Health Quality Subcommittee

Wednesday, March 8, 2017
9:00 AM – 11:00 AM
Mashburn Hall (306 HOB)

Richard Corcoran
Speaker

Cary Pigman
Chair

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Quality Subcommittee

Start Date and Time:	Wednesday, March 08, 2017 09:00 am
End Date and Time:	Wednesday, March 08, 2017 11:00 am
Location:	Mashburn Hall (306 HOB)
Duration:	2.00 hrs

Consideration of the following bill(s):

HB 229 Programs For Impaired Health Care Practitioners by Byrd
HB 645 Involuntary Examinations Under the Baker Act by Lee
HB 729 Music Therapists by Ponder
HB 763 Access to Health Care Practitioner Services by Grant, M.
HB 785 Stroke Centers by Magar

Pursuant to rule 7.11, the deadline for amendments to bills on the agenda by non-appointed members shall be 6:00 p.m., Tuesday, March 7, 2017.

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., Tuesday, March 7, 2017.

NOTICE FINALIZED on 03/06/2017 4:00PM by Iseminger.Bobbye

HB 229

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 229 Programs For Impaired Health Care Practitioners
SPONSOR(S): Byrd
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Siples	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The impaired practitioner program was established within the Department of Health (DOH), by s. 456.076, F.S., to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or of a mental or physical condition, which could affect the ability to practice with skill and safety.

Currently, DOH must contract with at least one entity to serve as a consultant for the impaired practitioner program. The consultant receives referrals from DOH, a regulatory board or health care entities, as well as self-referrals. Upon receipt of a referral, the consultant coordinates an evaluation of the practitioner. After the evaluation, a treatment plan, if needed, is developed, and as the practitioner undergoes treatment, the consultant monitors the progress. The consultant advises the appropriate board, or DOH if there is no board, when a practitioner successfully completed treatment and is able to practice safely. However, if a practitioner fails to complete treatment, the consultant notifies the appropriate board or DOH to initiate disciplinary proceedings, as warranted. Consultants have sovereign immunity currently.

HB 229 authorizes, rather than requires, DOH to retain one or more consultants to operate its impaired practitioner program. Under the bill, the contract with the consultant must require the consultant to accept referrals of practitioners who have or are suspected of having an impairment; arrange the evaluation and treatment of such practitioners, and monitor their progress and status to determine if and when they are able to safely to return to practice. The bill prohibits the consultant from providing evaluation and treatment services. Under the bill, a practitioner found to have an impairment may be accepted into the impaired practitioner program, and must enter into a participant contract which defines the planned or recommended treatment.

The bill requires DOH or licensure boards, rather than probable cause panels, to oversee matters involving impaired practitioners. As with current law, if a participant fails or is terminated from the impaired practitioner program, a consultant must notify DOH for disciplinary proceedings. If the consultant concludes that a practitioner's impairment constitutes an immediate, serious danger to public health, the consultant must notify DOH, rather than the Surgeon General.

Current law requires to report violations of the core licensure statute (ch. 456, F.S.) and individual practice acts, the bill creates an exception that allows licensees to report individuals having an impairment or suspected of having an impairment to the consultant, rather than DOH.

The bill eliminates consultant sovereign immunity. Instead, the bill grants the consultant protection from any civil liability related to its actions under the impaired practitioner program. The bill retains the responsibility of the Department of Financial Services to provide a defense for any claim, suit, action, or proceeding brought against the consultant's directors and agents. The bill also protects a consultant, or an employee or agent of the consultant from liability for information it provides to a medical review committee.

The bill repeals the authority of a regulatory board, or DOH if there no board, to adopt rules relating to the impaired practitioner program. Currently, the rules adopted under this section provide definitions of terms and designates the entities authorized as consultants.

The bill may have an indeterminate, insignificant negative fiscal impact on Department of Financial Services and no fiscal impact on local governments.

The bill provides the act is effective upon becoming law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Medical Quality Assurance

The Department of Health (DOH) is created under the authority of s. 20.43, F.S., which outlines the composition of the agency structure to include the Division of Medical Quality Assurance (MQA). MQA is statutorily responsible for the following boards and professions established within the division:

- The Board of Acupuncture, created under chapter 457.
- The Board of Medicine, created under chapter 458.
- The Board of Osteopathic Medicine, created under chapter 459.
- The Board of Chiropractic Medicine, created under chapter 460.
- The Board of Podiatric Medicine, created under chapter 461.
- Naturopathy, as provided under chapter 462.
- The Board of Optometry, created under chapter 463.
- The Board of Nursing, created under part I of chapter 464.
- Nursing assistants, as provided under part II of chapter 464.
- The Board of Pharmacy, created under chapter 465.
- The Board of Dentistry, created under chapter 466.
- Midwifery, as provided under chapter 467.
- The Board of Speech-Language Pathology and Audiology, created under part I of chapter 468.
- The Board of Nursing Home Administrators, created under part II of chapter 468.
- The Board of Occupational Therapy, created under part III of chapter 468.
- Respiratory therapy, as provided under part V of chapter 468.
- Dietetics and nutrition practice, as provided under part X of chapter 468.
- The Board of Athletic Training, created under part XIII of chapter 468.
- The Board of Orthotists and Prosthetists, created under part XIV of chapter 468.
- Electrolysis, as provided under chapter 478.
- The Board of Massage Therapy, created under chapter 480.
- The Board of Clinical Laboratory Personnel, created under part III of chapter 483.
- Medical physicists, as provided under part IV of chapter 483.
- The Board of Opticianry, created under part I of chapter 484.
- The Board of Hearing Aid Specialists, created under part II of chapter 484.
- The Board of Physical Therapy Practice, created under chapter 486.
- The Board of Psychology, created under chapter 490.
- School psychologists, as provided under chapter 490.
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under chapter 491.
- Emergency medical technicians and paramedics, as provided under part III of chapter 401.

DOH regulates most health care professions.[1] Each profession is governed by an individual practice act and by ch. 456, F.S., which contains core licensure provisions that apply uniformly across all individual practice acts for health care practitioners[2].

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[1] The Department of Business and Professional Regulation regulates veterinarians pursuant to ch. 474, F.S.
[2] Section 456.001(4), defines "health care practitioner" as any person licensed under: ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry, dental hygiene, and dental laboratories); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, and XIV of ch. 468, F.S., (speech-language

Impaired Practitioner Treatment Program

The impaired practitioner treatment program was created in s. 456.076, F.S., to provide resources to assist health care practitioners who are impaired as a result of the misuse or abuse of alcohol or drugs, or both, or a mental or physical condition which could affect the practitioners' ability to practice with skill and safety.[3] For a profession that does not have a program established within its individual practice act, the DOH is required to designate an approved program by rule.[4] DOH has designated by rule that an approved impaired practitioner program is one that is designated by DOH through contract with a consultant to initiate intervention, recommend evaluation, and refer impaired practitioners to treatment providers and monitor progress of impaired practitioners. The impaired practitioner program may not provide medical services.[5] The terms "impaired practitioner program" and "consultant" appear to be used interchangeably.

DOH must retain at least one impaired practitioner consultant[6] who is licensed under the jurisdiction of MQA and who is a licensed physician or nurse; or an entity that employs a medical director who is a licensed physician, or an executive director who is a licensed nurse.[7] DOH currently contracts with the Professionals Resource Network (PRN) and the Intervention Project for Nurses (IPN) to provide approved treatment programs[8] for impaired practitioners.[9] PRN performs evaluation, treatment referrals, and monitoring for medical doctors and all allied health professions, except nurses and certified nursing assistants, which are served by IPN.[10]

A consultant may also to enter into a contract with a school or program to provide services to students preparing for a licensure as a health care practitioner or a veterinarian who may be impaired as a result of the misuse or abuse of alcohol or drugs, or both or due to a mental or physical condition.[11] DOH is not responsible for paying costs of care by an approved treatment program or the services provided by the consultant for students. Additionally, a school that is governed by accreditation standards requiring notice and the provision of due process procedures to students, is not liable in any civil action for referring a student to the consultant or for any disciplinary action that adversely affects the status of a student when the disciplinary actions are instituted in reasonable reliance on the recommendations, reports, or conclusions provide by a consultant.[12]

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pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage therapy); parts III and IV of ch. 483, F.S., (clinical laboratory personnel or medical physicists); ch. 484, F.S., (dispensing of optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); and ch. 491, F.S. (clinical, counseling, and psychotherapy services).

[3] Section 456.076, F.S. The provisions of s. 456.076, also apply to veterinarians under s. 474.221, F.S. and radiological personnel under s. 486.315, F.S.

[4] Section 456.076(1), F.S.

[5] Rule 64B31-10.001(1)(a), F.A.C.

[6] Rule 64B31-10.001(1)(b), F.A.C., provides that a consultant operate an approved impaired practitioner program which receives allegations of licensee impairment, personally intervene or arrange intervention with licensees, refer licensees to approved treatment programs or treatment providers, evaluate treatment progress, and monitor continued care provided by approved programs and providers.

[7] Section 456.076(2), F.S.

[8] A treatment program is approved by a designated impaired practitioner program and must be a nationally accredited or state licensed residential, intensive outpatient, partial hospital, or other program with a multidisciplinary team approach with individual treatment providers treating licensees depending on the licensee's individual diagnosis and treatment plan that has been approved by an approved practitioner program. A treatment provider is approved by a designated impaired practitioner program and must be a state licensed or nationally certified individual with experience treating specific types of impairment. 64B31-10.001(1)(c), F.A.C.

[9] DOH, Board of Medicine, *Help Center: Does the Department Have Assistance Programs for Impaired Health Care Professionals*, http://flboardofmedicine.gov/help-center/does-the-department-have-assistance-programs-for-impaired-health-care-professionals/ (last visited Jan. 11, 2016).

[10] DOH, *2017 Agency Legislative Bill Analysis: House Bill 229*, on file with the Health Quality Subcommittee.

[11] Section 456.076(2)(c)2., F.S.

[12] Section 456.076(2)(d), F.S.

Operation of the Program

When DOH receives a legally sufficient complaint[13] alleging that a licensed practitioner is impaired and no other complaints exist against the practitioner, the complaint is forwarded to the consultant, who assists DOH in determining if the practitioner is, in fact, impaired. In addition to assisting DOH in determining the existence of an impairment, the consultant also facilitates and monitors progress in the treatment of the impairment.

Impairment is not grounds for discipline, if the probable cause panel[14] of the appropriate board, or the department when there is no board, finds that the licensee:

- Acknowledges the impairment;
- Voluntarily enrolls in an appropriate, approved treatment program;
- Voluntarily withdraws from practice or limits his or her scope of practice, as required by the consultant, until the licensee has successfully completed an approved treatment program; and
- Authorizes the release of medical records, including all records of evaluations, diagnoses, and treatment, to the consultant.[15]

An impaired practitioner may voluntarily withdraw from practice and seek treatment from a provider approved by DOH without a complaint being filed. In such situations, DOH and the applicable board are not involved in the case.

After an evaluation is completed, the evaluator will submit a report to the consultant advising whether the practitioner is in fact impaired and recommending treatment or that the practitioner is not impaired. The impaired practitioners are referred to DOH-approved treatment providers or treatment programs.[16] Although the impaired practitioner is not responsible for paying for the services of the consultant, the impaired practitioner must pay for his or her treatment.

The consultant evaluates the treatment progress of an impaired practitioner and monitors the continued care provided by treatment programs.[17] Consultants do not provide medical treatment, nor do they have the authority to render decisions relating to licensure of a particular practitioner. However, the consultant is required to make recommendations to DOH regarding a practitioner patient's ability to practice.[18]

If, in the opinion of the consultant, the health care practitioner has not made satisfactory progress in a treatment program, the consultant must disclose all information regarding the licensee's impairment and participation in a treatment program in its possession to DOH. Such disclosure constitutes a complaint. If the consultant concludes that a health care practitioner's impairment constitutes an immediate danger to the public health, safety, or welfare, the Surgeon General must be notified.[19] DOH may then take any disciplinary action against the license as authorized under law, including issuing an emergency order restricting or suspending the license.[20]

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[13] A complaint is legally sufficient if it contains ultimate facts that show the occurrence of a violation of a practice act, ch. 456, F.S., or a rule adopted by the DOH or a board. Section 456.073(1), F.S.

[14] A probable cause panel is a panel designated by rule of each regulatory board that is composed of at least two members, including at least one current board member, that review investigative information related to a complaint and determine, based on that information, whether probable cause exists to believe that a health care practitioner violated statutes governing the practice of the licensee's profession. If probable cause exists, the probable cause panel will direct DOH to file a formal complaint against the licensee. (s. 456.073(4), F.S.)

[15] Section 456.076(4), F.S.

[16] *Supra* note 10.

[17] Rule 64B31-10.001, F.A.C.

[18] Section 456.076(6), F.S.

[19] Section 456.074(7), F.S.

[20] *Supra* note 10.

As of January 2017, there were approximately 928 practitioners enrolled in the PRN program,[21] and IPN was providing services to 1,216 individuals.[22]

Consultant Sovereign Immunity

Sovereign Immunity

The legal doctrine of sovereign immunity prevents a government from being sued in its own courts without its consent.[23] According to United States Supreme Court Justice Oliver Wendell Holmes, citing the noted 17th century Hobbes work, *Leviathan*, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends."[24] State governments in the United States, as sovereigns, inherently possess sovereign immunity.[25]

Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state[26] will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property.[27]

When an officer, employee, or agency of the state is sued, the state steps in as the party litigant and defends against the claim. The recovery by any one person is limited to $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000.[28] The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature.[29]

Whether sovereign immunity applies turns on the degree of control of the agent of the state retained by the state.[30] In *Stoll v. Noel*, the Florida Supreme Court explained that independent contractor physicians may be agents of the state for purposes of sovereign immunity: [31]

> One who contracts on behalf of another and subject to the other's control except with respect to his physical conduct is an agent and also independent contractor.

The Court examined the employment contract between the physicians and the state to determine whether the state's right to control was sufficient to create an agency relationship.[32] The facts of the case demonstrated the state's control over the independent contractor physicians and, therefore, the Court held that an agency relationship existed.[33]

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[21] PRN, "PRN Monthly Report for January 2017," (February 9, 2017), on file with the Health Quality Subcommittee.
[22] IPN, "January 2017 Monthly Report," (February 2, 2017), on file with the Health Quality Subcommittee.
[23] Black's Law Dictionary, 3rd Pocket Edition, 2006.
[24] *Kawananakoa v Polyblank*, 205 U.S. 349, 353 (1907).
[25] *See, e.g.,* Fla. Jur. 2d, Government Tort Liability, Sec. 1.
[26] The statutes define state agencies or subdivisions to include executive departments, the legislature, the judicial branch, and independent establishments of the state, such as state university boards of trustees, counties and municipalities, and corporations primarily acting as instrumentalities or agencies of the state, including the Florida Space Authority. Section 768.28(2), F.S.
[27] Section 768.28(9)(a), F.S.
[28] Section 768.28(5), F.S.
[29] *Id.*
[30] *Stoll v. Noel*, 694 So. 2d 701, 703 (Fla. 1997).
[31] *Id.* at 703, quoting from the *Restatement (Second) of Agency* s. 14N (1957).
[32] *Id.*
[33] *Id.* at 703.

