Select Committee on Affordable Healthcare Access

Monday, January 11, 2016
1:30 PM – 3:30 PM
Sumner Hall (404 HOB)

Steve Crisafulli
Speaker

Jose Oliva
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Select Committee on Affordable Healthcare Access

Start Date and Time:	Monday, January 11, 2016 01:30 pm
End Date and Time:	Monday, January 11, 2016 03:30 pm
Location:	Sumner Hall (404 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 1061 Nurse Licensure Compact by Pigman
HB 1063 Public Records and Meetings/Nurse Licensure Compact by Pigman

Workshop on Health Care Price & Quality Transparency and Hospital Efficiency

--Vivian Lee, M.D., PhD, MBA; CEO, University of Utah Health Care; Dean, University of Utah School of Medicine
--Denise Love, BSN, MBA, Executive Director, National Association of Health Data Organizations; Co-Chair, All Payer Claims Database Council
--Molly McKinstry, Deputy Secretary, Agency for Health Care Administration

Pursuant to rule 7.12, the deadline for amendments to bills on the agenda by non-appointed members is 6:00 p.m., Friday, January 8, 2016.

By request of the chair, all committee members are asked to have amendments to bills on the agenda submitted to staff by 6:00 p.m., Friday, January 8, 2016.

NOTICE FINALIZED on 01/04/2016 3:52PM by Iseminger.Bobbye

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1061 Nurse Licensure Compact
SPONSOR(S): Pigman
TIED BILLS: HB 1063 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access		Siples	Calamas
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Nurse Licensure Compact (NLC or compact) is a multi-state agreement that establishes a mutual recognition system for the licensure of registered nurses and licensed practical or vocational nurses. In 2015, the National Council of State Boards of Nursing adopted revised model legislation for the NLC and required any state entering the NLC to adopt the revised model legislation. The bill authorizes Florida to enter into the revised NLC.

Under the NLC, a nurse who is issued a multistate license from a state that is a party to the compact is permitted to practice in any other state that is also a party to the compact. However, the nurse must comply with the practice laws of the state in which he or she is practicing or where the patient is located. A party state may continue to issue a single-state license, authorizing practice only in that state.

Pursuant to the bill, a nurse who applies for or renews a multistate license in Florida must meet the minimum requirements of the NLC and any other requirements set by the Florida Board of Nursing (board) within the Department of Health (DOH). The NLC does not change the current licensure requirements under ch. 464, F.S., the Nurse Practice Act.

Under the NLC, a state may take adverse action against the multistate licensure privilege of any nurse practicing in that state. The home state has the exclusive authority to take adverse action against the home state license, including revocation and suspension. The NLC requires all states to report to a coordinated licensure information system (CLIS), all adverse actions taken against a nurse's license or multistate licensure practice privilege, any current significant investigative information, and denials of applications. All party states may access the CLIS to see licensure and disciplinary information for all nurses licensed in the party states. A state may designate the information it contributes to the CLIS as confidential, prohibiting disclosure to nonparty states.

The NLC establishes the Interstate Commission of Nurse Licensure Compact Administrators (commission) to oversee the operation of the NLC. Each party state's compact administrator (the head of the state's licensing board or designee) must participate as a member of the commission. The NLC grants the commission authority to promulgate uniform rules to, among other things, facilitate and coordinate the implementation and administration of the NLC. The commission may also take any necessary action to secure the compliance of a party state that fails to meet the obligations of the NLC, including termination of membership after exhausting all means of securing compliance.

The NLC provides for the qualified immunity, defense, and indemnification of the administrators, officers, executive director, representatives, and employees of the commission in civil actions that arise under certain circumstances. The NLC does not abrogate or waive the sovereign immunity of its party states.

The bill also requires the DOH to conspicuously designate each nurse license as a multistate license or a single-state license. The bill requires the Florida Center for Nursing to analyze the impact of the state's participation in the NLC and authorizes the center to request certain information held by the board to determine such impact.

The bill will have an indeterminate, negative fiscal impact on the DOH.

The bill takes effect on December 31, 2018, or upon enactment of the revised NLC into law by 26 other states, whichever occurs first.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Care Professional Shortage

There is currently a health care provider shortage in the U.S.[1] This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[2] and the passage of the Patient Protection and Affordable Care Act.[3] Aging populations create a disproportionately higher health care demand.[4] Additionally, as more individuals qualify for health care benefits, there will necessarily be a greater demand for more health care professionals to provide these services.

According to a 2010 report prepared by the Florida Center for Nursing, Florida was projected to experience a shortage of more than 62,800 nurses by 2025.[5] In an effort to increase the number of students enrolled in nursing programs and address the projected shortage, the Legislature streamlined the process used by the board to approve and monitor nursing education programs.[6] As a result, the number of nursing education programs in this state has increase by 114%.[7] Due to the new capacity, overall student enrollment grew and the number of students graduating increased from 2012-2013-2013-2014.[8]

With an increasing number of new graduates who will enter the workforce, the long term shortage of nurses appears to be decreasing. It is projected that Florida will have a small surplus of RNs and LPNs in 2025.[9] The South, in general, is projected to continue to have a shortage of nurses. However, this may not be an accurate reflection of the need for nurses because the rapidly changing healthcare delivery system is redefining the role of the nursing workforce.[10]

---

[1] For example, as of November 14, 2013, the U.S. Department of Health and Human Services has designated 6,100 Primary Care Health Professional Shortage Area (HPSA) (requiring 8,200 additional primary care physicians to eliminate the shortage), 4,900 Dental HPSAs (requiring 7,300 additional dentists to eliminate the shortage), and 4,000 Mental Health HPSAs (requiring 2,800 additional psychiatrists to eliminate the shortage). U.S. Department of Health and Human Services, Health Resources and Services Administration, *available at* http://www.hrsa.gov/shortage/ (last visited January 4, 2016).

[2] According to the U.S. Census Bureau, the U.S population is expected to increase by almost 100 million between 2014 and 2060, and by 2030, one in five Americans is projected to be 65 and over. Sandra L. Colby & Jennifer M. Ortman, U.S. Census Bureau, *Projections of the Size and Composition of the U.S.Population: 2014 to 2060* (March 2015), *available at* http://webcache.googleusercontent.com/search?q=cache:N9N3mfOmlzYJ:https://www.census.gov/content/dam/Census/library/publications/2015/demo/p25-1143.pdf+&cd=1&hl=en&ct=clnk&gl=us (last visited January 4, 2016).

[3] *Department of Health and Human Services Strategic Plan: Goal 1: Strengthen Health Care*, U.S. Department of Health and Human Services, *available at* http://www.hhs.gov/secretary/about/goal5.html (last visited on January 4, 2016).

[4] One 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. Petterson, Stephen M., et al., "Projecting U.S. Primary Care Physician Workforce Needs: 2010-2025", Annals of Family Medicine, vol. 10, No. 6 (November/December2012), *available at* http://www.annfammed.org/content/10/6/503.full.pdf+html (last visited on January 4, 2016).

[5] 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* (Oct. 2010), *available at* https://www.flcenterfornursing.org/ForecastsStrategies/FCNForecasts.aspx (last visited January 4, 2016).

[6] Chapter 2009-168, Laws of Fla. Additional statutory amendments were made pursuant to chs. 2010-37 and 2014-92, Laws of Fla.

[7] OPPAGA, *Florida's Nursing Education Programs Continue to Expand in 2014*, Report No. 15-04 (Jan. 2015, rev. Aug. 2015), *available at* http://www.oppaga.state.fl.us/Summary.aspx?reportNum=15-04 (last visited January 4, 2016).

[8] *Id.*

[9] U.S. Dep't of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *The Future of the Nursing Workforce: National- and State-Level Projections, 2012-2025*, (December 2014), *available at* http://bhpr.hrsa.gov/healthworkforce/supplydemand/nursing/workforceprojections/ (last visited January 4, 2016).

[10] *Id.*

Currently, Florida healthcare providers rely on temporary nurses when sufficient nursing staff is not available to meet the demand or there is a temporary need for specialty nursing.[11] Due to its popularity as a tourist destination, Florida experiences a cyclical need for additional nursing resources in winter months. For example, a temporary nursing agency has indicated that in November the request for temporary nurses increases by more than 200 percent for nurses to work the winter months.[12]

Nurse Licensure in Florida

The Nurse Practice Act, chapter 464, F.S., governs the licensure and regulation of nurses in Florida. The Department of Health (DOH) is the licensing agency and the Board of Nursing (BON or board) is the regulatory authority. The BON is comprised of 13 members appointed by the Governor and confirmed by the Senate.[13]

Applicants may apply to the DOH to be licensed as a registered nurse (RN) or a licensed practical nurse (LPN). An RN is licensed to practice "professional nursing," and an LPN is licensed to practice "practical nursing."[14] Florida provides two paths to licensure – licensure by examination and licensure by endorsement. There are currently 253,338 RNs and 73,942 LPNs actively licensed to practice in the state.[15]

To be licensed by examination, an individual must:

- Submit an application with the appropriate fee;
- Satisfactorily complete a criminal background screening;
- Demonstrate English competency;
- Successfully complete an approved nursing educational program; and
- Pass a licensure exam.[16]

Licensure by endorsement is the process by which a nurse validly licensed in another state may be licensed in Florida without having to sit for an examination. To be licensed by endorsement, a nurse must:

- Submit an application with the appropriate application fee;
- Hold a valid license in another state or territory of the U.S., provided that the licensure of such state or territory has licensure requirements that are substantially equivalent to or more stringent than those in Florida;
- Meet the qualifications for licensure by examination;

---

[11] Presentation by Lori Scheidt, Vice-Chair, Nurse Licensure Compact Administrators, before the House of Representative Select Committee on Affordable Healthcare Access in Tallahassee, Florida (Dec. 1, 2015), *available at* http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2883&Session=2016&DocumentType=Meeting%20Packets&FileName=scaha%2012-1-15.pdf (last visited January 4, 2016).

[12] Telephone call with Dwight Cooper, Co-Founder and Chief Executive Officer of PPR Healthcare Staffing on December 21, 2015. Mr. Cooper indicated that in November 2015, his company received approximately 1700 requests for immediate placement of temporary nurses to work the winter months; however, during non-winter months, placement requests average between 300 and 400. Mr. Cooper cautions that healthcare facilities generally requests temporary nurses once they have reached critical status and have redeployed local nursing staff as efficiently as possible, due to the expense associated with the use of temporary nurses.

[13] Section 464.004(1), F.S.

[14] Section 464.003(20), F.S., defines the "practice of professional nursing" as the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principals of psychological, biological, physical, and social sciences. Section 464.003(19), F.S., defines the "practice of practical nursing" as the performance of selected acts, including the administration of treatments and medications, under the direction of a registered nurse, licensed physician, or a licensed dentist, and is responsible and accountable for making decision that are based upon the individual's educational preparation and experience in nursing.

[15] E-mail with staff of the DOH (on file with the Health Quality Subcommittee).

[16] Section 464.008, F.S. For its licensure examination, the DOH uses the National Council Licensure Examination (NCLEX), developed by the National Council of State Boards of Nursing.

- Successfully pass a licensure exam that is substantially equivalent to or more stringent than the exam required by Florida;
- Have practiced in another state or territory of the U.S., for two of the proceeding three years without having any action taken against his or her license; and
- Satisfactorily complete a criminal background screening.[17]

Licenses are renewed biennially.[18] Each renewal period, an RN or LPN must document completion of one contact hour of continuing education for each calendar month of the licensure cycle.[19] As a part of the total continuing education hours required, all licensees must complete a two-hour course on the prevention of medical errors and a two-hour course in Florida laws and rules.[20] Effective August 1, 2017, all licensees must also complete a two-hour course in recognizing impairment in the workplace.[21]

Interstate Compacts

An interstate compact is an agreement between two or more states to address common problems or issues, create an independent, multistate governmental authority, or establish uniform guidelines, standards or procedures for the compact's member states.[22] Article 1, Section 10, Clause 3 (Compact Clause) of the U.S. Constitution authorizes states to enter into agreements with each other, without the consent of Congress. However, the case law has provided that not all interstate agreements are subject to congressional approval, but only those that may encroach on the federal government's power.[23] Florida is a party to 25 interstate compacts, including the Driver's License Compact, Compact on Adoption and Medical Assistance, and the Interstate Compact on Educational Opportunity for Military Children.[24]

Nurse Licensure Compact

In 2000, the National Council of State Boards of Nursing (NCSBN) established model legislation for the Nurse Licensure Compact (NLC), which allows a nurse to have one license, issued by the primary state of licensure, with the privilege to practice in other compact states. The NLC applies to registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVN).[25] In 2015, the NCSBN revised the model legislation for the NLC to address concerns related to uniform licensure requirements, governance, and rule-making.[26]

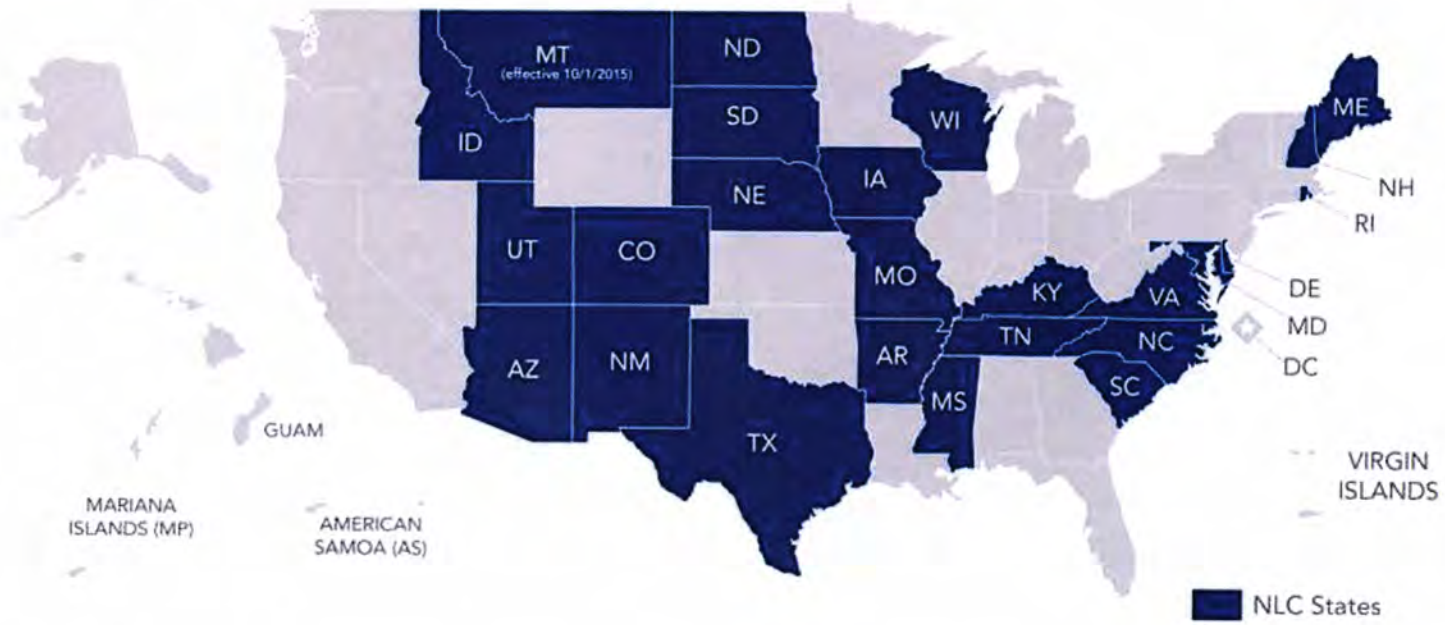
The NLC was modeled after the Driver's License Compact, which permits a person holding a license in one state to drive in other states without applying a for a driver's license in each state through which he

---

[17] Section 446.009, F.S. For spouses of active duty military personnel who relocate to Florida pursuant to official military orders, the spouse is deemed to meet the requirements of licensure by endorsement if he or she is licensed by a state that is a member of the Nurse Licensure Compact, and will be issued a license upon submission of an application for licensure with the appropriate fee and satisfactory completion of the required criminal background screening.
[18] Section 464.013, F.S.
[19] Rule 64B9-5.002, F.A.C. A course in HIV/AIDS is required in the first biennium only and a domestic violence course is required every third biennium.
[20] Rule 64B9-5.011, F.A.C.
[21] *Supra* note 18 and Rule 64B9-5.014, F.A.C.
[22] Council of State Governments, Capitol Research, *Special Edition – Interstate Compacts*, available at http://knowledgecenter.csg.org/kc/content/interstate-compacts-background-and-history (last visited January 4, 2016).
[23] *For example, see Virginia v. Tennessee*, 148 U.S. 503 (1893), *New Hampshire v. Maine*, 426 U.S. 363 (1976)
[24] OPPAGA, *2015 Nurse Licensure Compact Revisions Address Some Barriers and Disadvantages in 2006 OPPAGA Report, available at* floridasnursing.gov/forms/2015-oppaga-research-memo.pdf (last visited January 4, 2016).
[25] Another NCSBN licensure compact, the Advanced Practice Registered Nurse Compact, is a multi-state agreement that establishes a mutual recognition system for the licensure of advanced practice registered nurses (APRNs). Florida is not eligible to enter the Advanced Practice Nurse Compact because that compact requires APRNs to be able to provide patient care independent of a supervisory or collaborative relationship with a physician and Florida law requires such nurses to be supervised under a physician protocol. The APRN Compact is available at https://www.ncsbn.org/aprn-compact.htm (last visited January 4, 2016), and Florida's current supervision requirement for APRNs is in s. 464.012(3), F.S.
[26] The revised model legislation may be found at https://www.ncsbn.org/95.htm (last visited January 4, 2016).

or she may drive.[27] The NLC uses the same system of mutual recognition, which allows a nurse holding a multistate license to practice in any other party state.

Since its initial inception, the original NLC has been adopted by 25 states. According the NCSBN, an additional five states has NLC legislation pending.[28] States that adopted the prior NLC must adopt the revised NLC to become members of the new compact. Those states that are members of the original compact are indicated in the map below.[29]



To join the NLC, a state must pass the NLC model legislation, the state board of nursing must implement the compact, and the state licensing agency must pay an annual fee of $6,000.[30]

The model language of the NLC provides the framework under which party states must operate. The model language must be adopted in its entirety and any modifications must be approved by the NCSBN.[31] The compact is arranged in 11 articles and addresses the following issues:

Findings and Purpose (Article I)

The primary purpose of the NLC is to facilitate the cross-state practice of nursing by promoting compliance with the practice laws of each party state, facilitating the exchange of information between party states, and ensuring and encouraging the cooperation of party states[32] in the licensure and regulation of nurses.

Definitions (Article II)

The NLC provides definitions for terms used in the model legislation.

---

[27] NCSBN, *Nurse Licensure Compact: What Policymakers Need to Know*, *available at* https://www.ncsbn.org/6183.htm (last visited January 4, 2016).
[28] NCSBN, *Pending Legislation, available at* https://www.ncsbn.org/96.htm (last visited January 4, 2016).The states with pending NLC Legislation in 2015 included Illinois, Massachusetts, Minnesota, New York, and Oklahoma.
[29] NCSBN, *NLC Member States (Download Map)*, available at https://www.ncsbn.org/nurse-licensure-compact.htm (last visited January 4, 2016).
[30] NCSBN, *Pending Legislation*, *available at* https://www.ncsbn.org/96.htm (last visited January 4, 2016).
[31] *See generally* NCSBN, *Charter Documents*, *available at* https://www.ncsbn.org/95.htm (last visited January 4, 2016).
[32] A party state is a state that has adopted the NLC.

General Provisions and Jurisdiction (Article III)

Under the NLC, an applicant for a license to practice as an RN or LPN/LVN has to apply in his or her home state for a multistate license.[33] The home state is the applicant's primary state of residence.[34]

The NLC's uniform licensing standards require an applicant for a multistate license to:

- Undergo a criminal history records investigation which includes the submission of fingerprints or other biometric-based information for the purpose of obtaining criminal history records from the Federal Bureau of Investigations and the state agency responsible for retaining criminal records;
- Graduate or be eligible to graduate from a board approved RN or LPN/LVN educational program or an educational program approved by an authorized accrediting body in the applicable country and verified by a board approved independent credentials review agency as a comparable educational program;
- For a graduate of a foreign educational program, successfully pass an English proficiency examination that includes reading, speaking, listening, and writing;
- Successfully complete the NCLEX-RN® or NCLEX-PN® Exam or recognized predecessor;
- Possess or be eligible for an active, unencumbered license;
- Not have been convicted or found guilty, or entered into an agreed disposition of a felony offense;
- Not have been convicted or found guilty, or entered into an agreed disposition, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis;
- Not be currently enrolled in an alternative program or nondisciplinary monitoring program approved by the state board of nursing;
- Be subject to self-disclosure requirements regarding the current participation in an alternative program; and
- Have a valid social security number.

A nurse practicing in a party state under the multistate licensure privilege subjects himself or herself to the practice laws of that state, as well as the jurisdiction of that state's licensing board, courts, and other laws. The NLC vests with each party state the authority to take adverse action[35] against a multistate licensure privilege[36] in accordance with the state's due process laws. Adverse actions may include cease and desist orders or any other action that affects the nurse's ability to practice under a multistate licensure privilege. Upon taking adverse action against a multistate licensure privilege, the party state taking the adverse action must promptly notify the administrator of the coordinated licensure information system.[37] The administrator of the system will notify the home state of any adverse actions taken by a remote state.[38]

---

[33] A multistate license is a license to practice as an RN or LPN/LVN issued by a home state licensing board that authorizes the license holder to practice in all party states under a multistate licensure privilege.

[34] Pursuant to the model rules developed under the prior NLC, a nurse's home state may be evidenced by a drivers' license with a home address, voter registration card with a home address, federal income tax return, military documentation of state of legal residence, or a W2 from the U.S. government or any bureau, division, or agency thereof. *See* Nurse Licensure Compact Administrators, *Nurse Licensure Compact Model Rules and Regulations*, (Rev. Nov. 13, 2012, Aug. 4, 2008, Sept. 16, 2004), *available at* https://www.ncsbn.org/NLC_Model_Rules.pdf (last visited January 4, 2016).

[35] Adverse action means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse.

[36] Multistate licensing privilege refers to the legal authorization associated with a multistate license permitting the practice of nursing as either an RN or LPN/LVN in a remote state or party state other than the nurse's home state.

[37] The coordinated licensure information system is an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that are administered by a nonprofit organization composed of and controlled by licensing boards. Currently, the NCSBN operates the Nursys® system, which is a national database for verification of nurse licensure, discipline and practice privileges for RNs and LPN/LVNs licensed in participating boards of nursing, including all the states in the NLC. *See* https://www.nursys.com/About.aspx (last visited January 4, 2016).

[38] A remote state is a party state, other than the home state.

A party state may also issue single-state licenses for those individuals that meet the party state's requirements for a single-state license. The NLC does not govern the requirements for a single-state license issued by a party state or a single-state license issued by a nonparty state. A single-state license does not authorize the holder to practice nursing in any other state but the state of issuance.

The revised NLC grandfathers those licenses issued under the prior NLC. However, if a nurse changes home states after the effective date of the revised NLC, the nurse must meet all the uniform licensure requirements of the revised NLC. If a nurse fails to satisfy the uniform licensure requirements due to a disqualifying event occurring after the effective date of the NLC, the nurse will be ineligible to retain or renew his or her multistate license.

Applications for Licensure in a Party State (Article IV)

In reviewing an application for licensure, the licensing board of each party state must:

- Determine if the applicant currently holds or has ever held a license issued by any other state;
- Determine if there is any encumbrance on any single-state or multistate license;[39]
- Determine if any adverse action has been taken against any license;
- Determine whether the applicant is currently participating in an alternative program;[40] and
- Verify licensure information through the coordinated licensure information system.

A nurse may hold only one multistate license, which is issued by his or her home state. If a nurse changes his or her primary state of residence, the nurse must apply for licensure in the new home state and meet that state's licensure requirements.[41] Prior to issuing a multistate license under the NLC, the applicant must submit a Declaration of Primary State of Residence Form and any other documentation required by the licensing board to satisfactorily establish the change in the primary state of residence.[42] The multistate license issued by the prior home state must be deactivated in accordance with applicable rules adopted by the Interstate Commission of Nurse Licensure Compact Administrators. If a nurse moves his or her primary state of residence from a party state to a non-party state, the multistate license issued in the previous home state will convert to a single-state license, valid only in that state.

Additional Authority of the Party State Licensing Boards (Article V)

A state licensing board or state agency has the authority to:

- Take adverse action against a nurse's multistate licensure privilege to practice within that party state, but only a nurse's home state has the power to take action against the nurse's license issued in the home state.[43]
- Issue cease and desist orders or impose an encumbrance to practice within that party state.
- Complete any pending investigation of a nurse who changes his or her primary state of residence during the course of such investigation. The licensing board is authorized to taken any appropriate action and must promptly report the findings of such investigations to the

[39] An encumbrance is any revocation, suspension, or limitation on the full and unrestricted practice of nursing imposed by a licensing board.
[40] An alternative program is a non-disciplinary monitoring program approved by a licensing board.
[41] The nurse may apply for licensure in advance of the change of his or her primary state of residence.
[42] *See* NCSBN, *Nurse Licensure Compact Frequently Asked Questions*, *available at* https://www.ncsbn.org/94.htm (last visited January 4, 2016). Currently, each party state has its own Declaration of Primary State of Residence Form. For examples, see Texas' form, *available at* https://www.bon.texas.gov/forms_primary_state_of_residence_sworn_declaration.asp; New Mexico's form, *available at* http://nmbon.sks.com/primary-state-of-residence-declaration.aspx; Maryland's form, *available at* http://mbon.maryland.gov/Pages/msl-index.aspx; et al. (last visited each website on January 4, 2016).
[43] The home state must give the same priority and effect to conduct reported from a remote state as it would to conduct that occurred within the home state. The home state applies its own state laws to determine appropriate conduct. For example, if the nurse committed an offense in a remote state that would result in an emergency suspension of his or her license had it been committed in the home state, the home state should treat the offense as if it occurred in its state and suspend the license.

administrator of the coordinated licensure information system. The administrator will promptly report such actions to the new home state.
- Issue subpoenas for hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Party states will enforce, by a court of competent jurisdiction, such subpoenas issued by other party states. The party state issuing the subpoena must pay any fees or costs required by the service statutes of the state in which the witness or evidence is located.
- Obtain and submit fingerprints or other biometric information for federal and state criminal background checks and use the results to make licensure decisions.
- If permitted by state law, the licensing board may recover the costs of investigations and disposition of cases resulting from any adverse action taken against a license.
- Take adverse action based on the factual findings of a remote state.

If adverse action is taken by a home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice is deactivated until all encumbrances of his or her multistate license has been removed. In any disciplinary order issued by a home state that imposes adverse actions, a statement that the nurse's multistate licensure privilege has been deactivated must be included. If, in lieu of adverse action, a home state allows the nurse to participate in an alternative program, the multistate licensure privilege must be deactivated for the duration of such program.

Coordinated Licensure Information System and Exchange Information (Article VI)

All party states must participate in the coordinated licensure information system, which includes information on the licensure and disciplinary history of each nurse. Any adverse action, current significant investigative information, licensure denials and reason for denial, and nurse participation in alternative programs known to the licensure board, whether such participation is deemed nonpublic or confidential under state law, must be reported to the coordinated licensure information system. Although nonparty states may have access to licensure and disciplinary information in the coordinated licensure information system, information regarding current significant investigations and participation in nonpublic or confidential alternative programs is only available to the licensure boards of party states.

A party state may indicate that information it has submitted may not be shared with non-party states or other entities without express permission of that state. A party state may not share information obtained from the system that includes personally identifiable information except to the extent allowed by the laws of the party state contributing the information. Information on the system must be expunged in accordance with the laws of the contributing state.

The compact administrator of each state must submit a uniform data set to each party state, which includes:

- Identifying information;
- Licensure data;
- Information related to alternative program participation; and
- Other information that may facilitate the administration of the Compact, as determined by commission rules.

Upon request from another party state, a party state must provide all investigative documents and information.

Interstate Commission of Nurse Licensure Compact Administrators (Article VII)

The NLC creates the Interstate Commission of Nurse Licensure Compact Administrators (commission). The NLC contains a choice of forum provision that requires legal action to be brought solely and

exclusively in a court of competent jurisdiction where the principal office of the commission is located, unless waived by the commission.[44]

The head of the licensing board or his or her designee is designated as the compact administrator for each party state and is required to be a member of the commission. If a state removes or suspends a compact administrator from his or her office, such administrator's vacancy on the commission will be filled in accordance with the laws of the party state.

Each compact administrator is entitled to an equal vote on the promulgation of rules and the creation of bylaws, and is afforded the opportunity to participate in the business and affairs of the commission.

The commission is required to meet once a year; however, it may have additional meetings in accordance with the commission bylaws. All meetings are open to the public and publicly noticed. The notice must be posted on the commission's website and include the time, date, and location of the meeting and each party state must provide notice of the meeting on the licensing board's website or in accordance with its respective public notice requirements.

The NLC allows the commission to participate in closed, nonpublic meetings to discuss certain topics. Prior to a meeting being closed, legal counsel for the commission has to certify that the meeting may be closed for discussion involving the following topics:

- A party state's noncompliance with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the NLC; or
- Matters specifically exempted from disclosure by federal or state law.

The commission must keep comprehensive minutes of matters discussed in its meetings and provide a full and accurate summary of actions taken, and the reasons therefor. Minutes of a closed meeting will be sealed; however, such minutes may be released pursuant to a majority vote of the commission or an order of a court of competent jurisdiction.

The NLC directs the commission to adopt and publish bylaws or rules to govern its conduct in carrying out the purposes and the exercise of its power under the compact, including bylaws or rules related to standards and procedures for recordkeeping, holding meetings, selecting officers, establishing personnel policies, and winding up the commission's operations.

The NLC vests the commission with the powers to:

- Promulgate rules to facilitate and coordinate implementation and administration of the compact;
- Bring and prosecute legal proceedings or actions in the name of the commission; as long as a party state's standing to sue or be sued under applicable law is not affected;

[44] The principal office of the commission is located in Chicago, Illinois.

- Purchase and maintain insurance and bonds;
- Borrow, accept, or contract for services or personnel;
- Cooperate with other organizations that administer state compacts related to the regulation of nursing;
- Hire employees, elect or appoint officers, fix compensation, define duties, and grant such individuals appropriate authority to carry out the purposes of the compact;
- Establish personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters;
- Accept any and all appropriate donations, grants, and gifts of money, equipment, supplies, materials, and services, and to receive, utilize, and dispose of the same, provided the commission avoids any appearance of impropriety or conflict of interest;
- Lease, purchase, accept appropriate gifts or donations of, or otherwise to own, hold, improve or use any real, personal, or mixed property;
- Sell, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;
- Establish a budget and make expenditures;
- Pay its reasonable expenses;
- Levy, and collect an annual assessment from each state to cover the costs of operation, activities, and staff;
- Borrow money;
- Appoint committees;
- Provide and receive information from, and to cooperate with, law enforcement agencies;
- Adopt and use an official seal; and
- Perform any other lawful duties necessary or appropriate to achieve the purposes of the compact.

