anesthetist,
22 and certified nurse midwife practice; providing penalties;
23 amending s. 464.016, F.S.; prohibiting the use of any name
24 or title stating or implying that a person is a clinical
25 nurse specialist, certified registered nurse anesthetist,
26 or certified nurse midwife unless the person is licensed
27 or certified; providing penalties; amending s. 893.02,
28 F.S.; redefining the term "practitioner" under the Florida

29 Comprehensive Drug Abuse Prevention and Control Act to
30 include certain advanced registered nurse practitioners;
31 reenacting s. 921.0022(3)(g), F.S., relating to the
32 offense severity ranking chart of the Criminal Punishment
33 Code, to incorporate the amendment to s. 464.016, F.S., in
34 a reference thereto; amending s. 458.348, F.S.; conforming
35 cross-references; providing an effective date.
36
37 Be It Enacted by the Legislature of the State of Florida:
38
39 Section 1. Section 464.003, Florida Statutes, is amended
40 to read:
41 464.003 Definitions.--As used in this part, the term:
42 (1) "Department" means the Department of Health.
43 (2) "Board" means the Board of Nursing.
44 (3)(a) "Practice of professional nursing" means the
45 performance of those acts requiring substantial specialized
46 knowledge, judgment, and nursing skill based upon applied
47 principles of psychological, biological, physical, and social
48 sciences which shall include, but not be limited to:
49 1. The observation, assessment, nursing diagnosis,
50 planning, intervention, and evaluation of care; health teaching
51 and counseling of the ill, injured, or infirm; and the promotion
52 of wellness, maintenance of health, and prevention of illness of
53 others.
54 2. The administration of medications and treatments as
55 prescribed or authorized by a duly licensed practitioner
56 authorized by the laws of this state to prescribe such

57 medications and treatments.
58 3. The supervision and teaching of other personnel in the
59 theory and performance of any of the above acts.
60 (b) "Practice of practical nursing" means the performance
61 of selected acts, including the administration of treatments and
62 medications, in the care of the ill, injured, or infirm and the
63 promotion of wellness, maintenance of health, and prevention of
64 illness of others under the direction of a registered nurse, a
65 licensed physician, a licensed osteopathic physician, a licensed
66 podiatric physician, or a licensed dentist.
67
68 The professional nurse and the practical nurse shall be
69 responsible and accountable for making decisions that are based
70 upon the individual's educational preparation and experience in
71 nursing.
72 (c) "Clinical nurse specialist practice" means the
73 delivery and management of expert-level nursing care to
74 individuals or groups, including the ability to:
75 1. Assess the health status of individuals and families
76 using methods appropriate to the population and area of
77 practice.
78 2. Diagnose human responses to actual or potential health
79 problems.
80 3. Plan for health promotion, disease prevention, and
81 therapeutic intervention in collaboration with the patient or
82 client.
83 4. Implement therapeutic interventions based on the nurse
84 specialist's area of expertise, including, but not limited to,

85 direct nursing care, counseling, teaching, and collaboration
86 with other licensed health care providers.
87 5. Coordinate health care as necessary and appropriate and
88 evaluate with the patient or client the effectiveness of care.
89 (d) ~~(c)~~ "Advanced or specialized nursing practice" means,
90 in addition to the practice of professional nursing, the
91 performance of advanced-level nursing acts approved by the board
92 which, by virtue of postbasic specialized education, training,
93 and experience, are proper to be performed by an advanced
94 registered nurse practitioner. Within the context of advanced or
95 specialized nursing practice, the advanced registered nurse
96 practitioner may perform acts of nursing diagnosis and nursing
97 treatment of alterations of the health status. The advanced
98 registered nurse practitioner may also perform acts of medical
99 diagnosis and treatment, prescription, and operation which are
100 identified and approved by a joint committee composed of three
101 members appointed by the Board of Nursing, two of whom shall be
102 advanced registered nurse practitioners; three members appointed
103 by the Board of Medicine, two of whom shall have had work
104 experience with advanced registered nurse practitioners; and the
105 secretary of the department or the secretary's designee. Each
106 committee member appointed by a board shall be appointed to a
107 term of 4 years unless a shorter term is required to establish
108 or maintain staggered terms. The Board of Nursing shall adopt
109 rules authorizing the performance of any such acts approved by
110 the joint committee. Unless otherwise specified by the joint
111 committee, such acts shall be performed under the general
112 supervision of a practitioner licensed under chapter 458,

113 chapter 459, or chapter 466 within the framework of standing
114 protocols which identify the medical acts to be performed and
115 the conditions for their performance. The department may, by
116 rule, require that a copy of the protocol be filed with the
117 department along with the notice required by s. 458.348.
118 (e) ~~(d)~~ "Nursing diagnosis" means the observation and
119 evaluation of physical or mental conditions, behaviors, signs
120 and symptoms of illness, and reactions to treatment and the
121 determination as to whether such conditions, signs, symptoms,
122 and reactions represent a deviation from normal.
123 (f) ~~(e)~~ "Nursing treatment" means the establishment and
124 implementation of a nursing regimen for the care and comfort of
125 individuals, the prevention of illness, and the education,
126 restoration, and maintenance of health.
127 (4) "Registered nurse" means any person licensed in this
128 state to practice professional nursing.
129 (5) "Licensed practical nurse" means any person licensed
130 in this state to practice practical nursing.
131 (6) "Clinical nurse specialist" means any person licensed
132 in this state to practice professional nursing and certified in
133 clinical nurse specialist practice.
134 (7) ~~(6)~~ "Advanced registered nurse practitioner" means any
135 person licensed in this state to practice professional nursing
136 and certified in advanced or specialized nursing practice,
137 including certified registered nurse anesthetists, certified
138 nurse midwives, nurse practitioners, and clinical nurse
139 specialists.
140 (8) ~~(7)~~ "Approved program" means a nursing program

141 conducted in a school, college, or university which is approved
142 by the board pursuant to s. 464.019 for the education of nurses.
143 Section 2. Section 464.0115, Florida Statutes, is created
144 to read:
145 464.0115 Certification of clinical nurse specialists.--
146 (1) Any nurse desiring to be certified as a clinical nurse
147 specialist shall apply to the department and submit proof that
148 he or she holds a current license to practice professional
149 nursing, a master's degree in a clinical nursing specialty, and
150 current certification in a specialty area as a clinical nurse
151 specialist from a nationally recognized certifying body as
152 determined by the board.
153 (2) The board shall certify, and the department shall
154 issue a certificate to, any nurse fulfilling the qualifications
155 in this section. The board shall establish an application fee
156 not to exceed $25 and a biennial renewal fee not to exceed $10.
157 (3) The board may adopt rules pursuant to ss. 120.536(1)
158 and 120.54 necessary to administer this section.
159 Section 3. Subsections (2) and (3) of section 464.012,
160 Florida Statutes, are amended to read:
161 464.012 Certification of advanced registered nurse
162 practitioners; fees.--
163 (2) The board shall provide by rule the appropriate
164 requirements for advanced registered nurse practitioners in the
165 categories of certified registered nurse anesthetist, certified
166 nurse midwife, ~~and~~ nurse practitioner, and clinical nurse
167 specialist.
168 (3) An advanced registered nurse practitioner shall

169 perform those functions authorized in this section within the
170 framework of an established protocol. A practitioner currently
171 licensed under chapter 458, chapter 459, or chapter 466 shall
172 maintain supervision for directing the specific course of
173 medical treatment. Within the established framework, an
174 advanced registered nurse practitioner may:
175 (a) Monitor and alter drug therapies.
176 (b) Initiate appropriate therapies for certain conditions.
177 (c) Perform additional functions as may be determined by
178 rule in accordance with s. 464.003(3)(d) ~~s. 464.003(3)(c)~~.
179 (d) Order diagnostic tests and physical and occupational
180 therapy.
181 Section 4. Section 464.0125, Florida Statutes, is created
182 to read:
183 464.0125 Registration of advanced registered nurse
184 practitioners to prescribe medicinal drugs.--
185 (1) Any advanced registered nurse practitioner certified
186 pursuant to s. 464.012 must register with the board in
187 accordance with this section to prescribe medicinal drugs.
188 (2) To register to prescribe medicinal drugs, an advanced
189 registered nurse practitioner must:
190 (a) Possess an active and unrestricted license and be
191 certified as an advanced registered nurse practitioner.
192 (b)1. Possess an active and current certification by an
193 appropriate specialty board; or
194 2. Submit documentation to the board demonstrating that
195 the advanced registered nurse practitioner has been prescribing
196 medicinal drugs for a period of at least 12 months before

197 registering as a prescribing practitioner.
198 (c)1. Submit documentation to the board demonstrating that
199 the advanced registered nurse practitioner has completed at
200 least 16 contact hours of approved continuing education in
201 pharmacology during the past 2 years, in addition to the
202 continuing education required for licensure renewal; or
203 2. Submit documentation to the board demonstrating that
204 the advanced registered nurse practitioner has been prescribing
205 medicinal drugs for a period of at least 12 months before
206 registering as a prescribing practitioner.
207 (d) Submit a copy of the protocol between the advanced
208 registered nurse practitioner and supervising physician which
209 complies with board rules, identifies the categories of
210 medicinal drugs that the advanced registered nurse practitioner
211 is authorized to prescribe, and requires as an element of
212 general supervision that the advanced registered nurse
213 practitioner confer with the supervising physician to review and
214 discuss patient care, prescribed treatments and medications, and
215 care outcomes. The board may by rule establish minimum
216 requirements for this conference. The supervising physician or
217 another physician designated by the supervising physician must
218 be available for consultation and collaboration with the
219 advanced registered nurse practitioner at all times, by phone or
220 other electronic means. The protocol must include a quality
221 assurance procedure. The board may by rule establish minimum
222 requirements for the quality assurance procedure to be included
223 in the protocol. The protocol must be filed with the initial
224 application for registration under this section, with the

225 application for renewal of license, and at any time there is a
226 change in the protocol or of any party to the protocol. For
227 purposes of this section, the supervising physician must have a
228 current and unrestricted license to practice medicine pursuant
229 to chapter 458 or osteopathic medicine pursuant to chapter 459,
230 a primary practice location in this state, and a current and
231 unrestricted federal Drug Enforcement Administration
232 registration number.
233 (e) Agree to maintain adequate medical records pursuant to
234 board rule which include evidence of a patient history and
235 physical examination and, at a minimum, the following
236 information about each prescription for a medicinal drug:
237 1. Drug name and strength.
238 2. Dose.
239 3. Amount prescribed.
240 4. Directions for use.
241 5. Number of refills.
242 6. The signature of the prescribing practitioner.
243 (f) Submit a completed registration form and remit a fee
244 set by the board not to exceed $75.
245 (3) To prescribe controlled substances, an advanced
246 registered nurse practitioner must:
247 (a) Possess a valid midlevel practitioner registration
248 issued by the federal Drug Enforcement Administration.
249 (b) Submit documentation to the board demonstrating that
250 the advanced registered nurse practitioner has completed an
251 approved course in legal and clinical aspects of prescribing
252 controlled substances of not less than 3 contact hours.

253 (c) Identify, as part of the protocol between the advanced
254 registered nurse practitioner and supervising physician, the
255 schedules of controlled substances that the advanced registered
256 nurse practitioner is authorized to prescribe.
257 (d) Complete at least 2 contact hours of approved
258 continuing education in the prescribing of controlled substances
259 during each 2-year licensure period, in addition to the
260 continuing education required for licensure renewal. This
261 continuing education may be part of the 16 hours of continuing
262 education required pursuant to subsection (4).
263 (4) To register or renew registration to prescribe
264 medicinal drugs, an advanced registered nurse practitioner must
265 complete at least 16 contact hours of approved continuing
266 education in pharmacology during each 2-year licensure period,
267 in addition to the continuing education required for licensure
268 renewal.
269 (5) The board shall provide by rule for biennial renewal
270 of registration and a renewal fee not to exceed $25.
271 (6) Advanced registered nurse practitioners who are
272 certified as certified registered nurse anesthetists pursuant to
273 s. 464.012 are not required to register under this section to
274 provide anesthesia care in accordance with s. 464.012(4).
275 (7) An advanced registered nurse practitioner who
276 registers to prescribe controlled substances may not prescribe
277 controlled substances for personal use or use by any member of
278 the advanced registered nurse practitioner's immediate family.
279 (8) The board may limit, suspend, or revoke an advanced
280 registered nurse practitioner's registration to prescribe under

281 this section in accordance with the provisions of s. 456.073.
282 (9) The board may adopt rules pursuant to ss. 120.536(1)
283 and 120.54 to administer this section.
284 Section 5. Section 464.015, Florida Statutes, is amended
285 to read:
286 464.015 Titles and abbreviations; restrictions; penalty.--
287 (1) Only persons who hold licenses to practice
288 professional nursing in this state or who are performing nursing
289 services pursuant to the exception set forth in s. 464.022(8)
290 shall have the right to use the title "Registered Nurse" and the
291 abbreviation "R.N."
292 (2) Only persons who hold licenses to practice as licensed
293 practical nurses in this state or who are performing practical
294 nursing services pursuant to the exception set forth in s.
295 464.022(8) shall have the right to use the title "Licensed
296 Practical Nurse" and the abbreviation "L.P.N."
297 (3) Only persons who are graduates of approved programs or
298 the equivalent may use the term "Graduate Nurse" and the
299 abbreviation "G.N.," pending the results of the first licensure
300 examination for which they are eligible.
301 (4) Only persons who are graduates of approved programs or
302 the equivalent may use the term "Graduate Practical Nurse" and
303 the abbreviation "G.P.N.," pending the results of the first
304 licensure examination for which they are eligible.
305 (5) Only persons who hold valid certificates to practice
306 as clinical nurse specialists in this state may use the title
307 "Clinical Nurse Specialist" and the abbreviation "C.N.S."
308 (6) Only persons who hold valid certificates to practice

309 as certified registered nurse anesthetists in this state may use
310 the title "Certified Registered Nurse Anesthetist" and the
311 abbreviations "C.R.N.A." or "anesthetist."
312 (7) Only persons who hold valid certificates to practice
313 as certified nurse midwives in this state may use the title
314 "Certified Nurse Midwife" and the abbreviations "C.N.M." or
315 "nurse midwife."
316 (8) ~~(5)~~ Only persons who hold valid certificates to
317 practice as advanced registered nurse practitioners in this
318 state may ~~shall have the right to~~ use the title "Advanced
319 Registered Nurse Practitioner" and the abbreviation "A.R.N.P."
320 (9) ~~(6)~~ A ~~No~~ person may not ~~shall~~ practice or advertise as,
321 or assume the title of, registered nurse, licensed practical
322 nurse, clinical nurse specialist, certified registered nurse
323 anesthetist, certified nurse midwife, or advanced registered
324 nurse practitioner or use the abbreviation "R.N.," "L.P.N.,"
325 "C.N.S.," "C.R.N.A.," "C.N.M.," or "A.R.N.P." or take any other
326 action that would lead the public to believe that person was
327 certified as such or is performing nursing services pursuant to
328 the exception set forth in s. 464.022(8), unless that person is
329 licensed or certified to practice as such.
330 (10) ~~(7)~~ A violation of this section is a misdemeanor of
331 the first degree, punishable as provided in s. 775.082 or s.
332 775.083.
333 Section 6. Section 464.016, Florida Statutes, is amended
334 to read:
335 464.016 Violations and penalties.--
336 (1) Each of the following acts constitutes a felony of the

337 third degree, punishable as provided in s. 775.082, s. 775.083,
338 or s. 775.084:
339 (a) Practicing advanced or specialized, professional, or
340 practical nursing, as defined in this part, unless holding an
341 active license or certificate to do so.
342 (b) Using or attempting to use a license or certificate
343 which has been suspended or revoked.
344 (c) Knowingly employing unlicensed persons in the practice
345 of nursing.
346 (d) Obtaining or attempting to obtain a license or
347 certificate under this part by misleading statements or knowing
348 misrepresentation.
349 (2) Each of the following acts constitutes a misdemeanor
350 of the first degree, punishable as provided in s. 775.082 or s.
351 775.083:
352 (a) Using the name or title "Nurse," "Registered Nurse,"
353 "Licensed Practical Nurse," "Clinical Nurse Specialist,"
354 "Certified Registered Nurse Anesthetist," "Certified Nurse
355 Midwife," "Advanced Registered Nurse Practitioner," or any other
356 name or title which implies that a person was licensed or
357 certified as same, unless such person is duly licensed or
358 certified.
359 (b) Knowingly concealing information relating to
360 violations of this part.
361 Section 7. Subsection (19) of section 893.02, Florida
362 Statutes, is amended to read:
363 893.02 Definitions.--The following words and phrases as
364 used in this chapter shall have the following meanings, unless

365 the context otherwise requires:
366 (19) "Practitioner" means a physician licensed pursuant to
367 chapter 458, a dentist licensed pursuant to chapter 466, a
368 veterinarian licensed pursuant to chapter 474, an osteopathic
369 physician licensed pursuant to chapter 459, a naturopath
370 licensed pursuant to chapter 462, or a podiatric physician
371 licensed pursuant to chapter 461, provided such practitioner
372 holds a valid federal controlled substance registry number. The
373 term includes an advanced registered nurse practitioner
374 certified pursuant to s. 464.012 who holds a valid controlled
375 substance registry number for midlevel practitioners and who is
376 registered to prescribe controlled substances under s. 464.0125.
377 Section 8. For the purpose of incorporating the amendment
378 made by this act to section 464.016, Florida Statutes, in a
379 reference thereto, paragraph (g) of subsection (3) of section
380 921.0022, Florida Statutes, is reenacted to read:
381 921.0022 Criminal Punishment Code; offense severity
382 ranking chart.--
383 (3) OFFENSE SEVERITY RANKING CHART

Florida Statute	Felony Degree	Description
384		
385		(g) LEVEL 7
386 316.027(1)(b)	2nd	Accident involving death, failure to stop; leaving scene.
387 316.193(3)(c)2.	3rd	DUI resulting in serious bodily

			injury.
388	316.1935(3)(b)	1st	Causing serious bodily injury or death to another person; driving at high speed or with wanton disregard for safety while fleeing or attempting to elude law enforcement officer who is in a patrol vehicle with siren and lights activated.
389	327.35(3)(c)2.	3rd	Vessel BUI resulting in serious bodily injury.
390	402.319(2)	2nd	Misrepresentation and negligence or intentional act resulting in great bodily harm, permanent disfiguration, permanent disability, or death.
391	409.920(2)	3rd	Medicaid provider fraud.
392	456.065(2)	3rd	Practicing a health care profession without a license.
393	456.065(2)	2nd	Practicing a health care profession without a license which results in serious bodily injury.
394	458.327(1)	3rd	Practicing medicine without a license.
395	459.013(1)	3rd	Practicing osteopathic medicine

			without a license.
396	460.411(1)	3rd	Practicing chiropractic medicine without a license.
397	461.012(1)	3rd	Practicing podiatric medicine without a license.
398	462.17	3rd	Practicing naturopathy without a license.
399	463.015(1)	3rd	Practicing optometry without a license.
400	464.016(1)	3rd	Practicing nursing without a license.
401	465.015(2)	3rd	Practicing pharmacy without a license.
402	466.026(1)	3rd	Practicing dentistry or dental hygiene without a license.
403	467.201	3rd	Practicing midwifery without a license.
404	468.366	3rd	Delivering respiratory care services without a license.
405	483.828(1)	3rd	Practicing as clinical laboratory personnel without a license.
406	483.901(9)	3rd	Practicing medical physics without a

			license.
407	484.013(1)(c)	3rd	Preparing or dispensing optical devices without a prescription.
408	484.053	3rd	Dispensing hearing aids without a license.
409	494.0018(2)	1st	Conviction of any violation of ss. 494.001-494.0077 in which the total money and property unlawfully obtained exceeded $50,000 and there were five or more victims.
410	560.123(8)(b)1.	3rd	Failure to report currency or payment instruments exceeding $300 but less than $20,000 by money transmitter.
411	560.125(5)(a)	3rd	Money transmitter business by unauthorized person, currency or payment instruments exceeding $300 but less than $20,000.
412	655.50(10)(b)1.	3rd	Failure to report financial transactions exceeding $300 but less than $20,000 by financial institution.
413	775.21(10)(a)	3rd	Sexual predator; failure to register; failure to renew driver's license or identification card; other

			registration violations.
414	775.21(10)(b)	3rd	Sexual predator working where children regularly congregate.
415	775.21(10)(g)	3rd	Failure to report or providing false information about a sexual predator; harbor or conceal a sexual predator.
416	782.051(3)	2nd	Attempted felony murder of a person by a person other than the perpetrator or the perpetrator of an attempted felony.
417	782.07(1)	2nd	Killing of a human being by the act, procurement, or culpable negligence of another (manslaughter).
418	782.071	2nd	Killing of human being or viable fetus by the operation of a motor vehicle in a reckless manner (vehicular homicide).
419	782.072	2nd	Killing of a human being by the operation of a vessel in a reckless manner (vessel homicide).
420	784.045(1)(a)1.	2nd	Aggravated battery; intentionally causing great bodily harm or disfigurement.

421	784.045(1)(a)2.	2nd	Aggravated battery; using deadly weapon.
422	784.045(1)(b)	2nd	Aggravated battery; perpetrator aware victim pregnant.
423	784.048(4)	3rd	Aggravated stalking; violation of injunction or court order.
424	784.048(7)	3rd	Aggravated stalking; violation of court order.
425	784.07(2)(d)	1st	Aggravated battery on law enforcement officer.
426	784.074(1)(a)	1st	Aggravated battery on sexually violent predators facility staff.
427	784.08(2)(a)	1st	Aggravated battery on a person 65 years of age or older.
428	784.081(1)	1st	Aggravated battery on specified official or employee.
429	784.082(1)	1st	Aggravated battery by detained person on visitor or other detainee.
430	784.083(1)	1st	Aggravated battery on code inspector.
431	790.07(4)	1st	Specified weapons violation subsequent

			to previous conviction of s. 790.07(1) or (2).
432	790.16(1)	1st	Discharge of a machine gun under specified circumstances.
433	790.165(2)	2nd	Manufacture, sell, possess, or deliver hoax bomb.
434	790.165(3)	2nd	Possessing, displaying, or threatening to use any hoax bomb while committing or attempting to commit a felony.
435	790.166(3)	2nd	Possessing, selling, using, or attempting to use a hoax weapon of mass destruction.
436	790.166(4)	2nd	Possessing, displaying, or threatening to use a hoax weapon of mass destruction while committing or attempting to commit a felony.
437	796.03	2nd	Procuring any person under 16 years for prostitution.
438	800.04(5)(c)1.	2nd	Lewd or lascivious molestation; victim less than 12 years of age; offender less than 18 years.
439	800.04(5)(c)2.	2nd	Lewd or lascivious molestation; victim

			12 years of age or older but less than 16 years; offender 18 years or older.
440	806.01(2)	2nd	Maliciously damage structure by fire or explosive.
441	810.02(3)(a)	2nd	Burglary of occupied dwelling; unarmed; no assault or battery.
442	810.02(3)(b)	2nd	Burglary of unoccupied dwelling; unarmed; no assault or battery.
443	810.02(3)(d)	2nd	Burglary of occupied conveyance; unarmed; no assault or battery.
444	812.014(2)(a)1.	1st	Property stolen, valued at $100,000 or more; property stolen while causing other property damage; 1st degree grand theft.
445	812.014(2)(b)2.	2nd	Property stolen, cargo valued at less than $50,000, grand theft in 2nd degree.
446	812.014(2)(b)3.	2nd	Property stolen, emergency medical equipment; 2nd degree grand theft.
447	812.0145(2)(a)	1st	Theft from person 65 years of age or older; $50,000 or more.
448			

812.019(2)	1st	Stolen property; initiates, organizes, plans, etc., the theft of property and traffics in stolen property.
812.131(2)(a)	2nd	Robbery by sudden snatching.
812.133(2)(b)	1st	Carjacking; no firearm, deadly weapon, or other weapon.
817.234(8)(a)	2nd	Solicitation of motor vehicle accident victims with intent to defraud.
817.234(9)	2nd	Organizing, planning, or participating in an intentional motor vehicle collision.
817.234(11)(c)	1st	Insurance fraud; property value $100,000 or more.
817.2341(2)(b)& (3)(b)	1st	Making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity which are a significant cause of the insolvency of that entity.
825.102(3)(b)	2nd	Neglecting an elderly person or disabled adult causing great bodily harm, disability, or disfigurement.

	825.103(2)(b)	2nd	Exploiting an elderly person or disabled adult and property is valued at $20,000 or more, but less than $100,000.
457			
	827.03(3)(b)	2nd	Neglect of a child causing great bodily harm, disability, or disfigurement.
458			
	827.04(3)	3rd	Impregnation of a child under 16 years of age by person 21 years of age or older.
459			
	837.05(2)	3rd	Giving false information about alleged capital felony to a law enforcement officer.
460			
	838.015	2nd	Bribery.
461			
	838.016	2nd	Unlawful compensation or reward for official behavior.
462			
	838.021(3)(a)	2nd	Unlawful harm to a public servant.
463			
	838.22	2nd	Bid tampering.
464			
	847.0135(3)	3rd	Solicitation of a child, via a computer service, to commit an unlawful sex act.
465			

	872.06	2nd	Abuse of a dead human body.
466	893.13(1)(c)1.	1st	Sell, manufacture, or deliver cocaine (or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4.) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
467	893.13(1)(e)1.	1st	Sell, manufacture, or deliver cocaine or other drug prohibited under s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4., within 1,000 feet of property used for religious services or a specified business site.
468	893.13(4)(a)	1st	Deliver to minor cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)4. drugs).
469	893.135(1)(a)1.	1st	Trafficking in cannabis, more than 25 lbs., less than 2,000 lbs.
470	893.135 (1)(b)1.a.	1st	Trafficking in cocaine, more than 28 grams, less than 200 grams.
471	893.135	1st	Trafficking in illegal drugs, more

(1)(c)1.a.		than 4 grams, less than 14 grams.
893.135 (1)(d)1.	1st	Trafficking in phencyclidine, more than 28 grams, less than 200 grams.
893.135(1)(e)1.	1st	Trafficking in methaqualone, more than 200 grams, less than 5 kilograms.
893.135(1)(f)1.	1st	Trafficking in amphetamine, more than 14 grams, less than 28 grams.
893.135 (1)(g)1.a.	1st	Trafficking in flunitrazepam, 4 grams or more, less than 14 grams.
893.135 (1)(h)1.a.	1st	Trafficking in gamma-hydroxybutyric acid (GHB), 1 kilogram or more, less than 5 kilograms.
893.135 (1)(j)1.a.	1st	Trafficking in 1,4-Butanediol, 1 kilogram or more, less than 5 kilograms.
893.135 (1)(k)2.a.	1st	Trafficking in Phenethylamines, 10 grams or more, less than 200 grams.
896.101(5)(a)	3rd	Money laundering, financial transactions exceeding $300 but less than $20,000.
896.104(4)(a)1.	3rd	Structuring transactions to evade

		reporting or registration requirements, financial transactions exceeding $300 but less than $20,000.
943.0435(4)(c)	2nd	Sexual offender vacating permanent residence; failure to comply with reporting requirements.
943.0435(8)	2nd	Sexual offender; remains in state after indicating intent to leave; failure to comply with reporting requirements.
943.0435(9)(a)	3rd	Sexual offender; failure to comply with reporting requirements.
943.0435(13)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
943.0435(14)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.
944.607(9)	3rd	Sexual offender; failure to comply with reporting requirements.
944.607(10)(a)	3rd	Sexual offender; failure to submit to the taking of a digitized photograph.

944.607(12)	3rd	Failure to report or providing false information about a sexual offender; harbor or conceal a sexual offender.
944.607(13)	3rd	Sexual offender; failure to report and reregister; failure to respond to address verification.

Section 9. Paragraph (a) of subsection (1) and subsection (2) of section 458.348, Florida Statutes, are amended to read:

458.348 Formal supervisory relationships, standing orders, and established protocols; notice; standards.--

(1) NOTICE.--

(a) When a physician enters into a formal supervisory relationship or standing orders with an emergency medical technician or paramedic licensed pursuant to s. 401.27, which relationship or orders contemplate the performance of medical acts, or when a physician enters into an established protocol with an advanced registered nurse practitioner, which protocol contemplates the performance of medical acts identified and approved by the joint committee pursuant to s. 464.003(3)(d) ~~s. 464.003(3)(c)~~ or acts set forth in s. 464.012(3) and (4), the physician shall submit notice to the board. The notice shall contain a statement in substantially the following form:

I, (name and professional license number of physician) , of (address of physician) have hereby entered into a formal supervisory relationship, standing orders, or an established

511 protocol with (number of persons) emergency medical
512 technician(s), (number of persons) paramedic(s), or
513 (number of persons) advanced registered nurse practitioner(s).
514 (2) ESTABLISHMENT OF STANDARDS BY JOINT COMMITTEE.--The
515 joint committee created under s. 464.003(3)(d) ~~by s.~~
516 ~~464.003(3)(c)~~ shall determine minimum standards for the content
517 of established protocols pursuant to which an advanced
518 registered nurse practitioner may perform medical acts
519 identified and approved by the joint committee pursuant to s.
520 464.003(3)(d) ~~s. 464.003(3)(c)~~ or acts set forth in s.
521 464.012(3) and (4) and shall determine minimum standards for
522 supervision of such acts by the physician, unless the joint
523 committee determines that any act set forth in s. 464.012(3) or
524 (4) is not a medical act. Such standards shall be based on risk
525 to the patient and acceptable standards of medical care and
526 shall take into account the special problems of medically
527 underserved areas. The standards developed by the joint
528 committee shall be adopted as rules by the Board of Nursing and
529 the Board of Medicine for purposes of carrying out their
530 responsibilities pursuant to part I of chapter 464 and this
531 chapter, respectively, but neither board shall have disciplinary
532 powers over the licensees of the other board.
533 Section 10. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 485**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Farkas offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 183-283 and insert:
6
7 464.0125 A statewide pilot project is created to authorize
8 advanced registered nurse practitioners who provide services in
9 skilled nursing homes and assisted living facilities licensed
10 under chapter 400, veterans administration facilities and
11 clinics where veterans receive health and medical services,
12 hospices, and designated rural clinics, to prescribe controlled
13 substances as defined in chapter 893 under the general
14 supervision of a physician licensed under chapter 458 or 459,
15 and in accordance with a protocol. The protocol shall clearly
16 state the schedules of controlled substances the advanced
17 registered nurse practitioner is authorized to prescribe and set
18 limits on the number/doses of such controlled substances that
19 the advanced registered nurse practitioner may prescribe.
20 1. Advanced registered nurse practitioners who prescribe
21 controlled substances under this section are only authorized to

22 prescribe controlled substances for patients who receive health
23 care services through or in the facilities referenced in this
24 section.
25 2. Advanced registered nurse practitioners who prescribe
26 controlled substances under this section must have a current DEA
27 mid-level practitioner number issued by the United States Drug
28 Enforcement Administration.
29 3. Protocols authorizing advanced registered nurse
30 practitioners to prescribe under this section must be made
31 available for review by a pharmacist who requests to review the
32 protocol.
33 4. The Department of Health, with assistance of the Board
34 of Nursing, and the joint committee of the Board of Nursing and
35 the Board of Medicine shall prepare an annual report to the
36 President of the Senate, the Speaker of the House and the
37 Governor on the safety and increased efficiency in the delivery
38 of health care services resulting from permitting advanced
39 registered nurse practitioners to prescribe controlled
40 substances under this provision.
41 5. The Board of Nursing may adopt rules pursuant to ss.
42 120.073(1) and 120.54 to implement this section.
43
44 ========== T I T L E A M E N D M E N T ==========
45 Remove line(s) 10-19 and insert:
46 practitioners; creating s. 464.0125, F.S.; creating a statewide
47 pilot project to authorize certain advance registered nurse
48 practitioners to prescribe controlled substances under certain
49 circumstances; providing limitations and requirements for
50 advance registered nurse practitioners practicing under the
51 pilot project; requiring the Department of Health to prepare an

52 annual report; authorizing the Board of Nursing to adopt rules;
53 amending s. 464.015, F.S.; restricting the use of

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **HB 485**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Farkas offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 376 and insert:
6
7 authorized to prescribe controlled substances in accordance with
8 the pilot created under s. 464.0125.

000000

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 569 Athletic Trainers
SPONSOR(S): Kreegel
TIED BILLS: **IDEN./SIM. BILLS:** SB 266

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) PreK-12 Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

HB 569 revises the licensure and renewal requirements for athletic trainers. The bill removes several provisions, including: an exemption relating to teacher apprentice athletic trainers; required supervised athletic training experience and continuing education in standard first aid; and a grandfather clause that allowed for an alternative avenue for individuals seeking licensure prior to October 1, 1996. The bill requires athletic trainers employed by a school district to be licensed under part XIII of ch. 468, F.S., as an athletic trainer.

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

The bill takes effect upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government-The bill removes several regulations related to the standards of the profession of athletic training in Florida.

B. EFFECT OF PROPOSED CHANGES:

The bill amends the following provisions to s. 468.707, F.S., relating to licensure by examination for the profession of athletic training:

- Requires the completion of an approved athletic training curriculum from an accredited college or university, or a program approved by the board; and removes specific coursework requirements;
- Removes all requirements of direct supervision under a certified athletic trainer, and that the applicant must have practiced athletic training 3 out of the last 5 years; and removes the alternative to the direct supervision, that allows an individual to be certified by the National Athletic Trainers' Association or a comparable National Athletic standards organization; and
- Removes a grandfather clause that was created as an alternative pathway for licensure to individuals prior to October 1, 1996.

The bill amends s. 468.711, F.S., to delete the requirement that at the time of licensure renewal an athletic trainer must be certified in standard first aid.

The bill amends s. 468.723, F.S., to delete an exemption for the classification of teacher apprentice trainer I and II, that according to the Department of Education are no longer valid in s. 1012.46, F.S.

The bill amends s. 1012.46, F.S., to remove first responders and teacher athletic trainers as employment classifications within a school district's athletic injuries prevention and treatment program. The bill provides that a licensed athletic trainer *may* possess certification as an educator. So, a fully licensed athletic trainer employed by a school district is not required to have a teaching certificate issued by the Department of Education unless he or she is providing instruction. According to the Department of Education, this provides greater flexibility to school districts in the employment of licensed athletic trainers.

BACKGROUND

The Department of Health's Division of Medical Quality Assurance

The Department of Health's Division of Medical Quality Assurance (MQA) regulates health care practitioners to ensure the health, safety and welfare of the public. Currently, MQA supports licensure and disciplinary activities for 37 professions and 6 facilities, and works with 28 boards and councils. Boards are responsible for approving or denying applications for licensure and are involved in disciplinary hearings. The range of disciplinary actions taken by boards includes citations, suspensions, reprimands, probations, and revocations. Licensed athletic trainers are governed by rules adopted by the Board of Athletic Training.

Licensed Athletic Trainers in Florida

Section 468.707, F.S. provides the licensure by examination requirements for licensed athletic trainers in the state. Accordingly, the Department of Health may license an individual who:

- Has completed the application form and remitted the required fees, which may total $500;[1]
- Is at least 21 years of age;
- Has obtained a baccalaureate degree from a college or university accredited by an accrediting agency recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, or approved by the board;
- Has completed coursework from an accredited college or university in each of the following areas, as provided by rule: health, human anatomy, kinesiology/biomechanics, human physiology, physiology of exercise, basic athletic training, and advanced athletic training;
- Is certified in standard first aid and cardiovascular pulmonary resuscitation (CPR) from the American Red Cross or an equivalent certification;
- Has, within 2 of the preceding 5 years, attained a minimum of 800 hours of athletic training experience under the direct supervision of a licensed athletic trainer or an athletic trainer certified by the National Athletic Trainers' Association or a comparable national athletic standards organization; and
- Has passed an examination administered or approved by the board.

The department may also grandfather in an individual who:

- Has completed the application form and remitted the required fees no later than October 1, 1996;
- Is at least 21 years of age;
- Is certified in standard first aid and cardiovascular pulmonary resuscitation from the American Red Cross or an equivalent certification;
- Has practiced athletic training for at least 3 of the 5 years preceding application; or
- Is currently certified by the National Athletic Trainers' Association or a comparable national athletic standards organization.

Pursuant to the requirements of s. 456.034, F.S., each applicant must complete a continuing education course on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) as part of initial licensure.

Certified Athletic Trainers and the National Athletic Trainers' Association

According to the National Athletic Trainers' Association, certified Athletic Trainers are medical experts in preventing, recognizing, managing and rehabilitating injuries that result from physical activity. Athletic trainers can help athletes avoid unnecessary medical treatment and disruption of normal daily life.[2]

The American Medical Association (AMA) recognized athletic training as an allied health care profession in 1990. AMA recommends placement of certified athletic trainers in every high school to keep America's youth safe and healthy.[3] A certified athletic trainer specializes in six practice areas or domains:

- Prevention
- Recognition, Evaluation & Assessment
- Immediate Care
- Treatment, Rehabilitation & Reconditioning
- Organization & Administration
- Professional Development & Responsibility

---

[1] See s. 468.709. F.S.
[2] Online at the National Athletic Trainers Association website: http://www.nata.org/downloads/documents/306CareerInfoBrochure.htm
[3] Ibid.

As part of a complete health care team, the certified athletic trainer works under the direction of a licensed physician and in cooperation with other health care professionals, athletics administrators, coaches and parents. The certified athletic trainer gets to know each athlete individually and can treat injuries more effectively.

A certified athletic trainer's day may, for example, include these tasks:

- Prepare athletes for practice or competition, including taping, bandaging and bracing;
- Evaluate injuries to determine their management and possible referral;
- Develop conditioning programs; and
- Implement treatment and rehabilitation programs.

Students who want to become certified athletic trainers must earn a degree from an accredited athletic training curriculum or meet other requirements set by the Board of Certification. A growing number of universities are gaining accreditation through the Commission on Accreditation of Allied Health Education Programs (CAAHEP).

The Athletic Trainer curriculum includes formal instruction in a variety of areas, such as:

- Assessment and Evaluation
- Acute Care
- General Medical Conditions and Disabilities
- Pathology of Injury and Illness
- Pharmacological Aspects of Injury and Illness
- Nutritional Aspects of Injury and Illness
- Therapeutic Exercise
- Therapeutic Modalities
- Risk Management and Injury Prevention
- Health Care Administration
- Professional Development and Responsibilities
- Psychosocial Intervention and Referral

The National Board of Certification for National Certification of Athletic Trainers

National Certification of Athletic Trainers Requires Continuing Education for National Certification

The Board of Certification (BOC) was incorporated in 1989 to provide a certification program for entry-level athletic trainers and recertification standards for certified athletic trainers. The National Certification of Athletic Trainers Examination is recognized in 40 states.

The BOC has established continuing education requirements that a certified athletic trainer is required to complete in order to maintain their status as a BOC certified athletic trainer.[4] Annually, the Board of Certification reviews the requirements for certification eligibility and standards for continuing education. The Board reviews and revises the certification examination every five years.

National Athletic Training Examination Requires Emergency Cardiac Care Certification

National Examination Candidates must be graduates of an accredited Athletic Training Curriculum Program. Candidates for certification must pass a three-part examination. The three parts are: written, simulation, and practical.

Until recently, individuals wishing to take Part 3 of the exam application were required to have a current CPR certification card. This requirement has been updated and requires that they have an Emergency Cardiac Care Certification (ECCC). ECCC must be current and include the following: adult & pediatric

[4] Online at the Board on Certification for Athletic Trainers at: http://www.bocatc.org/athtrainer/DEFINE/

CPR, airway obstruction, 2nd rescuer CPR, AED and barrier devices (e.g., pocket mask, bag valve mask). Organizations that provide the ECCC certification are: CPR/AED for the Professional Rescuer by the American Red Cross or BLS Healthcare Provider CPR by the American Heart Association. A valid EMT card may be substituted for the ECCC requirement.

