HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: PCB SCHCWI 14-01 Advanced Practice Registered Nurses
SPONSOR(S): Select Committee on Health Care Workforce Innovation; Pigman
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Select Committee on Health Care Workforce Innovation	13 Y, 2 N	O'Callaghan	Calamas

SUMMARY ANALYSIS

Florida is the most restrictive practice state for advanced registered nurse practitioners (ARNPs) in the country. Florida's laws require ARNPs to practice under a supervising physician and only to the extent that a written protocol allows. Additionally, Florida is the only state that prohibits ARNPs from prescribing controlled substances. The proposed committee bill (PCB) amends laws governing ARNPs by:

- Changing the term "advanced registered nurse practitioner" to "advanced practice registered nurse" (APRN) throughout Florida Statutes, which aligns Florida with a majority of other states that use that title;
- Authorizing them to prescribe controlled substances if allowed under a written protocol signed by the supervising physician;
- Authorizing them certify a person to be involuntarily examined under the Baker Act; and
- Authorizing those who are nationally certified as psychiatric-mental health advanced practice nurses to examine persons admitted into receiving facilities under the Baker Act and approve their releases.

The PCB sets standards for controlled substance prescribing by APRNs, requiring them to:

- Be designated on their practitioner profile as a prescriber of controlled substances for the treatment of chronic nonmalignant pain and meet the same requirements provided for physicians under current law to be able to prescribe controlled substances for chronic nonmalignant pain.
- Comply with the prescribing and dispensing requirements and limitations under the Florida Comprehensive Drug Abuse Prevention and Control Act.
- Be subject to administrative disciplinary actions for committing certain prohibited acts related to prescribing, administering, and dispensing medicinal drugs, including controlled substances.

The PCB allows APRNs who meet certain criteria to register with the Board of Nursing (Board) to practice any authorized nursing act without physician supervision or a protocol. These "independent advanced practice registered nurses" (IAPRNs) are given title protection in the PCB. In addition to currently authorized APRN nursing acts, the PCB authorizes IAPRNs to:

- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be signed by a physician;
- Certify a cause of death and sign, correct, and file death certificates;
- 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; and
- Be reimbursed under personal injury protection insurance for initial and follow-up medical services, consistent with current law applicable to physicians.

IAPRNs may be administratively disciplined if they commit specified prohibited acts related to unethical and substandard business practices. The PCB also imposes additional requirements on IAPRNs for controlled substance prescribing. IAPRNs must complete 10 hours of continuing education related to pharmacology prior to biennial registration renewal and report controlled substance-related adverse incidents to the Board.

The fiscal impact of the PCB is indeterminate. The PCB provides an effective date of July 1, 2014.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Health Care Workforce Supply and Demand

Due to the aging and growth of the U.S. population and implementation of the Patient Protection and Affordable Care Act (PPACA), demand of the national health care workforce will outpace supply through 2025 and beyond.[1] Such demand will be magnified even further in Florida where there is a more abundant aging population, and consequently, both a disproportionately higher health care demand and a larger retiring health care workforce. Future shortages will likely result in longer wait times for medical appointments, increased travel distances to access care, shorter visit times with practitioners, and increased costs of care.[2]

Some states are acting to counter health care workforce shortages in their respective states. For example, New Mexico's Governor proposed on November 13, 2013, that the state streamline the requirements for nurses licensed in other states to become licensed in New Mexico and proposed that almost $220,000 in recurring marketing and advertising funds be used to recruit certified nurse practitioners to the state.[3] Other states have formed advisory councils and task forces to conduct workforce studies, have funded educational and training programs to recruit and retain health care workers, and have used resources to aggregate comprehensive workforce data to link workforce supply to demand.[4]

In 2008, the Robert Wood Johnson Foundation and the Institute of Medicine launched a two-year initiative to research and analyze the nursing profession and how it may be reformed in order to combat the current and projected workforce shortage. The effort resulted in a report, which included as its number one recommendation that scope of practice barriers should be removed for advanced practice nurses and they should be able to practice to the full extent of their education and training.[5]

Physician Workforce Data

The Association of American Medical Colleges Center for Workforce Studies estimates that, in 2015, the U.S. will face a physician shortage of 62,900 that will increase to 130,000 across all specialties by 2025.[6]

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[1] The Association of American Medical Colleges (AAMC), "The Complexities of Physician Supply and Demand: Projections Through 2025," available at: https://members.aamc.org/eweb/upload/The%20Complexities%20of%20Physician%20Supply.pdf (last visited on February 9, 2014). *See also*, American Association of Colleges of Nursing, "Nursing Shortage," available at: https://www.aacn.nche.edu/media-relations/fact-sheets/nursing-shortage (last visited on February 9, 2014).

[2] *Id.*, AAMC, "The Complexities of Physician Supply and Demand: Projections Through 2025," at pg. 7.

[3] State of New Mexico, Office of the Governor, Susana Martinez, Press Release, "Governor Susana Martinez Proposes Streamlining Licensure for Nurses Relocating to New Mexico," available at: http://www.governor.state.nm.us/uploads/PressRelease/191a415014634aa89604e0b4790e4768/Governor_Susana_Martinez_Proposes_Streamlining_Licensure_for_Nurses_Relocating_to_New_Mexico.pdf (last visited on February 12, 2014).

[4] Association of Academic Health Centers, "State Actions and the Health Workforce Crisis," available at: http://www.aahcdc.org/policy/reddot/AAHC_Workforce_State_Actions.pdf (last visited on February 12, 2014).

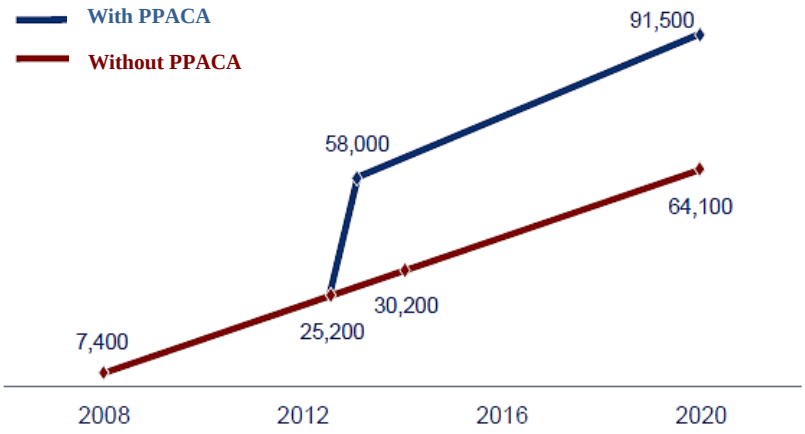
[5] Institute of Medicine of the National Academies, "The Future of Nursing: Leading Change, Advancing Health," "Report Recommendations," available at: http://www.iom.edu/~/media/Files/Report%20Files/2010/The-Future-of-Nursing/Future%20of%20Nursing%202010%20Recommendations.pdf (last visited on February 12, 2014).

[6] American Medical Association, "Reducing medical student debt strengthens the physician workforce," available at: http://www.ama-assn.org/resources/doc/mss/student-debt-mss-advocacy.pdf (last visited on February 14, 2014).

In 2012, there were 260.5 physicians[7] actively practicing per 100,000 population in the U.S., ranging from a high of 421.5 in Massachusetts to a low of 180.8 in Mississippi. The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states.[8] Regarding primary care physicians, there were 90.1 per 100,000 population.[9]

The following chart illustrates the projected physician shortage, nationally, with and without full implementation of the PPACA.

