HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 607 Health Care Practitioners
SPONSOR(S): Health Quality Subcommittee, Pigman
TIED BILLS: HB 7017 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee	14 Y, 1 N, As CS	Siples	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Florida law requires advanced practice registered nurses (APRNs) to practice under a supervising protocol with a physician and only to the extent that a written protocol allows. Similarly, physician assistants (PAs) must practice under a supervising physician and may only perform those tasks delegated by the physician. CS/HB 607 authorizes APRNs who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol and authorizes PAs to practice primary care without physician supervision. These APRNs and PAs may act as a patient's primary care provider; provide a signature, certification, stamp, verification, affidavit, or other endorsement currently required to be provided by a physician; certify a cause of death and sign, correct, and file death certificates.

The bill authorizes an advisory committee comprised of physicians and APRNs to develop a list of medical acts that an APRN engaging in autonomous practice may perform. The bill requires the Council on Physician Assistants (Council) to develop rules defining the primary specialties in which an autonomous PA may practice.

Pursuant to the bill, an APRN or a PA who practices autonomously must report adverse incidents that result in the death of a patient, permanent physical injury to the patient, or a need to transfer a patient to hospital to the Department of Health (DOH). DOH must review each report to determine whether the APRN or PA is subject to disciplinary action. The bill also subjects autonomous APRNs to disciplinary action if they commit specified prohibited acts related to unethical and substandard business practices.

The bill requires all APRNs to apply to the Board of Nursing for licensure, rather than DOH, to reflect current practices.

The bill revises the composition of the Council so that it has a PA majority. The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill expands the scope of practice for all PAs by authorizing them to certify a person for involuntary examination under the Baker Act, file death certificates and certify a cause of death, and participate in guardianship plans. The bill authorizes an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse to examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court. The bill removes a requirement that a PA must notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill appropriates 3.5 FTE and $219,089 in recurring and $17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to implement the requirements of the bill. The bill has no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Care Professional Shortage

The U.S. has a current health care provider shortage.[1] As of September 30, 2019, the U.S. Department of Health and Human Services has designated 7,578 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,087 additional primary care physicians to eliminate the shortage), 6,782 Dental HPSAs (requiring 9,951 additional dentists to eliminate the shortage), and 6,069 Mental Health HPSAs (requiring 6,166 additional psychiatrists to eliminate the shortage).[2]

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[3] and the expanded access to health care under the Affordable Care Act.[4] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[5] Additionally, as more individuals qualify for health care benefits, there will necessarily be greater demand for more health care professionals to provide these services. There are several other factors that will likely increase the demand for a larger health care workforce. These include:[6]

- Shortage of health care professionals being educated, trained and licensed;
- Lack of specialists and health facilities in rural areas;
- Adverse events, injuries and illness at hospitals and physician's offices; and
- Need to improve community and population health.

Florida is not immune to the national problem and also has a health care provider shortage itself. Florida has 735 HPSAs just for primary care, dental care, and mental health.[7] It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.[8]

Health Care Workforce Data

Physician Workforce

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 46,900 and 121,900 across all specialties by 2032.[9] In 2018, there were 277.8 physicians[10] actively practicing per 100,000 population in the U.S., ranging from a

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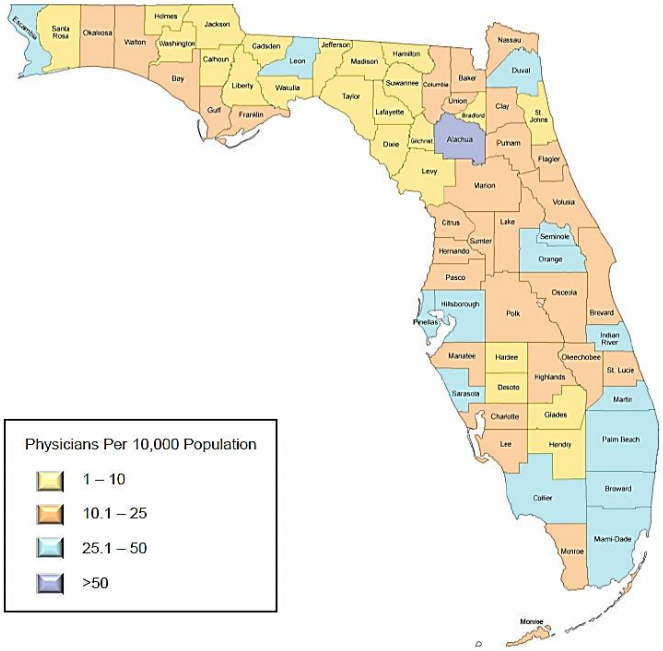
[1] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Sept. 30, 2019), available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited November 15, 2019). Click on "Designated HPSA Quarterly Summary" to access the report.
[2] Id.
[3] There will be an increase in the U.S. population, estimated to grow from just over 323 million in 2016 to approximately 355 million in 2030, eventually reaching just under 405 million in 2060. *See* U.S. Census Bureau, *2017 National Populations Projections Tables* available at https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf (last visited November 15, 2019). Click on "Table 1. Projected population size and births, deaths, and migration."
[4] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, (April 2019), available at https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf (last visited November 15, 2019).
[5] Id.
[6] Matthew A. Hein, *Telemedicine: An Important Force in the Transformation of Healthcare,* (June 25, 2009), available at https://2016.trade.gov/td/health/telemedicine_2009.pdf (last visited on November 15, 2019).
[7] *Supra* note 1.
[8] Id.
[9] *Supra* note 4.
[10] These totals include allopathic and osteopathic physicians.

high of 449.5 in Massachusetts to a low of 191.3 in Mississippi.[11] The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states. Regarding primary care physicians, there were 92.5 per 100,000 population.[12]

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.[13] Although Florida is the third most populous state in the nation,[14] it ranks as having the 23rd highest physician to population ratio.[15] In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population, ranking Florida 31st compared to other states.[16]

In its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.[17] Additionally, 35 percent of practicing physicians are age 60 and older.[18]

The following map[19] illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.