C. SECTION DIRECTORY:

Section 1. Amends s. 468.707, F.S., to revise licensure by examination requirements.
Section 2. Amends s. 468.711, F.S., to revise licensure renewal and continuing education requirements.
Section 3. Amends s. 468.723, F.S., to provide that a person employed as an apprentice trainer or athletic trainer is not exempt from part XIII of ch. 468, F.S.
Section 4. Amends s. 1012.46, F.S., to provide for the replacement of teacher athletic trainers by licensed athletic trainers; remove a first responder classification; require that an athletic trainer employed by a school district must be licensed; and remove the provision that they must be certified as an educator.
Section 5. Provides that the bill takes effect upon becoming a law.

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:

   This bill does not require counties or municipalities to spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

DRAFTING ISSUES:
Section 456.017(1)(c), F.S., prohibits the Department of Health and boards from administering a state-developed written examination if a national examination is available. On line 51, the bill provides "has passed an examination administered or approved by the board." It may be advantageous to update the language by removing the reference to "administered."

OTHER COMMENTS:
According to the Department of Health, courts have viewed licensure for health care practitioners as a property right. In practitioner licensure protocol, once an applicant is licensed, whether by examination, endorsement, or grandfathering, they will continue to be licensed as long as they meet the renewal criteria. Only if their license becomes null and void would they have to meet any new criterion that has been implemented since they were initially licensed. According to DOH, if the grandfather clause in s. 468.707(1)(b), F.S., is deleted, it is unclear as to the impact to individuals licensed in accordance with that grandfather clause when read against s. 468.711(1), F.S.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to athletic trainers; amending s. 468.707,
3 F.S.; revising the requirements for licensure as an
4 athletic trainer; amending s. 468.711, F.S.; revising the
5 criteria for continuing education in athletic training;
6 amending s. 468.723, F.S.; providing that a person
7 employed as an apprentice trainer or athletic trainer is
8 not exempt from part XIII of ch. 468, F.S.; amending s.
9 1012.46, F.S.; deleting the classification of first
10 responder in a school district's athletic injuries
11 prevention and treatment program; requiring that an
12 athletic trainer employed by a school district be licensed
13 as an athletic trainer; deleting a requirement that such
14 person possess certain certification as an educator;
15 providing an effective date.
16
17 Be It Enacted by the Legislature of the State of Florida:
18
19 Section 1. Subsection (1) of section 468.707, Florida
20 Statutes, is amended to read:
21 468.707 Licensure by examination; requirements.--
22 (1) Any person desiring to be licensed as an athletic
23 trainer shall apply to the department on a form approved by the
24 department.
25 ~~(a)~~ The department shall license each applicant who:
26 (a)~~1.~~ Has completed the application form and remitted the
27 required fees.
28 (b)~~2.~~ Is at least 21 years of age.

29 (c)~~3.~~ Has obtained a baccalaureate degree from a college
30 or university accredited by an accrediting agency recognized and
31 approved by the United States Department of Education or the
32 Commission on Recognition of Postsecondary Accreditation, or
33 approved by the board.
34 (d)~~4.~~ Has completed an approved athletic training
35 curriculum ~~coursework~~ from a college or university accredited by
36 an accrediting agency recognized and approved by the United
37 States Department of Education or the Commission on Recognition
38 of Postsecondary Accreditation, or approved by the board~~, in~~
39 ~~each of the following areas, as provided by rule: health, human~~
40 ~~anatomy, kinesiology/biomechanics, human physiology, physiology~~
41 ~~of exercise, basic athletic training, and advanced athletic~~
42 ~~training~~.
43 (e)~~5.~~ Has current certification in ~~standard first aid and~~
44 cardiovascular pulmonary resuscitation from the American Red
45 Cross or an equivalent certification as determined by the board.
46 ~~6. Has, within 2 of the preceding 5 years, attained a~~
47 ~~minimum of 800 hours of athletic training experience under the~~
48 ~~direct supervision of a licensed athletic trainer or an athletic~~
49 ~~trainer certified by the National Athletic Trainers' Association~~
50 ~~or a comparable national athletic standards organization.~~
51 (f)~~7.~~ Has passed an examination administered or approved
52 by the board.
53 ~~(b) The department shall also license each applicant who:~~
54 ~~1. Has completed the application form and remitted the~~
55 ~~required fees no later than October 1, 1996.~~
56 ~~2. Is at least 21 years of age.~~

57 ~~3. Has current certification in standard first aid and~~
58 ~~cardiovascular pulmonary resuscitation from the American Red~~
59 ~~Cross or an equivalent certification as determined by the board.~~
60 ~~4.a. Has practiced athletic training for at least 3 of the~~
61 ~~5 years preceding application; or~~
62 ~~b. Is currently certified by the National Athletic~~
63 ~~Trainers' Association or a comparable national athletic~~
64 ~~standards organization.~~
65 Section 2. Section 468.711, Florida Statutes, is amended
66 to read:
67 468.711 Renewal of license; continuing education.--
68 (1) The department shall renew a license upon receipt of
69 the renewal application and fee, provided the applicant is in
70 compliance with the provisions of this part, chapter 456, and
71 rules promulgated pursuant thereto.
72 (2) The board may, by rule, prescribe continuing education
73 requirements, not to exceed 24 hours biennially. The criteria
74 for continuing education shall be approved by the board and
75 shall <u>include a current certificate in</u> ~~include 4 hours in~~
76 ~~standard first aid and~~ cardiovascular pulmonary resuscitation
77 from the American Red Cross or equivalent training as determined
78 by the board.
79 (3) Pursuant to the requirements of s. 456.034, each
80 licensee shall complete a continuing education course on human
81 immunodeficiency virus and acquired immune deficiency syndrome
82 as part of biennial relicensure.
83 Section 3. Section 468.723, Florida Statutes, is amended
84 to read:

85 468.723 Exemptions.--~~Nothing in~~ This part does not prevent
86 or restrict ~~shall be construed as preventing or restricting~~:
87 (1) The professional practice of a licensee of the
88 department who is acting within the scope of such practice.
89 (2) An athletic training ~~A~~ student ~~athletic trainer~~ acting
90 under the direct supervision of a licensed athletic trainer.
91 ~~(3) A person employed as a teacher apprentice trainer I, a~~
92 ~~teacher apprentice trainer II, or a teacher athletic trainer~~
93 ~~under s. 1012.46.~~
94 (3) ~~(4)~~ A person from administering standard first aid
95 treatment to an athlete.
96 (4) ~~(5)~~ A person licensed under chapter 548, provided such
97 person is acting within the scope of such license.
98 (5) ~~(6)~~ A person providing personal training instruction
99 for exercise, aerobics, or weightlifting, if the person does not
100 represent himself or herself as able to provide "athletic
101 trainer" services and if any recognition or treatment of
102 injuries is limited to the provision of first aid.
103 Section 4. Section 1012.46, Florida Statutes, is amended
104 to read:
105 1012.46 Athletic trainers.--
106 (1) School districts may establish and implement an
107 athletic injuries prevention and treatment program. Central to
108 this program should be the employment and availability of
109 persons trained in the prevention and treatment of physical
110 injuries that ~~which~~ may occur during athletic activities. The
111 program should reflect opportunities for progressive advancement
112 and compensation in employment as provided in subsection (2) and

113 meet certain other minimum standards developed by the Department
114 of Education. The goal of the Legislature is to have school
115 districts employ and have available a full-time ~~teacher~~ athletic
116 trainer in each high school in the state.
117 ~~(2) To the extent practicable, a school district program~~
118 ~~should include the following employment classification and~~
119 ~~advancement scheme:~~
120 ~~(a) First responder.--To qualify as a first responder, a~~
121 ~~person must possess a professional, temporary, part-time,~~
122 ~~adjunct, or substitute certificate pursuant to s. 1012.56, be~~
123 ~~certified in cardiopulmonary resuscitation, first aid, and have~~
124 ~~15 semester hours in courses such as care and prevention of~~
125 ~~athletic injuries, anatomy, physiology, nutrition, counseling,~~
126 ~~and other similar courses approved by the Commissioner of~~
127 ~~Education. This person may only administer first aid and similar~~
128 ~~care.~~
129 (2)~~(b)~~ ~~Teacher athletic trainer.--~~To qualify as an ~~a~~
130 ~~teacher~~ athletic trainer, a person must be licensed as required
131 by part XIII of chapter 468 and may possess a professional,
132 temporary, part-time, adjunct, or substitute certificate
133 pursuant to s. 1012.35, s. 1012.56, or s. 1012.57~~, and be~~
134 ~~licensed as required by part XIII of chapter 468~~.
135 Section 5. This act shall take effect upon becoming a law.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 569**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Kreegel offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 70 and insert:
6
7 compliance with the provisions of this section ~~part~~, chapter
8 456, and

000000

HB569-Kreegel1.doc

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **HB 569**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Kreegel offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 45 and insert:
6
7 Cross, American Heart Association, or an equivalent
8 certification as determined by the board.

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HB569-Kreegel2.doc

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 575 Practice of Podiatric Medicine
SPONSOR(S): Garcia and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2624

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Insurance Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 575 changes the scope of practice of podiatric physicians by amending the definition of "practice of podiatric medicine" to limit the area that a podiatrist may diagnose or treat to the areas of the ankle and foot. The bill also limits the optional podiatric Medicaid services for which podiatric physicians may be reimbursed. Under the provisions of the bill, a podiatric physician treating a Medicaid recipient for podiatric services may only receive payment for treatment and diagnosis of conditions of the human foot and ankle, not the leg.

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

The bill will take effect on July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government-The bill will legislatively overturn a Court decision and limit the scope of practice of podiatric physicians.

B. EFFECT OF PROPOSED CHANGES:

The bill provides that podiatric physicians in Florida will only be able to diagnose and treat ailments of the foot and ankle, not the leg. Medicaid optional covered services paid to podiatrists by the Agency for Health Care Administration will also be limited to the diagnosis and treatment of ailments of the foot and ankle. Individuals receiving care for conditions of the leg by a podiatric physician will have to seek care from another practitioner such as a general practitioner or orthopedist.

Current Scope of Practice for Podiatric Physicians
Section 461.003(5), F.S., provides the definition for the "practice of podiatric medicine" as the diagnosis or medical, surgical, palliative, and mechanical treatment of ailments of the human foot and leg. The surgical treatment of ailments of the human foot and leg shall be limited anatomically to that part below the anterior tibial tubercle (which is located beneath the knee on the very upper part of the shin). The practice of podiatric medicine includes the amputation of the toes or other parts of the foot but does not include the amputation of the foot or leg in its entirety. A podiatric physician may prescribe drugs that relate specifically to their scope of practice.

According to administrative rule, the term "human leg," as used in s. 461.003(5), F.S., means the entire lower extremity, extending from the head of the femur to the foot, but does not include the hip joint.[1]

The Board of Podiatry also adopted a definition for the term "surgical treatment," that means a distinctly operative kind of treatment, such as a cutting operation. As such, injections, x-rays, and other medical, palliative, and mechanical diagnostic techniques and treatments are not surgery.[2]

Court Decision and Debate over the Administrative Rule Defining "Human Leg"
Since 1997, the definitions of "human leg" and "surgical treatment" adopted by the Board of Podiatry have been a source of controversy.

During a rule challenge hearing, the evidence submitted indicated that references to the human leg may have multiple meanings within the anatomical, medical, and podiatric fields. A limited meaning refers to the lower limb between the knee and the ankle. Whereas, a broader meaning referring to the entire limb, which encompasses the lower leg below the knee and the upper leg above the knee. In 1997 an administrative law judge ruled that the meaning of the definition of "human leg" was limited, not broad.[3]

The Board of Podiatric Medicine appealed the ruling by the administrative law judge and prevailed in the First District Court of Appeal where the Court reversed the ruling. The Court ruled that the Board's rule defining "human leg" is valid. The term was meant to be broad and includes the entire limb from the waist down; excluding the hip socket.[4]

This bill will legislatively overturn a Court decision and the Board of Podiatry's administrative rule.

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[1] See 64B18-23.001 F.A.S.
[2] Ibid.
[3] *Board of Podiatric Medicine v. Florida Medical Association*, 779 So. 2d 658 (Fla. 1st DCA 2001).
[4] Ibid.

BACKGROUND

History of Podiatry

In 1932, US podiatrists used the term chiropody, originally written 'Chirurgpodist," or "surgeon of the foot" to define their profession. Later the word "chiropodist" was coined. "Chiro" a Greek word that means hand and foot and "Pod" a Latin word that means foot. In the 1950s, U.S. chiropodists changed their name to podiatrists.

In 1933, the practice of Chiropody became regulated in Florida. The definition provided for "chiropody" was "the diagnosis, medical, surgical, palliative, and mechanical treatment of ailments of the human foot or leg, except the amputation thereof; and will include the use and prescription of local anesthetics."[5]

Educational Background of a Podiatric Physician

According to the US Department of Labor Bureau of Labor Statistics, podiatrists need a state license that requires the completion of at least 90 hours of undergraduate study; a 4-year post-graduate program at a college of podiatric medicine; and, in most states, a postdoctoral residency program lasting at least 2 years.

To receive a license in Florida, an applicant must meet certain educational criteria:[6]

- Possess a degree from a school or college of podiatric medicine or chiropody recognized and approved by the Council on Podiatry Education of the American Podiatric Medical Association;
- Complete one year of residency or 10 years in the active practice of podiatry in another state immediately preceding the submission of application for licensure in Florida; and
- Pass an examination.

According to the American Podiatric Medical Association website, there are 8 accredited schools in the United States. At this time, Barry University has the only accredited school in Florida.

C. SECTION DIRECTORY:

Section 1. Amends s. 409.906, F.S., to limit the scope of practice of a podiatric physician for which optional Medicaid services may be reimbursed by the Agency for Health Care Administration.
Section 2. Amends s. 461.003, F.S. to limit the scope of practice of podiatric medicine to the foot and ankle.
Section 3. Provides that the bill will take effect on July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

[5] See 1933-15911, Laws of Florida.
[6] See s. 461.006, F.S.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A Medicaid recipient and other patients will need to seek treatment for the lower leg through a general physician or an orthopedist and not through a podiatric physician.

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 spend funds or take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

No additional rulemaking authority is required to implement the provisions of this bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

According to the Department of Health, there may be an indirect impact on disciplinary action against Medicaid providers that do not limit their practice to the ankle and foot. The Department of Health states that they are unaware of any health or safety issues occurring under the existing scope of practice.

According to the Florida Orthopaedic Society, they are concerned that a small segment of podiatric physicians are performing knee surgery.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to the practice of podiatric medicine;
3 amending ss. 409.906 and 461.003, F.S.; redefining the
4 scope of the practice of podiatric medicine; providing an
5 effective date.
6
7 Be It Enacted by the Legislature of the State of Florida:
8
9 Section 1. Subsection (19) of section 409.906, Florida
10 Statutes, is amended to read:
11 409.906 Optional Medicaid services.--Subject to specific
12 appropriations, the agency may make payments for services which
13 are optional to the state under Title XIX of the Social Security
14 Act and are furnished by Medicaid providers to recipients who
15 are determined to be eligible on the dates on which the services
16 were provided. Any optional service that is provided shall be
17 provided only when medically necessary and in accordance with
18 state and federal law. Optional services rendered by providers
19 in mobile units to Medicaid recipients may be restricted or
20 prohibited by the agency. Nothing in this section shall be
21 construed to prevent or limit the agency from adjusting fees,
22 reimbursement rates, lengths of stay, number of visits, or
23 number of services, or making any other adjustments necessary to
24 comply with the availability of moneys and any limitations or
25 directions provided for in the General Appropriations Act or
26 chapter 216. If necessary to safeguard the state's systems of
27 providing services to elderly and disabled persons and subject
28 to the notice and review provisions of s. 216.177, the Governor

29 may direct the Agency for Health Care Administration to amend
30 the Medicaid state plan to delete the optional Medicaid service
31 known as "Intermediate Care Facilities for the Developmentally
32 Disabled." Optional services may include:
33 (19) PODIATRIC SERVICES.--The agency may pay for services,
34 including diagnosis and medical, surgical, palliative, and
35 mechanical treatment, related to ailments of the human foot and
36 ankle ~~lower leg~~, if provided to a recipient by a podiatric
37 physician licensed under state law.
38 Section 2. Subsection (5) of section 461.003, Florida
39 Statutes, is amended to read:
40 461.003 Definitions.--As used in this chapter:
41 (5) "Practice of podiatric medicine" means the diagnosis
42 or medical, surgical, palliative, and mechanical treatment of
43 ailments of the human foot and ankle ~~leg~~. ~~The surgical treatment~~
44 ~~of ailments of the human foot and leg shall be limited~~
45 ~~anatomically to that part below the anterior tibial tubercle.~~
46 The practice of podiatric medicine shall include the amputation
47 of the toes or other parts of the foot but shall not include the
48 amputation of the foot or leg in its entirety. A podiatric
49 physician may prescribe drugs that relate specifically to the
50 scope of practice authorized herein.
51 Section 3. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 819 Radiologist Assistants
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Hamrick	Mitchell
2) Health Care Appropriations Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

Section 11.62, F.S., the Sunrise Act that establishes criteria for new regulation of professions, states that it is the intent of the Legislature that no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage; and no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation.

HB 819 provides for the certification of a relatively new profession called a radiologist assistant. The radiologist assistant functions as a physician extender for a radiologist. Currently only three states regulate radiologist assistants: Montana, Tennessee and Mississippi.

A "radiologist assistant" is a person, other than a licensed practitioner, who is qualified by education and certification as an advanced-level radiologic technologist, who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the medical imaging environment. A radiologist assistant may perform, under the supervision of a radiologist (who is a medical doctor), certain procedures such as arthograms, upper and lower gastrointestinal tract examinations, placements of feeding tubes, and central venous catheters.

The bill provides that the scope of practice for a radiologist assistant must be adopted by rule and be consistent with the national scope of practice adopted by the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT). The bill restricts the scope of practice of radiologist assistant such that they may not interpret images, make a diagnosis, or prescribe medications or therapies. A radiologist assistant must be under the "direct" supervision of a radiologist who must be present in the office suite and immediately available to furnish assistance and direction throughout a medical procedure. The bill clarifies that this does not mean that the radiologist must be in the room while the procedure is performed. The bill provides for fees and educational requirements to include a clinical preceptorship. The bill adds a radiologist assistant to the Advisory Council on Radiation Protection.

Fiscal Impact: According to the Department of Health, the fiscal impact to the department will be minimal since the fees to regulate the profession would cover their administrative costs. According to the Bureau of Radiation Control within DOH, only about 10 radiologist assistants become certified in the nation annually. This number may increase to 20 if the national examination is offered biannually.

The bill takes effect on July 31, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited government and safeguard individual liberty-The bill will allow a radiologist (who is a medical doctor) to use a radiologist assistant as a physician extender, which may allow increased access to radiologic services by consumers.

B. EFFECT OF PROPOSED CHANGES:

Current Situation

The State of Florida currently regulates several general types of individuals who use radiological techniques in health care: basic x-ray machine operators, general radiographers, radiologic technologists and radiologists. Current statute recognizes specializations within each of these categories. For example, a basic x-ray machine operator may specialize in podiatric medicine or a certified radiologic technologist may specialize in nuclear medicine.[1] These professions are not regulated by a board, but an Advisory Council makes recommendations to the Division of Medical Quality Assurance within the Department of Health concerning the requirements and qualifications for all the professions in the field of radiology.

A person may not use radiation or otherwise practice radiologic technology on a human being unless he or she possesses a license or is certified by the Department of Health. The term "radiation" encompasses x rays and gamma rays, alpha and beta particles, high-speed electrons, neutrons, and other nuclear particles. If an individual uses radiation on another person and is not in compliance with s. 468.302, F.S., they may be charged with a second degree misdemeanor pursuant to s. 468.311, F.S.

The bill provides for the certification of radiologist assistants (RA). A radiologist assistant will act as a radiologist extender. The proponents for the legislation provided examples of other physician extenders such as anesthesiologist and nurse anesthetists. According to the proponents of the bill only three states: Montana, Tennessee and Mississippi have passed laws regulating RAs, while others are seeking legislation.

Sunrise Act

The proponents of this legislation did not submit a sunrise questionnaire for staff to review.

According to s. 11.62(3), F.S., of the Florida Sunrise Act, the Legislature is required to consider the following factors when determining whether to regulate a profession:

- **The unregulated practice of the profession will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote.**

  Currently, an individual who is not certified or licensed by the Department of Health may not use radiation on a human being. A prerequisite for national certification as a radiologist assistant is that the individual be certified as a general radiographer (or radiologic technologist). Currently, if an individual performed the duties of a radiologist assistant in Florida they would be practicing out of the scope of their profession and subject to disciplinary charges. Since this is a new profession, not just to Florida, but across the nation, the potential harm or danger to the public is unknown. The duties outlined in the scope of practice of a radiologic assistant in the bill are currently performed by a licensed medical doctor.

[1] See s. 468.302, F.S.

- **The practice of the profession requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements reasonably assure initial and continuing professional ability.**

  Based on the information gathered by staff, the role of a radiologist assistant will require specialized skill and training. According to the American Society of Radiologic Technologists (ASRT) and the American Registry of Radiologic Technologists (ARRT) their training will be readily measurable or quantifiable.

- **The regulation will not unreasonably effect job creation or retention in the state, or place unreasonable restrictions on finding employment by individuals who practice or seek to practice the profession.**

  Since this is a new profession and limited schools in the US offer the program the impact on other professions such as the radiologic technologist or basic x-ray machine operator is difficult to project. However, the educational backgrounds for both of these professions is substantially different from the radiologist assistant who is required to have at least a bachelors degree. Radiologic technologists and x-ray operators may only have an associates degree or certificate of completion. If passed this legislation may provide an avenue for individuals in the field to advance their knowledge and skill in the field if they return to school.

- **Whether the public is not, or can not, be effectively protected by other means.**

  Currently, the public is receiving the services of a radiologic assistant by a radiologist, who is a licensed medical doctor. Due to workforce shortages in the field of radiology, the provisions of the bill may increase assess to radiologic services.

- **Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, is favorable.**

  The bill creates another tier of practitioner in the field of radiology. The services that are currently provided to consumers are performed by a medical doctor (a radiologist) or a technician (radiologic technologist or x-ray operator) who may have an associate's degree. The radiologist assistant (RA) must have at least a bachelor's degree. For this reason, a radiologist assistant may want to be paid at a higher rate than a radiologic technologist.

The Effects of the Bill

The bill provides for the certification of a new profession called a radiologist assistant. The radiologist assistant will function as a physician extender for a radiologist. A "radiologist assistant" is defined as a person, other than a licensed practitioner, who is qualified by education and certification as an advanced-level radiologic technologist who works under the supervision of a radiologist to enhance patient care by assisting the radiologist in the medical imaging environment. The scope of practice for a radiologist assistant must be adopted by rule and be consistent with the national scope of practice adopted by the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT), and the American Registry of Radiologic Technologists (ARRT). The bill restricts the scope of practice of radiologist assistants such that they may not interpret images, make a diagnosis, or prescribe medications or therapies. A radiologist assistant is supervised such that the radiologist (who is a medical doctor) must be present in the office suite and immediately available to furnish assistance and direction throughout a medical procedure. This does not require the radiologist to be in the room while the procedure is performed. The bill provides for fees and educational requirements to include a clinical preceptorship. The bill adds a radiologist assistant to the Advisory Council on Radiation Protection.

BACKGROUND

American Society of Radiologic Technologists (ASRT) Radiologist Assistant Certification Program

The concept of a radiologist extender was first explored in the early 1970s and revived in the mid-1990s. In early 2002, the American Society of Radiologic Technologists (ASRT) convened a panel to explore the concept of a physician extender in radiology. Representatives from the American College of Radiology (ACR), the American Society of Radiologic Technologists (ASRT, or the Society), the American Registry of Radiologic Technologists (ARRT, or the Registry), state licensing agencies, the National Society of Radiology Practitioner Assistants, and the industry produced a consensus document proposing the positions title and definition and addressing educational preparation, roles and responsibilities, level of supervision, and regulatory issues. Building on the panel's concept and consensus, the Registry developed certification standards. The radiologist assistant program incorporates educational, ethical and exam standards.

According to the Society, educational standards for a radiologist assistant are designed to address the didactic and clinical components of the field as well as a national certification and registration in radiography. Clinical education is provided through a preceptorship with a radiologist. Radiologist assistant programs provide a baccalaureate degree or higher. In 2005, six universities offered radiologist assistant educational programs. An individual must be certified as a radiographer by the Registry, as a prerequisite to enrollment in a radiologist assistant program.

Graduates of a radiologist assistant program may sit for the radiologist assistant certification examination administered by the Registry.

The Radiologist Assistant and National Scope of Practice Outlined by the ACR, ASRT, and ARRT

A radiologist assistant works under the supervision of a radiologist to provide patient care as a radiologist extender in the diagnostic imaging environment.

Radiologist assistants (RAs) have three major areas of responsibility.

First, they have a leading role in patient management and assessment. Duties in this area may include determining whether a patient has been appropriately prepared for a procedure, obtaining patient consent prior to beginning the procedure, answering questions from the patient and his or her family, and adapting exam protocols to improve diagnostic quality. The radiologist assistant is expected to serve as a patient advocate, ensuring that each patient receives quality care while in the radiology department or clinic.[2]

Second, the radiologist assistant performs selected radiology examinations and procedures under the supervision of a radiologist. A RA's responsibilities may include assisting radiologists with invasive procedures such as arthograms, upper and lower gastrointestinal tract examinations, urinary tract examinations, lymphanogiograms, performing fluoroscopy for noninvasive procedures under direct supervision of the radiologist, placement of nasoenteric and oroenteric feeding tubes, and performing selected peripheral venous diagnostic procedures such as venograms, paracentesis, thoracentesis or the insertion of central venus catheters.[3]

Third, the radiologist assistant may be responsible for evaluating image quality, making initial image observations and forwarding those observations to the supervising radiologist. The supervising radiologist remains responsible for providing a final written report, an interpretation, or a diagnosis.[4]

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[2] American Society of Radiologic Technologists. The Radiologist Assistant. http://www.asrt.org/content/RTs/SpecialtySpecific/RadiologistAssistant/Radiologist_Assistant.aspx (March 25, 2006).
[3] Ibid.
[4] Ibid.

Current Professions in the Field of Radiology that are Regulated in Florida

Basic X-ray Machine Operator is Certified

A basic x-ray machine operator may perform general diagnostic radiographic and general fluoroscopic procedures under the direct supervision of a licensed practitioner (doctor, podiatrist, or chiropractor), excluding radiation therapy and nuclear medicine. They are limited to the locations they may work such that they are not allowed to work in a hospital with less than 150 beds or a walk-in emergency center.[5]

Radiologic Technologist is trained to Operate Equipment and is Certified

A radiologic technologist is trained to operate radiographic equipment to produce images. The radiologic technologist may explain the imaging procedure to the patient and assist in positioning the patient for imaging specific areas of the patient's body as prescribed by the referring physician.[6] A radiologic technologist may use radiation on human beings under the specific direction and general supervision of a licensed practitioner as defined in s. 468.301(14), F.S.

A Radiologist is a Licensed Medical Doctor

A radiologist is a licensed medical or osteopathic physician trained to diagnose diseases by obtaining and interpreting medical images through the use of imaging techniques such as X-rays, ultrasound, computed tomography, and magnetic resonance imaging. A radiologist must have graduated from an accredited medical school, passed a national licensing examination, and completed a residency of at least 4 years. Such health care practitioners are usually board-certified to practice in the field of radiology by the American Board of Radiology or the American Osteopathic Board of Radiology.

Advisory Council on Radiation Protection

In Florida, there is an Advisory Council on Radiation Protection, not a board, that oversees the practice of radiology. The Council consists of 15 specified professionals and consumers appointed by the Secretary of Health:

- Certified radiologic technologist-radiographer,
- Certified radiologic technologist-nuclear medicine,
- Certified radiologic technologist-therapy,
- Basic X-ray machine operator or a licensed practitioner who employs such an operator,
- Board-certified radiologist,
- Board-certified nuclear medicine physician,
- Certified health physicist,
- Representative from the administration of a hospital affiliated with a radiologic technology educational program,
- An expert in environmental radiation matters,
- Chiropractic radiologist, a board-certified podiatric physician,
- Board-certified radiological physicist,
- Board-certified therapeutic radiologist or board-certified radiation oncologist, and
- Two persons, neither of whom has ever been certified as a radiologic technologist or been a member of any closely related profession.

C. SECTION DIRECTORY:

Section 1. Amends s. 468.301, F.S., to provide a definition for radiologist and radiologist assistant.
Section 2. Amends s. 468.302, F.S., to provide title protection for a certified radiologist assistant or the abbreviation "CRA"; and specify the duties and limitations of a radiologist assistant.
Section 3. Amends s. 468.304, F.S., to provide certification criteria for an applicant seeking a radiologist assistant certificate.
Section 4. Amends s. 468.3065, F.S., to provide authorization and fees for a certificate by endorsement.

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[5] See s. 468.302(3), F.S.
[6] Ibid.

Section 5. Amends s. 468.314, F.S., to provide for an additional member to the Advisory Council on Radiation Protection.
Section 6. Provides that the bill will take effect on July 31, 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:

Radiologist assistant applicants for certification by endorsement must pay a nonrefundable application fee no greater than $50.

D. FISCAL COMMENTS:

According to the Department of Health, the fiscal impact to the department to enforce regulatory provisions relating to the certification of radiologist assistants will be minimal since the fees to regulate the profession will cover their administrative costs. According to the Bureau of Radiation Control within DOH, only about 10 radiologist assistants become certified in the nation on an annually. This number may increase to 20 if the exam is offered biannually.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides the Department of Health with adequate rule-making authority to implement the provisions provided for in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The enactment date of the bill is July 31, 2006. Usually the enactment date of a bill occurs on the first day of the month.

A strike-all amendment may be offered.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to radiologist assistants; amending s.
3 468.301, F.S.; providing definitions; amending s. 468.302,
4 F.S.; providing for identification of certified
5 radiologist assistants; providing for the duties and
6 limitations on duties of radiologist assistants; amending
7 s. 468.304, F.S.; providing conditions for qualification
8 for a radiologist assistant's certificate; amending s.
9 468.3065, F.S.; authorizing the Department of Health to
10 issue certificates by endorsement to certain radiologist
11 assistants; providing for a fee; amending s. 468.314,
12 F.S.; revising membership on the Advisory Council on
13 Radiation Protection; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Subsection (15) of section 468.301, Florida
18 Statutes, is renumbered as subsection (17), and new subsections
19 (15) and (16) are added to that section, to read:
20 468.301 Definitions.--As used in this part, the term:
21 (15) "Radiologist" means a physician specializing in
22 radiology certified by or eligible for certification by the
23 American Board of Radiology or the American Osteopathic Board of
24 Radiology, the British Royal College of Radiology, or the
25 Canadian College of Physicians and Surgeons.
26 (16) "Radiologist assistant" means a person, other than a
27 licensed practitioner, who is qualified by education and
28 certification, as set forth in s. 468.304, as an advanced-level

29 radiologic technologist who works under the supervision of a
30 radiologist to enhance patient care by assisting the radiologist
31 in the medical imaging environment.
32 Section 2. Paragraph (g) is added to subsection (2) of
33 section 468.302, Florida Statutes, and paragraph (h) is added to
34 subsection (3) of that section, to read:
35 468.302 Use of radiation; identification of certified
36 persons; limitations; exceptions.--
37 (2)
38 (g) A person holding a certificate as a radiologist
39 assistant may use the title "Certified Radiologist Assistant" or
40 the letters "CRA" after his or her name.
41
42 No other person is entitled to so use a title or letters
43 contained in this subsection or to hold himself or herself out
44 in any way, whether orally or in writing, expressly or by
45 implication, as being so certified.
46 (3)
47 (h) A person holding a certificate as a radiologist
48 assistant may:
49 1. Perform specific duties allowed for a radiologist
50 assistant as defined by the department by rule. The rule must be
51 consistent with guidelines adopted by the American College of
52 Radiology, the American Society of Radiologic Technologists, and
53 the American Registry of Radiologic Technologists, with the
54 level of supervision required by such guidelines.
55 2. Not interpret images, make diagnoses, or prescribe
56 medications or therapies.

57

58 For the purposes of this paragraph as it relates to the
59 radiologist assistant, "supervision" means the radiologist must
60 be present in the office suite and immediately available to
61 furnish assistance and direction throughout the performance of
62 the procedure. It does not mean that the radiologist must be
63 present in the room when the procedure is performed.
64 Section 3. Paragraph (e) of subsection (3) of section
65 468.304, Florida Statutes, is amended to read:
66 468.304 Certification.--The department shall certify any
67 applicant who meets the following criteria:
68 (3) Submits satisfactory evidence, verified by oath or
69 affirmation, that she or he:
70 (e)1. Has successfully completed an educational program,
71 which program may be established in a hospital licensed pursuant
72 to chapter 395 or in an accredited postsecondary academic
73 institution which is subject to approval by the department as
74 maintaining a satisfactory standard; or
75 2.a. With respect to an applicant for a basic X-ray
76 machine operator's certificate, has completed a course of study
77 approved by the department with appropriate study material
78 provided the applicant by the department;
79 b. With respect to an applicant for a basic X-ray machine
80 operator-podiatric medicine certificate, has completed a course
81 of study approved by the department, provided that such course
82 of study shall be limited to that information necessary to
83 perform radiographic procedures within the scope of practice of
84 a podiatric physician licensed pursuant to chapter 461;

85 c. With respect only to an applicant for a general
86 radiographer's certificate who is a basic X-ray machine operator
87 certificateholder, has completed an educational program or a 2-
88 year training program that takes into account the types of
89 procedures and level of supervision usually and customarily
90 practiced in a hospital, which educational or training program
91 complies with the rules of the department; ~~or~~
92 d. With respect only to an applicant for a nuclear
93 medicine technologist's certificate who is a general
94 radiographer certificateholder, has completed an educational
95 program or a 2-year training program that takes into account the
96 types of procedures and level of supervision usually and
97 customarily practiced in a hospital, which educational or
98 training program complies with the rules of the department; or~~.~~
99 e. With respect to an applicant for a radiologist
100 assistant's certificate who is a general radiographer
101 certificateholder, has completed an advanced educational program
102 encompassing a nationally recognized radiologist assistant
103 curriculum culminating in a baccalaureate degree,
104 postbaccalaureate certificate, or graduate degree and that
105 incorporates a radiologist-directed clinical preceptorship.
106
107 The department may not certify any applicant who has committed
108 an offense that would constitute a violation of any of the
109 provisions of s. 468.3101 or the rules adopted thereunder if the
110 applicant had been certified by the department at the time of
111 the offense. No application for a limited computed tomography
112 certificate shall be accepted. All persons holding valid

113 computed tomography certificates as of October 1, 1984, are
114 subject to the provisions of s. 468.309.
115 Section 4. Section 468.3065, Florida Statutes, is amended
116 to read:
117 468.3065 Certification by endorsement.--
118 (1) The department may issue a certificate by endorsement
119 to practice as a radiologist assistant to an applicant who, upon
120 applying to the department and remitting a nonrefundable fee not
121 to exceed $50, demonstrates to the department that he or she
122 holds a current certificate or registration as a radiologist
123 assistant granted by the American Registry of Radiologic
124 Technologists.
125 (2) The department may issue a certificate by endorsement
126 to practice radiologic technology to an applicant who, upon
127 applying to the department and remitting a nonrefundable fee not
128 to exceed $50, demonstrates to the department that he or she
129 holds a current certificate, license, or registration to
130 practice radiologic technology, provided that the requirements
131 for such certificate, license, or registration are deemed by the
132 department to be substantially equivalent to those established
133 under this part and rules adopted under this part.
134 Section 5. Subsection (1) of section 468.314, Florida
135 Statutes, is amended, paragraphs (h) through (n) of subsection
136 (2) of that section are redesignated as paragraphs (i) through
137 (o), respectively, and a new paragraph (h) is added to that
138 subsection, to read:
139 468.314 Advisory Council on Radiation Protection;
140 appointment; terms; powers; duties.--

141 (1) The Advisory Council on Radiation Protection is
142 created within the Department of Health and shall consist of 16
143 ~~15~~ persons to be appointed by the secretary for 3-year terms.
144 (2) The council shall be comprised of:
145 (h) A certified radiologist assistant.
146 Section 6. This act shall take effect July 31, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 819**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Grant offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Section 468.3001, Florida Statutes, is amended
7 to read:
8 468.3001 Short title.--This part ~~shall be known and~~ may be
9 cited as the "Radiological Personnel ~~Radiologic Technologist~~
10 Certification Act."
11 Section 2. Present subsections (4) through (15) of section
12 468.301, Florida Statutes, are redesignated as subsections (5)
13 through (18),respectively, new subsections (4), (16), and (17)
14 are added to that section, and present subsection (14) of that
15 section is amended, to read:
16 468.301 Definitions.--As used in this part, the term:
17 (4) "Certificateholder" means any person who holds a
18 certificate under this part that authorizes that person to use
19 radiation on human beings.
20 (15) ~~(14)~~ "Radiologic technologist" means a person, other
21 than a licensed practitioner, who is qualified by education,
22 training, or experience, as more specifically defined in s.

23 468.302(3)(d)-(g) ~~s. 468.302~~, to use radiation on human beings
24 under the specific direction and general supervision of a
25 licensed practitioner in each particular case.
26 (16) "Radiologist" means a physician specializing in
27 radiology certified by or eligible for certification by the
28 American Board of Radiology or the American Osteopathic Board of
29 Radiology, the British Royal College of Radiology, or the
30 Canadian College of Physicians and Surgeons.
31 (17) "Radiologist assistant" means a person, other than a
32 licensed practitioner, who is qualified by education and
33 certification, as set forth in s. 468.304, as an advanced-level
34 radiologic technologist who works under the supervision of a
35 radiologist to enhance patient care by assisting the radiologist
36 in the medical imaging environment.
37 Section 3. Subsections (1), (5), and (6) of section
38 468.302, Florida Statutes, are amended, paragraph (g) is added
39 to subsection (2) of that section, and paragraph (h) is added to
40 subsection (3) of that section, to read:
41 468.302 Use of radiation; identification of certified
42 persons; limitations; exceptions.--
43 (1) Except as provided in this section, a person may not
44 use radiation or otherwise practice radiologic technology or any
45 of the duties of a radiologist assistant on a human being unless
46 he or she:
47 (a) Is a licensed practitioner; ~~or~~
48 (b) Is the holder of a certificate, as provided in this
49 part, and is operating under the direct supervision or general
50 supervision of a licensed practitioner in each particular case;
51 or~~.~~

52 (c) Is the holder of radiologist assistant certificate, as
53 provided in this part, and is operating under the supervision of
54 a radiologist, as specified in paragraph (3)(h).
55 (2)
56 (g) A person holding a certificate as a radiologist
57 assistant may use the title "Certified Radiologist Assistant" or
58 the letters "CRA" after his or her name.
59
60 No other person is entitled to so use a title or letters
61 contained in this subsection or to hold himself or herself out
62 in any way, whether orally or in writing, expressly or by
63 implication, as being so certified.
64 (3)
65 (h) A person holding a certificate as a radiologist
66 assistant may:
67 1. Perform specific duties allowed for a radiologist
68 assistant as defined by the department by rule. The rule must be
69 consistent with guidelines adopted by the American College of
70 Radiology, the American Society of Radiologic Technologists, and
71 the American Registry of Radiologic Technologists, with the
72 level of supervision required by such guidelines.
73 2. Not perform nuclear medicine or radiation therapy
74 procedures unless currently certified and trained to perform
75 those duties under the person's nuclear medicine technologist or
76 radiation therapy technologist certificate; not interpret
77 images; not make diagnoses; and not prescribe medications or
78 therapies.
79 (5) Nothing contained in this part relating to radiologic
80 technology or a radiologist assistant shall be construed to
81 limit, enlarge, or affect in any respect the practice by duly
82 licensed practitioners of their respective professions.