Pursuant to the NLC, the commission may not incur any financial obligation until it has secured adequate funds to meet such obligation. The commission may not pledge the credit of any party state, without the party state's explicit authority. The NLC requires the commission to maintain accurate fiscal records, which must be audited annually by a certified public accountant. The results of the audit must be included in the commission's annual report.

The NLC provides immunity to the administrators, executive director, employees, and representatives from suit and liability, either personally or in their official capacity, for claims arising out of their official duties and responsibilities, as long as the damage is not caused by intention, willful, or wanton misconduct. The NLC also provides that it will provide defense and indemnification in any such actions.

Nothing in the compact is to be construed as a waiver of sovereign immunity.

Rule-making (Article VIII)

The NLC provides rule-making authority to the commission. Rules and amendments to the rules passed by the commission are binding on the party states as of the effective date specified in each rule or amendment.

Prior to the promulgation and adoption of a rule, the commission must provide notice of the meeting at which the rule is to be considered and voted upon, at least 60 days in advance. The notice must be posted on the commission's website and the website of the licensing board of each member state and include:

- The time, date, and location of the meeting;
- The text of the proposed rule or amendment,
- The reason for the proposed rule or amendment;
- A request for comment from interested persons; and

- The manner in which interested persons may submit comments.

The commission must provide an opportunity for a public hearing before the adoption of a rule or an amendment, and provide sufficient notice of the time, place, and date of the hearing. Final action on proposed rules is taken by a majority vote of all administrators. The commission may make technical revisions, such as typographical or grammatical errors, without engaging in the rule-making process, by posting such revisions to the commission's website. Members of the public may challenge a revision on grounds that the revision results in a material change to a rule. The challenge must be in writing and delivered to the commission within 30 days of the notice of the technical revision being posted. If the revision is challenged, the revision may not take effect without approval of the commission.

The commission has the authority to consider and adopt emergency rules, without prior notice, if there is an imminent threat to public health, safety, or welfare; to prevent a loss of funds of the commission or a party state; or to meet a deadline for the promulgation of an administrative rule that is required by federal law. The standard rule-making procedure is to be applied retroactively as soon as possible but no later than 90 days after the effective date of the emergency rule.

Oversight, Dispute Resolution, and Enforcement (Article IX)

The commission is charged with enforcing the provisions and rules of the NLC. However, all party states are obligated to enforce the NLC and to take any necessary action to effectuate its purpose and intent. The commission is entitled to receive service of process relating to its powers, responsibilities, or actions, and may intervene in any proceeding affecting such.

If a party state defaults in the performance of its duties or responsibilities under the NLC, the commission will notify the defaulting state, as well as other party states, in writing of the nature of the default and proposed cure(s) of the default. The commission will also provide remedial training and technical assistance related to the default. If the defaulting state fails to cure the default, the commission may terminate its membership in the NLC, upon majority affirmative vote of the majority of the administrators. The commission must notify the governor and the head of the licensing board of the defaulting state, as well as all party states, of its intent to suspend or terminate the state's membership in the NLC. However, termination of membership is to only be imposed after all other means of compliance have been exhausted.

A termination of membership in the NLC may be appealed by petitioning the U.S. District Court for the District of Columbia or the federal district in which the commission's principal office is located. The commission's principal office is located in Chicago, Illinois. The commission may also bring an action in federal court against a defaulting state to enforce compliance with the provisions of the NLC. The commission may seek injunctive relief, damages, or any other remedies available under state or federal law. A prevailing party in either action is entitled to court costs and reasonable attorneys' fees.

In the event that a dispute arises between party states, the commission will attempt to resolve such disputes. The NLC directs the commission to promulgate a rule that provides for mediation and binding dispute resolution. If a dispute cannot be resolved by the commission, the NLC provides that the issue may be submitted to an arbitration panel, whose decision is final and binding.

Effective Date, Withdrawal and Amendment (Article X)

The NLC becomes effective and binding on the earlier of the date of legislative enactment by at least 26 states or December 31, 2018. The NLC provides a procedure for adopting the revised compact for states that were a party to the prior contract.

To withdraw from the NLC, a state must enact a statute repealing the NLC. Such withdrawal does not take effect until six months after the enactment of the repealing legislation. Any adverse actions or

significant investigations that occur prior to the effective date of a withdrawal or termination must be reported as required under the NLC.

The NLC may be amended by the party states; however, an amendment will not be effective until it is enacted into the laws of all the party states. The NLC authorizes non-party states to be invited to participate in the activities of the commission, on a nonvoting basis.

Construction and Severability

The NLC is to be liberally construed to effectuate its purposes. The NLC contains a severability clause that provides that any provision that is found to be unconstitutional pursuant to a state constitution or the U.S. Constitution is severed and the other provisions of the compact remain valid. If the entire compact is found to be unconstitutional in a party state, the NLC remains in full force and effect for all other party states.

OPPAGA Review of the NLC

2006 OPPAGA Report

In 2006, the Office of Program Policy Analysis and Government Accountability (OPPAGA) released a report evaluating the possibility of Florida adopting the original NLC.[45] OPPAGA concluded that adopting the NLC would allow the state to alleviate short-term nursing shortages but would not resolve the state's long-term nursing shortage. The report identified several benefits that would be realized by adopting the NLC. Those benefits included:

- Access to NURSYS®, the coordinated licensure information system, would provide improved access to information regarding disciplinary action taken against a nurse's license and notification of a nurse under investigation for patient safety issues, including information that is only available to party states.
- As a party state, Florida would be able to influence interstate nursing policies as a member of the Nurse Licensure Compact Administrators.

Conversely, the report also identified several disadvantages to joining the compact at that time:

- Potentially, there could be an increase in disciplinary cases, both domestic and multistate, which could have a negative fiscal impact on the DOH.
- Florida's continuing education requirements would not apply to a nurse working in Florida but whose home state is not Florida.
- A nurse whose home state was not Florida may not be subject to a criminal background screening because some party states did not a require criminal background screening for licensure.
- Public access to licensure and disciplinary action may be impaired.
- The DOH and BON will incur some initial start-up costs in implementing the NLC.

Additionally, OPPAGA identified barriers to implementing the original NLC legislation:

- The provisions of the original NLC language may conflict with Florida's public records and open meetings laws. The original NLC required states receiving information to honor the confidentiality restrictions of the state providing the information, and did not address notice requirements for open meetings.

[45] OPPAGA, *Nurse Licensure Compact Would Produce Some Benefits But Not Resolve the Nursing Shortage*, Report No. 06-02 (Jan. 2006), *available at* http://www.oppaga.state.fl.us/Summary.aspx?reportNum=06-02 (last visited January 4, 2016).

- The original NLC provided general and broad authorization for the compact administrators to develop rules that were required to be adopted by party states, which raised concern about an unlawful delegation of legislative authority.
- The DOH and the BON would need to educate nurses and employers on the NLC and its requirements for the NLC to operate as intended.
- A compact nurse is not required to notify the BON when he or she enters the state to practice nursing, making it difficult for the workforce data to be captured. Additionally, the BON would not be on notice that a nurse under investigation in another state has entered Florida to work.

The report made several recommendations, including seeking approval to use alternative compact language to address the barriers identified in the report. Other recommendations including authorizing the BON to require employers to report employment data, providing a later effective date to allow for education of the public regarding the NLC, and requiring the BON to report information to the legislature on the effect of the NLC two years after its implementation.

2015 OPPAGA Memorandum

In 2015, the revised NLC was reviewed by OPPAGA to determine if it adequately addresses concerns identified in the 2006 report.[46] OPPAGA found that the revised NLC resolved some of the barriers and disadvantages listed above, and specifically it found:

- The revised NLC partially addresses the concerns regarding constitutional issues related to public meetings but did not address public records concerns.
    - Under the revised NLC, there are provisions requiring the commission to publicly notice meetings on its website, as well as the websites of party states. However, the commission is allowed to have closed door meetings to address certain issues. Such meetings may be deemed inconsistent with Florida's open meetings law.
    - A party state may still designate information it provides as confidential and restrict the sharing of such information. However, once the information is in the possession of the BON, it may be considered a public record under Florida law, available through the BON.
- The revised NLC addresses the issue of delegation of legislative authority, by limiting the scope of the rules the commission may adopt to only those rules that would facilitate and coordinate the implementation and administration of the NLC. OPPAGA suggests that the legislature include an expiration date, an automatic repeal provision, or a required review of the NLC to provide the legislature with an opportunity to review the rules adopted by the commission.
- The revised NLC does not become effective until it has been enacted by 26 states or December 31, 2018, whichever is earlier. This provides the state with the time needed to educate nurses and employers about the NLC.
- The revised NLC does not require employers of compact nurses who are practicing in a state under a multistate licensure privilege to report such employment to the state's board of nursing.
- Public access to nurse disciplinary information has improved due to the increased state participation in NURSYS®, the coordinated licensure information system.
- The revised NLC requires a criminal background screening for licensees. However, this requirement only applies to new multistate licensure applicants, and a nurse who currently holds a multistate license will not have to undergo a criminal background screening unless required by his or her home state.
- The NLC does not address continuing education requirements. Although most states require some continuing education, not all states do. Florida authorities would be unable to enforce continuing education requirements for those practicing in the state under the multistate licensing privilege.

[46] *Supra* fn. 24. *See also* OPPAGA, Presentation to the House Select Committee on Affordable Healthcare Access (December 1, 2015), *available at* http://www.oppaga.state.fl.us/Presentations.aspx (last visited January 4, 2016).

OPPAGA advises that the revised NLC does not affect the benefits it identified in its 2006 report. In addition to those benefits, it noted that as a member of the NLC, the processing time and resources required to process a licensure by endorsement would be reduced or eliminated. Florida would also be able to access investigative information earlier and would be able to open its own investigation if the nurse is practicing in this state.

Effect of Proposed Changes

Nurse Licensure Compact

The bill enacts the Nurse Licensure Compact in full (see description of compact provisions in the Current Situation section) and authorizes Florida to enter into the NLC with all other jurisdictions that have legally joined the NLC. The bill makes minor changes to the language of the NLC, including stylistic and grammatical changes and adding definitions for "commission" and "compact." Some of the primary purposes of the NLC include addressing the expanded mobility of nurses and use of advanced communication technologies, such as telehealth. Furthermore, in Florida, the bill would expedite or eliminate the time it requires a military spouse who is a nurse to be able to practice here and address the demand for temporary nurses during seasonal increases in population caused by tourism.

The bill amends current law to allow NLC implementation. It authorizes the DOH to charge a fee to convert a single-state license to a multistate license. The bill exempts an individual who holds a multistate license from having to comply with the licensure by examination or licensure by endorsement requirements. The DOH must designate each nurse license it issues as either a single-state or multistate license.

The bill makes conforming changes to statute to reference the multistate license and the requirements under the NLC. The bill does not require changes to Florida's licensure and license renewal requirements. However, an applicant that wishes to apply for a multistate license must meet the requirements of the NLC, in addition to the Florida licensure requirements.

Single-State Licenses

A party state may also issue single-state licenses for those individuals that meet the party state's requirements for a single-state license. The NLC does not govern the requirements for a single-state license. A single-state-license does not authorize the holder to practice nursing in any other state but the state of issuance. Nonparty states will continue to issue single-state licenses.

Florida may issue a single-state license upon the request of an applicant or for individuals who do not qualify for a multistate license but otherwise qualify to be licensed in Florida. For example, the NLC does not allow an individual who has been convicted of a felony to be issued a multistate license. However, under Florida law, the Board will review the application of individuals with felony convictions on a case-by-case basis to determine eligibility for licensure. If the board deems that the applicant does not pose a threat to public safety, the board may issue only a single-state license.

The bill requires that all licenses must be conspicuously designated as either a single-state license or a multistate license.

The Florida Center for Nursing

The Florida Center for Nursing was established by the Legislature in 2001, to address the issues of supply and demand for nursing, including the recruitment, retention, and utilization of nurse workforce resources.[47] The bill requires the Florida Center for Nursing to include the impact of the state's participation in the NLC in its supply and demand calculations and projections for the need for nurse

[47] Chapter 2001-277, L.O.F. and s. 464.0195, F.S.

workforce resources. The Florida Center for Nursing is authorized to request any information held by the board regarding nurses licensed in this state, holding a multistate license, or any information reported by employers of such nurses, other than personally identifiable information.

Enactment Date

The bill provides an effective date of December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by twenty-six other states, whichever date occurs first in time.

B. SECTION DIRECTORY:

Section 1. Amends s. 456.073, F.S., relating to disciplinary proceedings.
Section 2. Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners.
Section 3. Amends s. 464.003, F.S., relating to definitions.
Section 4. Amends s. 464.004, F.S., relating to the Board of Nursing.
Section 5. Amends s. 464.008, F.S., relating to licensure by examination.
Section 6. Amends s. 464.009, F.S., relating to licensure by endorsement.
Section 7. Creates s. 464.0095, F.S., relating to the Nurse Licensure Compact.
Section 8. Amends s. 464.012, F.S., relating to certification of advanced registered nurse practitioners.
Section 9. Amends s. 464.019, F.S., relating to titles and abbreviations.
Section 10. Amends s. 464.018, F.S., relating to disciplinary actions.
Section 11. Amends s. 464.0195, F.S., relating to the Florida Center for Nursing.
Section 12. Provides an effective date of December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by twenty-six other states, whichever date occurs first in time.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

Due to the authorized fee for conversion of a single-state license to a multistate license, the DOH may realize an indeterminate, positive fiscal impact. The DOH has not yet determined the fee it will charge for conversion. The fee for initial licensure will not change.

The DOH may incur an indeterminate, negative fiscal impact due the loss of fees associated with licensure by endorsement and licensure renewal fees for those who are licensed in Florida but holds a multistate license from their home state. There are currently 16,351 nurses licensed in Florida who are also licensed in compact states.[48] However, this loss will likely be off-set by a reduction in expenditures related to the processing of licensure by endorsement applications, as nurses from member states will no longer need to obtain a Florida license to practice.

2. Expenditures:

The DOH will incur an indeterminate, negative fiscal impact associated with implementation of the NLC, including a one-time modification of computer software and education of the public.

The DOH may incur an indeterminate, negative fiscal impact due to an increase in complaints filed against nurses practicing in the state under the NLC.

The DOH may incur indeterminate, insignificant costs associated with the activities of the commission, such as travel for the compact administrator.

The DOH will incur a negative fiscal impact of $6,000 annually to pay the compact membership fee.

[48] E-mail from the staff of the DOH (December 10, 2015), on file with the Health Quality Subcommittee.

The bill requires the DOH to comply with the rules adopted by the commission. Until the content of the rules is known, the fiscal impact for compliance is indeterminate.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

A nurse currently licensed in Florida would be subject to a fee for the conversion of his or her single-state license to a multistate license.

Fees associated with applying for a license in a party state would be eliminated for a nurse whose home state is Florida and wants to practice in a party state, as well as a nurse whose home state is in a party state and wishes to practice in Florida. In addition, employers of nurses will likely experience improved ease of recruitment, as nurses can more easily move between states, both permanently and temporarily.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

As discussed below in the section entitled, "RULE-MAKING AUTHORITY," the bill delegates authority to the commission to adopt rules that facilitate and coordinate the implementation and administration of the Nurse Licensure Compact.

If enacted into law, the state will effectively bind itself to rules not yet adopted by the commission. The Florida Supreme Court has held that while it is within the province of the Legislature to adopt federal statutes enacted by Congress and rules promulgated by federal administrative bodies that are in existence at the time the Legislature acts, it is an unconstitutional delegation of legislative power to prospectively adopt federal statutes not yet enacted by Congress and rules not yet promulgated by federal administrative bodies.[49][50] Under this holding, the constitutionality of the bill's adoption of prospective rules might be questioned, and there does not appear to be binding Florida case law that squarely address this issue in the context of interstate compacts.

[49] *Freimuth v. State*, 272 So.2d 473, 476 (Fla. 1972) (quoting *Fla. Ind. Comm'n v. State ex rel. Orange State Oil Co.*, 155 Fla. 772 (1945).

[50] This prohibition is based on the separation of powers doctrine, set forth in Article II, Section 3 of the Florida Constitution, which has been construed in Florida to require the Legislature, when delegating the administration of legislative programs, to establish the minimum standards and guidelines ascertainable by reference to the enactment creating the program. *See Avatar Development Corp. v. State*, 723 So.2d 199 (Fla. 1998).

The most recent opportunity Florida courts have had to address this issue appears to be in *Department of Children and Family Services v. L.G.*, involving the Interstate Compact for the Placement of Children (ICPC).[51] The First District Court of Appeal considered an argument that the regulations adopted by the Association of Administrators of the Interstate Compact were binding and that the lower court's order permitting a mother and child to relocate to another state was in violation of the ICPC. The court denied the appeal and held that the Association's regulations did not apply as they conflicted with the ICPC and the regulations did not apply to the facts of the case.

The court also references language in the ICPC that confers to its compact administrators the "power to promulgate rules and regulations to carry out more effectively the terms and provisions of this compact."[52] The court states that "the precise legal effect of the ICPC compact administrators' regulations in Florida is unclear," but noted that it did not need to address the question to decide the case.[53] However, in a footnote, the court provided:

> Any regulations promulgated before Florida adopted the ICPC did not, of course, reflect the vote of a Florida compact administrator, and no such regulations were ever themselves enacted into law in Florida. When the Legislature did adopt the ICPC, it did not (and could not) enact as the law of Florida or adopt prospectively regulations then yet to be promulgated by an entity not even covered by the Florida Administrative Procedure Act. *See Freimuth v. State,* 272 So.2d 473, 476 (Fla.1972); *Fla. Indus. Comm'n v. State ex rel. Orange State Oil Co.,* 155 Fla. 772, 21 So.2d 599, 603 (1945) ("[I]t is within the province of the legislature to approve and adopt the provisions of federal statutes, and all of the administrative rules made by a federal administrative body, that are in existence and in effect at the time the legislature acts, but it would be an unconstitutional delegation of legislative power for the legislature to adopt in advance any federal act or the ruling of any federal administrative body that Congress or such administrative body might see fit to adopt in the future."); *Brazil v. Div. of Admin.*, 347 So.2d 755, 757–58 (Fla. 1st DCA 1977), *disapproved on other grounds by LaPointe Outdoor Adver. v. Fla. Dep't of Transp.,* 398 So.2d 1370, 1370 (Fla.1981). The ICPC compact administrators stand on the same footing as federal government administrators in this regard.[54]

In accordance with the discussion provided by the court in this above-cited footnote, it may be argued that the bill's delegation of rule-making authority to the commission is similar to the delegation to the ICPC compact administrators, and thus, could constitute an unlawful delegation of legislative authority. This case, however, does not appear to be binding as precedent as the court's footnote discussion is dicta.[55]

The bill requires the Florida Center for Nursing to assess the impact on the state's participation in the Nurse Licensure Agreement, and include such impact in its strategy for meeting the state's needs for nursing resources. Based on the assessment provided by the Florida Center for Nursing, the Legislature may make decisions on Florida's continued participation in the NLC. The Legislature may also review and reenact the NLC post-adoption of the commission's rules, which may counter a claim that the authority given to the NLC commission to adopt rules is an unlawful delegation.[56]

---

[51] 801 So.2d 1047 (Fla. 1st DCA 2001).
[52] *Id* at 1052.
[53] *Id.*
[54] *Id.*
[55] Dicta are statements of a court that are not essential to the determination of the case before it and are not a part of the law of the case. Dicta has no biding legal effect and is without force as judicial precedent. 12A FLA JUR. 2D *Courts and Judges* s. 191 (2015).
[56] *Supra* fn. 24.

B. RULE-MAKING AUTHORITY:

The bill authorizes the Interstate Commission of Nurse Licensure Compact Administrators to adopt rules to facilitate and coordinate the implementation and administration of the compact. The NLC specifies that the rules have the force and effect of law and are binding in all party states. If a party state fails to meet its obligations under the NLC or the promulgated rules, the state may be subject to remedial training, alternative dispute resolution, suspension, termination, or legal action.

The compact details the rule-making process that must be followed including, notice, an opportunity for public participation, and hearings. The compact also provides a procedure for emergency rule-making in cases of imminent danger to public health, safety, or welfare, to prevent financial loss to the state's or commission, or to comply with federal laws or regulations. All rules and amendments are binding on party state as of the effective date specified.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to the Nurse Licensure Compact; amending s. 456.073, F.S.; requiring the Department of Health to report certain investigative information to the coordinated licensure information system; amending s. 456.076, F.S.; requiring an impaired practitioner consultant to disclose certain information to the department; requiring a nurse holding a multistate license to report participation in a treatment program to the department; amending s. 464.003, F.S.; revising definitions, to conform; amending s. 464.004, F.S.; requiring the executive director of the Board of Nursing or his or her designee to serve as state administrator of the Nurse Licensure Compact; amending s. 464.008, F.S.; providing eligibility criteria for a multistate license; requiring that multistate licenses be distinguished from single-state licenses; exempting certain persons from licensed practical nurse and registered nurse licensure requirements; amending s. 464.009, F.S.; exempting certain persons from requirements for licensure by endorsement; creating s. 464.0095, F.S.; creating the Nurse Licensure Compact; providing findings and purpose; providing definitions; providing for the recognition of nursing licenses in party states; requiring party states to perform criminal history checks of licensure applicants;

providing requirements for obtaining and retaining a multistate license; authorizing party states to take adverse action against a nurse's multistate licensure privilege; requiring notification to the home licensing state of an adverse action against a licensee; requiring nurses practicing in party states to comply with state practice laws; providing limitations for licensees not residing in a party state; providing the effect of the act on a current licensee; providing application requirements for a multistate license; providing licensure requirements when a licensee moves between party states or to a nonparty state; providing certain authority to state licensing boards of party states; requiring deactivation of a nurse's multistate licensure privilege under certain circumstances; authorizing participation in an alternative program in lieu of adverse action against a license; requiring all party states to participate in a coordinated licensure information; providing for the development of the system, reporting procedures, and the exchange of certain information between party states; establishing the Interstate Commission of Nurse Licensure Compact Administrators; providing for the jurisdiction and venue for court proceedings; providing membership and duties; authorizing the commission to adopt rules;

providing rulemaking procedures; providing for state enforcement of the compact; providing for the termination of compact membership; providing procedures for the resolution of certain disputes; providing an effective date of the compact; providing a procedure for membership termination; providing compact amendment procedures; authorizing nonparty states to participate in commission activities before adoption of the compact; providing construction and severability; amending s. 464.012, F.S.; authorizing a multistate licensee under the compact to be certified as an advanced registered nurse practitioner if certain eligibility criteria are met; amending s. 464.015, F.S.; authorizing registered nurses and licensed practical nurses holding a multistate license under the compact to use certain titles and abbreviations; amending s. 464.018, F.S.; revising the grounds for denial of a nursing license or disciplinary action against a nursing licensee; authorizing certain disciplinary action under the compact for certain prohibited acts; amending s. 464.0195, F.S.; revising the information required to be included in the database on nursing supply and demand; requiring the Florida Center for Nursing to analyze and make future projections of the supply and demand for nurses; authorizing the center to request,

and requiring the Board of Nursing to provide, certain information about licensed nurses; providing an effective date.

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

Section 1. Subsection (10) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.—Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(10) The complaint and all information obtained pursuant to the investigation by the department are confidential and exempt from s. 119.07(1) until 10 days after probable cause has been found to exist by the probable cause panel or by the department, or until the regulated professional or subject of the investigation waives his or her privilege of confidentiality, whichever occurs first. The department shall report any significant investigation information relating to a nurse holding a multistate license to the coordinated licensure information system pursuant to s. 464.0095. Upon completion of the investigation and a recommendation by the department to find probable cause, and pursuant to a written request by the subject or the subject's attorney, the department shall provide the subject an opportunity to inspect the investigative file or, at the subject's expense, forward to the subject a copy of the

investigative file. Notwithstanding s. 456.057, the subject may inspect or receive a copy of any expert witness report or patient record connected with the investigation if the subject agrees in writing to maintain the confidentiality of any information received under this subsection until 10 days after probable cause is found and to maintain the confidentiality of patient records pursuant to s. 456.057. The subject may file a written response to the information contained in the investigative file. Such response must be filed within 20 days of mailing by the department, unless an extension of time has been granted by the department. This subsection does not prohibit the department from providing such information to any law enforcement agency or to any other regulatory agency.

Section 2. Subsection (9) of section 456.076, Florida Statutes, is amended to read:

456.076 Treatment programs for impaired practitioners.—

(9) An impaired practitioner consultant is the official custodian of records relating to the referral of an impaired licensee or applicant to that consultant and any other interaction between the licensee or applicant and the consultant. The consultant may disclose to the impaired licensee or applicant or his or her designee any information that is disclosed to or obtained by the consultant or that is confidential under paragraph (6)(a), but only to the extent that it is necessary to do so to carry out the consultant's duties under this section. The department, and any other entity that

enters into a contract with the consultant to receive the services of the consultant, has direct administrative control over the consultant to the extent necessary to receive disclosures from the consultant as allowed by federal law. The consultant must disclose to the department, upon the department's request, whether an applicant for a multistate license under s. 464.0095 is participating in a treatment program and must report to the department when a nurse holding a multistate license under s. 464.0095 enters a treatment program. A nurse holding a multistate license pursuant to s. 464.0095 must report to the department within 2 business days after entering a treatment program pursuant to this section. If a disciplinary proceeding is pending, an impaired licensee may obtain such information from the department under s. 456.073.

Section 3. Subsections (16) and (22) of section 464.003, Florida Statutes, are amended to read:

464.003 Definitions.—As used in this part, the term:

(16) "Licensed practical nurse" means any person licensed in this state or holding an active multistate license under s. 464.0095 to practice practical nursing.

(22) "Registered nurse" means any person licensed in this state or holding an active multistate license under s. 464.0095 to practice professional nursing.

Section 4. Subsection (5) is added to section 464.004, Florida Statutes, to read:

464.004 Board of Nursing; membership; appointment; terms.—

(5) The executive director of the board appointed pursuant to s. 456.004(2) or his or her designee shall serve as the state administrator of the Nurse Licensure Compact as required under s. 464.0095.

Section 5. Subsection (2) of section 464.008, Florida Statutes, is amended, and subsection (5) is added to that section, to read:

464.008 Licensure by examination.—

(2)(a) Each applicant who passes the examination and provides proof of meeting the educational requirements specified in subsection (1) shall, unless denied pursuant to s. 464.018, be entitled to licensure as a registered professional nurse or a licensed practical nurse, whichever is applicable.

(b) An applicant who resides in this state, meets the licensure requirements of this section, and meets the criteria for multistate licensure under s. 464.0095 may request the issuance of a multistate license from the department.

(c) A nurse who holds a single-state license in this state and applies to the department for a multistate license must meet the eligibility criteria for a multistate license under s. 464.0095 and must pay an application and licensure fee to change the licensure status.

(d) The department shall conspicuously distinguish a multistate license from a single-state license.

(5) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the

licensure requirements of this section.

Section 6. Subsection (7) is added to section 464.009, Florida Statutes, to read:

464.009 Licensure by endorsement.—

(7) A person holding an active multistate license in another state pursuant to s. 464.0095 is exempt from the requirements for licensure by endorsement in this section.

Section 7. Section 464.0095, Florida Statutes, is created to read:

464.0095 Nurse Licensure Compact.—The Nurse Licensure Compact is hereby enacted into law and entered into by this state with all other jurisdictions legally joining therein in the form substantially as follows:

ARTICLE I

FINDINGS AND DECLARATION OF PURPOSE

(1) The party states find that:

(a) The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to state nurse licensure laws.

(b) Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public.

(c) The expanded mobility of nurses and the use of advanced communication technologies as part of the nation's health care delivery system require greater coordination and cooperation among states in the areas of nurse licensure and

regulation.

(d) New practice modalities and technology make compliance with individual state nurse licensure laws difficult and complex.

(e) The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant for both nurses and states.

(f) Uniformity of nurse licensure requirements throughout the states promotes public safety and public health benefits.

(2) The general purposes of this compact are to:

(a) Facilitate the states' responsibility to protect the public's health and safety.

(b) Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation.

(c) Facilitate the exchange of information among party states in the areas of nurse regulation, investigation, and adverse actions.

(d) Promote compliance with the laws governing the practice of nursing in each jurisdiction.

(e) Invest all party states with the authority to hold a nurse accountable for meeting all state practice laws in the state in which the patient is located at the time care is rendered through the mutual recognition of party state licenses.

(f) Decrease redundancies in the consideration and issuance of nurse licenses.

(g) Provide opportunities for interstate practice by

nurses who meet uniform licensure requirements.

ARTICLE II

DEFINITIONS

As used in this compact, the term:

(1) "Adverse action" means any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege, such as revocation, suspension, probation, monitoring of the licensee, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.

(2) "Alternative program" means a nondisciplinary monitoring program approved by a licensing board.

(3) "Commission" means the Interstate Commission of Nurse Licensure Compact Administrators established by this compact.

(4) "Compact" means the Nurse Licensure Compact recognized, established, and entered into by the state under this compact.

(5) "Coordinated licensure information system" means an integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws which is administered by a nonprofit organization composed of and controlled by licensing boards.

(6) "Current significant investigative information" means:

(a) Investigative information that a licensing board, after a preliminary inquiry that includes notification and an opportunity for the nurse to respond, if required by state law, has reason to believe is not groundless and, if proved true, would indicate more than a minor infraction; or

(b) Investigative information that indicates that the nurse represents an immediate threat to public health and safety regardless of whether the nurse has been notified and had an opportunity to respond.

(7) "Encumbrance" means a revocation or suspension of, or any limitation on, the full and unrestricted practice of nursing imposed by a licensing board.

(8) "Home state" means the party state that is the nurse's primary state of residence.

(9) "Licensing board" means a party state's regulatory body responsible for issuing nurse licenses.

(10) "Multistate license" means a license to practice as a registered nurse (RN) or a licensed practical/vocational nurse (LPN/VN) issued by a home state licensing board which authorizes the licensed nurse to practice in all party states under a multistate licensure privilege.

(11) "Multistate licensure privilege" means a legal authorization associated with a multistate license permitting the practice of nursing as either an RN or an LPN/VN in a remote state.

(12) "Nurse" means an RN or LPN/VN, as those terms are defined by each party state's practice laws.