The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.[20] Currently, primary care physicians make up 28 percent of the physician workforce.[21] In 2018, 26 percent of new medical school graduates entered the workforce as primary care providers,

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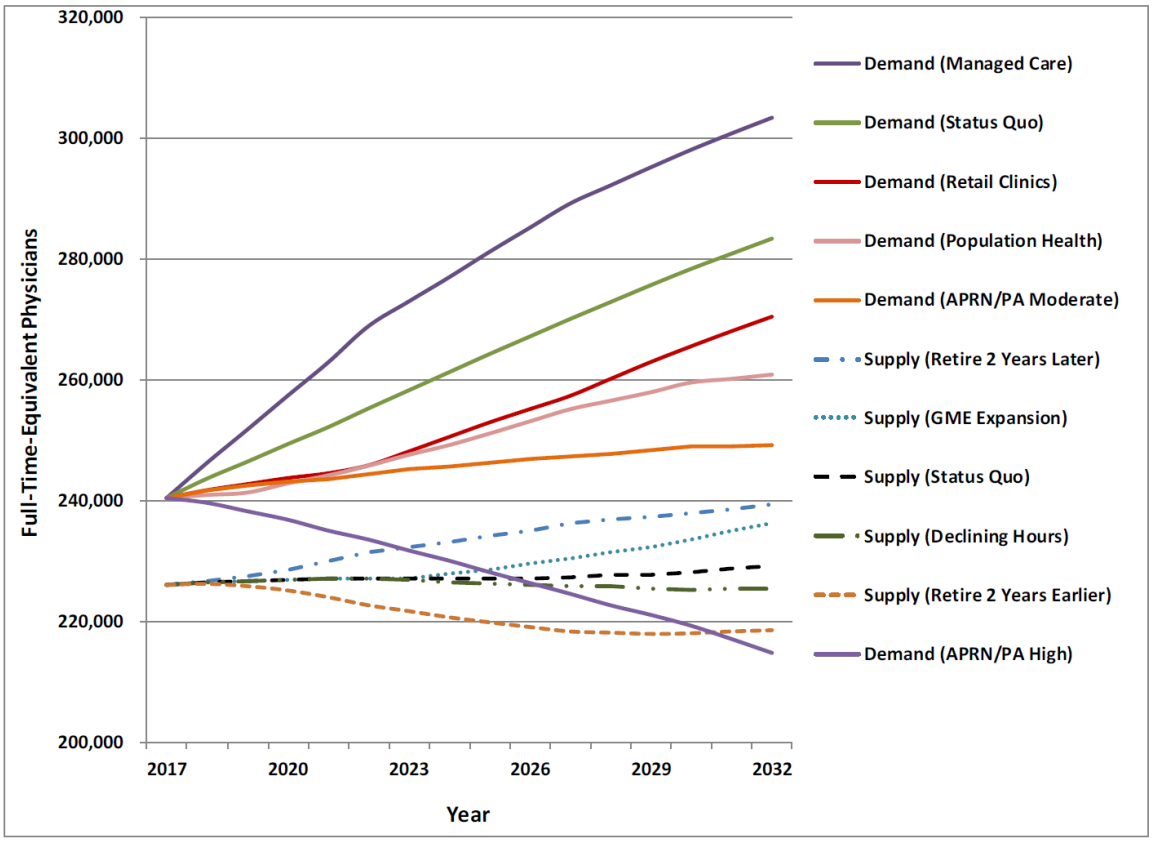
[11] Association of American Medical Colleges, *2019 State Physician Workforce Data Book,* November 2019, pg. 5, available at https://store.aamc.org/2019-state-physician-workforce-data-report.html (last visited on November 18, 2019). The book must be downloaded to view its contents.
[12] Id.
[13] *Supra* note 11, at pp. 7-8
[14] As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 20,984,400 residents, behind California (39,536,653) and Texas (28,304,596). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2017: 2017 Population Estimates*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on November 18, 2019).
[15] *Supra* note 11, at pp. 7-8.
[16] *Supra* note 11, at pp. 12-13.
[17] Florida Department of Health, "2019 Physician Workforce Annual Report," (November 2019), available at: http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2019DOHPhysicianWorkforceReport-10-30-19.pdf (last visited on November 18, 2019).
[18] Id. at p. 9.
[19] Id. at p. 42.
[20] *Supra* note 4. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.
[21] Id. at p. 45.

and this rate will maintain the status quo of the supply of primary care physicians.[22] However, in almost any scenario, the projected supply and demand for primary care physicians demonstrate that demand will exceed supply except the scenario that reflects the highest use of APRNs and PAs.[23]

The table below compares the effects of a moderate increase in the use of APRNs and PAs, greater use of alternate settings such as retail clinics, delayed physician retirement, expansion in graduate medical education, and changes in payment and delivery system, on the supply and demand for primary care physicians.[24]

Exhibit 3: Projected Supply and Demand for Primary Care Physicians, 2017-2032



In Florida, more than a third of the practicing physicians are primary care physicians (34.9 percent).[25] Of these, 14.2 percent of family medicine physicians and 11.0 percent of general internal medicine physicians have expressed an intention to retire in the next five years and approximately 4.5 percent and 4.4 percent, respectively, have expressed an intention to relocate out of the state in the next five years.[26]

Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNPs), 45,000 certified registered nurse anesthetists (CRNAs), 6,500 certified nurse midwives (CNMs), and 3,059,800 registered nurses (RNs) employed in the U.S.[27] There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.[28]

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[22] Id. at p. 46.
[23] Id at p. 18.
[24] Id.
[25] *Supra* note 17 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.
[26] Id at p. 25.
[27] U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," *available at*: http://data.bls.gov/projections/occupationProj (last visited on November 18, 2019).
[28] These ratios were calculated using the U.S. Census Bureau's total population estimate for 2018, which was 327,167,434, which is available at:

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.[29] There are also 309,761 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 156 APRNs and 1,469 RNs.[30] The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs who are actually working is 22,795,[31] and the number of RNs who are actually working is 208,870.[32] Using these numbers the figures are: 108 APRNs and 990 RNs per 100,000 population.