83 (6) Requirement for certification does not apply to:
84 (a) A hospital resident who is not a licensed practitioner
85 in this state or a student enrolled in and attending a school or
86 college of medicine, osteopathic medicine, chiropody, podiatric
87 medicine, or chiropractic medicine or a radiologic technology
88 educational program or a radiologist assistant educational
89 program and who applies radiation to a human being while under
90 the direct supervision of a licensed practitioner.
91 (b) A person who is engaged in performing the duties of a
92 radiologic technologist or of a radiologist assistant in his or
93 her employment by a governmental agency of the United States.
94 (c) A person who is trained and skilled in cardiopulmonary
95 technology and who provides cardiopulmonary technology services
96 at the direction, and under the direct supervision, of a
97 licensed practitioner.
98 Section 4. Paragraph (e) of subsection (3) of section
99 468.304, Florida Statutes, is amended to read:
100 468.304 Certification.--The department shall certify any
101 applicant who meets the following criteria:
102 (3) Submits satisfactory evidence, verified by oath or
103 affirmation, that she or he:
104 (e)1. Has successfully completed an educational program,
105 which program may be established in a hospital licensed pursuant
106 to chapter 395 or in an accredited postsecondary academic
107 institution which is subject to approval by the department as
108 maintaining a satisfactory standard; or
109 2.a. With respect to an applicant for a basic X-ray
110 machine operator's certificate, has completed a course of study
111 approved by the department with appropriate study material
112 provided the applicant by the department;

113 b. With respect to an applicant for a basic X-ray machine
114 operator-podiatric medicine certificate, has completed a course
115 of study approved by the department, provided that such course
116 of study shall be limited to that information necessary to
117 perform radiographic procedures within the scope of practice of
118 a podiatric physician licensed pursuant to chapter 461;
119 c. With respect only to an applicant for a general
120 radiographer's certificate who is a basic X-ray machine operator
121 certificateholder, has completed an educational program or a 2-
122 year training program that takes into account the types of
123 procedures and level of supervision usually and customarily
124 practiced in a hospital, which educational or training program
125 complies with the rules of the department; ~~or~~
126 d. With respect only to an applicant for a nuclear
127 medicine technologist's certificate who is a general
128 radiographer certificateholder, has completed an educational
129 program or a 2-year training program that takes into account the
130 types of procedures and level of supervision usually and
131 customarily practiced in a hospital, which educational or
132 training program complies with the rules of the department; or~~.~~
133 e. With respect to an applicant for a radiologist
134 assistant's certificate who demonstrates to the department that
135 he or she holds a current certificate or registration as a
136 radiologist assistant granted by the American Registry of
137 Radiologic Technologists.
138
139 The department may not certify any applicant who has committed
140 an offense that would constitute a violation of any of the
141 provisions of s. 468.3101 or the rules adopted thereunder if the
142 applicant had been certified by the department at the time of
143 the offense. No application for a limited computed tomography

144 certificate shall be accepted. All persons holding valid
145 computed tomography certificates as of October 1, 1984, are
146 subject to the provisions of s. 468.309.
147 Section 5. Section 468.306, Florida Statutes, is amended
148 to read:
149 468.306 Examinations.--All applicants for certification as
150 a radiologic technologist, basic X-ray machine operator, or
151 basic X-ray machine operator-podiatric medicine, except those
152 certified pursuant to s. 468.3065, shall be required to pass an
153 examination. In lieu of an examination for a radiologist
154 assistant certificate, the department shall accept a
155 demonstration by the applicant for such a certificate that he or
156 she holds a current certificate or registration as a radiologist
157 assistant granted by the American Registry of Radiologic
158 Technologists. The department may ~~is authorized to~~ develop or
159 use examinations for each type of certificate. The department
160 may require an applicant who does not pass an examination after
161 five attempts to complete additional remedial education, as
162 specified by rule of the department, before admitting the
163 applicant to subsequent examinations.
164 (1) The department may ~~shall have the authority to~~
165 contract with organizations that develop such test examinations.
166 Examinations may be administered by the department or the
167 contracting organization.
168 (2) Examinations shall be given for each type of
169 certificate at least twice a year at such times and places as
170 the department may determine to be advantageous for applicants.
171 (3) All examinations shall be written and include
172 positioning, technique, and radiation protection. The department
173 shall either pass or fail each applicant on the basis of his or
174 her final grade. The examination for a basic X-ray machine

175 operator shall include basic positioning and basic techniques
176 directly related to the skills necessary to safely operate
177 radiographic equipment.
178 (4) A nonrefundable fee not to exceed $75 plus the actual
179 per-applicant cost for purchasing the examination from a
180 national organization shall be charged for any subsequent
181 examination.
182 Section 6. Section 468.3065, Florida Statutes, is amended
183 to read:
184 468.3065 Certification by endorsement.--
185 (1) The department may issue a certificate by endorsement
186 to practice as a radiologist assistant to an applicant who, upon
187 applying to the department and remitting a nonrefundable fee not
188 to exceed $50, demonstrates to the department that he or she
189 holds a current certificate or registration as a radiologist
190 assistant granted by the American Registry of Radiologic
191 Technologists.
192 (2) The department may issue a certificate by endorsement
193 to practice radiologic technology to an applicant who, upon
194 applying to the department and remitting a nonrefundable fee not
195 to exceed $50, demonstrates to the department that he or she
196 holds a current certificate, license, or registration to
197 practice radiologic technology, provided that the requirements
198 for such certificate, license, or registration are deemed by the
199 department to be substantially equivalent to those established
200 under this part and rules adopted under this part.
201 Section 7. Subsection (3) of section 468.307, Florida
202 Statutes, is amended to read:
203 468.307 Certificate; issuance; display.--

204 (3) Every employer of certificateholders ~~radiologic~~
205 ~~technologists~~ shall display the certificates of all of such
206 employees in a place accessible to view.
207 Section 8. Paragraph (a) of subsection (1), and
208 subsections (4), (5), (6), and (7) of section 468.309, Florida
209 Statutes, are amended to read:
210 468.309 Certificate; duration; renewal; reversion to
211 inactive status; members of Armed Forces and spouses.--
212 (1)(a) A ~~radiologic technologist's~~ certificate issued in
213 accordance with this part expires as specified in rules adopted
214 by the department which establish a procedure for the biennial
215 renewal of certificates. A certificate shall be renewed by the
216 department for a period of 2 years upon payment of a renewal fee
217 in an amount not to exceed $75 and upon submission of a renewal
218 application containing such information as the department deems
219 necessary to show that the applicant for renewal is a
220 certificateholder ~~radiologic technologist~~ in good standing and
221 has completed any continuing education requirements that the
222 department establishes.
223 (4) Any certificate that is not renewed by its expiration
224 date shall automatically be placed in an expired status, and the
225 certificateholder may not practice radiologic technology or
226 perform the duties of a radiologist assistant until the
227 certificate has been reactivated.
228 (5) A certificateholder in good standing remains in good
229 standing when he or she becomes a member of the Armed Forces of
230 the United States on active duty without paying renewal fees or
231 accruing continuing education credits as long as he or she is a
232 member of the Armed Forces on active duty and for a period of 6
233 months after discharge from active duty, if he or she is not
234 engaged in practicing radiologic technology or performing the

235 duties of a radiologist assistant in the private sector for
236 profit. The certificateholder must pay a renewal fee and
237 complete continuing education not to exceed 12 classroom hours
238 to renew the certificate.
239 (6) A certificateholder who is in good standing remains in
240 good standing if he or she is absent from the state because of
241 his or her spouse's active duty with the Armed Forces of the
242 United States. The certificateholder remains in good standing
243 without paying renewal fees or completing continuing education
244 as long as his or her spouse is a member of the Armed Forces on
245 active duty and for a period of 6 months after the spouse's
246 discharge from active duty, if the certificateholder is not
247 engaged in practicing radiologic technology or performing the
248 duties of a radiologist assistant in the private sector for
249 profit. The certificateholder must pay a renewal fee and
250 complete continuing education not to exceed 12 classroom hours
251 to renew the certificate.
252 (7) A certificateholder may resign his or her
253 certification by submitting to the department a written,
254 notarized resignation on a form specified by the department. The
255 resignation automatically becomes effective upon the
256 department's receipt of the resignation form, at which time the
257 certificateholder's certification automatically becomes null and
258 void and may not be reactivated or renewed or used to practice
259 radiologic technology or to perform the duties of a radiologist
260 assistant. A certificateholder who has resigned may become
261 certified again only by reapplying to the department for
262 certification as a new applicant and meeting the certification
263 requirements pursuant to s. 468.304 or s. 468.3065. Any
264 disciplinary action that had been imposed on the
265 certificateholder prior to his or her resignation shall be

266 tolled until he or she again becomes certified. Any disciplinary
267 action proposed at the time of the certificateholder's
268 resignation shall be tolled until he or she again becomes
269 certified.
270 Section 9. Paragraphs (a) and (c) of subsection (2) of
271 section 468.3095, Florida Statutes, are amended to read:
272 468.3095 Inactive status; reactivation; automatic
273 suspension; reinstatement.--
274 (2)(a) A certificate that has been expired for less than
275 10 years may be reactivated upon payment of the biennial renewal
276 fee and a late renewal fee, not to exceed $100, and submission
277 of a reactivation application containing any information that
278 the department deems necessary to show that the applicant is a
279 certificateholder ~~radiologic technologist~~ in good standing and
280 has met the requirements for continuing education. The
281 department shall prescribe, by rule, continuing education
282 requirements as a condition of reactivating a certificate. The
283 continuing education requirements for reactivating a certificate
284 may not exceed 10 classroom hours for each year the certificate
285 was expired and may not exceed 100 classroom hours for all years
286 in which the certificate was expired.
287 (c) A certificate that has been inactive or expired for 10
288 years or more automatically becomes null and void and may not be
289 reactivated, renewed, or used to practice radiologic technology
290 or to perform the duties of a radiologist assistant. A
291 certificateholder whose certificate has become null and void may
292 become certified again only by reapplying to the department as a
293 new applicant and meeting the requirements of s. 468.304 or s.
294 468.3065.
295 Section 10. Subsections (1), (2), (3), and (5) of section
296 468.3101, Florida Statutes, are amended to read:

297 468.3101 Disciplinary grounds and actions.--
298 (1) The department may make or require to be made any
299 investigations, inspections, evaluations, and tests, and require
300 the submission of any documents and statements, which it
301 considers necessary to determine whether a violation of this
302 part has occurred. The following acts shall be grounds for
303 disciplinary action as set forth in this section:
304 (a) Procuring, attempting to procure, or renewing a
305 certificate ~~to practice radiologic technology~~ by bribery, by
306 fraudulent misrepresentation, or through an error of the
307 department.
308 (b) Having a voluntary or mandatory certificate to
309 practice radiologic technology <u>or to perform the duties of a</u>
310 <u>radiologist assistant</u> revoked, suspended, or otherwise acted
311 against, including being denied certification, by a national
312 organization; by a specialty board recognized by the department;
313 or by a certification authority of another state, territory, or
314 country.
315 (c) Being convicted or found guilty, regardless of
316 adjudication, in any jurisdiction of a crime that directly
317 relates to the practice of radiologic technology <u>or to the</u>
318 <u>performance of the duties of a radiologist assistant,</u> or to the
319 ability to practice radiologic technology <u>or the ability to</u>
320 <u>perform the duties of a radiologist assistant</u>. Pleading nolo
321 contendere shall be considered a conviction for the purpose of
322 this provision.
323 (d) Being convicted or found guilty, regardless of
324 adjudication, in any jurisdiction of a crime against a person.
325 Pleading nolo contendere shall be considered a conviction for
326 the purposes of this provision.

(e) Making or filing a false report or record that the certificateholder knows to be false, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing such filing or inducing another to do so. Such reports or records include only those reports or records which are signed in the capacity of the certificateholder ~~as a radiologic technologist~~.

(f) Engaging in unprofessional conduct, which includes, but is not limited to, any departure from, or the failure to conform to, the standards of practice of radiologic technology or the standards of practice for radiologist assistants as established by the department, in which case actual injury need not be established.

(g) Being unable to practice radiologic technology or to perform the duties of a radiologist assistant with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or other materials or as a result of any mental or physical condition. A certificateholder ~~radiologic technologist~~ affected under this paragraph shall, at reasonable intervals, be afforded an opportunity to demonstrate that he or she can resume the competent practice of his or her certified profession ~~radiologic technology~~ with reasonable skill and safety.

(h) Failing to report to the department any person who the certificateholder knows is in violation of this part or of the rules of the department.

(i) Violating any provision of this part, any rule of the department, or any lawful order of the department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the department.

357 (j) Employing, for the purpose of applying ionizing
358 radiation or otherwise practicing radiologic technology or
359 performing the duties of a radiologist assistant on a human
360 being, any individual who is not certified under the provisions
361 of this part.
362 (k) Testing positive for any drug, as defined in s.
363 112.0455, on any confirmed preemployment or employer-required
364 drug screening when the certificateholder ~~radiologic~~
365 ~~technologist~~ does not have a lawful prescription and legitimate
366 medical reason for using such drug.
367 (l) Failing to report to the department in writing within
368 30 days after the certificateholder has had a voluntary or
369 mandatory certificate to practice radiologic technology or to
370 perform the duties of a radiologist assistant revoked,
371 suspended, or otherwise acted against, including being denied
372 certification, by a national organization, by a specialty board
373 recognized by the department, or by a certification authority of
374 another state, territory, or country.
375 (m) Having been found guilty of, regardless of
376 adjudication, or pleading guilty or nolo contendere to, any
377 offense prohibited under s. 435.03 or under any similar statute
378 of another jurisdiction.
379 (n) Failing to comply with the recommendations of the
380 department's impaired practitioner program for treatment,
381 evaluation, or monitoring. A letter from the director of the
382 impaired practitioner program that the certificateholder is not
383 in compliance shall be considered conclusive proof under this
384 part.
385 (2) If the department finds any person or firm guilty of
386 any of the grounds set forth in subsection (1), it may enter an
387 order imposing one or more of the following penalties:

388 (a) Refusal to approve an application for certification.
389 (b) Revocation or suspension of a certificate.
390 (c) Imposition of an administrative fine not to exceed
391 $1,000 for each count or separate offense.
392 (d) Issuance of a reprimand.
393 (e) Placement of the certificateholder ~~radiologic~~
394 ~~technologist~~ on probation for such period of time and subject to
395 such conditions as the department may specify, including
396 requiring the certificateholder ~~radiologic technologist~~ to
397 submit to treatment, to undertake further relevant education or
398 training, to take an examination, or to work under the
399 supervision of a licensed practitioner.
400 (3) The department shall not reinstate a person's ~~the~~
401 certificate ~~of a radiologic technologist~~, or cause a certificate
402 to be issued to a person it has deemed unqualified, until such
403 time as the department is satisfied that such person has
404 complied with all the terms and conditions set forth in the
405 final order and is capable of safely engaging in the practice of
406 his or her certified profession ~~radiologic technology~~.
407 (5) A final disciplinary action taken against a
408 certificateholder ~~radiologic technologist~~ in another
409 jurisdiction, whether voluntary or mandatory, shall be
410 considered conclusive proof of grounds for a disciplinary
411 proceeding under this part.
412 Section 11. Section 468.311, Florida Statutes, is amended
413 to read:
414 468.311 Violations; penalties.--Each of the following acts
415 constitutes a misdemeanor of the second degree, punishable as
416 provided in s. 775.082 or s. 775.083:

417 (1) Practicing radiologic technology or performing the
418 duties of a radiologist assistant without holding an active
419 certificate to do so.
420 (2) Using or attempting to use a certificate which has
421 been suspended or revoked.
422 (3) The willful practice of radiologic technology or the
423 willful performance of the duties of a radiologist assistant by
424 a student ~~radiologic technologist~~ without a direct supervisor
425 being present.
426 (4) Knowingly allowing a student ~~radiologic technologist~~
427 to practice radiologic technology or perform the duties of a
428 radiologist assistant without a direct supervisor being present.
429 (5) Obtaining or attempting to obtain a certificate under
430 this part through bribery or fraudulent misrepresentation.
431 (6) Using any ~~the~~ name or title specified in s. 468.302(2)
432 ~~"Certified Radiologic Technologist"~~ or any other name or title
433 which implies that a person is certified to practice radiologic
434 technology or to perform the duties of a radiologist assistant,
435 unless such person is duly certified as provided in this part.
436 (7) Knowingly concealing information relating to the
437 enforcement of this part or rules adopted pursuant to this part.
438 (8) Employing, for the purpose of applying ionizing
439 radiation to, or otherwise practicing radiologic technology or
440 any of the duties of a radiologist assistant on, any human
441 being, any individual who is not certified under the provisions
442 of this part.
443 Section 12. Section 468.3115, Florida Statutes, is amended
444 to read:
445 468.3115 Injunctive relief.--The practice of radiologic
446 technology or the performance of the duties of a radiologist
447 assistant in violation of this part, or the performance of any

448 act prohibited in this part, is declared a nuisance inimical to
449 the public health, safety, and welfare of this state. In
450 addition to other remedies provided in this part, the
451 department, or any state attorney in the name of the people of
452 this state, may bring an action for an injunction to restrain
453 such violation until compliance with the provisions of this part
454 and the rules adopted pursuant to this part has been
455 demonstrated to the satisfaction of the department.
456 Section 13. Subsections (1), (2), and (5) of section
457 468.314, Florida Statutes, are amended to read:
458 468.314 Advisory Council on Radiation Protection;
459 appointment; terms; powers; duties.--
460 (1) The Advisory Council on Radiation Protection is
461 created within the Department of Health and shall consist of 16
462 ~~15~~ persons to be appointed by the secretary for 3-year terms.
463 (2) The council shall be comprised of:
464 (a) A certified radiologic technologist-radiographer.
465 (b) A certified radiologic technologist-nuclear medicine.
466 (c) A certified radiologic technologist-therapy.
467 (d) A basic X-ray machine operator or a licensed
468 practitioner who employs such an operator.
469 (e) A board-certified radiologist.
470 (f) A board-certified nuclear medicine physician.
471 (g) A certified health physicist.
472 (h) A certified radiologist assistant.
473 (i) ~~(h)~~ A representative from the administration of a
474 hospital affiliated with a radiologic technology educational
475 program.
476 (j) ~~(i)~~ An expert in environmental radiation matters.
477 (k) ~~(j)~~ A chiropractic radiologist.
478 (l) ~~(k)~~ A board-certified podiatric physician.

479 (m) ~~(l)~~ A board-certified radiological physicist.
480 (n) ~~(m)~~ A board-certified therapeutic radiologist or board-
481 certified radiation oncologist.
482 (o) ~~(n)~~ Two persons, neither of whom has ever been
483 certified pursuant to this part ~~as a radiologic technologist~~ or
484 been a member of any closely related profession.
485 (5)(a) The council may recommend to the department
486 examination procedures for applicants and minimum requirements
487 for qualification of applicants.
488 (b) The council shall:
489 1. Recommend to the department a code of ethics for the
490 certificateholder's practice of his or her certified profession
491 ~~radiologic technology~~.
492 2. Make recommendations for the improvement of continuing
493 education courses.
494 3. Make recommendations to the department on matters
495 relating to the practice of radiologic technology, the
496 performance of the duties of a radiologist assistant, and
497 radiation protection.
498 4. Study the utilization of medical imaging and
499 nonionizing radiation, such as nuclear magnetic resonance or
500 similarly related technology, and make recommendations to the
501 department on the personnel appropriate to conduct such
502 procedures and the minimum qualifications for such personnel.
503 Section 14. This act shall take effect July 1, 2006.
504
505
506 ========== T I T L E A M E N D M E N T ==========
507 Remove the entire title and insert:
508 An act relating to radiologist assistants; amending s. 468.3001,
509 F.S.; redesignating part IV of ch. 468, F.S., as the

510 "Radiological Personnel Certification Act"; amending s. 468.301,
511 F.S.; providing definitions; amending s. 468.302, F.S.;
512 providing for identification and duties of a radiologist
513 assistant; providing for rulemaking by the Department of Health;
514 providing limitations on duties a radiologist assistant may
515 perform; amending s. 468.304, F.S.; providing conditions for
516 qualification for a radiologist assistant's certificate;
517 amending s. 468.306, F.S.; requiring certain applicants for
518 certification as a radiographer to pass an examination;
519 requiring the department to accept certain demonstrations by an
520 applicant for a certification to practice as a radiologist
521 assistant in lieu of any examination requirement; amending s.
522 468.3065, F.S.; authorizing the Department of Health to issue
523 certificates by endorsement to certain radiologist assistants;
524 providing for a fee; amending ss. 468.307, 468.309, 468.3095,
525 468.3101, 468.311, and 468.3115, F.S.; including radiologist
526 assistants in provisions applicable to radiologic technologists
527 with respect to requirements for certificate display,
528 certificate renewal, change of certificate status, grounds for
529 disciplinary action, violations, penalties, and injunctive
530 relief; amending s. 468.314, F.S.; adding a certified
531 radiologist assistant to the membership of the Advisory Council
532 on Radiation Protection; providing an effective date.

HB 1111

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1111 Financial Responsibility of Advanced Registered Nurse Practitioners
SPONSOR(S): Proctor
TIED BILLS: **IDEN./SIM. BILLS:** SB 2212

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Halperin	Mitchell
2) Judiciary			
3) Health Care Appropriations			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 1111 creates s. 464.028, F.S., to provide an exemption for licensed Advanced Registered Nurse Practitioners (ARNPs) from the requirement to either carry medical malpractice insurance or self-insure through a line of credit, under certain circumstances. The terms "exemption" and "uninsured" refer to those ARNPs who neither carry malpractice insurance nor self-insure through a line of credit.

According to the DOH, ARNPs have experienced increased liability exposure in the past two years, and costs of liability have doubled or tripled during this same time frame.[1] As a consequence, licensees report increased difficulty in obtaining liability insurance at affordable rates, if at all. These difficulties have caused some ARNPs to discontinue their practice; and are especially problematic for ARNPs in rural and underserved areas of Florida who are not covered by a facility umbrella liability policy.

The bill requires that uninsured licensees post notice in the waiting room or provide a written statement to potential patients disclosing the lack of malpractice insurance. The bill further requires that ARNPs pay malpractice claims of certain amounts under specified conditions: up to $100,000 if he or she does not maintain hospital staff privileges or $250,000 if the licensee maintains hospital staff privileges. The bill specifies the time frame and process for probable cause judgments and licensee appeals; and requires the Department of Health (DOH) to oversee disciplinary actions.

According to the Department of Health, the bill has an indeterminate fiscal impact.

The effective date of the bill is July 1, 2006.

[1] Department of Health analysis on HB 1111, March 14, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill removes a current requirement for ARNPs to carry liability protection through either malpractice insurance or a line of credit, and permits them to self-insure. At the same time, the bill increases the responsibilities of the DOH to regulate malpractice claims against ARNPs.

Safeguard individual liberty – The bill removes the requirement for ARNPs to self-insure, which may decrease the likelihood of judgment payout in malpractice suits.

B. EFFECT OF PROPOSED CHANGES:

Advanced Registered Nurse Practitioners are currently required to carry liability protection through either medical malpractice insurance or through a line of credit. HB 1111 creates s. 464.028, F.S., to provide an exemption from these requirements under certain circumstances. For ARNPs who choose to practice without coverage, the bill requires that he or she post notice in the waiting room or provide a written statement to potential patients disclosing the lack of malpractice insurance.

The bill sets minimum financial responsibility requirements of $100,000 for ARNPs without hospital staff privileges or $250,000 for ARNPs with hospital staff privileges. This payment would be due within 60 days after a malpractice judgment becomes final.

The bill requires the Department of Health to notify a licensee of possible disciplinary actions upon notification of an unsatisfied judgment; and requires the department to issue an emergency order suspending the license and certification of any licensee who fails to pay a claim or file an appeal within 30 days of notice. The bill provides that the probable cause panel must determine at its next meeting whether to take disciplinary action against the licensee. Penalties may include probation of the license, payments to the judgment creditor on a schedule determined by the board, or suspension of the license and certification for up to 5 years.

The department must provide an agreed upon schedule for payment or proof of appeal; and requires that the department reinstate the licensee's license and certification after proof of payment or a payment schedule is received.

The effective date of the bill is July 1, 2006.

PRESENT SITUATION

According to the DOH, ARNPs have experienced increased liability exposure in the past two years, and costs of liability have doubled or tripled during this same time frame.[2] Many insurance underwriters are looking to decrease their risk by not writing new policies for ARNPs in Florida, by canceling coverage, limiting the amount of coverage, or by raising premiums.[3] As a consequence, licensees report increased difficulty in obtaining liability insurance at affordable rates, if at all. These difficulties have caused some ARNPs to discontinue their practice; and are especially problematic for ARNPs in rural and underserved areas of Florida who are not covered by a facility umbrella liability policy.

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[2] Department of Health analysis on HB 1111, March 14, 2006.

[3] *Florida Nurse Practitioner Network.* "Professional Liability Insurance for Nurse Practitioners in Florida: Two Issues: Policies and Bad Information in Print." December 2005. www.fnpn.org/~main/id43.html

Current ARNP Financial Responsibility and Licensing Requirements

Section 456.048, F.S., requires ARNPs to carry malpractice insurance coverage or liability protection through a line of credit as a requisite for licensure and licensure renewal. The Board of Nursing is required by rule to determine the amount and manner of insurance sufficient to cover claims arising out of the rendering or failure to render professional care. All licensees must submit such proof as a condition of license renewal. ARNPs may meet this requirement by purchasing malpractice insurance, by getting a letter of credit, or by demonstrating exemption based on certain circumstances.

ARNP's must be covered in one of the following capacities[4]:

1. Carry professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000. Policies may be written from an authorized insurer, a surplus lines insurer, a joint underwriting association, a self-insurance plan, or a risk retention group;[5] or

2. Attain an unexpired irrevocable letter of credit[6] in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the ARNP as beneficiary.

Exemptions from Financial Responsibility

Exemptions from financial responsibility are provided in s. 456.048(2), F.S. An ARNP must meet one of the following criterions to be exempt from the malpractice requirements:

1. Practice exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions, or as a volunteer;[7]
2. Have a license or certification that has become inactive;
3. Hold a limited license and practice under the scope of such limited license;[8]
4. Practice only in conjunction with his or her teaching duties at an accredited school or in its main teaching hospitals;
5. Does not practice in the State of Florida; or
6. Can demonstrate that he or she has no malpractice exposure in the state.

Consequences of Self-Insurance or "Going Bare"

Currently in Florida, all health care professionals[9] except for physicians are required to maintain financial responsibility and do not have the option to carry a license without malpractice insurance. Experiences of physicians in "going bare" may suggest implications for ARNPs receiving this option. According to the Board of Medicine, approximately seven percent of Florida's physicians chose to go without insurance in 2004. Certain regions of the state have higher levels; for example, it was estimated that in Broward and Miami-Dade Counties between one-third and one-half of physicians were without liability insurance in 2005.[10]

The Department of Health reports that in the past eight years there have been five cases involving judgments against physicians without insurance. In each of these cases, the Board of Medicine required suspension of the licensee until proof of payment, or until a payment plan for the judgment

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[4] Rule 64B9-4.002(5)(a), Florida Administrative Code

[5] "Authorized insurer" is defined in s. 624.09, F.S; "surplus lines insurer" is defined in s. 626.914(2), F.S.; "joint underwriting association" is defined in s. 627.351(4), F.S., "self insurance plan" is defined in s. 627.357, F.S; and "risk retention group" is defined in s. 627.942, F.S.

[6] As defined by Chapter 675, F.S.

[7] Employee defined in s. 768.28(9)(b), F.S. and volunteer is defined in s. 110.501(1), F.S.

[8] Limited licenses are defined in s. 456.015, F.S.

[9] Acupuncturists, chiropractors, podiatrists, midwives, dentists, and advanced registered nurse practitioners, under Florida statute, do not have the option to fulfill their financial responsibility through self-insurance.

[10] "Doctors HUG or go bare" by John Dorschner, *Miami Herald,* July 18, 2005.

was provided. There have been a few cases of self-insured physicians who, when faced with a judgment against them, went bankrupt instead of paying the injured patient.[11] Courts have not consistently found hospitals liable for physicians who refuse to pay a judgment against them, but courts have noted the growing controversy.[12]

Different Criterion for Physicians Exemptions

The exemptions from financial responsibility for physicians to "go bare" are more extensive than those provided for ARNPs in HB 1111. In addition to the exemptions described for ARNPs above, physicians must also meet all of the following criteria in order to "go bare":

- Physicians hold an active license to practice in this state or another state or some combination thereof for more than 15 years;
- Physicians are retired or maintain part-time practice of no more than 1000 patient contact hours per year;
- Physicians have had no more than two claims resulting in an indemnity exceeding $10,000 within the previous five-year period;
- Physicians have not been convicted of or pled guilty to any criminal violation specified in Chapter 458 or 459, F.S.; and
- Physicians have not been subject, within the past ten years of practice, to license revocation or suspension, probation for a period of three years or longer, or a fine of $500 or more for a violation of Chapter 458 or 459, F.S., or the medical practice act of another jurisdiction.

C. SECTION DIRECTORY:

Section 1. Creates s. 464.028, F.S: provides for exempting licensed ARNPs from medical malpractice insurance requirements under specified circumstances; requires licensees to pay medical malpractice judgment amounts when rendered; increases Board of Nursing disciplinary procedures.

Section 2. Provides enacting date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   According to the Department of Health this bill would increase the number of emergency suspension orders and disciplinary actions against ARNPs. Because the actual increased number is indeterminate, the department cannot estimate the increase in enforcement costs against ARNPs who do not comply with the requirements of this bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

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[11] Daily Business Review, *Hospitals off hook for doctor's malpractice,* March 9, 2005.

[12] See *Baker v. Tenet Healthsystem Hospital Inc.*, 780 So.2d 170, 2001; *Robert v. A. Paschall,* 767 So.2d, 2000; and *Mercy Hospital v. Baumgardner,* 870 So. 2d 130, 2004.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Department of Health, there will be a minimal fiscal impact for rule promulgation which can be covered with existing resources.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None required.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Impact on the Department of Health

The DOH reports that this bill will require the department to create forms and have those forms officially adopted. The creation and approval of these forms could take as long as 90 days after the enactment of the law. Therefore, the department requests the effective date be changed to October 1, 2006.

Stakeholder Opinions

Proponents of the bill express concerns over the availability and affordability of malpractice insurance for ARNPs, and have noted the different standards for ARNPs and physicians to carry insurance coverage. Proponents argue that problems of availability and the cost of insurance are driving much needed health professionals out of the state.

Opponents of the bill express concerns that physicians who "go-bare" are hurting health care consumers, and that the same problems would occur if ARNPs were allowed to do so. They argue that when there are judgments against a "bare" practitioner and the practitioner does not pay, the injured patients and families receive no compensation.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to financial responsibility of advanced
3 registered nurse practitioners; creating s. 464.028, F.S.;
4 providing for exempting licensed advanced registered nurse
5 practitioners from certain medical malpractice insurance
6 requirements under certain circumstances; providing
7 criteria; requiring licensees to pay certain medical
8 malpractice judgment amounts under certain circumstances;
9 requiring the Department of Health to notify a licensee of
10 possible disciplinary action under certain circumstances;
11 providing requirements; requiring the department to
12 suspend the license and certification of such licensed
13 practitioners for certain failures to comply; providing
14 duties of a probable cause panel relating to disciplinary
15 actions against a licensee; requiring the Board of Nursing
16 to take certain disciplinary actions against a licensee
17 under certain circumstances; authorizing the board to
18 remove certain restrictions on a license and
19 certification; requiring certain licensees to post a
20 notice disclosing lack of medical malpractice insurance
21 under certain circumstances; specifying notice contents;
22 requiring the department to suspend the license and
23 certification of a licensee for failing to pay certain
24 judgments or awards for damages; providing for
25 reinstatement of the license and certification; providing
26 an effective date.
27
28 Be It Enacted by the Legislature of the State of Florida:

29

30 Section 1. Section 464.028, Florida Statutes, is created
31 to read:
32 464.028 Financial responsibility of advanced registered
33 nurse practitioners; exemption.--
34 (1)(a) Any person holding an active license and
35 certification to practice as an advanced registered nurse
36 practitioner under s. 464.012 who meets the criteria of
37 paragraph (b) may be exempt from the requirement to maintain
38 medical malpractice insurance as prescribed in s. 456.048 or by
39 rule of the board.
40 (b) Upon the entry of an adverse final judgment arising
41 from a medical malpractice arbitration award, from a claim of
42 medical malpractice in contract or in tort, or from
43 noncompliance with the terms of a settlement agreement arising
44 from a claim of medical malpractice in contract or in tort, the
45 licensee shall pay the judgment creditor the lesser of the
46 entire amount of the judgment with all accrued interest or
47 $100,000 if the advanced registered nurse practitioner is
48 licensed pursuant to this chapter but does not maintain hospital
49 staff privileges or $250,000 if the advanced registered nurse
50 practitioner is licensed pursuant to this chapter and maintains
51 hospital staff privileges, within 60 days after the date such
52 judgment becomes final and subject to execution, unless
53 otherwise mutually agreed to by the parties. Such adverse final
54 judgment shall include any cross claim, counterclaim, or claim
55 for indemnity or contribution arising from the claim of medical
56 malpractice. Upon notification of the existence of an

57 unsatisfied judgment or payment pursuant to this paragraph, the
58 department shall notify the licensee by certified mail that he
59 or she shall be subject to disciplinary action unless, within 30
60 days after the date of mailing, he or she:
61 1. Shows proof that the unsatisfied judgment has been paid
62 in the amount specified in this paragraph; or
63 2. Provides the department a copy of a timely filed notice
64 of appeal, and:
65 a. A copy of a supersedeas bond properly posted in the
66 amount required by law; or
67 b. An order from a court of competent jurisdiction staying
68 execution on the final judgment pending disposition of the
69 appeal.
70 (2) The department shall issue an emergency order
71 suspending the license and certification of any licensee who,
72 after 30 days following the receipt of a notice from the
73 department, has failed to:
74 (a) Satisfy a medical practice claim against him or her;
75 or (b) Provide the Department of Health:
76 1. A copy of a timely filed notice of appeal; and
77 2.a. A copy of a supersedeas bond properly posted in the
78 amount declared by law; or
79 b. An order from a court of competent jurisdiction staying
80 execution on the final judgment pending disposition of the
81 appeal.
82 (3) Upon the next meeting of a probable cause panel of the
83 board following 30 days after the date of mailing the notice of
84 disciplinary action to the licensee, the panel shall make a

85 determination of whether probable cause exists to take
86 disciplinary action against the licensee pursuant to subsection
87 (2).
88 (4) If the board determines that the factual requirements
89 of subsection (2) are met, the board shall take such
90 disciplinary action against the licensee as the board deems
91 appropriate. Such disciplinary action shall include, at a
92 minimum, probation of the license with the restriction that the
93 licensee must make payments to the judgment creditor on a
94 schedule determined by the board to be reasonable and within the
95 financial capability of the licensee. Notwithstanding any other
96 disciplinary action imposed, the disciplinary penalty may
97 include suspension of the license and certification for a period
98 not to exceed 5 years. If an agreement to satisfy a judgment has
99 been met and the licensee has completed a form supplying any
100 necessary information required by the department, the board may
101 remove any restriction on the license and certification.
102 (5) A licensee who meets the requirements of this section
103 shall post a notice in the form of a sign prominently displayed
104 in the reception area and clearly noticeable by all patients or
105 provide a written statement to any person to whom advanced
106 registered nurse practitioner services are provided stating:
107 "Under Florida law, advanced registered nurse practitioners
108 (ARNPs) are generally required to carry medical malpractice
109 insurance or otherwise demonstrate financial responsibility to
110 cover potential claims for medical malpractice. YOUR ADVANCED
111 REGISTERED NURSE PRACTITIONER HAS DECIDED NOT TO CARRY MEDICAL
112 MALPRACTICE INSURANCE. This is permitted under Florida law

113 subject to certain conditions. Florida law imposes penalties
114 against noninsured advanced registered nurse practitioners who
115 fail to satisfy adverse judgments arising from claims of medical
116 malpractice. This notice is provided pursuant to Florida law."
117 (6) Notwithstanding any other provision of this section,
118 the department shall suspend the license and certification of
119 any advanced registered nurse practitioner against whom has been
120 entered a final judgment, arbitration award, or other order or
121 who has not entered into a settlement agreement to pay damages
122 arising out of a claim for medical malpractice, if all appellate
123 remedies have been exhausted and payment of up to the amounts
124 required by this section has not been made within 30 days after
125 the entering of such judgment, award, order, or agreement until
126 proof of payment is received by the department or a payment
127 schedule has been agreed upon by the advanced registered nurse
128 practitioner and the claimant and presented to the department.
129 After proof of payment is received by the department or a
130 payment schedule has been agreed upon by the advanced registered
131 nurse practitioner and the claimant and presented to the
132 department, the department shall reinstate the licensee's
133 license and certification.
134 Section 2. This act shall take effect July 1, 2006.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1177 Patient Handling and Moving Practices
SPONSOR(S): Roberson and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2244

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Bell AJB	Mitchell
2) Elder & Long-Term Care Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 1177 address staff back injuries in hospitals and nursing homes. According to the Bureau of Labor Statistics, nursing personnel are consistently listed as one of the top ten occupations for work-related musculoskeletal disorders, with incident rates of 8.8 per 100 in hospital settings and 13.5 in nursing home settings.[1]

The bill requires that nursing homes and hospitals develop a program to adopt and implement safe patient handling and moving practices. The program requirements include:

- Establishment of a safe patient handling and moving committee to implement a minimal lift program in the facility;
- Education of staff on back injuries;
- Acquisition of equipment that aids lifting; and
- Development of procedures that allow a nurse to refuse patient handling because the nurse believes it will result in injury.

The bill authorizes the Agency for Health Care Administration to develop rules to require compliance by January 1, 2007.

According to the Agency for Health Care Administration (AHCA) the total expenditures for the first year will be $65,269 and $62,659 for the second year.

The effective date of the bill is July 1, 2006.

[1] 2002.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide Limited Government – The bill increases the Agency for Health Care Administration's regulatory oversight of safe patient handling and lifting practices in nursing homes and hospitals. The estimated fiscal impact of the bill is $65,269 in the first year and $62,659 in the second year.

B. EFFECT OF PROPOSED CHANGES:

HB 1177 creates s. 381.029, F.S., to require hospitals and nursing homes to develop a program to adopt and implement safe patient handling and moving practices. The program requires hospitals and nursing homes to:

- Establish a safe patient handling and moving committee to implement a minimal lifting program in the facility;
- Analyze the risk of injury to patients and staff posed by handling and moving of patients and the physical environment in which the moving occurs;
- Educate staff on back injuries and alternative ways to reduce risks;
- Establish a program that eliminates manual lifting;
- Acquire equipment that aids lifting;
- Develop procedures that allow a nurse to refuse a patient handling or moving task because the nurse believes he or she will pose the patient or themselves to an unacceptable risk of injury; and
- Report annually to the governing body of the facility on the identification, assessment, and development of strategies to control risk of injury to patients and staff associated with the program.

The bill also requires facilities to publish their lift policy and plan, and the results of an annual evaluation that uses data analysis to measure the success of the program. The policy must be submitted to the Agency for Health Care Administration (AHCA).

The bill requires that a hospital or nursing home may not penalize, discriminate against, or retaliate in any manner against an employee if such employee reports a suspected violation, participates in an investigation, or discusses suspected violations with any other employee, patient or public.

The bill authorizes AHCA to develop rules to require compliance with the bill by January 1, 2007.

The effective date of the bill is July 1, 2006.

CURRENT SITUATION

Hospitals licensed under ch. 395, F.S., have requirements for nursing services, functional safety, and plans submission. Section 59A-3.2085(5)(d), Florida Administrative Code (F.A.C.) requires that each hospital must develop written standards of nursing practice and related policies and procedures to define and describe the scope and conduct of patient care provided by the nursing staff.

Currently there are no requirements for specific policies and procedures for patient handling and moving in hospitals. Section 59A-3.277, F.A.C., requires each hospital to have a hospital safety committee to adopt, implement and monitor a comprehensive, hospital-wide safety program. The program must adopt written policies and procedures to enhance the safety of the hospital, its personnel and patients.