National projected physician shortages



Source: Kirch DG, Henderson MK, Dill MJ (2011). "Physician Workforce Projections in an Era of Health Care Reform." *Annual Review of Medicine.*

Florida had 252.9 actively practicing physicians per 100,000 population in 2012. Although Florida is the fourth most populous state in the nation,[10] it ranks as having the 23rd highest physician to population ratio.[11] In 2012, Florida had a ratio of 84.8 primary care physicians per 100,000 population, ranking Florida 30th compared to other states.[12]

In 2013, 13.2 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.[13] The following map[14] illustrates that not only does Florida have a shortage of physicians, but there is a maldistribution of physicians and they are generally concentrated in urban areas.

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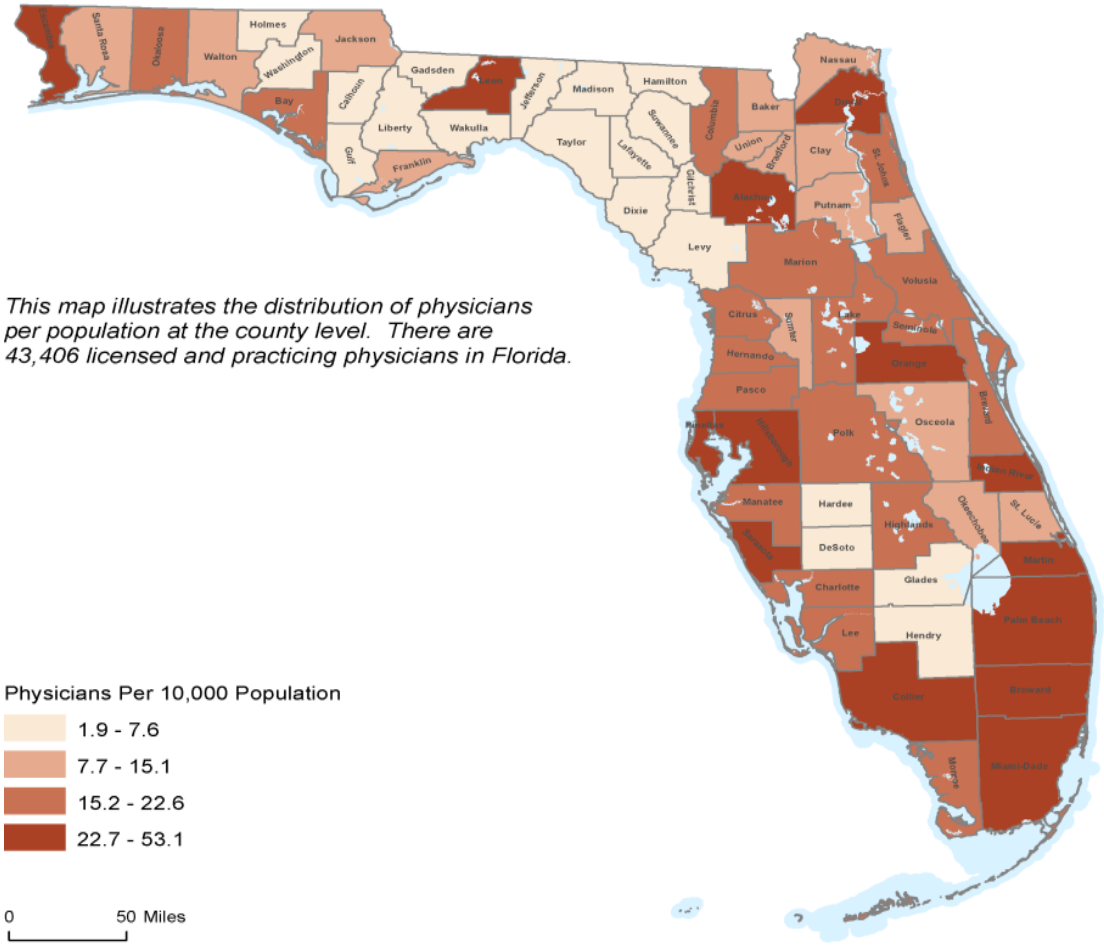
[7] These totals include allopathic and osteopathic doctors.
[8] AAMC, "2013 State Physician Workforce Data Book," November 2013, pg. 4, available at: https://www.aamc.org/download/362168/data/2013statephysicianworkforcedatabook.pdf (last visited on February 11, 2014).
[9] *Id*. at pg. 5.
[10] The U.S. Census Bureau estimated Florida to have 19,552,860 residents in 2013, behind California (38,332,521), Texas (26,448,193), and New York (19,651,127). U.S. Census Bureau, "Annual Estimates of the Resident Population: 2013 Population Estimates," available at: http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited on February 11, 2014).
[11] *Supra* fn. 8, at pg. 9.
[12] *Supra* fn. 8, at pg. 13.
[13] Florida Department of Health, "2013 Physician Workforce Annual Report," available at: http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/physicianworkforce13final.pdf (last visited on February 11, 2014).
[14] *Id*. at pg. 8.

Florida's Physician Workforce by County
2012-2013



As of November 2013, the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services designated approximately 5,800 locations in the U.S. as primary care Health Professional Shortage Areas (HPSAs).[15] Primary care HPSAs are based on a physician to population ratio of 1:3,500. In other words, when there are 3,500 or more people per primary care physician, an area is eligible to be designated as a primary care HPSA. Applying this formula, it would take approximately 7,500 additional primary care physicians to eliminate the current primary care HPSA designations, nationally.[16]

As of November 2014, there were 327 primary care HPSAs in Florida. Those HPSAs would need at least 890 primary care physicians to remove the HPSA designation.

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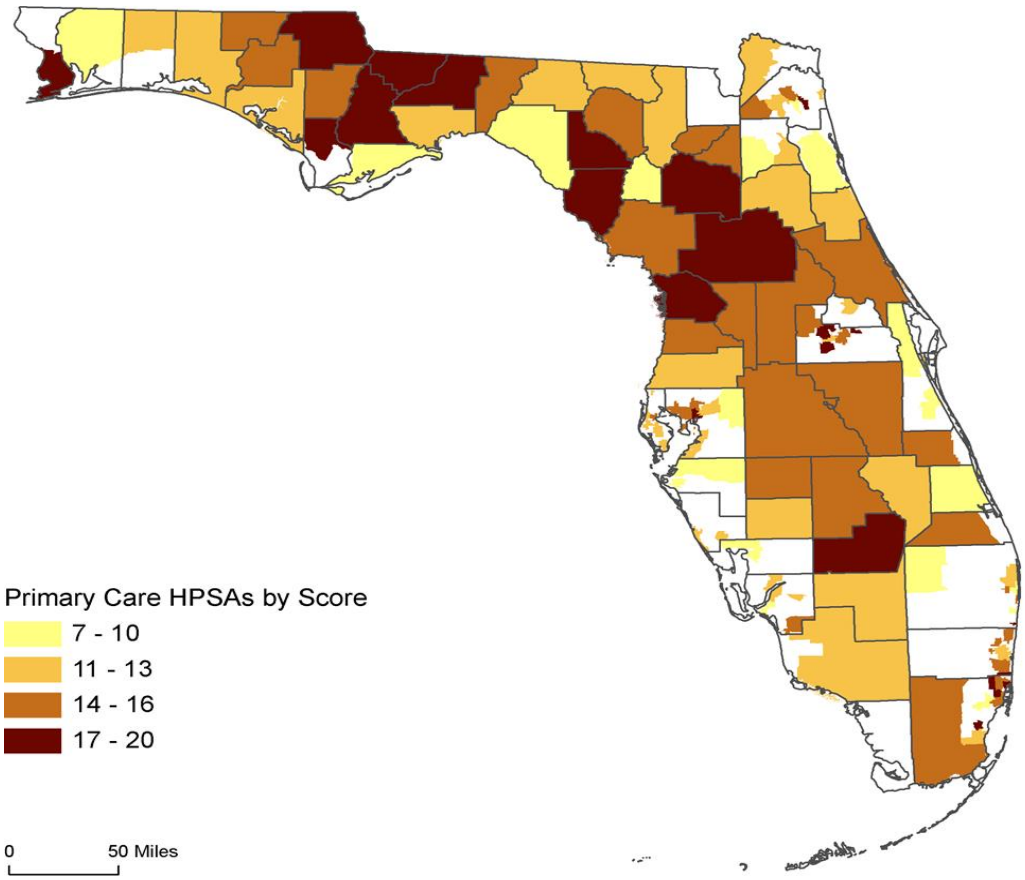
[15] U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations," available at: http://www.hrsa.gov/shortage/ (last visited on February 11, 2014).