Impaired Practitioner Program Consultant

Impaired practitioner consultants have sovereign immunity for the limited purpose of an emergency intervention, for actions taken within the scope of its contract with DOH.[34] Such contract must:

- Require the consultant to indemnify the state for any liabilities incurred up to the limits set out in chapter 768, F.S.;
- Require the consultant to establish a quality assurance program to monitor services delivered under the contract;
- Require the consultant's quality assurance program, treatment, and monitoring records to be evaluated quarterly;
- Require the consultant's quality assurance program to be subject to review and approval by DOH;
- Require the consultant to operate under policies and procedures approved by the DOH;
- Require the consultant to provide the DOH, for its approval, a policy and procedure manual that comports with all statutes, rules, and contract provisions;
- Require DOH to be entitled to review the records relating to the consultant's performance under the contract for purposes of management and financial audits or program evaluation;
- Require all performance measures and standards to be subject to verification and approval by DOH; and
- Allow DOH to terminate the contract with the consultant for noncompliance.[35]

The Department of Financial Services is required to defend the consultant, its officers, employees, and any person acting at the direction of the consultant for the limited purpose of an emergency intervention, when the consultant is unable to perform the intervention, from any legal action brought as a result of contracted program activities.

Mandatory Reporting

A licensed health care practitioner must report any person who the licensee knows is violating ch. 456, F.S., or the provisions of an individual practice act, or the rules adopted thereunder. [36] If a licensed health care practitioner knows that a person is unable to practice with reasonable skill and safety due to an impairment due to the use of alcohol or drugs, or due to a physical or mental illness in violation of ch. 456, F.S., or a practice act, that practitioner is obligated to report such impairment to the appropriate board, or DOH if there is not board.[37]

Failure to report such information may result in discipline for the licensed health care practitioner.

Effect of Proposed Changes

The bill authorizes, rather than requires, DOH to retain one or more consultants[38] to operate its impaired practitioner program.[39] DOH's contract with a consultant must specify the types of licenses, registrations, or certifications of the practitioners to be served by the consultant, and at a minimum, provide for the consultant to:

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[34] Section 768.28, F.S., provides the procedures that must be followed if an individual wishes to bring an action against the state for injury due to the negligence of a state employee, agent, or volunteer.
[35] Section 456.076(8), F.S.
[36] Section 456.072, F.S. *See also* s. 457.109, F.S., (acupuncture); s. 458.331, F.S., (medical practice); s. 459.015, F.S., (osteopathic medicine); s. 460.413, F.S., (chiropractic medicine); s. 461.013, F.S., (podiatric medicine); s. 462.14, F.S., (naturopathy); s. 463.016, F.S., (optometry); s. 464.018, F.S., (nursing); s. 465.016, F.S., (pharmacy); s. 466.028, F.S., (dentistry, dental hygiene, and dental laboratories); s. 467.203, F.S., (midwifery); s. 468.217, F.S.; (occupational therapy); and s. 474.221, F.S., (veterinary medicine).
[37] Section 456.072(1)(z), F.S.
[38] The bill defines consultant as the individual or entity which operates an approved impaired practitioner program pursuant to a contract with DOH.
[39] The bill defines impaired practitioner program as a program established by DOH by contract with one or more consultants to serve impaired or potentially impaired practitioners for the protection of the health, safety, and welfare of the public.

- Accept referrals of practitioners who have or are suspected of having an impairment;
- Arrange for the evaluation and treatment of such practitioners who have or are suspected of having an impairment as recommended by the consultant; and
- Monitor the recovery progress and status of impaired practitioners to ensure such practitioners are able to practice the profession in which they are licensed with skill and safety until such time as the consultant or DOH concludes such monitoring is no longer necessary or until such time the practitioner's participation in the program is terminated for material noncompliance[40] or inability to progress.[41]

The bill prohibits the consultant from evaluating, treating, or otherwise providing direct patient care to practitioners in the operation of the impaired practitioner program. Evaluations are provided by an evaluator,[42] and treatment is provided by a treatment program[43] or treatment provider.[44] Current law also prohibits the consultant from providing medical services.[45]

The bill requires the consultant to enter into a participant contract[46] with each impaired practitioner which establishes the terms of monitoring, which may be based on recommendations from evaluators, treatment programs, or treatment providers. If through the course of monitoring, the consultant determines that extended, additional, or amended terms are necessary to ensure public health, safety, and welfare, the consultant may modify the terms of the participant contract.

The bill requires DOH to refer a practitioner to the consultant if it receives a legally sufficient complaint alleging that the practitioner has an impairment and no other complaint exists against the practitioner. Such impairment will not be considered grounds for discipline if the practitioner:

- Acknowledges the impairment;
- Becomes a participant in an impaired practitioner program and successfully completes the participant contract;
- Voluntarily withdraws for practice or limits the scope of his or her practice, if required by the consultant;
- Provides to the consultant, or authorizes the consultant to obtain all records and information relating to the impairment from any and all sources and all other medical records requested by the consultant; and
- Authorizes the consultant, in the event of the practitioner's termination from the impaired practitioner program, to report the termination to DOH and provide DOH will all information in the consultant's possession relating to the practitioner.

Under current law, probable cause panels reviewing complaints against a practitioner may work directly with a consultant to determine if an impairment played a role in the complaint against a practitioner, and what, if any, disciplinary action needs to be taken. The bill requires the consultant to assist DOH and

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[40] The bill defines material noncompliance as an act or omission by a participant in violation of his or her participant contract as determined by the consultant or DOH.
[41] The bill defines inability to progress as a determination by the consultant based on a participant's response to treatment and prognosis that the participant is unable to safely practice despite compliance with treatment requirements and his or her participant contract.
[42] The bill defines an evaluator as a state-licensed or nationally certified individual who has been approved by a consultant or DOH, has completed an evaluator training program established by the consultant, and who is therefore authorized to evaluate practitioners as a part of impaired practitioner program.
[43] The bill defines treatment program as a DOH- or consultant-approved residential, intensive outpatient, partial hospitalization, or other program through which an impaired practitioner is treated based on the impaired practitioner's diagnosis and the treatment program approved by the consultant.
[44] The bill defines treatment provider as a DOH- or consultant-approved state-licensed or nationally certified individual who provides treatment to an impaired practitioner based on the practitioner's diagnosis and the treatment program approved by the consultant.
[45] Rule 64B31-10.001(1)(a), F.A.C.
[46] The bill defines participant contract as a formal written document outlining the requirements established by a consultant for a participant to successfully complete the impaired practitioner program, including the participant's monitoring plan.

licensure boards in matters involving impaired practitioners, including a determination of whether a practitioner is in fact impaired rather than this process taking place before probable cause panels.

The bill also authorizes emergency medical personnel who have or are suspected of having an impairment due to the use of alcohol or drugs, or as a result of a mental or physical condition to be reported to the consultant rather than DOH.

If an impaired practitioner self-reports to a consultant, the bill prohibits the consultant from providing information to DOH on such individual if there is no pending complaint or disciplinary action and the individual is in compliance with the terms of the impaired practitioner program and participant contract, unless the participant authorizes the release of such information to DOH. It is unclear how the consultant will have access to information regarding pending complaints or disciplinary action without notifying DOH, because complaints and investigative information are confidential and exempt until 10 days after probable cause is found or until waived.[47]

Currently, a licensed health care practitioner must report any person that he or she knows is in violation of the provisions of the core licensure statute (ch. 456, F.S.), or the provisions of an individual practice act. However, the bill creates an exception to this mandatory reporting to allow a licensee who knows that a person is unable to practice with reasonable skill and safety due to an impairment, to report such information to the consultant, rather than DOH or the applicable regulatory board. Both the core licensure statute and individual practice acts are amended to include this language.[48] However the disciplinary status of the reported individual is unclear: Because the report does not meet the definitions of a referral or a participant, the consultant is not obligated to inform DOH or the applicable board if the practitioner refuses to enter the program.

The bill authorizes an evaluator or treatment program to disclose information to the consultant regarding a referral or participant upon the request of the consultant and with the authorization of the practitioner when required by law.[49]

The bill requires a consultant to provide DOH with all the information in its possession for a referral or participant who is terminated from the impaired practitioner program for material noncompliance with the participant contract, inability to progress, or any other reason. If the consultant concludes that a practitioner has an impairment that affects his or her ability to practice and such impairment constitutes an immediate, serious danger to public health, the consultant must notify DOH, rather than the Surgeon General, and provide all information it has in its possession regarding that practitioner. This provision brings the process into the established disciplinary process at DOH.[50]

The bill retains the civil liability protections afforded to consultants for providing information regarding a participant to medical review committees[51] if the participant authorizes such disclosure, but eliminates such protection for DOH and the board. However, civil liability protections are provided elsewhere in current law: Section 766.101, F.S., currently provides that health care practitioners or other persons furnishing information to a medical review committee have no personal liability for any act or

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[47] Section 456.073(10), F.S.

[48] This includes the core licensure provision in s. 456.072, F.S., as well as s. 457.109, F.S., (acupuncture); s. 458.331, F.S., (medical practice); s. 459.015, F.S., (osteopathic medicine); s. 460.413, F.S., (chiropractic medicine); s. 461.013, F.S., (podiatric medicine); s. 462.14, F.S., (naturopathy); s. 463.016, F.S., (optometry); s. 464.018, F.S., (nursing); s. 465.016, F.S., (pharmacy); s. 466.028, F.S., (dentistry, dental hygiene, and dental laboratories); s. 467.203, F.S., (midwifery); s. 468.217, F.S.; (occupational therapy); and s. 474.221, F.S., (veterinary medicine).

[49] The bill defines a referral as a practitioner who has been referred to a consultant for impaired practitioner program services, but is not under a participant contract. The bill defines a participant as a practitioner who is participating in the impaired practitioner program by having entered into a participant contract.

[50] *Supra* note 10.

[51] Pursuant to s. 766.101, F.S., a medical review committee are committees found within entities such as health care facilities, insurers, professional societies of health care practitioners, mental health treatment facilities, and rural health networks, which may evaluate the quality of health care rendered by health care practitioners, determine if services rendered were professionally indicated or performed in compliance with applicable standards of care, or determine if the cost of health care rendered was reasonable. A medical review committee may also be formed by an insurer to perform medical malpractice pre-suit procedures.

proceeding undertaken or performed within the scope of the functions of the committee, if the information provided is not intentionally fraudulent.[52]

The bill eliminates sovereign immunity to the consultant. Instead, the bill grants civil liability protection to the consultant, its directors, officers, employees, or agents for disclosure made pursuant to the impaired practitioner program, or for any other action or omission relating to the impaired practitioner program, or the consequences of such disclosure or action or omission, including without limitation, action by DOH against a license, registration, or certification. This means that instead of a limit on the damages under sovereign immunity, the consultant would not be liable at all. The bill retains the requirement in current law that the Department of Financial Services must also provide a defense for any claim, suit, action, or proceeding brought against the consultant, but makes it applicable to the new civil liability protection.

However, a court may still find that DOH exercises sufficient control over the consultant so that an agency relationship exists and it is entitled to sovereign immunity.[53] Without a specific statutory provision declaring the consultant an agent of the state, Department of Financial Services may have to argue that the consultant is entitled to sovereign immunity each time it provides legal defense services in civil actions against the consultant.

If the consultant is retained to provide an impaired practitioner program for another state agency, the bill provides that the provisions of s. 456.076, F.S., will apply to that agencies impaired practitioner program. This provision will essentially bind another agency to the impaired practitioner program contract that DOH negotiates, without such agency being a party to the negotiations.

The bill repeals the authority of a regulatory board, or DOH if there no board, to adopt rules relating to the impaired practitioner program. Current rules designate the consultants of the impaired practitioner program as PRN and IPN and provide definitions; but do not provide any other provisions related to the operation of the program. The bill incorporates the definitions of the terms that are currently defined in rule. The designation of the consultant is no longer needed, as the bill authorizes DOH to contract with any entity that qualifies under the provisions of the bill.

The bill preserves the ability of a consultant to contract with a school to provide impaired practitioner services to its students but moves the provision to another paragraph within the subsection.

Under current law, the consultant has a public records exemption for all materials it receives pursuant to s. 456.076, F.S. Currently, the consultant receives information regarding the evaluation, as well as information from a treatment provider regarding the participant's participation in a treatment program. The bill retains the public records exemption and relocates it. The consultant will still hold the same information under the bill as it holds under current law.

The bill provides that the act shall take effect upon becoming law.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.076, F.S., relating to treatment programs for impaired practitioners.
Section 2: Amends s. 401.411, F.S., relating to disciplinary action; penalties.
Section 3: Amends s. 455.227, F.S., relating to grounds for discipline; penalties; enforcement.
Section 4: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; enforcement.
Section 5: Amends s. 457.109, F.S., relating to disciplinary actions; grounds; action by the board.
Section 6: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 7: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.

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[52] Section 766.101, F.S.
[53] *Supra* note 33.