Section 59A-3.080, F.A.C., states that no construction work, including demolition, shall be started until written approval has been given by the Agency's Office of Plans and Construction. This includes all construction of new facilities and any and all additions, modifications or renovations to existing facilities. Presently, any remodeling plans for the purpose of incorporating patient handling and moving equipment would have to be submitted to the Office of Plans and Construction for approval.

Currently, most hospitals and nursing homes have voluntarily adopted additional programming to prevent injury to personnel who move patients. Hospitals and nursing homes are responsible for paying worker's compensation claims and paying for temporary help when staff is unavailable because of injury.

BACKGROUND

Health Care Injury

According to the Bureau of Labor Statistics nursing personnel are consistently listed as one of the top ten occupations for work-related musculoskeletal disorders, with incident rates of 8.8 per 100 in hospital settings and 13.5 per 100 in nursing home settings.[2] The Occupational Safety and Health Administration (OSHA) reports that most health care industries report more injuries than other high risk industries, such as construction. Nursing aides, orderlies, and attendants have a risk of lost workday injuries and illnesses about 3.5 times that of the average private industry worker. The most common injury is various forms of back injury. The U.S. Department of Labor reports that nursing, psychiatric, and home health aides are especially susceptible to lifting injuries, because mechanical lifting devices available in some institutional settings are seldom available in the home care setting.

The National Institute for Occupational Safety and Health (NIOSH) is currently developing safe patient handling and movement principles. NIOSH, Centers for Disease Control (CDC) and many other national organizations have developed a model for protecting the safety and health of health care workers.

Challenges to Patient Lifting

Patient handling and movement tasks are physically demanding, performed under unfavorable conditions, and are often unpredictable in nature. Patients offer multiple challenges including variation in size, physical disabilities, cognitive function, level of cooperation, and fluctuations in condition. As a load to be lifted, patients lack the convenience of handles and even distribution of weight, and have been known to be combative during the lifting process. One study has estimated that the cumulative weight lifted by a nurse in a typical 8-hour shirt is equivalent to 1.8 tons.[3] Lifting patients is also challenging because patient lifts are often accomplished in awkward positions such as bending or reaching over beds or chairs while a nurse's back is flexed.[4]

Costs of Back Injury

Back injury can result in days away from work, expensive rehabilitation costs, surgery, and a change in career. The estimated cost to treat a back strain is $4,000 and back surgery costs around $25,000. Indirect costs related to lost production, retraining, and sick or administration time is estimated to be at least four times that of direct costs.[5]

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[2] 2002.
[3] Tuohy-Main, K. (1997) Why manual handling should be eliminated for resident and career safety. Geriaction, 15, 10-14.
[4] Blue, C.L. (1996). Preventing back injury among nurses. Orthopaedic Nursing, 15, 9-22., & Videman, T., Nurminen, T., Tolas, S., Juorinka, I., Vanharanta, H., & Troup, J. (1984). Low back pain in nurses and some loading factors of work. Spine, 9(4), 400-404.
[5] Occupational Safety and Health Administration, 1999.

Patient Moving Legislation in other States

States have begun to pass legislation regarding patient handling in hospitals and nursing homes. Last July, Texas was the first state in the nation to require hospitals and nursing homes to implement safe patient handling and movement programs. California, Massachusetts, and New York are considering bills that address patient handling in differing ways. Ohio recently created a program that provides nursing homes interest free loans to implement a no-manual-lift program. Most recently Washington passed a law similar to HB 1177. The Washington bill provides a tax credit for hospitals to comply with the law, which is not included in HB 1177. The maximum tax credit for each hospital is $1,000 for each acute care inpatient bed.[6]

C. SECTION DIRECTORY:

Section 1. – Creates s. 381.029, F.S., to require hospitals and nursing home governing bodies to create and implement a program to decrease injury to nurses and patients.

Section 2. – The effective date of the bill is July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

FISCAL IMPACT ON AHCA/FUNDS:

	FTE	Amount Year 1 FY 06-07	Amount Year 2 FY 07-08
Expenditures:			
Health Services & Facilities Consultant			
Total Salary and Benefits	1.0	$51,326	$51,326
Expenses			
Professional Staff	1.0		
Total Expenses		$10,940	$10,940
Human Resources Services			
Total Human Resources Services		$393	$393
Total Recurring Expenditures	**1.0**	**$62,659**	**$62,659**
Sub-Total Non-Recurring Expenditures		$2,610	$0
Sub-Total Recurring Expenditures		$62,659	$62,659
Total Expenditures	**1.0**	**$65,269**	**$62,659**

[6] House Bill 1672 passed the Washington Legislature March 7, 2006.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Nursing homes and hospitals will incur costs to implement the provisions in the bill. It is possible that the affected facilities may pass on the costs to their patients. The provisions in the bill may decrease back injuries in nursing homes and hospitals, thus, decreasing workers compensation payments and decreasing costs related to time away from work due to injury.

D. FISCAL COMMENTS:

According to the Agency for Health Care Administration (AHCA), one Health Services and Facilities Consultant, Pay Grade 24, full time employee (FTE) would be needed by AHCA for rule promulgation, setting up a format for the annual reports, collecting the reports, reviewing the reports, and entering the data into a format for internal reports or for the public. The total expenditures for FY 06-07, including salary, benefits, and taxes, will be $65,269 and $62,659 for FY 07-08.

According to AHCA, the proposed bill implies that AHCA may get complaints about violations of the requirements so there may be a potential increase in complaints and investigations affecting the Complaint Administration Unit and the field offices of the Division of Health Quality Assurance in the Agency, as well as the Office of the General Counsel.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority to the Agency for Health Care Administration (AHCA) to carry out the provisions in the bill. However, ch. 381, F.S., is not a licensing statute for nursing homes or hospitals and AHCA may not be able to promulgate rules or enforce the bill. The bill should reference hospital and nursing home licensing statutes chapters 395 and 400, part II, F.S. respectively.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill references "nurses" several times in the bill, however, nurses are not the only staff who handle and lift patients. Nursing aides and orderlies do the majority of patient lifting. The scope of staff included in the bill also should be expanded to include all staff involved in lifting and moving patients.

[See B. RULE-MAKING AUTHORITY]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to patient handling and moving practices;
3 creating s. 381.029, F.S.; providing definitions;
4 requiring hospitals and nursing homes to adopt and
5 implement a safe patient handling and moving policy and
6 providing requirements thereof; requiring establishment of
7 a safe patient handling and moving committee; providing
8 for the incorporation of patient handling and moving
9 equipment into certain architectural plans for
10 construction or remodeling of a hospital or nursing home
11 or units thereof; requiring the submission of policies and
12 remodeling plans to the Agency for Health Care
13 Administration; providing certain protection for employees
14 of hospitals and nursing homes who report certain
15 violations or suspected violations; providing rulemaking
16 authority to the agency; providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 381.029, Florida Statutes, is created
21 to read:
22 381.029 Safe patient handling and moving practices.--
23 (1) As used in this section:
24 (a) "Agency" means the Agency for Health Care
25 Administration.
26 (b) "Good faith" means that an employee believes that the
27 information he or she reported or disclosed is true and that a
28 violation has occurred or may occur.

29 (c) "Hospital" means a facility licensed under chapter
30 395.
31 (d) "Minimal-lift philosophy" means to the greatest extent
32 possible minimizing lifting tasks, encouraging a patient to
33 assist with any lifting or moving activities without
34 exacerbating his or her condition or putting himself or herself
35 at risk, and avoiding any handling that involves manually
36 lifting or moving the whole or a large part of a patient's
37 weight.
38 (e) "Nurse" means a registered nurse, a licensed practical
39 nurse, or an advanced registered nurse practitioner as those
40 terms are defined in s. 464.003.
41 (f) "Nursing home" means a facility licensed under part II
42 of chapter 400.
43 (2)(a) The governing body of a hospital or nursing home
44 shall adopt and ensure implementation of a policy and program to
45 identify, develop, and assess strategies to control the risk of
46 injury to patients and nurses associated with lifting,
47 transferring, repositioning, or moving a patient.
48 (b) The policy shall be consistent with a minimal-lift
49 philosophy and establish a process that, at a minimum, includes:
50 1. Establishment of a safe patient handling and moving
51 committee with the responsibility of implementing a minimal
52 manual lift program in the facility. The committee may be a
53 subcommittee of any already existing committee and shall include
54 in its membership representatives of the bargaining unit, where
55 one is recognized, and members of the nursing staff from various
56 units of the facility.

57 2. Analysis of the risk of injury to patients, nurses, and
58 health care workers posed by the handling and moving needs of
59 the patient populations served by the hospital or nursing home
60 and the physical environment in which patient handling and
61 moving occurs.
62 3. Education of a back injury resource nurse to serve as
63 an expert resource and educational source for all nurses in the
64 identification, assessment, and control of risks of injury to
65 patients and nurses during patient handling and moving.
66 4. Evaluation of alternative ways to reduce risks
67 associated with patient handling and moving, including
68 evaluation of equipment and the environment.
69 5. Establishment of a program that will eliminate manual
70 lifting, repositioning, and moving of patients based on current
71 research and practice.
72 6. Acquisition of, training with, and deployment of
73 sufficient equipment and aids so that manual lifting,
74 repositioning, or moving all or most of a patient's weight is
75 restricted to emergency, life-threatening, or otherwise
76 exceptional circumstances.
77 7. Collaboration between the staffing committee and the
78 nurse and the submission of an annual report to the committee.
79 8. Procedures that a nurse may employ to refuse to perform
80 or be involved in patient handling or moving that the nurse
81 believes in good faith will expose the patient or the nurse to
82 an unacceptable risk of injury.
83 9. Submission of an annual report to the governing body of
84 the hospital or nursing home and the agency on activities

85 related to the identification, assessment, and development of
86 strategies to control risk of injury to patients, nurses, and
87 other health care workers associated with lifting, transferring,
88 repositioning, or moving a patient.
89 10. Publication of the policy and plan for implementation
90 of the program and of the results of an annual evaluation that
91 uses data analysis to measure the success of the program.
92 (3) The feasibility of incorporating patient handling and
93 moving equipment or the physical space and construction design
94 needed to incorporate that equipment at a later date shall be
95 considered in the development of architectural plans for
96 constructing or remodeling a hospital or nursing home or a unit
97 of a hospital or nursing home in which patient handling and
98 moving occurs. The hospital or nursing home shall submit its
99 policy and any plans for remodeling to the agency.
100 (4) A hospital or nursing home may not penalize,
101 discriminate against, or retaliate in any manner against an
102 employee with respect to compensation for, or terms, conditions,
103 or privileges of, employment if such an employee in good faith,
104 individually or in conjunction with another person or persons:
105 (a) Reports a violation or suspected violation of this
106 section to a regulatory agency, private accrediting body, or
107 management personnel of the hospital or nursing home;
108 (b) Initiates, cooperates in, or otherwise participates in
109 an investigation or proceeding brought by a regulatory agency or
110 private accrediting body concerning matters covered by this
111 section;

112 (c) Informs or discusses with any other employee, with any
113 representative of an employee, with a patient or patient
114 representative, or with the public violations or suspected
115 violations of this section; or
116 (d) Otherwise avails himself or herself of the rights set
117 forth in this section.
118 (5) The agency shall develop rules for administering this
119 act that require compliance with policy development and
120 reporting by January 1, 2007, and full implementation of safe
121 handling and moving policies by July 1, 2007.
122 Section 2. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 38-40 and insert:
6
7 (e) "Nursing staff" means nurses licensed pursuant to part
8 I of chapter 464, certified nursing assistants certified
9 pursuant to part II of chapter 464, and any other staff
10 designated by the governing body of a hospital or quality
11 assurance committee of a nursing home, involved in the handling,
12 lifting, and moving of patients.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 43 and insert:
6
7 (2)(a) The governing body of a hospital or quality
8 assurance committee of a nursing home

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 46-81 and insert:
6 injury to patients and nursing staff associated with lifting,
7 transferring, repositioning, or moving a patient.
8 (b) The policy shall be consistent with a minimal-lift
9 philosophy and establish a process that, at a minimum, includes:
10 1. Establishment of a safe patient handling and moving
11 committee with the responsibility of implementing a minimal
12 manual lift program in the facility. The committee may be a
13 subcommittee of any already existing committee and shall include
14 in its membership representatives of the bargaining unit, where
15 one is recognized, and members of the nursing staff from various
16 units of the facility.
17 2. Analysis of the risk of injury to patients, nurses, and
18 health care workers posed by the handling and moving needs of
19 the patient populations served by the hospital or nursing home
20 and the physical environment in which patient handling and
21 moving occurs.

22 3. Education of a back injury resource nurse to serve as
23 an expert resource and educational source for all nurses in the
24 identification, assessment, and control of risks of injury to
25 patients and nursing staff during patient handling and moving.
26 4. Evaluation of alternative ways to reduce risks
27 associated with patient handling and moving, including
28 evaluation of equipment and the environment.
29 5. Establishment of a program that will eliminate manual
30 lifting, repositioning, and moving of patients based on current
31 research and practice.
32 6. Acquisition of, training with, and deployment of
33 sufficient equipment and aids so that manual lifting,
34 repositioning, or moving all or most of a patient's weight is
35 restricted to emergency, life-threatening, or otherwise
36 exceptional circumstances.
37 7. Collaboration between the staffing committee and the
38 nurse and the submission of an annual report to the committee.
39 8. Procedures that nursing staff may employ to refuse to
40 perform or be involved in patient handling or moving that the
41 nursing staff believes in good faith will expose the patient or
42 the nursing staff to

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 4 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 84 and insert:
6
7 the hospital or quality assurance committee of a nursing home on
8 activities

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 5 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 118-121 and insert:
6
7 (5) The agency shall develop rules for administering this
8 act that require compliance with policy development by January
9 1, 2007, and full implementation of safe handling and moving
10 policies by July 1, 2007. The agency shall enforce the
11 requirements of this section under its authority to regulate
12 hospitals and nursing homes pursuant to chapter 395, and part II
13 of chapter 400 respectively.

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HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 6 (for drafter's use only)

Bill No. **HB 1177**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation Committee
2 Representative(s) Roberson offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 121 and insert:
6
7 handling and moving policies by July 1, 2010.

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HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1213 Exceptional Student Evaluation
SPONSOR(S): Barreiro
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Mitchell	Mitchell
2) PreK-12 Committee			
3) Health & Families Council			
4)			
5)			

SUMMARY ANALYSIS

House Bill 209 requires the parent of a public school student to be fully informed and sign an extensive disclosure statement established in statute that identifies known and potential consequences before any evaluation of the student for an emotional, behavioral, or mental disorder, specific learning disability, or other health impairment, including psychological or psychiatric evaluations. The disclosure form identifies that there are alternatives to such evaluations. The signed statement must be maintained in the student's school records.

The bill addresses concerns with over medication of children with psychotropic medication and control of personal identity and behavior, through public school psychological assessments and the medicalizing of personality characteristics.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill restricts the ability of state-funded education or school-related services providers to professionally assess children for any psychological or behavioral difficulties they may have that affect their ability to learn, without a parent's signed authorization of a required disclosure form.

Safeguard individual liberty – Students receiving state-funded education or school-related services could not be assessed for any psychological or and behavioral difficulties they may have that affect their learning.

Empower Families – Families of students receiving state-funded education or school-related services would have to approve any assessment of their child's psychological or behavioral difficulties without full disclosure of the potential negative results of such assessment.

B. EFFECT OF PROPOSED CHANGES:

The bill requires that before a public school student can be evaluated for an emotional, behavioral, or mental disorder, specific learning disability, or other health impairment, including a psychological or psychiatric evaluation, the child's parent must be fully informed of all known and potential consequences of such evaluation and alternatives. The parent must acknowledge and sign an extensive statement established in law, which must be maintained in the student's school records.

The disclosure statement established in statute by the bill is:

> I understand that my child has been referred to be evaluated for an emotional, behavioral, or mental disorder, a specific learning disability, or other health impairment, including psychological or psychiatric evaluation. The evaluation may result in the assignment of a diagnosis of "mental disorder" or "syndrome" as described in the formal text published by the American Psychiatric Association for the purpose of diagnosing and providing billing codes according to the Diagnostic and Statistical Manual of Mental Disorders Fourth Edition (DSM-IV). Such a diagnosis will be based on the variable observation and subjective interpretation of my child's behavior, intermittently reported by teachers, psychologists, psychiatrists, or others.
>
> I understand that physical problems such as poor nutrition, exposure to toxins, or structural disorders can cause emotional, behavioral, or mental symptoms and that I should provide for my child's complete and thorough medical examination, including, but not limited to, blood testing, to determine if my child has any objectively verifiable nutritional deficiency, allergy, metal toxicity, or physical disease or disorder which may be causing the symptoms and that anything so found should be medically treated.
>
> I understand that the State of Florida mandates screening of children for lead poisoning and that the Centers for Disease Control and Prevention, in a report entitled "Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials," determined that children with lead poisoning can present with seizures, other neurological symptoms, abdominal pain, developmental delay, attention deficit, hyperactivity, other behavioral disorders, school problems, hearing loss, or anemia.
>
> I understand that, unlike most medical diagnostic methods, a diagnosis of mental disorder or syndrome, including, but not limited to, attention deficit hyperactivity disorder (ADHD), bipolar disorder, and depression, is not based on any medical test, such as a brain scan, chemical imbalance test, X-ray, biopsy, blood test, or urinalysis, that can scientifically detect a physical

abnormality in an infant, child, adolescent, or adult. As stated in the 1999 report entitled "Mental Health: A Report of the Surgeon General," the diagnosis of mental disorders is often believed to be more difficult than diagnosis of somatic or general medical disorders since there is no definitive lesion, laboratory test, or abnormality in brain tissue that can identify the illness. And as stated in the DSM-IV that although this manual provides a classification of mental disorders, it must be admitted that no definition adequately specifies precise boundaries for the concept of mental disorder.

I understand that if my child is diagnosed or labeled with any mental disorder or syndrome listed in the DSM-IV, treatment is likely to include prescriptions for psychotropic or psychiatric medications, such as antidepressants or stimulants, which may have dangerous side effects and uncertain effectiveness. Most antidepressants are not approved by the U. S. Food and Drug Administration (FDA) for treatment of children though they are often prescribed by medical doctors. On October 14, 2004, the FDA ordered the addition of a "black box" warning of suicide risk on the health professional labeling of all antidepressant medications prescribed to children under 18 years of age. On June 28, 2005, the FDA ordered labeling changes to methylphenidate (Ritalin) products to warn that these drugs can cause psychiatric events described as visual hallucinations, suicidal ideation, or psychotic behavior, as well as aggression or violent behavior. On July 1, 2005, an FDA panel recommended stronger labels for Concerta, another methylphenidate-based drug, to more clearly warn of the possibility of hallucinations, suicidal tendencies, or aggression in patients taking the drug. The amphetamine Adderall is the subject of an FDA health warning because of reports linking the drug to sudden deaths in children. On September 25, 2005, the FDA issued a warning that atomoxetine (Strattera) can cause suicidal thoughts in children.

I understand that I have the right to be informed of all the known side effects of any recommended drug, including the current information listed on the drug in the Physicians' Desk Reference.

I understand that I may request full information on the short-term and long-term benefits and risks of a drug, any interactions the drug has with other medications, how long my child will need to be taking the drug, and all of the up-to-date accumulation of FDA adverse reaction reports of the drug. I understand that psychotropic or psychiatric drugs are addictive and create dependency and that drug withdrawal can pose serious problems.

I understand that there are alternatives to psychotropic or psychiatric drug treatment and that I should ask the evaluation personnel and my physician about such alternatives. I understand it is my responsibility to take the necessary time and trouble to fully research the relevant necessary information in order to make an informed decision on behalf of my child.

I acknowledge that I have read and understood the above information and, based on my understanding, I hereby:

(1) Give my full and informed consent for my child to undergo evaluation for an emotional, behavioral, or mental disorder, a specific learning disability, or other health impairment.

....(Signature of Parent)...

(2) Do not give my consent for my child to undergo evaluation for an emotional, behavioral, or mental disorder, a specific learning disability, or other health impairment.

...(Signature of Parent)...

Background

Individuals with Disabilities Education Act

The Individuals with Disabilities Education Act (IDEA) was reauthorized in 2004. Schools are required by IDEA to provide services or make modifications or adaptations for students whose disability adversely affects their educational performance. According to federal regulations, a student is determined to have a disability when they have been evaluated and determined to have mental retardation, hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism, traumatic brain injury, or other health impairment, deaf-blindness, or multiple disabilities that require special education and related services.[1]

Section 1003.01(3)(a), F.S., provides a definition for an exceptional student, which is any student who has been determined eligible for a special program in accordance with rules of the State Board of Education. The term includes students with disabilities who are mentally handicapped, speech and language impaired, deaf or hard of hearing, visual impaired, dual sensory impaired, physically impaired, emotionally handicapped, specific learning disabled, hospital and homebound, autistic, developmentally delayed children, ages birth through 2 years, with established conditions that are identified in the rules set by the State Board of Education.

Children with Behavioral and Emotional Difficulties

Primary care physicians identify approximately 19 percent of the children they see as having behavioral and emotional problems.[2] A number of treatment options are available to address mental health problems of students, including psychotropic medications. While generally not the first option, the National Institute of Mental Health reports that psychotropic medications may be prescribed when the possible benefits of the medications outweigh the risk and, in particular, when psychosocial interventions are not effective by themselves and there are potentially serious negative consequences for the student.[3] The U.S. Department of Education provides that prescribing medications is the responsibility of the medical professionals, not the educational professionals.[4]

Students Diagnosed with Attention Deficit Hyperactivity Disorder

It is estimated that 1.46-2.46 million children or 3-5 percent of the student population have Attention Deficit Hyperactivity Disorder (ADHD).[5] The diagnostic methods, treatment options, and medications have become controversial subjects, particularly in education.[6] One of the concerns raised has been that school officials are reported to be offering their diagnosis of ADHD and urging parents to obtain drug treatment for the child.[7]

Students with ADHD may need the services as provided under the Individuals with Disabilities Education Act and Section 504 of the Rehabilitation Act of 1973 to assist them with their educational needs. Adaptations available to assist students with ADHD include "curriculum adjustments, alternative classroom organization and management, specialized teaching techniques and study skills, use of behavior management, and increased parent/teacher collaboration.[8]

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[1] See 34 CFR 300.7(a)(1)
2 President's New Freedom Commission on Mental Health: Report to the President, May 2003.
3 Treatment of Children with Mental Disorders, National Institute of Mental Health, updated June 18, 2001.
4 Letter from Richard Riley of the U.S. Department of Education to Congressman Peter Hoekstra, November 21, 2000.
5 Identifying and Treating Attention Deficit Hyperactivity Disorder: A resource for School and Home, U.S. Department of Education, 2003, p. 2.
6 Identifying and Treating Attention Deficit Hyperactivity Disorder, Supra, p. 1.
7 Child Medication Safety Act of 2003, 108th Congress, House of Representatives Report, May 21, 2003, p. 5
[8] Identifying and Treating Attention Deficit Hyperactivity Disorder, Supra, p. 6.

School Psychologists

School psychologists help children and youth succeed academically, socially, and emotionally. They collaborate with educators, parents, and other professionals to create safe, healthy, and supportive learning environments for all students that strengthen connections between home and school. Licensed school psychologists are governed by chapter 490, F.S., and licensed in accordance to ss. 490.005(1) and 490.006, F.S. In Florida a licensed school psychologist must have a doctoral degree and successfully pass a licensure examination.

School psychologists are highly trained in both psychology and education. Their education emphasizes preparation in mental health, child development, school organization, learning styles and processes, behavior, motivation, and effective teaching. They also may be nationally certified by the National School Psychology Certification Board (NSPCB).[9]

School psychologists may provide the following services[10]:

Consultation
- Collaborate with teachers, parents, and administrators to find effective solutions to learning and behavior problems.
- Help others understand child development and how it affects learning and behavior.
- Strengthen working relationships between teachers, parents, and service providers in the community.

Evaluation
- Evaluate eligibility for special services.
- Assess academic skills and aptitude for learning.
- Determine social-emotional development and mental health status.
- Evaluate learning environments.

Intervention
- Provide psychological counseling to help resolve interpersonal or family problems that interfere with school performance.
- Work directly with children and their families to help resolve problems in adjustment and learning.
- Provide training in social skills and anger management.
- Help families and schools manage crises, such as death, illness, or community trauma.

Prevention
- Design programs for children at risk of failing at school.
- Promote tolerance, understanding, and appreciation of diversity within the school community.
- Develop programs to make schools safer and more effective learning environments.
- Collaborate with school staff and community agencies to provide services directed at improving psychological and physical health.
- Develop partnerships with parents and teachers to promote healthy school environments.

Research and Planning
- Evaluate the effectiveness of academic and behavior management programs.
- Identify and implement programs and strategies to improve schools.
- Use evidence-based research to develop and/or recommend effective interventions.

DSM and ICD-10 Codes for Mental Illnesses

A student's academic, social, and emotional difficulties, which may interfere with learning, are often first detected in the educational environment. School districts are required to identify, locate, and evaluate suspected students with disabilities as noted in the "child find" requirements within state and federal regulations. Most of the disabilities associated with exceptional student education programs can be

[9] National Association of School Psychologist, www.nasponline.org
[10] Ibid.

found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) or in the International Classification of Diseases-Version 10 (ICD-10). ICD-10 codes are not applicable to schools. They are used by medical professionals, including mental health practitioners as Medicaid billing codes. Schools that participate in the Medicaid Certified School Match Program assign ICD-10 diagnosis codes to enable Medicaid billing.

The State Board of Education establishes administrative rules for special programs that govern the diagnostic criteria utilized by school psychologists within the State.[11]

C. SECTION DIRECTORY:

Section 1: Amends s. 1003.57, F.S., relating to Exceptional Student Instruction and Evaluation to require full disclosure to parents of the consequences of a school psychological evaluation of their child and require them to sign a specified disclosure form before any psychological or behavioral evaluation of a student.

Section 2: Establishes an effective date upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. See D. Fiscal Comments.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Indeterminate. See D. Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

According to the Department of Education, schools receive funding depending upon the needs of the student. The funding received varies by the services a student needs to assist them in their ability to learn identified in Individual Education Plans based on professional assessment and evaluation. The funding schools receive to assist a child in learning vary from $3,600-$20,000.

[11] See administrative rules 6A-6.010-6A-6.0131.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The Department of Education has rule making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The disclosure statement established in statute by the bill includes information specific to current products and events that will not be easily updated as new medications are developed. Because the disclosure statement as written in statute includes statements that appear unclear and may be challenged in court.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to exceptional student evaluation;
3 amending s. 1003.57, F.S.; requiring fully informed
4 consent by a parent prior to his or her child's evaluation
5 for an emotional, behavioral, or mental disorder, a
6 specific learning disability, or other health impairment;
7 specifying the contents of a statement that must be signed
8 by a parent and maintained in a student's school records;
9 including in the statement an understanding that an
10 evaluation may result in a diagnosis for which
11 psychotropic or psychiatric medications may be prescribed;
12 providing an effective date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Subsection (8) is added to section 1003.57,
17 Florida Statutes, to read:
18 1003.57 Exceptional students instruction;
19 evaluation.--Each district school board shall provide for an
20 appropriate program of special instruction, facilities, and
21 services for exceptional students as prescribed by the State
22 Board of Education as acceptable, including provisions that:
23 (8) Before a public school student may be evaluated for an
24 emotional, behavioral, or mental disorder, a specific learning
25 disability, or other health impairment, including psychological
26 or psychiatric evaluation, the parent of such student be fully
27 informed of all known and potential consequences of and
28 alternatives for such evaluation and acknowledge and sign the

29 following statement which must be maintained in the student's
30 school records:
31
32 I understand that my child has been referred to be
33 evaluated for an emotional, behavioral, or mental
34 disorder, a specific learning disability, or other health
35 impairment, including psychological or psychiatric
36 evaluation. The evaluation may result in the assignment of
37 a diagnosis of "mental disorder" or "syndrome" as
38 described in the formal text published by the American
39 Psychiatric Association for the purpose of diagnosing and
40 providing billing codes according to the Diagnostic and
41 Statistical Manual of Mental Disorders Fourth Edition
42 (DSM-IV). Such a diagnosis will be based on the variable
43 observation and subjective interpretation of my child's
44 behavior, intermittently reported by teachers,
45 psychologists, psychiatrists, or others.
46
47 I understand that physical problems such as poor
48 nutrition, exposure to toxins, or structural disorders can
49 cause emotional, behavioral, or mental symptoms and that I
50 should provide for my child's complete and thorough
51 medical examination, including, but not limited to, blood
52 testing, to determine if my child has any objectively
53 verifiable nutritional deficiency, allergy, metal
54 toxicity, or physical disease or disorder which may be
55 causing the symptoms and that anything so found should be
56 medically treated.

57
58 I understand that the State of Florida mandates screening
59 of children for lead poisoning and that the Centers for
60 Disease Control and Prevention, in a report entitled
61 "Screening Young Children for Lead Poisoning: Guidance for
62 State and Local Public Health Officials," determined that
63 children with lead poisoning can present with seizures,
64 other neurological symptoms, abdominal pain, developmental
65 delay, attention deficit, hyperactivity, other behavioral
66 disorders, school problems, hearing loss, or anemia.
67
68 I understand that, unlike most medical diagnostic methods,
69 a diagnosis of mental disorder or syndrome, including, but
70 not limited to, attention deficit hyperactivity disorder
71 (ADHD), bipolar disorder, and depression, is not based on
72 any medical test, such as a brain scan, chemical imbalance
73 test, X-ray, biopsy, blood test, or urinalysis, that can
74 scientifically detect a physical abnormality in an infant,
75 child, adolescent, or adult. As stated in the 1999 report
76 entitled "Mental Health: A Report of the Surgeon General,"
77 the diagnosis of mental disorders is often believed to be
78 more difficult than diagnosis of somatic or general
79 medical disorders since there is no definitive lesion,
80 laboratory test, or abnormality in brain tissue that can
81 identify the illness. And as stated in the DSM-IV that
82 although this manual provides a classification of mental
83 disorders, it must be admitted that no definition

84 adequately specifies precise boundaries for the concept of
85 mental disorder.
86
87 I understand that if my child is diagnosed or labeled with
88 any mental disorder or syndrome listed in the DSM-IV,
89 treatment is likely to include prescriptions for
90 psychotropic or psychiatric medications, such as
91 antidepressants or stimulants, which may have dangerous
92 side effects and uncertain effectiveness. Most
93 antidepressants are not approved by the U. S. Food and
94 Drug Administration (FDA) for treatment of children though
95 they are often prescribed by medical doctors. On October
96 14, 2004, the FDA ordered the addition of a "black box"
97 warning of suicide risk on the health professional
98 labeling of all antidepressant medications prescribed to
99 children under 18 years of age. On June 28, 2005, the FDA
100 ordered labeling changes to methylphenidate (Ritalin)
101 products to warn that these drugs can cause psychiatric
102 events described as visual hallucinations, suicidal
103 ideation, or psychotic behavior, as well as aggression or
104 violent behavior. On July 1, 2005, an FDA panel
105 recommended stronger labels for Concerta, another
106 methylphenidate-based drug, to more clearly warn of the
107 possibility of hallucinations, suicidal tendencies, or
108 aggression in patients taking the drug. The amphetamine
109 Adderall is the subject of an FDA health warning because
110 of reports linking the drug to sudden deaths in children.
111 On September 25, 2005, the FDA issued a warning that

112 atomoxetine (Strattera) can cause suicidal thoughts in
113 children.
114
115 I understand that I have the right to be informed of all
116 the known side effects of any recommended drug, including
117 the current information listed on the drug in the
118 Physicians' Desk Reference.
119
120 I understand that I may request full information on the
121 short-term and long-term benefits and risks of a drug, any
122 interactions the drug has with other medications, how long
123 my child will need to be taking the drug, and all of the
124 up-to-date accumulation of FDA adverse reaction reports of
125 the drug. I understand that psychotropic or psychiatric
126 drugs are addictive and create dependency and that drug
127 withdrawal can pose serious problems.
128
129 I understand that there are alternatives to psychotropic
130 or psychiatric drug treatment and that I should ask the
131 evaluation personnel and my physician about such
132 alternatives. I understand it is my responsibility to take
133 the necessary time and trouble to fully research the
134 relevant necessary information in order to make an
135 informed decision on behalf of my child.
136
137 I acknowledge that I have read and understood the above
138 information and, based on my understanding, I hereby:
139

140 (1) Give my full and informed consent for my child
141 to undergo evaluation for an emotional, behavioral, or
142 mental disorder, a specific learning disability, or other
143 health impairment.
144
145 ....(Signature of Parent)...
146
147 (2) Do not give my consent for my child to undergo
148 evaluation for an emotional, behavioral, or mental
149 disorder, a specific learning disability, or other health
150 impairment.
151
152 ...(Signature of Parent)...
153
154 Section 2. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 1213**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Barreiro offered the following:
3
4 **Amendment (with title amendment)**
5 Remove everything after the enacting clause and insert:
6 Section 1. Subsections (8) and (9) are added to section
7 1003.57, Florida Statutes, to read:
8 1003.57 Exceptional students instruction.--Each district
9 school board shall provide for an appropriate program of special
10 instruction, facilities, and services for exceptional students
11 as prescribed by the State Board of Education as acceptable,
12 including provisions that:
13 (8) Before a public school student may be evaluated for an
14 emotional, behavioral, or mental disorder or any other
15 psychological or psychiatric disorder listed in the Diagnostic
16 and Statistical Manual of Mental Disorders, the parent must be
17 fully informed of all known and potential consequences of and
18 alternatives for such evaluation, including, but not limited to,
19 the following:
20 (a) The behaviors prompting the evaluation could be the
21 result of underlying physical conditions, including, but not
22 limited to, one or more of the following: poor nutrition;

23 exposure to toxins, including, but not limited to, lead,
24 mercury, pesticides, organic biocides, plastizers, and other
25 neurotoxins; allergies; or sleep deprivation.
26 (b) The parent may want to consider consulting a medical
27 doctor to rule out physical causes before pursuing psychological
28 or psychiatric evaluation for his or her child.
29 (c) Psychological and psychiatric evaluation and diagnosis
30 of mental and behavioral disorders, such as attention deficit
31 disorder (ADD), attention deficit hyperactivity disorder (ADHD),
32 obsessive compulsive disorder (OCD), depression, bipolar
33 disorder, or any other disorder listed in the Diagnostic and
34 Statistical Manual of Mental Disorders, are based on subjective
35 interpretation and not on objective medical tests or physical
36 markers, such as blood tests, brain scans, or X-rays.
37 (d) Treatment of disorders described in the Diagnostic and
38 Statistical Manual of Mental Disorders often consists of
39 psychotropic medications. The relationship of psychotropic
40 medications to actual disorders is unknown and their
41 effectiveness has not been proven. Psychotropic medications are
42 often not approved for children and many have potential
43 dangerous side effects, including suicidal and psychotic
44 behavior and other side effects which parents should inform
45 themselves of by consulting the current FDA-approved package
46 insert for the medication, the current edition of Mosby's Drug
47 Consult, or any equivalent comprehensive drug guidance document,
48 including, where equivalent, the current edition of the
49 Physicians' Desk Reference.
50 (e) There are alternative treatments for mental and
51 behavioral disorders that do not include psychotropic
52 medications which the parent has the right to consider and use.

53 (9) The Department of Education shall provide a written
54 form to each of the school districts that includes the
55 information contained in subsection (8), which shall be provided
56 to the parent of any child referred for evaluation of an
57 emotional, behavioral, or mental disorder or any other
58 psychological or psychiatric disorder. The form must contain a
59 provision for signed acknowledgement of having read the
60 information and consent or lack of consent provided by the
61 parent for the evaluation. The form shall be provided to each
62 parent concurrent with any procedural safeguard notification
63 provided to the parent of a student being considered for
64 inclusion in an exceptional student education program.
65 Section 2. Section 1006.0625, Florida Statutes, is amended
66 to read:
67 1006.0625 Administration of psychotropic medication;
68 prohibition; conditions.--
69 (1) As used in this section, the term "psychotropic
70 medication" means a prescription medication that is used for the
71 treatment of mental disorders and includes, without limitation,
72 hypnotics ~~antihypnotics~~, antipsychotics, antidepressants,
73 anxiety agents, sedatives, psychomotor stimulants, and mood
74 stabilizers.
75 (2) A public school may not deny any student access to
76 programs or services because the parent of the student has
77 refused to place the student on psychotropic medication.
78 (3) A public school teacher and school district personnel
79 may share school-based observations of a student's academic,
80 functional, and behavioral performance with the student's parent
81 and offer program options and other assistance that is available
82 to the parent and the student based on the observations.
83 However, a public school teacher and school district personnel

84 may not compel or attempt to compel any specific actions by the
85 parent or require that a student take medication. The ~~A~~ parent
86 of a student must consent to any psychological screening of the
87 student and may refuse such ~~psychological~~ screening of the
88 student.
89 (4) Public school and school district personnel may not
90 recommend psychotropic medications to any parent. The parent of
91 a student who refuses to provide psychotropic medication to his
92 or her child may not be charged with child neglect or abuse.
93
94 Any medical decision made to address a student's needs is a
95 matter between the student, the student's parent, and a
96 competent health care professional chosen by the parent.
97 Section 3. This act shall take effect July 1, 2006.
98
99 ========== T I T L E A M E N D M E N T ==========
100 Remove everything before the enacting clause and insert:
101 A bill to be entitled
102 An act relating to exceptional student evaluation;
103 amending s. 1003.57, F.S.; requiring a parent to be fully
104 informed of consequences and alternatives prior to his or
105 her child's evaluation for an emotional, behavioral, or
106 mental disorder or other psychological or psychiatric
107 disorder; specifying information relating to consequences
108 of and alternatives for such evaluation; requiring the
109 Department of Education to provide to school districts a
110 form to obtain a parent's informed consent; amending s.
111 1006.0625, F.S.; revising provisions relating to
112 administration of psychotropic medication in public
113 schools; requiring parental consent for psychological

114 screening; prohibiting certain recommendations for use of
115 psychotropic medications; providing an effective date.
116
117 WHEREAS, the Individuals with Disabilities Education Act
118 (IDEA), which was first enacted in 1975 and provides for equal
119 access to education for every disabled child, requires that
120 every child referred for exceptional education programs first be
121 evaluated by the school and requires that each state "shall
122 obtain informed consent from the parent of such child before
123 evaluation is conducted," and
124 WHEREAS, Rule 6A-6.03311 (1)-(3), Florida Administrative
125 Code, entitled "Exceptional Student Education Rules," which
126 implements IDEA, requires that before a student may be
127 evaluated, the parent must be "fully informed of all information
128 relevant to the activity for which consent is sought," that
129 "consent describes the activity," that it must be "informed
130 parental consent," and that the parent must also be informed of
131 "procedural safeguards," and
132 WHEREAS, the legal definition of "informed consent" means,
133 "a person's agreement to allow something to happen, made with
134 full knowledge of the risks involved and the alternatives," and
135 WHEREAS, in practice, school districts throughout this
136 state provide information only on the parent's due process
137 rights and should provide information to parents on the risks
138 and alternatives to the evaluation process and the potential
139 consequences of evaluation, including likely courses of
140 treatment, NOW, THEREFORE,

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1A (for drafter's use only)

Bill No. **HB 1213**

COUNCIL/COMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Sobel offered the following:
3
4 **Amendment to Amendment #1 (with directory and title**
5 **amendments)**
6 Remove line(s) 13-96 and insert:
7 (8) The Department of Education shall draft a document or
8 documents of informed consent that shall be consistent with
9 current state and federal statutes and regulations, to be used
10 by all school districts to obtain the written consent of the
11 parent of a minor student being considered for exceptional
12 education services prior to the evaluation of the student for
13 such services.
14
15 ========== D I R E C T O R Y A M E N D M E N T ==========
16 Remove line(s) 6 and insert:
17 Section 1. Subsection (8) is added to section
18
19 ========== T I T L E A M E N D M E N T ==========
20 Remove line(s) 103-115 and insert:
21 amending s. 1003.57, F.S.; requiring an informed consent
22 document consistent with current statutes and regulations;

23 requiring use by all school districts; providing an effective
24 date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1265 Small Business Health Care Insurance Assistance
SPONSOR(S): Hukill and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 2428

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Halperin	Mitchell
2) Insurance Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 1265 creates a statewide pilot program designed to encourage small businesses to offer comprehensive major medical health insurance for employees. The pilot program offers companies with more than one, and fewer than six employees, a one-time rebate of $1,000 per employee covered. Employers are required to pay at least 50 percent but less than 100 percent of the cost of coverage, and employees are required to contribute the remaining cost.