[16] While the 1:3,500 ratio has been a long-standing ratio used to identify high need areas, it is important to note that there is no generally accepted ratio of physician to population ratio. Furthermore, primary care needs of an individual community will vary by a number of factors such as the age of the community's population. Additionally, the formula used to designate primary care HPSAs does not take into account the availability of additional primary care services provided by Nurse Practitioners and Physician Assistants in an area. U.S. Department of Health and Human Services, Health Resources and Services Administration, "Shortage Designation: Health Professional Shortage Areas & Medically Underserved Areas/Populations," available at: http://www.hrsa.gov/shortage/ (last visited on February 11, 2014).

Florida Primary Care Health Professional Shortage Areas



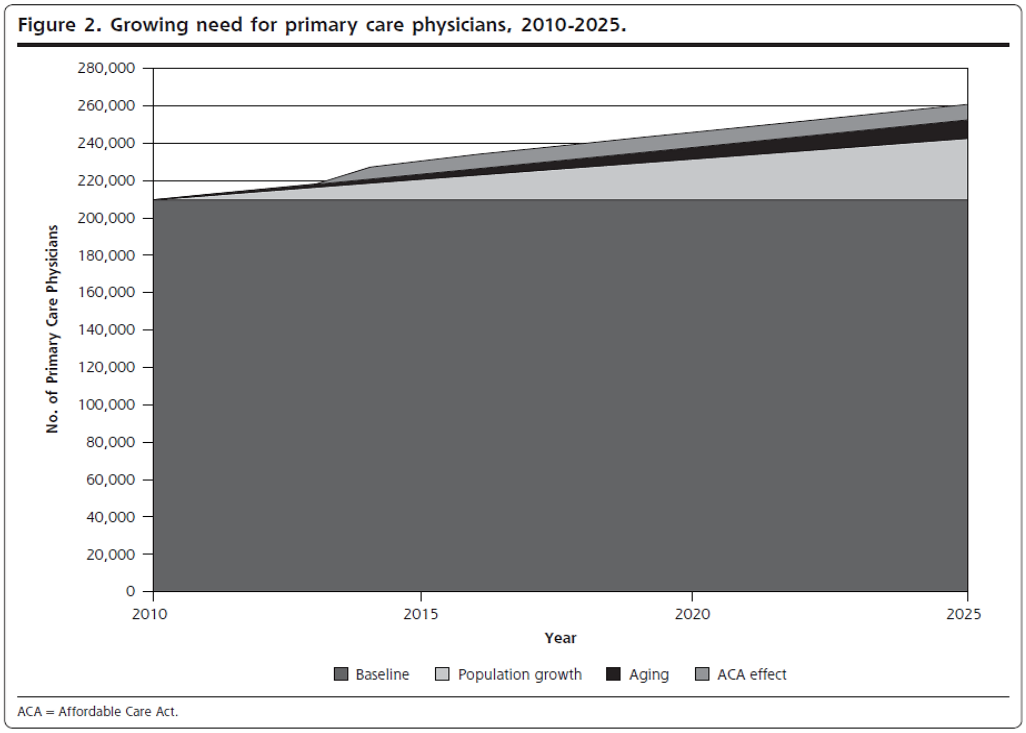
Source: Health Resources and Services Administration, October 2013.

In addition to Florida's primary care HPSAs, the state has 275 dental HPSAs and 306 mental health care HPSAs, which would require 870 dentists and 155 psychiatrists, respectively, to remove the HPSA designation.[17]

A different analysis measured current primary care utilization (office visits) and projected the impact of population increases, aging, and insured status changes. The study found that the total number of office visits to primary care physicians will increase from 462 million in 2008 to 565 million in 2025, and (because of aging) the average number of visits will increase from 1.60 to 1.66. The study concluded that the U.S. will require 51,880 *additional* primary care physicians by 2025.[18] The table below illustrates the study's findings.

[17] Florida Department of Health, Presentation on Health Care Workforce: Physician Workforce and Florida CHARTS Data, November 6, 2013, available at: http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2786&Session=2014&DocumentType=Meeting Packets&FileName=schcwi 11-6-13.pdf (last visited on February 11, 2014).

[18] Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", Annals of Family Medicine, vol. 10, No. 6, Nov./Dec. 2012, available at: http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on February 24, 2014).



One factor contributing to the shortage of primary care physicians is that medical students are choosing to go into specialty practice to pay off large student loans that they have accumulated.[19] Physicians in 12 specialties, such as radiology, psychiatry and anesthesiology, may earn up to twice the income (from $191,000 to >$400,000 per year) of primary care physicians (from $183,000 to $201,000 per year).[20] It is estimated that 86% of the medical school graduating class of 2013 will have education-related debt.[21] With an average medical student debt of $169,901, debt plays a major role in medical students' career decisions.[22]

The type of residencies that are available to medical school graduates also has a role in those career decisions. Data on residencies funded by Medicare (1998-2008) indicates program growth is predominantly in subspecialty training and non-primary-care core specialties.[23] For example, 133 internal medicine subspecialty programs opened in that time. Conversely, there was a net loss of 390 first-year family medicine resident positions. Similarly, 865 general internal medicine positions were lost, converted to preliminary year positions, or offset by opportunities to subspecialize. Primary care also lost 40 family medicine and 25 internal medicine programs during this time. The chart below indicates the change in the number of first-year residency programs by specialty in that time.[24]

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[19] A study conducted by the Robert Graham Center found that the income gap between primary care and subspecialists has an impressively negative impact on choice of primary care specialties and of practicing in rural or underserved settings. Robert Graham Center, "What Influences Medical Student & Resident Choices?", March 2, 2009, available at: http://www.graham-center.org/online/etc/medialib/graham/documents/publications/mongraphs-books/2009/rgcmo-specialty-geographic.Par.0001.File.tmp/Specialty-geography-compressed.pdf (last visited on February 14, 2014).

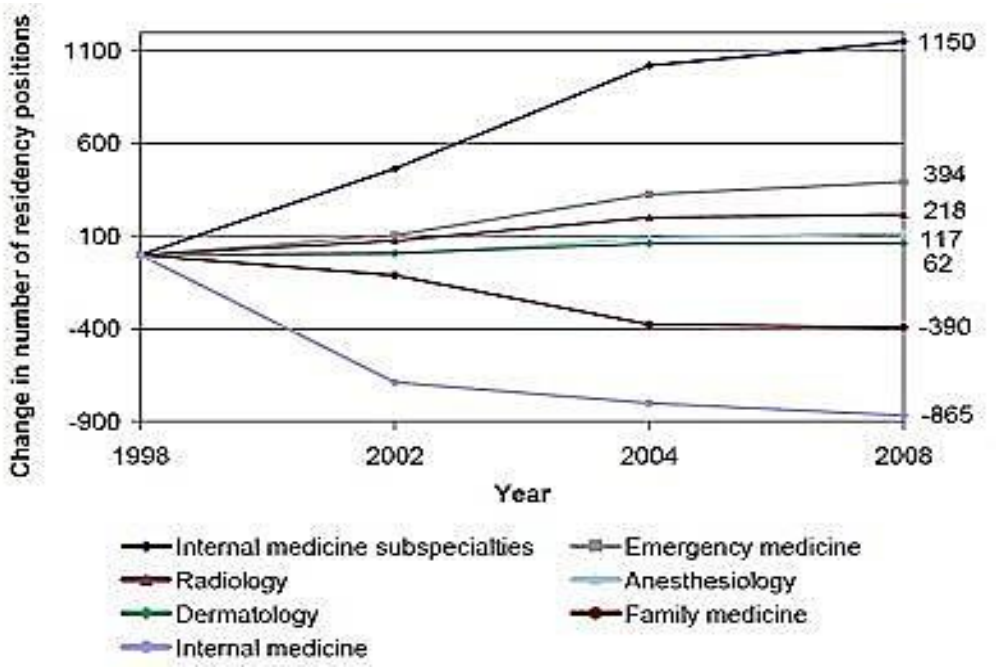
[20] Grayson, M., Newton, D., Thompson, L., "Payback time: the associations of debt and income with medical student career choice," *Medical Education*, Vol. 46, Issue 10, pg. 984, October 2012, on file with committee staff.