(13) "Party state" means any state that has adopted this compact.

(14) "Remote state" means a party state other than the home state.

(15) "Single-state license" means a nurse license issued by a party state which authorizes practice only within the issuing state and does not include a multistate licensure privilege to practice in any other party state.

(16) "State" means a state, territory, or possession of the United States, or the District of Columbia.

(17) "State practice laws" means a party state's laws, rules, and regulations that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for imposing discipline. The term "state practice laws" does not include requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

ARTICLE III

GENERAL PROVISIONS AND JURISDICTION

(1) A multistate license to practice registered or licensed practical/vocational nursing issued by a home state to a resident in that state shall be recognized by each party state as authorizing a nurse to practice as an RN or as an LPN/VN under a multistate licensure privilege in each party state.

(2) Each party state must implement procedures for considering the criminal history records of applicants for initial multistate licensure or licensure by endorsement. Such procedures shall include the submission of fingerprints or other biometric-based information by applicants for the purpose of obtaining an applicant's criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(3) In order for an applicant to obtain or retain a multistate license in the home state, each party state shall require that the applicant fulfills the following criteria:

(a) Meets the home state's qualifications for licensure or renewal of licensure, as well as all other applicable state laws.

(b)1. Has graduated or is eligible to graduate from a licensing board-approved RN or LPN/VN prelicensure education program; or

2. Has graduated from a foreign RN or LPN/VN prelicensure education program that has been approved by the authorized accrediting body in the applicable country and has been verified by a licensing board-approved independent credentials review agency to be comparable to a licensing board-approved prelicensure education program.

(c) If the applicant is a graduate of a foreign prelicensure education program not taught in English, or if English is not the applicant's native language, has successfully

passed a licensing board-approved English proficiency examination that includes the components of reading, speaking, writing, and listening.

(d) Has successfully passed an NCLEX-RN or NCLEX-PN Examination or recognized predecessor, as applicable.

(e) Is eligible for or holds an active, unencumbered license.

(f) Has submitted, in connection with an application for initial licensure or licensure by endorsement, fingerprints or other biometric data for the purpose of obtaining criminal history record information from the Federal Bureau of Investigation and the agency responsible for retaining that state's criminal records.

(g) Has not been convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, of a felony offense under applicable state or federal criminal law.

(h) Has not been convicted or found guilty, or has entered into an agreed disposition other than a disposition that results in nolle prosequi, of a misdemeanor offense related to the practice of nursing as determined on a case-by-case basis.

(i) Is not currently enrolled in an alternative program.

(j) Is subject to self-disclosure requirements regarding current participation in an alternative program.

(k) Has a valid United States social security number.

(4) All party states may, in accordance with existing

state due process law, take adverse action against a nurse's multistate licensure privilege, such as revocation, suspension, probation, or any other action that affects the nurse's authorization to practice under a multistate licensure privilege, including cease and desist actions. If a party state takes such action, it shall promptly notify the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the home state of any such actions by remote states.

(5) A nurse practicing in a party state must comply with the state practice laws of the state in which the patient is located at the time service is provided. The practice of nursing is not limited to patient care but shall include all nursing practice as defined by the state practice laws of the party state in which the patient is located. The practice of nursing in a party state under a multistate licensure privilege subjects a nurse to the jurisdiction of the licensing board, the courts, and the laws of the party state in which the patient is located at the time service is provided.

(6) A person not residing in a party state shall continue to be able to apply for a party state's single-state license as provided under the laws of each party state. The single-state license granted to such a person does not grant the privilege to practice nursing in any other party state. This compact does not affect the requirements established by a party state for the issuance of a single-state license.

(7) A nurse holding a home state multistate license, on the effective date of this compact, may retain and renew the multistate license issued by the nurse's then-current home state, provided that:

(a) A nurse who changes his or her primary state of residence after the effective date must meet all applicable requirements under subsection (3) to obtain a multistate license from a new home state.

(b) A nurse who fails to satisfy the multistate licensure requirements under subsection (3) due to a disqualifying event occurring after the effective date is ineligible to retain or renew a multistate license, and the nurse's multistate license shall be revoked or deactivated in accordance with applicable rules adopted by the commission.

ARTICLE IV

APPLICATIONS FOR LICENSURE IN A PARTY STATE

(1) Upon application for a multistate license, the licensing board in the issuing party state shall ascertain, through the coordinated licensure information system, whether the applicant has ever held, or is the holder of, a license issued by any other state, whether there are any encumbrances on any license or multistate licensure privilege held by the applicant, whether any adverse action has been taken against any license or multistate licensure privilege held by the applicant, and whether the applicant is currently participating in an alternative program.

(2) A nurse may hold a multistate license, issued by the home state, in only one party state at a time.

(3) If a nurse changes his or her primary state of residence by moving from one party state to another party state, the nurse must apply for licensure in the new home state, and the multistate license issued by the prior home state shall be deactivated in accordance with applicable rules adopted by the commission.

(a) The nurse may apply for licensure in advance of a change in his or her primary state of residence.

(b) A multistate license may not be issued by the new home state until the nurse provides satisfactory evidence of a change in his or her primary state of residence to the new home state and satisfies all applicable requirements to obtain a multistate license from the new home state.

(4) If a nurse changes his or her primary state of residence by moving from a party state to a nonparty state, the multistate license issued by the prior home state shall convert to a single-state license valid only in the former home state.

ARTICLE V

ADDITIONAL AUTHORITY VESTED IN PARTY STATE LICENSING BOARDS

(1) In addition to the other powers conferred by state law, a licensing board or state agency may:

(a) Take adverse action against a nurse's multistate licensure privilege to practice within that party state.

1. Only the home state has the power to take adverse

action against a nurse's license issued by the home state.

2. For purposes of taking adverse action, the home state licensing board or state agency shall give the same priority and effect to conduct reported by a remote state as it would if such conduct had occurred within the home state. In so doing, the home state shall apply its own state laws to determine appropriate action.

(b) Issue cease and desist orders or impose an encumbrance on a nurse's authority to practice within that party state.

(c) Complete any pending investigation of a nurse who changes his or her primary state of residence during the course of such investigation. The licensing board or state agency may also take appropriate action and shall promptly report the conclusions of such investigation to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any such action.

(d) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses or the production of evidence. Subpoenas issued by a licensing board or state agency in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the latter state by any court of competent jurisdiction according to the practice and procedure of that court applicable to subpoenas issued in proceedings pending before it. The issuing authority shall pay any witness

fees, travel expenses, and mileage and other fees required by the service statutes of the state in which the witnesses or evidence is located.

(e) Obtain and submit, for each nurse licensure applicant, fingerprint or other biometric-based information to the Federal Bureau of Investigation for criminal background checks, receive the results of the Federal Bureau of Investigation record search on criminal background checks, and use the results in making licensure decisions.

(f) If otherwise permitted by state law, recover from the affected nurse the costs of investigations and disposition of cases resulting from any adverse action taken against that nurse.

(g) Take adverse action based on the factual findings of the remote state, provided that the licensing board or state agency follows its own procedures for taking such adverse action.

(2) If adverse action is taken by the home state against a nurse's multistate license, the nurse's multistate licensure privilege to practice in all other party states shall be deactivated until all encumbrances are removed from the multistate license. All home state disciplinary orders that impose adverse action against a nurse's multistate license shall include a statement that the nurse's multistate licensure privilege is deactivated in all party states during the pendency of the order.

(3) This compact does not override a party state's decision that participation in an alternative program may be used in lieu of adverse action. The home state licensing board shall deactivate the multistate licensure privilege under the multistate license of any nurse for the duration of the nurse's participation in an alternative program.

ARTICLE VI

COORDINATED LICENSURE INFORMATION SYSTEM AND EXCHANGE INFORMATION

(1) All party states shall participate in a coordinated licensure information system relating to all licensed RNs and LPNs/VNs. This system shall include information on the licensure and disciplinary history of each nurse, as submitted by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(2) The commission, in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this compact.

(3) All licensing boards shall promptly report to the coordinated licensure information system any adverse action, any current significant investigative information, denials of applications, the reasons for application denials, and nurse participation in alternative programs known to the licensing board regardless of whether such participation is deemed nonpublic or confidential under state law.

(4) Current significant investigative information and participation in nonpublic or confidential alternative programs shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(5) Notwithstanding any other provision of law, all party state licensing boards contributing information to the coordinated licensure information system may designate information that may not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing state.

(6) Any personal identifying information obtained from the coordinated licensure information system by a party state licensing board may not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(7) Any information contributed to the coordinated licensure information system which is subsequently required to be expunged by the laws of the party state contributing that information shall also be expunged from the coordinated licensure information system.

(8) The compact administrator of each party state shall furnish a uniform data set to the compact administrator of each other party state, which shall include, at a minimum:

(a) Identifying information.

(b) Licensure data.

(c) Information related to alternative program participation.

(d) Other information that may facilitate the administration of this compact, as determined by commission rules.

(9) The compact administrator of a party state shall provide all investigative documents and information requested by another party state.

ARTICLE VII

ESTABLISHMENT OF THE INTERSTATE COMMISSION OF NURSE LICENSURE COMPACT ADMINISTRATORS

(1) The party states hereby create and establish a joint public entity known as the Interstate Commission of Nurse Licensure Compact Administrators.

(a) The commission is an instrumentality of the party states.

(b) Venue is proper, and judicial proceedings by or against the commission shall be brought solely and exclusively, in a court of competent jurisdiction where the commission's principal office is located. The commission may waive venue and jurisdictional defenses to the extent it adopts or consents to participate in alternative dispute resolution proceedings.

(c) This compact does not waive sovereign immunity.

(2)(a) Each party state shall have and be limited to one administrator. The executive director of the state licensing board or his or her designee shall be the administrator of this

compact for each party state. Any administrator may be removed or suspended from office as provided by the law of the state from which the administrator is appointed. Any vacancy occurring on the commission shall be filled in accordance with the laws of the party state in which the vacancy exists.

(b) Each administrator is entitled to one vote with regard to the adoption of rules and the creation of bylaws and shall otherwise have an opportunity to participate in the business and affairs of the commission. An administrator shall vote in person or by such other means as provided in the bylaws. The bylaws may provide for an administrator's participation in meetings by telephone or other means of communication.

(c) The commission shall meet at least once during each calendar year. Additional meetings shall be held as set forth in the commission's bylaws or rules.

(d) All meetings shall be open to the public, and public notice of meetings shall be given in the same manner as required under Article VIII of this compact.

(e) The commission may convene in a closed, nonpublic meeting if the commission must discuss:

1. Failure of a party state to comply with its obligations under this compact;

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures;

3. Current, threatened, or reasonably anticipated litigation;

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate;

5. Accusing any person of a crime or formally censuring any person;

6. Disclosure of trade secrets or commercial or financial information that is privileged or confidential;

7. Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

8. Disclosure of investigatory records compiled for law enforcement purposes;

9. Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with this compact; or

10. Matters specifically exempted from disclosure by federal or state statute.

(f) If a meeting, or portion of a meeting, is closed pursuant to this subsection, the commission's legal counsel or designee shall certify that the meeting, or portion of the meeting, is closed and shall reference each relevant exempting provision. The commission shall keep minutes that fully and clearly describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, and the reasons therefor, including a description of the views

expressed. All documents considered in connection with an action shall be identified in such minutes. All minutes and documents of a closed meeting shall remain under seal, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

(3) The commission shall, by a majority vote of the administrators, prescribe bylaws or rules to govern its conduct as may be necessary or appropriate to carry out the purposes and exercise the powers of this compact, including, but not limited to:

(a) Establishing the commission's fiscal year.

(b) Providing reasonable standards and procedures:

1. For the establishment and meetings of other committees.

2. Governing any general or specific delegation of any authority or function of the commission.

(c) Providing reasonable procedures for calling and conducting meetings of the commission, ensuring reasonable advance notice of all meetings, and providing an opportunity for attendance of such meetings by interested parties, with enumerated exceptions designed to protect the public's interest, the privacy of individuals, and proprietary information, including trade secrets. The commission may meet in closed session only after a majority of the administrators vote to close a meeting in whole or in part. As soon as practicable, the commission must make public a copy of the vote to close the meeting revealing the vote of each administrator, with no proxy

votes allowed.

(d) Establishing the titles, duties and authority, and reasonable procedures for the election of the commission's officers.

(e) Providing reasonable standards and procedures for the establishment of the commission's personnel policies and programs. Notwithstanding any civil service or other similar laws of any party state, the bylaws shall exclusively govern the commission's personnel policies and programs.

(f) Providing a mechanism for winding up the commission's operations and the equitable disposition of any surplus funds that may exist after the termination of this compact after the payment or reserving of all of its debts and obligations.

(4) The commission shall publish its bylaws and rules, and any amendments thereto, in a convenient form on the commission's website.

(5) The commission shall maintain its financial records in accordance with the bylaws.

(6) The commission shall meet and take such actions as are consistent with this compact and the bylaws.

(7) The commission has the power to:

(a) Adopt uniform rules to facilitate and coordinate implementation and administration of this compact. The rules shall have the force and effect of law and are binding in all party states.

(b) Bring and prosecute legal proceedings or actions in

the name of the commission, provided that the standing of any licensing board to sue or be sued under applicable law are not affected.

(c) Purchase and maintain insurance and bonds.

(d) Borrow, accept, or contract for services of personnel, including employees of a party state or nonprofit organizations.

(e) Cooperate with other organizations that administer state compacts related to the regulation of nursing, including sharing administrative or staff expenses, office space, or other resources.

(f) Hire employees, elect or appoint officers, fix compensation, define duties, grant such individuals appropriate authority to carry out the purposes of this compact, and establish the commission's personnel policies and programs relating to conflicts of interest, qualifications of personnel, and other related personnel matters.

(g) Accept any and all appropriate donations, grants, and gifts of money, equipment, supplies, materials, and services and receive, use, and dispose of the same, provided that, at all times, the commission shall avoid any appearance of impropriety or conflict of interest.

(h) Lease, purchase, accept appropriate gifts or donations of, or otherwise own, hold, improve, or use any property, whether real, personal, or mixed, provided that, at all times, the commission shall avoid any appearance of impropriety.

(i) Sell, convey, mortgage, pledge, lease, exchange,

abandon, or otherwise dispose of any property, whether real, personal, or mixed.

(j) Establish a budget and make expenditures.

(k) Borrow money.

(l) Appoint committees, including advisory committees comprised of administrators, state nursing regulators, state legislators or their representatives, consumer representatives, and other interested persons.

(m) Provide information to, receive information from, and cooperate with law enforcement agencies.

(n) Adopt and use an official seal.

(o) Perform such other functions as may be necessary or appropriate to achieve the purposes of this compact consistent with the state regulation of nurse licensure and practice.

(8) Relating to the financing of the commission, the commission:

(a) Shall pay, or provide for the payment of, the reasonable expenses of its establishment, organization, and ongoing activities.

(b) May also levy and collect an annual assessment from each party state to cover the cost of its operations, activities, and staff in its annual budget as approved each year. The aggregate annual assessment amount, if any, shall be allocated based on a formula to be determined by the commission, which shall adopt a rule that is binding on all party states.

(c) May not incur obligations of any kind before securing

the funds adequate to meet the same; and the commission may not pledge the credit of any of the party states, except by and with the authority of such party state.

(d) Shall keep accurate accounts of all receipts and disbursements. The commission's receipts and disbursements are subject to the audit and accounting procedures established under its bylaws. However, all receipts and disbursements of funds handled by the commission shall be audited yearly by a certified or licensed public accountant, and the report of the audit shall be included in, and become part of, the commission's annual report.

(9) Relating to the sovereign immunity, defense, and indemnification of the commission:

(a) The administrators, officers, executive director, employees, and representatives of the commission are immune from suit and liability, either personally or in their official capacity, for any claim for damage to or loss of property or personal injury or other civil liability caused by or arising out of any actual or alleged act, error, or omission that occurred, or that the person against whom the claim is made had a reasonable basis for believing occurred, within the scope of commission employment, duties, or responsibilities. This paragraph does not protect any such person from suit or liability for any damage, loss, injury, or liability caused by the intentional, willful, or wanton misconduct of that person.

(b) The commission shall defend any administrator,

officer, executive director, employee, or representative of the commission in any civil action seeking to impose liability arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that the person against whom the claim is made had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from that person's intentional, willful, or wanton misconduct. This paragraph does not prohibit that person from retaining his or her own counsel.

(c) The commission shall indemnify and hold harmless any administrator, officer, executive director, employee, or representative of the commission for the amount of any settlement or judgment obtained against that person arising out of any actual or alleged act, error, or omission that occurred within the scope of commission employment, duties, or responsibilities or that such person had a reasonable basis for believing occurred within the scope of commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from the intentional, willful, or wanton misconduct of that person.

ARTICLE VIII

RULEMAKING

(1) The commission shall exercise its rulemaking powers pursuant to the criteria set forth in this article and the rules

adopted thereunder. Rules and amendments become binding as of the date specified in each rule or amendment and have the same force and effect as provisions of this compact.

(2) Rules or amendments to the rules shall be adopted at a regular or special meeting of the commission.

(3) Before adoption of a final rule or final rules by the commission, and at least 60 days before the meeting at which the rule will be considered and voted upon, the commission shall file a notice of proposed rulemaking:

(a) On the commission's website.

(b) On the website of each licensing board or the publication in which each state would otherwise publish proposed rules.

(4) The notice of proposed rulemaking shall include:

(a) The proposed time, date, and location of the meeting in which the rule will be considered and voted upon.

(b) The text of the proposed rule or amendment and the reason for the proposed rule.

(c) A request for comments on the proposed rule from any interested person.

(d) The manner in which an interested person may submit notice to the commission of his or her intention to attend the public hearing and any written comments.

(5) Before adoption of a proposed rule, the commission shall allow persons to submit written data, facts, opinions, and arguments, which shall be made available to the public.

(6) The commission shall grant an opportunity for a public hearing before it adopts a rule or amendment.

(7) The commission shall publish the place, time, and date of the scheduled public hearing.

(a) Hearings shall be conducted in a manner providing each person who wishes to comment a fair and reasonable opportunity to comment orally or in writing. All hearings will be recorded, and a copy will be made available upon request.

(b) This article does not require a separate hearing on each rule. Rules may be grouped for the convenience of the commission at hearings required by this article.

(8) If no interested person appears at the public hearing, the commission may proceed with adoption of the proposed rule.

(9) Following the scheduled hearing date, or by the close of business on the scheduled hearing date if the hearing is not held, the commission shall consider all written and oral comments received.

(10) The commission shall, by majority vote of all administrators, take final action on the proposed rule and shall determine the effective date of the rule, if any, based on the rulemaking record and the full text of the rule.

(11) Upon determination that an emergency exists, the commission may consider and adopt an emergency rule without prior notice, opportunity for comment, or hearing, provided that the usual rulemaking procedures provided in this compact and in this article shall be applied retroactively to the rule as soon

as reasonably possible within 90 days after the effective date of the rule. For the purposes of this subsection, an emergency rule is one that must be adopted immediately in order to:

(a) Meet an imminent threat to public health, safety, or welfare;

(b) Prevent a loss of commission or party state funds; or

(c) Meet a deadline for the adoption of an administrative rule that is required by federal law or rule.

(12) The commission may direct revisions to a previously adopted rule or amendment for purposes of correcting typographical errors, errors in format, errors in consistency, or grammatical errors. Public notice of any revisions shall be posted on the commission's website. The revision is subject to challenge by any person for 30 days after posting. The revision may be challenged only on grounds that the revision results in a material change to a rule. A challenge must be made in writing and delivered to the commission before the end of the notice period. If no challenge is made, the revision shall take effect without further action. If the revision is challenged, the revision may not take effect without the commission's approval.

ARTICLE IX

OVERSIGHT, DISPUTE RESOLUTION, AND ENFORCEMENT

(1) Oversight of this compact shall be accomplished by:

(a) Each party state, which shall enforce this compact and take all actions necessary and appropriate to effectuate this compact's purposes and intent.

(b) The commission, which is entitled to receive service of process in any proceeding that may affect the powers, responsibilities, or actions of the commission and has standing to intervene in such a proceeding for all purposes. Failure to provide service of process in such proceeding to the commission renders a judgment or order void as to the commission, this compact, or adopted rules.

(2) When the commission determines that a party state has defaulted in the performance of its obligations or responsibilities under this compact or the adopted rules, the commission shall:

(a) Provide written notice to the defaulting state and other party states of the nature of the default, the proposed means of curing the default, or any other action to be taken by the commission.

(b) Provide remedial training and specific technical assistance regarding the default.

(3) If a state in default fails to cure the default, the defaulting state's membership in this compact may be terminated upon an affirmative vote of a majority of the administrators, and all rights, privileges, and benefits conferred by this compact may be terminated on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of default.

(4) Termination of membership in this compact shall be

imposed only after all other means of securing compliance have been exhausted. Notice of intent to suspend or terminate shall be given by the commission to the governor of the defaulting state, to the executive officer of the defaulting state's licensing board, and each of the party states.

(5) A state whose membership in this compact is terminated is responsible for all assessments, obligations, and liabilities incurred through the effective date of termination, including obligations that extend beyond the effective date of termination.

(6) The commission shall not bear any costs related to a state that is found to be in default or whose membership in this compact is terminated unless agreed upon in writing between the commission and the defaulting state.

(7) The defaulting state may appeal the action of the commission by petitioning the United States District Court for the District of Columbia or the federal district in which the commission has its principal offices. The prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(8) Dispute resolution may be used by the commission in the following manner:

(a) Upon request by a party state, the commission shall attempt to resolve disputes related to the compact that arise among party states and between party and nonparty states.

(b) The commission shall adopt a rule providing for both

mediation and binding dispute resolution for disputes, as appropriate.

(c) In the event the commission cannot resolve disputes among party states arising under this compact:

1. The party states may submit the issues in dispute to an arbitration panel, which will be comprised of individuals appointed by the compact administrator in each of the affected party states and an individual mutually agreed upon by the compact administrators of all the party states involved in the dispute.

2. The decision of a majority of the arbitrators is final and binding.

(9)(a) The commission shall, in the reasonable exercise of its discretion, enforce the provisions and rules of this compact.

(b) By majority vote, the commission may initiate legal action in the United States District Court for the District of Columbia or the federal district in which the commission has its principal offices against a party state that is in default to enforce compliance with this compact and its adopted rules and bylaws. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation, including reasonable attorney fees.

(c) The remedies provided in this subsection are not the exclusive remedies of the commission. The commission may pursue

any other remedies available under federal or state law.

ARTICLE X

EFFECTIVE DATE, WITHDRAWAL, AND AMENDMENT

(1) This compact becomes effective and binding on the date of legislative enactment of this compact into law by no fewer than 26 states or on December 31, 2018, whichever occurs first. All party states to this compact which were also parties to the prior Nurse Licensure Compact ("prior compact"), superseded by this compact, are deemed to have withdrawn from the prior compact within 6 months after the effective date of this compact.

(2) Each party state to this compact shall continue to recognize a nurse's multistate licensure privilege to practice in that party state issued under the prior compact until such party state is withdrawn from the prior compact.

(3) Any party state may withdraw from this compact by enacting a statute repealing the compact. A party state's withdrawal does not take effect until 6 months after enactment of the repealing statute.

(4) A party state's withdrawal or termination does not affect the continuing requirement of the withdrawing or terminated state's licensing board to report adverse actions and significant investigations occurring before the effective date of such withdrawal or termination.

(5) This compact does not invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a

party state and a nonparty state that is made in accordance with the other provisions of this compact.

(6) This compact may be amended by the party states. An amendment to this compact does not become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

(7) Representatives of nonparty states to this compact shall be invited to participate in the activities of the commission, on a nonvoting basis, before the adoption of this compact by all party states.

ARTICLE XI

CONSTRUCTION AND SEVERABILITY

This compact shall be liberally construed so as to effectuate the purposes thereof. The provisions of this compact are severable, and if any phrase, clause, sentence, or provision of this compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this compact and the applicability thereof to any government, agency, person, or circumstance is not affected thereby. If this compact is declared to be contrary to the constitution of any party state, the compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters.

Section 8. Subsection (1) of section 464.012, Florida

Statutes, is amended to read:

464.012 Certification of advanced registered nurse practitioners; fees.—

(1) Any nurse desiring to be certified as an advanced registered nurse practitioner shall apply to the department and submit proof that he or she holds a current license to practice professional nursing or holds an active multistate license to practice professional nursing pursuant to s. 464.0095 and that he or she meets one or more of the following requirements as determined by the board:

(a) Satisfactory completion of a formal postbasic educational program of at least one academic year, the primary purpose of which is to prepare nurses for advanced or specialized practice.

(b) Certification by an appropriate specialty board. Such certification shall be required for initial state certification and any recertification as a registered nurse anesthetist or nurse midwife. The board may by rule provide for provisional state certification of graduate nurse anesthetists and nurse midwives for a period of time determined to be appropriate for preparing for and passing the national certification examination.

(c) Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills. For applicants graduating on or after October 1, 1998, graduation from a master's degree program

shall be required for initial certification as a nurse practitioner under paragraph (4)(c). For applicants graduating on or after October 1, 2001, graduation from a master's degree program shall be required for initial certification as a registered nurse anesthetist under paragraph (4)(a).

Section 9. Subsections (1), (2), and (9) of section 464.015, Florida Statutes, are amended to read:

464.015 Titles and abbreviations; restrictions; penalty.—

(1) Only a person ~~persons~~ who holds a license in this state or a multistate license pursuant to s. 464.0095 ~~hold licenses~~ to practice professional nursing ~~in this state~~ or who performs ~~are performing~~ nursing services pursuant to the exception set forth in s. 464.022(8) may ~~shall have the right to~~ use the title "Registered Nurse" and the abbreviation "R.N."

(2) Only a person ~~persons~~ who holds a license in this state or a multistate license pursuant to s. 464.0095 ~~hold licenses~~ to practice as a licensed practical nurse ~~nurses in this state~~ or who performs ~~are performing~~ practical nursing services pursuant to the exception set forth in s. 464.022(8) may ~~shall have the right to~~ use the title "Licensed Practical Nurse" and the abbreviation "L.P.N."

(9) A person may not practice or advertise as, or assume the title of, registered nurse, licensed practical nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, or advanced registered nurse practitioner or use the abbreviation "R.N.," "L.P.N.,"

"C.N.S.," "C.R.N.A.," "C.N.M.," or "A.R.N.P." or take any other action that would lead the public to believe that person was authorized by law to practice ~~certified~~ as such or is performing nursing services pursuant to the exception set forth in s. 464.022(8)~~.~~ unless that person is licensed, ~~or~~ certified, or authorized pursuant to s. 464.0095 to practice as such.

Section 10. Subsections (1) and (2) of section 464.018, Florida Statutes, are amended to read:

464.018 Disciplinary actions.—

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in ss. ~~s.~~ 456.072(2) and 464.0095:

(a) Procuring, attempting to procure, or renewing a license to practice nursing or the authority to practice practical or professional nursing pursuant to s. 464.0095 by bribery, by knowing misrepresentations, or through an error of the department or the board.

(b) Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of nursing or to the ability to practice nursing.

(d) Being convicted or found guilty of, or entering a plea

of guilty or nolo contendere to, regardless of adjudication, ~~of~~ any of the following offenses:

1. A forcible felony as defined in chapter 776.

2. A violation of chapter 812, relating to theft, robbery, and related crimes.

3. A violation of chapter 817, relating to fraudulent practices.

4. A violation of chapter 800, relating to lewdness and indecent exposure.

5. A violation of chapter 784, relating to assault, battery, and culpable negligence.

6. A violation of chapter 827, relating to child abuse.

7. A violation of chapter 415, relating to protection from abuse, neglect, and exploitation.

8. A violation of chapter 39, relating to child abuse, abandonment, and neglect.

9. For an applicant for a multistate license or for a multistate licenseholder under s. 464.0095, a felony offense under Florida law or federal criminal law.

(e) Having been found guilty of, regardless of adjudication, or entered a plea of nolo contendere or guilty to, any offense prohibited under s. 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence as defined in s. 741.28.

(f) Making or filing a false report or record, which the nurse ~~licensee~~ knows to be false, intentionally or negligently

failing to file a report or record required by state or federal law, willfully impeding or obstructing such filing or inducing another person to do so. Such reports or records shall include only those which are signed in the nurse's capacity as a licensed nurse.

(g) False, misleading, or deceptive advertising.

(h) Unprofessional conduct, as defined by board rule.

(i) Engaging or attempting to engage in the possession, sale, or distribution of controlled substances as set forth in chapter 893, for any other than legitimate purposes authorized by this part.

(j) Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General's designee that probable cause exists to believe that the nurse ~~licensee~~ is unable to practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a nurse ~~licensee~~ to submit to a mental or physical examination by physicians designated by the department. If the nurse ~~licensee~~ refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the nurse ~~licensee~~ resides or does business. The nurse ~~licensee~~ against whom the

petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A nurse affected by ~~the provisions of~~ this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

(k) Failing to report to the department any person who the nurse ~~licensee~~ knows is in violation of this part or of the rules of the department or the board; however, if the nurse ~~licensee~~ verifies that such person is actively participating in a board-approved program for the treatment of a physical or mental condition, the nurse ~~licensee~~ is required to report such person only to an impaired professionals consultant.

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

(m) Failing to report to the department any licensee under chapter 458 or under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that person is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part I of chapter

641, in which the nurse also provides services.

(n) Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the nurse ~~licensee~~ is not qualified by training or experience.

(o) Violating any provision of this chapter or chapter 456, or any rules adopted pursuant thereto.

(2)(a) The board may enter an order denying licensure or imposing any of the penalties in s. 456.072(2) against any applicant for licensure or nurse ~~licensee~~ who is found guilty of violating ~~any provision of~~ subsection (1) ~~of this section~~ or ~~who is found guilty of violating any provision of~~ s. 456.072(1).

(b) The board may take adverse action against a nurse's multistate licensure privilege and impose any of the penalties in s. 456.072(2) when the nurse is found guilty of violating subsection (1) or s. 456.072(1).

Section 11. Paragraph (a) of subsection (2) of section 464.0195, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

464.0195 Florida Center for Nursing; goals.—

(2) The primary goals for the center shall be to:

(a) Develop a strategic statewide plan for nursing manpower in this state by:

1. Establishing and maintaining a database on nursing supply and demand in the state, to include current supply and demand~~, and future projections~~; ~~and~~

2. Analyzing the current supply and demand in the state and making future projections of such, including assessing the impact of this state's participation in the Nurse Licensure Compact under s. 464.0095; and

3.~~2.~~ Selecting from the plan priorities to be addressed.