The bill provides that the pilot program shall be funded by General Revenue and shall be administered by the Agency for Health Care Administration (AHCA).

This bill has a fiscal impact of $15 million from General Revenue.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote Personal Responsibility – The bill encourages small businesses and individual employees to each pay a portion of the cost of health insurance coverage.

Empower Families – The bill increases the opportunity for small business employees to receive the health benefits of medical insurance.

B. EFFECT OF PROPOSED CHANGES:

Background

HB 1265 is the product of recommendations by a diverse Citizen Advisory Committee that was commissioned by Representative Dorothy Hukill in December 2005 to workshop ideas for a bill that would provide support and incentives to small businesses to offer health care coverage to their employees.[1]

Structure of the Pilot Program

HB 1265 creates the Small Business Health Care Insurance Assistance Pilot Program as a statewide pilot program for a period of two years. The program is designed to encourage small businesses with more than one and fewer than six employees to begin to provide full comprehensive major medical health insurance for employees for the first time. The program will offer a one-time rebate of $1,000 per employee[2] covered; and requires that both employers and employees contribute to the cost of the policies. Employers must pay at least 50 percent, but less than 100 percent, of the cost of coverage, and employees are required to pay the remaining cost. Applicants for the rebate must demonstrate that they have provided such coverage for their employees for the first time. The bill handles this by stating that a business is eligible for the rebate if, at the time of applying, the business had provided and paid for such coverage for 12 consecutive months but had not previously provided such coverage for at least six months prior to the 12-month period. Businesses may only receive the rebate once.

The pilot program is to be administered by the Agency for Health Care Administration (AHCA). Applicants must apply for the rebate through the agency. The agency shall adopt any rules[3] necessary to administer and ensure accountability of the pilot program, and can enforce compliance with the requirements of the program. The agency may also conduct audits of any businesses applying for rebates.

The bill provides that the pilot program shall be funded by General Revenue at a cost of $15 million.

The effective date of the bill is July 1, 2006.

PRESENT SITUATION

This bill addresses the ability of small businesses in Florida to provide health insurance coverage for employees. According to the Office of Labor Market Statistics, Agency for Workforce Innovation, there were 488,595, or 62.3 percent of businesses in Florida that employed between 1 and 4 workers at the

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[1] http://www.myhometownnews.net/index.php?id=3517.
[2] Employees are counted based on the Florida unemployment compensation tax form 6.
[3] Rules shall be adopted pursuant to ss. 120.536(1) and 120.54, F.S.

end of 2004.[4] Businesses that are required to pay the most for health insurance are often the ones that can least afford it. Small businesses cannot dilute their risk by spreading it over large numbers of employees, so insurance providers compensate by charging small businesses higher per-employee rates.[5] Proponents of the pilot program say that the bill will both assist small businesses in providing insurance coverage, and will save the state funds above the cost of the program by reducing the number of uninsured patients who utilize emergency room visits as their primary health care source.[6]

Overview of the Uninsured

More than 45 million Americans are uninsured, with nearly 60% of those employed by small businesses.[7] Although the majority of Americans obtain insurance through their employer as a benefit, employment does not guarantee coverage. The uninsured are primarily working families with low and moderate incomes for whom coverage is not available in the workplace or is unaffordable. Medicare covers most citizens age 65 and older, while Medicaid and the State Children's Health Insurance Program (SCHIP) provide coverage for millions of low-income people. There remains a significant gap in coverage, in part because employer-sponsored health insurance is sensitive to changes in the general economy and in rising insurance premiums. Between the years 2000 and 2002, there was a nearly 10 percent growth in the number of uninsured Americans.[8]

Consequences of the Uninsured

There is a strong relationship between insurance coverage and access to medical services. Health insurance influences the amount and type of care that people are able to afford, and increases the ability of people to seek preventative care. Insurance coverage improves overall health and is estimated to reduce mortality rates by 10 to 15 percent. For example, according to Florida Cancer Registry data, the uninsured have a 70 percent greater chance of a late diagnosis, which significantly decreases the chances of a positive health outcome.[9] The uninsured are more likely to be hospitalized for avoidable health problems and are more likely to be diagnosed in the late-stages of disease. Insurance also has an impact on the financial well-being of families: insurance helps reduce financial uncertainty associated with health care, and reduces vulnerability to unexpected out-of-pocket costs.

The problem of the uninsured impacts not just those individuals and families without coverage, but also has considerable externalities on employers and on the state. The cost of uncompensated care in the US totaled about $36 billion in 2001, about 75-80 percent of which was paid for by federal and state dollars directly to hospitals. According to the Agency for Health Care Administration (AHCA), uncompensated care in Florida's hospitals totaled more than $4.3 billion in 2001 and is growing at the rate of twelve to thirteen percent per year.[10]

The Uninsured in Florida

Approximately 22.2 percent Floridian adults and 12.1 percent of Floridian children were without health insurance in 2004. Employees of small-businesses appear to have an especially difficult time obtaining or affording health insurance. The 2004 Florida Health Insurance Study (FHIS 2004)[11] evaluated levels of insurance coverage based on both employment status of the individual, and on the firm size that the

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[4] No statistics were available for the bracket of 1-5 employees.
[5] http://www.microsoft.com/smallbusiness/resources/finance/business_insurance/best_and_worst_states_for_health_insurance_costs.mspx.
[6] http://www.myhometownnews.net/index.php?id=3517
[7] http://www.microsoft.com/smallbusiness/resources/finance/business_insurance/best_and_worst_states_for_health_insurance_costs.mspx.
[8] Kaiser Commission on Medicaid and the Uninsured. "The Uninsured: A Primer." December 2003. www.kff.org.
[9] Florida Cancer Registry, http://www.doh.state.fl.us/Disease_Ctrl/epi/cancer/CancerIndex.htm.
[10] Governor Bush announces creation of Governor's Task Force on Access to Affordable Health Insurance. http://www.flains.org/newfic/mediapublic/latebreakingnews/govhealth825.html.
[11] 2004 Florida Health Insurance Study. http://www.fdhc.state.fl.us/Medicaid/Research/Projects/fhis2004/index.shtml.

employee works for. The study found that approximately 48.1% of the unemployed in Florida are also uninsured. Data further made clear that obstacles to employer-provided health insurance are greatest for the smallest firms. In companies with four or fewer employees, 36.3 percent of workers are uninsured; in companies with between five and nine employees, 35.2 percent of workers are uninsured; in companies with between ten and 24 employees, 31.8 percent are uninsured; and in companies with between 25 and 49 employees, 22.7 percent are uninsured. Rates of coverage do increase significantly for larger firms. These statistics are summarized in the table below:

Number of Employees	Percent Uninsured
1-4	36.3%
5-9	35.2
10-24	31.8
25-49	22.7
50-99	16
100-249	14
250-499	10.1
500-999	6.4
1000+	5.2

Among uninsured employed adults, the reasons for lacking coverage vary. A strong majority of 69 percent report that the employer does not offer insurance. For 13.6 percent, the employer offers insurance but the employee is ineligible for coverage; for 12.7 percent, the employer offers insurance but the cost sharing for the employee is too high; and 4.5 percent of uninsured employees declined for other reasons. Finally, 32 percent of exclusively self-employed workers are uninsured.

Costs of Insurance

Since 2000, the cost of health insurance in the United States has increased by 73 percent. In 2005, premiums for family coverage increased 9.2 percent nationally with comparable rates in Florida. This is the first year of single digit increases since 2000. The 9.2 percent increase exceeds the overall rate of inflation by nearly 6 percentage points and the increase in workers' earnings by over 6 percentage points. Covered workers in small firms experienced even greater premium increases of 9.8 percent.

The average cost of single coverage for covered workers in 2005 is $335 per month or $4,024 per year. This figure includes both the employer and employee contribution. The average cost of family coverage is $10,880 a year, which exceeds the annual gross earnings of a minimum wage worker who is fully employed throughout the year. Premiums further vary based on the type of policy workers are covered under. PPO plans have the highest enrollment and face higher average premiums for both single and family coverage than HMO plans. The average premium for workers in PPO plans is $4,150 for the individual and $11,090 for the family, while the average premium for workers in HMO plans is $3,767 for the individual and $10,556 for the family. [12]

The Medical Expenditure Panel Survey (MEPS) is conducted annually by the federal Agency for Healthcare Research and Quality and evaluates the price of insurance coverage across the states. According to the 2000 Employer-Sponsored Health Insurance Data, Florida was rated the seventh most expensive state in the average insurance premiums that small businesses pay for family coverage. [13]

[12] Kaiser Foundation. "Employer Health Benefits 2005 Annual Survey." www.kff.org/insurance/7315/sections/ehbs05-sec-1-print.cfm

[13] The Medical Expenditure Panel Survey (MEPS) conducted by the federal Agency for Healthcare Research and Quality, http://www.meps.ahrq.gov/.

Other Efforts to Help Small Businesses Provide Health Insurance

There are currently a number of national and state efforts to increase the capacity of small businesses to provide health coverage for employees. The US and Florida Chambers of Commerce are particularly in support of Health Savings Accounts (HSAs) and group association rates. The Chamber encourages expansion of the HSAs to make it easier for small businesses and individuals to receive coverage and lobbies for the passage of legislation establishing Association Health Plans, which allow small businesses to pool risk and access health coverage. [14] Incentive plans in other states include pilot programs to allow small businesses to buy into the state employee's health care system at no cost to the state[15]; proposals to offer incentives for insurance companies to cut the cost of premiums in exchange for reductions in the premium tax they pay to the state; $1,000 tax credit rewards to small businesses that offer health care; and proposals to reduce the number of coverage items mandated by state government in order to reduce the cost of coverage. [16]

C. SECTION DIRECTORY:

Section 1. Provides legislative intent and allocates funds from General Revenue; and creates a statewide pilot program to encourage small businesses to provide health insurance for their employees with a one time rebate of $1,000 per employee.

Section 2. Provides an enacting date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

The bill appropriates $15 million to fund the program from General Revenue.

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[14] US Chamber of Commerce, Priorities for 2005-2006. http://www.uschamber.com/sb/default.htm?n=ln.
[15] http://www.kssmallbiz.com/articles/article_442.asp
[16] http://www.azcentral.com/health/news/articles/0120healthcare20.html.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

None.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill delegates rule-making and administrative authority to the Agency for Health Care Administration (AHCA). The agency shall adopt rules pursuant to ss. 120.536(1) and 120.54, F.S.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill is unclear whether businesses can apply for the rebate only once, or receive the rebate only once. The language currently reads in paragraph (3)(a): "The business may apply only once for the rebate." If businesses are only allowed to "apply" one time, this would mean a business would be prevented from applying again if they are rejected for the refund on the first attempt. If the intention of the bill is to mean that a business may only "receive" the rebate once, the language should reflect this intent explicitly by stating: the business may receive the rebate one time only.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to small business health care insurance
3 assistance; providing legislative intent; establishing a
4 pilot program to provide rebates to small businesses
5 providing comprehensive major medical health insurance
6 coverage for employees; requiring employer and employee
7 participation in certain costs; specifying the amount of
8 the rebate; providing for additional eligibility for
9 certain businesses; providing for payment of the rebates
10 from general revenue; providing for administration of the
11 program by the Agency for Health Care Administration;
12 requiring the agency to adopt rules; providing enforcement
13 and audit authority for the agency; providing an effective
14 date.
15
16 Be It Enacted by the Legislature of the State of Florida:
17
18 Section 1. (1) It is the intent of the Legislature to
19 encourage small businesses to provide comprehensive major
20 medical health insurance coverage to employees of the
21 businesses. It is the intent of this act to establish a
22 statewide pilot program that will allocate $15 million from
23 general revenue for such purposes.
24 (2) The Small Business Health Care Insurance Assistance
25 Pilot Program is created as a statewide pilot program for a
26 period of 2 years to provide a one-time rebate for small
27 businesses that employ more than one but fewer than six
28 employees and that provide full coverage of comprehensive major

29 medical health insurance for such employees pursuant to s.
30 627.6699, Florida Statutes. The employer shall pay at least 50
31 percent but less than 100 percent of the cost of the coverage,
32 and the employees must share in the remainder of the cost of the
33 coverage.
34 (3)(a) The amount of the rebate shall be $1,000 per each
35 employee as reported on the business' Florida unemployment
36 compensation tax form 6.
37 (b) A small business must apply through the Agency for
38 Health Care Administration.
39 (c) A business is eligible for the rebate under this
40 section if, at the time of applying for a rebate under the pilot
41 program, the business had provided and paid for such coverage
42 for 12 consecutive months but had not provided and paid for such
43 coverage for at least 6 months prior to such 12-month period.
44 The business may apply only once for the rebate.
45 (4) The pilot program shall be funded by general revenue
46 and shall be administered by the Agency for Health Care
47 Administration. The agency shall adopt any rules pursuant to ss.
48 120.536(1) and 120.54, Florida Statutes, necessary to administer
49 and ensure accountability of the pilot program and enforce
50 compliance with the requirements of the program. The agency may
51 conduct audits of any business applying for rebates under the
52 program to ensure compliance with program requirements.
53 Section 2. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **HB 1265**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation

2 Representative(s) Hukill offered the following:

3

4 **Amendment (with directory and title amendments)**

5 Remove line(s) 44 and insert:

6

7 The business may receive the rebate one time only.

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HB1265-Hukill1.doc

HB 1319

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1319 Certification of Swimming Instructors
SPONSOR(S): Goldstein
TIED BILLS: **IDEN./SIM. BILLS:** SB 2426

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Care Regulation Committee		Halperin	Mitchell
2) Business Regulation Committee			
3) Health Care Appropriations Committee			
4) Health & Families Council			
5)			

SUMMARY ANALYSIS

HB 1319 creates s. 514.072, F.S., to require additional certification of swimming instructors who teach people who have developmental disabilities. The bill provides the Department of Health with the authority to enforce compliance.

The bill allocates $535,000 from General Revenue to the department for the purpose of implementing the act, to be distributed as follows:

- $185,000 in recurring revenue to the Dan Marino Foundation, Inc., to implement and operate the certification program;
- $150,000 in nonrecurring revenue to Broward County Parks and Recreation for SWIM Central to develop the curriculum for the Special Needs Certification; and
- $200,000 in nonrecurring revenue to the Weston Family YMCA for pool modifications and enhancements for the developmentally disabled.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Provide limited government – The bill adds new certification requirements to the practice of swimming instruction in Florida.

B. EFFECT OF PROPOSED CHANGES:

HB 1319 creates s. 514.072, F.S., to require additional certification of individuals who work at public swimming pools as swimming instructors for people who have developmental disabilities, as defined in s. 393.063(10), F.S. Currently, swimming instructors are certified under s. 514.071, F.S., which provides that any person working as a swimming instructor or lifeguard at a public swimming pool must be certified by the American Red Cross, the YMCA, or other nationally recognized aquatic training program.

The bill provides that the "special needs" swimming instructor certification requirements will be developed by the Dan Marino Foundation, Inc., and instructors must meet these additional certification requirements in order teach individuals with developmental disabilities.

Swimming instructors certified under s. 514.071, F.S. before July 1, 2006, must meet the additional requirements by January 1, 2007. Individuals certified under s. 514.071, F.S. on or after July 1, 2006, must meet the additional requirements within 6 months after receiving the original certification.

In addition to other remedies available to the Department of Health, the bill provides the department the right to sue to prohibit or restrain by injunction the operation of any public swimming pool that uses any swimming instructor in violation of certification requirements.

The bill allocates $535,000 from General Revenue to the department for the purpose of implementing the act to be distributed as follows:

- $185,000 in recurring revenue to the Dan Marino Foundation, Inc., to implement and operate the certification program;
- $150,000 in nonrecurring revenue to Broward County Parks and Recreation for SWIM Central to develop the curriculum for the Special Needs Certification; and
- $200,000 in nonrecurring revenue to the Weston Family YMCA for pool modifications and enhancements for the developmentally disabled.

The effective date of the bill is July 1, 2006.

PRESENT SITUATION

Proponents of the bill claim that many developmentally disabled children are not being taught to swim properly because instructors lack expertise in training special needs students. While teachers in classrooms must receive additional certification to instruct special needs children, swimming instructors are not required to have additional training.

Florida Geography

Florida has 11,761 square miles covered by water, making it the third wettest state behind Alaska and Michigan.[1] Florida also has the second longest coastline of 1350 miles, and the second longest

[1] http://www.netstate.com/states/geography/fl_geography.htm.

shoreline of 8,426 miles.[2] Approximately 80 percent of residents live by the coast, and no resident is more than 75 miles from water. [3]

Drowning statistics

Drowning is the second leading cause of injury death of infants and children younger than 15 in the U.S. and children under the age of five have the highest drowning rates. For every child who drowns, four children are hospitalized for near-drowning. Of the estimated 5,000 children who are hospitalized annually for near-drowning, 15 percent die in the hospital and one third suffer significant neurological damage. In Florida, drowning is the leading cause of death to children age 14 and under[4], and the state has the highest number of drowning accidents in the nation.[5] Children under one year of age are most likely to drown in bathtubs and buckets, while children between the ages of 1 and 4 most frequently drown in residential swimming pools. Children usually enter pools through unprotected gates and are only out of eyesight for moments before immersing in the water. Children and adolescents between the ages of 5 and 19 most often drown in lakes, ponds, rivers and pools. The annual cost of care per year for an impaired survivor of a near-drowning is approximately $100,000. [6]

Factors that increase the risk of drowning

Some underlying medical conditions are known to increase the risk of drowning. Persons with developmental disabilities are at higher risk of pedestrian accidents in general, including falls, fires, and drowning. [7] Children with epilepsy are estimated to be 4 to 14 times more at risk of submersion[8]; and two recent studies suggest that children with autism may also be at increased risk.[9] However, both studies are based on a small number of drowning deaths and more research is necessary to evaluate the relation between autism and drowning. For some parents of children with autism, fears about the child's wellbeing sometimes lead them to avoid swimming lessons all together.[10] Minority and underprivileged children are also at increased risk of drowning. According to 2002 statistics, 40 percent of children who die from drowning are minority children. This is due to factors of race, class, privilege and poverty that limit a child's access to aquatic facilities and swimming lessons. [11]

Developmental Disabilities in Florida

Section 393.063(10), F.S defines a developmental disability as a disorder or syndrome that is attributable to retardation, cerebral palsy, autism, spina bifida, or Prader-Willi syndrome and that constitutes a substantial handicap that can reasonably be expected to continue indefinitely. Developmental disabilities begin anytime during development up to 22 years of age and usually last

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[2] http://www.50states.com/florida.htm.
[3] Florida Department of Environmetnal Protection. http://www.floridadep.org/law/grants/cmp/.
[4] Orange County, CA, Fire Authority. http://www.poolalarms.com/pool_drowning_statistics.htm.
[5] http://www.poolalarms.com/statistics_florida_swimming_pool_accidents.htm.
[6] Statistics on Drowning. http://hsc.usf.edu/CLASS/JulieJ/Statistics.htm.
[7] Strauss, D., Shavelle, R., Anderson, T. and Baumeister, A. "External Causes of Death among Persons with Developmental Disability." *American Jounral of Epidemiology.* 1998, Vol. 147, No. 9: 855-862. http://aje.oxfordjournals.org/cgi/content/abstract/147/9/855
[8] Smith GS, Brenner RA. The changing risks of drowning for adolescents in the US and effective control strategies. *Adolescent Medicine.* 1995; 6 :153 –170. See also footnotes 39-41 in Brenner, R.A. "Prevention of Drowning in Infants, Children, and Adolescents. *Pediatrics.* Vol. 112 No. 2 August 2003, pp. 440-445. Available at http://aappolicy.aappublications.org/cgi/content/full/pediatrics;112/2/440.
[9] Sibert JR, Lyons RA, Smith BA, et al. Preventing deaths by drowning in children in the United Kingdom: have we made progress in 10 years? Population based incidence study. *British Journal of Medicine* .2002; 324 :1070–1071; and Shavelle RM, Strauss DJ, Pickett J. Causes of death in autism. *Journal of Autism and Developmental Disorders.* 2001; 31 :569 –576.
[10] Life Science Services Contract with NASA.http://fitness.ksc.nasa.gov/articles/autism.php.
[11] Anderson, Kelli. "Just Add Water: A Complete Guide to Aquatic Centers." *Recreation Management.* http://www.recmanagement.com/feature_print.php?fid=200602fe01.

throughout a person's lifetime.[12] As of 2003 there were 7,151 children with autism in Florida. This represents a 690 percent cumulative growth rate of autism from 1992 to 2003, or an average annual growth rate of 19 percent. The increase in autism prevalence is systemic across the U.S., with rates having grown from 1 in 10,000 births in the 1980s to 1 in 166 births today.[13]

Current Regulations of Swimming Instructors

Section 514.071, F.S. requires that any person working as a swimming instructor or lifeguard at a public swimming pool must be certified by the American Red Cross, the Y.M.C.A., or another nationally recognized aquatic training program.[14] Swimming instructors are to be certified in swimming instruction, first aid, and cardiopulmonary resuscitation. Rule 64E-9.008, F.A.C., further requires that swimming instructors be certified in child and infant cardiopulmonary resuscitation through the American Red Cross, or the American Heart Association or the National Safety Council. In terms of enforcement, the Department of Health may currently sue to enjoin the operation of any public swimming pool that uses any swimming instructor or lifeguard in violation of this section, in addition to any other remedies available to the department.

Current Swimming Instruction Provided to Developmentally Disabled Children

Broward County has a unique program for serving developmentally disabled individuals, and currently provides instruction to between 4,000 and 5,000 special needs children each year in their regular swim instruction program.

New Certification Requirements

The certification program required in the bill is being drafted by a workgroup organized by the Broward County Swim Central in conjunction with the Dan Marino Foundation. The new proposed certification requirements are not currently available for review. According to the Department of Health analysis on this bill, there are currently nationally recognized courses that are required for swimming instructors and lifeguards. It is not known how the certification requirements in the bill will integrate with the national requirements for certification. The department suggests that an alternative way of designing additional certification requirements is to submit the idea to the Red Cross, YMCA or other national swimming instruction program for incorporation into existing swimming courses for certification.

About the Dan Marino Foundation

The Dan Marino Foundation, Inc. is based in Weston, Florida, and was founded in 1992 as a non-profit organization supporting medical, emotional or behavioral programs that provide integrated intervention services for children with special needs. The foundation has distributed and pledged over $7 million dollars to provide research, programs, and services that have benefited more than one hundred thousand children. [15]

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[12] U.S. Centers for Disease Control. http://www.cdc.gov/ncbddd/dd/default.htm.

[13] Public Schools Autism Prevalence Report Series, 1992-2003, www.fightingautism.org. Data Note: The Individuals with Disabilities Education Act (IDEA) requires each state's Department of Education and the U.S. Department of Education to record specific childhood disabilities, including autism, for each school year. This means that in order for a child to be recorded in the autism disability category the student must require special academic support for the disability; and means that some children with autism who attend private school or other facilities are not included in these counts. Data sources include www.ideadata.org and www.cdc.gov.nchs/.

[14] Pursuant to Rule 64E-9.008, "nationally recognized aquatic training programs" adopt as reference the standards found in the 2000 edition of the American Red Cross Lifeguarding Instructors Manual, the 1995 edition of the American Red Cross Water Safety Guide for Training Instructors, the On the Guard II, The YMCA Lifeguard Manual, Fourth Edition, (YMCA) The Youth and Adult Aquatic Program Manual (1999), and (YMCA) The Parent/Child and Preschool Aquatic Program Manual (1999).

[15] Dan Marino Foundation, Inc. www.danmarinofoundation.org.

About the Broward County Parks and Recreation SWIM Central Program

SWIM Central is housed at Broward County Parks and Recreation and is the county's chief coordinating agency for water safety instruction and awareness. SWIM Central was formally established in 1999 with funding from the Broward County Commission, and then formed a collaborative partnership with the Broward County School Board. The Florida Legislature provided a special appropriation of $200,000. In 2005 additional funding came from the Children's Service Council of Broward County, with moneys allocated for recruitment, training, and certification of swimming instructors, and basic First Aid and CPR instruction for parents and guardians. Under the auspices of the Broward County Commission's 2000 Safe Parks and Land Preservation Bond Program, nearly $20 million has been allocated for SWIM Central Capital Bond Grants to construct new aquatic facilities in many of Broward's municipalities and at several facilities of eligible nonprofit organizations, such as area Boys and Girls Clubs, YMCAs, and JCCs. SWIM Central provides ten 30-minute classes over a two-week period for children to learn basic and valuable water safety and swimming skills, at no cost to the parent. The success of SWIM Central has gained attention nationwide and is the only program of its type in the country.[16]

About the Weston Family YMCA

The Weston Family YMCA is a 65,000-square-foot facility located at the Weston Regional Park, and includes an Olympic-size outdoor swimming pool. The center serves youth and families throughout West Broward County, including the cities of Cooper City, Davie, Miramar, Pembroke Pines, Plantation, Southwest Ranches, Sunrise and Weston.[17]

C. SECTION DIRECTORY:

Section 1. Creates s. 514.072, F.S., to require additional certification for swimming instructors who teach people who have developmental disabilities.

Section 2. Allocates $535,000 from General Revenue for the purpose of implementing the act.

Section 3. 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:

   The bill allocates $535,000 from General Revenue to the department for the purpose of implementing the act, to be distributed as follows:
   - $185,000 in recurring revenue to the Dan Marino Foundation, Inc., to implement and operate the certification program;
   - $150,000 in nonrecurring revenue to Broward County Parks and Recreation for SWIM Central to develop the curriculum for the Special Needs Certification; and
   - $200,000 in nonrecurring revenue to the Weston Family YMCA for pool modifications and enhancements for the developmentally disabled.

[16] Broward County SWIM Central. http://www.broward.org/parks/swimcentral.htm.
[17] Weston Community Guide. http://www.communitylink.com/us/fl/weston/profile/leisure.htm.

According to Department of Health (DOH) analysis, staff time spent at public pools will be increased during the routine inspections, which will result in additional costs. Increased violations could also result in a significant increase in the workload of DOH legal staff. The amount of these costs are both undeterminable at this time.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

2. Revenues:

None.

3. Expenditures:

See Fiscal Comments.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

See Fiscal Comments.

D. FISCAL COMMENTS:

According to Department of Health (DOH) analysis, each city or county that operates a public pool and offers swimming instruction to developmentally disabled persons will incur a cost for each staff member certified under the requirements of bill. Travel costs may be also be incurred for instructors to go to Broward County in order to receive training and certification.[18]

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or taken an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

None required.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The department suggests that the certification proposed in the bill be done initially in Broward County only to ensure its effectiveness prior to implementation statewide. If not, DOH would prefer an effective date of January 1, 2007, as the department would have to train inspectors and develop processes and procedures for incorporating the certification requirement into public pool inspections. The department is responsible for 34,000 public pools statewide.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

[18] Berrios, J. "Swimming teachers could get extra duties." *Miami Herald*. March 20, 2006. http://www.miami.com/mld/miamiherald/news/local/states/florida/counties/broward_county/13994776.htm.

1 A bill to be entitled
2 An act relating to certification of swimming instructors;
3 creating s. 514.072, F.S.; requiring additional
4 certification of swimming instructors for people who have
5 developmental disabilities; providing a remedy for
6 certification violations; providing an appropriation;
7 providing an effective date.
8
9 Be It Enacted by the Legislature of the State of Florida:
10
11 Section 1. Section 514.072, Florida Statutes, is created
12 to read:
13 514.072 Certification of swimming instructors for people
14 who have developmental disabilities required.--
15 (1) Any person working at a public swimming pool as a
16 swimming instructor for people who have developmental
17 disabilities, as defined in s. 393.063(10), must be certified by
18 the Dan Marino Foundation, Inc., in addition to being certified
19 under s. 514.071. A person certified under s. 514.071 before
20 July 1, 2006, must meet the additional certification
21 requirements of this section by January 1, 2007. A person
22 certified under s. 514.071 on or after July 1, 2006, must meet
23 the additional certification requirements of this section within
24 6 months after receiving certification under s. 514.071.
25 (2) In addition to any other remedies available to the
26 department, the department may sue to enjoin the operation of
27 any public swimming pool that uses any swimming instructor in
28 violation of subsection (1).

29 Section 2. The sum of $535,000 is appropriated from the
30 General Revenue Fund to the Department of Health for the 2006-
31 2007 fiscal year for the purpose of implementing this act, to be
32 distributed as follows: $185,000 in recurring revenue to the Dan
33 Marino Foundation, Inc., for swimming certification; $150,000 in
34 nonrecurring revenue to Broward County Parks and Recreation for
35 the SWIM Central Special Needs Certification, and $200,000 in
36 nonrecurring revenue to the Weston YMCA for special needs
37 modifications and enhancement for the developmentally disabled.
38 Section 3. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. _____ (for drafter's use only)

Bill No. **HB 1319**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 29-37 and insert:
6
7 Section 2. The sum of $535,000, of which $185,000 is
8 reoccurring, is appropriated to the Department of Health for
9 distribution to the Dan Marino Foundation, Inc. for the 2006-
10 2007 fiscal year for the purpose of implementing this act.

PCB HCR 06-06

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCR 06-06 Rural Health Care
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee		Mitchell	Mitchell
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Rural Health Care, Proposed Committee Bill (PCB) reorganizes existing rural health support functions of the Department of Health, to provide planning and support for the development of networks of rural health providers. It creates a joint advisory board appointed by the Secretaries of the Department of Health and the Agency for Health Care Administration, to coordinate efforts of the agencies and stakeholders. The bill moves grant programs that support rural hospitals under the purvue of the Agency for Health Care Administration, and establishes two new programs to support financially distressed rural hospitals, and the development of Rural Provider Service Networks.

Health care providers in Florida's rural areas continue to face major challenges in establishing and maintaining services. The relative isolation, lack of community resources, and high proportion of uninsured and government funded patients make rural health care delivery a continual struggle to maintain financial solvency.

As in the rest of the country, small, rural hospitals especially face declining public and private reimbursements and a poor and aging population with a greater likelihood of being uninsured and unhealthy. Often they are taken advantage of by unqualified outside management companies. Two North Florida rural hospitals have recently closed--Gulf Pines in Port St. Joe, Gulf County, and Gadsden Memorial Hospital in Quincy.

Because the underlying system of health care financing and delivery, including Florida's Medicaid Reform, is changing from fee-for-service payments to capitation and other risk-sharing payment methods, and cost containment is moving away from regulatory to more market-based strategies, the development of provider service networks are needed to strengthen the rural health care infrastructure and improve access to services. Currently financially stressed rural health providers, especially the hospitals that serve as critical anchors to rural health care, are not prepared to meet these challenges and communities face the prospect of losing access to care.

The bill includes grant programs that use existing state and federal funding. Additional capacity is dependent on any specific appropriations.

The enacting date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Limited Government – The bill provides for better coordination of existing efforts to help health care providers meet the needs of rural communities. It provides assistance in establishing Provider Service Networks and financially viable hospitals to meet changes in managed care financing and regulation of health care, including Florida's Medicaid Reform.

Empower Families – The bill increases the opportunity for rural families to access quality health care in their communities.

B. EFFECT OF PROPOSED CHANGES:

The Proposed Committee Bill reorganizes existing rural health support functions of the Department of Health to provide planning and support for the development of rural health provider networks, and creates a joint advisory board appointed by the Secretaries of the department and the Agency for Health Care Administration to coordinate efforts of the agencies and stakeholders. The bill moves grant programs that support rural hospitals to the Agency for Health Care Administration and establishes two new programs to support the development of Rural Provider Service Networks and financially distressed small rural hospitals.

The Proposed Committee Bill:

Amends s. 381.0405, F.S., Office of Rural Health to:

- Provide for the Office of Rural Health to coordinate its activities with and administer grants to Rural Health Networks.
- Increase technical assistance in planning.
- Establish an advisory council appointed by the Secretaries of the Department of Health and Agency for Health Care Administration.

Amends s. 381.0406, F.S., Rural Health Networks, to:

- Reorganize and specify functions related to planning and coordination of service providers and remove requirements to provide health care services.
- Add findings related to rural preparation for managed care and capitation-reimbursement methodologies.
- Encourage participation by Federally Qualified Health Centers, EMS providers and County Health Departments in rural networks.
- Clarify network functions to improve quality and access to services.
- Require rural health infrastructure development plans.
- Require coordination with other entities including health education centers, health planning councils & regional college & university education consortia.
- Establish a grant program to support network operations and rural infrastructure development.
- Delete obsolete language related to network implementation in two phases.

Amends s. 395.602(2), F.S., Rural Hospitals, to:

- Remove definitions for obsolete federal programs.
- It retains and amends the definition for "rural primary care hospitals" to continue to allow for licensure of smaller facilities that provide emergency care and temporary inpatient care.

Amends s. 395.603(1), F.S., relating to Deactivation of Hospital Beds, to remove provisions for obsolete federal programs, and it repeals s. 395.605, F.S., relating to an obsolete federal rural hospital programs.

Amends s. 395.604, F.S., relating to Rural Primary Care Hospitals, to establish provisions for funding and support for very small rural primary care hospitals that provide only emergency and temporary care, including expedited CON review and certain exemptions.

Amends s. 395.6061, F.S., relating to Rural Hospital Capital Improvement Grants, to:

- Clarify the purpose of the program to include assistance in development of needed infrastructure and professional standards in the operation of rural hospitals.
- Require department technical assistance.
- Remove requirement that all rural hospitals receive an equal grant amount of $100,000 regardless of need or purpose, and specify criteria for awarding grants.

Creates s. 395.6063, F.S., establishing an Assistance Program for Financially Distressed Rural Hospitals, to:

- Limit eligibility to critical access hospitals, and rural hospitals with an annual occupancy rate of less than 30 percent.
- Establish application requirements.
- Require a participation agreement and other requirements to receive funding.
- Provide for the option of conversion to a very small Rural Primary Care Hospital.

Amends s. 408.05, F.S., relating to the State Center for Health Statistics, to:

- Establish the Rural Provider Service Network Development Program in the Agency for Health Care Administration to:
- Administer the Rural Hospital Capitalization Grant program in s. 395.6061, F.S.
- Administer the program to assist Financially Distressed Rural and Critical Access Hospital program, established in 395.6063, F.S.
- Administer the Rural Provider Service Network Development Grant program.
- Carry out a study of barriers and options for developing provider service networks in rural areas and make recommendations to the Legislature.
- Establish requirements for the Rural Provider Service Network Development grants.

Amends s. 408.07, F.S., relating to Reimbursement of Medicaid Providers, to require a 10 percent reimbursement bonus to physicians who have provider agreements with a rural health network.

The bill establishes the enacting date to be July 1, 2006.

CURRENT SITUATION

Rural Counties in Florida

Although Florida is the fourth most populous state in the U.S., it has substantial areas that are rural both by definition and use. As of the 2000 U.S. Census, 33 of Florida's 67 counties are considered rural based on the statutory definition of "an area with a population density of less than 100 individuals per square mile or an area defined by the most recent United States Census as rural." In area, these 33 counties cover just over 42 percent of Florida's nearly 54,000 square miles of land area. Rural counties are located primarily in the Florida Panhandle, north central Florida, the south central portion of the state, and the Florida Keys.

As of 2000, approximately 1.1 million of Florida's 16 million residents live in rural counties. Portions of other Florida counties also contain large, rural areas but are not classified as rural. Many of the counties bordering on the Atlantic Ocean and Gulf of Mexico have populations concentrated near the coast, but thinly populated interiors (e.g., Collier, Palm Beach, or Escambia counties).

Rural Health Infrastructure and Outcomes
In general, rural residents have more health problems than urban residents. Rural communities have:

- Higher rates of chronic illnesses, such as hypertension and cardiovascular disease;
- Problems unique to rural occupations, such as machinery accidents, skin cancer from sun exposure, and breathing problems from exposure to agricultural chemicals; and
- Lower rates of having health insurance with pharmacy coverage plans.

The relative disparity between the health and access to health care of Florida's urban and rural residents is an ongoing concern for policymakers. Florida has been involved in a variety of state and federal efforts to address the health care needs of rural residents over the past half-century that include:

- Hill-Burton program that provided federal funding for the construction of community hospitals during the 1950s and 60s;
- Establishment of state and regional comprehensive health planning and health systems agencies from the 1960s through 1985;
- Regional health planning efforts by local health councils from 1985 to present;
- Establishment of the Office of Rural Health in 1991;
- Authorization of rural health networks in 1993;
- Implementation of the federal critical access hospital program in 1997;
- Provision of rural emergency medical and hospital capital improvement grants to sustain essential services in rural communities and enhance the development of coordinated health care delivery in rural communities; and
- Legislative approval in 2000, for a new medical school at Florida State University to train primary care physicians to practice in underserved and rural communities.

Insufficient Health Services
While Florida has made considerable progress through these efforts, more still needs to be done to ensure that rural residents continue to have reasonable access to quality health services. These investments in Florida's health care infrastructure have not provided the significant return on investment that was anticipated. Despite advances over the past decade in reducing morbidity and mortality, the health of Florida's rural population remains at risk. Rural Florida residents have a higher mortality rate than urban residents for motor vehicle accidents, infant mortality, diabetes, Alzheimer's disease, and chronic lower respiratory disease.

Health care providers in Florida's rural areas continue to face major challenges in establishing and maintaining services. The relative isolation, lack of community resources, and high proportion of uninsured and government funded patients make rural health care delivery for many health care providers a continual struggle to maintain financial solvency. Some of Florida's 29 rural hospitals lack sufficient patient revenue to meet operating expenses, forcing the hospitals to make decisions about reducing or eliminating essential health services. Although recent federal and state programs have eased the financial burden for rural hospitals, future attempts to curb government health spending will pose an ongoing challenge for rural providers.

Approximately 20 percent of the adult population in rural areas is without health insurance coverage. This is primarily because during economic downturns, rural areas have higher levels of unemployment, and rural residents have greater difficulty obtaining health insurance coverage.

Rural Hospital Financial Problems
Rural hospitals are the hub of health care for their service areas. Skilled-nursing, home, clinical, and primary-care services often are available solely due to the presence of a hospital. The hospitals are also critical for the economic development of rural communities, as employers of skilled professionals and hospital access are needed to attract outside investment.

As in the rest of the country, small, rural hospitals in Florida face numerous challenges. Among them are declining public and private reimbursements, workforce shortages and a poor and aging population with a greater likelihood of being uninsured and unhealthy. Often they are taken advantage of by unqualified outside management companies. Two North Florida rural hospitals have recently closed--Gulf Pines in Port St. Joe, Gulf County, and Gadsden Memorial Hospital in Quincy.

The mission of the rural hospitals is to provide appropriate, life-saving health care in rural/isolated areas of the state. By definition, rural hospitals have 100 or fewer beds. Nineteen rural hospitals have 50 or fewer beds. The majority of rural hospitals are located in the Panhandle. Rural hospitals represent approximately two percent of hospital admissions statewide.

To participate in state and federal programs, rural hospitals may have no more than 100 beds. In the most rural areas, hospitals may be designated as Critical Access Hospitals. Eleven of Florida's 29 rural hospitals are Critical Access Hospitals. These hospitals must have no more than 25 beds of which only 15 may be acute care beds.