[21] Association of American Medical Colleges, "Medical Student Education: Debt, Costs, and Loan Repayment Fact Card," October 2013, available at: https://www.aamc.org/download/152968/data/debtfactcard.pdf (last visited on February 14, 2014).

[22] *Id.*

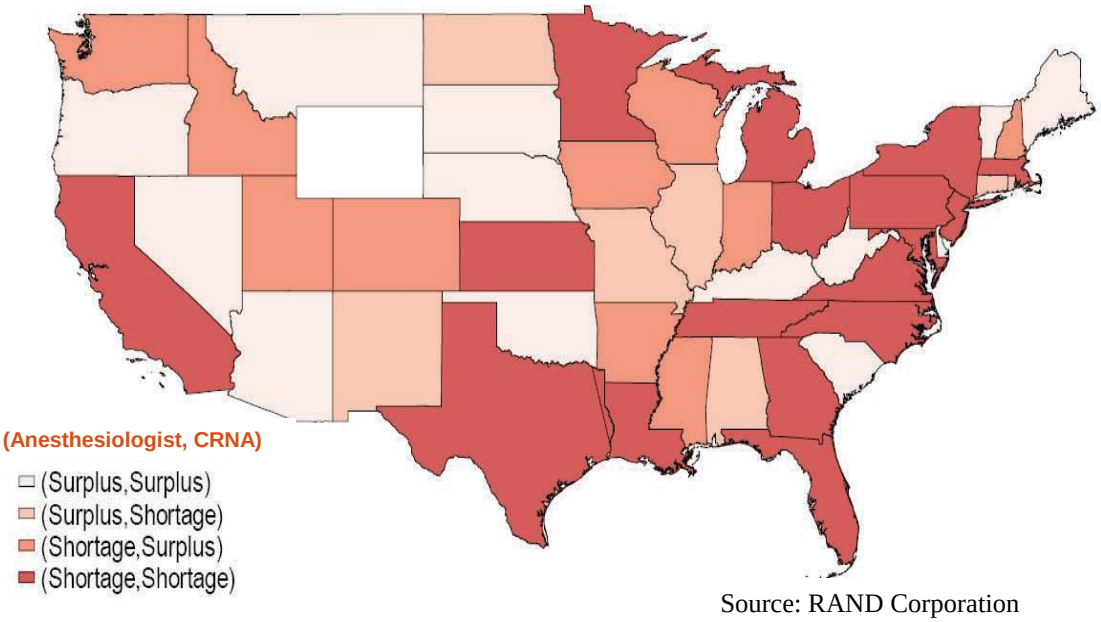
[23] Weida NA, Phillips RL Jr, Bazemore AW, Dodoo MS, Petterson SM, Xierali I, Teevan B., "Loss of Primary Care Residency Positions Amidst Growth in other Specialties. *Am Fam Physician*, 2010 Jul 15;82(2):121, available at: http://www.graham-center.org/online/graham/home/publications/onepagers/2010/op66-loss-primary.html (last visited on February 25, 2014).

[24] *Id.*



In 2010, the RAND Corporation published a study reporting that Florida, Alabama, and North Carolina had the least number of anesthesiologists in the nation.[25] Overall, the study found that 27 states are experiencing a shortage of anesthesiologists, which is reflected in the chart below.[26]

Surpluses and Shortages of Anesthesiologists and CRNAs



Source: RAND Corporation

[25] Daugherty, L., Fonseca, R., Kumar, K., Michaud, P.; "An Analysis of the Labor Markets for Anesthesiology," RAND Corp., available at: http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR688.pdf (last visited on February 19, 2014).

[26] *Id*. Note that some states are not provided or are not shaded because they were not included in the study due to an inadequate number of observations on which to base an analysis.

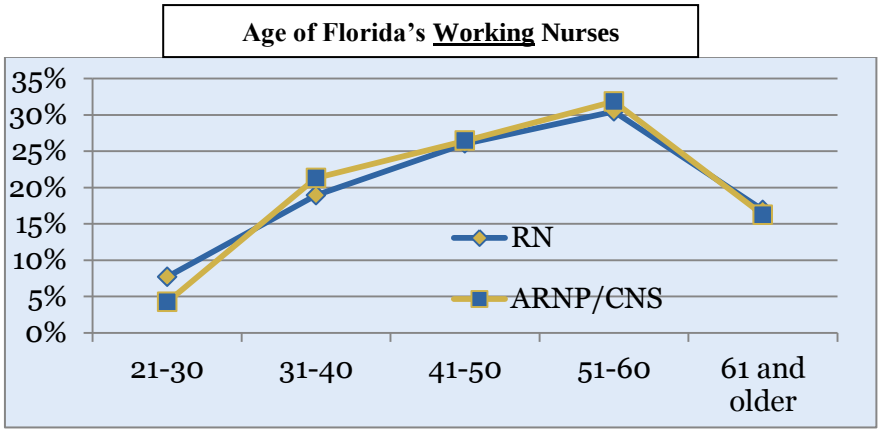
Nurse Workforce Data

In 2012, there were approximately 110,200 certified nurse practitioners (CNPs), 35,200 certified registered nurse anesthetists (CRNAs), 6,000 certified nurse midwives (CNMs), and 2,711,000 registered nurses (RNs) employed in the U.S.[27] There were 34.8 CNPs, 1.89 CNMs, 11.1 CRNAs, and 857.3 RNs per 100,000 population in 2012.[28]

As of January 2014, there were 18,843 advanced registered nurse practitioners (ARNPs) holding a certificate to practice in Florida, including 13,590 CNPs, 4,550 CRNAs, and 703 CNMs. There were also 246,397 RNs with active licenses as of January 2014.[29] Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 69.5 CNPs, 3.6 CNMs, 23.2 CRNAs, and 1,260.4 RNs.[30,31]

The Florida Center for Nursing (center) projects that there will be a shortage of approximately 20,600 RNs in 2025, and if PPACA were to be fully implemented Florida would have a shortage of approximately 50,300 RNs.[32]

The center has also reported that over 30 percent of Florida's ARNPs and RNs are 51 to 60 years old, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[33]



[27] U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," available at: http://data.bls.gov/projections/occupationProj (last visited on February 11, 2014).
[28] These ratios were calculated using the U.S. Census Bureau's population estimate for 2012 was 316,266,000, which is available at: https://www.census.gov/prod/2011pubs/12statab/pop.pdf (last visited on February 11, 2014) and the U.S. Bureau of Labor Statistics 2012 data on employment projections available at: http://data.bls.gov/projections/occupationProj (last visited on February 11, 2014).
[29] The Florida Department of Health, Division of Medical Quality Assurance, provided the licensee information, which is on file with committee staff.
[30] These ratios were calculated using population estimates for FY 2013-2014 provided by the Florida Office of Economic & Demographic Research and available at: http://edr.state.fl.us/Content/conferences/population/ComponentsofChange.pdf (last visited on February 11, 2014).
[31] Although it appears from this data that Florida has a higher ratio of nurses than the national ratio, the national data used to calculate the ratios only considers the number of nurses "employed" in the U.S. No similar employment data exists in Florida for 2012 to correlate with the national numbers. The numbers used to calculate Florida's ratios includes all active licensees, whom may not necessarily be employed, hence the larger ratios.
[32] The estimates are based on full-time equivalent (FTE) registered nurses. The Florida Center for Nursing, "RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform," October 2010, available at: http://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/Download.aspx?Command=Core_Download&EntryId=17&PortalId=0&TabId=151 (last visited on February 11, 2014).
[33] Florida Center for Nursing, Presentation on Florida's Nurse Workforce, November 6, 2013, available at: http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2786&Session=2014&DocumentType=Meeting Packets&FileName=schcwi 11-6-13.pdf (last visited on February 11, 2014).