(4) The center may request from the board, and the board must provide to the center upon its request, any information held by the board regarding nurses licensed in this state or holding a multistate license pursuant to s. 464.0095 or information reported to the board by employers of such nurses, other than personal identifying information.

Section 12. This act shall take effect December 31, 2018, or upon enactment of the Nurse Licensure Compact into law by 26 states, whichever occurs first.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1063 Public Records and Meetings/Nurse Licensure Compact
SPONSOR(S): Pigman
TIED BILLS: HB 1061 **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Select Committee on Affordable Healthcare Access		Siples	Calamas
2) Government Operations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 1063 authorizes Florida to become a party state to the Nurse Licensure Compact (NLC or compact) enacting its provisions into the laws of the state. The NLC is a multistate compact that establishes a mutual recognition system for the licensure of registered nurses and licensed practical or vocational nurses. The NLC requires states to submit nurse licensure and regulation records, including any actions taken against the ability to practice, to a coordinated licensure information system. The NLC also requires a commission to be formed to oversee the implementation and administration of the compact and the coordinated licensure information system.

The bill, which is linked to passage of HB 1061, creates public record and public meeting exemptions for certain records and meetings relating to the NLC.

The bill makes personal identifying information of nurses obtained pursuant to compact and held by the Department of Health or Board of Nursing exempt from the public record requirements, unless the laws of the state that originally reported the information authorizes its disclosure.

The bill also creates a public meeting exemption for commission meetings, if the commission must discuss:

- Noncompliance of a party state with its obligations under the NLC;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public;
- Disclosure of active investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation for compliance with the NLC;
- Matters specifically exempted from disclosure by federal law or the laws of any party state; and
- Information made exempt pursuant to the rules or the bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

The bill provides that the public record and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October, 2, 2021, unless saved from repeal by reenactment by the Legislature. It also provides a public necessity statement as required by the State Constitution.

The bill will have an indeterminate, negative fiscal impact on the Department of Health.

The bill will be effective on the same date as HB 1061 or similar legislation takes effect.

Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates public record and public meeting exemptions; thus, it appears to require a two-thirds vote for final passage.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Public Records Law

Article I, s. 24(a) of the State Constitution sets forth the state's public policy regarding access to government records. The section guarantees every person a right to inspect or copy any public record of the legislative, executive, and judicial branches of government.

Public policy regarding access to government records is addressed further in the Florida Statutes. Section 119.07(1), F.S., guarantees every person a right to inspect and copy any state, county, or municipal record.

Public Meetings Law

Article I, s. 24(b) of the State Constitution sets forth the state's public policy regarding access to government meetings. The section requires that all meetings of any collegial public body of the executive branch of state government or of any collegial public body of a county, municipality, school district, or special district, at which official acts are to be taken or at which public business of such body is to be transacted or discussed, be open and noticed to the public.

Public policy regarding access to government meetings also is addressed in the Florida Statutes. Section 286.011, F.S., known as the "Government in the Sunshine Law" or "Sunshine Law," further requires that all meetings of any board or commission of any state agency or authority or of any agency or authority of any county, municipal corporation, or political subdivision, at which official acts are to be taken be open to the public at all times.[1] The board or commission must provide reasonable notice of all public meetings.[2] Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin or economic status or which operates in a manner that unreasonably restricts the public's access to the facility.[3] Minutes of a public meeting must be promptly recorded and open to public inspection.[4]

Public Record and Public Meeting Exemptions

The Legislature, however, may provide by general law for the exemption of records and meetings from the requirements of Article I, s. 24(a) and (b) of the State Constitution. The general law must state with specificity the public necessity justifying the exemption (public necessity statement) and must be no broader than necessary to accomplish its purpose.[5]

Furthermore, the Open Government Sunset Review Act[6] provides that a public record or public meeting exemption may be created or maintained only if it serves an identifiable public purpose. In addition, it may be no broader than is necessary to meet one of the following purposes:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;

[1] Section 286.011(1), F.S.
[2] *Ibid.*
[3] Section 286.011(6), F.S.
[4] Section 286.011(2), F.S.
[5] Art. I, s. 24(c), Fla. Const.
[6] Section 119.15, F.S.

- Protects sensitive personal information that, if released, would be defamatory or would jeopardize an individual's safety; however, only the identity of an individual may be exempted under this provision; or
- Protects trade or business secrets.

The Open Government Sunset Review Act requires the automatic repeal of a newly created exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.

Nurse Licensure Compact

HB 1061 authorizes Florida to become a party to the Nurse Licensure Compact (NLC or compact) by enacting its provisions into Florida law. The NLC is a multistate compact that establishes a mutual recognition system for the licensure of registered nurses (RNs) and licensed practical or vocational nurses (LPN/LVN). The primary purposes of the NLC is to address the expanded mobility of nurses and the use of advanced communication technologies, such as telemedicine.

The Department of Health (DOH) licenses nurses and the Board of Nursing regulates the practice of nursing in this state. The NLC establishes uniform requirements for the issuance of a multistate license. States retain the right to establish additional qualifications for licensure and to issue single-state licenses, which allows the holder to practice only in the state of issuance. The state in which a nurse is a permanent resident is considered the nurse's home state and the nurse is subject to the home state's licensure and regulation.

Under the compact, a nurse who holds a multistate license issued by one of the party states is permitted to practice in any other party state, without obtaining a license from that state. A nurse practicing under the multistate licensure practice privilege must comply with the practice laws of the state in which he or she is practicing or where the patient is located.

Under the NLC, the party states are required to report all adverse actions[7] taken against a nurse's license or a nurse's multistate licensure practice privilege; any current, significant investigative information that has not yet been acted upon; and denials of applications and reasons for such denials; and nurse participation in alternative programs[8] to a coordinated licensure information system. Only party states have access to information related to ongoing investigations and participation in alternative programs. A party state may designate information it reports as confidential and therefore, cannot be shared with nonparty states or other entities without the express permission of the reporting state.

The compact also creates the Interstate Commission of Nurse Licensure Compact Administrators (commission) to oversee and administer the provisions of the NLC. Each party state has one administrator, the head of the licensing board, who is a member of the commission. The compact details the authority and responsibilities of the commission, such as the promulgation of rules, the oversight of fiscal matters, the mediation of conflict between party states, and the management of noncompliant party states.

Effect of Proposed Changes

The bill creates public record and public meeting exemptions related to the Nurse Licensure Compact.

Specifically, the bill provides that personal identifying information of nurses obtained from the coordinated licensure information system held by the DOH or Board of Nursing is exempt from the

[7] Adverse action is any administrative, civil, equitable, or criminal action permitted by a state's laws which is imposed by a licensing board or other authority against a nurse, including actions against an individual's license or multistate licensure privilege, such as revocation, suspension, probation, monitoring of the license, limitation on the licensee's practice, or any other encumbrance on licensure affecting a nurse's authorization to practice, including issuance of a cease and desist action.
[8] An alternative program is a non-disciplinary monitoring program approved by a licensing board.

public record requirements, unless the laws of the state that originally reported the information authorizes its disclosure. Disclosure under such circumstance is limited to the extent permitted under the laws of the reporting state.

The bill also creates a public meeting exemption for those portions of the commission meetings during which the following is discussed:

- Noncompliance of a party state with its obligations under the NLC;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public;
- Disclosure of active investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the NLC;
- Matters specifically exempted from disclosure by federal law or the laws of any party state; and
- Information made exempt pursuant to the rules or the bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

The NLC requires the commission to keep minutes of any closed meeting. The bill provides that any recordings, minutes, and records are exempt from public records requirements. The NLC provides that such minutes may be disclosed pursuant to a majority vote of the commission or pursuant to a court order.

The bill provides that the public record and public meeting exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2021, unless saved from repeal by reenactment by the Legislature.

The bill provides a public necessity statement as required by the State Constitution, which states the exemptions are necessary for the state's effective and efficient implementation and administration of the provisions of the Nurse Licensure Compact, which requires such exemptions.

B. SECTION DIRECTORY:

Section 1: Creates s. 464.0096, F.S., relating to public records and meetings exemptions for records and meetings relating to the Nurse Licensure Compact.
Section 2: Provides a public necessity statement.
Section 3: Provides a contingent effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

The bill may create an insignificant, negative impact on the DOH because staff responsible for complying with public record requests may require training related to the public record exemption.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

Vote Requirement
Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created public record or public meeting exemption. The bill creates new exemptions; thus, it requires a two-thirds vote for final passage.

Public Necessity Statement
Article I, s. 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public record or public meeting exemption. The bill creates new exemptions; thus, it includes a public necessity statement.

Exemption Bills
Article I, s. 24(c) of the State Constitution provides that an exemption must be created by general law and the law must contain only exemptions from public record or public meeting requirements. The exemption does not appear to be in conflict with the constitutional requirement.

B. RULE-MAKING AUTHORITY:

The bill does not appear to create a need for rule-making or rule-making authority.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

A bill to be entitled

An act relating to public records and meetings; creating s. 464.0096, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 464.0096, Florida Statutes, is created to read:

464.0096 Nurse Licensure Compact; public records and meetings exemptions.—

(1) A nurse's personal identifying information obtained from the coordinated licensure information system, as defined in

s. 464.0095, and held by the department or the board is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated licensure information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be disclosed to the extent permitted by the reporting state's law.

(2)(a) A meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095 during which any of the following is discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002 or commercial or financial information required by the commission's bylaws or

rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes. For the purposes of this subparagraph, the term "active" has the same meaning as provided in s. 119.011(3)(d).

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest and the privacy of individuals, and proprietary information.

(b) Recordings, minutes, and records generated during an exempt meeting are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a nurse's personal identifying information

obtained from the coordinated licensure information system, as defined in s. 464.0095, Florida Statutes, and held by the Department of Health or the Board of Nursing be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Nurse Licensure Compact, which the state must adopt in order to become a party state to the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095, Florida Statutes, at which any of the following is discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002, Florida Statutes, or commercial or financial information required by the commission's bylaws or rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes.

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

(b) The Nurse Licensure Compact requires any meeting or portion of a meeting in which the substance of paragraph (a) is discussed to be closed to the public. Without the public meeting exemption, this state will be prohibited from becoming a party state to the compact. Thus, this state will be unable to effectively and efficiently administer the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 464.0096, Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that HB 1061 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

Dr. Vivian Lee
U. of Utah Health Care

Dr. Vivian Lee – University of Utah Health Care

Since 2011, Dr. Vivian S. Lee has served as Senior Vice President for Health Sciences at the University of Utah, Dean of the University's School of Medicine, and CEO of University of Utah Health Care. She oversees an annual budget of $3.3 billion; four hospitals, ten health centers, the Huntsman Cancer Institute and Moran Eye Center, a health insurance plan, over 1,330 board-certified physicians; and five colleges including the Schools of Medicine and Dentistry and the Colleges of Nursing, Pharmacy and Health.

During her tenure, Dr. Lee has established the University of Utah Health Care system as one of the most innovative, high-performing, and transformative health care systems in the nation. It has consistently ranked in the top 10 in quality and safety among university hospitals. Its providers enjoy the highest patient satisfaction rankings in the nation, and Utah was the first health care system in the country to post patient satisfaction scores online. The health system has bent the cost curve through innovative value management tools, physician engagement and Lean training.

Under Dr. Lee's leadership, the University of Utah launched a new School of Dentistry in 2013. The Utah Genome Project, based on the Utah Population Database, is the cornerstone of Precision Medicine with an expected 6000 genomes sequenced by the end of 2015. The Center for Medical Innovation partners the health sciences with Colleges of Engineering, Business, Law, Fine Arts, and Architecture to develop new devices, apps and videogames.

Working with the legislature and Governor, Dr. Lee secured additional state funding in 2013 to increase the medical school class size by 50% over 2 years. Enhanced communications and best practices have been shared through the Algorithms for Innovation publication and portal, sparking a national discourse about challenges facing academic medicine.

A recognized leader in academic medicine and health sciences, Dr. Lee serves on the Council of Councils of the National Institutes of Health, the Administrative Board of the Council of Deans for the AAMC, the Journal of the American Medical Association Journal Oversight Committee, the Health Care Delivery System Reform Advisory Committee of The Commonwealth Fund, and the Scientific Advisory Board of Massachusetts General Hospital. She also serves on the board of directors the American Association of Rhodes Scholars.

A graduate of Harvard-Radcliffe College, Dr. Lee received a doctorate in medical engineering on a Rhodes Scholarship at Oxford University. At Harvard Medical School, she earned her M.D. with honors. She completed her residency in Diagnostic Radiology at Duke, where she also served as Chief Resident and trained as a fellow in MRI at NYU. Dr. Lee completed an M.B.A. at NYU's Stern School of Business in 2006. Prior to coming to Utah, she served as the inaugural Vice Dean for Science, Senior Vice-President and Chief Scientific Officer of New York University Medical Center.

A radiologist who is currently principal investigator for two NIH R01 grants, Dr. Lee has authored over 150 peer-reviewed research publications and a popular textbook on Cardiovascular MRI and chaired the Medical Imaging NIH study section. A Fellow and past President of the International Society for Magnetic Resonance in Medicine (ISMRM), Dr. Lee received the Outstanding Teacher Award and delivered the ISMRM keynote Lauterbur Lecture in 2012. Elected to the American Society for Clinical Investigation, Dr. Lee's research focuses on the development of quantitative functional MRI for the improved understanding of physiology and disease.

New York Times

What Are a Hospital's Costs? Utah System Is Trying to Learn

http://www.nytimes.com/2015/09/08/health/what-are-a-hospitals-costs-utah-system-is-trying-to-learn.html?_r=0

By GINA KOLATA
SEPT. 7, 2015

Dr. Vivian Lee set in motion a process that the University of Utah Health Care is using to save money and to improve care. Credit Sallie Dean Shatz for The New York Times

SALT LAKE CITY — Only in the world of medicine would Dr. Vivian Lee's question have seemed radical. She wanted to know: What do the goods and services provided by the hospital system where she is chief executive actually cost?

Most businesses know the cost of everything that goes into producing what they sell — essential information for setting prices. Medicine is different. Hospitals know what they are paid by insurers, but it bears little relationship to their costs.

No one on Dr. Lee's staff at the University of Utah Health Care could say what a minute in an M.R.I. machine or an hour in the operating room actually costs. They chuckled when she asked.

But now, thanks to a project Dr. Lee set in motion after that initial query several years ago, the hospital is getting answers, information that is not only saving money but also improving care.

The effort is attracting the attention of institutions from Harvard to the Mayo Clinic. The secretary of health and human services, Sylvia Mathews Burwell, visited last month to see the results. While costs at other academic medical centers in the area have increased an average of 2.9 percent a year over the past few years, the University of Utah's have declined by 0.5 percent a year. "We have bent the cost curve," Dr. Lee said.

Inpatient hospital costs account for nearly 30 percent of health care spending in the United States and are increasing by a little less than 2 percent a year, adjusted for inflation, according to the federal Agency for Healthcare Research and Quality.

The cost issue has taken on new urgency as the Affordable Care Act accelerates the move away from fee-for-service medicine and toward a system where hospitals will get one payment for the entire course of a treatment, like hospitalization for pneumonia. Medicare, too, is setting new goals for payments based on the value of care.

Under such a system, if a hospital does additional tests and procedures or if patients get infections or are readmitted, the hospital bears the cost. To make money, medical centers have to figure out what it actually costs to provide care and how to spend less while maintaining or improving outcomes.

The linchpin of this effort at the University of Utah Health Care is a computer program — still a work in progress — with 200 million rows of costs for items like drugs, medical devices, a doctor's time in the operating room and each member of the staff's time. The software also tracks such outcomes as days in the hospital and readmissions. A pulldown menu compares each doctor's costs and outcomes with others' in the department.

The hospital has been able to calculate, for instance, the cost per minute in the emergency room (82 cents), in the surgical intensive care unit ($1.43), and in the operating room for an orthopedic surgery case ($12).

With such information, as well as data on the cost of labor, supplies and labs, the hospital has pared excess expenses and revised numerous practices for more efficient and effective care.

Michael Porter, an economist and professor at Harvard Business School, called the accomplishments "epic progress."

Recently, Dr. Porter and a colleague, Robert Kaplan, visited Utah and concluded that the hospital group was one of the few in health care to properly measure the costs of care. Elsewhere, with a very few exceptions, Dr. Porter said, "it's a total mess."

Other medical institutions, including MD Anderson Cancer Center in Houston and the Mayo Clinic, based in Rochester, Minn., are also trying to get a handle on costs.

"I can give you an unambiguous endorsement" of the Utah system, Dr. Russell M. Howerton, chief medical officer at Wake Forest Baptist Health in North Carolina, said after a recent visit.

It is not easy, said Dr. Thomas W. Feeley, who is leading the effort at MD Anderson. His group decided to go through every single process a patient experiences and figure out what the hospital paid for each person caring for the patient.

The group began with head and neck cancer, treatment of which turned out to involve 160 processes requiring measurement. To assess outcomes, it asked patients which they thought were most important. Head and neck cancer patients wanted to be able to talk and to swallow. (Survival, which many doctors had thought was a top priority, was not something patients raised; many assumed they would survive.)

At the Utah hospital, the group began by looking at how much supplies cost — bandages, sutures, medications. Then it started tracing use of those items to individual patients.

"Let's say I need a hip replacement," said Dr. Robert C. Pendleton, Utah's chief quality officer. "Well, how many bandages did you use for me, and how many did you use for the guy in the bed next to me and the lady in the next room who also had hip replacements?

"Then you can start to say, 'Well, wait a minute, patients who have their hips replaced by Dr. Jones are using twice as many bandages. Why is that?' "

They added in labor costs, a more complicated question. Dr. Kaplan and Dr. Porter of Harvard tell hospitals to go in to hospital rooms with a stopwatch and time how long each staff member spends on each procedure and with each patient.

At the Mayo Clinic, the stopwatch is changing practices. Instead of having doctors in the emergency department type in notes on each patient, for example, the clinic has started a pilot project in using lower cost scribes do that work.

With their new computer program, executives at the Utah hospital are also finding some simple ways to improve outcomes and reduce costs.

When internal medicine doctors looked at their costs per day, they were stunned to see how much they were spending on lab tests. Each was cheap, $10 or $20, but the total bill came to about $2 million a year.

Studies have found that 20 percent to 50 percent of hospital lab tests were completely unnecessary, ordered by residents with no questions asked. Most insurers were paying a lump sum for patients' treatment so the cost for extra tests was borne by the hospital. Patients were getting so many blood tests that some became anemic.

The Utah doctors decided to require residents to justify each lab test. Orders plummeted. The hospital saved $200,000 a year.

Changes also involved bypass surgery in a project led by Dr. David A. Bull, chief of cardiothoracic surgery at the University of Utah. He and his colleagues asked what variables made a difference in costs and outcomes, hoping to improve both.

That led them to nine measures they called "perfect care," the primary determinants of how long a patient stays in the hospital after surgery, which is a major contributor to costs and a harbinger of poorer outcomes.

The variables included such practices as keeping blood sugar under control — 75 percent of their bypass patients had diabetes — and giving oxygen to patients who are having trouble breathing when they are taken off the ventilator. The usual quality measures, like giving antibiotics before surgery, did not affect length of stay.

The group standardized the care after surgery with those nine items in mind, and nurses were permitted to give medications or oxygen without having to contact a doctor first.

Some were skeptical the program would make a difference, Dr. Bull said. But costs fell by 30 percent because patients spent less time in the hospital and had fewer complications. Letting nurses initiate treatment meant patients got needed medications faster, and the emphasis on "perfect care" meant the most important things got done.

"When I first started working in health care, like everybody I thought: 'Oh, my God. It's such a tough problem.' " Dr. Porter, the Harvard economist, said.

Now he has changed his mind. "I have no doubt we can solve it," he said. "We know exactly what we have to do."

UNIVERSITY OF UTAH
HEALTH SCIENCES

CONTROLLING

costs in health care

VIVIAN S. LEE, M.D., Ph.D., M.B.A.
SENIOR VICE PRESIDENT, UNIVERSITY OF UTAH HEALTH SCIENCES
CEO, UNIVERSITY OF UTAH HEALTH CARE
DEAN, UNIVERSITY OF UTAH SCHOOL OF MEDICINE

@vivianleemd

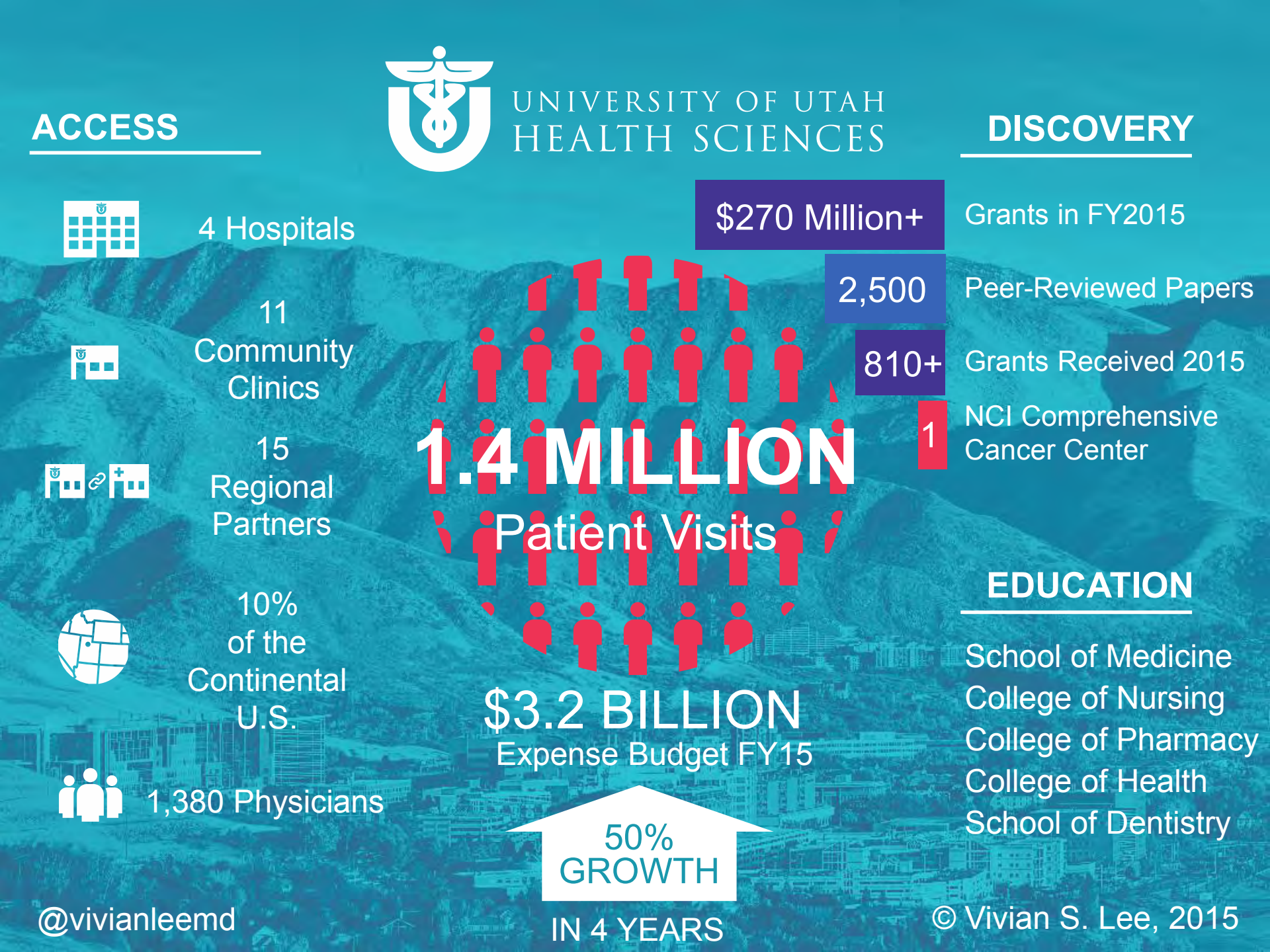
UNIVERSITY OF UTAH
HEALTH SCIENCES

Who is the

UNIVERSITY

of Utah…

@vivianleemd

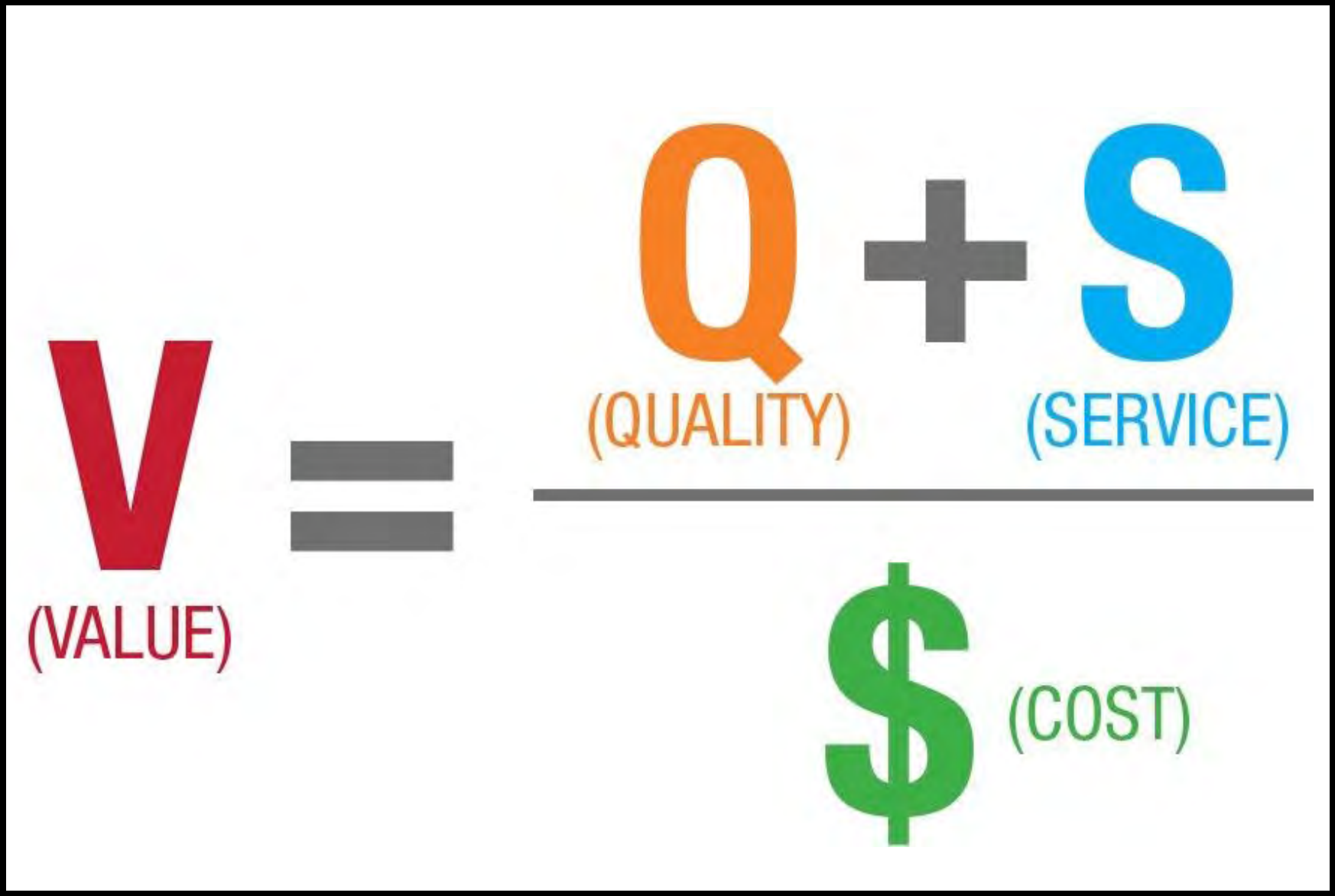

UNIVERSITY OF UTAH
HEALTH SCIENCES
ACCESS
4 Hospitals
11
Community
Clinics
15
Regional
Partners
10%
of the
Continental
U.S.
1,380 Physicians
1.4 MILLION
Patient Visits
$3.2 BILLION
Expense Budget FY15
50%
GROWTH
IN 4 YEARS
DISCOVERY
$270 Million+
Grants in FY2015
2,500
Peer-Reviewed Papers
810+
Grants Received 2015
1
NCI Comprehensive
Cancer Center
EDUCATION
School of Medicine
College of Nursing
College of Pharmacy
College of Health
School of Dentistry
@vivianleemd
© Vivian S. Lee, 2015