Section 8: Amends s. 460.413, F.S., relating to grounds for disciplinary action; action by the board or department.
Section 9: Amends s. 461.013, F.S., relating to grounds for disciplinary action; action by the board; investigations by the department.
Section 10: Amends s. 462.14, F.S., relating to grounds for disciplinary action; action by the department.
Section 11: Amends s. 463.016, F.S., relating to grounds for disciplinary action; action by the board.
Section 12: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 13: Amends s. 464.204, F.S., relating to denial, suspension, or revocation of certification; disciplinary actions.
Section 14: Amends s. 465.016, F.S., relating to disciplinary actions.
Section 15: Amends s. 466.028, F.S., relating to grounds for disciplinary action; action by the board.
Section 16: Amends s. 467.203, F.S., relating to disciplinary actions; penalties.
Section 17: Amends s. 468.217, F.S., relating to denial of or refusal to renew license; suspension and revocation of license and other disciplinary measures.
Section 18: Amends s. 468.3101, F.S., relating to disciplinary grounds and actions.
Section 19: Amends s. 474.221, F.S., relating to impaired practitioner provisions; applicability.
Section 20: Amends s. 483.825, F.S., relating to grounds for disciplinary action.
Section 21: Provides that the act shall take effect upon becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Due to the expansion of individuals that are afforded a defense by the Department of Financial Services for claims, actions, suits, or proceedings, there may be an indeterminate, insignificant negative fiscal impact on the Risk Management Trust Fund.[54]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

[54] Department of Financial Services, "House Bill 229 Analysis," (January 25, 2017), on file with the Health Quality Subcommittee.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill repeals the authority of DOH to adopt rules designating an approved impaired practitioner program for professions that do not have a board, and provides DOH the freedom to contract with any entity to operate an impaired practitioner program.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to programs for impaired health care
3 practitioners; amending s. 456.076, F.S.; revising
4 provisions related to impaired practitioner programs;
5 providing definitions; deleting a requirement that the
6 Department of Health designate approved programs by
7 rule; deleting provisions related to probable cause
8 panels; deleting provisions related to agency of
9 specified persons; amending ss. 401.411, 456.072,
10 457.109, 458.331, 459.015, 460.413, 461.013, 462.14,
11 463.016, 464.018, 465.016, 466.028, 467.203, 468.217,
12 and 483.825, F.S; providing that an impaired
13 practitioner may be reported to a consultant rather
14 than the department under certain circumstances;
15 amending s. 468.3101, F.S.; revising grounds for
16 disciplinary action to include termination from an
17 impaired practitioner program under certain
18 circumstances; amending ss. 455.227, 464.204, and
19 474.221, F.S.; conforming provisions; providing an
20 effective date.
21
22 Be It Enacted by the Legislature of the State of Florida:
23
24 Section 1. Section 456.076, Florida Statutes, is amended
25 to read:

26 456.076 Impaired practitioner programs ~~Treatment programs~~
27 ~~for impaired practitioners~~.—
28 (1) As used in this section, the term:
29 (a) "Consultant" means the individual or entity which
30 operates an approved impaired practitioner program pursuant to a
31 contract with the department and who is retained by the
32 department as provided in subsection (2).
33 (b) "Evaluator" means a state-licensed or nationally
34 certified individual who has been approved by a consultant or
35 the department, has completed an evaluator training program
36 established by the consultant, and who is therefore authorized
37 to evaluate practitioners as part of an impaired practitioner
38 program.
39 (c) "Impaired practitioner" means a practitioner with an
40 impairment.
41 (d) "Impaired practitioner program" means a program
42 established by the department by contract with one or more
43 consultants to serve impaired and potentially impaired
44 practitioners for the protection of the health, safety, and
45 welfare of the public.
46 (e) "Impairment" means a potentially impairing health
47 condition that is the result of the misuse or abuse of alcohol,
48 drugs, or both, or a mental or physical condition which could
49 affect a practitioner's ability to practice with skill and
50 safety.

51 (f) "Inability to progress" means a determination by a
52 consultant based on a participant's response to treatment and
53 prognosis that the participant is unable to safely practice
54 despite compliance with treatment requirements and his or her
55 participant contract.
56 (g) "Material noncompliance" means an act or omission by a
57 participant in violation of his or her participant contract as
58 determined by the department or consultant.
59 (h) "Participant" means a practitioner who is
60 participating in the impaired practitioner program by having
61 entered into a participant contract. A practitioner ceases to be
62 a participant when the participant contract is successfully
63 completed or is terminated for any reason.
64 (i) "Participant contract" means a formal written document
65 outlining the requirements established by a consultant for a
66 participant to successfully complete the impaired practitioner
67 program, including the participant's monitoring plan.
68 (j) "Practitioner" means a person licensed, registered,
69 certified, or regulated by the department under part III of
70 chapter 401; chapters 457 through 467; parts I, II, III, V, X,
71 XIII, or XIV of chapter 468; chapter 478; chapter 480; part III
72 or IV of chapter 483; chapter 484; chapter 486; chapter 490; or
73 chapter 491, Florida Statutes; or an applicant under the same
74 laws.
75 (k) "Referral" means a practitioner who has been referred

76 to a consultant for impaired practitioner program services,
77 either as a self-referral or otherwise, but who is not under a
78 participant contract.
79 (l) "Treatment program" means a department or consultant-
80 approved residential, intensive outpatient, partial
81 hospitalization, or other program through which an impaired
82 practitioner is treated based on the impaired practitioner's
83 diagnosis and the treatment plan approved by the consultant.
84 (m) "Treatment provider" means a department or consultant-
85 approved state-licensed or nationally-certified individual who
86 provides treatment to an impaired practitioner based on the
87 practitioner's individual diagnosis and a treatment plan
88 approved by the consultant For professions that do not have
89 impaired practitioner programs provided for in their practice
90 acts, the department shall, by rule, designate approved impaired
91 practitioner programs under this section. The department may
92 adopt rules setting forth appropriate criteria for approval of
93 treatment providers. The rules may specify the manner in which
94 the consultant, retained as set forth in subsection (2), works
95 with the department in intervention, requirements for evaluating
96 and treating a professional, requirements for continued care of
97 impaired professionals by approved treatment providers,
98 continued monitoring by the consultant of the care provided by
99 approved treatment providers regarding the professionals under
100 their care, and requirements related to the consultant's

101 ~~expulsion of professionals from the program~~.
102 (2)(a) The department may ~~shall~~ retain one or more
103 ~~impaired practitioner~~ consultants to operate its impaired
104 practitioner program. Each consultant ~~who are each licensees~~
105 ~~under the jurisdiction of the Division of Medical Quality~~
106 ~~Assurance within the department and who~~ must be:
107 1. A practitioner ~~or recovered practitioner~~ licensed under
108 chapter 458, chapter 459, or part I of chapter 464; or
109 2. An entity that employs:
110 a. A medical director who is ~~must be a practitioner or~~
111 ~~recovered practitioner~~ licensed under chapter 458 or chapter
112 459; or
113 b. An executive director who is ~~must be a registered nurse~~
114 ~~or a recovered registered nurse~~ licensed under part I of chapter
115 464.
116 (3) The terms and conditions of the impaired practitioner
117 program must be established by the department by contract with a
118 consultant for the protection of the health, safety, and welfare
119 of the public and must provide, at a minimum, for each
120 consultant to accept referrals of practitioners who have or are
121 suspected of having an impairment, arrange for the evaluation
122 and treatment of such practitioners as recommended by the
123 consultant, and monitor the recovery progress and status of
124 impaired practitioners to ensure that such practitioners are
125 able to practice the profession in which they are licensed with

126 skill and safety until such time as the consultant or department
127 concludes that monitoring by the consultant is no longer
128 required for the protection of the public or the practitioner's
129 participation in the program is terminated for material
130 noncompliance or inability to progress.
131 (4) The department shall specify, in its contract with
132 each consultant, the types of licenses, registrations, or
133 certifications of the practitioners to be served by that
134 consultant.
135 (5) A consultant shall establish the terms of monitoring
136 of an impaired practitioner and shall include the terms in a
137 participant contract. In establishing the terms of monitoring,
138 the consultant may consider the recommendations of one or more
139 approved evaluators, treatment programs, or treatment providers.
140 A consultant may modify the terms of monitoring if the
141 consultant concludes, through the course of monitoring, that
142 extended, additional, or amended terms of monitoring are
143 required for the protection of the health, safety, and welfare
144 of the public.
145 (6) A consultant may not evaluate, treat, or otherwise
146 provide direct patient care to practitioners in the operation of
147 the impaired practitioner program.
148 (7)~~(b)~~ A ~~An entity retained as an impaired practitioner~~
149 consultant ~~under this section which employs a medical director~~
150 ~~or an executive director~~ is not required to be licensed as a

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151 substance abuse provider or mental health treatment provider
152 under chapter 394, chapter 395, or chapter 397 for purposes of
153 providing services under this program.
154 (8)~~(c)1.~~ Each ~~The~~ consultant shall assist the department
155 and licensure boards on matters of impaired practitioners,
156 including the determination of ~~probable cause panel and the~~
157 ~~department in carrying out the responsibilities of this section.~~
158 ~~This includes working with department investigators to determine~~
159 whether a practitioner is, in fact, impaired, as specified in
160 the consultant's contract with the department.
161 ~~2. The consultant may contract with a school or program to~~
162 ~~provide services to a student enrolled for the purpose of~~
163 ~~preparing for licensure as a health care practitioner as defined~~
164 ~~in this chapter or as a veterinarian under chapter 474 if the~~
165 ~~student is allegedly impaired as a result of the misuse or abuse~~
166 ~~of alcohol or drugs, or both, or due to a mental or physical~~
167 ~~condition. The department is not responsible for paying for the~~
168 ~~care provided by approved treatment providers or a consultant.~~
169 ~~(d) A medical school accredited by the Liaison Committee~~
170 ~~on Medical Education or the Commission on Osteopathic College~~
171 ~~Accreditation, or another school providing for the education of~~
172 ~~students enrolled in preparation for licensure as a health care~~
173 ~~practitioner as defined in this chapter or a veterinarian under~~
174 ~~chapter 474 which is governed by accreditation standards~~
175 ~~requiring notice and the provision of due process procedures to~~

176 ~~students, is not liable in any civil action for referring a~~
177 ~~student to the consultant retained by the department or for~~
178 ~~disciplinary actions that adversely affect the status of a~~
179 ~~student when the disciplinary actions are instituted in~~
180 ~~reasonable reliance on the recommendations, reports, or~~
181 ~~conclusions provided by such consultant, if the school, in~~
182 ~~referring the student or taking disciplinary action, adheres to~~
183 ~~the due process procedures adopted by the applicable~~
184 ~~accreditation entities and if the school committed no~~
185 ~~intentional fraud in carrying out the provisions of this~~
186 ~~section.~~
187 (9) ~~(3)~~ Before certifying or declining to certify an
188 application for licensure to the department, each board and
189 profession within the Division of Medical Quality Assurance may
190 delegate to its chair or other designee its authority to
191 determine~~, before certifying or declining to certify an~~
192 ~~application for licensure to the department,~~ that an applicant
193 for licensure under its jurisdiction may have an impairment ~~be~~
194 ~~impaired as a result of the misuse or abuse of alcohol or drugs,~~
195 ~~or both, or due to a mental or physical condition that could~~
196 ~~affect the applicant's ability to practice with skill and~~
197 ~~safety~~. Upon such determination, the chair or other designee may
198 refer the applicant to the consultant to facilitate ~~for~~ an
199 evaluation before the board certifies or declines to certify his
200 or her application to the department. If the applicant agrees to

201 be evaluated ~~by the consultant~~, the department's deadline for
202 approving or denying the application pursuant to s. 120.60(1) is
203 tolled until the evaluation is completed and the result of the
204 evaluation and recommendation ~~by the consultant~~ is communicated
205 to the board by the consultant. If the applicant declines to be
206 evaluated ~~by the consultant~~, the board shall certify or decline
207 to certify the applicant's application to the department
208 notwithstanding the lack of an evaluation and recommendation by
209 the consultant.
210 (10)~~(4)~~(a) When ~~Whenever~~ the department receives a ~~written~~
211 ~~or oral~~ legally sufficient complaint alleging that a
212 practitioner has an impairment ~~licensee under the jurisdiction~~
213 ~~of the Division of Medical Quality Assurance within the~~
214 ~~department is impaired as a result of the misuse or abuse of~~
215 ~~alcohol or drugs, or both, or due to a mental or physical~~
216 ~~condition which could affect the licensee's ability to practice~~
217 ~~with skill and safety,~~ and no complaint exists against the
218 practitioner ~~licensee~~ other than impairment ~~exists~~, the
219 department shall refer the practitioner to the consultant, along
220 with all information in the department's possession relating to
221 the impairment. The impairment does ~~reporting of such~~
222 ~~information shall~~ not constitute grounds for discipline pursuant
223 to s. 456.072 or ~~the corresponding grounds for discipline within~~
224 the applicable practice act if ~~the probable cause panel of the~~
225 ~~appropriate board, or the department when there is no board,~~

226 ~~finds~~:
227 1. The practitioner ~~licensee~~ has acknowledged the
228 impairment ~~problem~~.
229 2. The practitioner becomes a participant ~~licensee has~~
230 ~~voluntarily enrolled~~ in an impaired practitioner program and
231 successfully completes a participant contract under terms
232 established by the consultant ~~appropriate, approved treatment~~
233 ~~program~~.
234 3. The practitioner ~~licensee~~ has voluntarily withdrawn
235 from practice or has limited the scope of his or her practice if
236 ~~as~~ required by the consultant~~, in each case, until such time as~~
237 ~~the panel, or the department when there is no board, is~~
238 ~~satisfied the licensee has successfully completed an approved~~
239 ~~treatment program~~.
240 4. The practitioner ~~licensee~~ has provided to the
241 consultant, or has authorized the consultant to obtain, all
242 records and information relating to the impairment from any
243 source and all other medical records of the practitioner
244 requested by the consultant ~~executed releases for medical~~
245 ~~records, authorizing the release of all records of evaluations,~~
246 ~~diagnoses, and treatment of the licensee, including records of~~
247 ~~treatment for emotional or mental conditions, to the consultant.~~
248 ~~The consultant shall make no copies or reports of records that~~
249 ~~do not regard the issue of the licensee's impairment and his or~~
250 ~~her participation in a treatment program~~.