In 2010, it was reported that Florida and two other states, Pennsylvania and Michigan, have the largest shortage of CRNAs in the U.S. The study also reported that a large number of CRNAs in the U.S. will be reaching retirement age by 2020.[34]

Advanced Practice Nurses

The term advanced practice nurse (APN) refers to registered nurses who have completed rigorous training and advanced education, usually resulting in a master's degree or higher. The titles of APNs vary from state to state. The National Council of State Boards of Nursing encourages states to use the term "advanced practice registered nurse" (APRN) to promote uniformity and title recognition across the nation.[35]

Florida APNs

In Florida, an APN is titled as an "advanced registered nurse practitioner" (ARNP)[36] and is categorized as a certified nurse practitioner (CNP), certified nurse midwife (CNM), or certified registered nurse anesthetist (CRNA).[37] As of January 2014, Florida had 13,590 CNPs, 4,550 CRNAs, and 703 CNMs.[38]

ARNPs 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 certified as ARNPs and the applicable regulatory standards for ARNP nursing practices. Additionally, the Board is responsible for administratively disciplining an ARNP 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.[39]

In addition to advanced or specialized nursing practices, ARNPs are authorized to practice certain medical acts, as opposed to nursing acts, approved by a joint committee, formed pursuant to s. 464.003(2), F.S. The joint committee consists of three members appointed by the Board of Nursing, two of whom must be ARNPs; three members appointed by the Board of Medicine, two of whom must have had work experience with ARNPs; and the State Surgeon General or the State Surgeon General's designee.[40] The joint committee has not met since 1999 and has never approved a medical act. Currently, there are no members appointed to the joint committee.[41]

For an applicant to be eligible to be certified as an ARNP, the applicant must be licensed as a registered nurse, must have a master's degree, and must submit to the Board proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[42] A nursing specialty board must attest to the competency of nurses in a clinical specialty area, require nurses to take a written examination prior to certification, require nurses to complete a formal

[34] *Supra* fn. 25. *See also* the map of surpluses and shortages of anesthesiologists and CRNAs on page 7.
[35] National Council of State Boards of Nursing, "APRN Talking Points: Consensus Model for APRN Regulation," available at: https://www.ncsbn.org/2010_APRN_TalkingPoints_web.pdf (last visited on February 11, 2014).
[36] Section 464.003(3), F.S.
[37] Section 464.012(4), F.S.
[38] *Supra* fn. 29.
[39] *Supra* fn. 36.
[40] Section 464.003(2), F.S.
[41] Email correspondence from DOH, February 20, 2014, on file with committee staff.
[42] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.

program prior to eligibility of examination, maintain program accreditation, and identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all ARNPs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for certification is required to submit proof of coverage or financial responsibility within sixty days of certification and prior to each biennial certification renewal. The ARNP 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 ARNP as beneficiary.[43] By comparison, physicians are required by Florida law to establish some method of financial responsibility, 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, and must notify patients that they have chosen not to carry malpractice insurance.[44]

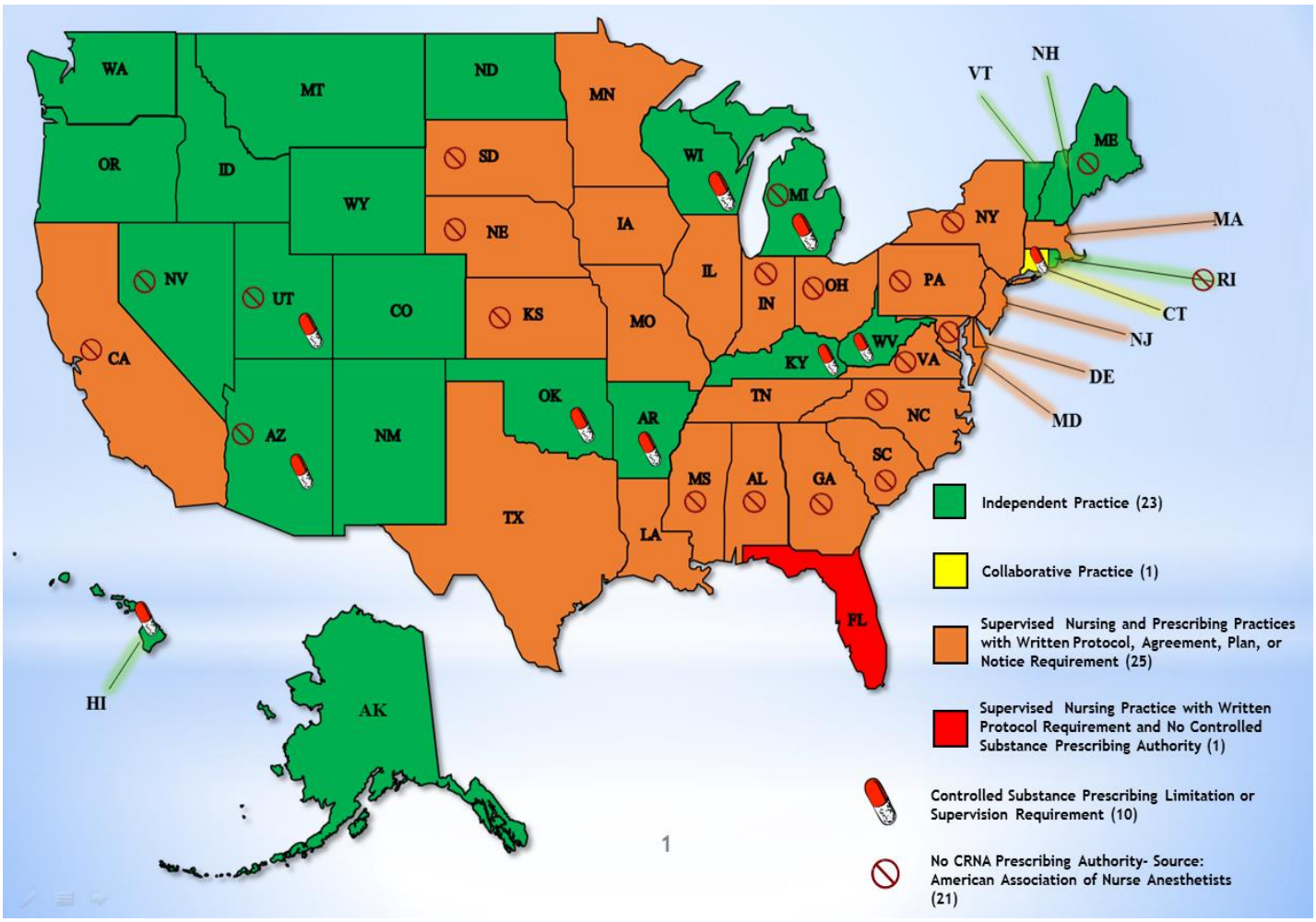
Autonomy of Practice

APN autonomy of practice varies widely by state. Generally, states align with four types of autonomy:

1. Independent nursing practice;
2. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement;
3. Supervised nursing practice 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; or
4. Supervised nursing practice 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, except controlled substance prescribing which is statutorily prohibited.[45]

Within these four categories, a total of 23 states allow an APN to diagnose and treat a patient without physician supervision. One state requires a collaborative arrangement (without a written agreement or protocol). Twenty-six states require supervision, in which the APN must enter into or file with a regulatory board a written protocol, agreement, plan, or notice signed by a physician.[46] The following map illustrates the different levels of autonomy of practice for APNs throughout the U.S.