UNIVERSITY OF UTAH HEALTH SCIENCES

UTAH HAS THE BEST HEALTH AT THE LOWEST COST

UNIVERSITY OF UTAH HEALTH SCIENCES

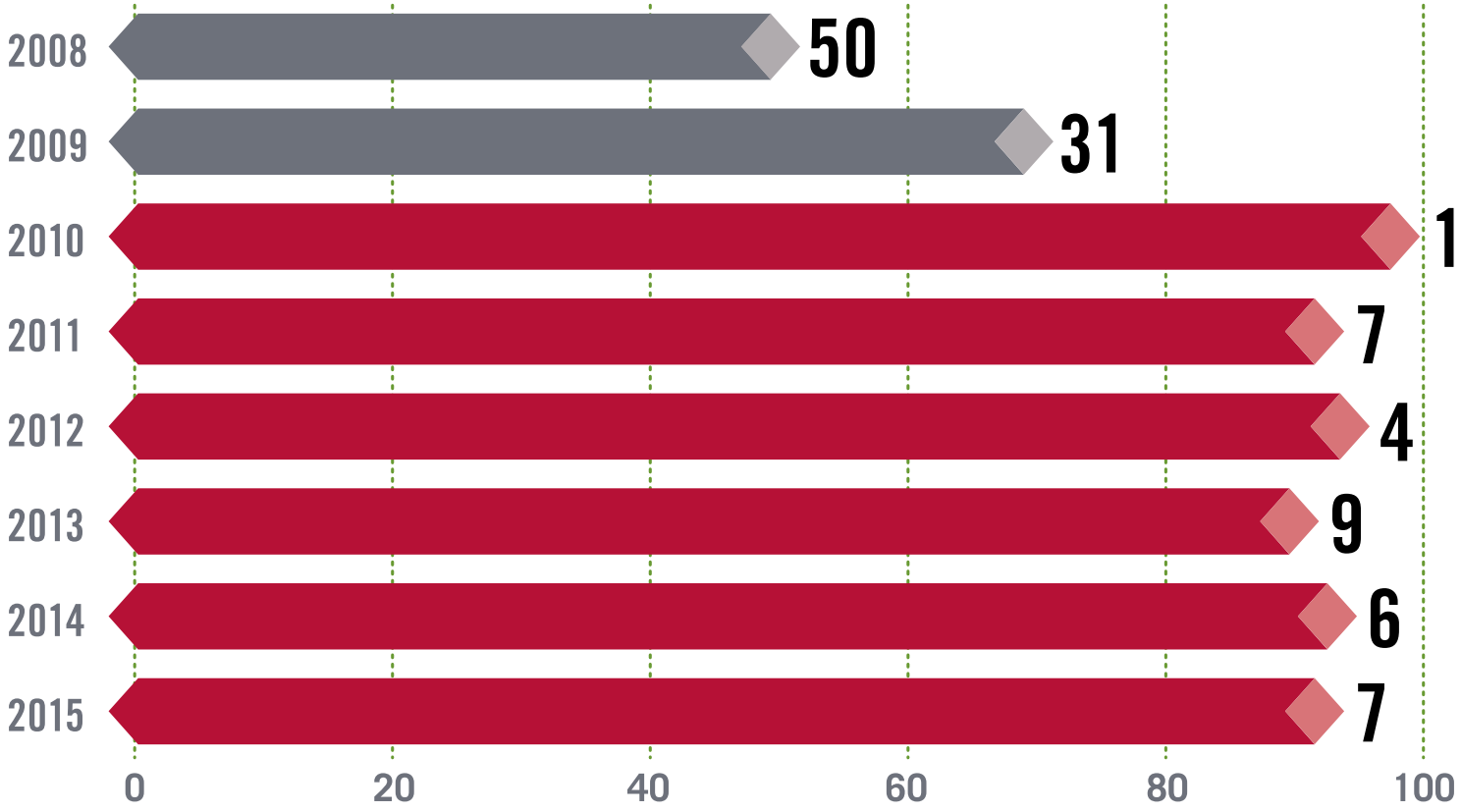
HOW WE THINK ABOUT VALUE



HOW WE THINK ABOUT QUALITY

NATIONAL QUALITY RANKING FOR UNIVERSITY OF UTAH HEALTH CARE

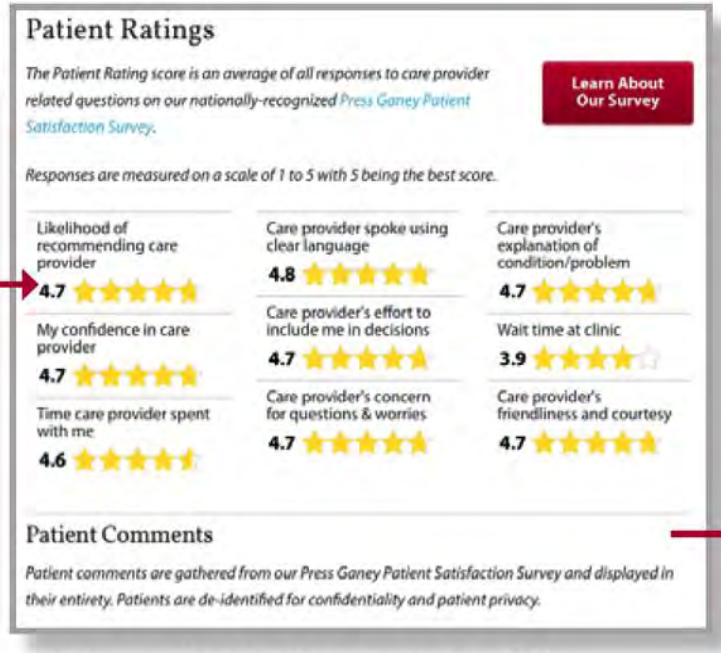
Out of 117 academic medical centers and more than 331 of their affiliated hospitals



Source: University HealthSystem Consortium, 2008–2015

HOW WE THINK ABOUT SERVICE

UNIVERSITY OF UTAH FIND-A-DOC WEBSITE:
Online patient ratings and comments



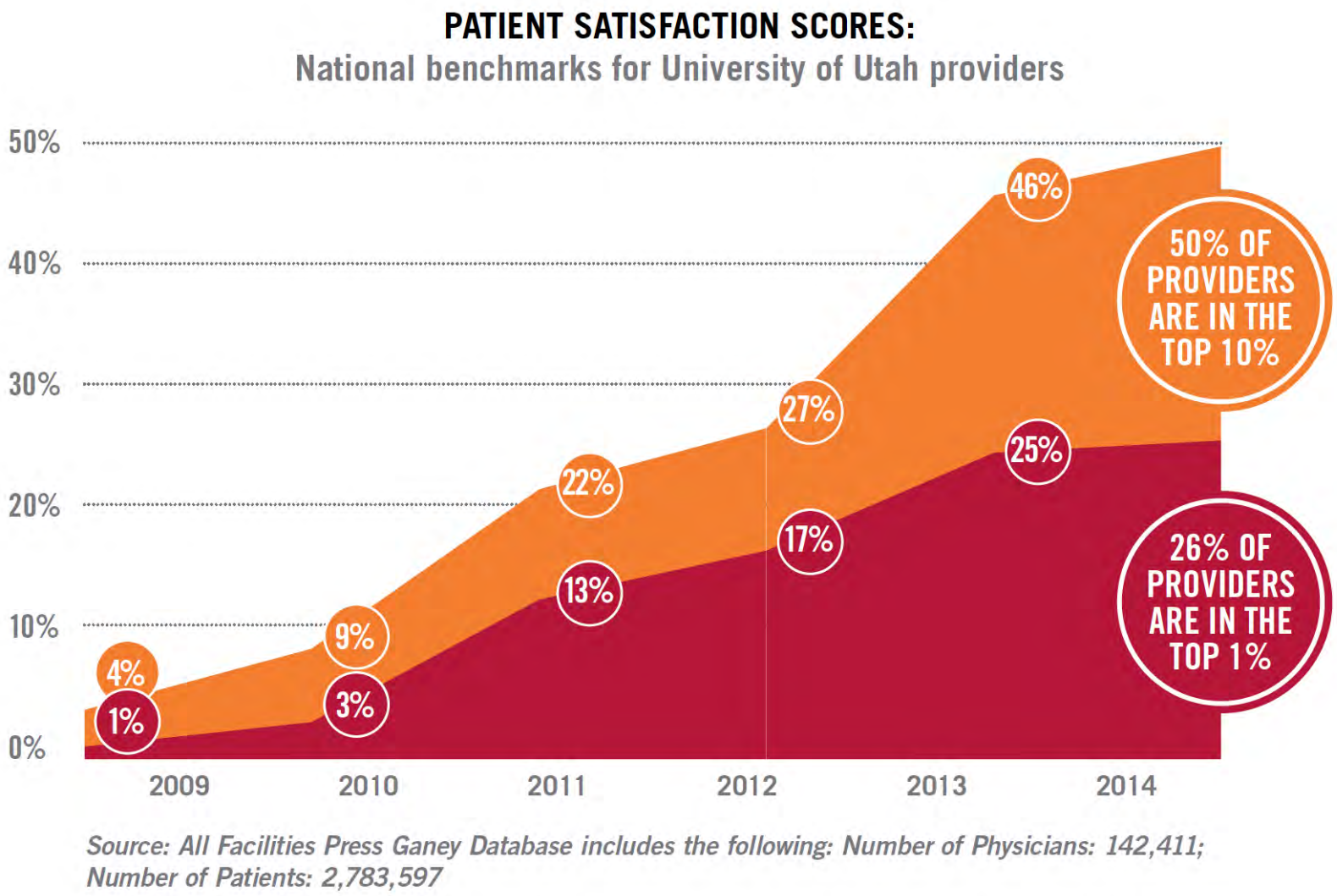
UofU Patient *December 2, 2013*
I had some concerns that were bothering me about my surgery and monitoring of my illness. Dr. Scaife was very thorough in answering my questions. She alleviated many of the fears I have, and she set up a monitoring program for every six months that will help us keep track of the disease progression.

UofU Patient *November 21, 2014*
Dr. Scaife and Dr. Adler were great. Felt so confident and secure with all of their information and treatment plan. They were amazing. Dr Adler even called my home several days later to see how I was doing and if I had any questions. It really meant a lot to me. Can't tell you how happy I was with the whole experience.

UofU Patient *January 27, 2015*
Totally loved them all and have told several family and friends how pleased we are. Dr Scaife made sure we understood everything and drew lots of pictures to explain what she was saying. I am so blessed to have her as my surgeon.

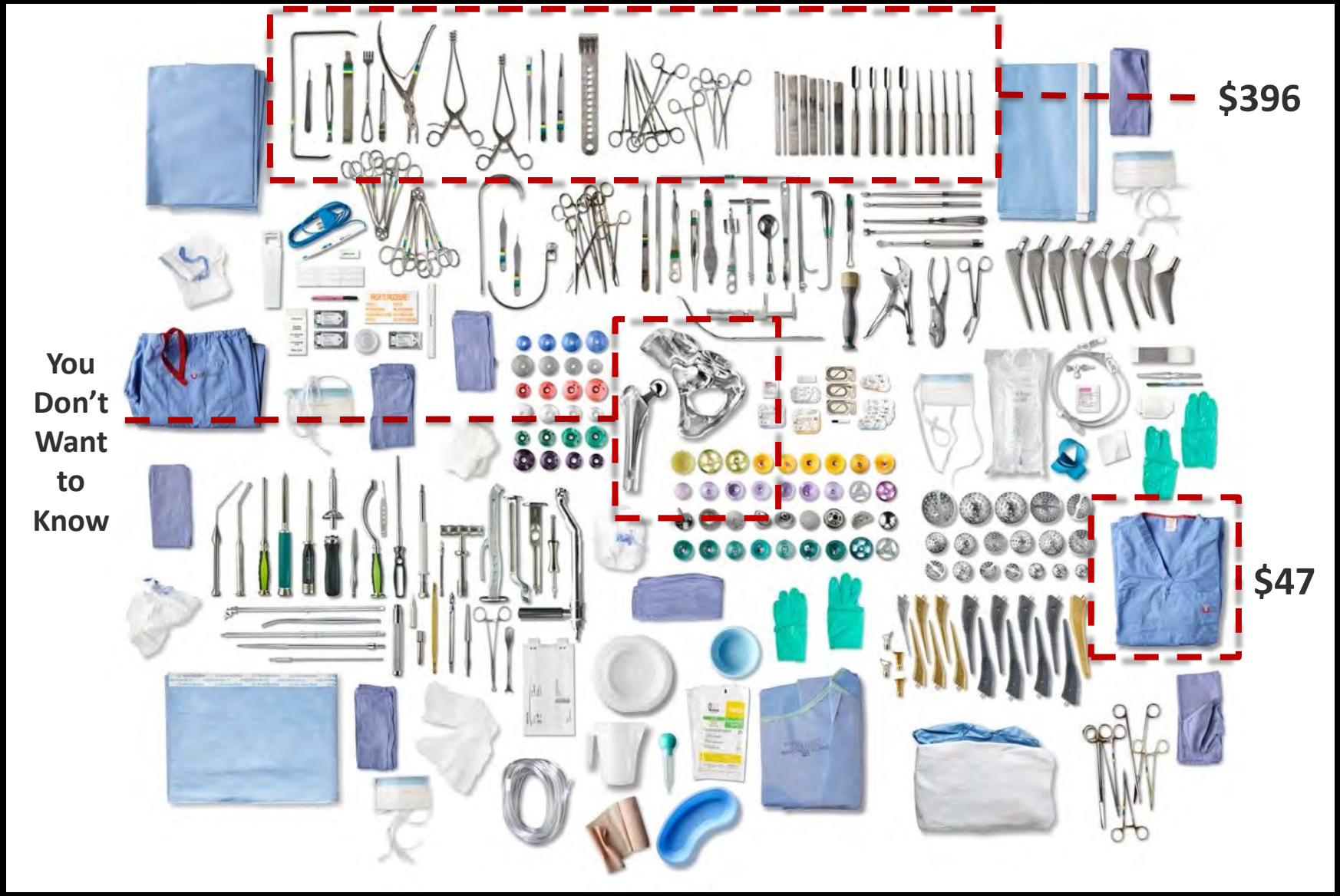
UNIVERSITY OF UTAH HEALTH SCIENCES

HOW WE THINK ABOUT SERVICE



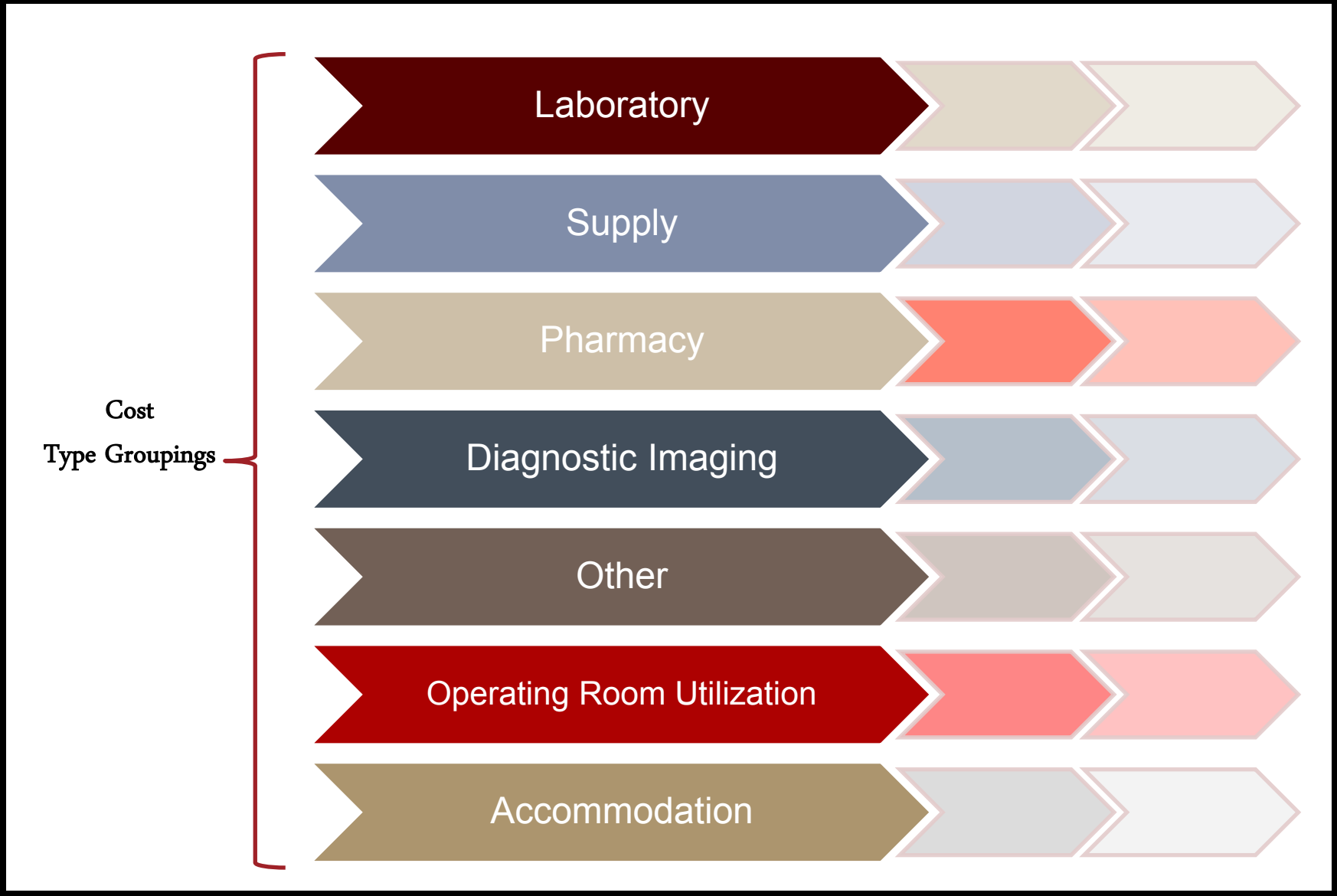
UNIVERSITY OF UTAH HEALTH SCIENCES

WE FIGURED OUT OUR COSTS



UNIVERSITY OF UTAH HEALTH SCIENCES

VALUE DRIVEN OUTCOMES



UNIVERSITY OF UTAH HEALTH SCIENCES

VALUE DRIVEN OUTCOMES –APPENDECTOMY

10:54am - Day 1	Day 2	Day 3	Day 4 – 1:45pm

Emergency Department 10:54am

OR 9:46 to 10:48

SICU Surgical ICU 2:16am

IMCU Intermediate Care Unit 1:30pm

SSTU Surgical Specialty & Trans. Unit 3:25pm

Emergency Department

Labor
Supplies
Imaging
Pharmacy
Lab
Other Services

Operating Room

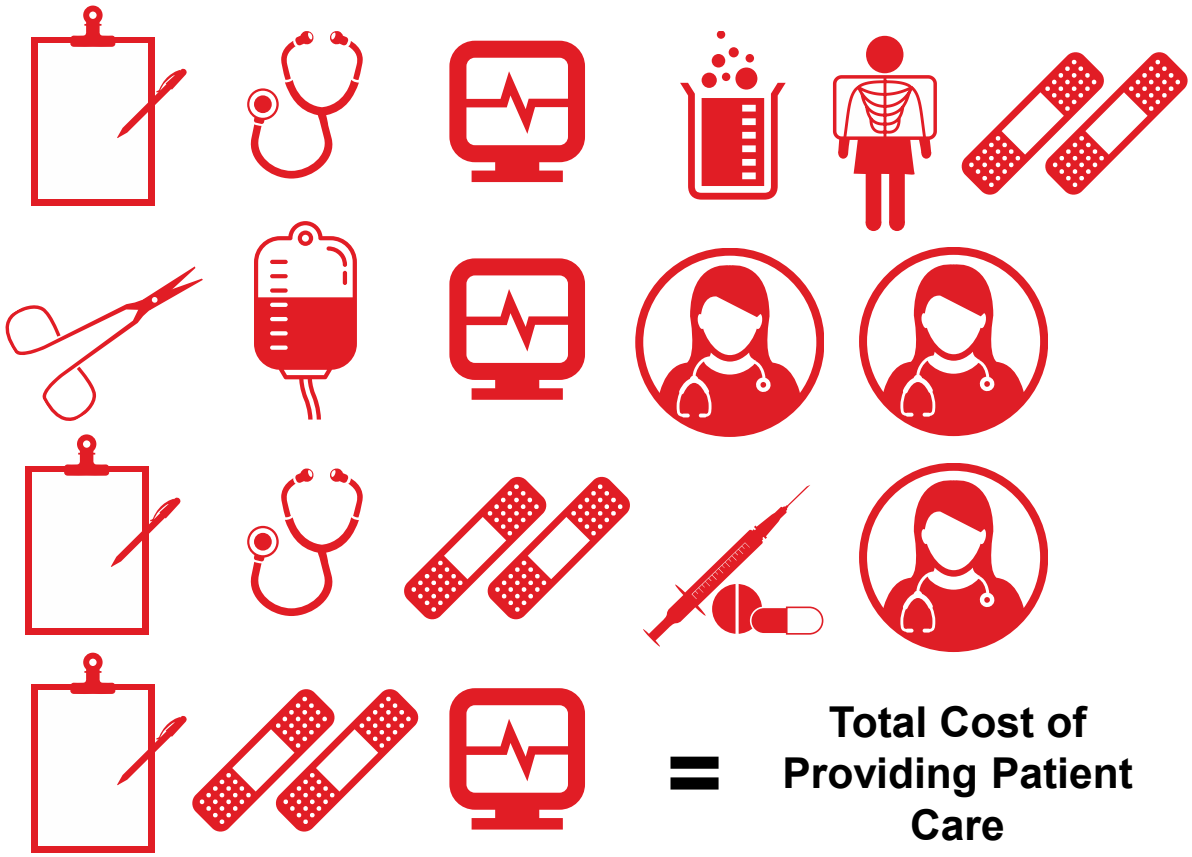
Labor
Supplies
Other Services

Surgical ICU

Labor
Supplies
Pharmacy
Lab

Step down and Floor Units

Labor
Supplies
Other Services



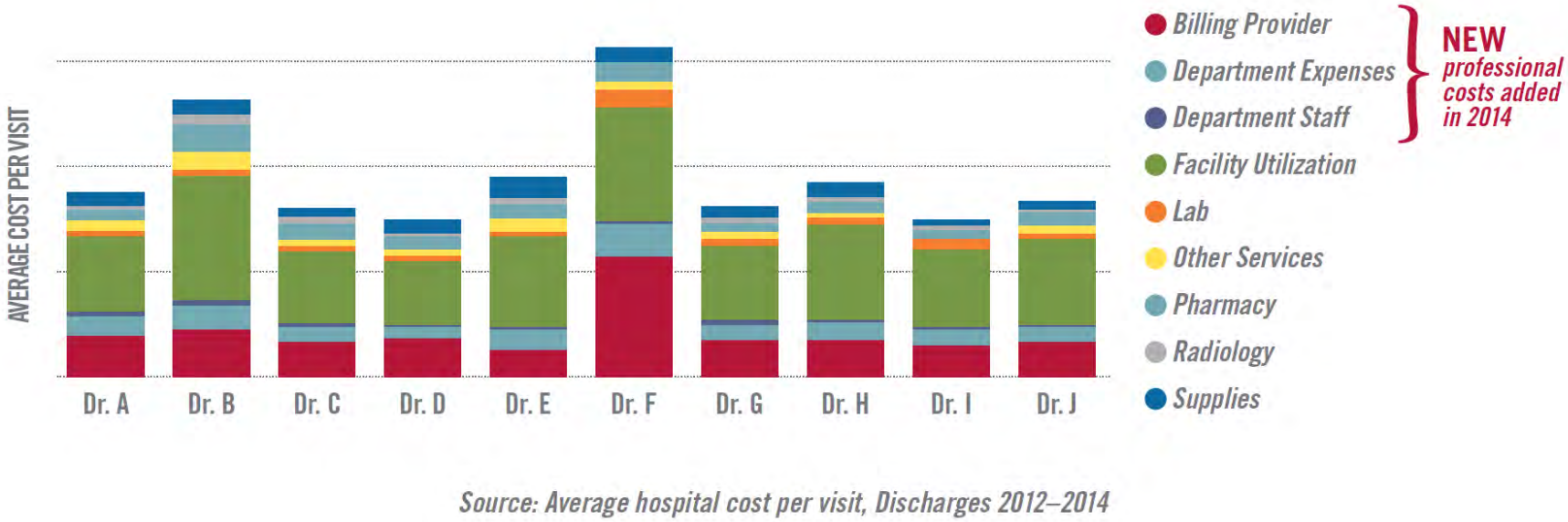
= **Total Cost of Providing Patient Care**

UNIVERSITY OF UTAH HEALTH SCIENCES

VALUE DRIVEN OUTCOMES

UNIVERSITY OF UTAH: AVERAGE COSTS OF CARE FOR TOTAL JOINT REPLACEMENT

Value-Driven Outcomes (VDO) Report
DRG 470 – Major joint replacement of the lower extremity



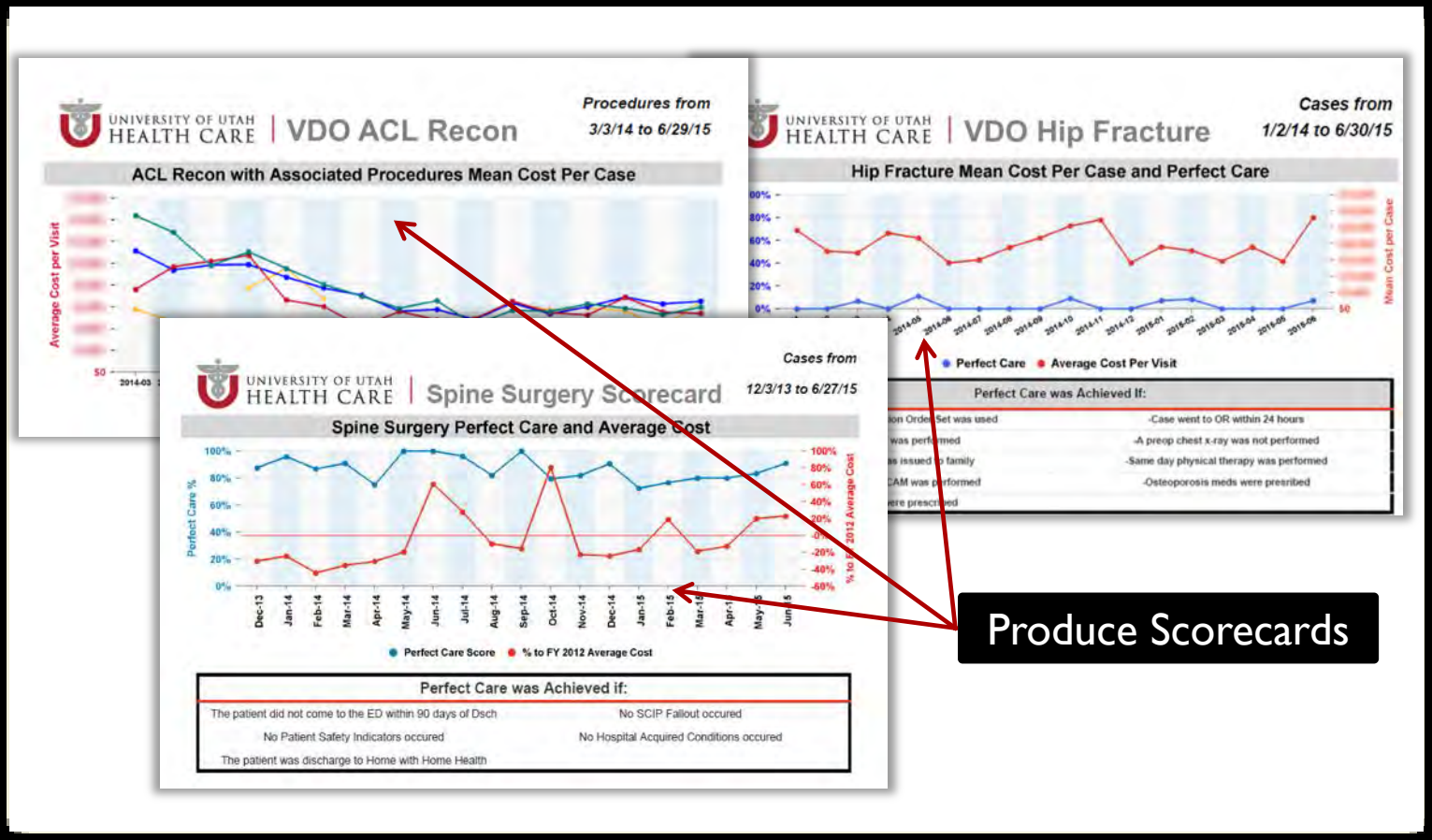
Source: Average hospital cost per visit, Discharges 2012–2014

UNIVERSITY OF UTAH HEALTH SCIENCES

DATA FOR FRONT LINE PROVIDERS

UNIVERSITY OF UTAH HEALTH SCIENCES

DATA FOR FRONT LINE PROVIDERS

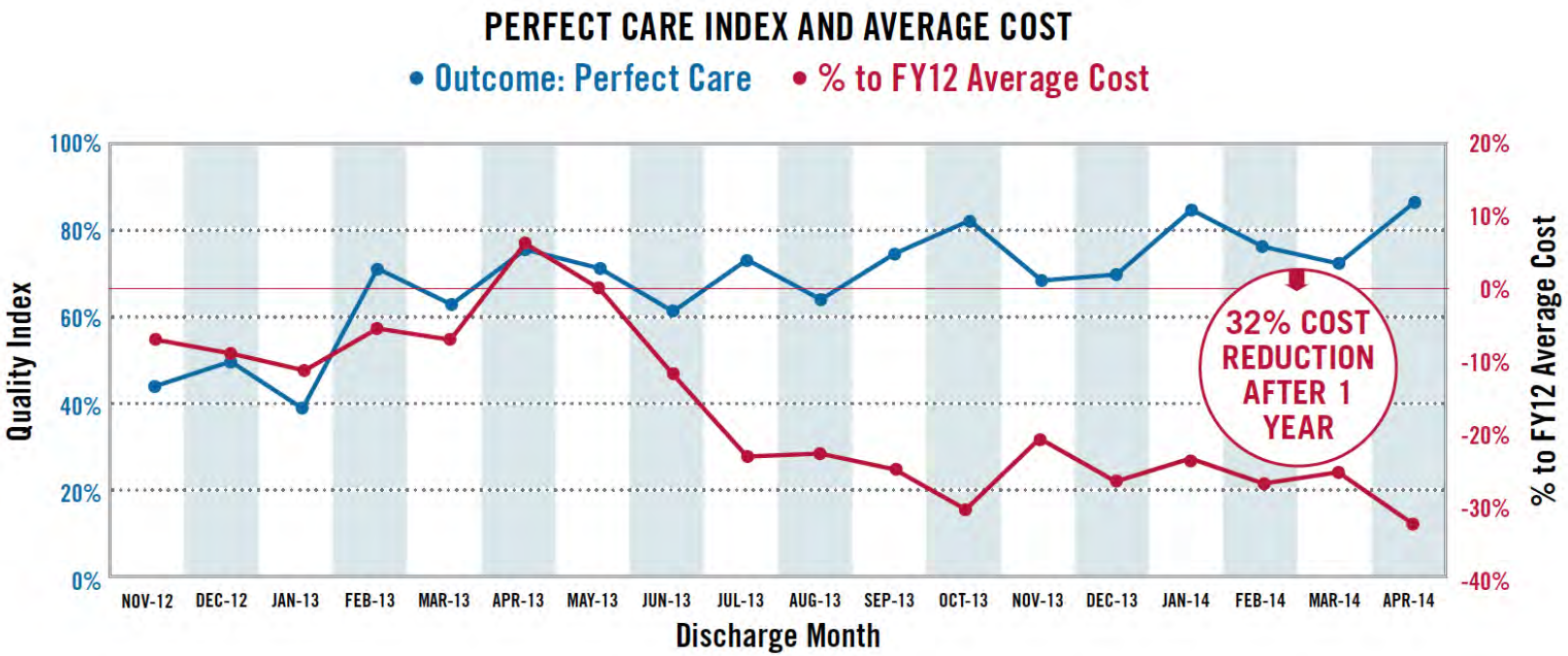


Produce Scorecards

UNIVERSITY OF UTAH HEALTH SCIENCES

QUALITY GOES UP AND COSTS GO DOWN

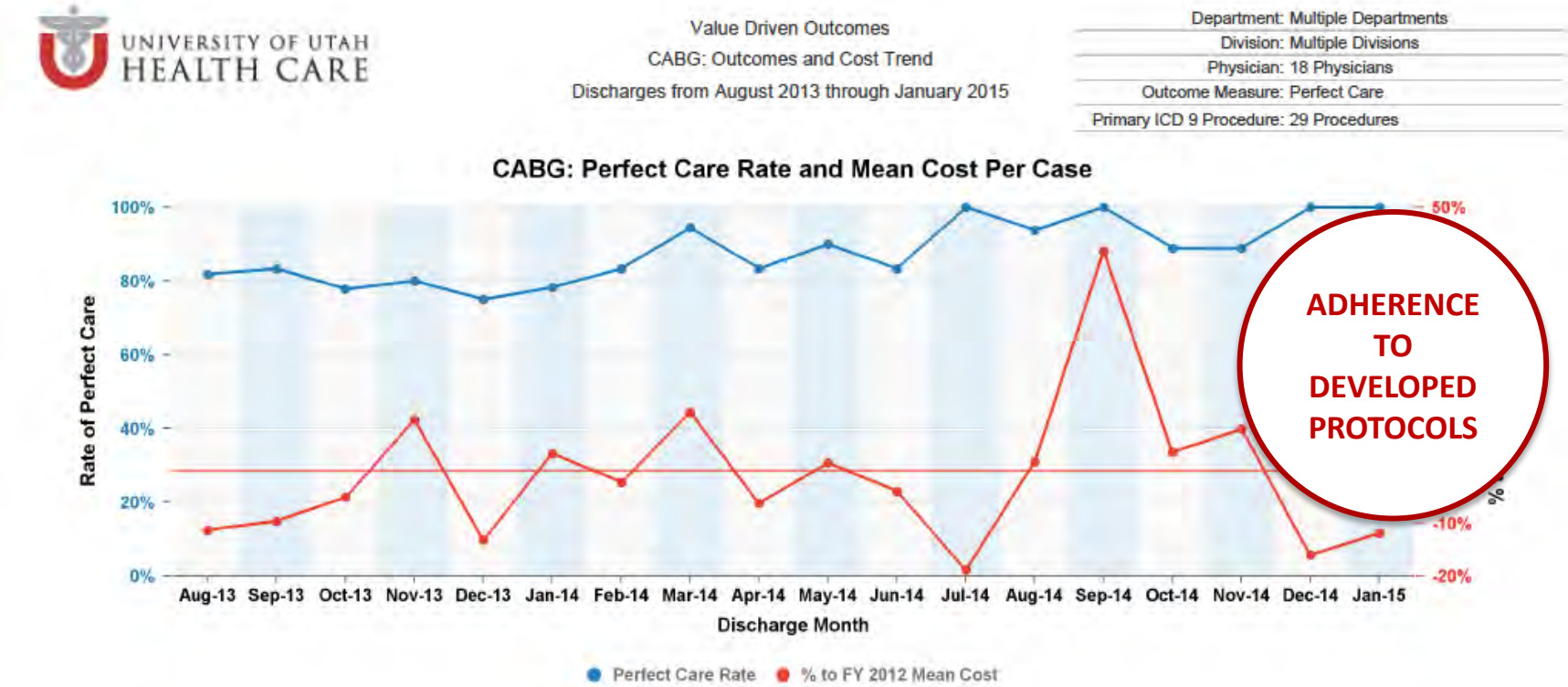
VALUE-DRIVEN OUTCOMES IN TOTAL JOINT REPLACEMENT:
Higher quality drives lower cost