251 5. The practitioner has authorized the consultant, in the
252 event of the practitioner's termination from the impaired
253 practitioner program, to report the termination to the
254 department and provide the department with copies of all
255 information in the consultant's possession relating to the
256 practitioner.
257 (b) To encourage practitioners who are or may be impaired
258 to voluntarily self-report to a consultant, the consultant may
259 not provide information to the department relating to a self-
260 reporting participant if there is no pending department
261 investigation, complaint, or disciplinary action against the
262 participant and if the participant is in compliance with the
263 terms of the impaired practitioner program and any participant
264 contract, unless authorized by the participant If, however, the
265 department has not received a legally sufficient complaint and
266 the licensee agrees to withdraw from practice until such time as
267 the consultant determines the licensee has satisfactorily
268 completed an approved treatment program or evaluation, the
269 probable cause panel, or the department when there is no board,
270 shall not become involved in the licensee's case.
271 (c) Inquiries related to impairment treatment programs
272 designed to provide information to the licensee and others and
273 which do not indicate that the licensee presents a danger to the
274 public shall not constitute a complaint within the meaning of s.
275 456.073 and shall be exempt from the provisions of this

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276 ~~subsection.~~
277 ~~(d) Whenever the department receives a legally sufficient~~
278 ~~complaint alleging that a licensee is impaired as described in~~
279 ~~paragraph (a) and no complaint against the licensee other than~~
280 ~~impairment exists, the department shall forward all information~~
281 ~~in its possession regarding the impaired licensee to the~~
282 ~~consultant. For the purposes of this section, a suspension from~~
283 ~~hospital staff privileges due to the impairment does not~~
284 ~~constitute a complaint.~~
285 ~~(e) The probable cause panel, or the department when there~~
286 ~~is no board, shall work directly with the consultant, and all~~
287 ~~information concerning a practitioner obtained from the~~
288 ~~consultant by the panel, or the department when there is no~~
289 ~~board, shall remain confidential and exempt from the provisions~~
290 ~~of s. 119.07(1), subject to the provisions of subsections (6)~~
291 ~~and (7).~~
292 ~~(f) A finding of probable cause shall not be made as long~~
293 ~~as the panel, or the department when there is no board, is~~
294 ~~satisfied, based upon information it receives from the~~
295 ~~consultant and the department, that the licensee is progressing~~
296 ~~satisfactorily in an approved impaired practitioner program and~~
297 ~~no other complaint against the licensee exists.~~
298 (11)~~(5)~~ In any disciplinary action for a violation other
299 than impairment in which a practitioner ~~licensee~~ establishes the
300 violation for which the licensee is being prosecuted was due to

301 or connected with impairment and further establishes the
302 practitioner ~~licensee~~ is satisfactorily progressing through or
303 has successfully completed an approved treatment program
304 pursuant to this section, such information may be considered by
305 the board, or the department when there is no board, as a
306 mitigating factor in determining the appropriate penalty. This
307 subsection does not limit mitigating factors the board may
308 consider.
309 (12)~~(6)~~(a) Upon request by the consultant, and with the
310 authorization of the practitioner when required by law, an
311 approved evaluator, treatment program, or treatment provider
312 shall~~, upon request,~~ disclose to the consultant all information
313 in its possession regarding a referral or participant ~~the issue~~
314 ~~of a licensee's impairment and participation in the treatment~~
315 ~~program. All information obtained by the consultant and~~
316 ~~department pursuant to this section is confidential and exempt~~
317 ~~from the provisions of s. 119.07(1), subject to the provisions~~
318 ~~of this subsection and subsection (7)~~. Failure to provide such
319 information to the consultant is grounds for withdrawal of
320 approval of such evaluator, treatment program, or treatment
321 provider.
322 (b) When a referral or participant is terminated from the
323 impaired practitioner program for material noncompliance with a
324 participant contract, inability to progress, or any other
325 reason, the consultant shall disclose all information in the

326 consultant's possession relating to the practitioner to the
327 department ~~If in the opinion of the consultant, after~~
328 ~~consultation with the treatment provider, an impaired licensee~~
329 ~~has not progressed satisfactorily in a treatment program, all~~
330 ~~information regarding the issue of a licensee's impairment and~~
331 ~~participation in a treatment program in the consultant's~~
332 ~~possession shall be disclosed to the department~~. Such disclosure
333 shall constitute a complaint pursuant to the general provisions
334 of s. 456.073. In addition, whenever the consultant concludes
335 that impairment affects a practitioner's ~~licensee's~~ practice and
336 constitutes an immediate, serious danger to the public health,
337 safety, or welfare, the consultant shall immediately communicate
338 such ~~that~~ conclusion ~~shall be communicated~~ to the department and
339 disclose all information in the consultant's possession relating
340 to the practitioner to the department ~~State Surgeon General~~.
341 (13) All information obtained by the consultant pursuant
342 to this section is confidential and exempt from s. 119.07(1) and
343 s. 24(a), Art. I of the State Constitution.
344 (14)~~(7)~~ A consultant, or a director, officer, employee or
345 agent of a consultant, may not be held liable financially or
346 have a cause of action for damages brought against them for
347 making a disclosure pursuant to this section, or for any other
348 action or omission relating to the impaired practitioner
349 program, or the consequences of such disclosure or action or
350 omission, including, without limitation, action by the

351 department against a license, registration, or certification.
352 ~~licensee, or approved treatment provider who makes a disclosure~~
353 ~~pursuant to this section is not subject to civil liability for~~
354 ~~such disclosure or its consequences.~~
355 (15) The provisions of s. 766.101 apply to any consultant,
356 employee, or agent of a consultant in regards to providing
357 information relating to a participant to a medical review
358 committee if the participant authorized such disclosure ~~officer,~~
359 ~~employee, or agent of the department or the board and to any~~
360 ~~officer, employee, or agent of any entity with which the~~
361 ~~department has contracted pursuant to this section~~.
362 ~~(8)(a) A consultant retained pursuant to subsection (2), a~~
363 ~~consultant's officers and employees, and those acting at the~~
364 ~~direction of the consultant for the limited purpose of an~~
365 ~~emergency intervention on behalf of a licensee or student as~~
366 ~~described in subsection (2) when the consultant is unable to~~
367 ~~perform such intervention shall be considered agents of the~~
368 ~~department for purposes of s. 768.28 while acting within the~~
369 ~~scope of the consultant's duties under the contract with the~~
370 ~~department if the contract complies with the requirements of~~
371 ~~this section. The contract must require that:~~
372 ~~1. The consultant indemnify the state for any liabilities~~
373 ~~incurred up to the limits set out in chapter 768.~~
374 ~~2. The consultant establish a quality assurance program to~~
375 ~~monitor services delivered under the contract.~~

376 ~~3. The consultant's quality assurance program, treatment,~~
377 ~~and monitoring records be evaluated quarterly.~~
378 ~~4. The consultant's quality assurance program be subject~~
379 ~~to review and approval by the department.~~
380 ~~5. The consultant operate under policies and procedures~~
381 ~~approved by the department.~~
382 ~~6. The consultant provide to the department for approval a~~
383 ~~policy and procedure manual that comports with all statutes,~~
384 ~~rules, and contract provisions approved by the department.~~
385 ~~7. The department be entitled to review the records~~
386 ~~relating to the consultant's performance under the contract for~~
387 ~~the purpose of management audits, financial audits, or program~~
388 ~~evaluation.~~
389 ~~8. All performance measures and standards be subject to~~
390 ~~verification and approval by the department.~~
391 ~~9. The department be entitled to terminate the contract~~
392 ~~with the consultant for noncompliance with the contract.~~
393 <u>(16)</u>~~(b)~~ In accordance with s. 284.385, the Department of
394 Financial Services shall defend any claim, suit, action, or
395 proceeding, including a claim, suit, action, or proceeding for
396 injunctive, affirmative, or declaratory relief, against the
397 consultant, the consultant's <u>directors,</u> officers<u>,</u> ~~or~~ employees,
398 <u>or agents brought as the result of any action or omission</u>
399 <u>relating to the impaired practitioner program</u> ~~or those acting at~~
400 ~~the direction of the consultant for the limited purpose of an~~

401 ~~emergency intervention on behalf of a licensee or student as~~
402 ~~described in subsection (2) when the consultant is unable to~~
403 ~~perform such intervention, which claim, suit, action, or~~
404 ~~proceeding is brought as a result of an act or omission by any~~
405 ~~of the consultant's officers and employees and those acting~~
406 ~~under the direction of the consultant for the limited purpose of~~
407 ~~an emergency intervention on behalf of the licensee or student~~
408 ~~when the consultant is unable to perform such intervention, if~~
409 ~~the act or omission arises out of and is in the scope of the~~
410 ~~consultant's duties under its contract with the department~~.
411 (17) ~~(c)~~ If a ~~the~~ consultant retained by the department
412 pursuant to this section ~~subsection (2)~~ is also retained by
413 another ~~any other~~ state agency to operate an impaired
414 practitioner program for that agency, this section also applies
415 to the consultant's operation of an impaired practitioner
416 program for that agency~~, and if the contract between such state~~
417 ~~agency and the consultant complies with the requirements of this~~
418 ~~section, the consultant, the consultant's officers and~~
419 ~~employees, and those acting under the direction of the~~
420 ~~consultant for the limited purpose of an emergency intervention~~
421 ~~on behalf of a licensee or student as described in subsection~~
422 ~~(2) when the consultant is unable to perform such intervention~~
423 ~~shall be considered agents of the state for the purposes of this~~
424 ~~section while acting within the scope of and pursuant to~~
425 ~~guidelines established in the contract between such state agency~~

426 ~~and the consultant~~.
427 (18) ~~(9)~~ A ~~An impaired practitioner consultant is the~~
428 ~~official custodian of records relating to the referral of an~~
429 ~~impaired licensee or applicant to that consultant and any other~~
430 ~~interaction between the licensee or applicant and the~~
431 ~~consultant. The~~ consultant may disclose to a referral or
432 participant documents, records, or other information from the
433 consultant's file on the referral or participant ~~the impaired~~
434 ~~licensee or applicant or his or her designee any information~~
435 ~~that is disclosed to or obtained by the consultant or that is~~
436 ~~confidential under paragraph (6)(a), but only~~ to the extent that
437 it is necessary to do so to carry out the consultant's duties
438 under the impaired practitioner program and this section, or as
439 otherwise required by law. ~~The department, and any other entity~~
440 ~~that enters into a contract with the consultant to receive the~~
441 ~~services of the consultant, has direct administrative control~~
442 ~~over the consultant to the extent necessary to receive~~
443 ~~disclosures from the consultant as allowed by federal law.~~ If a
444 disciplinary proceeding is pending, a referral or participant
445 may obtain a complete copy of the consultant's file from the
446 department as provided by ~~an impaired licensee may obtain such~~
447 ~~information from the department under~~ s. 456.073.
448 (19)(a) The consultant may contract with a school or
449 program to provide impaired practitioner program services to a
450 student enrolled for the purpose of preparing for licensure as a

451 health care practitioner as defined in this chapter or as a
452 veterinarian under chapter 474 if the student has or is
453 suspected of having an impairment. The department is not
454 responsible for paying for the care provided by approved
455 treatment providers or approved treatment programs or for the
456 services provided by a consultant to a student.
457 (b) A medical school accredited by the Liaison Committee
458 on Medical Education or the Commission on Osteopathic College
459 Accreditation, or another school providing for the education of
460 students enrolled in preparation for licensure as a health care
461 practitioner, as defined in this chapter, or a veterinarian
462 under chapter 474, which is governed by accreditation standards
463 requiring notice and the provision of due process procedures to
464 students, is not liable in any civil action for referring a
465 student to the consultant retained by the department or for
466 disciplinary actions that adversely affect the status of a
467 student when the disciplinary actions are instituted in
468 reasonable reliance on the recommendations, reports, or
469 conclusions provided by such consultant, if the school, in
470 referring the student or taking disciplinary action, adheres to
471 the due process procedures adopted by the applicable
472 accreditation entities and if the school committed no
473 intentional fraud in carrying out the provisions of this
474 section.
475 Section 2. Paragraph (l) of subsection (1) of section

476 401.411, Florida Statutes, is amended to read:
477 401.411 Disciplinary action; penalties.—
478 (1) The department may deny, suspend, or revoke a license,
479 certificate, or permit or may reprimand or fine any licensee,
480 certificateholder, or other person operating under this part for
481 any of the following grounds:
482 (l) The failure to report to the department any person
483 known to be in violation of this part. However, a professional
484 known to be operating under this part without reasonable skill
485 and without regard for the safety of the public by reason of
486 illness, drunkenness, or the use of drugs, narcotics, chemicals,
487 or any other substance, or as a result of a mental or physical
488 condition may be reported to a consultant operating an impaired
489 practitioner program as described in s. 456.076 rather than to
490 the department.
491 Section 3. Paragraph (u) of subsection (1) of section
492 455.227, Florida Statutes, is amended to read:
493 455.227 Grounds for discipline; penalties; enforcement.—
494 (1) The following acts shall constitute grounds for which
495 the disciplinary actions specified in subsection (2) may be
496 taken:
497 (u) Termination from an impaired practitioner program ~~a~~
498 ~~treatment program for impaired practitioners~~ as described in s.
499 456.076 for failure to comply, without good cause, with the
500 terms of the monitoring or participant ~~treatment~~ contract

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501 entered into by the licensee or failing to successfully complete
502 a drug or alcohol treatment program.
503 Section 4. Paragraphs (i) and (hh) of subsection (1) of
504 section 456.072, Florida Statutes, are amended to read:
505 456.072 Grounds for discipline; penalties; enforcement.—
506 (1) The following acts shall constitute grounds for which
507 the disciplinary actions specified in subsection (2) may be
508 taken:
509 (i) Except as provided in s. 465.016, failing to report to
510 the department any person who the licensee knows is in violation
511 of this chapter, the chapter regulating the alleged violator, or
512 the rules of the department or the board. However, a person who
513 the licensee knows is unable to practice with reasonable skill
514 and safety to patients by reason of illness or use of alcohol,
515 drugs, narcotics, chemicals, or any other type of material, or
516 as a result of a mental or physical condition may be reported to
517 a consultant operating an impaired practitioner program as
518 described in s. 456.076 rather than to the department.
519 (hh) Being terminated from an impaired practitioner
520 program ~~a treatment program for impaired practitioners~~, which is
521 overseen by a ~~an impaired practitioner~~ consultant as described
522 in s. 456.076, for failure to comply, without good cause, with
523 the terms of the monitoring or participant ~~treatment~~ contract
524 entered into by the licensee, or for not successfully completing
525 any drug treatment or alcohol treatment program.

526 Section 5. Paragraph (f) of subsection (1) of section
527 457.109, Florida Statutes, is amended to read:
528 457.109 Disciplinary actions; grounds; action by the
529 board.—
530 (1) The following acts constitute grounds for denial of a
531 license or disciplinary action, as specified in s. 456.072(2):
532 (f) Failing to report to the department any person who the
533 licensee knows is in violation of this chapter or of the rules
534 of the department. However, a person who the licensee knows is
535 unable to practice acupuncture with reasonable skill and safety
536 to patients by reason of illness or use of alcohol, drugs,
537 narcotics, chemicals, or any other type of material, or as a
538 result of a mental or physical condition may be reported to a
539 consultant operating an impaired practitioner program as
540 described in s. 456.076 rather than to the department.
541 Section 6. Paragraph (e) of subsection (1) of section
542 458.331, Florida Statutes, is amended to read:
543 458.331 Grounds for disciplinary action; action by the
544 board and department.—
545 (1) The following acts constitute grounds for denial of a
546 license or disciplinary action, as specified in s. 456.072(2):
547 (e) Failing to report to the department any person who the
548 licensee knows is in violation of this chapter or of the rules
549 of the department or the board. However, a person who the
550 licensee knows is unable to practice medicine with reasonable

551 skill and safety to patients by reason of illness or use of
552 alcohol, drugs, narcotics, chemicals, or any other type of
553 material, or as a result of a mental or physical condition may
554 be reported to a consultant operating an impaired practitioner
555 program as described in s. 456.076 rather than to the department
556 ~~A treatment provider approved pursuant to s. 456.076 shall~~
557 ~~provide the department or consultant with information in~~
558 ~~accordance with the requirements of s. 456.076(4), (5), (6),~~
559 ~~(7), and (9)~~.
560 Section 7. Paragraph (e) of subsection (1) of section
561 459.015, Florida Statutes, is amended to read:
562 459.015 Grounds for disciplinary action; action by the
563 board and department.—
564 (1) The following acts constitute grounds for denial of a
565 license or disciplinary action, as specified in s. 456.072(2):
566 (e) Failing to report to the department or the
567 department's impaired professional consultant any person who the
568 licensee or certificateholder knows is in violation of this
569 chapter or of the rules of the department or the board. However,
570 a person who the licensee knows is unable to practice
571 osteopathic medicine with reasonable skill and safety to
572 patients by reason of illness or use of alcohol, drugs,
573 narcotics, chemicals, or any other type of material, or as a
574 result of a mental or physical condition may be reported to a
575 consultant operating an impaired practitioner program as