[43] Rule 64B9-4.002(5), F.A.C.
[44] 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.
[45] Findings based on research conducted in 2013 by staff of the Select Committee on Health Care Workforce Innovation.
[46] *Id*.



CRNA Autonomy

The Centers for Medicare & Medicaid Services (CMS) established a rule on CRNA autonomy for the purpose of Medicare coverage and reimbursement. The rule requires CRNAs to be supervised by a physician performing the procedure or by an anesthesiologist who is immediately available if needed.[47] However, the rule provides for an exemption from the physician supervision requirement for CRNAs practicing in states in which the Governor makes a written request to CMS. The request must attest to awareness of the State's right to an exemption and state that it is in the best interests of the State's residents to exercise this option.[48] As of August 2012, 17 states have chosen to opt out of the federal CRNA physician supervision regulation.[49] Florida has not opted out of the CMS supervision requirement.

[47] Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Medicare Information for Advanced Practice Registered Nurses, Anesthesiologist Assistants, and Physician Assistants, " September 2011, pg. 2, available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Medicare_Information_for_APNs_and_PAs_Booklet_ICN901623.pdf (last visited on February 19, 2014).

[48] Department of Health and Human Services, Centers for Medicare & Medicaid Services, "Spotlight: Anesthesia Supervision," available at: http://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs/Spotlight.html (last visited on February 19, 2014).

[49] The states are: California, Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, South Dakota, Wisconsin, Montana, Colorado, and Kentucky.

APN Autonomy in Veterans Health Administration Facilities

The Veterans Health Administration (VHA) of the U.S. Department of Veterans Affairs is drafting a new Nursing Handbook to recognize APNs as "Licensed Independent Practitioners" in all VHA facilities and allow such nurses to practice to the full extent of their education and training without physician supervision.[50] In Florida, there are 56 VHA medical centers and health care clinics that would be affected by this policy change.[51]

APN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APNs may only perform nursing practices delineated in a written physician protocol filed with the Board.[52]

Florida law allows a physician providing primary health care services to supervise APNs in up to four medical offices,[53] 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.[54] 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.[55]

Scope of Practice

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

Eleven of the 23 independent practice states authorize an APN to prescribe controlled substances to a patient without physician supervision. Two of the 23 independent practice states, Kentucky and Michigan, require APNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.[56] Only one state, Florida, both requires APNs to practice under written physician protocols and also prohibits APNs from prescribing controlled substances. Twenty-one states specifically prohibit CRNAs from prescribing drugs.[57] The map on p. 11 illustrates the varying controlled substance prescribing requirements throughout the U.S.

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[50] U.S. Department of Veterans Affairs, Office of Nursing Services, "APRN Practice," updated February 20, 2013, on file with committee staff. Although APRNs will be able to practice independently in VHA facilities, they may not be able to prescribe controlled substances because they must adhere to the laws in the state in which they are licensed regarding prescribing authority for controlled substances. Under current law, Florida-licensed ARNPs practicing in the VHA cannot prescribe controlled substances while working alongside APN peers who can.

[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 on February 12, 2014).

[52] Allopathic and osteopathic physicians are also required to provide notice of the written protocol and the supervisory relationship to the Board of Medicine or Board of Osteopathic Medicine, respectively. Sections 458.348 and 459.025, F.S.

[53] 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(4)(e), and 459.025(3)(e), F.S.

[54] Sections 458.348, and 459.025, F.S.

[55] *Id*.

[56] *Supra* fn. 45. The remaining 10 states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.

[57] American Association of Nurse Anesthetists, Presentation on "Current State Legislative and Regulatory Trends," November 9, 2013, available at: http://www.aana.com/meetings/meeting-

At least 4 states grant APNs authority to sign or certify any document that is required by law to be signed by a physician.[58] This authority is often referred to as "global signature authority." Many states specify in law the types of things an APN may sign, such as death certificates, handicapped license designations, and advanced directives.[59]

Nineteen states statutorily recognize APNs as "primary care providers."[60] Recognizing APNs 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.[61] Insurers may be unwilling to contract directly with a provider who is supervised by another provider.[62]

APN Scope of Practice in Florida

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

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy;
- Perform certain acts within his or her specialty; and
- Perform medical acts authorized by a joint committee.[63]

However, Florida law does not authorize APNs to prescribe, administer, or dispense controlled substances.[64] Florida is the only state in the U.S. that requires an APN to be supervised by a physician, authorizes APNs to only perform those nursing practices delineated under a physician's written protocol, and *also* prohibits an APN from prescribing, administering, dispensing, mixing or otherwise preparing controlled substances.[65]

Additionally, APNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APNs 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.[66]

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materials/Fall%20Leadership%20Academy/Documents/Chacko_Conover_Current%20State%20Legislative%20and%20Regulatory%20Trends%20FLA%202013.pdf (last visited on February 21, 2014).

[58] The states with global signature authority are Hawaii, Maine, Rhode Island, and Vermont.

[59] *Supra* fn. 45.

[60] Office of Program Policy Analysis & Government Accountability, "States Vary in Their Treatment of Advanced Registered Nurse Practitioners as Primary Care Providers," October 2013, on file with committee staff.

[61] 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, abstract available at: http://www.ncbi.nlm.nih.gov/pubmed/17071708 (last visited on February 12, 2014).

[62] ARNP services are mandatory services in the current Florida Medicaid program, and are required minimum services in the Managed Medical Assistance program being implemented this year. Sections 409.905, 409.973, F.S. Florida law does not require Medicaid managed care plans to contract directly with ARNPs.

[63] Sections 464.012(3),(4), and 464.003, F.S.

[64] Sections 893.02(21), and 893.05(1), F.S.

[65] Sections 464.012, 893.02(21), and 893.05(1), F.S.

[66] *See* ss. 394.463(2) and 382.008, F.S.

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APNs provide a different quality of care than physicians,[67] a multitude of reports and studies suggest treatment by an APN is just as safe, if not safer, than treatment by a physician. In 2009, the Cochrane Collaboration published a review of the findings of 25 articles comparing physician and APN patient outcomes. The review found that, in general, there are no appreciable differences between physicians and APNs in health outcomes for patients, process of care, resource utilization, or cost.[68]

Certified Nurse Practitioners

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.[69]

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.[70]

Certified Nurse Midwives

Some studies have shown that birth outcomes and survival rates for infants delivered by CNMs are comparable to, if not better than, those for infants delivered by physicians.[71] One study found that there was a 19 percent reduction in infant deaths when a CNM attended a birth rather than a physician and that the mean birthweight was 37 grams heavier for CNM-attended births.[72]

In a systematic review of studies conducted between 1990 and 2008 comparing birthing outcomes of CNM-attended births and physician-attended births, there were several categories of more positive outcomes for CNM-attended births. The review found that there is a high level of evidence that care by

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[67] 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#t=articleTop (last visited on February 13, 2014).

[68] Laurant, M., et al., The Cochrane Collaboration, "Substitution of doctors by nurses in primary care," October 18, 2004, on file with committee staff.

[69] 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 February 14, 2014).

[70] Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," March 15, 2013, available at: http://www.lafollette.wisc.edu/research/health_economics/Traczynski.pdf (last visited on February 12, 2014).