Quality Index: Percentage of all visits where selected care measure was met
% to FY12 Average Cost: Ratio of that months avg. cost compared to baseline 2012 avg. cost

UNIVERSITY OF UTAH HEALTH SCIENCES

QUALITY GOES UP WITHOUT INCREASED COSTS



UNIVERSITY OF UTAH HEALTH SCIENCES

VDO: OPERATING ROOM EFFICIENCY

Space

Labor

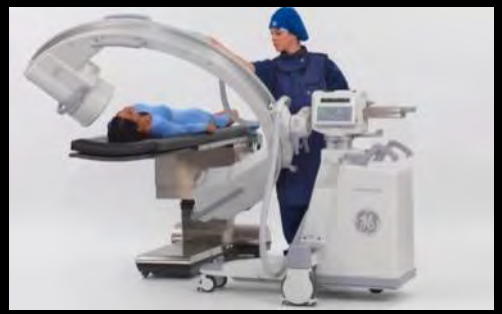
Supplies/Implants

Key Operating Room Areas

Anesthesiology

Pre-Op Care

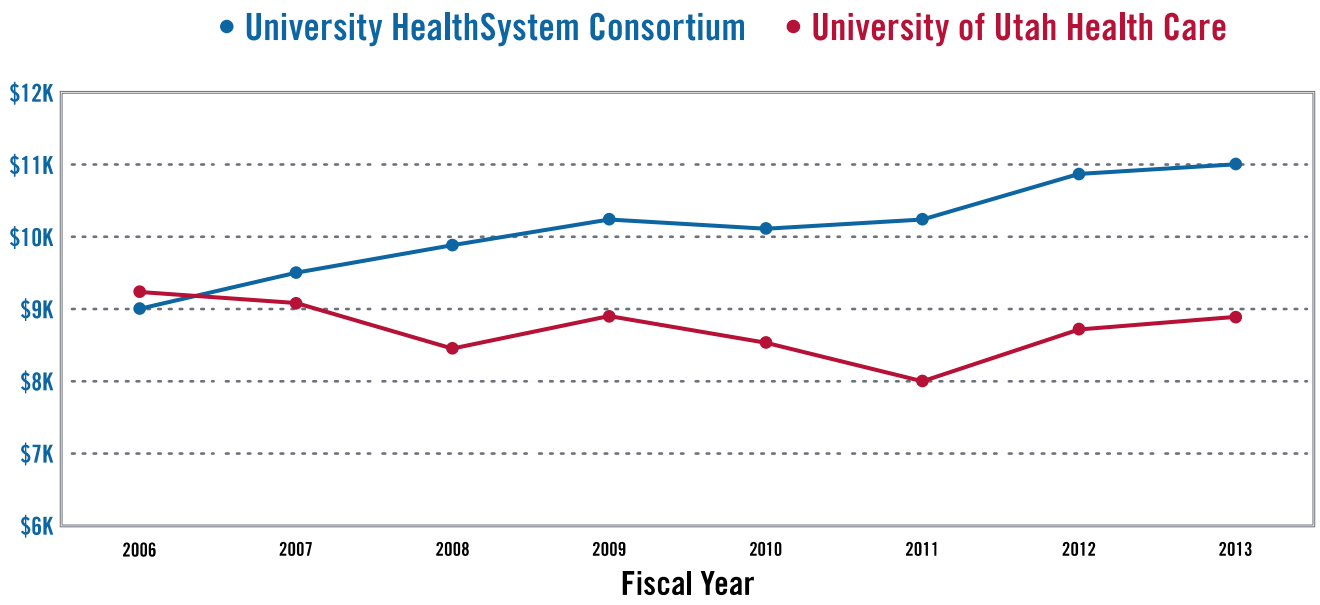
Post-Op Care



Equipment

HOW WE THINK ABOUT COST

BENCHMARKING AGAINST UHC PRINCIPAL MEMBERS:
Total Facility Expense per CMI Adjusted Discharge



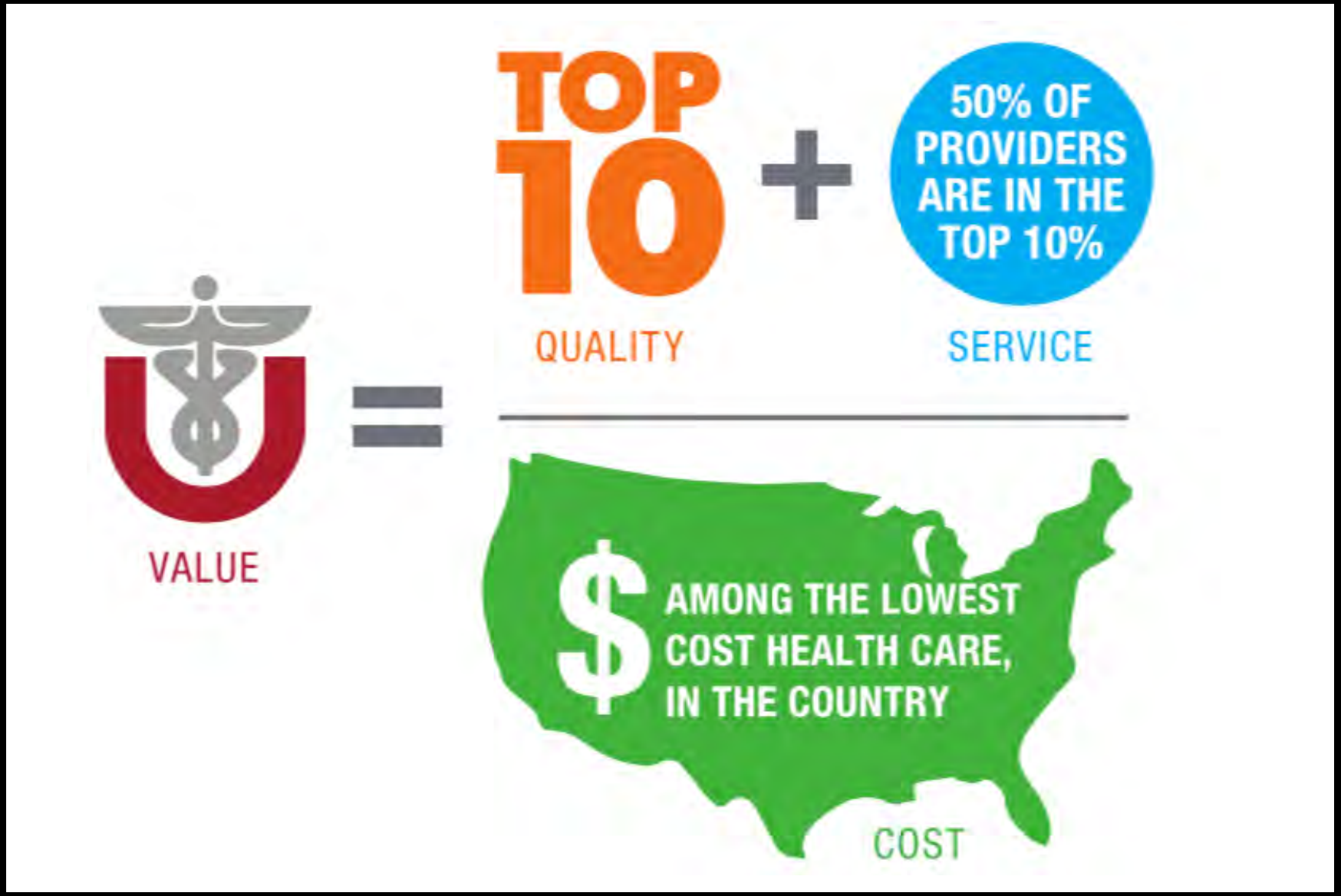
ANNUAL GROWTH RATE = 2.9%

ANNUAL GROWTH RATE = -0.5%

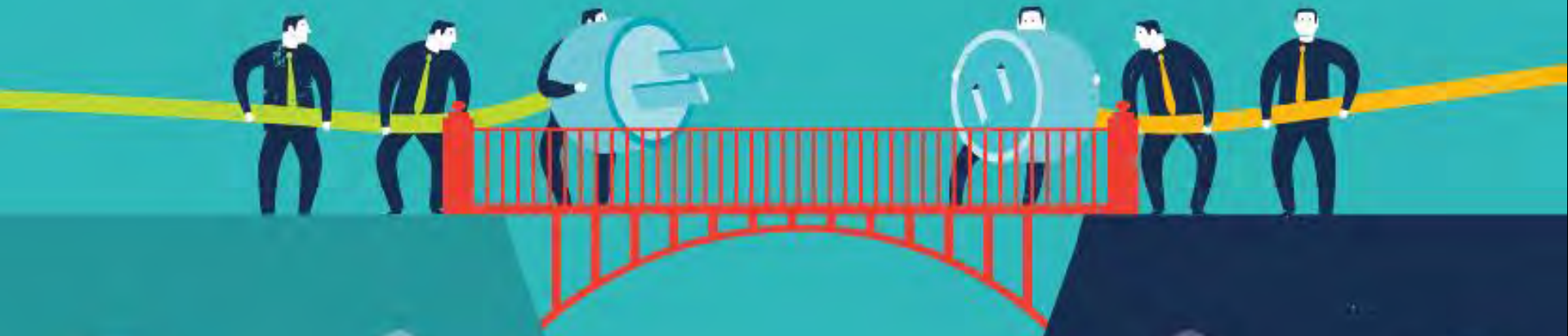
Comparative analysis includes 108 U.S. University HealthSystem Consortium (UHC) principal members. UHC values represent means by FY based off of CMS cost reports 2552-10/2552-96 and the CMS Impact File Medicare patient Case Mix Index by fiscal year. The annual growth rate is the compound annual growth rate from FY2006 to FY2013.

UNIVERSITY OF UTAH HEALTH SCIENCES

HOW WE DELIVER VALUE



UNIVERSITY OF UTAH
HEALTH SCIENCES



ENGAGING PROVIDERS

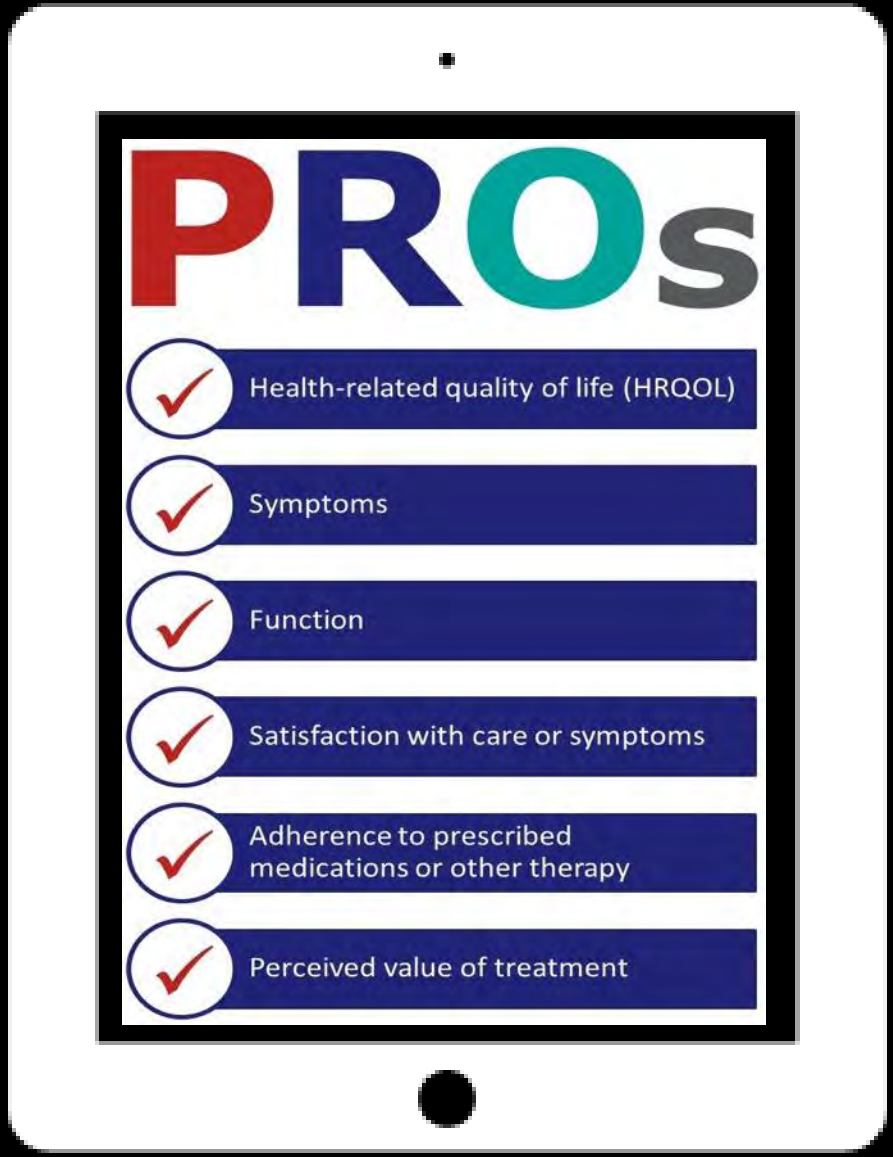
&

ENGAGING PATIENTS

@vivianleemd

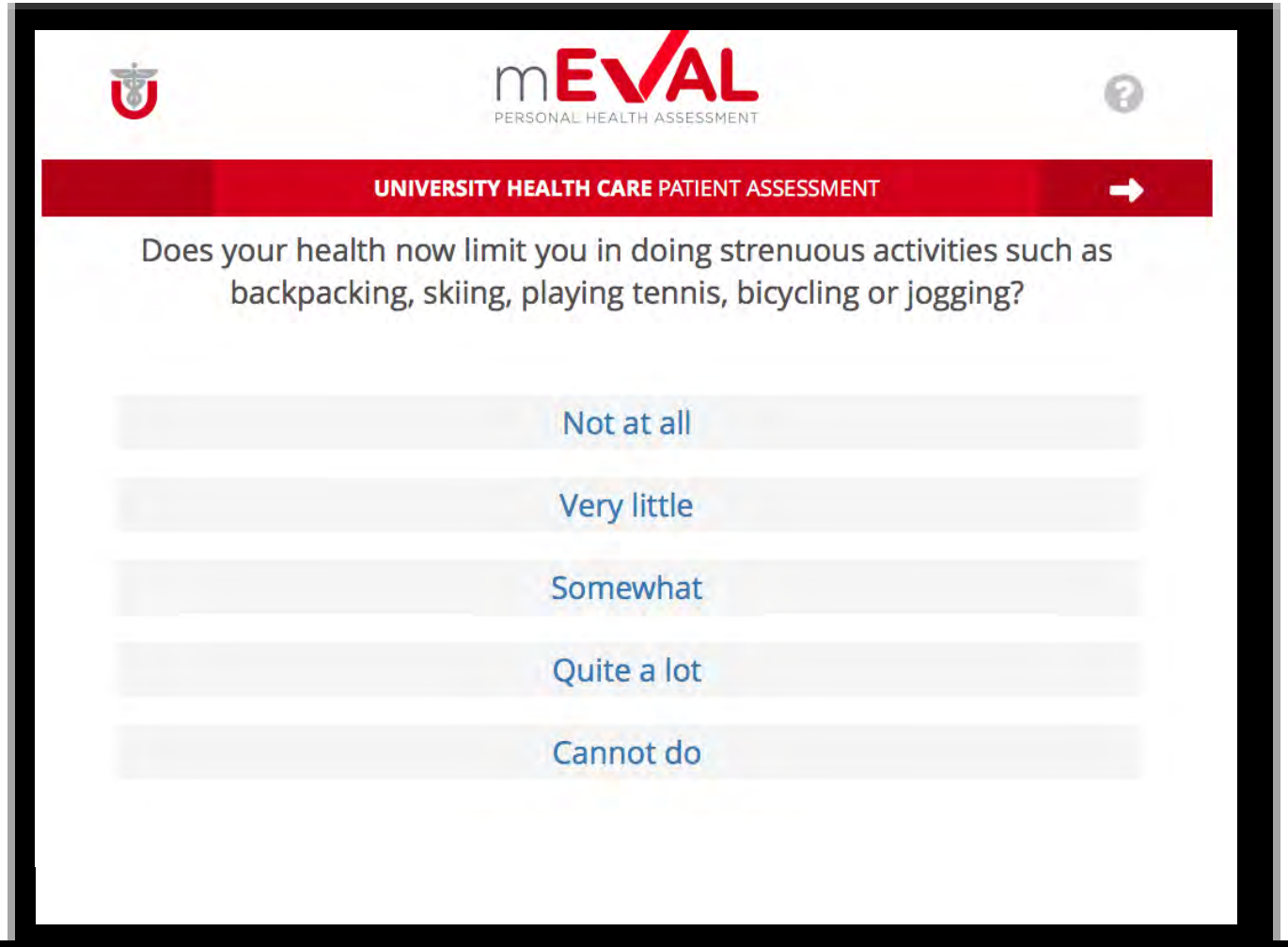
UNIVERSITY OF UTAH HEALTH SCIENCES

CREATING VALUE FOR THE PATIENT



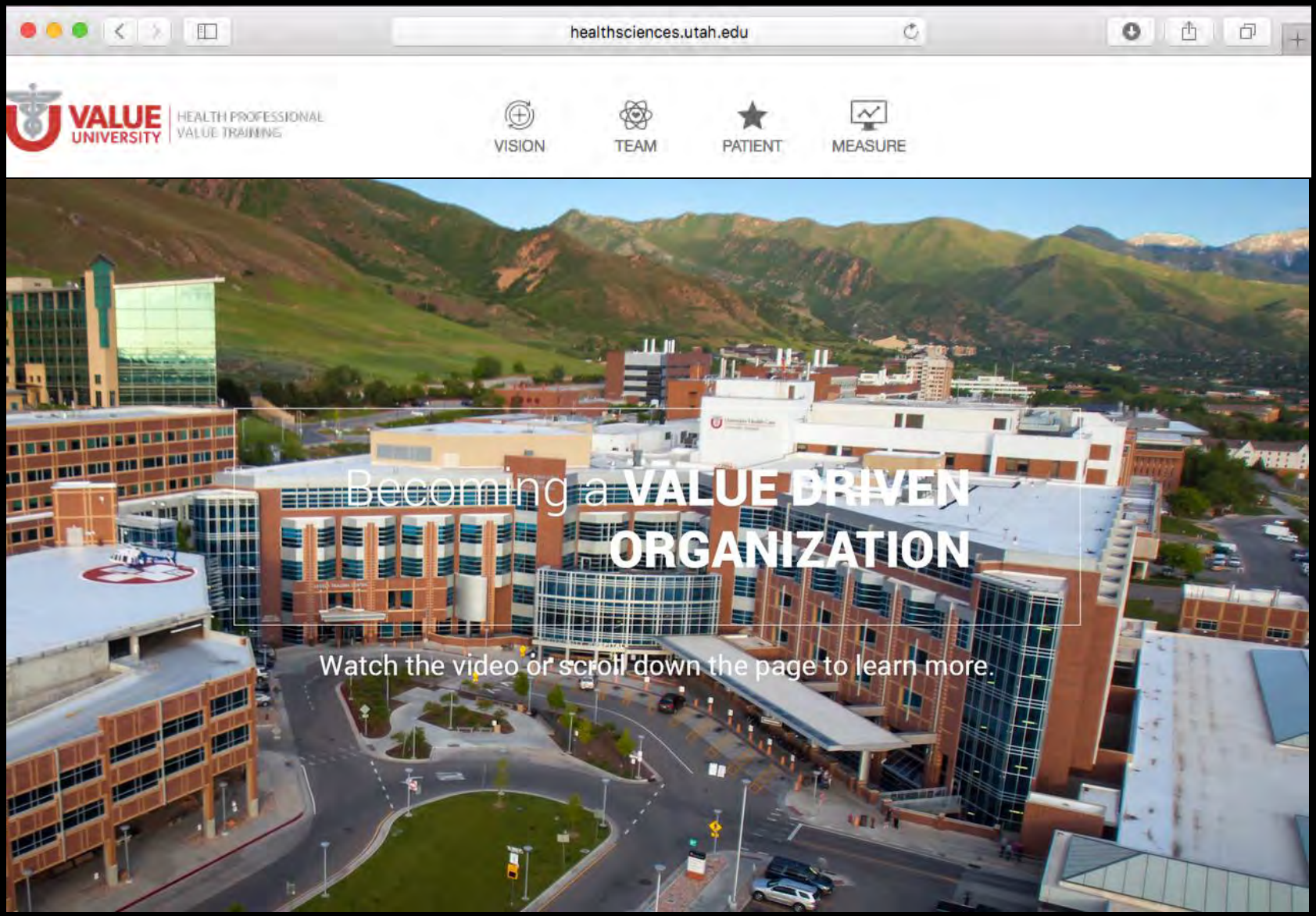
UNIVERSITY OF UTAH HEALTH SCIENCES

CREATING VALUE FOR THE PATIENT



UNIVERSITY OF UTAH
HEALTH SCIENCES

SHARING AND GROWING



SHARING AND GROWING

UNIVERSITY OF UTAH
HEALTH SCIENCES

THANK

you

VIVIAN S. LEE, M.D., Ph.D., M.B.A.

SENIOR VICE PRESIDENT, UNIVERSITY OF UTAH HEALTH SCIENCES
CEO, UNIVERSITY OF UTAH HEALTH CARE
DEAN, UNIVERSITY OF UTAH SCHOOL OF MEDICINE

@vivianleemd

Josephine Porter
APCD Council

Josephine Porter

Josephine Porter, MPH, serves as Interim Director for the Institute for Health Policy and Practice in the College of Health and Human Services at the University of New Hampshire. In this role, she has oversight responsibility across IHPP, and does project specific work in the Health Analytics and Informatics focus area. She serves as co-chair of the national All-Payer Claims Database Council (APCD Council: www.apcdcouncil.org), a learning network for state APCD development. Jo's background includes several years of health care-related project management and program development experience in the private and public sectors.

Her research interests are in health data collection and dissemination, and using data to effectively improve health care quality.

She completed her education with a Bachelor of Science in Microbiology, Health Management and Policy, University of New Hampshire and a Master of Public Health in Epidemiology/Biostatistics and Social and Behavioral Health, Boston University.

All Payer Claims Databases: An Overview

Presentation to the Florida House of Representatives:
Select Committee on Affordable Healthcare Access

1/11/2016

About the APCD Council

The APCD Council is a learning collaborative of government, private, non-profit, and academic organizations focused on improving the development and deployment of state-based all payer claims databases (APCDs). The APCD Council is convened and coordinated by the Institute for Health Policy and Practice (IHPP) at the University of New Hampshire (UNH) and the National Association of Health Data Organizations (NAHDO).

Our Work

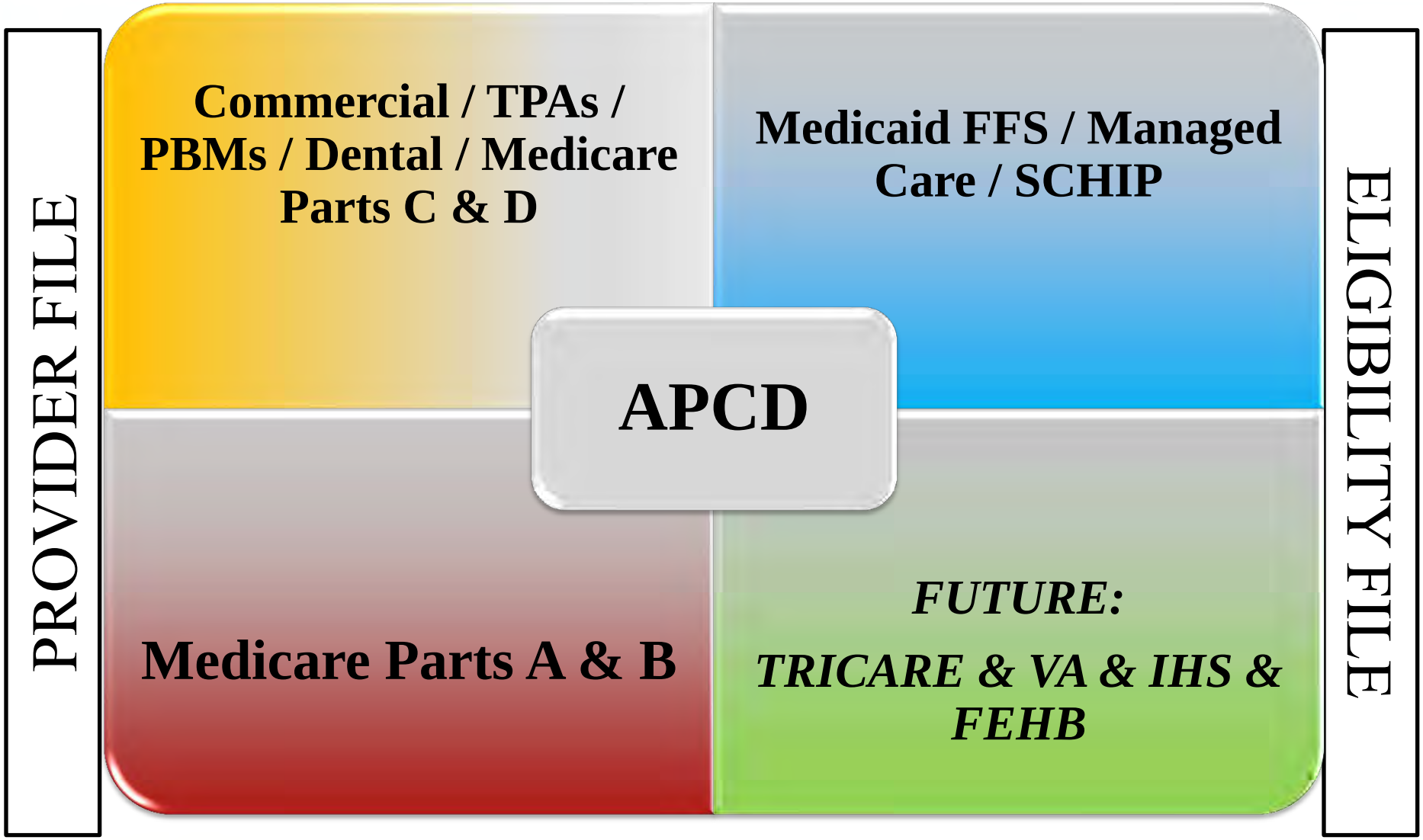
- Early Stage Technical Assistance to States
- Shared Learning
- Catalyzing States to Achieve Mutual Goals

APCD Definition

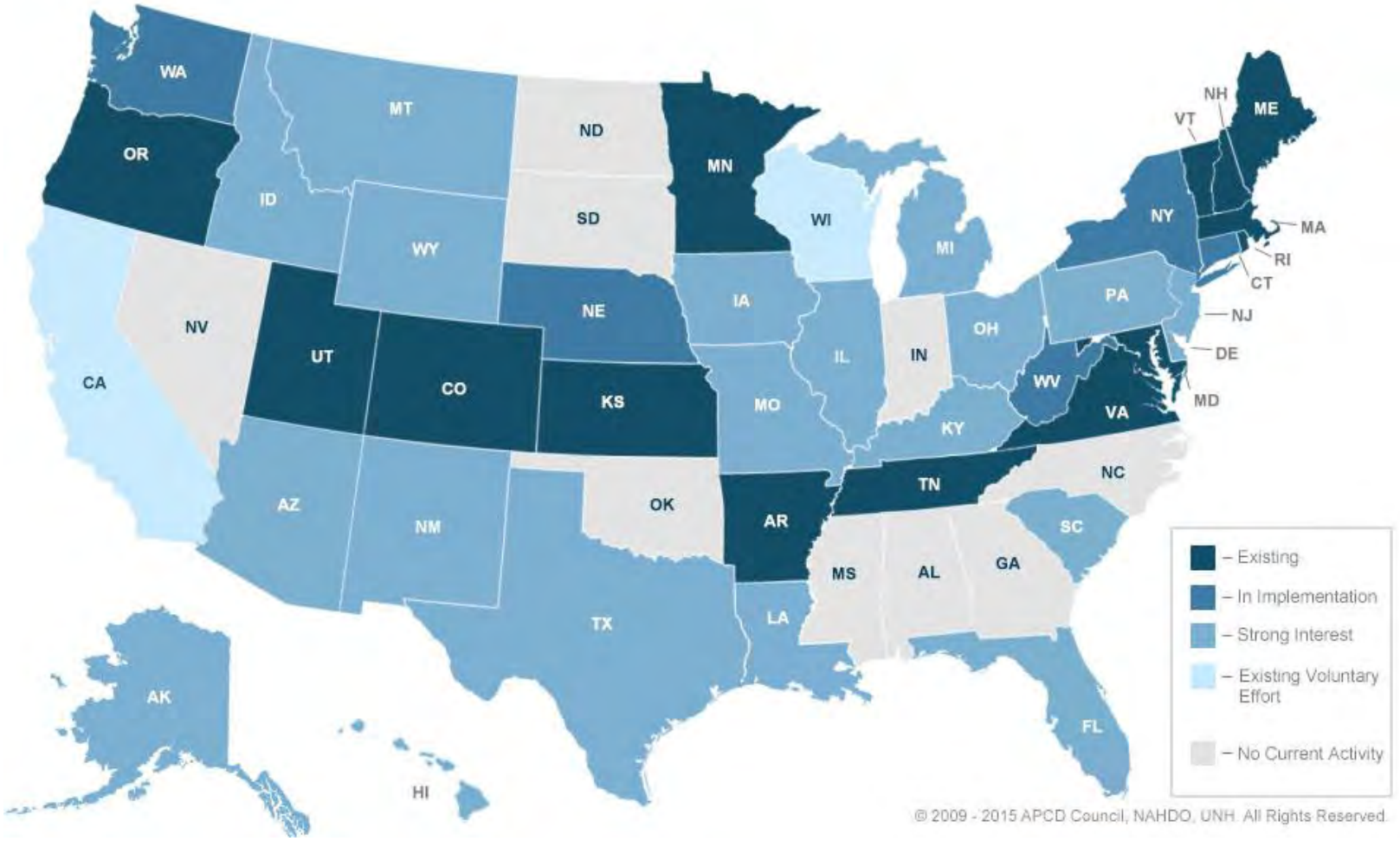
Databases, created by state mandate, that typically include data derived from medical, pharmacy, and dental claims with eligibility and provider files from private and public payers:

- **Commercial insurance carriers (medical, dental, TPAs, PBMs)**
- **Public payers (Medicaid, Medicare)**

Typical APCD Data Sets



September 2015 State Progress Map



Framework for APCD Development

- For more information, please see the APCD Development Manual: http://www.apcdcouncil.org/manual.