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576 described in s. 456.076 rather than to the department ~~A~~
577 ~~treatment provider, approved pursuant to s. 456.076, shall~~
578 ~~provide the department or consultant with information in~~
579 ~~accordance with the requirements of s. 456.076(4), (5), (6),~~
580 ~~(7), and (9)~~.
581 Section 8. Paragraph (g) of subsection (1) of section
582 460.413, Florida Statutes, is amended to read:
583 460.413 Grounds for disciplinary action; action by board
584 or department.—
585 (1) The following acts constitute grounds for denial of a
586 license or disciplinary action, as specified in s. 456.072(2):
587 (g) Failing to report to the department any person who the
588 licensee knows is in violation of this chapter or of the rules
589 of the department or the board. However, a person who the
590 licensee knows is unable to practice chiropractic medicine with
591 reasonable skill and safety to patients by reason of illness or
592 use of alcohol, drugs, narcotics, chemicals, or any other type
593 of material, or as a result of a mental or physical condition
594 may be reported to a consultant operating an impaired
595 practitioner program as described in s. 456.076 rather than to
596 the department.
597 Section 9. Paragraph (f) of subsection (1) of section
598 461.013, Florida Statutes, is amended to read:
599 461.013 Grounds for disciplinary action; action by the
600 board; investigations by department.—

601 (1) The following acts constitute grounds for denial of a
602 license or disciplinary action, as specified in s. 456.072(2):
603 (f) Failing to report to the department any person who the
604 licensee knows is in violation of this chapter or of the rules
605 of the department or the board. However, a person who the
606 licensee knows is unable to practice podiatric medicine with
607 reasonable skill and safety to patients by reason of illness or
608 use of alcohol, drugs, narcotics, chemicals, or any other type
609 of material, or as a result of a mental or physical condition
610 may be reported to a consultant operating an impaired
611 practitioner program as described in s. 456.076 rather than to
612 the department.
613 Section 10. Paragraph (f) of subsection (1) of section
614 462.14, Florida Statutes, is amended to read:
615 462.14 Grounds for disciplinary action; action by the
616 department.—
617 (1) The following acts constitute grounds for denial of a
618 license or disciplinary action, as specified in s. 456.072(2):
619 (f) Failing to report to the department any person who the
620 licensee knows is in violation of this chapter or of the rules
621 of the department. However, a person who the licensee knows is
622 unable to practice naturopathic medicine with reasonable skill
623 and safety to patients by reason of illness or use of alcohol,
624 drugs, narcotics, chemicals, or any other type of material, or
625 as a result of a mental or physical condition may be reported to

626 a consultant operating an impaired practitioner program as
627 described in s. 456.076 rather than to the department.
628 Section 11. Paragraph (l) of subsection (1) of section
629 463.016, Florida Statutes, is amended to read:
630 463.016 Grounds for disciplinary action; action by the
631 board.—
632 (1) The following acts constitute grounds for denial of a
633 license or disciplinary action, as specified in s. 456.072(2):
634 (l) Willfully failing to report any person who the
635 licensee knows is in violation of this chapter or of rules of
636 the department or the board. However, a person who the licensee
637 knows is unable to practice optometry with reasonable skill and
638 safety to patients by reason of illness or use of alcohol,
639 drugs, narcotics, chemicals, or any other type of material, or
640 as a result of a mental or physical condition may be reported to
641 a consultant operating an impaired practitioner program as
642 described in s. 456.076 rather than to the department.
643 Section 12. Paragraph (k) of subsection (1) of section
644 464.018, Florida Statutes, is amended to read:
645 464.018 Disciplinary actions.—
646 (1) The following acts constitute grounds for denial of a
647 license or disciplinary action, as specified in s. 456.072(2):
648 (k) Failing to report to the department any person who the
649 licensee knows is in violation of this part or of the rules of
650 the department or the board. However, a person who the licensee

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651 knows is unable to practice nursing with reasonable skill and
652 safety to patients by reason of illness or use of alcohol,
653 drugs, narcotics, chemicals, or any other type of material, or
654 as a result of a mental or physical condition may be reported to
655 a consultant operating an impaired practitioner program as
656 described in s. 456.076 rather than to the department~~; however,~~
657 ~~if the licensee verifies that such person is actively~~
658 ~~participating in a board-approved program for the treatment of a~~
659 ~~physical or mental condition, the licensee is required to report~~
660 ~~such person only to an impaired professionals consultant~~.
661 Section 13. Paragraph (c) of subsection (2) of section
662 464.204, Florida Statutes, is amended to read:
663 464.204 Denial, suspension, or revocation of
664 certification; disciplinary actions.—
665 (2) When the board finds any person guilty of any of the
666 grounds set forth in subsection (1), it may enter an order
667 imposing one or more of the following penalties:
668 (c) Imposition of probation or restriction of
669 certification, including conditions such as corrective actions
670 as retraining or compliance with the department's impaired
671 practitioner program, operated by a consultant as described in
672 s. 456.076 ~~an approved treatment program for impaired~~
673 ~~practitioners~~.
674 Section 14. Paragraph (o) of subsection (1) of section
675 465.016, Florida Statutes, is amended to read:

676 465.016 Disciplinary actions.—
677 (1) The following acts constitute grounds for denial of a
678 license or disciplinary action, as specified in s. 456.072(2):
679 (o) Failing to report to the department any licensee under
680 chapter 458 or under chapter 459 who the pharmacist knows has
681 violated the grounds for disciplinary action set out in the law
682 under which that person is licensed and who provides health care
683 services in a facility licensed under chapter 395, or a health
684 maintenance organization certificated under part I of chapter
685 641, in which the pharmacist also provides services. However, a
686 person who the licensee knows is unable to practice medicine or
687 osteopathic medicine with reasonable skill and safety to
688 patients by reason of illness or use of alcohol, drugs,
689 narcotics, chemicals, or any other type of material, or as a
690 result of a mental or physical condition may be reported to a
691 consultant operating an impaired practitioner program as
692 described in s. 456.076 rather than to the department.
693 Section 15. Paragraph (f) of subsection (1) of section
694 466.028, Florida Statutes, is amended to read:
695 466.028 Grounds for disciplinary action; action by the
696 board.—
697 (1) The following acts constitute grounds for denial of a
698 license or disciplinary action, as specified in s. 456.072(2):
699 (f) Failing to report to the department any person who the
700 licensee knows, or has reason to believe, is clearly in

701 violation of this chapter or of the rules of the department or
702 the board. However, a person who the licensee knows, or has
703 reason to believe, is clearly unable to practice her or his
704 profession with reasonable skill and safety to patients by
705 reason of illness or use of alcohol, drugs, narcotics,
706 chemicals, or any other type of material, or as a result of a
707 mental or physical condition may be reported to a consultant
708 operating an impaired practitioner program as described in s.
709 456.076 rather than to the department.
710 Section 16. Paragraph (h) of subsection (1) of section
711 467.203, Florida Statutes, is amended to read:
712 467.203 Disciplinary actions; penalties.—
713 (1) The following acts constitute grounds for denial of a
714 license or disciplinary action, as specified in s. 456.072(2):
715 (h) Failing to report to the department any person who the
716 licensee knows is in violation of this chapter or of the rules
717 of the department. However, a person who the licensee knows is
718 unable to practice midwifery with reasonable skill and safety to
719 patients by reason of illness or use of alcohol, drugs,
720 narcotics, chemicals, or any other type of material, or as a
721 result of a mental or physical condition may be reported to a
722 consultant operating an impaired practitioner program as
723 described in s. 456.076 rather than to the department.
724 Section 17. Paragraph (f) of subsection (1) of section
725 468.217, Florida Statutes, is amended to read:

726 468.217 Denial of or refusal to renew license; suspension
727 and revocation of license and other disciplinary measures.—
728 (1) The following acts constitute grounds for denial of a
729 license or disciplinary action, as specified in s. 456.072(2):
730 (f) Failing to report to the department any person who the
731 licensee knows is in violation of this part or of the rules of
732 the department or of the board. However, a person who the
733 licensee knows is unable to practice occupational therapy with
734 reasonable skill and safety to patients by reason of illness or
735 use of alcohol, drugs, narcotics, chemicals, or any other type
736 of material, or as a result of a mental or physical condition
737 may be reported to a consultant operating an impaired
738 practitioner program as described in s. 456.076 rather than to
739 the department.
740 Section 18. Paragraph (n) of subsection (1) of section
741 468.3101, Florida Statutes, is amended to read:
742 468.3101 Disciplinary grounds and actions.—
743 (1) The department may make or require to be made any
744 investigations, inspections, evaluations, and tests, and require
745 the submission of any documents and statements, which it
746 considers necessary to determine whether a violation of this
747 part has occurred. The following acts shall be grounds for
748 disciplinary action as set forth in this section:
749 (n) Being terminated from an impaired practitioner program
750 operated by a consultant as described in s. 456.076 for failure

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751 to comply, without good cause, with the terms of monitoring or a
752 participant contract entered into by the licensee, or for not
753 successfully completing a drug treatment or alcohol treatment
754 program ~~Failing to comply with the recommendations of the~~
755 ~~department's impaired practitioner program for treatment,~~
756 ~~evaluation, or monitoring. A letter from the director of the~~
757 ~~impaired practitioner program that the certificateholder is not~~
758 ~~in compliance shall be considered conclusive proof under this~~
759 ~~part~~.
760 Section 19. Section 474.221, Florida Statutes, is amended
761 to read:
762 474.221 Impaired practitioner provisions; applicability.—
763 Notwithstanding the transfer of the Division of Medical Quality
764 Assurance to the Department of Health or any other provision of
765 law to the contrary, veterinarians licensed under this chapter
766 shall be governed by the ~~treatment of~~ impaired practitioner
767 program provisions of s. 456.076 as if they were under the
768 jurisdiction of the Division of Medical Quality Assurance,
769 except that for veterinarians the Department of Business and
770 Professional Regulation shall, at its option, exercise any of
771 the powers granted to the Department of Health by that section,
772 and "board" shall mean board as defined in this chapter.
773 Section 20. Paragraph (o) of subsection (1) of section
774 483.825, Florida Statutes, is amended to read:
775 483.825 Grounds for disciplinary action.—

776 (1) The following acts constitute grounds for denial of a
777 license or disciplinary action, as specified in s. 456.072(2):
778 (o) Failing to report to the department a person or other
779 licensee who the licensee knows is in violation of this chapter
780 or the rules of the department or board adopted hereunder.
781 However, a person or other licensee who the licensee knows is
782 unable to perform or report on clinical laboratory examinations
783 with reasonable skill and safety to patients by reason of
784 illness or use of alcohol, drugs, narcotics, chemicals, or any
785 other type of material, or as a result of a mental or physical
786 condition may be reported to a consultant operating an impaired
787 practitioner program as described in s. 456.076 rather than to
788 the department.
789 Section 21. This act shall take effect upon becoming a
790 law.

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

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

1 Committee/Subcommittee hearing bill: Health Quality
2 Subcommittee
3 Representative Byrd offered the following:
4
5 **Amendment**
6 Remove lines 46-393 and insert:
7 (e) "Impairment" means an impairing health condition that
8 is the result of the misuse or abuse of alcohol, drugs, or both,
9 or a mental or physical condition which could affect a
10 practitioner's ability to practice with skill and safety.
11 (f) "Inability to progress" means a determination by a
12 consultant based on a participant's response to treatment and
13 prognosis that the participant is unable to safely practice
14 despite compliance with treatment requirements and his or her
15 participant contract.
16 (g) "Material noncompliance" means an act or omission by a

17 participant in violation of his or her participant contract as
18 determined by the department or consultant.
19 (h) "Participant" means a practitioner who is
20 participating in the impaired practitioner program by having
21 entered into a participant contract. A practitioner ceases to be
22 a participant when the participant contract is successfully
23 completed or is terminated for any reason.
24 (i) "Participant contract" means a formal written document
25 outlining the requirements established by a consultant for a
26 participant to successfully complete the impaired practitioner
27 program, including the participant's monitoring plan.
28 (j) "Practitioner" means a person licensed, registered,
29 certified, or regulated by the department under part III of
30 chapter 401; chapters 457 through 467; parts I, II, III, V, X,
31 XIII, or XIV of chapter 468; chapter 478; chapter 480; part III
32 or IV of chapter 483; chapter 484; chapter 486; chapter 490; or
33 chapter 491, Florida Statutes; or an applicant under the same
34 laws.
35 (k) "Referral" means a practitioner who has been referred,
36 either as a self-referral or otherwise, or reported to a
37 consultant for impaired practitioner program services but who is
38 not under a participant contract.
39 (l) "Treatment program" means a department or consultant-
40 approved residential, intensive outpatient, partial
41 hospitalization, or other program through which an impaired

42 practitioner is treated based on the impaired practitioner's
43 diagnosis and the treatment plan approved by the consultant.
44 (m) "Treatment provider" means a department or consultant-
45 approved state-licensed or nationally-certified individual who
46 provides treatment to an impaired practitioner based on the
47 practitioner's individual diagnosis and a treatment plan
48 approved by the consultant ~~For professions that do not have~~
49 ~~impaired practitioner programs provided for in their practice~~
50 ~~acts, the department shall, by rule, designate approved impaired~~
51 ~~practitioner programs under this section. The department may~~
52 ~~adopt rules setting forth appropriate criteria for approval of~~
53 ~~treatment providers. The rules may specify the manner in which~~
54 ~~the consultant, retained as set forth in subsection (2), works~~
55 ~~with the department in intervention, requirements for evaluating~~
56 ~~and treating a professional, requirements for continued care of~~
57 ~~impaired professionals by approved treatment providers,~~
58 ~~continued monitoring by the consultant of the care provided by~~
59 ~~approved treatment providers regarding the professionals under~~
60 ~~their care, and requirements related to the consultant's~~
61 ~~expulsion of professionals from the program~~.
62 (2)(a) The department may ~~shall~~ retain one or more
63 ~~impaired practitioner~~ consultants to operate its impaired
64 practitioner program. Each consultant ~~who are each licensees~~
65 ~~under the jurisdiction of the Division of Medical Quality~~
66 ~~Assurance within the department and who~~ must be:

67 1. A practitioner ~~or recovered practitioner~~ licensed under
68 chapter 458, chapter 459, or part I of chapter 464; or
69 2. An entity that employs:
70 a. A medical director who <u>is</u> ~~must be a practitioner or~~
71 ~~recovered practitioner~~ licensed under chapter 458 or chapter
72 459; or
73 b. An executive director who <u>is</u> ~~must be a registered nurse~~
74 ~~or a recovered registered nurse~~ licensed under part I of chapter
75 464.
76 <u>(3) The terms and conditions of the impaired practitioner</u>
77 <u>program must be established by the department by contract with a</u>
78 <u>consultant for the protection of the health, safety, and welfare</u>
79 <u>of the public and must provide, at a minimum, the consultant:</u>
80 <u>(a) Accept referrals of practitioners who have or are</u>
81 <u>suspected of having an impairment;</u>
82 <u>(b) Arrange for the evaluation and treatment of such</u>
83 <u>practitioners as recommended by the consultant;</u>
84 <u>(c) Monitor the recovery progress and status of impaired</u>
85 <u>practitioners to ensure that such practitioners are able to</u>
86 <u>practice their profession with skill and safety. Such montoring</u>
87 <u>must continue until the consultant or department concludes that</u>
88 <u>monitoring by the consultant is no longer required for the</u>
89 <u>protection of the public or the practitioner's participation in</u>
90 <u>the program is terminated for material noncompliance or</u>
91 <u>inability to progress; and</u>

92 (d) May not evaluate, treat, or otherwise provide direct
93 patient care to practitioners in the operation of the impaired
94 practitioner program.
95 (4) The department shall specify, in its contract with
96 each consultant, the types of licenses, registrations, or
97 certifications of the practitioners to be served by that
98 consultant.
99 (5) A consultant shall enter into a participant contract
100 and an impaired practitioner which establishes the terms of
101 monitoring and shall include the terms in a participant
102 contract. In establishing the terms of monitoring, the
103 consultant may consider the recommendations of one or more
104 approved evaluators, treatment programs, or treatment providers.
105 A consultant may modify the terms of monitoring if the
106 consultant concludes, through the course of monitoring, that
107 extended, additional, or amended terms of monitoring are
108 required for the protection of the health, safety, and welfare
109 of the public.
110 (7)~~(b)~~ A ~~An entity retained as an impaired practitioner~~
111 consultant ~~under this section which employs a medical director~~
112 ~~or an executive director~~ is not required to be licensed as a
113 substance abuse provider or mental health treatment provider
114 under chapter 394, chapter 395, or chapter 397 for purposes of
115 providing services under this program.
116 (8)~~(c)1.~~ Each ~~The~~ consultant shall assist the department

117 and licensure boards on matters of impaired practitioners,
118 including the determination of ~~probable cause panel and the~~
119 ~~department in carrying out the responsibilities of this section.~~
120 ~~This includes working with department investigators to determine~~
121 whether a practitioner is, in fact, impaired, as specified in
122 the consultant's contract with the department.
123 ~~2. The consultant may contract with a school or program to~~
124 ~~provide services to a student enrolled for the purpose of~~
125 ~~preparing for licensure as a health care practitioner as defined~~
126 ~~in this chapter or as a veterinarian under chapter 474 if the~~
127 ~~student is allegedly impaired as a result of the misuse or abuse~~
128 ~~of alcohol or drugs, or both, or due to a mental or physical~~
129 ~~condition. The department is not responsible for paying for the~~
130 ~~care provided by approved treatment providers or a consultant.~~
131 ~~(d) A medical school accredited by the Liaison Committee~~
132 ~~on Medical Education or the Commission on Osteopathic College~~
133 ~~Accreditation, or another school providing for the education of~~
134 ~~students enrolled in preparation for licensure as a health care~~
135 ~~practitioner as defined in this chapter or a veterinarian under~~
136 ~~chapter 474 which is governed by accreditation standards~~
137 ~~requiring notice and the provision of due process procedures to~~
138 ~~students, is not liable in any civil action for referring a~~
139 ~~student to the consultant retained by the department or for~~
140 ~~disciplinary actions that adversely affect the status of a~~
141 ~~student when the disciplinary actions are instituted in~~

142 ~~reasonable reliance on the recommendations, reports, or~~
143 ~~conclusions provided by such consultant, if the school, in~~
144 ~~referring the student or taking disciplinary action, adheres to~~
145 ~~the due process procedures adopted by the applicable~~
146 ~~accreditation entities and if the school committed no~~
147 ~~intentional fraud in carrying out the provisions of this~~
148 ~~section.~~
149 (9)~~(3)~~ Before issuing an approval or intent to deny, each
150 board and profession within the Division of Medical Quality
151 Assurance may delegate to its chair or other designee its
152 authority to determine~~, before certifying or declining to~~
153 ~~certify an application for licensure to the department,~~ that an
154 applicant for licensure under its jurisdiction may have an
155 impairment ~~be impaired as a result of the misuse or abuse of~~
156 ~~alcohol or drugs, or both, or due to a mental or physical~~
157 ~~condition that could affect the applicant's ability to practice~~
158 ~~with skill and safety~~. Upon such determination, the chair or
159 other designee may refer the applicant to the consultant to
160 facilitate ~~for~~ an evaluation before the board issues an approval
161 ~~certifies~~ or intent to deny ~~declines to certify~~ his or her
162 application~~ to the department~~. If the applicant agrees to be
163 evaluated ~~by the consultant~~, the department's deadline for
164 approving or denying the application pursuant to s. 120.60(1) is
165 tolled until the evaluation is completed and the result of the
166 evaluation and recommendation ~~by the consultant~~ is communicated

167 to the board by the consultant. If the applicant declines to be
168 evaluated ~~by the consultant~~, the board shall issue an approval
169 or intent to deny ~~certify or decline to certify~~ the applicant's
170 application ~~to the department~~ notwithstanding the lack of an
171 evaluation and recommendation by the consultant.

172 (10) ~~(4)~~ (a) When ~~Whenever~~ the department receives a ~~written~~
173 ~~or oral~~ legally sufficient complaint alleging that a
174 practitioner has an impairment ~~licensee under the jurisdiction~~
175 ~~of the Division of Medical Quality Assurance within the~~
176 ~~department is impaired as a result of the misuse or abuse of~~
177 ~~alcohol or drugs, or both, or due to a mental or physical~~
178 ~~condition which could affect the licensee's ability to practice~~
179 ~~with skill and safety,~~ and no complaint exists against the
180 practitioner ~~licensee~~ other than impairment ~~exists~~, the
181 department shall refer the practitioner to the consultant, along
182 with all information in the department's possession relating to
183 the impairment. The impairment does ~~reporting of such~~
184 ~~information shall~~ not constitute grounds for discipline pursuant
185 to s. 456.072 or ~~the corresponding grounds for discipline within~~
186 the applicable practice act if ~~the probable cause panel of the~~
187 ~~appropriate board, or the department when there is no board,~~
188 ~~finds~~:

189 1. The practitioner ~~licensee~~ has acknowledged the
190 impairment ~~problem~~.

191 2. The practitioner becomes a participant ~~licensee has~~

192 voluntarily enrolled in an impaired practitioner program and
193 successfully completes a participant contract under terms
194 established by the consultant appropriate, approved treatment
195 program.
196 3. The practitioner licensee has voluntarily withdrawn
197 from practice or has limited the scope of his or her practice if
198 as required by the consultant, in each case, until such time as
199 the panel, or the department when there is no board, is
200 satisfied the licensee has successfully completed an approved
201 treatment program.
202 4. The practitioner licensee has provided to the
203 consultant, or has authorized the consultant to obtain, all
204 records and information relating to the impairment from any
205 source and all other medical records of the practitioner
206 requested by the consultant executed releases for medical
207 records, authorizing the release of all records of evaluations,
208 diagnoses, and treatment of the licensee, including records of
209 treatment for emotional or mental conditions, to the consultant.
210 The consultant shall make no copies or reports of records that
211 do not regard the issue of the licensee's impairment and his or
212 her participation in a treatment program.
213 5. The practitioner has authorized the consultant, in the
214 event of the practitioner's termination from the impaired
215 practitioner program, to report the termination to the
216 department and provide the department with copies of all

217 information in the consultant's possession relating to the
218 practitioner.
219 (b) To encourage practitioners who are or may be impaired
220 to voluntarily self-refer to a consultant, the consultant may
221 not provide information to the department relating to a self-
222 reporting participant if the consultant has no knowledge of a
223 pending department investigation, complaint, or disciplinary
224 action against the participant and if the participant is in
225 compliance with the terms of the impaired practitioner program
226 and any participant contract, unless authorized by the
227 participant ~~If, however, the department has not received a~~
228 ~~legally sufficient complaint and the licensee agrees to withdraw~~
229 ~~from practice until such time as the consultant determines the~~
230 ~~licensee has satisfactorily completed an approved treatment~~
231 ~~program or evaluation, the probable cause panel, or the~~
232 ~~department when there is no board, shall not become involved in~~
233 ~~the licensee's case~~.
234 ~~(c) Inquiries related to impairment treatment programs~~
235 ~~designed to provide information to the licensee and others and~~
236 ~~which do not indicate that the licensee presents a danger to the~~
237 ~~public shall not constitute a complaint within the meaning of s.~~
238 ~~456.073 and shall be exempt from the provisions of this~~
239 ~~subsection.~~
240 ~~(d) Whenever the department receives a legally sufficient~~
241 ~~complaint alleging that a licensee is impaired as described in~~

242 ~~paragraph (a) and no complaint against the licensee other than~~
243 ~~impairment exists, the department shall forward all information~~
244 ~~in its possession regarding the impaired licensee to the~~
245 ~~consultant. For the purposes of this section, a suspension from~~
246 ~~hospital staff privileges due to the impairment does not~~
247 ~~constitute a complaint.~~
248 ~~(e) The probable cause panel, or the department when there~~
249 ~~is no board, shall work directly with the consultant, and all~~
250 ~~information concerning a practitioner obtained from the~~
251 ~~consultant by the panel, or the department when there is no~~
252 ~~board, shall remain confidential and exempt from the provisions~~
253 ~~of s. 119.07(1), subject to the provisions of subsections (6)~~
254 ~~and (7).~~
255 ~~(f) A finding of probable cause shall not be made as long~~
256 ~~as the panel, or the department when there is no board, is~~
257 ~~satisfied, based upon information it receives from the~~
258 ~~consultant and the department, that the licensee is progressing~~
259 ~~satisfactorily in an approved impaired practitioner program and~~
260 ~~no other complaint against the licensee exists.~~
261 (11) ~~(5)~~ In any disciplinary action for a violation other
262 than impairment in which a practitioner ~~licensee~~ establishes the
263 violation for which the licensee is being prosecuted was due to
264 or connected with impairment and further establishes the
265 practitioner ~~licensee~~ is satisfactorily progressing through or
266 has successfully completed an impaired practitioner program

267 ~~approved treatment program~~ pursuant to this section, such
268 information may be considered by the board, or the department
269 when there is no board, as a mitigating factor in determining
270 the appropriate penalty. This subsection does not limit
271 mitigating factors the board may consider.
272 (12) ~~(6)~~ (a) Upon request by the consultant, and with the
273 authorization of the practitioner when required by law, an
274 approved evaluator, treatment program, or treatment provider
275 shall~~, upon request,~~ disclose to the consultant all information
276 in its possession regarding a referral or participant ~~the issue~~
277 ~~of a licensee's impairment and participation in the treatment~~
278 ~~program. All information obtained by the consultant and~~
279 ~~department pursuant to this section is confidential and exempt~~
280 ~~from the provisions of s. 119.07(1), subject to the provisions~~
281 ~~of this subsection and subsection (7)~~. Failure to provide such
282 information to the consultant is grounds for withdrawal of
283 approval of such evaluator, treatment program, or treatment
284 provider.
285 (b) When a referral or participant is terminated from the
286 impaired practitioner program for material noncompliance with a
287 participant contract, inability to progress, or any other
288 reason, the consultant shall disclose all information in the
289 consultant's possession relating to the practitioner to the
290 department ~~If in the opinion of the consultant, after~~
291 ~~consultation with the treatment provider, an impaired licensee~~

292 ~~has not progressed satisfactorily in a treatment program, all~~
293 ~~information regarding the issue of a licensee's impairment and~~
294 ~~participation in a treatment program in the consultant's~~
295 ~~possession shall be disclosed to the department~~. Such disclosure
296 shall constitute a complaint pursuant to the general provisions
297 of s. 456.073. In addition, whenever the consultant concludes
298 that impairment affects a practitioner's ~~licensee's~~ practice and
299 constitutes an immediate, serious danger to the public health,
300 safety, or welfare, the consultant shall immediately communicate
301 such ~~that~~ conclusion ~~shall be communicated~~ to the department and
302 disclose all information in the consultant's possession relating
303 to the practitioner to the department ~~State Surgeon General~~.
304 (13) All information obtained by the consultant pursuant
305 to this section is confidential and exempt from s. 119.07(1) and
306 s. 24(a), Art. I of the State Constitution.
307 (14)~~(7)~~ A consultant, or a director, officer, employee or
308 agent of a consultant, may not be held liable financially or
309 have a cause of action for damages brought against them for
310 making a disclosure pursuant to this section, or for any other
311 action or omission relating to the impaired practitioner
312 program, or the consequences of such disclosure or action or
313 omission, including, without limitation, action by the
314 department against a license, registration, or certification.
315 ~~licensee, or approved treatment provider who makes a disclosure~~
316 ~~pursuant to this section is not subject to civil liability for~~

317 ~~such disclosure or its consequences.~~

318 (15) The provisions of s. 766.101 apply to any consultant,

319 employee, or agent of a consultant in regards to providing

320 information relating to a participant to a medical review

321 committee if the participant authorized such disclosure ~~officer,~~

322 ~~employee, or agent of the department or the board and to any~~

323 ~~officer, employee, or agent of any entity with which the~~

324 ~~department has contracted pursuant to this section~~.

325 (16 ~~8~~)(a) A consultant retained pursuant to this section

326 and ~~subsection (2),~~ a consultant's directors, officers, ~~and~~

327 employees, or agents ~~and those acting at the direction of the~~

328 ~~consultant for the limited purpose of an emergency intervention~~

329 ~~on behalf of a licensee or student as described in subsection~~

330 ~~(2) when the consultant is unable to perform such intervention~~

331 shall be considered agents of the department for purposes of s.

332 768.28 while acting within the scope of the consultant's duties

333 under the contract with the department ~~if the contract complies~~

334 ~~with the requirements of this section. The contract must require~~

335 ~~that:~~

336 ~~1. The consultant indemnify the state for any liabilities~~

337 ~~incurred up to the limits set out in chapter 768.~~

338 ~~2. The consultant establish a quality assurance program to~~

339 ~~monitor services delivered under the contract.~~

340 ~~3. The consultant's quality assurance program, treatment,~~

341 ~~and monitoring records be evaluated quarterly.~~

342 ~~4. The consultant's quality assurance program be subject~~
343 ~~to review and approval by the department.~~
344 ~~5. The consultant operate under policies and procedures~~
345 ~~approved by the department.~~
346 ~~6. The consultant provide to the department for approval a~~
347 ~~policy and procedure manual that comports with all statutes,~~
348 ~~rules, and contract provisions approved by the department.~~
349 ~~7. The department be entitled to review the records~~
350 ~~relating to the consultant's performance under the contract for~~
351 ~~the purpose of management audits, financial audits, or program~~
352 ~~evaluation.~~
353 ~~8. All performance measures and standards be subject to~~
354 ~~verification and approval by the department.~~
355 ~~9. The department be entitled to terminate the contract~~
356 ~~with the consultant for noncompliance with the contract~~.
357 (b) In accordance with s. 284.385, the Department of

HB 645

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 645 Involuntary Examinations Under the Baker Act
SPONSOR(S): Lee, Jr.
TIED BILLS: **IDEN./SIM. BILLS:** SB 634

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Siples	McElroy
2) Civil Justice & Claims Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act") to address the mental health needs of individuals in the state. The Baker Act allows for voluntary and, under certain circumstances, involuntary, examinations of individuals suspected of having a mental illness, and establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations.