[71] Oakely, et al., "Comparisons of Outcomes of Maternity Care by Obstetricians and Certified Nurse-Midwives," *Obstetrics & Gynecology*, Vol. 88, No. 5, November 1996; and MacDorman, M.F., Singh, G.K., "Midwifery care, social and medical risk factors, and birth outcomes in the USA," *J. Epidemiol Community Health*, 1198; 52:310-317, on file with committee staff.

[72] These results were produced after the study controlled for social and medical risk factors. "Midwifery care, social and medical risk factors, and birth outcomes in the USA," *id*. at pg. 310.

CNMs results in lower rates of cesarean sections, lower rates of episiotomy, lower levels of labor analgesia, and lower levels of third and fourth-degree perineal laceration.[73]

Certified Registered Nurse Anesthetists

Studies have shown that there is no evidence that CRNAs providing services without physician supervision result in increased inpatient deaths or complications.[74] One study found that, while comparing maternal outcomes, anesthesia complication rates in anesthesiologist-only hospitals were 0.27 percent compared with 0.23 percent in CRNA-only hospitals.[75]

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 resulting from implementation of the PPACA and the shortage of health care workers.[76]

In 2012, the Perryman Group conducted a study to determine whether Texas could achieve any cost-savings by increasing the utilization of APNs. A report of the study's findings concluded that greater utilization of APNs would improve patient outcomes, reduce overall health care costs, and increase access to health care. The estimated savings were $16.1 billion in total expenditures and $8 billion in output (gross product) each year. 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.[77]

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. 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).[78]

The U.S. Federal Trade Commission (FTC) has authored several letters to states regarding the negative effects of restrictive scope of practice laws for APNs. The main concern of the FTC is that scope of practice restrictions are anti-competitive and that they, in effect, reduce competitive market pressures, increase out-of-pocket prices, allow for more limited service hours, and reduce the distribution of services. The FTC poses that if such constraints were eliminated, not only would access

[73] Newhouse, et al., "Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review," *Nursing Economic$*, Sept.-Oct. 2011, Vol. 29/No. 5, on file with committee staff.
[74] Dulisse, B., and Cromwell, J.; "No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians," *Health Affairs,* August 2010, 29:8, available at: http://www.oana.org/pdf/No%20Harm%20Found%20Study%20article%20%20(RTI).pdf (last visited on February 19, 2014), and Needleman, J., and Minnick, A.; "Anesthesia Provider Model, Hospital Resources, and Maternal Outcomes," *Health Serv. Res.* April 2009, 44(2 Pt 1): 464-482, available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2677049/ (last visited on February 19, 2014).
[75] "Anesthesia Provider Model, Hospital Resources, and Maternal Outcomes," *id.* at 464.
[76] 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 February 13, 2014).
[77] *Id*.
[78] *Supra* fn. 70.

to services be increased, but there would be benefits to price competition that would help contain health care costs.[79]

Effect of Proposed Changes

To address the current and impending health care workforce shortage in Florida, this PCB expands the scope of practice for ARNPs and authorizes certain qualified ARNPs to practice autonomously.

Advanced Practice Registered Nurses

The PCB authorizes APRNs to prescribe controlled substances, if allowed under a supervising physician's protocol. The PCB imposes safeguards to ensure APRNs safely prescribe controlled substances and are held accountable if they do otherwise. Specifically, APRNs:

- Must report adverse incidents attributable to the prescription of a controlled substance. Adverse incidents are only those events that require the transfer of a patient to a hospital or cause permanent physical injury or death.
- May be administratively disciplined for several delineated prohibited acts related to inappropriate prescribing, relationships with patients, business practices, and nursing practices.
- Are required to register as prescribers of controlled substances for chronic nonmalignant pain, if they prescribe such substances, and must meet statutory requirements related to treatment plans, recordkeeping, patient examinations, written agreements, and referrals.
- Must comply with the prescribing and dispensing requirements and limitations under the Florida Comprehensive Drug Abuse Prevention and Control Act.[80]
- Are authorized to access the Prescription Drug Monitoring Program database to determine if a patient is abusing controlled substances.

The PCB also authorizes APRNs to:

- Execute a certificate to subject a person to involuntary examination under the Baker Act.[81]
- Certify causes of death and sign, correct, and file death certificates.
- 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.

Additionally, the PCB changes the term "advanced registered nurse practitioner" to "advanced practice registered nurse" to align with a majority of states that use this title and to facilitate title recognition across state lines. The PCB makes numerous conforming changes throughout Florida Statutes to accommodate this title change.

Independent Practice

The PCB allows a certified APRN who meets certain eligibility criteria to register as an "Independent Advanced Practice Registered Nurse" (IAPRN). The PCB establishes title protection for this new title.

To register as an IAPRN, the applicant must hold an active and unencumbered APRN certificate, pay an application fee set by the Board (not to exceed $100), and must have:

[79] U.S. Federal Trade Commission, Office of Policy Planning, Bureau of Competition and Bureau of Economics, letters to the Illinois State Senate, Connecticut House of Representatives, and Texas State Senate, on file with committee staff.
[80] Section 893.01, F.S.
[81] The Baker Act is also titled the "Florida Mental Health Act" under s. 394.451, F.S.

- Completed, in any U.S. jurisdiction, at least 2,000 clinical practice hours within a three-year period immediately prior to applying for registration;
- Not been subject to any disciplinary action during the five years immediately preceding the application; and
- Completed a graduate level course in pharmacology.

To maintain their registration, IAPRNs must complete at least 10 hours of continuing education approved by the Board in pharmacology prior to biennial renewal, unless an exception applies for the first biennial renewal. APRNs registered as IAPRNs must also ensure that their practitioner profiles created by the Department of Health reflect their registration as an IAPRN.

IAPRNs are authorized to perform any act currently authorized for an APRN and the new functions noted above, but may perform such acts without the supervision of a physician or a written protocol. In addition to those acts, an IAPRN may independently 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.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- 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.
- Be reimbursed under personal injury protection insurance for initial and follow-up medical services, consistent with current law applicable to physicians.

IAPRNs are subject to all the controlled substance prescribing requirements imposed on APRNs, noted above. To align IAPRNs with the same oversight and accountability measures required for physicians, IAPRNs are prohibited from making certain referrals when certain financial arrangements between referring health care providers or practitioners exist. These current prohibitions on self-referral and kick-backs will now apply to IAPRNs, not only to physicians, under the PCB. In addition, IAPRNs are required to maintain malpractice insurance or prove financial responsibility as provided by Board rule to ensure claims due to malpractice are covered.

The PCB requires an IAPRN, instead of an APRN, to serve on an existing joint committee, which is charged with determining whether APRNs or IAPRNs may perform certain medical acts.

The PCB revises the definition of “registered nurse” to continue to require supervision of those nurses, and revises the definition of “psychiatric nurse” to include APRNs and IAPRNs who have obtained national certification as a psychiatric-mental health advanced practice nurse.

Finally, the PCB also removes certain obsolete provisions and makes numerous conforming changes.

The PCB provides an effective date of July 1, 2014.

B. SECTION DIRECTORY:

Section 1: Amends s. 464.003, F.S., relating to definitions.
Section 2: Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners and fees.
Section 3: Creates s. 464.0125, F.S., relating to registration of independent advanced practice registered nurses and fees.
Section 4: Amends s. 464.015, F.S., relating to titles and abbreviations, restrictions, and penalty.