According to information provided by the Agency for Health Care Administration, the 29 rural hospitals in Florida have an overall average operating margin of 2.4 percent. The Critical Access Hospitals have an average operating margin of -.2 percent. Specific hospitals, such as Cambellton-Graceville Hospital in Jackson County, which has a -6.5 percent operating margin and Hendry Regional Medical Center in Hendry Co, with a -4.8 percent operating margin, are in very difficult financial and operating circumstances. (Hospital Bed and Service Utilization 1/17/06, Rural Hospital Payer Mix for FY 2004 based on data reported 2/2006.)

Occupancy rates are low. Information on bed days reported by rural hospitals for the second quarter of 2005 shows an overall average rural occupancy rate of 37 percent. Critical Access Hospitals have an overall occupancy rate of 25 percent. Three Critical Access Hospitals had much lower occupancy rates. Cambellton-Graceville Hospital in Jackson County reported an occupancy rate of 11 percent; George Weems Memorial Hospital in Franklin County reported an occupancy rate of 15 percent; and Gadsden County Community Hospital in Quincy, which is now closed, had an occupancy rate of only 6 percent.

Critical Access Hospitals disproportionately depend on federal programs, especially Medicare, for funding. While rural hospitals overall have a payer mix that is 60 percent Medicare Days and 14 percent Medicaid Days, Critical Access Hospitals overall have a mix that is 66 percent Medicare Days and 16 percent Medicaid Days. Hospitals with very low operating margins, such as George Weems Memorial Hospital in Appalachicola, which has a mix of 81 percent Medicare and 4.3 percent Medicaid, and Gadsden Memorial, which had a mix of 75 percent Medicare and 3 percent Medicaid, are uniquely dependent on increasingly restricted sources of reimbursement. Furthermore, they receive very little Disproportionate Share Hospital Funds that are based on Medicaid.

Case Study of the Failure of Gadsden Memorial Hospital in Quincy Florida

In November 2005, the state closed the 25-bed hospital in Quincy, Florida, as a threat to public health. As reported in the Tallahassee Democrat, February 23, 2006, county officials have been trying ever since to reopen it by getting its existing state operating license transferred from Ashford Community Health Care Systems, the management company that ran it. Ashford filed for bankruptcy protection shortly after the hospital was closed, and the license has become a valuable asset to creditors, including GE HFS Holdings Inc., a company which gave Ashford a nearly $3 million secured loan, so that Ashford is not willing to give up its lease to the hospital. Two other rural North Florida hospitals that were also run by Ashford are also in trouble, Weems Hospital in Appalachiacola, and Calhoun-Liberty Hospital in Blountstown.

The county still has to evict Ashford from the hospital, an effort begun last April and interrupted by Ashford's bankruptcy filing. County officials plan now to push ahead with terminating the lease. Gadsden County is trying to set up a temporary urgent-care clinic to meet residents' health-care needs, while officials begin the arduous process of getting a new operating license for Gadsden Memorial Hospital.

CURRENT STATE PROGRAMS

Office of Rural Health

Florida's Office of Rural Health, ORH, is located within the Department of Health and has been the focal point for the development and administration of Florida's rural health policy since 1991 (s. 381.0405, F.S.). Currently, the office is staffed by two full-time positions: the Director of the Office of Rural Health and a Critical Access Hospital Coordinator.

The office's mission is to actively foster the provision of health care services in rural areas and serve as a catalyst for improved health services to citizens in rural areas of the state. The office works with other state and federal programs as Florida's rural health representative, disseminates information on Florida's rural health services, and acquires and distributes state and federal funds to assist in maintaining a coordinated and sustainable system of rural health services. Specifically, ORH is assigned responsibility for the following:

- Coordinating with other state programs and agencies (e.g., Medical Quality Assurance, Emergency Medical Services, Planning, Evaluation and Data Analysis within the larger Department of Health; the Agency for Health Care Administration; the Department of Children and Families), area health education centers, state universities, and rural health interest groups such as the Florida Hospital Association and the Florida Rural Health Association;
- Providing technical assistance to rural providers;
- Collecting and disseminating information about rural health;
- Acquiring grant funds for rural health programs and providers; and
- Working to improve access to emergency medical services in rural areas.

Since 1997, the office has focused on three key programs within rural health, the Medicare Rural Hospital Flexibility Program, the Rural Hospital Capital Improvement Grant Program, and the development and support of the state's rural health networks.

Rural Health Networks

In 1993, the Legislature established the basis for the formation of cooperative, nonprofit health networks in rural areas of Florida in s. 381.0406, F.S. These organizations were directed to address the fundamental problems in rural health: inadequate financing, problems with recruitment and retention of health personnel, and migration of patients from rural providers to urban providers, thus undermining the abilities of rural hospitals to continue to provide timely and effective care. The networks are intended to integrate public and private health resources, to emphasize cooperation over competition, and to increase usage of statutory rural hospitals in an effort to support rural economies.

Nine rural health networks have been formed in Florida. Currently, these cover 28 of the 33 rural counties as well as parts of 13 non-rural counties. The department has the responsibility for certifying the networks and for distributing grant funds to eligible participants. Florida's rural health networks have been in operation since 1993 and serve as the regional organizations responsible for carrying out much of Florida's rural health policy. Rural health networks work closely with rural communities and providers to encourage, organize, and coordinate actions to provide increased health access and improved health care services to rural communities.

Rural Hospital Capital Improvement Grant Program

In 1999, the Florida Legislature established the rural hospital capital improvement grant program through which statutory rural hospitals, as defined by s. 395.602, F.S., may apply for financial assistance to "acquire, repair, improve, or upgrade systems, facilities, or equipment" (s. 395.6061, F.S.). Upon fulfilling basic application conditions, each qualifying rural hospital receives a minimum of $100,000 per year for such capital improvements, if funds have been appropriated by the Legislature. The application, review, and administration procedures for this program are responsibilities of ORH.

State Center for Health Statistics

The State Center for Health Statistics has become the office for policy development and new initiatives in the Agency for Health Care Administration. It oversees the development of Florida's Health Information Infrastructure to support communication of health records among health care providers to provide better coordination of patient health care, and improved quality and safety of care. With a staff of researchers, analysts and writers, the office currently collects and disseminates information based on patient data, and provides technical assistance in the development and use of information for planning, oversight and consumer choice. The State Center for Health Statistics uses agency data to create detailed reports that examine health care trends and outcomes of specific diagnoses in the Health Outcome Series. In addition, the center produces a variety of publications within the Consumer Awareness Series and the Florida HMO Report to assist the public in making well-informed health care decisions.

BACKGROUND

PROBLEMS FACING RURAL HOSPITALS

While many rural hospitals have survived by shifting to outpatient services such as skilled nursing, home health and hospice, the shift has made them more vulnerable to changes in reimbursement and other policies as federal and state programs seek to constrain the increasing costs of health care.

Aging Facilities and Professional Shortages

Within the context of changing health care economics, small rural hospitals face several critical problems that include the need for capital improvements to many aging hospitals and the need to recruit and retain a skilled workforce. Many of America's small rural hospitals were built with the support of 1946-1970s era Hill-Burton Act funds. These facilities are collectively beginning to show their age and obsolescence. In a survey of rural hospitals conducted by the Florida Hospital Association, eight rural hospitals reported their facilities were 40-50 years old. Rural hospitals face a chronic and critical problem recruiting and retaining nurses, technicians, midlevel practitioners, and physicians.

Lack of Information Infrastructure

There is a growing need for telemedicine services between rural hospitals and specialists to provide remote consultation for treating individual patients. Many rural hospitals do not have full-time radiologists to interpret X-rays. Most rural hospital telemedicine now involves only telephone service and faxing to other physicians at hospitals that might receive patients transferred from rural hospitals to provide services not available in the rural settings. Most Florida health insurance does not provide compensation for telemedicine consultations.

Where telemedicine consults are available, it has been reported anecdotally that approximately 80 percent of patients can be successfully treated at the rural hospitals without incurring patient transfer costs. Rural clinics are often formally affiliated with larger hospitals that accept transfer patients with serious ailments.

Rural hospitals lack the technology and equipment to support the delivery and management of these health care services. They lack building wiring for networking and other resources typically employed for distance learning. To date:

- A majority of rural hospitals have implemented some form of automated billing, but very few have automated patient records.
- Many of the computer workstations in rural hospitals are not networked and billing and patient care records systems are generally not integrated.
- Most rural hospitals have no satellite or Instructional Television Fixed Service capability for receiving video signals for accessing continuing education training material.

EFFORTS TO ADDRESS THE PROBLEMS OF SMALL RURAL HOSPITALS

A 2001 report by the National Advisory Committee for Rural Hospitals offered several suggestions to address these problems, including:

- Incentive programs for nurses working in underserved rural areas to help alleviate nursing shortages.
- Training and technical assistance to rural providers as they try to keep up with reimbursement and regulatory demands.
- Careful analysis of the effects of proposed reimbursement and regulatory changes on small rural communities prior to enactment.
- Addressing sustainability for rural telemedicine applications through additional funding for site coordinators and/or communication charges.

Managed Care

Traditionally, improving access to health care services has been addressed by increasing payments to providers and creating special programs to recruit and retain health professionals. Even as these efforts continue, however, the underlying system of health care financing and delivery is changing across the entire health system—marked by the move to managed care and the rise of more integrated health care organizations. Most major health care purchasers are switching from fee-for-service payments to capitation and other risk-sharing payment methods, and policymakers in general are moving away from regulatory to more market-based strategies for containing costs. It appears that the development of provider networks and managed care systems holds some promise for strengthening the rural health care infrastructure and improving access to health care services.

Many rural providers perceive managed care organizations (MCOs) as a threat, because they:

- May impose more financial risk on rural providers than they are capable of bearing;
- May not make concessions for circumstances particular to rural areas (e.g., transportation barriers, larger caseloads for practitioners, and limited infrastructure in general); and
- May absorb most or all the new primary care practitioners and give them incentives to locate in urban and suburban areas, draining health care resources away from rural areas and exacerbate the shortage of primary care providers.

On the other hand, because many MCOs are large organizations with considerable resources, they have the potential to invest in building adequate rural health care delivery systems. They may enable rural providers to participate in more sophisticated medical management information systems. They can provide a steady income stream via capitation and other contracts to physicians and hospitals, which may be especially welcome in more economically depressed areas. It has also been argued that MCOs can better use mid-level and non-physician practitioners than can independent providers. They may also improve access to relevant medical technologies by linking rural providers to urban health centers through telecommunications and mobile health units.

In this context, states need to consider the special effects on rural areas as they implement new regulations for managed care, such as rules for provider networks that bear insurance risk, and integrate rural network development into other initiatives, such as network demonstration projects with Medicaid managed care expansion.

FEDERAL PROGRAMS

Medicare Rural Hospital Flexibility Program

Beginning with the Balanced Budget Act of 1997 (Public Law 105-33), the U.S. Congress started a process designed to improve the financial viability of small, rural hospitals. The initial program was "fine-tuned" through provisions of the Balanced Budget Refinement Act of 1999 and the Benefits Improvement and Protection Act (BIPA) of 2000. Rural hospitals suffer not only from small, relatively poor patient populations but they have also been penalized by Medicare which provided service

reimbursement rates lower than those provided to urban hospitals for the same services. Oftentimes, the reimbursement was for less than the actual cost of care, thereby actually costing the hospital money. This is especially important for rural hospitals since they have proportionally more Medicare patients than do urban hospitals. The Medicare Rural Hospital Flexibility Program was intended to rectify some of these imbalances. The program presented a new reimbursement category for rural hospitals, that of the Critical Access Hospital. This new type of hospital is an acute care facility that provides emergency, outpatient, and limited inpatient services.

Critical Access Hospitals may have no more than 15 acute care beds and another 10 "swing beds" (these are inpatient beds that may also be used for other services such as part of a Skilled Nursing Facility). Average annual length of stay for all inpatients must be 96 hours (4 days) or less. Emergency services must be available 24 hours per day, seven days per week. Certain other regulations must be followed concerning physical location, relations with larger, tertiary care hospitals, and credentialing and quality assurance procedures. In return, these hospitals will be reimbursed on a "reasonable cost" basis for inpatient, outpatient, and laboratory services delivered to Medicare patients. For small hospitals with significant numbers of Medicare patients this, at the very least, allows them to stop losing money on services delivered. The office oversees the conversion applications, financial feasibility studies; community needs assessments, and conversion of rural hospitals to Critical Access status.

The vast majority of CAHs are located in health professional shortage areas, are the only hospitals in the county, and are located in counties where the over-65 population is higher than the state average. The states with the largest number of CAHs are Kansas, Nebraska, Iowa, Texas, Minnesota, and Montana. Out of 31 rural hospitals in Florida, 12 are Critical Access Hospitals. The three North Florida hospitals currently in financial crisis are all Critical Access Hospitals.

The Medicare Rural Hospital Flexibility Program also contains a grant program, administered by the Federal Office of Rural Health Policy. Grants of up to $775,000 per state per year are provided to improve rural health systems with an emphasis on improving Emergency Medical Services. The office applies for, receives, and administers these grant funds.

Medicare and Medicaid Bonus Payments

In addition to the challenges facing rural hospitals, another issue limiting health care access in rural communities is the sparse number of physicians in practice in rural counties. The persistent shortage of primary care physicians in rural and underserved areas of the nation has become one of the most challenging health care policy issues facing medical educators and health care policymakers in the U.S. in the past half century. Incentives, both financial and personal, have combined to create a modern-day physician workforce overloaded with specialists who choose to practice primarily in metropolitan and suburban markets. The ultimate consequence of this skewed distribution of physician location and services is a shortage of basic health care services for certain groups of the U.S. population, particularly in rural areas.

The federal government, recognizing the need for economic incentives to facilitate this process, has established several key programs that promote the provision of primary care services to those of greatest need. Of these, two programs involve bonus payments in the Medicare program for physicians practicing in Health Professional Shortage Areas and Physician Scarcity Areas.

Health Professional Shortage Areas Bonus Payments

The federal Health Professional Shortage Area designation identifies an area or population as having a shortage of dental, mental, and primary health care providers. Those designations are used to qualify for state and federal programs aimed at increasing primary care services to underserved areas and populations.

Among these programs is a ten percent bonus Medicare payment for providers practicing medicine in a Health Professional Shortage Area. The bonus is paid for all Medicare services provided in the shortage area and may be billed along with other incentives programs.

Physician Scarcity Areas Bonus Payments
The Medicare Modernization Act of 2003, §413(a), requires that a new 5 percent bonus payment be established and paid for services rendered by physicians in geographic areas designated as Physician Scarcity Areas. Under the program, physician scarcity designations are based on the lowest primary care and specialty care ratios of Medicare beneficiaries to active physicians in a particular county. Medicare will pay a 5 percent bonus on a quarterly basis based on where the service is performed and not on the address of the beneficiary. The bonus may be billed in conjunction with other bonus payments under Medicare.

Both of these Medicare bonus programs are authorized under the federal physician payment regulations found in 42 CFR 447.200 and 42 CFR 447.203. A similar bonus payment system in Medicaid would require a state plan amendment that clearly explains how the bonus payment is provided.

C. SECTION DIRECTORY:

Section 1. Amends s. 381.0405, F.S., Office of Rural Health to provide for rural health networks planning and technical assistance and establish a joint DOH and AHCA advisory council.

Section 2. Amends s. 381.0406, F.S., Rural Health Networks, to reorganize and specify functions related to planning and coordination of service providers and remove requirements to provide health care services and establish a grant program to support network operations and rural infrastructure development.

Section 3. Amends s. 395.602(2), F.S., Rural Hospitals, to remove definitions for obsolete federal programs and amends the definition for "rural primary care hospitals" to continue to allow for smaller facilities that provide emergency.

Section 4. Amends s. 395.603(1), F.S., relating to Deactivation of Hospital Beds, to remove provisions for obsolete federal programs.

Section 5. Amends s. 395.604, F.S., relating to Rural Primary Care Hospitals, to establish provisions for funding and support for very small rural primary care hospitals, including expedited CON review and certain exemptions.

Section 6. Amends s. 395.6061, F.S., relating to Rural Hospital Capital Improvement Grants, to clarify the purpose of the program to include assistance in development of needed infrastructure and professional standards in the operation of rural hospitals, and remove the requirement that all rural hospitals receive an equal grant amount of $100,000, regardless of need or purpose, and specify criteria for awarding grants.

Section 7. Creates s. 395.6063, F.S., establishing an Assistance Program for Financially Distressed Rural Hospitals, to establish eligibility for grants and requirements.

Section 8. Amends s. 408.05, F.S., relating to the State Center for Health Statistics, to establish the Rural Provider Service Network Development Program in AHCA, to administer hospital grant programs in ss. 395.6061 and 395.6063, F.S.; establish and administer the Rural Provider Service Network Development Grant program; and carry out a study for developing provider service networks in rural areas and make recommendations to the Legislature.

Section 10. Amends s. 408.07, F.S., relating to Reimbursement of Medicaid Providers, to require a 10 percent bonus to physicians who have provider agreements with a rural health network.

Section 9 and Sections 11 and 12. Amend ss. 408.07(43), 409.9116, and 1009.65, F.S., to conform cross-references.

Section 13. Repeals s. 395.605, F.S., relating to an obsolete federal rural hospital programs.

Section 14. Provides an effective date of July 1, 2006.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   See Fiscal Comments below.

2. Expenditures:

   See Fiscal Comments below.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill will provide increase funding to rural health care providers, including physicians, hospitals and provider service networks.

D. FISCAL COMMENTS:

Grant programs established in the bill are contingent on funding from General Revenure. According to the Department of Health, existing funding for current programs in 2005-2006 includes:

Office of Rural Health	$ 150,000	state
Rural Health Networks	$ 500,000	state
Rural Hospital Capital Improvement Program	$ 3,500,000	state
Small Hospital Improvement Program (SHIP)	$ 177,460	federal
Medicare Rural Hospital Flexibility Program (FLEX)	$ 540,000	federal

In addition, some rural hospitals and some rural health networks receive funds that do not flow through the DOH Office of Rural Health. State funds include Rural Hospital Disproportionate Share funds and member projects. Federal funds include Office of Rural Health Policy Grants for rural health outreach and network development. In addition, there are federal funds for bioterrorism.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

   This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health and Agency for Health Care Administration have rule making authority to administer existing programs and specific authority is provided in the bill for new responsibilities.

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 rural health care; amending s.
3 381.0405, F.S.; revising the purpose and functions of the
4 Office of Rural Health in the Department of Health;
5 requiring the Secretary of Health and the Secretary of
6 Health Care Administration to appoint an advisory council
7 to advise the office; providing for terms of office of the
8 members of the advisory council; authorizing per diem and
9 travel reimbursement for members of the advisory council;
10 amending s. 381.0406, F.S.; revising legislative findings
11 and intent with respect to rural health networks; revising
12 the definition of "rural health network"; providing
13 additional functions of and requirements for membership in
14 rural health networks; requiring rural health networks to
15 submit rural health infrastructure development plans to
16 the office by a specified date; revising provisions
17 relating to the governance and organization of rural
18 health networks; revising the services to be provided by
19 provider members of rural health networks; requiring
20 coordination among rural health networks and area health
21 education centers, health planning councils, and regional
22 education consortia; establishing a grant program for
23 funding rural health networks; defining projects that may
24 be funded through the grant program; requiring the
25 department to establish rules governing rural health
26 network grant programs and performance standards; amending
27 s. 395.602, F.S.; defining "critical access hospital";
28 revising and deleting definitions; amending s. 395.603,
29 F.S.; deleting a requirement that the Agency for Health

30 Care Administration adopt a rule relating to deactivation
31 of rural hospital beds under certain circumstances;
32 requiring that rural critical access hospitals maintain a
33 certain number of actively licensed beds; amending s.
34 395.604, F.S.; removing emergency care hospitals and
35 essential access community hospitals from certain
36 licensure requirements; specifying certain special
37 conditions for rural primary care hospitals; amending s.
38 395.6061, F.S.; specifying the purpose of the rural
39 hospital capital improvement grant program; providing for
40 grant management by the agency; modifying the conditions
41 for receiving a grant; deleting a requirement for a
42 minimum grant for every rural hospital; creating s.
43 395.6063, F.S.; establishing an assistance program within
44 the agency for financially distressed rural and critical
45 access hospitals; providing purpose of the program;
46 providing requirements for receiving assistance; requiring
47 the agency to adopt rules; requiring a participation
48 agreement and providing for contents thereof; amending s.
49 408.05, F.S.; establishing the Rural Provider Service
50 Network Development Program; providing purposes and
51 responsibilities; establishing a development grant
52 program; providing eligibility requirements; authorizing
53 preferential funding to certain providers; requiring the
54 agency to adopt rules; amending s. 409.908, F.S.;
55 requiring the agency to pay certain physicians a bonus for
56 Medicaid physician services provided within a rural
57 county; amending ss. 408.07, 409.9116, and 1009.65, F.S.;
58 conforming cross-references; repealing s. 395.605, F.S.,

59 relating to the licensure of emergency care hospitals;
60 providing an effective date.
61
62 Be It Enacted by the Legislature of the State of Florida:
63
64 Section 1. Section 381.0405, Florida Statutes, is amended
65 to read:
66 381.0405 Office of Rural Health.--
67 (1) ESTABLISHMENT.--The Department of Health shall
68 establish an Office of Rural Health, which shall assist rural
69 health care providers in improving the health status and health
70 care of rural residents of this state and assist rural health
71 care providers in integrating their efforts. The Office of Rural
72 Health shall coordinate its activities with rural health networks
73 established under s. 381.0406, local health councils established
74 under s. 408.033, the area health education center network
75 established under ~~pursuant to~~ s. 381.0402, and ~~with~~ any
76 appropriate research and policy development centers within
77 universities that have state-approved medical schools. The Office
78 of Rural Health may enter into a formal relationship with any
79 center that designates the office as an affiliate of the center.
80 (2) PURPOSE.--The Office of Rural Health shall actively
81 foster the provision of high-quality health care services in
82 rural areas and serve as a catalyst for improved health services
83 to residents ~~citizens~~ in rural areas of the state.
84 (3) GENERAL FUNCTIONS.--The office shall:
85 (a) Integrate policies related to physician workforce,
86 hospitals, public health, and state regulatory functions.
87 (b) Work with rural stakeholders in order to foster the

88 development of strategic planning that addresses ~~Propose~~
89 ~~solutions to~~ problems affecting health care delivery in rural
90 areas.
91 (c) Foster the expansion of rural health network service
92 areas to include rural counties that are not served by a rural
93 health network.
94 (d) ~~(c)~~ Seek grant funds from foundations and the Federal
95 Government.
96 (e) Administer state grant programs for rural health
97 networks.
98 (4) COORDINATION.--The office shall:
99 (a) Identify federal and state rural health programs and
100 provide information and technical assistance to rural providers
101 regarding participation in such programs.
102 (b) Act as a clearinghouse for collecting and disseminating
103 information on rural health care issues, research findings on
104 rural health care, and innovative approaches to the delivery of
105 health care in rural areas.
106 (c) Foster the creation of regional health care systems
107 that promote cooperation~~, rather than competition~~.
108 (d) Coordinate the department's rural health care
109 activities, programs, and policies.
110 (e) Design initiatives to improve access to primary, acute,
111 and emergency medical services and promote the coordination of
112 such services in rural areas.
113 (f) Assume responsibility for state coordination of ~~the~~
114 ~~Rural Hospital Transition Grant Program, the Essential Access~~
115 ~~Community Hospital Program, and other~~ federal rural health care
116 grant programs.

117 (5) TECHNICAL ASSISTANCE.--The office shall:
118 (a) Assist ~~Help~~ rural health care providers in recruiting
119 ~~obtain~~ health care practitioners by promoting the location and
120 relocation of health care practitioners in rural areas and
121 promoting policies that create incentives for practitioners to
122 serve in rural areas.
123 (b) Provide technical assistance to hospitals, community
124 and migrant health centers, and other health care providers that
125 serve residents in rural areas.
126 (c) Assist with the design of strategies to improve health
127 care workforce recruitment and placement programs.
128 (d) Provide technical assistance to rural health networks
129 in the formulation of their rural health infrastructure
130 development plans.
131 (e) Provide links to best practices and other technical
132 assistance resources on the office's Internet website.
133 (6) ADVISORY COUNCIL.--The Secretary of Health and the
134 Secretary of Health Care Administration shall each appoint no
135 more than five members with relevant health care operations
136 management, practice, and policy experience to an advisory
137 council to advise the office regarding its responsibilities under
138 this section and ss. 381.0406, 395.6061, and 395.6063. Members
139 must be appointed for 4-year staggered terms and may be
140 reappointed to a second term of office. Members shall serve
141 without compensation but are entitled to reimbursement for per
142 diem and travel expenses as provided in s. 112.061. The council
143 may appoint technical advisory teams as needed. The department
144 shall provide staff and other administrative assistance
145 reasonably necessary to assist the advisory council in carrying

146 out its duties.
147 (7) ~~(6)~~ RESEARCH PUBLICATIONS AND SPECIAL STUDIES.--The
148 office shall:
149 (a) Conduct policy and research studies.
150 (b) Conduct health status studies of rural residents.
151 (c) Collect relevant data on rural health care issues for
152 use in department policy development.
153 (8) ~~(7)~~ APPROPRIATION.--The Legislature shall appropriate
154 such sums as are necessary to support the Office of Rural Health.
155 Section 2. Section 381.0406, Florida Statutes, is amended
156 to read:
157 381.0406 Rural health networks.--
158 (1) LEGISLATIVE FINDINGS AND INTENT.--
159 (a) The Legislature finds that, in rural areas, access to
160 health care is limited and the quality of health care is
161 negatively affected by inadequate financing, difficulty in
162 recruiting and retaining skilled health professionals, and the
163 ~~because of a~~ migration of patients to urban areas for general
164 acute care and specialty services.
165 (b) The Legislature further finds that the efficient and
166 effective delivery of health care services in rural areas
167 requires:
168 1. The integration of public and private resources.
169 2. The adoption of quality improvement and cost-
170 effectiveness measures. ~~and~~
171 3. The coordination of health care providers.
172 (c) The Legislature further finds that the availability of
173 a continuum of quality health care services, including
174 preventive, primary, secondary, tertiary, and long-term care, is

175 essential to the economic and social vitality of rural
176 communities.
177 (d) The Legislature further finds that health care
178 providers in rural areas are not prepared for market changes such
179 as the introduction of managed care and capitation reimbursement
180 methodologies into health care services.
181 (e) ~~(d)~~ The Legislature further finds that the creation of
182 rural health networks can help to alleviate these problems. Rural
183 health networks shall act in the broad public interest and, to
184 the extent possible, seek to improve the accessibility, quality,
185 and cost-effectiveness of rural health care by planning and
186 coordinating ~~be structured to provide~~ a continuum of quality
187 health care services for rural residents through the cooperative
188 efforts of rural health network members and other health care
189 providers.
190 ~~(e) The Legislature further finds that rural health~~
191 ~~networks shall have the goal of increasing the utilization of~~
192 ~~statutory rural hospitals for appropriate health care services~~
193 ~~whenever feasible, which shall help to ensure their survival and~~
194 ~~thereby support the economy and protect the health and safety of~~
195 ~~rural residents.~~
196 (f) Finally, the Legislature finds that rural health
197 networks may serve as "laboratories" to determine the best way of
198 organizing rural health services, to move the state closer to
199 ensuring that everyone has access to health care, and to promote
200 cost containment efforts. The ultimate goal of rural health
201 networks shall be to ensure that quality health care is available
202 and efficiently delivered to all persons in rural areas.
203 (2) DEFINITIONS.--

204 (a) "Rural" means an area with a population density of
205 fewer ~~less~~ than 100 individuals per square mile or an area
206 defined by the most recent United States Census as rural.
207 (b) "Health care provider" means any individual, group, or
208 entity, public or private, that provides health care, including~~:~~
209 preventive health care, primary health care, secondary and
210 tertiary health care, in-hospital health care, public health
211 care, and health promotion and education.
212 (c) "Rural health network" or "network" means a nonprofit
213 legal entity whose principal place of business is in a rural
214 county, whose members consist ~~consisting~~ of rural and urban
215 health care providers and others, and that is established
216 ~~organized~~ to plan the delivery of ~~and deliver~~ health care
217 services on a cooperative basis in a rural area~~, except for some~~
218 ~~secondary and tertiary care services~~.
219 (3) NETWORK MEMBERSHIP.--
220 (a) Because each rural area is unique, with a different
221 health care provider mix, health care provider membership may
222 vary, but all networks shall include members that provide public
223 health care, comprehensive primary care, emergency medical care,
224 and acute inpatient care.
225 (b) Federally qualified health centers, emergency medical
226 services providers, and county health departments are expected to
227 participate in rural health networks in the areas in which their
228 patients reside or receive services.
229 ~~(4) Network membership shall be available to all health~~
230 ~~care providers, provided that they render care to all patients~~
231 ~~referred to them from other network members, comply with network~~
232 ~~quality assurance and risk management requirements, abide by the~~

233 ~~terms and conditions of network provider agreements in paragraph~~
234 ~~(11)(c), and provide services at a rate or price equal to the~~
235 ~~rate or price negotiated by the network.~~
236 (4) ~~(5)~~ NETWORK SERVICE AREAS.--Network service areas are ~~do~~
237 not required ~~need~~ to conform to local political boundaries or
238 state administrative district boundaries. The geographic area of
239 one rural health network, however, may not overlap the territory
240 of any other rural health network.
241 (5) ~~(6)~~ NETWORK FUNCTIONS.--Networks shall:
242 (a) Seek to develop linkages with ~~provisions for referral~~
243 ~~to~~ tertiary inpatient care, specialty physician care, and ~~to~~
244 other services that are not available in rural service areas.
245 (b) ~~(7)~~ Seek to ~~Networks shall~~ make ~~available~~ health
246 promotion, disease prevention, and primary care services
247 accessible to all residents in order to improve the health status
248 of rural residents and to contain health care costs.
249 ~~(8) Networks may have multiple points of entry, such as~~
250 ~~through private physicians, community health centers, county~~
251 ~~health departments, certified rural health clinics, hospitals, or~~
252 ~~other providers; or they may have a single point of entry.~~
253 (c) ~~(9)~~ Encourage members through training and educational
254 programs to adopt standards of care, promote the evidence-based
255 practice of medicine ~~Networks shall establish standard protocols,~~
256 ~~coordinate and share patient records~~, and develop patient
257 information exchange systems in order to improve the quality of
258 and access to services.
259 (d) Develop quality improvement programs and train network
260 members and other health care providers in the implementation of
261 such programs.

262 (e) Develop disease management systems and train network
263 members and other health care providers in the implementation of
264 such systems.
265 (f) Promote outreach to areas with a high need for
266 services.
267 (g) Seek to develop community care alternatives for elders
268 who would otherwise be placed in nursing homes.
269 (h) Emphasize community care alternatives for persons with
270 mental health and substance abuse disorders who are at risk of
271 being admitted to an institution.
272 (i) Develop a rural health infrastructure development plan
273 for an integrated system of care that is responsive to the unique
274 local health care needs and the area health care services market.
275 Each rural health infrastructure development plan must address
276 strategies to improve access to specialty care, train health care
277 providers to use standards of care for chronic illness, develop
278 disease management capacity, and link to state and national
279 quality improvement initiatives. The initial development plan
280 must be submitted to the Office of Rural Health for review and
281 comment no later than July 1, 2007; thereafter, the plan must be
282 updated and submitted to the Office of Rural Health every 3
283 years.
284 ~~(10) Networks shall develop risk management and quality~~
285 ~~assurance programs for network providers.~~
286 (6)~~(11)~~ NETWORK GOVERNANCE AND ORGANIZATION.--
287 (a) Networks shall be incorporated under the laws of the
288 state.
289 (b) Each network ~~Networks~~ shall have a board of directors
290 that derives membership from local government, health care

291 providers, businesses, consumers, and others.
292 ~~(c) Network boards of directors shall have the~~
293 ~~responsibility of determining the content of health care provider~~
294 ~~agreements that link network members. The agreements shall~~
295 ~~specify:~~
296 ~~1. Who provides what services.~~
297 ~~2. The extent to which the health care provider provides~~
298 ~~care to persons who lack health insurance or are otherwise unable~~
299 ~~to pay for care.~~
300 ~~3. The procedures for transfer of medical records.~~
301 ~~4. The method used for the transportation of patients~~
302 ~~between providers.~~
303 ~~5. Referral and patient flow including appointments and~~
304 ~~scheduling.~~
305 ~~6. Payment arrangements for the transfer or referral of~~
306 ~~patients.~~
307 (c) ~~(d)~~ There shall be no liability on the part of, and no
308 cause of action of any nature shall arise against, any member of
309 a network board of directors, or its employees or agents, for any
310 lawful action taken by them in the performance of their
311 administrative powers and duties under this subsection.
312 (7) ~~(12)~~ NETWORK PROVIDER MEMBER SERVICES.--
313 (a) Networks, to the extent feasible, shall seek to develop
314 services that provide for a continuum of care for all residents
315 ~~patients~~ served by the network. Each network shall recruit
316 members that can provide ~~include the following core services:~~
317 ~~disease prevention, health promotion,~~ comprehensive primary care,
318 emergency medical care, and acute inpatient care. Each network
319 shall seek to ensure the availability of comprehensive maternity

320 care, including prenatal, delivery, and postpartum care for
321 uncomplicated pregnancies~~, either directly, by contract, or~~
322 ~~through referral agreements~~. Networks shall, to the extent
323 feasible, develop local services and linkages among health care
324 providers to ~~also~~ ensure the availability of the following
325 services ~~within the specified timeframes, either directly, by~~
326 ~~contract, or through referral agreements~~:
327 ~~1. Services available in the home.~~
328 1.~~a.~~ Home health care.
329 2.~~b.~~ Hospice care.
330 ~~2. Services accessible within 30 minutes travel time or~~
331 ~~less.~~
332 3.~~a.~~ Emergency medical services, including advanced life
333 support, ambulance, and basic emergency room services.
334 4.~~b.~~ Primary care, including~~.~~
335 ~~c.~~ prenatal and postpartum care for uncomplicated
336 pregnancies.
337 5.~~d.~~ Community-based services for elders, such as adult day
338 care and assistance with activities of daily living.
339 6.~~e.~~ Public health services, including communicable disease
340 control, disease prevention, health education, and health
341 promotion.
342 7.~~f.~~ Outpatient mental health ~~psychiatric~~ and substance
343 abuse services.
344 ~~3. Services accessible within 45 minutes travel time or~~
345 ~~less.~~
346 8.~~a.~~ Hospital acute inpatient care for persons whose
347 illnesses or medical problems are not severe.
348 9.~~b. Level I obstetrical care, which is~~ Labor and delivery

349 care for low-risk patients.
350 10.~~c.~~ Skilled nursing services and~~,~~ long-term care,
351 including nursing home care.
352 (b) Networks shall seek to foster linkages with out-of-area
353 services to the extent feasible to ensure the availability of:
354 ~~d. Dialysis.~~
355 ~~e. Osteopathic and chiropractic manipulative therapy.~~
356 ~~4. Services accessible within 2 hours travel time or less.~~
357 1.~~a.~~ Specialist physician care.
358 2.~~b.~~ Hospital acute inpatient care for severe illnesses and
359 medical problems.
360 3.~~c. Level II and III obstetrical care, which is~~ Labor and
361 delivery care for high-risk patients and neonatal intensive care.
362 4.~~d.~~ Comprehensive medical rehabilitation.
363 5.~~e.~~ Inpatient mental health ~~psychiatric~~ and substance
364 abuse services.
365 6.~~f.~~ Magnetic resonance imaging, lithotripter treatment,
366 oncology, advanced radiology, and other technologically advanced
367 services.
368 ~~g. Subacute care.~~
369 (8) COORDINATION WITH OTHER ENTITIES.--
370 (a) Area health education centers, health planning
371 councils, and regional education consortia are expected to
372 participate in the rural health networks' preparation of rural
373 health infrastructure development plans. The Department of Health
374 may require a written memorandum of agreement between a network
375 and an area health education center or health planning council.
376 (b) Rural health networks shall initiate activities, in
377 coordination with area health education centers, to carry out the

378 objectives of the adopted development plan, including continuing
379 education for health care practitioners performing functions such
380 as disease management, continuous quality improvement,
381 telemedicine, distance learning, and the treatment of chronic
382 illness using standards of care. For the purposes of this
383 section, the term "telemedicine" means the use of
384 telecommunications to deliver or expedite the delivery of health
385 care services.
386 (c) Health planning councils shall support the preparation
387 of rural health infrastructure development plans through data
388 collection and analysis in order to assess the health status of
389 area residents and the capacity of local health services.
390 (d) Regional education consortia that have the technology
391 available to assist rural health networks in establishing systems
392 for exchange of patient information and distance learning shall
393 provide technical assistance upon the request of a rural health
394 network.
395 ~~(b) Networks shall actively participate with area health~~
396 ~~education center programs, whenever feasible, in developing and~~
397 ~~implementing recruitment, training, and retention programs~~
398 ~~directed at positively influencing the supply and distribution of~~
399 ~~health care professionals serving in, or receiving training in,~~
400 ~~network areas.~~
401 ~~(c) As funds become available, networks shall emphasize~~
402 ~~community care alternatives for elders who would otherwise be~~
403 ~~placed in nursing homes.~~
404 ~~(d) To promote the most efficient use of resources,~~
405 ~~networks shall emphasize disease prevention, early diagnosis and~~
406 ~~treatment of medical problems, and community care alternatives~~

407 ~~for persons with mental health and substance abuse disorders who~~
408 ~~are at risk to be institutionalized.~~
409 (e) ~~(13) TRAUMA SERVICES.--~~In those network areas that ~~which~~
410 have an established trauma agency approved by the Department of
411 Health, the network shall seek the participation of that trauma
412 agency ~~must be a participant in the network~~. Trauma services
413 provided within the network area must comply with s. 395.405.
414 (9) ~~(14)~~ NETWORK FINANCING.--
415 (a) Networks may use all sources of public and private
416 funds to support network activities. ~~Nothing in this section~~
417 ~~prohibits networks from becoming managed care providers.~~
418 (b) The Department of Health shall establish a grant
419 program to provide funding to support the administrative cost of
420 operating and developing rural health networks. Rural health
421 networks may qualify for funding provided through:
422 1. Network operations grants to support development of a
423 rural health infrastructure development plan in a network service
424 area and to support network functions identified in subsection
425 (5).
426 2. Rural health infrastructure development grants to
427 support the development of clinical and administrative
428 infrastructure in the following priority areas:
429 a. Formation of joint contracting entities composed of
430 rural physicians, rural hospitals, and other rural providers.
431 b. Establishing disease management programs that meet
432 Medicaid requirements.
433 c. Establishing regional quality improvement programs
434 involving physicians and hospitals consistent with state and
435 national initiatives.