Key Considerations

Defining APCD Vision

- Define purpose
- Identify information needs across stakeholder groups
- Drives data use

Stakeholder Engagement

- Inclusiveness
- Guides implementation
- Broad representation

Engagement

Stakeholder	Key Interests in APCD
Policy Makers	May be a "champion" of the APCD program; Inform policy, payment, and health care reforms
Payers	Data suppliers and technical/content experts
Providers	How the data will be used
Employers	Costs of health services; Price transparency
State Agencies	Governance and use issues; Medicaid applications Leveraging existing infrastructure
Consumers	Informed choices, pricing
Researchers	Access to and use of data
HIE/HIX	Supplement clinical/benefits data with claims; Consumer support tools; Rate review

Key Considerations

APCD Legislation

- Mandatory & voluntary approaches

Data Collection

Data Release

- Reporting Requirements

Rules and Regulations

State Approaches to Governance

State Led	Public-Private	Private Non-profit
State agency led; policy development informed by multi-stakeholder advisory committee	Initial planning led by state agency; day-to-day operations delegated to private non-profit, selected by the state	Private, voluntary reporting initiatives
Kansas, Maine, Massachusetts, Maryland, Minnesota, New Hampshire, Oregon, Tennessee, Utah, Vermont, W. Virginia, Rhode Island, Connecticut, New York, Washington	Colorado, Virginia, Arkansas, Washington (in implementation)	Wisconsin, California

Key Considerations

Funding Estimates

- Cost drivers and considerations
- Start-up & sustainability

Funding Sources

- General appropriations
- Fee assessments
- Medicaid match
- Federal/state/local grants
- Data sales

Key Considerations

Technical Considerations

- Alignment with payer capabilities

Standards, Data Elements, Format

Data Quality Assurance

- Tests for data completeness, continuity

RFP Development

APCD Enhancements

- Non-claims based payments and supplemental fields

Key Considerations

Analytic Plan

- Balancing availability, utility, and privacy

Technical Advisory Group Roles

APCD Reporting & Measurement

- Meeting multiple user needs
- Adopting staged or tiered approaches to public reporting

Data Use & Release

- Data product development mapped to user needs
- Web-based reporting tools

Key Considerations

Continuous Engagement

- Initial and evolving vision
- Reflection of stakeholder values
- Ongoing commitment of staff and resources

Key Success Factors

- Inclusiveness
- Transparent and open process
- Managing stakeholder expectations
- Feedback loop

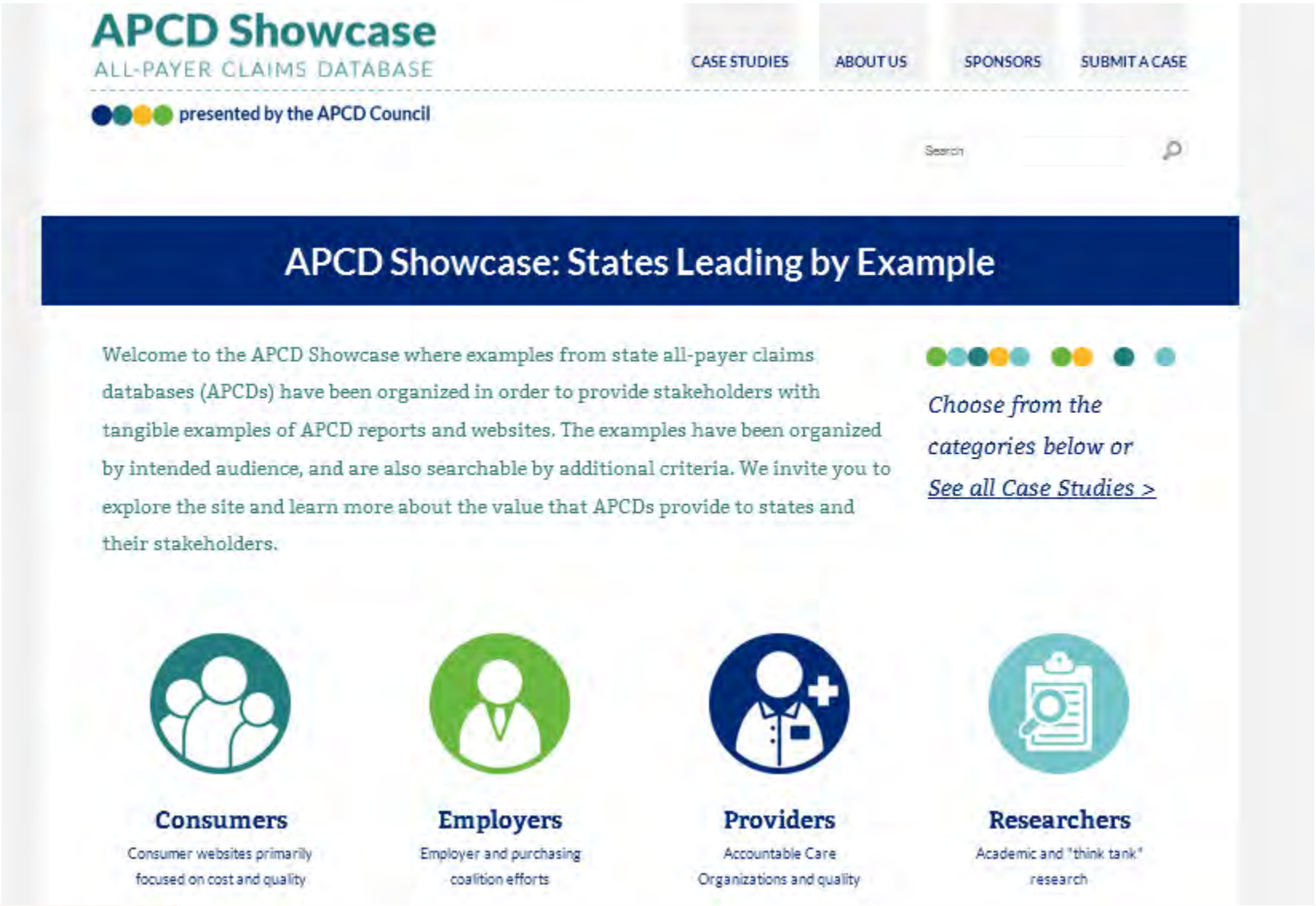
STATE EXPERIENCES AND LESSONS LEARNED

APCD use cases are maintained at the APCD Showcase, www.apcdshowcase.org

APCDs are filling critical information gaps for state agencies

- Understanding overall and categorical costs for care (e.g., CO, NH, ME, VT, UT, MA, MD)
- Consumer tools (e.g., MA, NH, ME)
- Intrastate cost variation (e.g., CO, ME, NH, VT)
- Benchmarks for purchasers (e.g., NH)
- Medical home evaluation (e.g., VT, NH)
- Accountable care – regional cost profiles (e.g., NH)

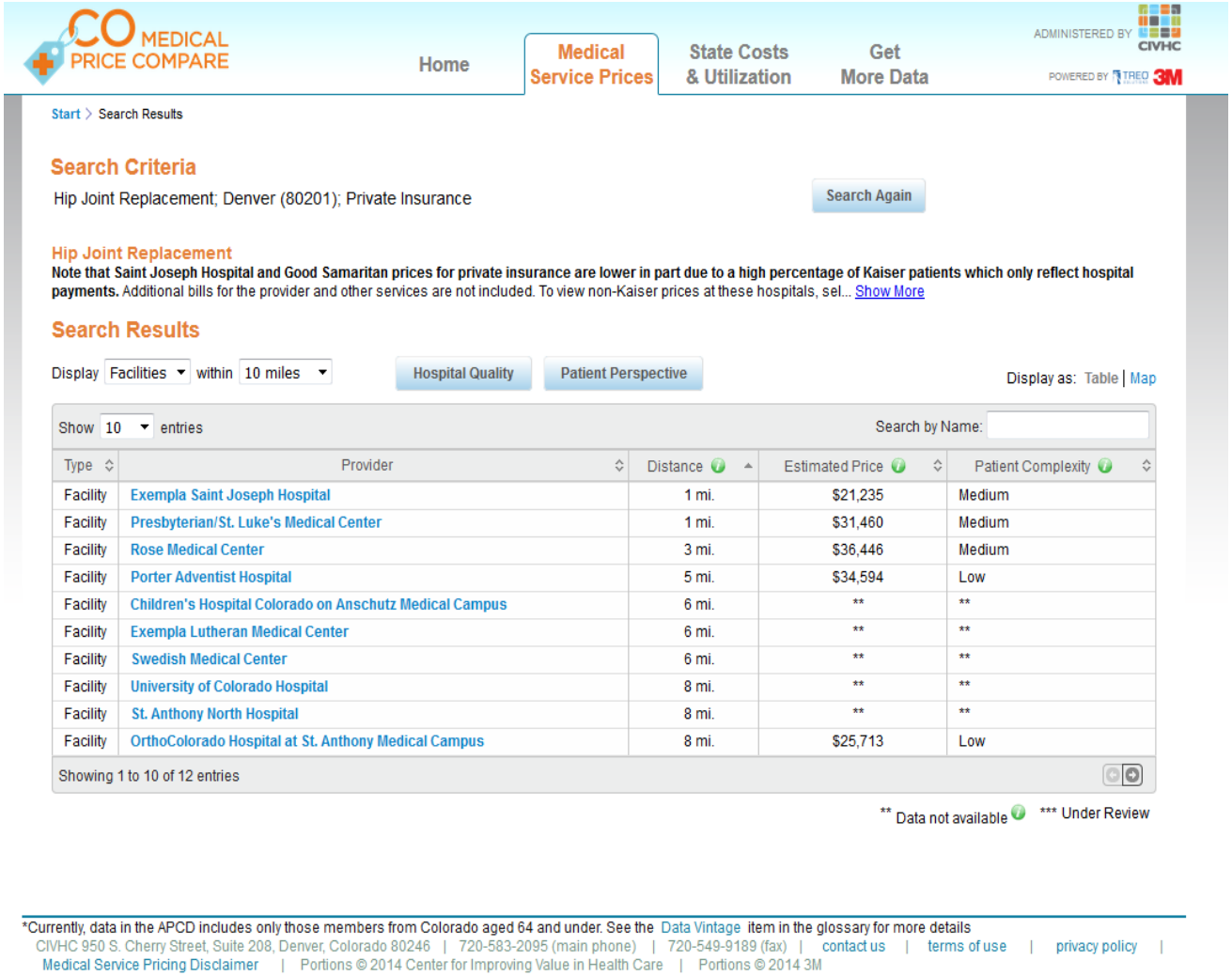
State Use Case Examples



Virginia Health Information: Health Care Prices

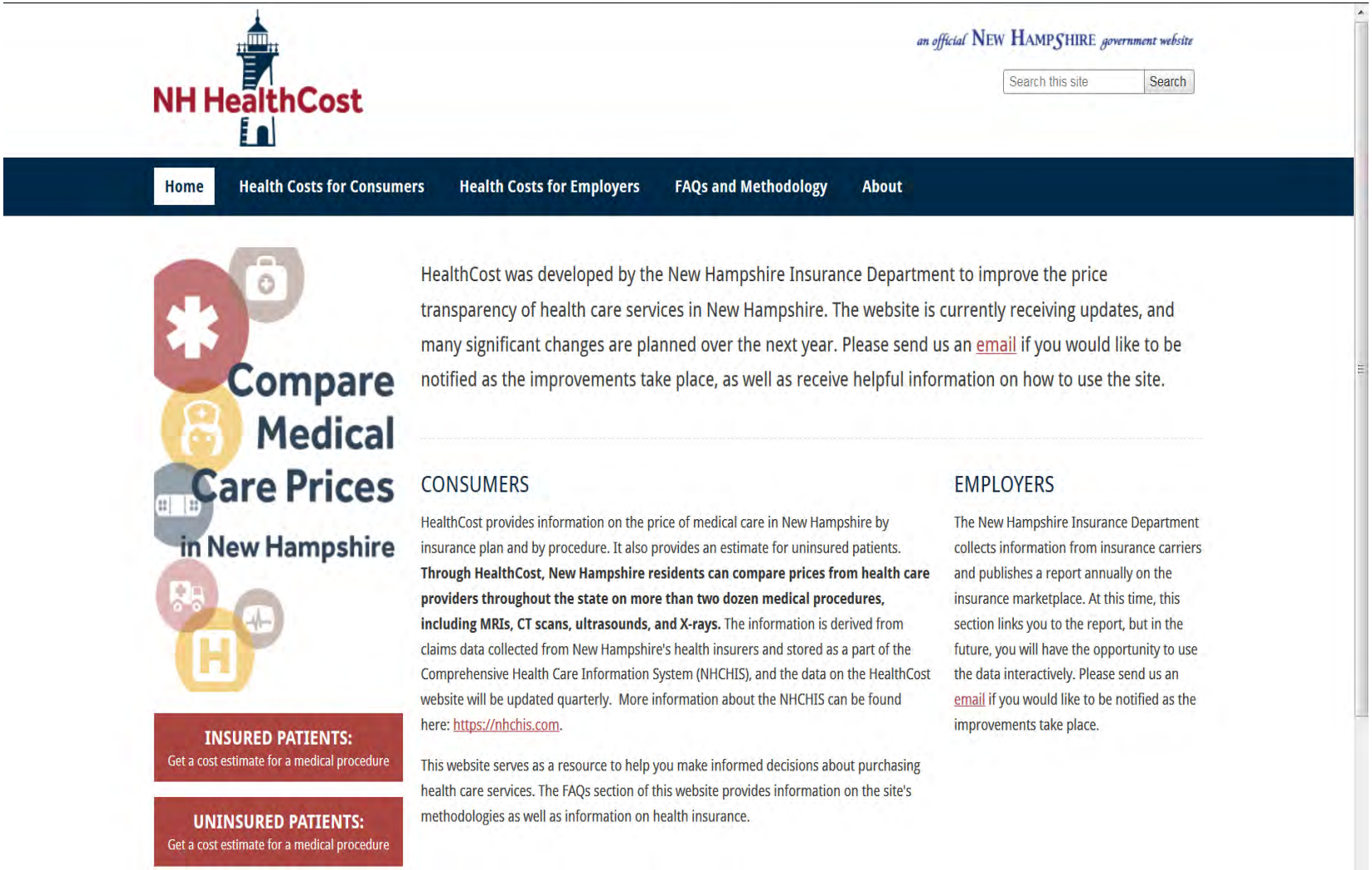
Source: http://www.vhi.org/health_care_prices.asp

Colorado Medical Price Compare



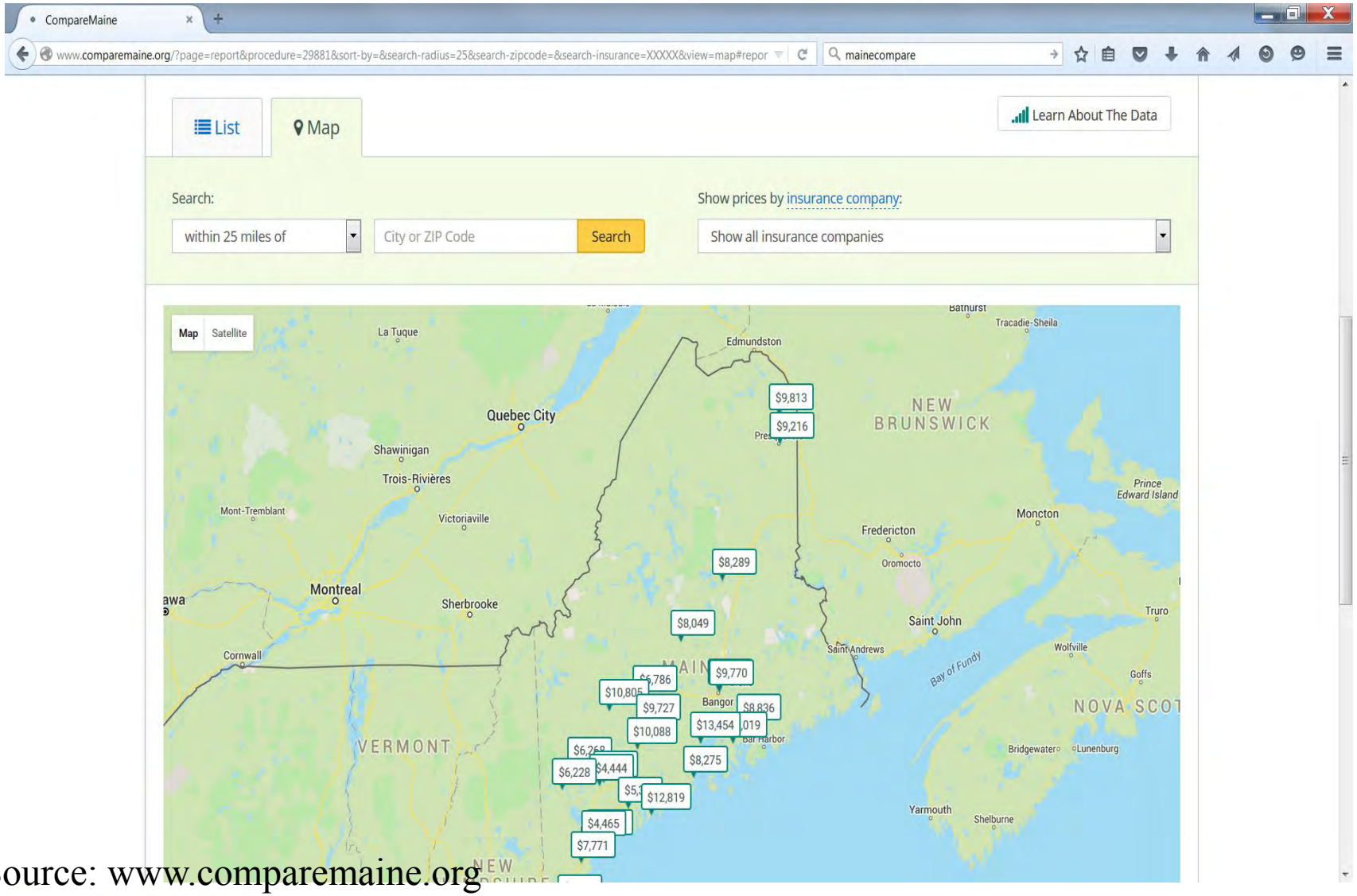
Source: www.comedprice.org

NH HealthCost



Source: http://nhhealthcost.nh.gov/

CompareMaine



Source: www.comparemaine.org

Vermont Blueprint for Health, HSA Profiles

APCD Council — All-Payer Claims Database

Hospital Service Area (HSA... | Blueprint Service Area Profiles (...

blueprintforhealth.vermont.gov/sites/blueprint/files/HSAProfiles/Adult2014/Blueprint Service Area Profiles (2014)b - Burlington.pdf

Page: 7 of 21 — 160%

VERMONT Blueprint for Health

Smart choices. Powerful tools.

HSA Profile: Burlington

Period: July 2013 - June 2014 **Profile Type:** Adults (18+ Years)

Plan All-Cause Readmissions (Core-1)

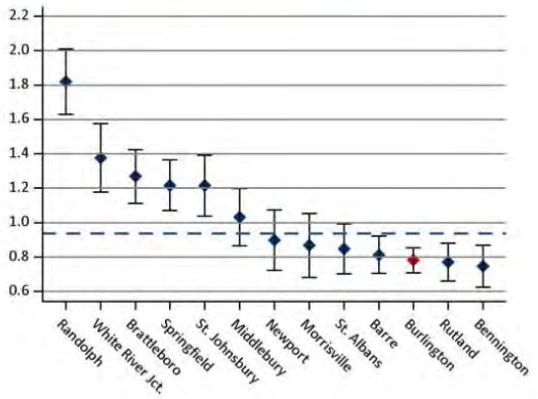


Figure 17: Presents the relative rate, including 95% confidence intervals, of continuously enrolled members, ages 18 years and older, that had an inpatient stay that was followed by an acute readmission for any diagnosis within 30 days during the measurement year. The rate is expressed as a ratio of observed to expected readmissions where the expected number of readmissions has been risk adjusted. The blue dashed line indicates the statewide average.

Follow-Up After Hospitalization for Mental Illness (Core-4)

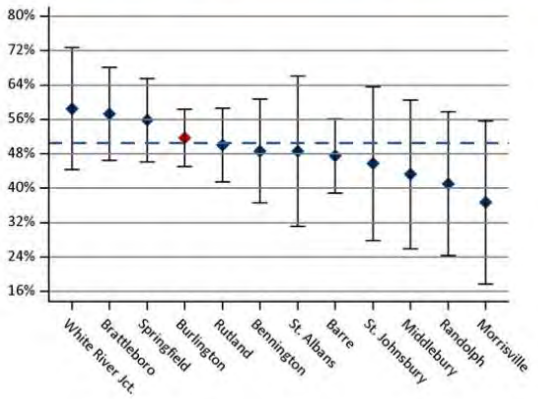


Figure 18: Presents the proportion, including 95% confidence intervals, of continuously enrolled members, ages 6 years and older, hospitalized for mental illness with an intensive outpatient encounter or partial hospitalization with a mental health practitioner and a follow-up visit within seven days of discharge. The blue dashed line indicates the statewide average.

Initiation of Alcohol/Drug Treatment (Core-5a)

Engagement of Alcohol/Drug Treatment (Core-5b)

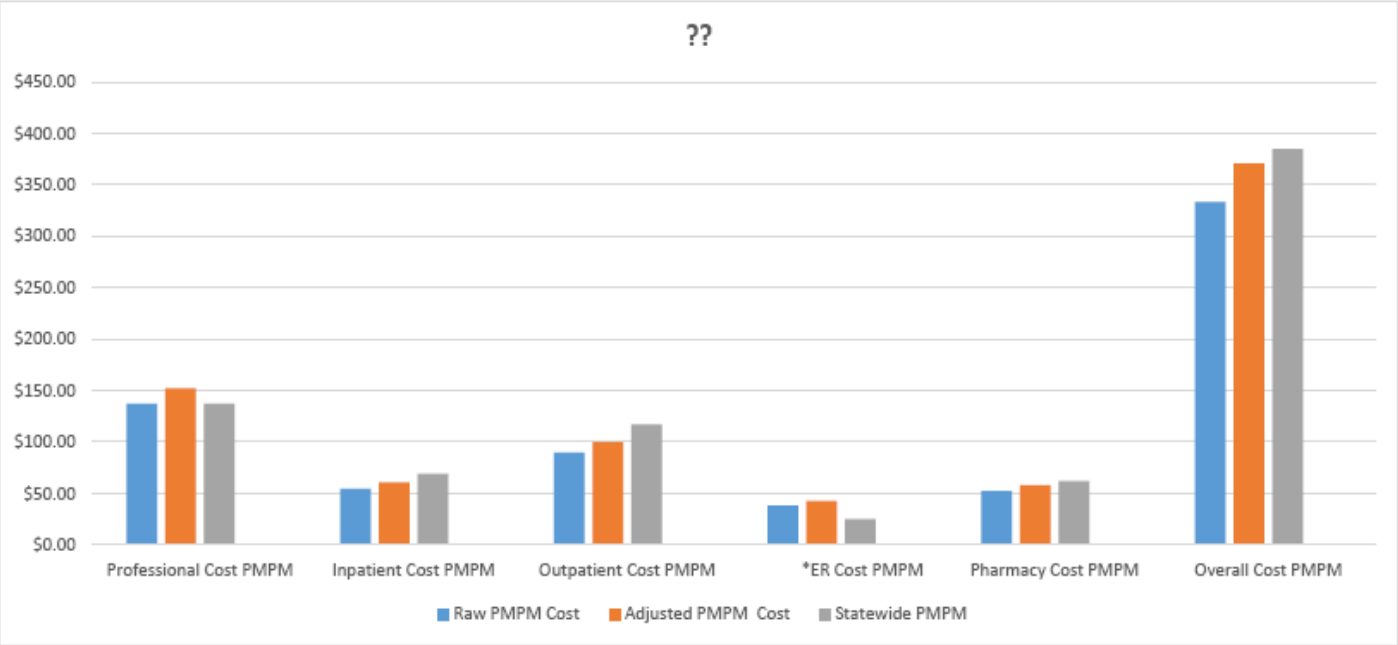
Source: http://blueprintforhealth.vermont.gov/node/680

CO Total Cost of Care Reporting

Physician Group Name:

Summary by Service Category	PCP Group Raw PMPM Cost	PCP Group Adjusted PMPM Cost	Colorado Statewide PMPM	PCP Group TCI =	Price Index	x RUI
Professional Cost PMPM	$137.19	$152.43	$137.19	1.11	1.11	1.00
Inpatient Cost PMPM	$54.65	$60.72	$68.99	0.88	0.73	1.20
Outpatient Cost PMPM	$89.56	$99.51	$116.95	0.85	1.04	0.82
*ER Cost PMPM	$38.25	$42.50	$24.96	1.70	2.00	0.85
Pharmacy Cost PMPM	$52.11	$57.90	$61.85	0.94	0.80	1.17
Overall Cost PMPM	$333.51	$370.57	$384.98	0.96	0.93	1.04

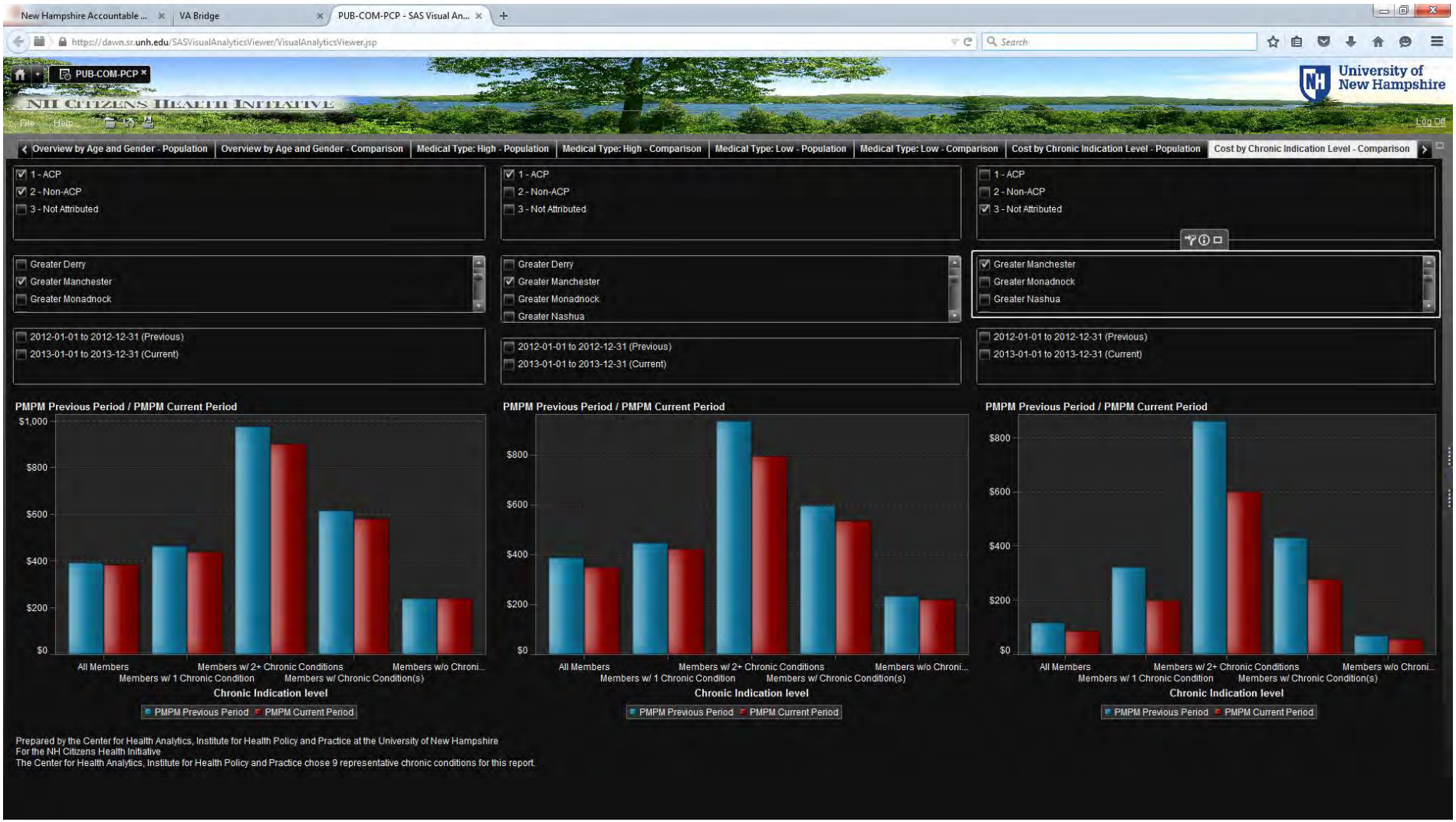
	Physician Group	Statewide
% Female	53	57
% Under 18	18	25
Attributed Members	1754	100,164
Risk Score	0.90	1.00



*ER is a subset of Outpatient.