Section 5: Creates s. 464.0155, F.S., relating to reports of adverse incidents by independent advanced practice registered nurses.
Section 6: Amends s. 464.016, F.S., relating to violations and penalties.
Section 7: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 8: Amends s. 39.303, F.S., relating to child protection teams, services, and eligible cases.
Section 9: Amends s. 39.304, F.S., relating to photographs, medical examinations, x rays, and medical treatment of abused, abandoned, or neglected child.
Section 10: Amends s. 90.503, F.S., relating to psychotherapist-patient privilege.
Section 11: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 12: Amends s. 112.0455, F.S., relating to the Drug-Free Workplace Act.
Section 13: Amends s. 121.0515, F.S., relating to special risk
Section 14: Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Act and immunity from civil liability.
Section 15: Amends s. 310.071, F.S., relating to deputy pilot certification.
Section 16: Amends s. 310.073, F.S., relating to state pilot licensing.
Section 17: Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots, vacancies.
Section 18: 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 19: Amends s. 381.00315, F.S., relating to public health advisories, public health emergencies, and quarantines.
Section 20: Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.
Section 21: Amends s. 381.026, F.S., relating to definitions.
Section 22: Amends s. 382.008, F.S., relating to death and fetal death registration.
Section 23: Amends s. 383.141, F.S., relating to prenatally diagnosed conditions, patient to be provided information, definitions, information clearinghouse, and advisory council.
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. 394.455, F.S., relating to definitions.
Section 27: Amends s. 394.463, F.S., relating to involuntary examination.
Section 28: Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
Section 29: Amends s. 395.602, F.S., relating to rural hospitals.
Section 30: Amends s. 395.605, F.S., relating to emergency care hospitals.
Section 31: Amends s. 397.311, F.S., relating to definitions.
Section 32: Amends s. 397.405, F.S., relating to exemptions from licensure.
Section 33: Amends s. 397.427, F.S., relating to medication-assisted treatment service providers, rehabilitation program, needs assessment and provisions of services, persons authorized to issue takeout medication, unlawful operation, and penalty.
Section 34: Amends s. 397.501, F.S., relating to rights of individuals.
Section 35: Amends s. 400.021, F.S., relating to definitions.
Section 36: Amends s. 400.0255, F.S., relating to resident transfer or discharge, requirements and procedures, and hearings.
Section 37: Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
Section 38: Amends s. 400.462, F.S., relating to definitions.
Section 39: Amends s. 400.487, F.S., relating to home health service agreements, physician's, physician assistant's, 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 40: Amends s. 400.506, F.S., relating to licensure of nurse registries, requirements, and penalties.

Section 41: Amends s. 400.9905, F.S., relating to definitions.
Section 42: Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
Section 43: Amends s. 409.905, F.S., relating to mandatory Medicaid services.
Section 44: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 45: Amends s. 409.9081, F.S., relating to copayments.
Section 46: Amends s. 409.973, F.S., relating to benefits.
Section 47: Amends s. 429.26, F.S., relating to appropriateness of placements and examinations of residents.
Section 48: Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
Section 49: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 50: Amends s. 456.0391, F.S., relating to advanced registered nurse practitioners; information required for certification.
Section 51: Amends s. 456.0392, F.S., relating to prescription labeling.
Section 52: Amends s. 456.041, F.S., relating to practitioner profile and creation.
Section 53: Amends s. 456.048, F.S., relating to financial responsibility requirements for certain health care practitioners.
Section 54: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 55: Amends s. 456.072, F.S., relating to grounds for discipline, penalties, and enforcement.
Section 56: Amends s. 456.44, F.S., relating to controlled substance prescribing.
Section 57: Amends s. 458.3265, F.S., relating to pain-management clinics.
Section 58: Amends s. 458.331, F.S., relating to grounds for disciplinary action, action by the board and department.
Section 59: Amends s. 458.348, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 60: Amends s. 459.0137, F.S., relating to pain-management clinics.
Section 61: Amends s. 459.015, F.S., relating to grounds for disciplinary action, action by the board and department.
Section 62: Amends s. 459.025, F.S., relating to formal supervisory relationships, standing orders, and established protocols; notice; standards.
Section 63: Amends s. 464.004, F.S., relating to Board of Nursing, membership, appointment, and terms.
Section 64: Amends s. 464.0205, F.S., relating to retired volunteer nurse certificate.
Section 65: Amends s. 467.003, F.S., relating to definitions.
Section 66: Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
Section 67: Amends s. 483.041, F.S., relating to definitions.
Section 68: Amends s. 483.181, F.S., relating to acceptance, collection, identification, and examination of specimens.
Section 69: Amends s. 483.801, F.S., relating to exemptions.
Section 70: Amends s. 486.021, F.S., relating to definitions.
Section 71: Amends s. 490.012, F.S., relating to violations, penalties, and injunction.
Section 72: Amends s. 491.0057, F.S., relating to dual licensure as a marriage and family therapist.
Section 73: Amends s. 491.012, F.S., relating to violations, penalty, and injunction.
Section 74: Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
Section 75: Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
Section 76: Amends s. 627.357, F.S., relating to medical malpractice self-insurance.
Section 77: Amends s. 627.6471, F.S., relating to contracts for reduced rates of payment, limitations, and coinsurance and deductibles.
Section 78: Amends s. 627.6472, F.S., relating to exclusive provider organizations.

Section 79: Amends s. 627.736, F.S., relating to required personal injury protection benefits, exclusions, priority, and claims.
Section 80: Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
Section 81: Amends s. 641.3923, F.S., relating to discrimination against providers prohibited.
Section 82: Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 83: Amends s. 744.331, F.S., relating to procedures to determine incapacity.
Section 84: Amends s. 744.703, F.S., relating to office of public guardian; appointment, notification.
Section 85: Amends s. 766.102, F.S., relating to medical negligence, standards of recovery, and expert witness.
Section 86: Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
Section 87: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 88: Amends s. 766.1116, F.S., relating to health care practitioner, waiver of license renewal fees, and continuing education requirements.
Section 89: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 90: Amends s. 768.135, F.S., relating to volunteer team physicians and immunity.
Section 91: Amends s. 782.071, F.S., relating to vehicular homicide.
Section 92: Amends s. 794.08, F.S., relating to female genital mutilation.
Section 93: Amends s. 893.02, F.S., relating to definitions.
Section 94: Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
Section 95: Amends s. 945.603, F.S., relating to powers and duties of authority.
Section 96: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 97: Amends s. 1002.42, F.S., relating to private schools.
Section 98: Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.
Section 99: Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
Section 100: Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
Section 101: Amends s. 1009.66, F.S., relating to Nursing Student Loan Forgiveness Program.
Section 102: Amends s. 1009.67, F.S., relating to nursing scholarship program.
Section 103: Provides an effective date of July 1, 2014.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   Applicants for registration as an IAPRN will have to pay an initial application fee, and registered IAPRNs will have to pay a biennial renewal fee, to the Department of Health. The total amount the Department of Health will receive from such fees is indeterminate, because the number of APRNs who choose to register as IAPRNs is not predictable.

2. Expenditures:

   The Board may incur indeterminate, but nominal costs associated with rulemaking, which can be absorbed within existing resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Applicants for registration as an IAPRN will have to pay an application fee and IAPRNs renewing their registration will be subject to renewal fees. The PCB authorizes the Board to set the application and biennial renewal fees, but they may not exceed $100 and $50 respectively.

The PCB requires IAPRNs to obtain medical malpractice insurance. The Board may require IAPRNs to have more coverage and therefore a more expensive policy than what is required for APRNs.

ARNPs who have paid physicians in order to be supervised under a protocol achieve some cost-savings if they register as an IAPRN and practice without a written protocol.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board and the Department of Health have sufficient rule-making authority to implement the provisions of the PCB.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 18, 2014, the Select Committee on Health Care Workforce Innovation adopted an amendment to PCB SCHCWI 14-01. The amendment requires the 10 hours of continuing education in pharmacology, which must be completed by an independent advanced practice registered nurse for renewal of registration, to be approved by the Board of Nursing.

The PCB was reported favorably as amended. This analysis reflects the bill as amended.