The Center also reports that approximately 45 percent of Florida's RNs[33] and 39 percent of the state's APRNs[34] are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[35]

Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),[36] which means there are approximately 46 PAs per 100,000 Florida population. Approximately 21 percent of certified PAs in Florida are practicing in primary care, which includes family medicine, general internal medicine, and general pediatrics.[37] On average, a full-time PA sees 73 patients a week.[38]

Advanced Practice Nurses

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)[39] is licensed in one of four roles: a certified nurse practitioner (CNP), certified nurse midwife (CNM), clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA).[40] As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.[41]

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http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on November 18, 2019) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.

[29] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan, Fiscal Year 2018-2019*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited November 18, 2019).

[30] These ratios were calculated using population estimates as of April 1, 2019 provided by the Florida Office of Economic & Demographic Research, which is 21,091,609, and available at: http://edr.state.fl.us/Content/population-demographics/data/2019_Pop_Estimates.pdf (last visited November 18, 2019).

[31] Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Advanced Registered Nurse Practitioners*, (June 2018), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1611&PortalId=0&TabId=151 (last visited on November 18, 2019).

[32] Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Registered Nurses*, (June 2018), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1608&PortalId=0&TabId=151 (last visited on November 18, 2019).)

[33] *Supra* note 32. Of working RNs in this state, 25.4 percent are 51 to 60 years old and 20.1 percent are 61 or older.

[34] *Supra* note 31. Of working APRNs in this state, 22.6 percent are 51 to 60 years old and 16.7 percent are 61 or older.

[35] Florida Center for Nursing, Presentation on Florida's Nurse Workforce, January 23, 2019, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting Packets&FileName=hqs 1-23-19.pdf (last visited on November 20, 2019).

[36] *Supra* note 29.

[37] National Commission on Certification of Physician Assistants, *2018 Statistical Profile of Certified Physician Assistants by State: An Annual Report of the National Commission on Certification of Physician Assistants*, (Jan. 2019), available at https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPhysicianAssistants.pdf (last visited March 12, 2019). Please note that PAs must pass the initial certification examination to qualify for licensure in Florida; however, certification is not an ongoing requirement for licensure.

[38] Id at p. 16.

[39] Section 464.003(3), F.S.

[40] Section 464.012(4), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from "Advanced Registered Nurse Practitioner (APRN)" to "Advanced Practice Registered Nurse (APRN)," and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (*see* ch. 2018-106, Laws of Fla.). DOH is still in the process of effectuating this transition.

[41] Email correspondence from DOH dated November 25, 2019, on file with committee staff.

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), established under s. 464.004, F.S., provides by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices. Additionally, the Board is responsible for administratively disciplining an APRN who commits an act prohibited under ss. 464.018 or 456.072, F.S.

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[42] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[43]

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[44] A nursing specialty board must:[45]

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal. The APRN must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the APRN as beneficiary.[46] By comparison, physicians must establish some method of financial responsibility with the same coverage amounts and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement but must notify patients that they have chosen not to carry malpractice insurance.[47]

Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.[48]

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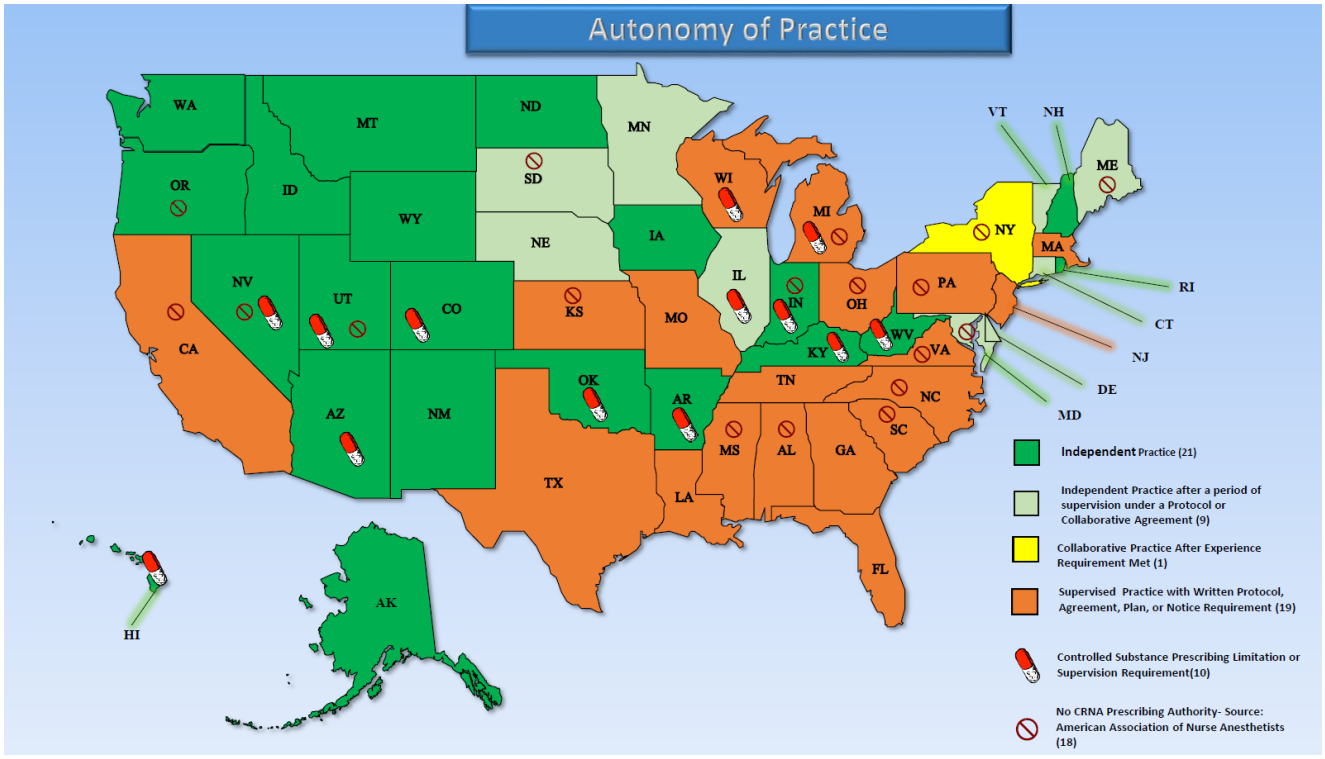
[42] Section 464.012(3)-(4), F.S.
[43] Section 464.003, F.S., and s. 464.012, F.S.
[44] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[45] Rule 64B9-4.002(3), F.A.C.
[46] Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09, "Financial Responsibility," is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.
[47] If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.
[48] Chapter 2016-224, Laws of Fla.

APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:[49]

1. Independent nursing practice;
2. Transitory period in which an APRN is supervised by a physician or independent APRN prior to authority to engage in independent nursing practice;
3. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or
4. Supervised nursing practice or prescribing that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.



APRN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which permits APRN full practice authority.[50] Under the rule, an APRN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APRN is subject to state law with regard to the prescribing or administration of controlled substances. The rule is limited to CNPs, CNMs, and CNSs, and does not apply to CRNAs. In Florida, 59 VA medical centers and health care clinics are affected by this policy change.[51]

[49] Findings based on research conducted by professional staff of the Health and Human Services Committee.
[50] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Grants Full Practice Authority to Advanced Practice Registered Nurses," (December 14, 2016), available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847 (last visited November 20, 2019). The final rule can be found at https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf (last visited on November 20, 2019).
[51] U.S. Department of Veterans Affairs, Veterans Health Administration, "Locations: Florida," available at: http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1 (last visited November 20, 2019).

APRN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APRNs may perform only those nursing and medical practices delineated in a written physician protocol. A physician providing primary health care services may supervise APRNs in up to four medical offices,[52] in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.[53] Furthermore, a special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.[54]

Scope of Practice

State laws vary as to the scope within which an APRN may practice, which is often determined by whether the APRN is a CNP, CNM, CNS, or CRNA, and often relates to the authority to prescribe drugs and sign documents.

Twenty of the 30 independent practice states authorize an APRN to prescribe controlled substances to a patient without physician supervision. Several independent practice states, such as Arkansas, Kentucky, Michigan, Oklahoma, and Wisconsin, require APRNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.[55] In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017. [56] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[57] as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.[58] The map on p. 7 illustrates the varying controlled substance prescribing requirements throughout the U.S.

Thirty-eight states explicitly recognize APRNs as "primary care providers" in policy.[59] Recognizing APRNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.[60] Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

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[52] The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.
[53] Sections 458.348, and 459.025, F.S.
[54] *Id*.
[55] *Supra* note 49. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.
[56] Chapter 2016-224, Laws of Fla.
[57] Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.
[58] *Supra* note 49.
[59] Scope of Practice Policy, *Nurse Practitioners: Nurse Practitioner as Primary Care Provider*, available at http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/ (last visited November 20, 2019). APRNs may practice as a primary care provider in states that do not specifically recognize them as such.
[60] National Nursing Centers Consortium, "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," *Policy, Politics & Nursing Practice, 7*(3), 216-226, August 2006, *available at*: http://journals.sagepub.com/doi/pdf/10.1177/1527154406294339 (last visited on December 12, 2018).

APRN Scope of Practice in Florida

Within the framework of the written protocol, an APRN may:

- Prescribe, dispense, administer, or order any drug;[61];
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and
- Perform certain acts within his or her specialty.[62]

APRNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APRNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.[63]

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APRNs provide a different quality of care than physicians,[64] a multitude of reports and studies suggest treatment by an APRN is just as safe as treatment by a physician. In 2018, the Cochrane Collaboration updated a review of the findings of 25 articles comparing physician and APRN patient outcomes, which was first published in 2009. The review found that, in general, compared to primary care physicians, APRNS:[65]

- Probably provide equal or possibly even better quality of care compared to primary care physicians;
- Probably achieve equal or better health outcomes for patients;
- Probably achieve higher levels of patient satisfaction;
- Had longer consultation lengths and higher return visits; and
- Had comparable resource utilization outcomes.

The study was unable to ascertain the effects of nurse-led care on the costs of care.

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.[66]

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[61] Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.
[62] Sections 464.012(3),(4), and 464.003, F.S.
[63] Sections 394.463(2) and 382.008, F.S.
[64] When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D.,"Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. Engl. J. Med. 2013, 368:1898-1906, available at http://www.nejm.org/doi/full/10.1056/NEJMsa1212938 (last visited on November 20, 2019).
[65] Laurant, M., et al., The Cochrane Collaboration, "Nurses as Substitute for Doctors in Primary Care," July 16, 2018, available at https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001271.pub3/full (last visited on November 20, 2019).
[66] National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available *at* http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf (last visited on November 20, 2019).