The bill adds advanced registered nurse practitioners and physician assistants to the list of health care practitioners who may initiate the involuntary examination of a person under the Baker Act.

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

The bill has an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Involuntary Examination under the Baker Act

In 1971, the Legislature passed the Florida Mental Health Act (also known as "The Baker Act"[1]), codified in part I of ch. 394, F.S., to address mental health needs in the state.[2] The Baker Act provides the authority and process for the voluntary and involuntary examination of persons who meet certain criteria, and the subsequent inpatient or outpatient placement of such individuals for treatment.

The Department of Children and Families (DCF) administers The Baker Act through receiving facilities which are designated by DCF and may be public or private facilities that provide the examination and short-term treatment of persons who meet the criteria under The Baker Act.[3] Subsequent to examination at a receiving facility, a person who requires further treatment may be transported to a treatment facility. Treatment facilities designated by DCF are state hospitals (e.g. Florida State Hospital) which provide extended treatment and hospitalization beyond what is provided in a receiving facility.[4]

Current law allows an involuntary examination if there is reason to believe a person has a mental illness and; because of the illness, the person:

- Has refused a voluntary examination after explanation of the purpose of the exam or is unable to determine for himself or herself that an examination is needed; and
- Is likely to suffer from self-neglect or substantial harm to her or his well-being, or be a danger to himself or herself or others.[5]

A person who is subject to an involuntary examination generally may not be held longer than 72 hours in a receiving facility.[6]

Courts, law enforcement officers, and certain health care practitioners are authorized to initiate such involuntary examinations.[7] A circuit court may enter an *ex parte* order stating a person meets the criteria for involuntary examination. A law enforcement officer[8] may take a person into custody who appears to meet the criteria for involuntary examination and transport them to a receiving facility for

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[1] "The Baker Act" is named for its sponsor, Representative Maxine E. Baker, one of the first two women from Dade County elected to office in the Florida Legislature. As chair of the House Committee on Mental Health, she championed the treatment of mental illness in a manner that would not sacrifice a patient's rights and dignity. Baker served five terms as a member of the Florida House of Representatives from 1963-1972 and was instrumental in the passage of the Florida Mental Health Act. *See* University of Florida Smathers Libraries, *A Guide to the Maxine E. Baker Papers, available at* http://www.library.ufl.edu/spec/pkyonge/baker.htm (last visited February 24, 2017), and Department of Children and Families and University of South Florida, Department of Mental Health Law and Policy, *2014 Baker Act User Reference Guide: The Florida Mental Health Act* (2014), *available at* http://www.dcf.state.fl.us/programs/samh/mentalhealth/laws/BakerActManual.pdf (last visited February 24, 2017).
[2] Chapter 71-131, s. 1, Laws of Fla.
[3] Section 394.455(39), F.S.
[4] Section 394.455(47), F.S.
[5] Section 394.463(1), F.S.
[6] Section 394.463(2)(g), F.S.
[7] Section 394.463(2)(a), F.S.
[8] "Law enforcement officer" means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency. Section 943.10(1), F.S.

examination. Health care practitioners may initiate an involuntary examination by executing the *Certificate of a Professional Initiating an Involuntary Examination*, an official form adopted in rule by the DCF.[9] The health care practitioner must have examined the person within the preceding 48 hours and state that the person meets the criteria for involuntary examination.[10] The Baker Act currently authorizes the following health care practitioners to initiate an involuntary examination by certificate:

- A physician licensed under ch. 458, F.S., or ch. 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders.
- A clinical psychologist, as defined in s. 490.003(7), F.S., with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure.
- A physician or psychologist employed by a facility operated by the United States Department of Veterans Affairs or the United States Department of Defense that qualifies as a receiving or treatment facility.
- A psychiatric nurse who is certified as an advanced registered nurse practitioner under s. 464.012, who has a master's degree or a doctorate in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advance practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.
- A mental health counselor licensed under ch. 491, F.S.
- A marriage and family therapist licensed under ch. 491, F.S.
- A clinical social worker licensed under ch. 491, F.S.[11]

In 2015, there were 193,410 involuntary examinations initiated in the state. Law enforcement initiated half of the involuntary examinations (50.54 percent), followed closely by mental health professionals (47.58 percent), with the remaining initiated pursuant to *ex parte* orders by judges (1.88 percent).[12]

Physician Assistants

Physician assistant (PA) licensure in Florida is governed by ss. 458.347(7) and 459.022(7), F.S. The Department of Health (DOH) licenses PAs and the Florida Council on Physician Assistants (Council) regulates them.[13] PAs are also regulated by either the Florida Board of Medicine for PAs licensed under ch. 458, F.S., or the Florida Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S. The duty of a board and its members is to make disciplinary decisions concerning whether a doctor or PA has violated the provisions of his or her practice act.[14] There are 7,527 PAs who hold active licenses in Florida.[15]

PAs may only practice under the direct or indirect supervision of a medical doctor or doctor of osteopathic medicine with whom they have a clinical relationship.[16] A supervising physician may only

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[9] The *Certificate of a Professional Initiating an Involuntary Examination* is a form created by the DCF which must be executed by health care practitioners initiating an involuntary examination under The Baker Act. The form contains information related to the person's diagnosis and the health care practitioner's personal observations of statements and behaviors that support the involuntary examination of such person. *See* Florida Department of Children and Families, *CF-MH 3052b*, incorporated by reference in Rule 65E-5.280, F.A.C., and *available at* http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/3052b.pdf. (last visited February 24, 2017).
[10] Section 394.463(2)(a)3., F.S.
[11] *Id.*
[12] Annette Christy & Christina Guenther, Baker Act Reporting Center, College of Behavioral & Community Sciences, University of South Florida, *Annual Report of Baker Act Data: Summary of 2015 Data, available at* https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/reports/BA_Annual_2015_Final.pdf (last visited February 24, 2017).
[13] The Council consists of three physicians who are members of the Board of Medicine; one member who is a member of the Board of Osteopathic Medicine, and a physician assistant appointed by the State Surgeon General. (Sections 458.347(9) and 459.022(8), F.S.)
[14] Sections 458.347(12) and 459.022(12), F.S.
[15] Email correspondence with the Department of Health, dated February 3, 2017 (on file with the Health Quality Subcommittee). The number of active licensed PAs include both in-state and out-of-state licensees.
[16] Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.

delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[17] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.[18]

To be licensed as a PA in Florida, an applicant must demonstrate to the Council:

- Satisfactory passage of the National Commission on Certification of Physician Assistant exam;
- Completion of the application and remittance of the application fee;[19]
- Completion of an approved PA training program;
- Acknowledgement of any prior felony convictions;
- Acknowledgement of any previous revocation or denial of licensure in any state;
- Two letters of recommendation; and
- If the applicant wishes to apply for prescribing authority, a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy.[20]

Licenses are renewed biennially.[21] At the time of renewal, a PA must demonstrate that he or she has met the continuing education requirements and must submit an acknowledgement that he or she has not been convicted of any felony in the previous two years.[22]

Current Florida law does not expressly allow PAs to refer for or initiate involuntary examinations under the Baker Act; however, in 2008, Attorney General Bill McCollum issued an opinion stating:

> A physician assistant pursuant to Chapter 458 or 459, Florida Statutes, may refer a patient for involuntary evaluation pursuant to section 394.463, Florida Statutes, provided that the physician assistant has experience regarding the diagnosis and treatment of mental and nervous disorders and such tasks are within the supervising physician's scope of practice.[23]

PAs are not required by law to have experience in the diagnosis and treatment of mental and nervous disorders.

Advanced Registered Nurse Practitioners

Nurse licensure is governed by part I of ch. 464, F.S. Nurses are licensed by the DOH and regulated by the Board of Nursing. Licensure requirements to practice nursing include completion of an approved educational course of study, passage of an examination approved by the DOH, acceptable criminal background screening results, and payment of applicable fees.[24]

A nurse who holds a current license to practice professional nursing may apply to be certified as an Advanced Registered Nurse Practitioner (ARNP), under s. 464.012, F.S., if the nurse meets one or more of the following requirements:

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[17] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[18] Sections 458.347(15) and 459.022(15), F.S.
[19] The application fee is $100 and the initial license fee is $205. *See* http://flboardofmedicine.gov/licensing/physician-assistant-licensure/ (last visited February 24, 2017).
[20] Sections 458.347(7) and 459.022(7), F.S.
[21] For timely renewed licenses, the renewal fee is $280 and the prescribing registration is $150. An applicant may be charged an additional fee if the license is renewed after expiration or is more than 120 days delinquent. *See* http://flboardofmedicine.gov/renewals/physician-assistants/ (last visited February 24, 2017).
[22] Sections 458.347(7)(b)-(c) and 459.022(7)(b)-(c), F.S.
[23] Op. Att'y Gen. Fla. 08-31 (2008), *available at* http://www.dcf.state.fl.us/programs/samh/MentalHealth/laws/agopinion.pdf (last visited February 24, 2017).
[24] Sections 464.008 and 464.009, F.S. As an alternative to licensure by examination, a nurse may also be eligible for licensure by endorsement.

- Satisfactory completion of a formal postbasic educational program of at least one academic year that prepares nurses for advanced or specialized practice;
- Certification by a specialty board; or
- Graduation from a program leading to a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills.

Current law defines three categories of ARNPs: certified registered nurse anesthetists, certified nurse midwives, and nurse practitioners.[25] All ARNPs, regardless of practice category, may only practice within the framework of an established protocol and under the supervision of an allopathic or osteopathic physician or dentist.[26] ARNPs may carry out treatments as specified in statute, including:[27]

- Prescribing, dispensing, administering, or ordering any drug;[28]
- Initiating appropriate therapies for certain conditions;
- Ordering diagnostic tests and physical and occupational therapy;
- Ordering any medication for administration patients in certain facilities; and
- Performing additional functions as maybe determined by rule in accordance with s. 464.003(2), F.S.[29]

In addition to the above-allowed acts, an ARNP may also perform other acts as authorized by statute and within his or her specialty.[30] Further, if it is within an ARNP's established protocol, the ARNP may establish behavioral problems and diagnosis and make treatment recommendations.[31]

Currently, only ARNPs who are "psychiatric nurses" may initiate involuntary examinations under the Baker Act.[32] To qualify as a psychiatric nurse, an ARNP must have a master's or doctoral degree in psychiatric nursing, hold a national advance practice certification as a psychiatric mental health advanced practice nurse, and two years post-master's clinical experience.

Effect of Proposed Changes

The bill authorizes PAs and ARNPs to initiate involuntary examinations under The Baker Act. The PA or ARNP must execute a certificate stating that a person he or she examined within the preceding 48 hours appears to meet the criteria for an involuntary examination for mental illness. Under current law, only a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist or clinical social worker may initiate an involuntary examination by executing such a certificate.

The bill defines a "physician assistant" and an "advanced registered nurse practitioner" in the same manner as their respective practice acts (ss. 458.347, 459.022, and 464.003, F.S.).

The bill makes necessary conforming changes due to the statutory changes made by the bill.

The bill provides an effective date of July 1, 2017.

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[25] Section 464.012(2), F.S.
[26] Section 464.012(3), F.S.
[27] *Id.*
[28] An ARNP may only prescribe controlled substances if he or she has graduated from a program leading to a master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills. An ARNP is limited to prescribing a 7-day supply of Schedule II controlled substances. Only a psychiatric nurse may prescribe psychotropic controlled substances for the treatment of mental disorders and psychiatric mental health controlled substances for children younger than 18.
[29] Section 464.003(2), F.S., defines "advanced or specialized nursing practice" to include additional activities that an ARNP may perform as approved by the Board of Nursing.
[30] Section 464.012(4), F.S.
[31] Section 464.012(4)(c)1., F.S.
[32] Section 394.463(2)(a), F.S.

B. SECTION DIRECTORY:

Section 1: Amends s. 394.455, F.S., relating to definitions.
Section 2: Amends s. 394.463, F.S., relating to involuntary examinations.
Section 3: Amends s. 39.407, F.S., relating to medical, psychiatric, and psychological examination and treatment of child; physical, mental, or substance abuse examination of person with or requesting child custody.