Source: https://www.nahdo.org/sites/nahdo.org/files/Conference/Annual_30/8.45%20Mathieu%20slides.pdf

NH Accountable Care Project



Source: www.nhaccountablecare.org

MN Potentially Preventable Health Care Events

APCD COUNCIL All-Payer Claims Database

Potentially Preventable Eve...

www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf

Page: 14 of 23 — Automatic Zoom

expected rates for a given population.

[16] Treatment for chronic illnesses does not include mental health, substance abuse, and malignancy.

[17] A recent survey of chest pain presenting to the PCP office found that 70% of the individuals with chest pain was causes by muscles surrounding the chest wall, stomach upset, and anxiety.

The specific symptoms and conditions for which people sought ED services that were potentially preventable cross a variety of clinical categories. The top four account for approximately 33 percent of all PPVs and include:

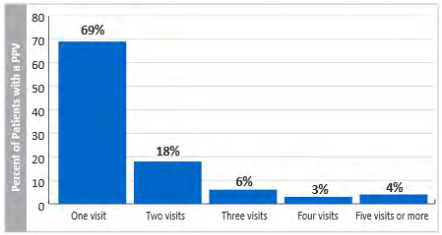
- Infections of the upper respiratory tract (9 percent);
- Abdominal pain (7 percent);
- Musculoskeletal systems and connective tissue diagnoses such as back pain (7 percent); and
- Chest pain (6 percent).[18]

Because many ED visits are for conditions that are primary care-treatable and because the PPV approach excludes visits that resulted in a hospital stay or were for trauma cases with surgical procedures, a sizable share of patients with PPVs did not have complex health conditions at their ED visit. As shown in Figure 2, patients who were identified as comparatively healthy based on their health care use pattern accounted for more than half of potentially preventable ED visits (53.3 percent).[19] Almost one-third of patients with a PPV (31 percent) had a significant chronic disease in one or multiple organ systems.[20] Healthy individuals accounted for a smaller share of PPVs in the Medicare population (about 35 percent, not shown), compared with 62.2 percent and 58.5 percent for Medicaid and commercially insured patients, respectively.

FIGURE 2: Distribution of Patient Clinical Risk for Patients with Potentially Preventable ED Visits, 2012

Our analysis found that approximately 710,000 individual patients accounted for the 1.2 million potentially preventable ED visits in 2012. Figure 3 shows that nearly 31 percent of patients with a PPV had more than one preventable visit, and seven percent, or about 50,000 Minnesotans, had four or more visits to the ED that were potentially preventable.

FIGURE 3: Frequency of Potentially Preventable ED Visits per Person, 2012



SOURCE: MDH/Health Economics Program, analysis of health care services provided in 2012 to MN residents, MN APCD (2015)

Patients with three or more potentially preventable visits to the ED differed from patients with fewer PPVs in the following ways, they were more likely to:

- Be a Medicaid patient. Half of all patients who had three or more PPVs were Medicaid patients;

Source: http://www.health.state.mn.us/healthreform/allpayer/potentially_preventable_events_072115.pdf

MA Health Care Enrollment Trends

APCD Council All-Payer Claims Database

Enrollment-Trends-Brief.pdf

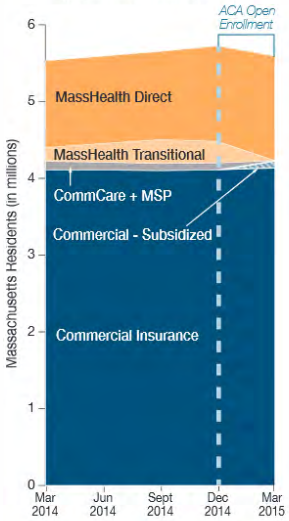
www.chiamass.gov/assets/Enrollment-Trends-Brief.pdf

MASSACHUSETTS HEALTH CARE COVERAGE: ENROLLMENT TRENDS

(JULY 2015 EDITION)

TOTAL NON-MEDICARE ENROLLMENT

(March 2014 - March 2015)

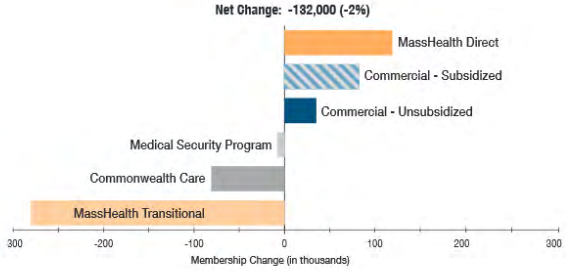


Total non-Medicare market membership remained steady (+1%) between March 2014 and March 2015, although it declined slightly (-2%) during Open Enrollment after temporarily peaking in December 2014.[1]

Massachusetts' second ACA Open Enrollment period (December 2014 – March 2015) coincided with the closure of several public coverage programs: the temporary MassHealth Transitional program, Commonwealth Care (CommCare), and the Medical Security Program (MSP). As these programs ended, membership shifted to other coverage sources. MassHealth Direct, MassHealth programs providing primary, medical coverage[2], added +119,000 enrollees. Commercial plans added +117,000 enrollees, most of whom (72%) obtained subsidized health insurance[3] through the Health Connector.

QUARTERLY ENROLLMENT CHANGE

(December 2014 - March 2015)



COMMERCIAL MARKET

From December 2014 to March 2015, Massachusetts commercial market membership increased by +117,000 enrollees (+3%) to 4.2 million members; this included the new subsidized population which was likely previously enrolled in "public" programs such as CommCare. Self-insured membership continued to comprise 58% of the market,[4] and remained almost exclusively within employers with more than 100 employees.[5] Preferred Provider Organization (PPO) membership grew slightly to 38% of the market over the year ending March 2015, continuing a longer-term shift — particularly by larger employers[6] — to plans with more flexible provider networks.

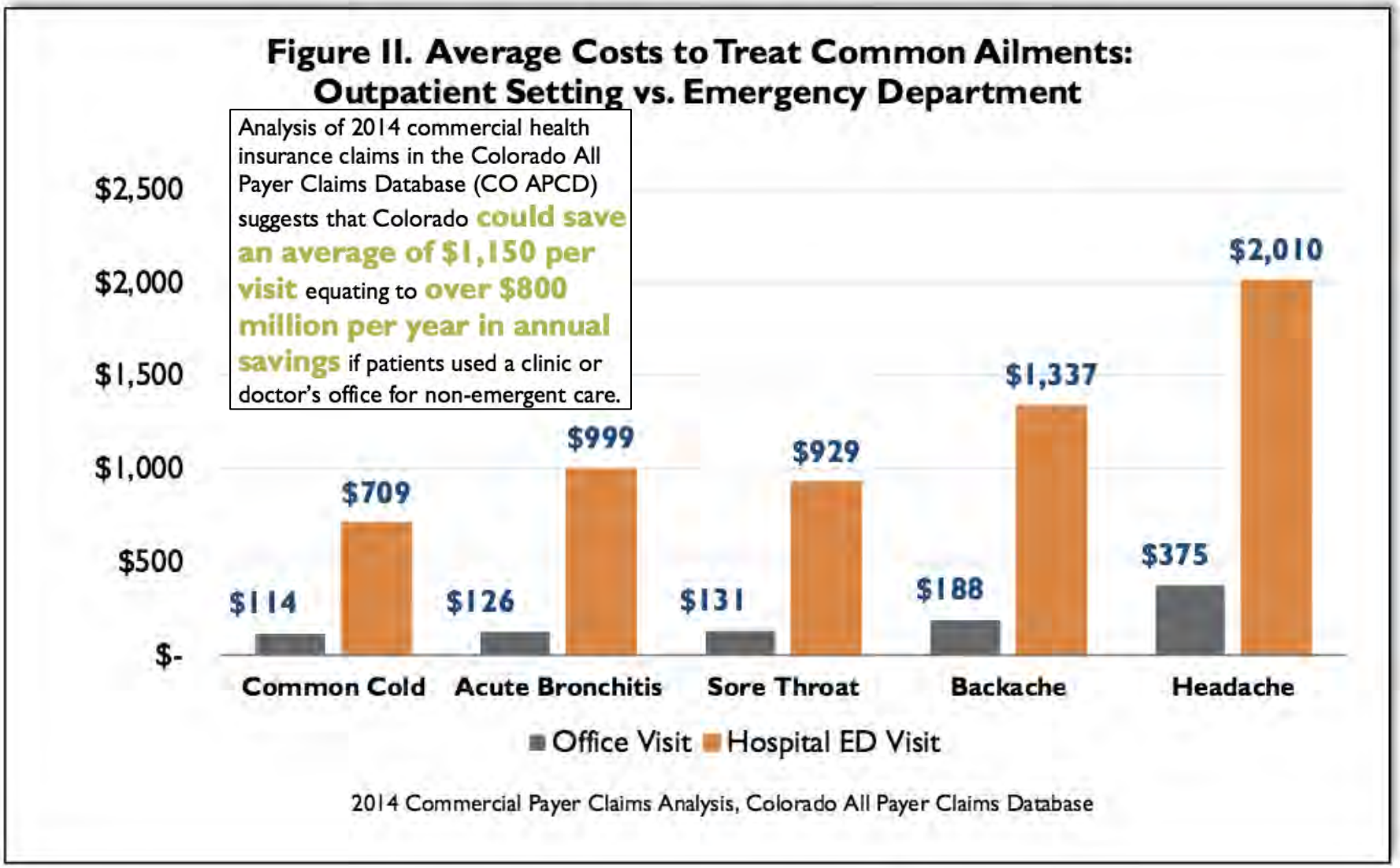
The Individual segment of the Merged Market doubled its share of commercial membership to 5% during Massachusetts' second Open Enrollment period, driven by membership gains in subsidized and unsubsidized Qualified Health Plans (QHPs) purchased through the Health Connector (+93,000). This growth in QHPs, which are predominantly Health Maintenance Organization (HMO) products, resulted in an HMO membership increase during the period, reversing several quarters of decline.

MASSACHUSETTS COMMERCIAL MEMBERSHIP

(March 2015)

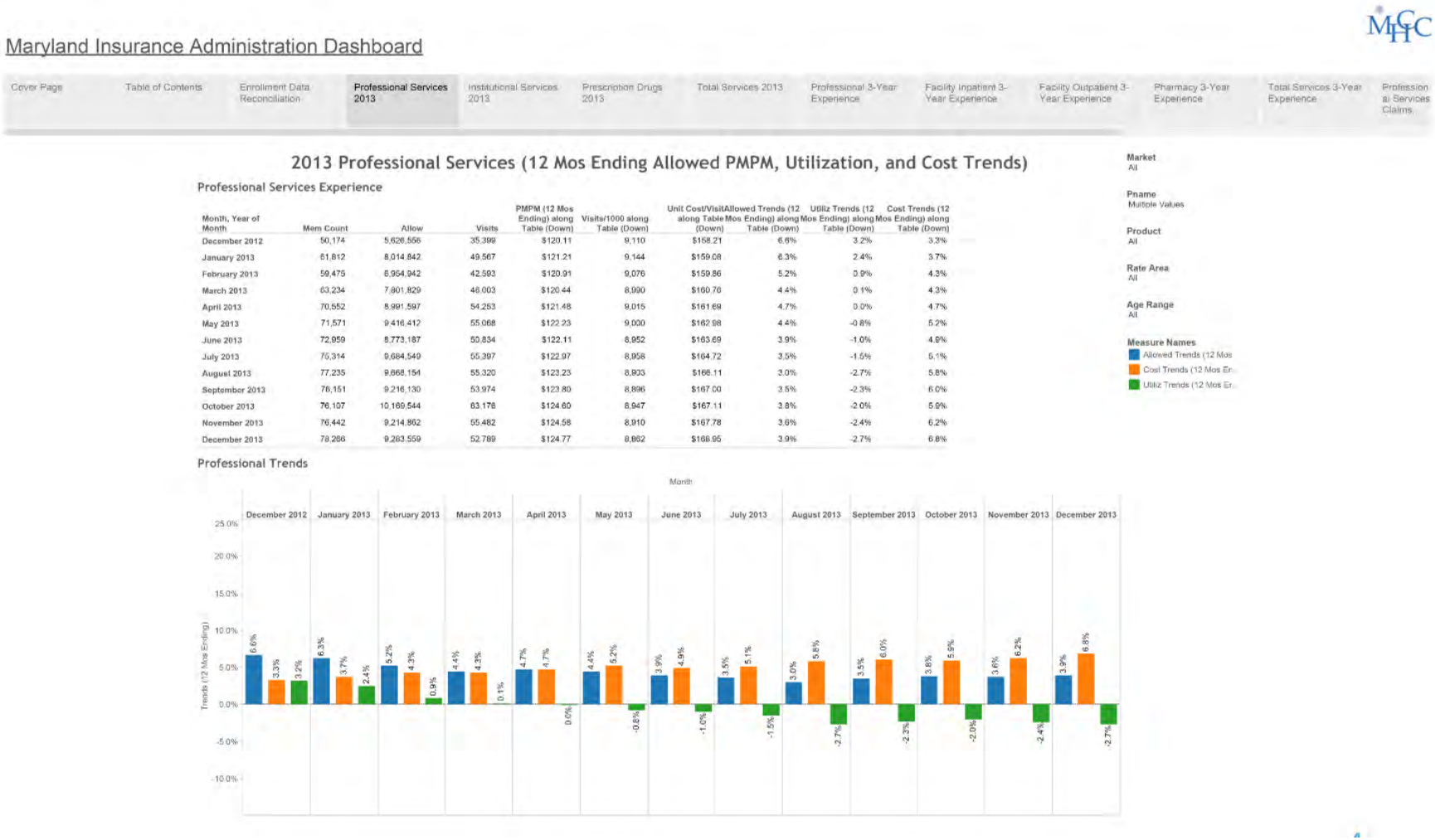
Source: http://www.chiamass.gov/assets/Enrollment-Trends-Brief.pdf

CO Emergency Department Initiative



Source: http://civhc.org/getmedia/6ee4d98f-a1a1-47af-8352-b62b0a3e8b10/ED-Use-Cost-Driver-Analysis.pdf.aspx/

Maryland Insurance Dashboard



Source: https://www.nahdo.org/sites/nahdo.org/files/Conference/Annual_30/8.45%20Sridhara%20slides.pdf

Lessons Learned by States

- Develop Multi-Stakeholder Approach
    - Form Provider Relationships
    - Form Payer Relationships
- Be Transparent and Document
- Understand Uses and Limitations
- Seize Integration & Linkage Opportunities
- Develop Use Cases
- Stage reporting to match APCD capabilities

Contact Information

Jo Porter
Co-Chair, APCD Council
Jo.Porter@unh.edu

Denise Love
Co-Chair, APCD Council
dlove@nahdo.org

Patrick Miller
Pero Group/APCD Consultant
patrick@perogroup.com

Emily Sullivan
Research, APCD Council
esullivan@nahdo.org

Ashley Peters
Communications and Research, APCD Council
Ashley.Peters@unh.edu

Amy Costello
Standards, APCD Council
Amy.Costello@unh.edu

www.apcdcouncil.org
www.apcdshowcase.org
info@apcdcouncil.org
@APCDCouncil

Molly McKinstry
AHCA

Healthcare Information Transparency

Presented by Molly McKinstry, Deputy Secretary
Agency for Health Care Administration

Select Committee on Affordable Healthcare Access
January 11, 2016

Healthcare Information Collected

- Regulatory
  - Demographic
  - Services Offered
  - Inspection Results – Reports and Quantified
  - Sanctions Imposed
- Clients and Services
  - Hospital and Ambulatory Surgery Discharge Data (State)
  - Nursing Home Resident Minimum Data Set (Federal)
  - Home Health Outcome and Assessment Information (Federal)
- Provide Specific Information
  - Satisfaction Results
  - Staffing

Provider Information Available

FloridaHealthFinder.gov

- Hospitals
- Nursing Homes
- Assisted Living Facilities
- Home Health Agencies
- Hospices
- Ambulatory Surgery Centers
- Health Care Clinics
- Laboratories
- Crisis Stabilization Units
- Transitional Living Facilities
- Birth Centers
- Adult Day Care Centers
- Health Plans
- 33 Total Regulated Provider Types

Medicare.gov

- Hospitals
- Nursing Homes
- Assisted Living Facilities
- Home Health Agencies
- Medical Equipment Suppliers
- Health Plans

Improved Health Care Transparency:
Enhanced Data Access and Interaction

The Agency collects, analyzes, and distributes critical health care data and information to improve the transparency of:

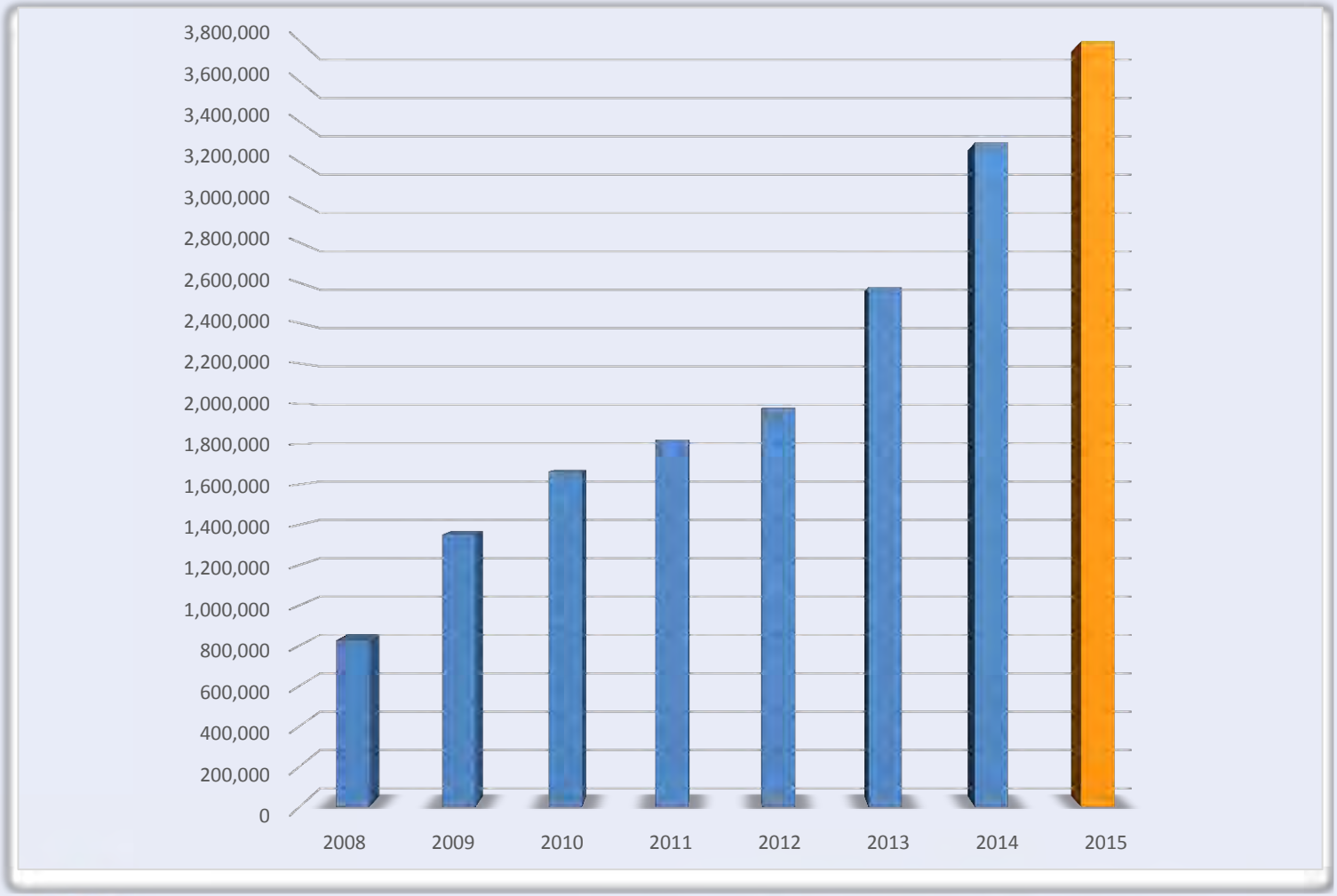
- Quality Information
- Patient and Member Satisfaction
- Health Service Volume, Pricing and Utilization
- Regulatory and Inspection Information

FloridaHealthFinder.gov Comparison Tools

Health Outcome, Pricing and Performance Information for:

- **Hospitals and Ambulatory Surgery Centers** –utilization, quality indicators, pricing information, and physician key procedure volume
- **Health Plans** – quality performance and member satisfaction survey results
- **Nursing Homes** – performance/inspection ratings and general information
- **Assisted Living Facilities** – complaints, sanctions and deficiency data
- **Hospice Providers** – family satisfaction scores
- **Prescription Drug Prices** – www.MyFloridaRx.com

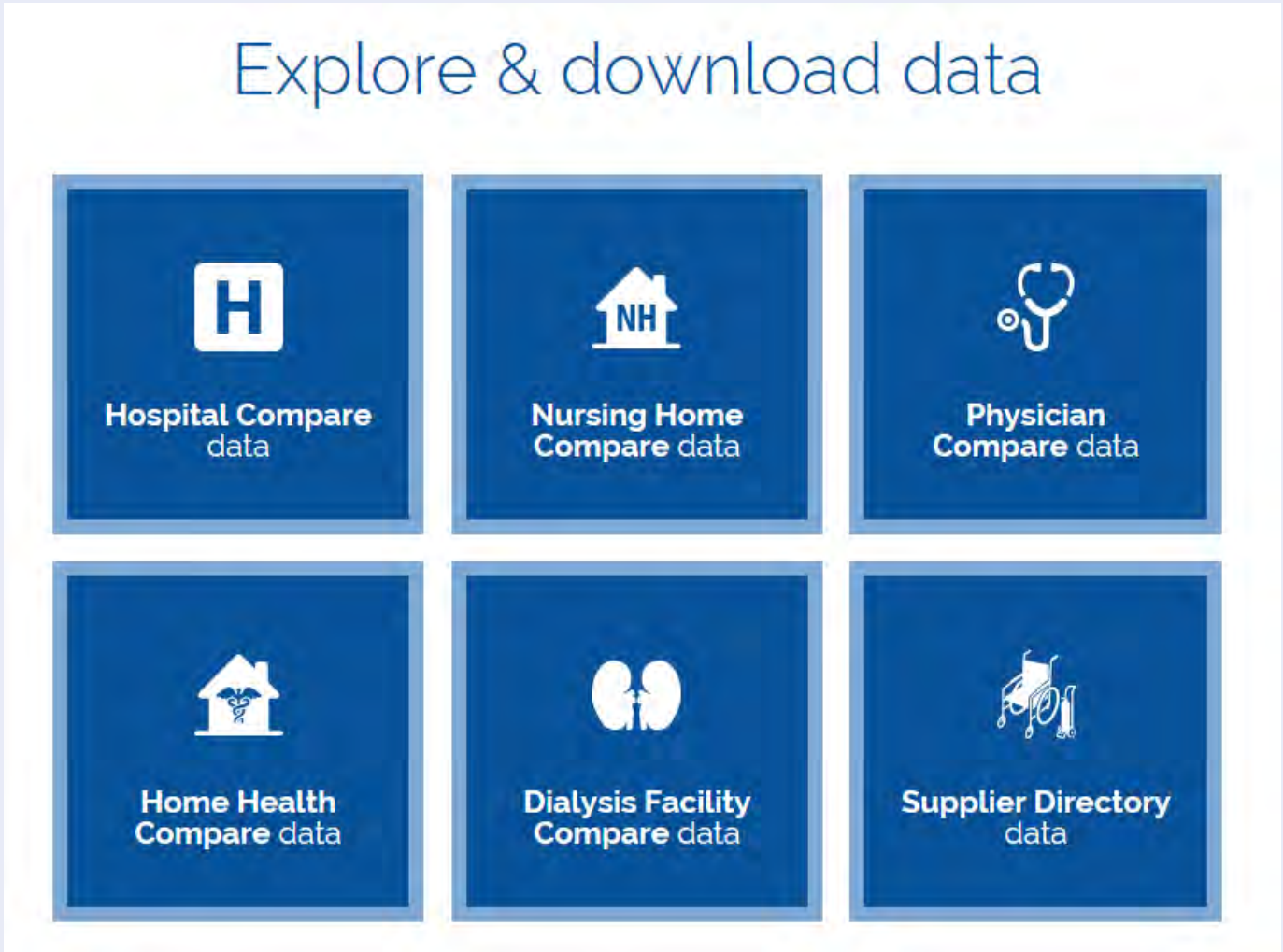
Visits to FloridaHealthFinder.gov 2008 – 2015*



Year	Number of Visits
2015	*3,800,000
2014	3,295,662
2013	2,578,443
2012	1,980,022
2011	1,820,047
2010	1,664,872
2009	1,351,713
2008	825,764

*Projected number of visits

Data.Medicare.gov



FloridaHealthFinder.gov
Facility Locator Smartphone App

Search by:

- Facility Type
- Facility/Provider Name
- Location/Proximity
  - County, City, Zip Code
- Owner/Administrator
- License Number

Resources

www.FloridaHealthFinder.gov

www.Medicare.gov

Hospital Information Available Online

Information	FloridaHealthFinder.gov	Medicare.gov
Hospitals Displayed	Acute care Florida-licensed hospitals and premise facilities	Medicare-certified hospitals nationwide
Ambulatory Surgery Information: Freestanding ASC and Hospital based	Yes – Volume and range of charges	No
Hospital Types	Acute	Acute, acute Veteran's Administration
Comparison Feature/Navigation	Compare for all facilities Search on age–pediatric/deliveries	Compare up to three facilities
Data Sources/ Methodologies	• Discharge patient data – all patients • HCAHPS (via CMS) • National Health Care Safety Network/CDC (via CMS) – all patients • AHRQ patient safety indicators - all patients • AHCA licensure data	• Medicare/VA Enrollment/Claims • HCAHPS • National Health Care Safety Network/CDC – all patients • AHRQ patient safety indicators - for Medicare claims • QIO clinical data • The Joint Commission
Facility Information Name, Address, County, Phone, Mapping/Directions.	Yes Updated nightly as reported for licensure	Yes Updated semi-annually or annually
County, Website, Licensed Bed Count and Bed Types, Accreditation	Yes Updated nightly	No
Ownership/ Administration: CEO, Owner, Ownership Date, Profit Status	Yes Updated nightly	No
Emergency Room	ER Yes or No Specific emergency services available Updated nightly	ER Yes or No
Electronic Health Record Status	No	Yes Electronic lab results, Patients ability to track lab results, tests and referrals
Patient Safety	No	Yes Use of Safe Surgery Checklist
Inspection reports/results	Yes Updated nightly	No
Sanctions: Emergency Actions, Legal Actions (fines/penalties)	Yes Updated nightly	No
Volume	• 150 conditions/procedures (including outpatient) – all payers • Physician volume • Updated quarterly	• 40 conditions/procedures -Medicare only • Hospital volume only • Updated annually
Length of Stay (LOS)	Yes Updated quarterly	No
Pricing Information	• Charge ranges for 150 conditions & procedures (inpatient & outpatient) • Compare to hospitals in Florida • Updated quarterly	• Medicare spending per beneficiary for heart attack, heart failure, pneumonia • Compare to all hospitals Nationally • Updated annually
Survey of Patients' Experiences: Hospital Consumer Assessment of Healthcare Providers and Systems	Yes Display as stars Compare state/nation Updated quarterly	Yes Display as stars, percentage, graphs Compare state/nation Updated quarterly

Information	FloridaHealthFinder.gov	Medicare.gov
Timely and Effective Care Measures (Process of Care)	N/A	Yes - 50 measures Updated quarterly
Readmissions	• 15-day potentially preventable readmissions • 84 conditions and procedures and overall readmission rate • Display as stars • Compare to state • Updated quarterly	• 30-day all-cause unplanned readmission outcomes • 8 conditions and procedures, and overall all-cause unplanned rate • Display as Better, No Different or Worse than National per Hospital • Compare percentage to national • Updated annually
Surgical Complications	Yes (4 measures) Display as stars Updated quarterly	Yes (7 measures) Display as Better, No Different or Worse than national per hospital Updated annually
Infections	Yes Display as stars Updated quarterly	Yes Displayed as Better, No Different or Worse than national per hospital Updated quarterly
Mortality	During admission Procedures (8) and conditions (7) Updated quarterly	30-day mortality outcomes Procedures (1) and conditions (5) Updated Annually
Use of Medical Imaging	No	Yes Use of medical imaging tests (MRIs and CT scans) for outpatients

Health Plan Information Available Online

Information	FloridaHealthFinder.gov	Medicare.gov
Health Plans Displayed	Commercial, Medicare, Medicaid	Medicare Plans
Plan Information Name, Plan Type, Address, County, Phone, Mapping/ Directions	Yes	Yes
General Information Organization, Address, Phone	No	Yes
Statewide enrollment, Accreditation, Counties Available, Website	Yes	No
Health Plan Costs	No	Monthly health plan premium, estimated costs (inpatient care, dental services), deductible, total estimated annual costs
Health Plan Drug Costs	No	Drug premium, estimated costs, deductible, total estimated annual costs
Health Plan Benefits	No	Ambulance, doctors office visits, emergency care, skilled nursing facility, etc.
Quality Measures	HEDIS - breast cancer screening, controlling high blood pressure, and diabetes care	No
Member Satisfaction Measures	Referred to Medicare.gov	Overall star rating (1-5), Prescription drug plan summary rating
Manage Drugs	No	Overview and general requirements of medication therapy management programs