A 2013 study, found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.[67]

Cost Savings

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.[68]

A 2012 Texas analysis of APRN practice concluded that more efficient use of APRNs in the provision of patient care, especially primary care, would improve patient outcomes, reduce overall health care costs, and increase access to health care.[69] The report estimated savings of $16.1 billion in total expenditures and $8 billion in output (gross product) each year.[70] Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to $483.9 million to the state and $233.2 million to local government entities each year.[71]

Another study found that states that allow APRNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use.[72] The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).[73]

Finally, a study found that individuals treated by primary care APRNs who were dually-eligible for Medicaid and Medicare had a lower risk of preventable hospitalizations and emergency department use than those cared for by primary care physicians.[74] The study also found that primary care APRNs treating those with chronic illnesses received the same health care services consistent with established guidelines as those treated by primary care physicians.[75]

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.[76] The FTC finds scope of practice restrictions anti-competitive, reduce competitive market pressures, increase out-of-pocket prices, limit service hours, and reduce the distribution of services.[77] The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.[78]

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[67] Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, *available at* http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf (last visited on November 20, 2019).
[68] The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at http://c.ymcdn.com/sites/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Ultilization%20Economic%20Impact%20Report%20May%202012.pdf (last visited on November 20, 2019).
[69] Id.
[70] Id.
[71] Id.
[72] *Supra* note 67.
[73] Id.
[74] Peter Buerhaus, American Enterprise Institute, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, (Sept. 2018), available at https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/ (last visited November 20, 2019).
[75] Id.
[76] Federal Trade Commission, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, (Mar. 2014), available at https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (last visited November 20, 2019).
[77] Id.
[78] Id.

Physician Assistants

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

Council on Physician Assistants

The Council consists of five members including three physicians who are members of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and one licensed PA appointed by the Surgeon General.[79] Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:[80]

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

Licensure and Regulation of PAs

An applicant for a PA license must apply to DOH, and DOH must issue a license to a person certified by the Council as having met all of the following requirements:[81]

- Completed an approved PA training program;
- Obtained a passing score on the National Commission on Certification of Physician Assistants exam;
- Acknowledged any prior felony convictions;
- Submitted to a background screening and have no disqualifying offenses;[82]
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.[83] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.[84]

PA Education

PA education programs are typically three years and award master's degrees.[85] Many programs require students to have health care experience as a condition for admission.[86] PA students receive classroom training in:[87]

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[79] Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307 and 459.004, F.S., respectively.
[80] Id,
[81] Sections 458.347(7) and 459.022(7), F.S.
[82] Section 456.0135, F.S.
[83] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[84] National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at https://www.nccpa.net/CertificationProcess (last visited November 20, 2019).
[85] American Academy of PAs, *Become a PA*, available at https://www.aapa.org/career-central/become-a-pa/ (last visited November 20, 2019).
[86] Id.
[87] Id.

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

A PA student must also complete approximately 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities.[88] A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.[89]

PA Scope of Practice

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[90] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[91] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.[92]

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

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[93]

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[94] A supervising physician may delegate the authority for a PA to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the Council;[95]

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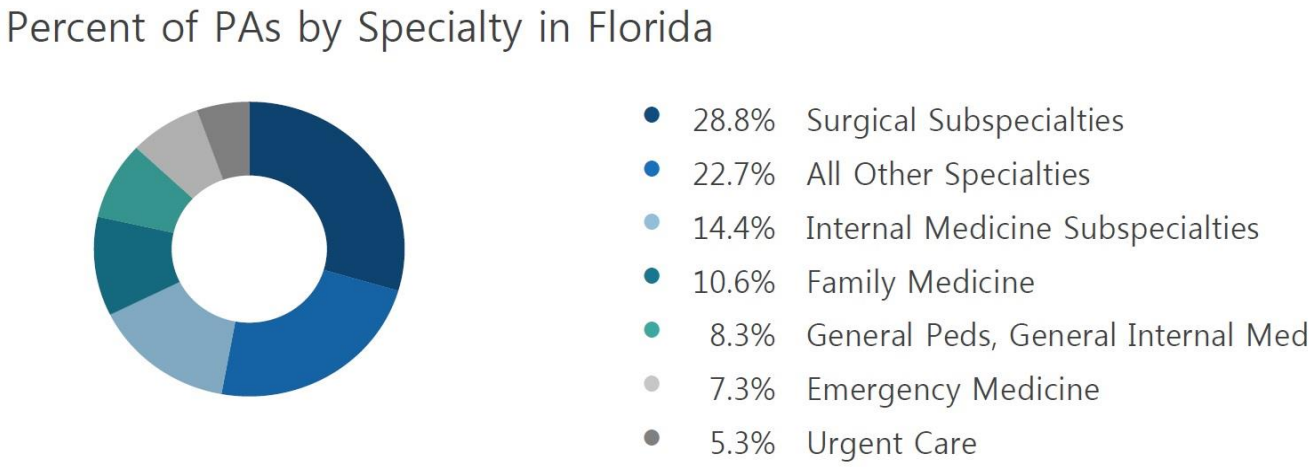
[88] Id.
[89] Id.
[90] Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[91] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[92] Sections 458.347(15) and 459.022(15), F.S.
[93] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[94] "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *Supra* note 93.
[95] Sections 458.347(4)(f), F.S., and 459.022(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing; general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a 7-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.

- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of chapter 400, F.S.;[96] and
- Perform any other service that are is not expressly prohibited in ch. 458, F.S., ch. 459, F.S., or the rules adopted thereunder.[97]

PA Practice Characteristics

In the United States, approximately 26 percent of PAs work in primary care, which includes family medicine, general internal medicine, and general pediatrics.[98] Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:[99]



Adverse Incident Reporting

A PA must report to DOH, any adverse incident occurring in an office practice setting within 15 days after the occurrence of the adverse incident.[100] DOH must review each report to determine if discipline against the PA's license is warranted.[101]

An adverse incident in an office setting is defined as an event over which the PA could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:[102]

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
    - A wrong-site surgical procedure;
    - A wrong surgical procedure; or

[96] Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.
[97] Sections 458.347(4) and 459.022(e), F.S.
[98] *Supra* note 37.
[99] American Academy of PAs, *Florida Practice Profile*, available at https://www.aapa.org/wp-content/uploads/2016/12/PAs_In_Florida.pdf (last visited March 14, 2019).
[100] Sections 458.351 and 459.026, F.S.
[101] Sections 458.351(5) and 459.026(5), F.S.
[102] Sections 458.351(4) and 459.026(4), F.S.

    - A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any condition that required the transfer of a patient to a hospital from an ambulatory surgical center or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

Reports and Studies Related to Physician Assistants

Several studies have shown that PAs provide care that is comparable to physicians. One study examined more than 23,000 patient visits to more than 1,100 practitioners to determine the quality of care provided by APRNs, PAs, and physicians.[103] The study found that there was no statistically significant differences in the care provided by APRNs and PAs and that provided by primary care physicians.[104] Additionally, the study noted that PAs provided more health education services than primary care physicians.[105]

Another study assessed the care PAs, APRNs, and primary care physicians provided to diabetic patients within the VA health care system. This study suggests that there are similar chronic illness outcomes for physicians, APRNs, and PAs.[106]

Effect of Proposed Changes

Autonomous Practice

Registration Requirements

The bill authorizes an APRN who meets certain eligibility criteria to register with the Board of Nursing to engage in autonomous practice and perform acts of advanced or specialized nursing practice without a supervisory protocol or supervision by a physician. The bill also authorizes a PA who meets certain eligibility to register with the Board of Medicine or the Board of Osteopathic Medicine to practice primary care as an autonomous PA without supervision by a physician.

To register to engage in autonomous practice, an APRN or PA must hold an active and unencumbered Florida license and must have:

- Completed, in any U.S. jurisdiction, at least 2,000 clinical instructional hours or clinical practice hours supervised by an actively licensed physician within the 5-year period for APRNs or 3-year period for PAs immediately preceding the registration request;
- Not been subject to any disciplinary action during the five years immediately preceding the application;
- Completed a graduate level course in pharmacology; and
- Any other appropriate requirement adopted by rule by the respective boards.

The bill also requires APRNs and PAs (jointly referred to as practitioners) who practice autonomously to obtain and maintain liability coverage at least $100,000 per claim with a minimum annual aggregate of at least $300,000. However, this requirement does not apply to practitioners who:

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[103] Kurtzman, Ellen T. PhD, MPH, RN, FAAN and Barnow, Burt S. PhD., "A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers," 55 Medical Care 6: 615 (June 2017), *abstract* available at https://journals.lww.com/lww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners,_Physician.11.aspx (last visited November 20, 2019).
[104] Id.
[105] Id.
[106] Jackson, G., et. al., "Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study," Annals of Internal Medicine 169:825–835 (Nov. 2018), *abstract* available at https://annals.org/aim/article-abstract/2716077/intermediate-diabetes-outcomes-patients-managed-physicians-nurse-practitioners-physician-assistants (last visited November 20, 2019).

- Practices exclusively as an officer, employee, or agent of the federal government or of the state or its agencies or subdivisions;
- Is not practicing in this state and whose license is inactive;
- Practices only in conjunction with teaching duties at an accredited school or its main teaching hospitals; and
- Not practicing in this state but holds an active license to practice. Such practitioners must notify DOH if they initiate or resume autonomous practice in this state.

The registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN or PA license. To maintain registration, an APRN must complete at least 10 hours of continuing education approved by the Board in pharmacology for each biennial renewal.[107] An autonomous PA does not have to complete any additional continuing medical education hours above the 100 hours required for PA licensure renewal.

The bill directs DOH to create practitioner profiles for autonomous PAs, which conspicuously informs the public of the autonomous PA's registration. The bill also requires that DOH conspicuously distinguishes the practitioner profiles of APRNs registered to engage in autonomous practice.

Scope of Practice

Pursuant to the bill, an APRN registered to engage in autonomous practice is authorized to perform any advanced or specialized nursing act currently authorized for an APRN, without the supervision of a physician or a written protocol. In addition to those acts, the registered APRN may autonomously and without supervision or a written protocol perform the following acts:

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or rule.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- Certify causes of death and sign, correct, and file death certificates.
- Act as a patient's primary care provider.
- Execute a certificate to subject a person to involuntary examination under the Baker Act.
- Examine, and approve the release of, a person admitted into a receiving facility under the Baker Act, if the APRN holds a national certification as a psychiatric-mental health advanced practice nurse.
- Perform certain physical examinations currently reserved to physicians and physician assistants by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims.
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

The bill reestablishes the advisory committee that was abolished in 2016, to make evidence-based recommendations about medical acts an APRN who is practicing autonomously may perform. The 7-member joint committee is to be composed of four APRNs appointed by the Board of Nursing, two physicians recommended by the Board of Medicine, and the State Surgeon General or his or her designee. The bill requires the Board of Nursing to act on any recommendation of the committee within 90 days of submission. The Board may choose to adopt a recommendation, reject a recommendation, or otherwise act on it as the Board deems appropriate. Under current law, APRNs may perform medical acts as authorized within the framework of a physician protocol. The list may provide autonomous APRNs the authority to perform certain medical acts that they are currently performing under protocols.