436 d. Establishing specialty networks connecting rural primary
437 care physicians and urban specialists.
438 e. Developing regional broadband telecommunications systems
439 with the capacity to share patient information in a secure
440 network.
441 f. Telemedicine and distance learning capacity.
442 ~~(15) NETWORK IMPLEMENTATION.--As funds become available,~~
443 ~~networks shall be developed and implemented in two phases.~~
444 ~~(a) Phase I shall consist of a network planning and~~
445 ~~development grant program. Planning grants shall be used to~~
446 ~~organize networks, incorporate network boards, and develop formal~~
447 ~~provider agreements as provided for in this section. The~~
448 ~~Department of Health shall develop a request-for-proposal process~~
449 ~~to solicit grant applications.~~
450 ~~(b) Phase II shall consist of network operations. As funds~~
451 ~~become available, certified networks shall be eligible to receive~~
452 ~~grant funds to be used to help defray the costs of network~~
453 ~~infrastructure development, patient care, and network~~
454 ~~administration. Infrastructure development includes, but is not~~
455 ~~limited to: recruitment and retention of primary care~~
456 ~~practitioners; development of preventive health care programs;~~
457 ~~linkage of urban and rural health care systems; design and~~
458 ~~implementation of automated patient records, outcome measurement,~~
459 ~~quality assurance, and risk management systems; establishment of~~
460 ~~one-stop service delivery sites; upgrading of medical technology~~
461 ~~available to network providers; enhancement of emergency medical~~
462 ~~systems; enhancement of medical transportation; and development~~
463 ~~of telecommunication capabilities. A Phase II award may occur in~~
464 ~~the same fiscal year as a Phase I award.~~

465 ~~(16) CERTIFICATION.--For the purpose of certifying networks~~
466 ~~that are eligible for Phase II funding, the Department of Health~~
467 ~~shall certify networks that meet the criteria delineated in this~~
468 ~~section and the rules governing rural health networks.~~
469 (10) ~~(17)~~ RULES.--The Department of Health shall establish
470 rules that govern the creation ~~and certification~~ of networks, the
471 provision of grant funds, and the establishment of performance
472 standards ~~including establishing outcome measures~~ for networks.
473 Section 3. Subsection (2) of section 395.602, Florida
474 Statutes, is amended to read:
475 395.602 Rural hospitals.--
476 (2) DEFINITIONS.--As used in this part:
477 (a) "Critical access hospital" means a hospital that meets
478 the definition of rural hospital in paragraph (d) and meets the
479 requirements for reimbursement by Medicare and Medicaid under 42
480 C.F.R. ss. 485.601-485.647. ~~"Emergency care hospital" means a~~
481 ~~medical facility which provides:~~
482 ~~1. Emergency medical treatment; and~~
483 ~~2. Inpatient care to ill or injured persons prior to their~~
484 ~~transportation to another hospital or provides inpatient medical~~
485 ~~care to persons needing care for a period of up to 96 hours. The~~
486 ~~96-hour limitation on inpatient care does not apply to respite,~~
487 ~~skilled nursing, hospice, or other nonacute care patients.~~
488 ~~(b) "Essential access community hospital" means any~~
489 ~~facility which:~~
490 ~~1. Has at least 100 beds;~~
491 ~~2. Is located more than 35 miles from any other essential~~
492 ~~access community hospital, rural referral center, or urban~~
493 ~~hospital meeting criteria for classification as a regional~~

494 ~~referral center;~~
495 ~~3. Is part of a network that includes rural primary care~~
496 ~~hospitals;~~
497 ~~4. Provides emergency and medical backup services to rural~~
498 ~~primary care hospitals in its rural health network;~~
499 ~~5. Extends staff privileges to rural primary care hospital~~
500 ~~physicians in its network; and~~
501 ~~6. Accepts patients transferred from rural primary care~~
502 ~~hospitals in its network.~~
503 (b) ~~(c)~~ "Inactive rural hospital bed" means a licensed acute
504 care hospital bed, as defined in s. 395.002(14), that is inactive
505 in that it cannot be occupied by acute care inpatients.
506 (c) ~~(d)~~ "Rural area health education center" means an area
507 health education center (AHEC), as authorized by Pub. L. No. 94-
508 484, that ~~which~~ provides services in a county with a population
509 density of no greater than 100 persons per square mile.
510 (d) ~~(e)~~ "Rural hospital" means an acute care hospital
511 licensed under this chapter, having 100 or fewer licensed beds
512 and an emergency room, that ~~which~~ is:
513 1. The sole provider within a county with a population
514 density of no greater than 100 persons per square mile;
515 2. An acute care hospital, in a county with a population
516 density of no greater than 100 persons per square mile, that
517 ~~which~~ is at least 30 minutes of travel time, on normally traveled
518 roads under normal traffic conditions, from any other acute care
519 hospital within the same county;
520 3. A hospital supported by a tax district or subdistrict
521 whose boundaries encompass a population of 100 persons or fewer
522 per square mile;

523 4. A hospital in a constitutional charter county with a
524 population of over 1 million persons that has imposed a local
525 option health service tax pursuant to law and in an area that was
526 directly impacted by a catastrophic event on August 24, 1992, for
527 which the Governor of Florida declared a state of emergency
528 pursuant to chapter 125, and has 120 beds or fewer ~~less~~ that
529 serves an agricultural community with an emergency room
530 utilization of no less than 20,000 visits and a Medicaid
531 inpatient utilization rate greater than 15 percent;
532 5. A hospital with a service area that has a population of
533 100 persons or fewer per square mile. As used in this
534 subparagraph, the term "service area" means the fewest number of
535 zip codes that account for 75 percent of the hospital's
536 discharges for the most recent 5-year period, based on
537 information available from the hospital inpatient discharge
538 database in the State Center for Health Statistics at the Agency
539 for Health Care Administration; or
540 6. A hospital designated as a critical access hospital, as
541 defined in s. 408.07(15).
542
543 Population densities used in this paragraph must be based upon
544 the most recently completed United States census. A hospital that
545 received funds under s. 409.9116 for a quarter beginning no later
546 than July 1, 2002, is deemed to have been and shall continue to
547 be a rural hospital from that date through June 30, 2012, if the
548 hospital continues to have 100 or fewer licensed beds and an
549 emergency room, or meets the criteria of subparagraph 4. An acute
550 care hospital that has not previously been designated as a rural
551 hospital and that meets the criteria of this paragraph shall be

552 granted such designation upon application, including supporting
553 documentation to the Agency for Health Care Administration.
554 (e) ~~(f)~~ "Rural primary care hospital" means any facility
555 that ~~meeting the criteria in paragraph (c) or s. 395.605 which~~
556 provides:
557 1. Twenty-four-hour emergency medical care;
558 2. Temporary inpatient care for periods of 96 ~~72~~ hours or
559 less to patients requiring stabilization before discharge or
560 transfer to another hospital. The 96-hour ~~72-hour~~ limitation does
561 not apply to respite, skilled nursing, hospice, or other nonacute
562 care patients; and
563 3. Has at least ~~no more than~~ six licensed acute care
564 inpatient beds.
565 (f) ~~(g)~~ "Swing-bed" means a bed that ~~which~~ can be used
566 interchangeably as either a hospital, skilled nursing facility
567 (SNF), or intermediate care facility (ICF) bed pursuant to 42
568 C.F.R. parts 405, 435, 440, 442, and 447.
569 Section 4. Subsection (1) of section 395.603, Florida
570 Statutes, is amended to read:
571 395.603 Deactivation of general hospital beds; rural
572 hospital impact statement.--
573 (1) ~~The agency shall establish, by rule, a process by which~~
574 A rural hospital, as defined in s. 395.602, that ~~seeks licensure~~
575 ~~as a rural primary care hospital or as an emergency care~~
576 ~~hospital, or~~ becomes a certified rural health clinic as defined
577 in Pub. L. No. 95-210~~,~~ or becomes a primary care program such as
578 a county health department, community health center, or other
579 similar outpatient program that provides preventive and curative
580 services~~,~~ may deactivate general hospital beds. A rural critical

581 access hospital ~~Rural primary care hospitals and emergency care~~
582 ~~hospitals~~ shall maintain the number of actively licensed general
583 hospital beds necessary for the facility to be certified for
584 Medicare reimbursement. Hospitals that discontinue inpatient care
585 to become rural health care clinics or primary care programs
586 shall deactivate all licensed general hospital beds. All
587 hospitals, clinics, and programs with inactive beds shall provide
588 24-hour emergency medical care by staffing an emergency room.
589 Providers with inactive beds shall be subject to the criteria in
590 s. 395.1041. The agency shall specify in rule requirements for
591 making 24-hour emergency care available. Inactive general
592 hospital beds shall be included in the acute care bed inventory,
593 maintained by the agency for certificate-of-need purposes, for 10
594 years from the date of deactivation of the beds. After 10 years
595 have elapsed, inactive beds shall be excluded from the inventory.
596 The agency shall, at the request of the licensee, reactivate the
597 inactive general beds upon a showing by the licensee that
598 licensure requirements for the inactive general beds are met.
599 Section 5. Section 395.604, Florida Statutes, is amended to
600 read:
601 395.604 ~~Other~~ Rural primary care hospitals ~~hospital~~
602 ~~programs~~.--
603 (1) The agency may license rural primary care hospitals
604 subject to federal approval for participation in the Medicare and
605 Medicaid programs. Rural primary care hospitals shall be treated
606 in the same manner as ~~emergency care hospitals and~~ rural
607 hospitals with respect to ss. ~~395.605(2)-(8)(a),~~ 408.033(2)(b)3.~~,~~
608 and 408.038.
609 ~~(2) The agency may designate essential access community~~

610 ~~hospitals.~~
611 (2)~~(3)~~ The agency may adopt licensure rules for rural
612 primary care hospitals ~~and essential access community hospitals~~.
613 Such rules must conform to s. 395.1055.
614 (3) For the purpose of Medicaid swing-bed reimbursement
615 pursuant to the Medicaid program, the agency shall treat rural
616 primary care hospitals in the same manner as rural hospitals.
617 (4) For the purpose of participation in the Medical
618 Education Reimbursement and Loan Repayment Program as defined in
619 s. 1009.65 or other loan repayment or incentive programs designed
620 to relieve medical workforce shortages, the department shall
621 treat rural primary care hospitals in the same manner as rural
622 hospitals.
623 (5) For the purpose of coordinating primary care services
624 described in s. 154.011(1)(c)10., the department shall treat
625 rural primary care hospitals in the same manner as rural
626 hospitals.
627 (6) Rural hospitals that make application under the
628 certificate-of-need program to be licensed as rural primary care
629 hospitals shall receive expedited review as defined in s.
630 408.032. Rural primary care hospitals seeking relicensure as
631 acute care general hospitals shall also receive expedited review.
632 (7) Rural primary care hospitals are exempt from
633 certificate-of-need requirements for home health and hospice
634 services and for swing beds in a number that does not exceed one-
635 half of the facility's licensed beds.
636 (8) Rural primary care hospitals shall have agreements with
637 other hospitals, skilled nursing facilities, home health
638 agencies, and providers of diagnostic-imaging and laboratory

639 services that are not provided on site but are needed by
640 patients.
641 ~~(4) The department may seek federal recognition of~~
642 ~~emergency care hospitals authorized by s. 395.605 under the~~
643 ~~essential access community hospital program authorized by the~~
644 ~~Omnibus Budget Reconciliation Act of 1989.~~
645 Section 6. Section 395.6061, Florida Statutes, is amended
646 to read:
647 395.6061 Rural hospital capital improvement.--There is
648 established a rural hospital capital improvement grant program.
649 (1)(a) The purpose of the rural hospital capital
650 improvement grant program is to support management improvement
651 and capitalization to:
652 1. Develop needed infrastructure to ensure continued access
653 to health care in rural areas.
654 2. Require professional standards in the operation and
655 management of rural hospitals.
656 (b) The rural hospital capital improvement grant program
657 includes technical assistance and grants managed by the agency.
658 (2)~~(1)~~ A rural hospital as defined in s. 395.602 may apply
659 to the agency ~~department~~ for a capital improvement grant to
660 acquire, repair, improve, or upgrade systems, facilities, or
661 equipment. The grant application must provide information that
662 includes:
663 (a) A statement indicating the problem the rural hospital
664 proposes to solve with the grant funds.~~;~~
665 (b) The strategy proposed to resolve the problem.~~;~~
666 (c) The organizational structure, financial system, and
667 facilities that are essential to the proposed solution.~~;~~

668 (d) The projected longevity of the proposed solution after
669 the grant funds are expended.~~;~~
670 ~~(e) Evidence of participation in a rural health network as~~
671 ~~defined in s. 381.0406;~~
672 (e)~~(f)~~ Evidence that the rural hospital has difficulty in
673 obtaining funding or that funds available for the proposed
674 solution are inadequate.~~;~~
675 (f)~~(g)~~ Evidence that the grant funds will assist in
676 maintaining or returning the hospital to an economically stable
677 condition or enable the transition to the status of rural primary
678 care hospital or that any plan for closure of the hospital or
679 realignment of services will involve development of innovative
680 alternatives for the provision of needed ~~discontinued~~ services.~~;~~
681 (g)~~(h)~~ Evidence of a satisfactory record-keeping system to
682 account for grant fund expenditures within the rural county.~~;~~
683 (h)~~(i)~~ ~~A rural health network plan that includes a~~
684 ~~description of how the plan was developed, the goals of the plan,~~
685 ~~the links with existing health care providers under the plan,~~
686 Indicators quantifying the ~~hospital's~~ financial status ~~well-~~
687 ~~being~~, measurable outcome targets, and ~~the~~ current physical and
688 operational condition of the hospital.
689 ~~(2) Each rural hospital as defined in s. 395.602 shall~~
690 ~~receive a minimum of $100,000 annually, subject to legislative~~
691 ~~appropriation, upon application to the Department of Health, for~~
692 ~~projects to acquire, repair, improve, or upgrade systems,~~
693 ~~facilities, or equipment.~~
694 (3) ~~Any remaining funds shall annually be disbursed to~~
695 ~~rural hospitals in accordance with this section.~~ The agency
696 ~~Department of Health~~ shall establish, by rule, criteria for

697 awarding grants ~~for any remaining funds~~, which must be used
698 exclusively for the support and assistance of rural hospitals as
699 defined in s. 395.602, including criteria relating to the level
700 of charity ~~uncompensated~~ care rendered by the hospital, the
701 financial status of the hospital, the performance standards of
702 the hospital ~~the participation in a rural health network as~~
703 ~~defined in s. 381.0406~~, and the proposed use of the grant by the
704 rural hospital to resolve a specific problem. The agency
705 ~~department~~ must consider any information submitted in an
706 application for the grants in accordance with subsection (2) ~~(1)~~
707 in determining eligibility for and the amount of the grant~~, and~~
708 ~~none of the individual items of information by itself may be used~~
709 ~~to deny grant eligibility~~.
710 (4) The agency ~~department~~ shall ensure that the funds are
711 used solely for the purposes specified in this section. The total
712 grants awarded pursuant to this section shall not exceed the
713 amount appropriated for this program.
714 Section 7. Section 395.6063, Florida Statutes, is created
715 to read:
716 395.6063 Assistance program for financially distressed
717 rural and critical access hospitals.--There is established within
718 the Agency for Health Care Administration an assistance program
719 for financially distressed rural and critical access hospitals.
720 The purpose of the assistance program is to provide planning,
721 management, and limited financial support to financially
722 distressed rural hospitals as defined in s. 395.602 and critical
723 access hospitals as defined in s. 408.07(15) that have an annual
724 occupancy rate of less than 30 percent.

725 (1) To receive assistance under this section, a financially
726 distressed hospital must participate in a rural health network.
727 The request for assistance must provide information that
728 includes:
729 (a) A statement indicating the problem the hospital is
730 proposing to resolve with the grant funds.
731 (b) A statement of support from the board of directors of
732 the hospital, the county commission, and the city commission.
733 (c) Evidence that the rural hospital and the community have
734 difficulty obtaining funding or that funds available for the
735 proposed solution are inadequate.
736 (2) The agency shall establish by rule pursuant to ss.
737 120.536(1) and 120.54 criteria for awarding assistance which must
738 be used exclusively for the support and assistance of a
739 financially distressed hospital.
740 (3) The financially distressed hospital receiving
741 assistance shall agree to be bound by the terms of a
742 participation agreement, which may include:
743 (a) The appointment of a health care expert under contract
744 with the agency to analyze and monitor the hospital operations
745 during the period of distress.
746 (b) The establishment of minimum standards for the
747 education and experience of the managers and administrators of
748 the hospital.
749 (c) The oversight and monitoring of a strategic plan to
750 restore the hospital to an economically stable condition or
751 transition to an alternative means to provide services.
752 (d) The establishment of a board orientation and
753 development program.

754 (e) The approval of any facility relocation plans.
755 (4) The agency shall ensure that the funds are used solely
756 for the purposes specified in this section. The total grants
757 awarded pursuant to this section shall not exceed the amount
758 appropriated for this program.
759 Section 8. Subsection (9) of section 408.05, Florida
760 Statutes, is renumbered as subsection (10) and amended, and a new
761 subsection (9) is added to that section, to read:
762 408.05 State Center for Health Statistics.--
763 (9) RURAL PROVIDER SERVICE NETWORK DEVELOPMENT PROGRAM.--
764 (a) There is established within the State Center for Health
765 Statistics the Rural Provider Service Network Development Program
766 to support the implementation of provider service networks in
767 rural counties of the state. The purpose of the program is to
768 assist in the establishment of the infrastructure needed for
769 Medicaid reform relating to prepaid and at-risk reimbursement
770 plans to improve access to quality health care in rural areas.
771 (b) The responsibilities of the program are to:
772 1. Administer the rural hospital capital improvement grant
773 program established under s. 395.6061.
774 2. Administer the assistance program for financially
775 distressed rural and critical access hospitals established under
776 s. 395.6063.
777 3. Administer the rural provider service network
778 development grant program established in paragraph (c).
779 4. Carry out a study to identify barriers and options for
780 developing provider service networks in rural counties of the
781 state and make recommendations to the Legislature by February 1,
782 2007. The study shall include issues related to capitation rates,

783 financing of provider service networks, contracting with
784 administrative service organizations, and support for and
785 alternatives to rural hospitals.
786 (c) There is established a rural provider service network
787 development grant program. The agency is authorized to provide
788 funding through a grant program to entities seeking to establish
789 rural provider service networks that have demonstrated interest
790 and experience organizing rural health care providers for this
791 purpose.
792 (d) Entities eligible for rural provider service network
793 development grants must meet the following criteria:
794 1. Have a written agreement signed by prospective members,
795 45 percent of whom must be providers in the targeted service
796 area.
797 2. Include all rural hospitals, at least one federally
798 qualified health center, and one county health department located
799 in the service area.
800 3. Have a defined service area, 80 percent of which
801 consists of rural counties.
802 (e) Each applicant for this funding shall provide the
803 agency with a detailed written proposal that includes, at a
804 minimum, a statement of need; a defined purpose; identification
805 and explanation of the role of prospective partners; a signed
806 memorandum of agreement or similar document attesting to the role
807 of prospective partners; documented actions related to provider
808 service network development; measurable objectives for the
809 development of clinical and administrative infrastructure; a
810 process of evaluation; and a process for developing a business
811 plan and securing additional funding.

812 (f) The agency is authorized to grant preferential funding
813 to a rural provider service network based on the number of rural
814 counties within the network's proposed service area that are
815 Medically Underserved Areas or Health Professional Shortage Areas
816 as defined by the Health Resources Services Administration,
817 Office of Rural Health Policy, and based on whether the provider
818 service network has a principal place of business located in a
819 rural county in the state.
820 (g) The agency shall establish by rule pursuant to ss.
821 120.536(1) and 120.54 criteria for awarding assistance for the
822 development of rural provider service networks and for other
823 responsibilities provided in this subsection.
824 (10) ~~(9)~~ APPLICABILITY.--Nothing in this section shall
825 limit, restrict, affect, or control the collection, analysis,
826 release, or publication of data by any state agency pursuant to
827 its statutory authority, duties, or responsibilities.
828 Section 9. Subsection (43) of section 408.07, Florida
829 Statutes, is amended to read:
830 408.07 Definitions.--As used in this chapter, with the
831 exception of ss. 408.031-408.045, the term:
832 (43) "Rural hospital" means an acute care hospital licensed
833 under chapter 395, having 100 or fewer licensed beds and an
834 emergency room, and which is:
835 (a) The sole provider within a county with a population
836 density of no greater than 100 persons per square mile;
837 (b) An acute care hospital, in a county with a population
838 density of no greater than 100 persons per square mile, which is
839 at least 30 minutes of travel time, on normally traveled roads

840 under normal traffic conditions, from another acute care hospital
841 within the same county;
842 (c) A hospital supported by a tax district or subdistrict
843 whose boundaries encompass a population of 100 persons or fewer
844 per square mile;
845 (d) A hospital with a service area that has a population of
846 100 persons or fewer per square mile. As used in this paragraph,
847 the term "service area" means the fewest number of zip codes that
848 account for 75 percent of the hospital's discharges for the most
849 recent 5-year period, based on information available from the
850 hospital inpatient discharge database in the State Center for
851 Health Statistics at the Agency for Health Care Administration;
852 or
853 (e) A critical access hospital.
854
855 Population densities used in this subsection must be based upon
856 the most recently completed United States census. A hospital that
857 received funds under s. 409.9116 for a quarter beginning no later
858 than July 1, 2002, is deemed to have been and shall continue to
859 be a rural hospital from that date through June 30, 2012, if the
860 hospital continues to have 100 or fewer licensed beds and an
861 emergency room, or meets the criteria of s. 395.602(2)(d) ~~(e)~~4. An
862 acute care hospital that has not previously been designated as a
863 rural hospital and that meets the criteria of this subsection
864 shall be granted such designation upon application, including
865 supporting documentation, to the Agency for Health Care
866 Administration.
867 Section 10. Subsection (12) of section 409.908, Florida
868 Statutes, is amended to read:

869 409.908 Reimbursement of Medicaid providers.--Subject to
870 specific appropriations, the agency shall reimburse Medicaid
871 providers, in accordance with state and federal law, according to
872 methodologies set forth in the rules of the agency and in policy
873 manuals and handbooks incorporated by reference therein. These
874 methodologies may include fee schedules, reimbursement methods
875 based on cost reporting, negotiated fees, competitive bidding
876 pursuant to s. 287.057, and other mechanisms the agency considers
877 efficient and effective for purchasing services or goods on
878 behalf of recipients. If a provider is reimbursed based on cost
879 reporting and submits a cost report late and that cost report
880 would have been used to set a lower reimbursement rate for a rate
881 semester, then the provider's rate for that semester shall be
882 retroactively calculated using the new cost report, and full
883 payment at the recalculated rate shall be effected retroactively.
884 Medicare-granted extensions for filing cost reports, if
885 applicable, shall also apply to Medicaid cost reports. Payment
886 for Medicaid compensable services made on behalf of Medicaid
887 eligible persons is subject to the availability of moneys and any
888 limitations or directions provided for in the General
889 Appropriations Act or chapter 216. Further, nothing in this
890 section shall be construed to prevent or limit the agency from
891 adjusting fees, reimbursement rates, lengths of stay, number of
892 visits, or number of services, or making any other adjustments
893 necessary to comply with the availability of moneys and any
894 limitations or directions provided for in the General
895 Appropriations Act, provided the adjustment is consistent with
896 legislative intent.

897 (12)(a) A physician shall be reimbursed the lesser of the
898 amount billed by the provider or the Medicaid maximum allowable
899 fee established by the agency.
900 (b) The agency shall adopt a fee schedule, subject to any
901 limitations or directions provided for in the General
902 Appropriations Act, based on a resource-based relative value
903 scale for pricing Medicaid physician services. Under this fee
904 schedule, physicians shall be paid a dollar amount for each
905 service based on the average resources required to provide the
906 service, including, but not limited to, estimates of average
907 physician time and effort, practice expense, and the costs of
908 professional liability insurance. The fee schedule shall provide
909 increased reimbursement for preventive and primary care services
910 and lowered reimbursement for specialty services by using at
911 least two conversion factors, one for cognitive services and
912 another for procedural services. The fee schedule shall not
913 increase total Medicaid physician expenditures unless moneys are
914 available~~, and shall be phased in over a 2-year period beginning~~
915 ~~on July 1, 1994~~. The Agency for Health Care Administration shall
916 seek the advice of a 16-member advisory panel in formulating and
917 adopting the fee schedule. The panel shall consist of Medicaid
918 physicians licensed under chapters 458 and 459 and shall be
919 composed of 50 percent primary care physicians and 50 percent
920 specialty care physicians.
921 (c) Notwithstanding paragraph (b), reimbursement fees to
922 physicians for providing total obstetrical services to Medicaid
923 recipients, which include prenatal, delivery, and postpartum
924 care, shall be at least $1,500 per delivery for a pregnant woman
925 with low medical risk and at least $2,000 per delivery for a

926 pregnant woman with high medical risk. However, reimbursement to
927 physicians working in Regional Perinatal Intensive Care Centers
928 designated pursuant to chapter 383, for services to certain
929 pregnant Medicaid recipients with a high medical risk, may be
930 made according to obstetrical care and neonatal care groupings
931 and rates established by the agency. Nurse midwives licensed
932 under part I of chapter 464 or midwives licensed under chapter
933 467 shall be reimbursed at no less than 80 percent of the low
934 medical risk fee. The agency shall by rule determine, for the
935 purpose of this paragraph, what constitutes a high or low medical
936 risk pregnant woman and shall not pay more based solely on the
937 fact that a caesarean section was performed, rather than a
938 vaginal delivery. The agency shall by rule determine a prorated
939 payment for obstetrical services in cases where only part of the
940 total prenatal, delivery, or postpartum care was performed. The
941 Department of Health shall adopt rules for appropriate insurance
942 coverage for midwives licensed under chapter 467. Prior to the
943 issuance and renewal of an active license, or reactivation of an
944 inactive license for midwives licensed under chapter 467, such
945 licensees shall submit proof of coverage with each application.
946 (d) Notwithstanding other provisions of this subsection,
947 the agency shall pay physicians licensed under chapter 458 or
948 chapter 459 who have a provider agreement with a rural health
949 network as established in s. 381.0406 a 10-percent bonus over the
950 Medicaid physician fee schedule for any physician service
951 provided within the geographic boundary of a county defined as a
952 rural county by the most recent United States Census.
953 Section 11. Subsection (6) of section 409.9116, Florida
954 Statutes, is amended to read:

955 409.9116 Disproportionate share/financial assistance
956 program for rural hospitals.--In addition to the payments made
957 under s. 409.911, the Agency for Health Care Administration shall
958 administer a federally matched disproportionate share program and
959 a state-funded financial assistance program for statutory rural
960 hospitals. The agency shall make disproportionate share payments
961 to statutory rural hospitals that qualify for such payments and
962 financial assistance payments to statutory rural hospitals that
963 do not qualify for disproportionate share payments. The
964 disproportionate share program payments shall be limited by and
965 conform with federal requirements. Funds shall be distributed
966 quarterly in each fiscal year for which an appropriation is made.
967 Notwithstanding the provisions of s. 409.915, counties are exempt
968 from contributing toward the cost of this special reimbursement
969 for hospitals serving a disproportionate share of low-income
970 patients.
971 (6) This section applies only to hospitals that were
972 defined as statutory rural hospitals, or their successor-in-
973 interest hospital, prior to January 1, 2001. Any additional
974 hospital that is defined as a statutory rural hospital, or its
975 successor-in-interest hospital, on or after January 1, 2001, is
976 not eligible for programs under this section unless additional
977 funds are appropriated each fiscal year specifically to the rural
978 hospital disproportionate share and financial assistance programs
979 in an amount necessary to prevent any hospital, or its successor-
980 in-interest hospital, eligible for the programs prior to January
981 1, 2001, from incurring a reduction in payments because of the
982 eligibility of an additional hospital to participate in the
983 programs. A hospital, or its successor-in-interest hospital,

984 which received funds pursuant to this section before January 1,
985 2001, and which qualifies under s. 395.602(2)(d) ~~(e)~~, shall be
986 included in the programs under this section and is not required
987 to seek additional appropriations under this subsection.
988 Section 12. Paragraph (b) of subsection (2) of section
989 1009.65, Florida Statutes, is amended to read:
990 1009.65 Medical Education Reimbursement and Loan Repayment
991 Program.--
992 (2) From the funds available, the Department of Health
993 shall make payments to selected medical professionals as follows:
994 (b) All payments shall be contingent on continued proof of
995 primary care practice in an area defined in s. 395.602(2)(d) ~~(e)~~,
996 or an underserved area designated by the Department of Health,
997 provided the practitioner accepts Medicaid reimbursement if
998 eligible for such reimbursement. Correctional facilities, state
999 hospitals, and other state institutions that employ medical
1000 personnel shall be designated by the Department of Health as
1001 underserved locations. Locations with high incidences of infant
1002 mortality, high morbidity, or low Medicaid participation by
1003 health care professionals may be designated as underserved.
1004 Section 13. Section 395.605, Florida Statutes, is repealed.
1005 Section 14. This act shall take effect July 1, 2006.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 1 (for drafter's use only)

Bill No. **PCB HCR 06-06**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 133-146 and insert:
6
7 (6) ADVISORY COUNCIL.--
8 (a) The Secretary of Health and the Secretary of Health
9 Care Administration shall each appoint no more than five members
10 with relevant health care operations management, practice, and
11 policy experience to an advisory council to advise the office
12 regarding its responsibilities under this section and ss.
13 381.0406, 395.6061, and 395.6063. Members must be appointed for
14 4-year staggered terms and may be reappointed to a second term
15 of office. Members shall serve without compensation but are
16 entitled to reimbursement for per diem and travel expenses as
17 provided in s. 112.061. The council may appoint technical
18 advisory teams as needed. The department shall provide staff and
19 other administrative assistance reasonably necessary to assist
20 the advisory council in carrying out its duties.

21 (b) The advisory council shall work with stakeholders to
22 develop recommendations that address barriers and identify
23 options for establishing provider networks in rural counties and
24 report to the Speaker of the House, the President of the Senate
25 and the Governor by February 1, 2007.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 2 (for drafter's use only)

Bill No. **PCB HCR 06-06**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 649-827 and insert:
6
7 (1)(a) The purpose of the program is to provide targeted
8 funding to rural hospitals to enable them to adapt to changes in
9 health care delivery and funding, and address disparities in
10 rural health care by:
11 1. Assisting in the development of needed infrastructure;
12 2. Assisting financially distressed rural hospitals; and
13 3. Ensuring accountability for state and federal funding.
14 (b) The rural hospital capital improvement grant program
15 includes technical assistance and grants managed by the agency.
16 (2)~~(1)~~ A rural hospital as defined in s. 395.602 may apply
17 to the agency ~~department~~ for a capital improvement grant to
18 acquire, repair, improve, or upgrade systems, facilities, or
19 equipment. The grant application must provide information that
20 includes:

21 (a) A statement indicating the problem the rural hospital
22 proposes to solve with the grant funds.~~;~~
23 (b) The strategy proposed to resolve the problem.~~;~~
24 (c) The organizational structure, financial system, and
25 facilities that are essential to the proposed solution.~~;~~
26 (d) The projected longevity of the proposed solution after
27 the grant funds are expended.~~;~~
28 ~~(e) Evidence of participation in a rural health network as~~
29 ~~defined in s. 381.0406;~~
30 (e)~~(f)~~ Evidence that the rural hospital has difficulty in
31 obtaining funding or that funds available for the proposed
32 solution are inadequate.~~;~~
33 (f)~~(g)~~ Evidence that the grant funds will assist in
34 maintaining or returning the hospital to an economically stable
35 condition or enable the transition to the status of rural
36 primary care hospital or that any plan for closure of the
37 hospital or realignment of services will involve development of
38 innovative alternatives for the provision of needed ~~discontinued~~
39 services.~~;~~
40 (g)~~(h)~~ Evidence of a satisfactory record-keeping system to
41 account for grant fund expenditures within the rural county.~~;~~
42 (h)~~(i)~~ ~~A rural health network plan that includes a~~
43 ~~description of how the plan was developed, the goals of the~~
44 ~~plan, the links with existing health care providers under the~~
45 ~~plan,~~ Indicators quantifying the ~~hospital's~~ financial status
46 ~~well-being~~, measurable outcome targets, and ~~the~~ current physical
47 and operational condition of the hospital.
48 ~~(2) Each rural hospital as defined in s. 395.602 shall~~
49 ~~receive a minimum of $100,000 annually, subject to legislative~~
50 ~~appropriation, upon application to the Department of Health, for~~

51 ~~projects to acquire, repair, improve, or upgrade systems,~~
52 ~~facilities, or equipment.~~
53 (3) ~~Any remaining funds shall annually be disbursed to~~
54 ~~rural hospitals in accordance with this section.~~ The agency
55 ~~Department of Health~~ shall establish, by rule, criteria for
56 awarding grants ~~for any remaining funds~~, which must be used
57 exclusively for the support and assistance of rural hospitals as
58 defined in s. 395.602, including criteria relating to the level
59 of charity ~~uncompensated~~ care rendered by the hospital, the
60 financial status of the hospital, the performance standards of
61 the hospital ~~the participation in a rural health network as~~
62 ~~defined in s. 381.0406~~, and the proposed use of the grant by the
63 rural hospital to resolve a specific problem. Up to 30 percent
64 of rural hospital capital improvement funds may be allocated to
65 assist financially distressed rural hospitals that meet the
66 requirements of subsection (3). The agency ~~department~~ must
67 consider any information submitted in an application for the
68 grants in accordance with subsection (2) ~~(1)~~ in determining
69 eligibility for and the amount of the grant~~, and none of the~~
70 ~~individual items of information by itself may be used to deny~~
71 ~~grant eligibility~~.
72 (4) Financially distressed rural hospitals and critical
73 access hospitals that have an annual occupancy rate of less than
74 30 percent may receive preferential assistance under the capital
75 improvement grant program to provide planning, management and
76 financial support. To receive this assistance the hospital must
77 meet the following requirements:
78 (a) Provide additional information that includes:
79 1. A statement of support from the board of directors of
80 the hospital, the county commission, and the city commission.

81 2. Evidence that the rural hospital and the community have
82 difficulty obtaining funding or that funds available for the
83 proposed solution are inadequate.
84 (b) Agree to be bound by the terms of a participation
85 agreement with the agency, which may include:
86 1. The appointment of a health care expert under contract
87 with the agency to analyze and monitor the hospital operations
88 during the period of distress.
89 2. The establishment of minimum standards for the
90 education and experience of the managers and administrators of
91 the hospital.
92 3. The oversight and monitoring of a strategic plan to
93 restore the hospital to an economically stable condition or
94 transition to an alternative means to provide services.
95 4. The establishment of a board orientation and
96 development program.
97 5. The approval of any facility relocation plans.
98 (5) ~~(4)~~ The agency ~~department~~ shall ensure that the funds
99 are used solely for the purposes specified in this section. The
100 total grants awarded pursuant to this section shall not exceed
101 the amount appropriated for this program.
102 Section 7. Section 408.7054, Florida Statutes, is created
103 to read:
104 408.7054 RURAL PROVIDER SERVICE NETWORK DEVELOPMENT
105 PROGRAM.--
106 (1) There is established within the Agency for Health Care
107 Administration the Rural Provider Service Network Development
108 Program to support the implementation of provider service
109 networks in rural counties of the state. The purpose of the
110 program is to assist in the establishment of the infrastructure

111 needed for Medicaid reform relating to prepaid and at-risk
112 reimbursement plans to improve access to quality health care in
113 rural areas.
114 (2) The responsibilities of the program are to:
115 (a) Administer the rural hospital capital improvement
116 grant program established under s. 395.6061.
117 (b) Administer the assistance program for financially
118 distressed rural and critical access hospitals established under
119 s. 395.6063.
120 (c) Administer the rural provider service network
121 development grant program established in subsection (3).
122 (3) There is established a rural provider service network
123 development grant program. The agency is authorized to provide
124 funding through a grant program to entities seeking to establish
125 rural provider service networks that have demonstrated interest
126 and experience organizing rural health care providers for this
127 purpose.
128 (4) Entities eligible for rural provider service network
129 development grants must meet the following criteria:
130 (a) Have a written agreement signed by prospective
131 members, 45 percent of whom must be providers in the targeted
132 service area.
133 (b) Include all rural hospitals, at least one federally
134 qualified health center, and one county health department
135 located in the service area.
136 (c) Have a defined service area, 80 percent of which
137 consists of rural counties.
138 (5) Each applicant for this funding shall provide the
139 agency with a detailed written proposal that includes, at a
140 minimum, a statement of need; a defined purpose; identification

141 and explanation of the role of prospective partners; a signed
142 memorandum of agreement or similar document attesting to the
143 role of prospective partners; documented actions related to
144 provider service network development; measurable objectives for
145 the development of clinical and administrative infrastructure; a
146 process of evaluation; and a process for developing a business
147 plan and securing additional funding.
148 (6) The agency is authorized to grant preferential funding
149 to a rural provider service network based on the number of rural
150 counties within the network's proposed service area that are
151 Medically Underserved Areas or Health Professional Shortage
152 Areas as defined by the Health Resources Services
153 Administration, Office of Rural Health Policy, and based on
154 whether the provider service network has a principal place of
155 business located in a rural county in the state.
156 (7) The agency is granted authority to develop rules
157 required to implement this section.
158
159 ========== T I T L E A M E N D M E N T ==========
160 Remove line(s) 42-54 and insert:
161
162 minimum grant for every rural hospital; establishing assistance
163 for financially distressed rural and critical access hospitals;
164 providing requirements for receiving assistance; requiring a
165 participation agreement and providing for contents thereof;
166 amending s. 408.05, F.S.; establishing the Rural Provider
167 Service Network Development Program; providing purposes and
168 responsibilities; establishing a development grant program;
169 providing eligibility requirements; authorizing preferential
170 funding to certain providers; amending s. 409.908, F.S.;

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 3 (for drafter's use only)

Bill No. **PCB HCR 06-06**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Garcia offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Between line(s) 713-714 insert:
6
7 Section 7. Section 395.6070, Florida Statutes, is created
8 to read:
9 395.6070 Rural hospital receivership.—
10 (1) As an alternative to or in conjunction with an
11 injunctive proceeding, the agency may petition a court of
12 competent jurisdiction for the appointment of a receiver for a
13 rural hospital as defined by s. 408.07, when any of the
14 following conditions exist:
15 (a) Any person is operating a hospital without a license
16 and refuses to make application for a license as required by ch.
17 395.
18 (b) The agency determines that conditions exist in the
19 hospital that present an imminent danger to the health, safety,
20 or welfare of the residents of the hospital or a substantial

21 probability that death or serious physical harm would result
22 therefrom.
23 (c) The licensee cannot meet its financial obligation for
24 providing food, shelter, care, and utilities. Evidence such as
25 the issuance of bad checks or an accumulation of delinquent
26 bills for such items as personnel salaries, food, drugs, or
27 utilities shall constitute prima facie evidence that the
28 ownership of the hospital lacks the financial ability to operate
29 the hospital.
30 (2) Petitions for receivership shall take precedence over
31 other court business unless the court determines that some other
32 pending proceeding, having similar statutory precedence, shall
33 have priority. A hearing shall be conducted within 5 days of the
34 filing of the petition, at which time all interested parties
35 shall have the opportunity to present evidence pertaining to the
36 petition. The agency shall notify the owner or administrator of
37 the hospital named in the petition of the filing of the petition
38 and the date set for the hearing. The court may grant the
39 petition only upon finding that the health, safety, or welfare
40 of patients of the hospital would be threatened if a condition
41 existing at the time the petition was filed is permitted to
42 continue. A receiver may be appointed when the owner or
43 administrator, or a representative of the owner or
44 administrator, is not present at the hearing on the petition,
45 unless the court determines that one or more of the conditions
46 in subsection (1) exist; that the hospital owner or
47 administrator cannot be found; that all reasonable means of
48 locating the owner or the administrator and notifying him or her
49 of the petition and hearing have been exhausted; or that the
50 owner or administrator, after notification of the hearing,

51 chooses not to attend. After such findings, the court may
52 appoint any person qualified by education, training, or
53 experience to carry out the responsibilities of a receiver
54 pursuant to this section, except that the court may not appoint
55 any owner or affiliate of the hospital which is in receivership.
56 The receiver may be selected from a list of persons qualified to
57 act as receivers developed by the agency and presented to the
58 court with each petition for receivership. Under no
59 circumstances shall the agency or designated agency employee be
60 appointed as a receiver.
61 (3) The receiver shall make provisions for the continued
62 health, safety, and welfare of all patients of the hospital and:
63 (a) Shall exercise those powers and perform those duties
64 set out by the court.
65 (b) Shall operate the hospital in such a manner as to
66 assure safety and adequate health care for the patients.
67 (c) Shall take such action as is reasonably necessary to
68 protect or conserve the assets or property of the hospital for
69 which the receiver is appointed, or the proceeds from any
70 transfer thereof, and may use them only in the performance of
71 the powers and duties set forth in this section and by order of
72 the court.
73 (d) May use the building, fixtures, furnishings, and any
74 accompanying consumable goods in the provision of care and
75 services to patients and to any other persons receiving services
76 from the hospital at the time the petition for receivership was
77 filed. The receiver shall collect payments for all goods and
78 services provided to residents or others during the period of
79 the receivership at the same rate of payment charged by the
80 owners at the time the petition for receivership was filed, or

81 at a fair and reasonable rate otherwise approved by the court
82 for private-pay patients. The receiver may apply to the agency
83 for a rate increase for Title XIX of the Social Security Act
84 patients if the hospital is not receiving the maximum allowable
85 payment and expenditures justify an increase in the rate.
86 (e) May correct or eliminate any deficiency in the
87 structure or furnishings of the hospital which endangers the
88 safety or health of patients while they remain in the hospital,
89 provided the total cost of correction does not exceed $100,000.
90 The court may order expenditures for this purpose in excess of
91 $100,000 on application from the receiver after notice to the
92 owner and a hearing.
93 (f) May let contracts and hire agents and employees to
94 carry out the powers and duties of the receiver under this
95 section.
96 (g) Shall honor all leases, mortgages, and secured
97 transactions governing the building in which the hospital is
98 located and all goods and fixtures in the building of which the
99 receiver has taken possession, but only to the extent of
100 payments which, in the case of a rental agreement, are for the
101 use of the property during the period of receivership, or which,
102 in the case of a purchase agreement, become due during the
103 period of receivership.
104 (h) Shall have full power to direct and manage and to
105 discharge employees of the hospital, subject to any contract
106 rights they may have. The receiver shall pay employees at the
107 rate of compensation, including benefits, approved by the court.
108 A receivership does not relieve the owner of any obligation to
109 employees made prior to the appointment of a receiver and not
110 carried out by the receiver.