The bill authorizes an autonomous PA to:

- Only render primary care services as defined by the applicable board rule;

[107] The bill provides an exception to the 10 hours of continuing education in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

- Render services consistent with the scope of his or her education and experience and provided in accordance with rules adopted by the applicable board;
- Prescribe, dispense, administer, or order any medicinal drug to the extent authorized under a formulary adopted by the Council;
- Order any medication for administration to a patient in a facility licensed under ch. 395, F.S., or part II of ch. 400, F.S.;[108]
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.

The bill requires the Council to develop rules defining the primary specialties in which an autonomous PA may practice. Such specialties may include internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology.

The bill also authorizes autonomous PAs to participate in the Public School Volunteer Health Care Practitioner Program. This program allows any participating health care practitioner who agrees to provide his or her services, without compensation, in a public school for at least 80 hours a year for each school year during the biennial licensure period to be eligible for waiver of the biennial license renewal fee for an active license and fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9), F.S.

The bill also requires autonomous PAs to comply with the Florida Patient's Bill of Rights and Responsibilities Act.

Accountability Measures

The bill imposes safeguards to ensure APRNs registered to engage in autonomous practice do so safely, similar to those for physicians.[109] The bill defines an adverse incident as an event over which the APRN could exercise control and which is associated with a medical or nursing intervention, including the prescribing of controlled substances, rather than a condition for which such intervention occurred, which results in at least one of the following:

- A condition that requires the transfer to a hospital;
- Permanent physical injury to the patient; or
- Death of the patient.

If such an event occurs, the APRN must report the adverse incident to DOH, in writing, within 15 days of its occurrence or discovery of its occurrence, consistent with the requirements for doctors. DOH must review the adverse incident to determine if the APRN committed any act that would make the APRN subject to disciplinary action.

PAs are subject to the existing adverse incident requirements for physicians.

In addition, the bill requires several other accountability measures for APRNs registered to engage in autonomous practice. The bill authorizes the Board to administratively discipline and APRN for several delineated prohibited acts related to relationships with patients, business practices, and nursing practices:

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a slit-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;

[108] This includes ambulatory surgical centers, hospitals, and nursing homes.
[109] *See* ss. 458.351 and 459.026, F.S.

- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Performing professional services that have not been authorized by the patient or his or her representative except as provided by the Medical Consent Law[110] and the Good Samaritan Act;[111]
- Performing any procedure or prescribing any medicinal drug that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

PAs are subject to the same discipline as physicians as it relates to relationships with patients, business practices, and medical practices.

General APRN Provisions

The bill requires APRNs to apply to the Board for licensure, rather than DOH, to reflect current practice. The bill also authorizes APRNs to sign, certify, stamp, verify, or endorse any document that requires the signature, certification, stamp, verification, or endorsement of a physician.

General PA Provisions

The bill also revises the composition of the Council so that it has a PA majority. Under the bill, the Council is composed of one physician who is a member of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and three licensed PAs appointed by the Surgeon General. The physician members must supervise PAs in their practices.

The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill removes a requirement that a PA must notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill expands the scope of practice for PAs to authorize them to:

- Certify a person for involuntary examination under the Baker Act;
- File death certificates and certify a cause of death; and
- Examine and provide a report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

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

B. SECTION DIRECTORY:

Section 1: Amends s. 456.0391, F.S., relating to advanced practice registered nurses; information required for licensure.

[110] Section 766.103, F.S.
[111] Section 768.13, F.S.

Section 2: Amends s. 456.041, F.S., relating to practitioner profile; creation.
Section 3: Amends s. 458.347, F.S., relating to physician assistants.
Section 4: Amends s. 459.022, F.S., relating to physician assistants.
Section 5: Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners; fees; and controlled substance prescribing.
Section 6: Creates s. 464.0123, F.S., autonomous practice by an advanced practice registered nurse.
Section 7: Creates s. 464.0155, F.S., relating to reports of adverse incidents by advanced practice registered nurses.
Section 8: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 9: Amends s. 39.01, F.S., relating to definitions.
Section 10: Amends s. 39.303, F.S., relating to child protection teams and sexual abuse treatment programs; services; eligible cases.
Section 11: Amends s. 39.304, F.S., relating to photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.
Section 12: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 13: Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Ac; immunity from civil liability.
Section 14: Amends s. 310.071, F.S., relating to deputy pilot certification.
Section 15: Amends s. 310.073, F.S., relating to state pilot licensing.
Section 16: Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots; vacancies.
Section 17: Amends s. 320.0848, F.S., relating to persons who have disabilities, issuance of disabled parking permits, temporary permits, and permits for certain providers of transportation services to persons who have disabilities.
Section 18: Amends s. 381.00315, F.S., relating to public health advisories, public health emergencies; isolation and quarantines.
Section 19: Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.
Section 20: Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
Section 21: Amends s. 382.008, F.S., relating to death, fetal death, and nonviable birth registration.
Section 22: Amends s. 382.011, F.S., relating to medical examiner determination of cause of death.
Section 23: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 24: Amends s. 390.0111, F.S., relating to termination of pregnancies.
Section 25: Amends s. 390.012, F.S., relating to powers of agency; rules; and disposal of fetal remains.
Section 26: Amends s. 394.463, F.S., relating to involuntary examination.
Section 27: Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
Section 28: Amends s. 395.602, F.S., relating to rural hospitals.
Section 29: Amends s. 397.501, F.S., relating to rights of individuals.
Section 30: Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
Section 31: Amends s. 397.6793, F.S., relating to professional's certificate for emergency admission.
Section 32: Amends s. 400.021, F.S., relating to definitions.
Section 33: Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
Section 34: Amends s. 400.487, F.S., relating to home health service agreements; physician's, physician assistants, and advanced registered nurse practitioner's treatment orders; patient assessment; establishment and review of plan of care; provision of services, and orders not to resuscitate.
Section 35: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; and penalties.
Section 36: Amends s. 400.9973, F.S., relating to client admission, transfer, and discharge.
Section 37: Amends s. 400.9974, F.S., relating to client comprehensive treatment plans; client services.
Section 38: Amends s. 400.9976, F.S., relating to administration of medication.
Section 39: Amends s. 400.9979, F.S., relating to restraint and seclusion; client safety.