111 (i) Shall be entitled to take possession of all property
112 or assets of patients which are in the possession of a hospital
113 or its owner. The receiver shall preserve all property or assets
114 and all patient records of which the receiver takes possession
115 and shall provide for the prompt transfer of the property,
116 assets, and records to the new placement of any transferred
117 patient. An inventory list certified by the owner and receiver
118 shall be made at the time the receiver takes possession of the
119 hospital.
120 (4)(a) A person who is served with notice of an order of
121 the court appointing a receiver and of the receiver's name and
122 address shall be liable to pay the receiver for any goods or
123 services provided by the receiver after the date of the order if
124 the person would have been liable for the goods or services as
125 supplied by the owner. The receiver shall give a receipt for
126 each payment and shall keep a copy of each receipt on file. The
127 receiver shall deposit accounts received in a separate account
128 and shall use this account for all disbursements.
129 (b) The receiver may bring an action to enforce the
130 liability created by paragraph (a).
131 (c) A payment to the receiver of any sum owing to the
132 hospital or its owner shall discharge any obligation to the
133 hospital to the extent of the payment.
134 (5)(a) A receiver may petition the court that he or she
135 not be required to honor any lease, mortgage, secured
136 transaction, or other wholly or partially executory contract
137 entered into by the owner of the hospital if the rent, price, or
138 rate of interest required to be paid under the agreement was
139 substantially in excess of a reasonable rent, price, or rate of
140 interest at the time the contract was entered into, or if any

141 material provision of the agreement was unreasonable, when
142 compared to contracts negotiated under similar conditions. Any
143 relief in this form provided by the court shall be limited to
144 the life of the receivership, unless otherwise determined by the
145 court.
146 (b) If the receiver is in possession of real estate or
147 goods subject to a lease, mortgage, or security interest which
148 the receiver has obtained a court order to avoid under paragraph
149 (a), and if the real estate or goods are necessary for the
150 continued operation of the hospital under this section, the
151 receiver may apply to the court to set a reasonable rental,
152 price, or rate of interest to be paid by the receiver during the
153 duration of the receivership. The court shall hold a hearing on
154 the application within 15 days. The receiver shall send notice
155 of the application to any known persons who own the property
156 involved or mortgage holders at least 10 days prior to the
157 hearing. Payment by the receiver of the amount determined by the
158 court to be reasonable is a defense to any action against the
159 receiver for payment or for possession of the goods or real
160 estate subject to the lease, security interest, or mortgage
161 involved by any person who received such notice, but the payment
162 does not relieve the owner of the hospital of any liability for
163 the difference between the amount paid by the receiver and the
164 amount due under the original lease, security interest, or
165 mortgage involved.
166 (6) The court shall set the compensation of the receiver,
167 which will be considered a necessary expense of a receivership.
168 (7) A receiver may be held liable in a personal capacity
169 only for the receiver's own gross negligence, intentional acts,
170 or breach of fiduciary duty.

171 (8) The court may require a receiver to post a bond.
172 (9) The court may terminate a receivership when:
173 (a) The court determines that the receivership is no
174 longer necessary because the conditions which gave rise to the
175 receivership no longer exist; or
176 (b) All of the patients in the hospital have been
177 transferred or discharged.
178 (10) Within 30 days after the termination, unless this
179 time period is extended by the court, the receiver shall give
180 the court a complete accounting of all property of which the
181 receiver has taken possession, of all funds collected and
182 disbursed, and of the expenses of the receivership.
183 (11) Nothing in this section shall be deemed to relieve
184 any owner, administrator, or employee of a hospital placed in
185 receivership of any civil or criminal liability incurred, or of
186 any duty imposed by law, by reason of acts or omissions of the
187 owner, administrator, or employee prior to the appointment of a
188 receiver; nor shall anything contained in this section be
189 construed to suspend during the receivership any obligation of
190 the owner, administrator, or employee for payment of taxes or
191 other operating and maintenance expenses of the hospital, or of
192 the owner, administrator, employee, or any other person for the
193 payment of mortgages or liens. The owner shall retain the right
194 to sell or mortgage any hospital under receivership, subject to
195 approval of the court which ordered the receivership. A licensee
196 that is placed in receivership by the court is liable for all
197 expenses and costs incurred by the Rural Hospital Patient
198 Protection Trust Fund that are related to capital improvement
199 and operating costs and are no more than 10 percent above the

200 hospital's Medicaid rate which occur as a result of the
201 receivership.
202 Section 8. Section 395.6071, Florida Statutes, is created
203 to read:
204 395.6071 Rural Hospital Patient Protection Trust Fund.--
205 (1) A Rural Hospital Patient Protection Trust Fund shall
206 be established for the purpose of collecting and disbursing
207 funds generated from a $1.00 fee assessed on each inpatient
208 discharge from a rural hospital as defined in s. 408.07. Such
209 funds shall be used for the continued operation of the hospital
210 and transition to another owner. Such funds may be used for the
211 purpose of paying for the appropriate alternate placement, care,
212 and treatment of patients who are removed from a facility
213 licensed under this part in which the agency determines that
214 existing conditions or practices constitute an immediate danger
215 to the health, safety, or security of the patients. If the
216 agency determines that it is in the best interest of the health,
217 safety, or security of the patients to provide for an orderly
218 removal of the patients from the facility, the agency may
219 utilize such funds to maintain and care for the patients in the
220 facility pending removal and alternative placement. The
221 maintenance and care of the patients shall be under the
222 direction and control of a receiver appointed pursuant to s.
223 395.6070. However, funds may be expended in an emergency upon a
224 filing of a petition for a receiver, upon the declaration of a
225 state of local emergency pursuant to s. 252.38(3)(a)5., or upon
226 a duly authorized local order of evacuation of a facility by
227 emergency personnel to protect the health and safety of the
228 patients.

229 (2) The agency is authorized to establish for each
230 facility, subject to intervention by the agency, a separate bank
231 account for the deposit to the credit of the agency of any
232 moneys received from the Rural Hospital Patient Protection Trust
233 Fund or any other moneys received for the maintenance and care
234 of patients in the facility, and the agency is authorized to
235 disburse moneys from such account to pay obligations incurred
236 for the purposes of this section. The agency is authorized to
237 requisition moneys from the Rural Hospital Patient Protection
238 Trust Fund in advance of an actual need for cash on the basis of
239 an estimate by the agency of moneys to be spent under the
240 authority of this section. Any bank account established under
241 this section need not be approved in advance of its creation as
242 required by s. 17.58, but shall be secured by depository
243 insurance equal to or greater than the balance of such account
244 or by the pledge of collateral security in conformance with
245 criteria established in s. 18.11. The agency shall notify the
246 Chief Financial Officer of any such account so established and
247 shall make a quarterly accounting to the Chief Financial Officer
248 for all moneys deposited in such account.
249 (3) Funds authorized under this section shall be expended
250 on behalf of all patients transferred to an alternate placement,
251 at the usual and customary charges of the facility used for the
252 alternate placement, provided no other source of private or
253 public funding is available. However, such funds may not be
254 expended on behalf of a resident who is eligible for Title XIX
255 of the Social Security Act, if the alternate placement accepts
256 Title XIX of the Social Security Act. Funds shall be utilized
257 for maintenance and care of patients in a facility in
258 receivership only to the extent private or public funds,

259 including funds available under Title XIX of the Social Security
260 Act, are not available or are not sufficient to adequately
261 manage and operate the facility, as determined by the agency.
262 The existence of the Rural Hospital Patient Protection Trust
263 Fund shall not make the agency liable for the maintenance of any
264 resident in any facility. The state shall be liable for the cost
265 of alternate placement of patients removed from a deficient
266 facility, or for the maintenance of patients in a facility in
267 receivership, only to the extent that funds are available in the
268 Rural Hospital Patient Protection Trust Fund.
269 (4) The agency is authorized to adopt rules necessary to
270 implement this section.
271
272 ========== T I T L E A M E N D M E N T ==========
273 Between line(s) 42-43 insert:
274
275 395.6070, F.S.; providing for a rural hospital
276 receivership; creating s. 395.6071, F.S.; creating a
277 Rural Hospital Patient Protection Trust Fund;
278 providing rulemaking authority; creating s.

HOUSE AMENDMENT FOR COUNCIL/COMMITTEE PURPOSES

Amendment No. 4 (for drafter's use only)

Bill No. **PCB HCR 06-06**

COUNCIL/COMMITTEE ACTION

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

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1 Council/Committee hearing bill: Health Care Regulation
2 Representative(s) Cretul offered the following:
3
4 **Amendment (with directory and title amendments)**
5 Remove line(s) 689-695 and insert:
6
7 (2) Each rural hospital as defined in s. 395.602 shall
8 receive a minimum of $100,000 annually, subject to legislative
9 appropriation, upon application to the agency ~~Department of~~
10 ~~Health~~, for projects to acquire, repair, improve, or upgrade
11 systems, facilities, or equipment.
12 (3) Any remaining funds shall annually be disbursed to
13 rural hospitals in accordance with this section. The agency

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB HCR 06-07 Obesity
SPONSOR(S): Health Care Regulation Committee
TIED BILLS: **IDEN./SIM. BILLS:** 1324

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
Orig. Comm.: Health Care Regulation Committee		Bell	Mitchell
1)			
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

The Obesity Proposed Committee Bill (PCB) addresses the issue of Obesity in Florida. In 2000, more than six and a half million Florida adults were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers.

The bill requires the Department of Health (DOH or department), in addition to its current health promotion and prevention activities, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency; and
- Advise Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

The bill requires DOH in partnership with the Department of Education to award grants to local school districts to implement a pilot program to promote healthy eating habits, increase physical activity, and improve fitness. The Office of Program Policy Analysis and Government Accountability must conduct a performance evaluation to determine the program's effectiveness and submit certain reports. School districts that participate in the pilot program must collect certain information to be used in the evaluation.

The initial review by the Department of Health estimated that the fiscal impact of the bill will be $31,800 in year one and $30,800 in year two.

Full implementation of the bill is dependent on an appropriation by the Legislature.

The effective date of the bill is July 1, 2006.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. HOUSE PRINCIPLES ANALYSIS:

Promote limited government – The bill directs the Department of Health to work with all the state agencies to offer wellness programming to employees, advises health care practitioners to provide healthy lifestyle recommendations to their patients, and creates a 3-year school-based pilot program to promote healthy eating habits and increased physical activity. According to the Department of Health the fiscal impact of the bill is $31,800 in year one and $30,800 in year two.

Empower Families – Obesity is a serious risk factor for diabetes, heart disease, stroke, asthma, and many other chronic diseases. Early obesity interventions improve quality and quantity of life.

B. EFFECT OF PROPOSED CHANGES:

CURRENT SITUATION

The Prevalence of Obesity

The prevalence of obesity doubled in the past few decades. Today, approximately 129 million U.S. adults are considered obese. The number of overweight and obese persons in the country surpasses the number of people who smoke, live in poverty, or drink heavily. The U.S. Surgeon General recognized in 2001 that overweight and obesity have reached epidemic proportions in America.[1] An "epidemic" is defined as any disease occurring at a greater frequency than usually expected. Although historically the term "epidemic" referred to occurrences of infectious diseases, the definition has evolved to include chronic diseases and conditions such as obesity.

Defining & Measuring Overweight and Obesity

Overweight and obesity are both labels for ranges of weight that are greater than what is generally considered healthy for a given height. For adults, overweight and obesity ranges are determined by using weight and height to calculate a number called the "body mass index" (BMI). The BMI is calculated by dividing weight in pounds by height in inches squared, then multiplying the quotient by 703. An adult who has a BMI between 24 and 29.9 is considered overweight. An adult who has a BMI of 30 or higher is considered obese. For children and teens, BMI ranges above a normal weight have different labels (at risk of overweight and overweight). Additionally, BMI ranges for children and teens are defined so that they take into account normal differences in body fat between boys and girls and differences in body fat at various ages.

Florida Statistics on Obesity and Overweight

In 2000, more than six and a half million Florida adults[2] were overweight or obese based on self-reported height and weight; and of those, approximately 2.5 million adults were obese. Since 1986, when height and weight were first monitored in Florida's adult population, overweight increased from

---

[1] U.S. Department of Health and Human Services. The Surgeon General's call to action to prevent and decrease overweight and obesity. [Rockville, MD]: U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General; [2001].

[2] Most of FL data comes from the Behavioral Risk Factor Surveillance System (BRFSS). This is an on-going, state-based, random-digit dialed telephone survey of the general civilian population aged 18 and over. Youth Physical Activity and Nutrition Survey (YPANS) are used for data on physical activity, nutrition, and sedentary lifestyles among public middle school students, and the Florida Youth Behavior Survey (YRBS) is used to collect similar data among high school students.

35.3% of the adult population in 1986 to 57.4% in 2002 to 60% in 2004[3]. The prevalence of obesity has increased dramatically among both men and women between 1990 and 2002; for men the prevalence of obesity has increased 61%, and among women, the prevalence has increased 27%.

The BMI is also used to identify children who are overweight or who are at risk of becoming overweight.[4] In 2004, approximately 12.4% of Florida's high school students were considered overweight, with the rates for boys (16.5%) nearly doubling that of girls (8.1%). An additional 14% of Florida's high school students were considered at risk of overweight, with similar trends between boys (14.6%) and girls (13.4%). In 2002, nearly one-third of students in kindergarten, third, sixth, and ninth grades were significantly above their ideal weights.

Health Costs of Obesity & Overweight

Obesity is second only to tobacco use as a threat to public health. Its implications include serious health consequences such as diabetes, coronary heart disease, high blood pressure, high cholesterol, osteoarthritis, sleep disturbances and breathing problems, and certain cancers. Further studies conclude that obesity is linked to higher rates of chronic health conditions than smoking, drinking or poverty.[5] The U.S. Surgeon General reports that 300,000 deaths per year are attributed to obesity. The problem of obesity is especially dangerous for children. The adverse health conditions that typically occur in adults are becoming more prevalent in adolescents, and these conditions in childhood lead to chronic illness. One out of four children, who are overweight, show early signs of type 2 diabetes.[6] Overweight children are far more likely to become overweight adults than children who maintain normal weight through adolescence.[7]

Economic Cost of Obesity & Overweight

The U.S. Surgeon General announced that obesity and overweight cost US taxpayers $117 billion per year in direct health care costs and indirect costs such as lost wages. Of this, the Centers for Disease Control (CDC) estimates that direct health care costs alone reached $75 billion in 2003. In Florida, obesity-related medical expenditures for adults total over $3.9 billion in that year, with over half of the costs financed by Medicare and Medicaid. Because of this, Florida's Agency for Health Care Administration (AHCA) reported that obesity and overweight have caused increased statewide healthcare expenditures for hospitalizations and treatments, including disability costs, related to chronic conditions.

Numerous studies have found a correlation between obesity and increased claims costs on insurance. A Kaiser-Oakland study found that individuals with a BMI of 30-30.49 had increased claims cost 25%; those with a BMI of more than 35% increased claims 44%. A Medstat Group study found that claims from individuals with a BMI of more than 27.5% cost 25% more than claims from those with an ideal body weight. Finally, a Bank One Study found that 24% of health care costs were due to overweight.

Causes of the Obesity Epidemic

In simple terms, obesity has reached epidemic proportions because our energy input through food exceeds our energy output through physical activity. Some contributors to this include: larger meal portions, diets higher in fat, frequency of meals away from home, higher calorie and high fat drinks, sedentary lifestyles. According to a recent study by the National Center for Health Statistics (NCHS), less than a third of US adults engage in regular leisure-time physical activity. One study looked at adults who were trying to lose or not gain weight and found that less than 20 % of them were following

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[3] CDC BRFSS 2004 data. http://www.cdc.gov/nccdphp/dnpa/obesity/state_programs/florida.htm

[4] These terms are defined based on a comparison of BMI to all other youth of the same age and sex. A child is considered at risk for overweight if his or her BMI is higher than the 85th percentile, and lower than the 95% percentile, of his or her peers. A child is considered overweight if his or her BMI is greater than or equal to the BMI of the 95th percentile of peers.

[5] RAND Corporation

[6] NEJM.

[7] National Library of Medicine

recommendations about increasing physical activity and reducing calories.[8] Another notable finding is that only 42.8% of obese people, who had routine checkups in past months, had been urged during those visits to lose weight.[9]

In 2002, only 25.7% of Floridian adults consumed five or more servings of fruit and vegetables a day. Also in this year, 26.4% of Floridian adults were physically inactive, with women and Hispanics the most likely to be sedentary. Even among those who reported being physically active, the level of intensity of physical activity has decreased since 1992.

Childhood learning has a significant role in establishing lasting habits for physical activity and nutrition throughout life. In 2003, more than 50% of Florida high school and 40% of middle school students reported that they did not participate in any physical education at school. Additionally, 42.7% of high school and 45.3% of middle school students reported watching television for more than three hours on an average school day; 23.1% of high school and 33% of middle school students reported playing video games or using the computer for fun three to six hours on average school day. And only 20.7% of high school and 11.3% of middle school students reported eating the recommended five or more servings of fruit or vegetables each day in the past week.

Solutions for Handling the Obesity Epidemic

Changing people's habits related to physical activity is challenging. Individuals who want to be more active often find it difficult to do so because of daily demands and other constraints associated with work and family. The U.S. Surgeon General reported, in his 2001 "Call to Action to Prevent and Decrease Overweight and Obesity", that individual behavior can only change in a supportive environment, by giving people access to affordable and healthy food choices, and by giving people the opportunity for regular physical activity. A number of initiatives have been developed in both the private and public sectors, to encourage individuals to adopt healthy nutrition and fitness behaviors. Research indicates that educational nutrition programming correlates positively with increased servings of fruit and vegetables in the school setting. In other words, the more activities that are done in the classroom in nutrition education and program promotion, the higher the rates of fruit and vegetable consumption there are in the schools.[10]

Obesity Prevention in Florida

In October 2003, the Governor of Florida created a task force to address the rising rates of overweight and obesity among adults and youth in Florida, to evaluate data and testimony to determine the extent of the problem in Florida, and to make recommendations on how to address obesity in Florida.[11] The Governor's Task Force on the Obesity Epidemic issued a final report in February 2004, with 22 comprehensive recommendations.[12]

Section 381.0054, F.S., requires DOH to promote healthy lifestyles to reduce the prevalence of overweight and obesity in Florida by implementing appropriate physical activity and nutrition programs that target all Floridians. These activities include:

- Using all appropriate media to promote maximum public awareness of the latest research on healthy lifestyles and chronic diseases and disseminating relevant information through a statewide clearinghouse relating to wellness, physical activity, and nutrition and their impact on chronic diseases and disabling conditions;

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[8] Mokdad AH, Bowman, BA, Ford ES, Vinicor F, Marks JS, Koplan JP. The continuing epidemics of obesity and diabetes in the United States. *JAMA* 2001; 286(10): 1195-1200.
[9] Ibid.
[10] Shelly Terry, M.S., Ed., School Food Service Consultant, Produce for Better Health.
[11] See Executive Order No. 2003-196.
[12] See http://www.doh.state.fl.us/Family/GTFOE/report.pdf (last visited on March 10, 2006).

- Providing technical assistance, training, and resources on healthy lifestyles and chronic diseases to the public, county health departments, health care providers, school districts, and other persons or entities, including faith-based organizations, that request such assistance to promote physical activity, nutrition, and healthy lifestyle programs;
- Developing, implementing, and using all available research methods to collect data, including, but not limited to, population-specific data, and track the incidence and effects of weight gain, obesity, and related chronic diseases. The department must include an evaluation and data collection component in all programs as appropriate;
- Partnering with the Department of Education, local communities, school districts, and other entities to encourage Florida schools to promote activities during and after school to help students meet a minimum goal of 60 minutes of activity per day;
- Partnering with the Department of Education, school districts, and the Florida Sports Foundation to develop a program that recognizes schools whose students demonstrate excellent physical fitness or fitness improvement; and
- Maximizing all local, state, and federal funding sources, including grants, public-private partnerships, and other mechanisms, to strengthen the department's current physical activity and nutrition programs and to enhance similar county health department programs.

The department implements s. 381.0054, F.S., contingent on an appropriation in the General Appropriations Act. The department reports that the implementation of this section is not currently funded with an appropriation.

The Obesity Prevention Program within DOH is funded through a cooperative agreement with a planning grant of $450,000 from the United States Centers for Disease Control and Prevention (CDC). This funding must be used to develop infrastructure within the program in an effort to reduce the burden of obesity among adults and youth in Florida, develop partnerships to combat obesity, and develop a five-year work plan which focuses on increased physical activity, healthy nutrition, initiation and duration of breastfeeding, and decreased TV, video, or computer screen time.

During fiscal year 2004-05, DOH used media for public awareness through limited partner funds to conduct a direct hit marketing campaign to affect physical activity in an identified five-county area, and a billboard campaign and bus placard campaign in Miami-Dade County to affect fruit and vegetable consumption. Due to the lack of funding, DOH has no plans for a public awareness media campaign for fiscal year 2005-06.

The department has launched an obesity prevention website that serves as a clearinghouse where limited resources can be downloaded and weblinks are available to other resources that may be purchased by the public. Limited resources are provided by DOH to county health departments, public or private agencies, schools, and community groups, as funding allows. Local media events are conducted by the Bureau of Chronic Disease Prevention and Health Promotion that cover all 67 Florida counties.

The Bureau of Chronic Disease Prevention and Health Promotion provides technical assistance to the public, county health departments, health care providers, school districts, and others who request assistance to promote physical activity, nutrition, and healthy lifestyle programs. The department uses the Behavior Risk Factor Surveillance System developed by CDC for state surveillance and data collection to assess overweight, obesity, physical activity levels, and fruit and vegetable consumption for adults. The department also surveys middle and high school students and conducts body-mass-index surveys on all full service school students enrolled in kindergarten, third, sixth, and ninth grades.

The department collaborates with the Department of Education through the school health program to: promote the CDC School Health Index Assessment; conduct seven regional trainings for the school health advisory committee regarding the development of school wellness policies, which include increased opportunities for physical activity during and after school; and the Step Up Florida physical activity campaign. On the local level, education coordinators for the Bureau of Chronic Disease Prevention and Health Promotion work with local schools to implement policy and environmental

changes, as well as programs for during- and after-school physical activity. According to DOH staff, no state standards have been developed for measuring school physical fitness levels or methods to assess physical fitness or fitness improvement among students.

The department collaborates with several state agencies on specific projects and programs to address increasing physical activity and healthy nutrition, such as the school health program with the Department of Education and the safe ways to schools program with the Department of Transportation. The department maximizes local, state and federal funding to strengthen the Obesity Prevention Program and other chronic disease prevention programs, through partnerships with state, local and federal organizations related to obesity prevention and related chronic diseases.

At the local level, the Bureau of Chronic Disease Prevention and Health Promotion emphasizes community-specific needs and planning, and establishes partnerships with local businesses, health care organizations, community organizations, schools, and faith-based organizations, requiring a 25 percent match in local resources, to address the leading preventable risk factors for all chronic diseases through community-based programs.

EFFECTS OF THE BILL

The bill amends s. 381.0054, F.S., to require DOH, in addition to its current health promotion and prevention activities aimed at reducing the prevalence of excess weight gain and obesity, to:

- Collaborate with other state agencies to develop policies and strategies for preventing obesity, which must be incorporated into programs administered by each agency and which must include promoting healthy lifestyles of employees of each agency; and
- Advise, in accordance with s. 456.081, F.S., Florida-licensed health care practitioners regarding the morbidity, mortality, and costs associated with the conditions of being overweight or obese, inform such practitioners of clinical best practices for preventing obesity, and encourage practitioners to counsel their patients regarding the adoption of healthy lifestyles.

The bill requires the Department of Health in partnership with the Department of Education to award grants to local school districts to implement a 3-year pilot program to promote healthy eating habits, increase physical activity, and improve fitness. The pilot program must target students in fourth and fifth grades and be located in 10 geographically and demographically diverse counties. The pilot program must have a program provider and the bill specifies the duties of the program provider. In addition to working with the Department of Education and local school districts, the department, working together with the pilot program provider, must seek partnerships with local businesses, industries, and other organizations that may assist in providing funding or resources to schools.

The bill requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) to conduct a performance evaluation to determine the pilot program's effectiveness and submit reports to the Legislature. To be eligible for the grant, the school districts must agree to collect information that OPPAGA needs to conduct its evaluation. The bill requires OPPAGA to supply a form for participating school districts to record the information and identify the information that must be collected for the evaluation. The school district must collect baseline and school-year-end information on the participating students.

The bill provides an appropriation of an unspecified amount from the General Revenue Fund to DOH to implement s. 381.0054, F.S.

The effective date of the bill is July 1, 2006.

BACKGROUND

Wellness Initiatives for State Employees

State governments have been increasingly active in encouraging healthy habits. A sample of programs is highlighted below.

Oklahoma: State employees are eligible to receive two wellness incentives in the OK Health Program. The first incentive offers employees an initial visit to a primary care physician along with lab work at no out-of-pocket cost. The second incentive is a discount at a participating fitness center. Agency directors are also given the authority to offer financial incentives to their employees who participate in the OK Health Program. The pay incentive program consist of three separate lump sum payable to an employee upon completion of specified steps and is available during the first year participation. The three levels of pay incentive are: $100 (Bronze), for enrolling in the program and completing the initial visit; $300 (Silver) for completing a twelve-week follow up visit; and $500 (Gold) for achieving goals at the twelve-month follow up.[13]

Arkansas: Offers nutrition counseling and smoking cessation aids, including the nicotine patch, to Medicaid recipients and state employees. Workers in the governor's office are offered "walking breaks" instead of smoking breaks.[14]

Wisconsin: The governor created, through an executive order, the Wisconsin Encourages Healthy Lifestyles (WEHL) initiative and council to promote healthy lifestyles for state employees. The WEHL Council encourages each state agency to create its own council; designs a plan to promote the overall health and well being of state employees; and is to identify incentives to promote participation by state employees in WEHL activities. The goals of WELH are to encourage physical activity for at least 30 minutes per day and to encourage healthy eating habits among state employees.[15]

Licensed Health Care Practitioners

Chapter 456, F.S., specifies the general provisions for licensed health care practitioners in DOH's Division of Medical Quality Assurance. In addition to ch. 456, F.S., each health care profession has its own practice act with specific regulatory provisions. Section 456.081, F.S., grants authority to DOH and the boards to advise licensees periodically, through the publication of a newsletter on the department's website, about information that the department or the board determines is of interest to the industry.

C. SECTION DIRECTORY:

Section 1. – Amends s. 381.0054, F.S., to direct the Department of Health to collaborate with other state agencies to develop workplace wellness programs and advise health care practitioners of the morbidity, mortality, and costs associated with obesity or overweight.

Section 2. – Creates an undesignated section of law to establish a 3-year pilot program to promote healthy eating and exercise habits in fourth and fifth grades. The program will be administered by the Department of Health and Department of Education. The Office of Program Policy Analysis and Government Accountability will evaluate the pilot project.

Section 3. – Provides an appropriation.

Section 4. – Provides the bill will take effect July 1, 2006.

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[13] Oklahoma's OK Health Program: http://www.ebc.state.ok.us/en/OkHealth/Finance_Incentives/FinancialIncentives.htm
[14] Kiely, Kathy. "Governor's healthy state." *USA Today.* July 7, 2004. http://www.usatoday.com/news/health/2004-07-11-arkansas-governor_x.htm
[15] State of Wisconsin, Executive Order on WEHL Council. http://oci.wi.gov/special/wehlcoun.htm

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Department of Health Fiscal Impact

Estimated Expenditures	1st Year	2nd Year (Annualized/Recurr.)
Salaries and Fringe	**0**	**0**
Expense		
State Agency Obesity Prevention Workgroup	*$ 1,800*	*$ 800*
Funding for DCF, DOEA, ADP, AHCA, DJJ, DOA to Implement Obesity Prevention in current programs @ $5,000 each	*$ 30,000*	*$ 30,000*
Compliance with s.456.081 – Providing information to Healthcare Practitioners	*0*	*0*
Total:	**$31,800**	**$30,800**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

Section 381.0054, F.S., Healthy Lifestyle Promotion, is currently unfunded. The Obesity Prevention program is funded by the Centers for Disease Control (CDC) and can only be used on CDC approved projects. The appropriation section of the bill does not specify if the funding only supports the changes made in the bill or the entire s. 381.0054, F.S.

Full implementation of s. 381.0054, F.S., is estimated as $3,310,674 in year one and $2,341,319 in year two.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or take action requiring the expenditure of funds. This bill does not reduce the percentage of state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenue.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Department of Health has the necessary rulemaking authority to carry out the provisions in the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

[See D. FISCAL COMMENTS]

IV. AMENDMENTS/COMMITTEE SUBSTITUTE & COMBINED BILL CHANGES

1 A bill to be entitled
2 An act relating to the prevention of obesity; amending s.
3 381.0054, F.S.; requiring the Department of Health to
4 collaborate with other state agencies in developing
5 policies and strategies to prevent obesity which shall be
6 incorporated into agency programs; requiring the
7 department to advise health care practitioners regarding
8 morbidity, mortality, and costs associated with the
9 condition of being overweight or obese; requiring the
10 department to inform health care practitioners about
11 clinical best practices for obesity prevention and to
12 encourage practitioners to counsel their patients
13 regarding the adoption of healthy lifestyles; requiring
14 the Department of Health in partnership with the
15 Department of Education to award grants to local school
16 districts to implement a pilot program to promote healthy
17 eating habits, increase physical activity, and improve
18 fitness; specifying requirements for the pilot program;
19 requiring the Office of Program Policy Analysis and
20 Government Accountability to complete a report to
21 determine the program's effectiveness in changing body
22 mass index, increasing knowledge, and improving attitudes
23 and behaviors of students related to nutrition and
24 physical activity; requiring the Department of Health and
25 the program provider to seek partnerships with various
26 entities and organizations for assistance in providing
27 funding and resources; requiring school districts that
28 participate in the pilot program to collect certain
29 information that is identified by the Office of Program

30 Policy Analysis and Government Accountability for the
31 evaluation of the program's effectiveness; providing an
32 appropriation; providing an effective date.
33
34 WHEREAS, in 2003, 14 percent of high school students were at
35 risk of being overweight and an additional 12.4 percent were
36 overweight, and
37 WHEREAS, in 2003, more than 50 percent of high school
38 students did not participate in any physical education at school,
39 and
40 WHEREAS, in 2003, only approximately 20.7 percent of high
41 school students in this state ate five or more servings of fruits
42 or vegetables each day in a 7-day period, and
43 WHEREAS, in 2003, 42.7 percent of high school students
44 watched television for 3 or more hours on an average school day,
45 and
46 WHEREAS, in 2003, 39.9 percent of middle school students did
47 not go to physical education classes at all during an average
48 school week, and
49 WHEREAS, in 2003, on an average school day, 45.3 percent of
50 middle school students watched television for 3 or more hours,
51 18.2 percent used the computer for fun for 3 or more hours, and
52 14.8 percent reported playing video games for 3 or more hours,
53 and
54 WHEREAS, in 2003, only 11.3 percent of middle school
55 students reported eating five or more servings of fruits and
56 vegetables per day, and
57 WHEREAS, approximately 60 percent of overweight children
58 have at least one risk factor for cardiovascular disease such as

59 high blood pressure or high cholesterol, and about 25 percent of
60 overweight children have two or more risk factors, and
61 WHEREAS, 25 percent of adults and children are obese and 15
62 million Americans are morbidly obese, and
63 WHEREAS, obesity as a cause of death is preventable and
64 20,000 Floridians die annually from obesity-related diseases, and
65 WHEREAS, obesity-related medical expenditures for adults in
66 this state total more than $3.9 billion yearly, with over half of
67 the costs being financed by Medicare and Medicaid, NOW,
68 THEREFORE,
69
70 Be It Enacted by the Legislature of the State of Florida:
71
72 Section 1. Subsection (1) of section 381.0054, Florida
73 Statutes, is amended to read:
74 381.0054 Healthy lifestyles promotion.--
75 (1) The Department of Health shall promote healthy
76 lifestyles to reduce the prevalence of <u>excess weight gain</u>
77 ~~overweight~~ and obesity in Florida by implementing appropriate
78 physical activity and nutrition programs that <u>are directed</u>
79 <u>towards</u> ~~target~~ all Floridians by:
80 (a) Using all appropriate media to promote maximum public
81 awareness of the latest research on healthy lifestyles and
82 chronic diseases and disseminating relevant information through a
83 statewide clearinghouse relating to wellness, physical activity,
84 and nutrition and their impact on chronic diseases and disabling
85 conditions.
86 (b) Providing technical assistance, training, and resources
87 on healthy lifestyles and chronic diseases to the public, county

88 health departments, health care providers, school districts, and
89 other persons or entities, including faith-based organizations,
90 that request such assistance to promote physical activity,
91 nutrition, and healthy lifestyle programs.
92 (c) Developing, implementing, and using all available
93 research methods to collect data, including, but not limited to,
94 population-specific data, and track the incidence and effects of
95 weight gain, obesity, and related chronic diseases. The
96 department shall include an evaluation and data collection
97 component in all programs as appropriate.
98 (d) Partnering with the Department of Education, local
99 communities, school districts, and other entities to encourage
100 Florida schools to promote activities during and after school to
101 help students meet a minimum goal of 60 minutes of activity per
102 day.
103 (e) Partnering with the Department of Education, school
104 districts, and the Florida Sports Foundation to develop a program
105 that recognizes schools whose students demonstrate excellent
106 physical fitness or fitness improvement.
107 (f) Collaborating with other state agencies to develop
108 policies and strategies for preventing obesity, which shall be
109 incorporated into programs administered by each agency and shall
110 include promoting healthy lifestyles of employees of each agency.
111 (g) Advising, in accordance with s. 456.081, health care
112 practitioners licensed in this state regarding the morbidity,
113 mortality, and costs associated with the condition of being
114 overweight or obese, informing such practitioners of clinical
115 best practices for preventing obesity, and encouraging
116 practitioners to counsel their patients regarding the adoption of

117 healthy lifestyles.
118 (h) ~~(f)~~ Maximizing all local, state, and federal funding
119 sources, including grants, public-private partnerships, and other
120 mechanisms, to strengthen the department's current physical
121 activity and nutrition programs and to enhance similar county
122 health department programs.
123 Section 2. (1) The Department of Health in partnership
124 with the Department of Education shall award grants to local
125 school districts to implement a 3-year pilot program that is
126 directed towards students in the 4th and 5th grades in 10
127 geographically and demographically diverse counties. The pilot
128 program must:
129 (a) Have a program provider. The program provider shall:
130 1. Have a prevention-education program currently in use
131 throughout the school districts in this state in order to receive
132 funds under the grants provided by the pilot program;
133 2. Promote the "Fresh 2-U" campaign by the Department of
134 Agriculture and Consumer Services;
135 3. Have an established partnership with the Produce for
136 Better Health Foundation and promote its "5 A Day the Color Way"
137 campaign; and
138 4. Work with school districts to use multimedia methods and
139 awareness events and promote healthful nutrition and physical
140 activity opportunities throughout the school year targeting
141 students, staff, parents, and caregivers.
142 (b) Establish a school-based program in elementary schools
143 for purposes of promoting healthy eating habits, increasing
144 physical activity, and improving fitness, and include a formal
145 curriculum on physical activity and nutrition that is consistent

146 with recommendations from the Governor's Task Force on the
147 Obesity Epidemic, February 2004.
148 (c) Provide education and professional-development training
149 to teachers on how to implement the program to model physical
150 activity and healthy eating behavior and on the importance of
151 building positive physical habits during school and away from
152 school.
153 (d) Empower teachers to facilitate educational
154 opportunities to support and sustain lifelong physical activity
155 and healthy eating.
156 (e) Incorporate physical activity and nutrition education
157 into core classroom subject areas and various curricula,
158 including, but not limited to, math, science, home economics, and
159 language arts, and must be linked to the Sunshine State
160 Standards.
161 (f) Integrate nutrition and physical activities into other
162 educational opportunities both inside and outside the classroom.
163 Teachers, administrators, school food service personnel, other
164 school personnel, and parents and students shall collaborate on
165 creating a positive physical activity and healthy nutrition
166 environment. The program must also include resources and
167 activities that engage and involve parents and caregivers.
168 (g) Provide resources and education for core classroom
169 teachers to promote collaboration between the physical education
170 and core classroom teachers and create a comprehensive
171 educational experience for the students to develop the skills,
172 knowledge, and attitudes to make healthy decisions using critical
173 thinking skills throughout their lives, while enhancing students'
174 reading and academic skills.

175 (h) Provide resources that are sustainable and provide
176 open, web-based resources to teachers and students across the
177 state.
178 (i) Be compliant with applicable state education standards.
179 (j) Have nutrition-education activities that are developed
180 in partnership with the Produce for Better Health Foundation.
181 (k) Be evidence based and research based and have had
182 results published in a peer-reviewed journal demonstrating a
183 statistically significant reduction in body mass index and an
184 increase in fruit and vegetable consumption and levels of
185 physical activity among participating students.
186 (l) Hire a statewide coordinator to provide ongoing support
187 for teachers and staff who implement the program.
188 (2) At the completion of the 3-year pilot program, the
189 Office of Program Policy Analysis and Government Accountability
190 shall conduct a performance evaluation to determine the program's
191 effectiveness in changing body mass index, increasing knowledge,
192 and improving attitudes and behaviors of students related to
193 nutrition and physical activity. Following the completion of the
194 2006-2007 and 2007-2008 school years, the Office of Program
195 Policy Analysis and Government Accountability shall submit
196 interim reports to the President of the Senate and the Speaker of
197 the House of Representatives.
198 (3) To be eligible for the grant, school districts must
199 agree to collect information that the Office of Program Policy
200 Analysis and Government Accountability needs to conduct its
201 evaluations. This information will facilitate the Office of
202 Program Policy Analysis and Government Accountability's
203 evaluation of the pilot program's effectiveness in changing body

204 mass index and increasing knowledge and improving attitudes and
205 behaviors related to nutrition and physical activity. The Office
206 of Program Policy Analysis and Government Accountability must
207 supply a form for participating school districts to record the
208 information and identify the information that must be collected
209 for the evaluation. The school district must collect baseline and
210 end-of-school-year information concerning the participating
211 students.
212 (4) In addition to working with the Department of Education
213 and local school districts, the Department of Health, working
214 together with the program provider, shall seek partnerships with
215 local businesses, industries, corporations, philanthropic
216 foundations, and other organizations and shall seek state and
217 federal grant opportunities that may assist in providing funding
218 or resources to schools.
219 Section 3. The sum of $ is appropriated from the
220 General Revenue Fund to the Department of Health for the 2006-
221 2007 fiscal year to implement the provisions of s. 381.0054,
222 Florida Statutes.
223 Section 4. This act shall take effect July 1, 2006.