Section 40: Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
Section 41: Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 42: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 43: Amends s. 409.973, F.S., relating to benefits.
Section 44: Amends s. 429.26, F.S., relating to appropriateness of placements and examinations of residents.
Section 45: Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
Section 46: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 47: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 48: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; and enforcement.
Section 49: Amends s. 456.44, F.S., relating to controlled substance prescribing.
Section 50: Amends s. 458.3265, F.S., relating to pain-management clinics.
Section 51: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 52: Amends s. 459.0137, F.S., relating to pain-management clinics.
Section 53: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 54: Amends s. 464.003, F.S., relating to definitions.
Section 55: Amends s. 464.0205, relating to retired volunteer nurse certificate.
Section 56: Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
Section 57: Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
Section 58: Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
Section 59: Amends s. 627.357, F.S., relating to medical malpractice self-insurance.
Section 60: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.
Section 61: Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
Section 62: Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 63: Amends s. 744.2006, F.S., relating to Office of Public and Professional Guardians; appointment, notification.
Section 64: Amends s. 744.331, F.S., relating to procedures to determine incapacity.
Section 65: Amends s. 744.3675, F.S., relating to the annual guardianship plan.
Section 66: Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
Section 67: Amends s. 766.105, F.S., relating to Florida Patient's Compensation Fund.
Section 68: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 69: Amends s. 766.1116, F.S., relating to health care practitioner; waiver of license renewal fees and continuing education requirements.
Section 70: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 71: Amends s. 768.135, F.S., relating to volunteer team physicians; immunity.
Section 72: Amends s. 794.08, F.S., relating to female genital mutilation.
Section 73: Amends s. 893.02, F.S., relating to definitions.
Section 74: Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
Section 75: Amends s. 945.603, F.S., relating to powers and duties of authority.
Section 76: Amends s. 948.03, F.S., relating to terms and conditions of probation.
Section 77: Amends s. 984.03, F.S., relating to definitions.
Section 78: Amends s. 985.03, F.S., relating to definitions.
Section 79: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 80: Amends s. 1002.42, F.S., relating to private schools.
Section 81: Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.

Section 82: Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
Section 83: Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
Section 84: Provides an appropriation.
Section 85: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   HB 7017, linked to CS/HB 607, authorizes an initial registration fee of $100 for APRNs who choose to practice autonomously, and a biennial renewal fee of $50 to maintain such registration. The total revenue DOH will receive from such fees is indeterminate because the number of APRNs who will choose to register to engage in autonomous practice is not predictable.

2. Expenditures:

   DOH will incur costs associated with rulemaking to implement the bill's provisions, developing the registration application, and updating the LEIDS licensing system. Current resources are adequate to absorb these costs.

   DOH will incur costs associated with the regulation of PAs who practice autonomously. Current resources are adequate to absorb these costs.

   DOH will incur costs associated with the regulation of APRNs who practice autonomously. DOH estimates 3.5 FTE positions will be required to implement the provisions of the bill. The below table summarizes the various functions and costs associated with the regulation of autonomous APRNs under the bill:

Function	*FTE Request and Description*	*Salary Rate*	*Salary/Expenses/ HR Transfer*	*NR Expenses*	*Total For Function*
Processing	One regulatory specialist to analyze, approve or deny registration applications, and update practitioner profiles	39,934	46,331	4,429	50,760
Investigation and Prosecution	One attorney and 1.5 FTE investigative specialists to review complaints and determine if legally sufficient for investigation and prosecution	143,961	172,758	13,287	186,045
Total	**3.50**	**183,895**	**$ 219,089**	**$ 17,716**	**$ 236,805**

   The bill appropriates from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs: 3.5 full-time equivalent positions, 183,895 in associated salary rate, $219,089 in recurring funds, and $17,716 in nonrecurring funds.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

APRNs who register to practice independently must pay a registration fee, as well as a fee to renew their registration. HB 7017 authorizes the Board of Nursing to set the application and biennial renewal fees, up to $100 and $50, respectively. Such APRNs will also have to pay for the additional continuing education hours required by the bill.

APRNs and PAs who have paid physicians for supervision will achieve some cost-savings if they register to practice autonomously since supervision will no longer be needed.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

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

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On December 11, 2019, the Health Quality Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee substitute. The strike-all amendment:

- Authorized advanced practice registered nurses to practice autonomously without a physician protocol;
- Authorized autonomous physician assistants to practice primary care without physician supervision;
- Established the qualifications for a physician assistant or an advanced practice registered nurse to practice autonomously, including a requirement to maintain liability coverage;
- Required the Department of Health to publish online practitioner profiles for autonomous physician assistants;
- Deleted a requirement that a physician assistant notify a patient of his or her right to see a doctor prior to a physician assistant prescribing a medication;
- Required the Boards of Medicine and Osteopathic Medicine to approve physician assistant education programs;
- Revised the composition of the Council on Physician Assistants;
- Appropriated 3.5 full-time equivalent positions, $183,895 in associated salary rate, $219,089 in recurring funds, and $17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs and PAs;
- Authorized an autonomous physician assistant, a physician assistant, or an advanced practice registered nurse to examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and

- Made conforming changes throughout statute.

The analysis is drafted to the committee substitute as passed by the Health Quality Subcommittee.