Section 4: Amends s. 394.495, F.S., relating to child and adolescent mental health system care; programs and services.
Section 5: Amends s. 394.496, F.S., relating to service planning.
Section 6: Amends s. 394.9085, F.S., relating to behavioral provider liability.
Section 7: Amends s. 409.972, F.S., relating to mandatory and voluntary enrollment.
Section 8: Amends s. 744.2007, F.S., relating to powers and duties.
Section 9: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   None.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

No additional rule-making is necessary to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to involuntary examinations under the
3 Baker Act; amending s. 394.455, F.S.; defining terms;
4 amending s. 394.463, F.S.; authorizing physician
5 assistants and advanced registered nurse practitioners
6 to execute a certificate under certain conditions
7 stating that he or she has examined a person and finds
8 the person appears to meet the criteria for
9 involuntary examination; amending ss. 39.407, 394.495,
10 394.496, 394.9085, 409.972, and 744.2007, F.S.;
11 conforming cross-references; providing an effective
12 date.
13
14 Be It Enacted by the Legislature of the State of Florida:
15
16 Section 1. Present subsections (5) through (48) of section
17 394.455, Florida Statutes, are redesignated as subsections (6)
18 through (49), respectively, a new subsection (5) is added to
19 that section, and present subsection (33) is amended, to read:
20 394.455 Definitions.—As used in this part, the term:
21 (5) "Advanced registered nurse practitioner" means a
22 person licensed in this state to practice professional nursing
23 and certified in advanced or specialized nursing practice, as
24 defined in s. 464.003.
25 (34) ~~(33)~~ "Physician assistant" has the same meaning as

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 defined in s. 458.347(2)(e) ~~means a person licensed under~~
27 ~~chapter 458 or chapter 459 who has experience in the diagnosis~~
28 ~~and treatment of mental disorders~~.
29 Section 2. Paragraph (a) of subsection (2) of section
30 394.463, Florida Statutes, is amended to read:
31 394.463 Involuntary examination.—
32 (2) INVOLUNTARY EXAMINATION.—
33 (a) An involuntary examination may be initiated by any one
34 of the following means:
35 1. A circuit or county court may enter an ex parte order
36 stating that a person appears to meet the criteria for
37 involuntary examination and specifying the findings on which
38 that conclusion is based. The ex parte order for involuntary
39 examination must be based on written or oral sworn testimony
40 that includes specific facts that support the findings. If other
41 less restrictive means are not available, such as voluntary
42 appearance for outpatient evaluation, a law enforcement officer,
43 or other designated agent of the court, shall take the person
44 into custody and deliver him or her to an appropriate, or the
45 nearest, facility within the designated receiving system
46 pursuant to s. 394.462 for involuntary examination. The order of
47 the court shall be made a part of the patient's clinical record.
48 A fee may not be charged for the filing of an order under this
49 subsection. A facility accepting the patient based on this order
50 must send a copy of the order to the department the next working

51 day. The order may be submitted electronically through existing
52 data systems, if available. The order shall be valid only until
53 the person is delivered to the facility or for the period
54 specified in the order itself, whichever comes first. If no time
55 limit is specified in the order, the order shall be valid for 7
56 days after the date that the order was signed.
57 2. A law enforcement officer shall take a person who
58 appears to meet the criteria for involuntary examination into
59 custody and deliver the person or have him or her delivered to
60 an appropriate, or the nearest, facility within the designated
61 receiving system pursuant to s. 394.462 for examination. The
62 officer shall execute a written report detailing the
63 circumstances under which the person was taken into custody,
64 which must be made a part of the patient's clinical record. Any
65 facility accepting the patient based on this report must send a
66 copy of the report to the department the next working day.
67 3. A physician, physician assistant, clinical
68 psychologist, psychiatric nurse, mental health counselor,
69 marriage and family therapist, ~~or~~ clinical social worker, or an
70 advanced registered nurse practitioner may execute a certificate
71 stating that he or she has examined a person within the
72 preceding 48 hours and finds that the person appears to meet the
73 criteria for involuntary examination and stating the
74 observations upon which that conclusion is based. If other less
75 restrictive means, such as voluntary appearance for outpatient

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

76 evaluation, are not available, a law enforcement officer shall
77 take into custody the person named in the certificate and
78 deliver him or her to the appropriate, or nearest, facility
79 within the designated receiving system pursuant to s. 394.462
80 for involuntary examination. The law enforcement officer shall
81 execute a written report detailing the circumstances under which
82 the person was taken into custody. The report and certificate
83 shall be made a part of the patient's clinical record. Any
84 facility accepting the patient based on this certificate must
85 send a copy of the certificate to the department the next
86 working day. The document may be submitted electronically
87 through existing data systems, if applicable.
88 Section 3. Paragraph (a) of subsection (3) of section
89 39.407, Florida Statutes, is amended to read:
90 39.407 Medical, psychiatric, and psychological examination
91 and treatment of child; physical, mental, or substance abuse
92 examination of person with or requesting child custody.—
93 (3)(a)1. Except as otherwise provided in subparagraph
94 (b)1. or paragraph (e), before the department provides
95 psychotropic medications to a child in its custody, the
96 prescribing physician shall attempt to obtain express and
97 informed consent, as defined in s. 394.455(16) ~~s. 394.455(15)~~
98 and as described in s. 394.459(3)(a), from the child's parent or
99 legal guardian. The department must take steps necessary to
100 facilitate the inclusion of the parent in the child's

101 consultation with the physician. However, if the parental rights
102 of the parent have been terminated, the parent's location or
103 identity is unknown or cannot reasonably be ascertained, or the
104 parent declines to give express and informed consent, the
105 department may, after consultation with the prescribing
106 physician, seek court authorization to provide the psychotropic
107 medications to the child. Unless parental rights have been
108 terminated and if it is possible to do so, the department shall
109 continue to involve the parent in the decisionmaking process
110 regarding the provision of psychotropic medications. If, at any
111 time, a parent whose parental rights have not been terminated
112 provides express and informed consent to the provision of a
113 psychotropic medication, the requirements of this section that
114 the department seek court authorization do not apply to that
115 medication until such time as the parent no longer consents.
116 2. Any time the department seeks a medical evaluation to
117 determine the need to initiate or continue a psychotropic
118 medication for a child, the department must provide to the
119 evaluating physician all pertinent medical information known to
120 the department concerning that child.
121 Section 4. Paragraphs (a) and (c) of subsection (3) of
122 section 394.495, Florida Statutes, are amended to read:
123 394.495 Child and adolescent mental health system of care;
124 programs and services.—
125 (3) Assessments must be performed by:

126 (a) A professional as defined in s. 394.455(6), (8), (33),
127 (36), or (37) ~~s. 394.455(5), (7), (32), (35), or (36)~~;
128 (c) A person who is under the direct supervision of a
129 qualified professional as defined in s. 394.455(6), (8), (33),
130 (36), or (37) ~~s. 394.455(5), (7), (32), (35), or (36)~~ or a
131 professional licensed under chapter 491.
132 Section 5. Subsection (5) of section 394.496, Florida
133 Statutes, is amended to read:
134 394.496 Service planning.—
135 (5) A professional as defined in s. 394.455(6), (8), (33),
136 (36), or (37) ~~s. 394.455(5), (7), (32), (35), or (36)~~ or a
137 professional licensed under chapter 491 must be included among
138 those persons developing the services plan.
139 Section 6. Subsection (6) of section 394.9085, Florida
140 Statutes, is amended to read:
141 394.9085 Behavioral provider liability.—
142 (6) For purposes of this section, the terms
143 "detoxification services," "addictions receiving facility," and
144 "receiving facility" have the same meanings as those provided in
145 ss. 397.311(25)(a)4., 397.311(25)(a)1., and 394.455(40)
146 ~~394.455(39)~~, respectively.
147 Section 7. Paragraph (b) of subsection (1) of section
148 409.972, Florida Statutes, is amended to read:
149 409.972 Mandatory and voluntary enrollment.—
150 (1) The following Medicaid-eligible persons are exempt

151 from mandatory managed care enrollment required by s. 409.965,
152 and may voluntarily choose to participate in the managed medical
153 assistance program:
154 (b) Medicaid recipients residing in residential commitment
155 facilities operated through the Department of Juvenile Justice
156 or a treatment facility as defined in s. 394.455(48) ~~s.~~
157 ~~394.455(47)~~.
158 Section 8. Subsection (7) of section 744.2007, Florida
159 Statutes, is amended to read:
160 744.2007 Powers and duties.—
161 (7) A public guardian may not commit a ward to a treatment
162 facility, as defined in s. 394.455(48) ~~s. 394.455(47)~~, without
163 an involuntary placement proceeding as provided by law.
164 Section 9. This act shall take effect July 1, 2017.

HB 729

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 729 Music Therapists
SPONSOR(S): Ponder
TIED BILLS: **IDEN./SIM. BILLS:** SB 562

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Langston	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Music therapy is clinical, evidence-based use of music interventions to accomplish individualized goals in a therapeutic relationship. Music therapists work in a variety of settings, including hospitals, outpatient clinics, rehabilitation facilities, day care treatment centers, drug and alcohol programs, senior centers, nursing homes, correctional facilities, schools and private practice settings.

The American Music Therapy Association (AMTA) and the Certification Board for Music Therapists (CBMT), working in tandem, have established the national board certification requirements for the practice of music therapy. AMTA requires music therapists to have a bachelor's degree or higher from one of AMTA's approved colleges and universities and 1,200 hours of clinical training. Initial certification requires passage of the board certification examination. CBMT indicates that over 6,549 music therapists in the U.S. currently maintain a Music Therapist-Board Certified (MT-BC) credential. It is estimated that 253 music therapists in Florida currently maintain an MT-BC credential.

Music therapists are regulated in Connecticut, Georgia, Nevada, North Dakota, Oklahoma, Oregon, Rhode Island, and Utah. Currently, music therapists are not regulated in Florida.

HB 729 creates s. 491.017, F.S., to require music therapists to register with the Department of Health (DOH). It defines "music therapy," provides examples of acts a music therapist is authorized to perform when providing music therapy, and specifies that music therapy does not include the diagnosis or assessment of any physical, mental, or communication disorder. To register, applicants must submit an application, proof of board certification by CBMT, and pay a fee. The bill requires biennial renewal.

The bill prohibits unregistered people from practicing music therapy or holding themselves out as music therapists in Florida. The bill provides registration exemptions for certain professionals and students, if such persons do not represent that they are music therapists.

The bill authorizes DOH to establish the application, fees, and to adopt rules as necessary to administer the registration of music therapists. Application, registration and renewal fees may not to exceed $50.

The bill will have a significant negative fiscal impact on DOH, which will be partially offset by fee revenue and partially absorbed within existing resources.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Regulation of Florida Health Care Practitioners

The Division of Medical Quality Assurance (MQA) within the Department of Health (DOH) and the boards under MQA are responsible for the licensure of health care practitioners in the state. In addition to the regulatory authority in specific practice acts for each profession or occupation, ch. 456, F.S., provides general regulatory provisions that apply to all health care practitioners.

Section 456.001, F.S., defines "health care practitioner" as any person licensed under chapters 457 (acupuncture); 458 (medicine); 459 (osteopathic medicine); 460 (chiropractic medicine); 461 (podiatric medicine); 462 (naturopathic medicine); 463 (optometry); 464 (nursing); 465 (pharmacy); 466 (dentistry and dental hygiene); 467 (midwifery); 478 (electrology or electrolysis); 480 (massage therapy); 484 (opticianry and hearing aid specialists); 486 (physical therapy); 490 (psychology); 491 (psychotherapy), F.S., or parts III or IV of ch. 483 (clinical laboratory personnel or medical physicists), F.S. Additionally, the miscellaneous professions and occupations regulated in parts I, II, III, V, X, XIII, or XIV (speech-language pathology and audiology; nursing home administration; occupational therapy; respiratory therapy; dietetics and nutrition practice; athletic trainers; and orthotics, prosthetics, and pedorthics) of ch. 468, F.S., are considered health care practitioners under s. 456.001, F.S.

Music Therapy

Music therapy is the specialized use of music by a credentialed professional who develops individualized treatment and supportive interventions for people of all ages and ability levels to address their social, communication, emotional, physical, cognitive, sensory and spiritual needs.[1] After assessing the strengths and needs of each client, the qualified music therapist provides the indicated treatment including creating, singing, moving to, and/or listening to music.[2] Through this treatment the clients' abilities are strengthened and transferred to other areas of their lives.[3] Music therapy also provides avenues for communication that can be helpful to those who find it difficult to express themselves in words.[4] Research in music therapy supports its effectiveness in many areas such as: overall physical rehabilitation and facilitating movement, increasing people's motivation to become engaged in their treatment, providing emotional support for clients and their families, and providing an outlet for expression of feelings.[5]

Clinical populations served by music therapy range in age from neonates in the NICU to older adults in hospice care.[6] Music therapy services are provided in a variety of clinical settings, including psychiatric hospitals, rehabilitative facilities, medical hospitals, outpatient clinics, day care treatment centers, agencies serving persons with developmental disabilities, community mental health centers, drug and alcohol programs, senior centers, nursing homes, hospice programs, correctional facilities, halfway houses, schools, and private practice.[7]

[1] THE CERTIFIED BOARD FOR MUSIC THERAPISTS, http://www.cbmt.org/ (last visited March 2, 2017).
[2] AMERICAN MUSIC THERAPY ASSOCIATION, *What is Music Therapy*, http://www.musictherapy.org/about/musictherapy/ (last visited March 2, 2017).
[3] AMERICAN MUSIC THERAPY ASSOCIATION, *What is Music Therapy: Definitions and Quotes About Music Therapy*, http://www.musictherapy.org/about/quotes/ (last visited March 2, 2017).
[4] Id.
[5] Id.
[6] FLORIDA SENATE SUNRISE QUESTIONNAIRE, Submitted by the Florida Music Therapy State Task Force, December 16, 2015 (on file with Health Quality Subcommittee Staff).
[7] Id.

Music Therapists

Music therapists typically work with individuals who have special needs, which may include medical, learning and academic, mental health, rehabilitation, developmental, communication, or wellness needs.[8] The use of live music interventions demands that the therapist not only possess the knowledge and skills of a trained therapist, but also the unique skill set of a trained musician in order to manipulate the music therapy intervention to fit clients' needs.[9] Given the diversity of diagnoses with which music therapists work and the practice settings in which they work independently, clinical training and experience are necessary.[10]

A music therapist's clinical practice is guided by the integration of the best available research evidence, the client's needs, values, and preferences, and the expertise of the clinician.[11] Music therapists are trained to independently analyze client non-verbal, verbal, psychological, and physiological responses to music and non-music stimuli in order to be clinically effective and refrain from contra-indicated practices.[12] Music therapists use their knowledge, skills, training and experience to facilitate therapeutic, goal oriented music-based interactions that are meaningful and supportive to the function and health of their clients.[13]

Accredited Music Therapy Degree Programs

In order to become a credentialed music therapist, a student must earn a bachelor's degree or higher in music therapy from an American Music Therapy Association's (AMTA's) approved college or university. These programs require academic coursework and 1,200 hours of clinical training, including an approved supervised internship.[14] Qualified supervision of clinical training is required and coordinated or verified by the academic institution.[15]

Currently in Florida, Florida State University (FSU)[16] and the University of Miami (UM)[17] have the only accredited music therapy programs. FSU and UM both offer Bachelor's, Master's, and Doctoral degrees in Music Therapy.[18] FSU graduates approximately 35 - 40 students annually and UM graduates 10 - 12 students annually.

National Certification of Music Therapists

Two national organizations recognize the music therapy profession: the AMTA and the Certification Board for Music Therapists (CBMT). The CBMT is the only organization that credentials music therapists nationally.[19] The professional credential, Music Therapist – Board Certified (MT-BC), is granted to individuals who have successfully completed an AMTA-approved academic and clinical

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[8] Id.
[9] AMERICAN MUSIC THERAPY ASSOCIATION, *Scope of Music Therapy Practice* (2015), *available at* http://www.cbmt.org/upload/CBMT-AMTA_SoMTP_V6.pdf (last visited March 2, 2017).
[10] Id.
[11] Id.
[12] Id.
[13] Id.
[14] An internship may be approved by the academic institution, the AMTA, or by both.
[15] Internship supervisors must meet minimum requirements outlined by the AMTA Education and Clinical Training Standards. A music therapy internship supervisor must have a clinical practice in music therapy (either private or institutional) and demonstrate the following: all professional level competencies; effectiveness as a music therapy clinician in at least one area of practice; general understanding of the supervisory needs of internship students, and established skills in supervision. See AMERICAN MUSIC THERAPY ASSOCIATION, *AMTA Standards for Education and Clinical Training*, http://www.musictherapy.org/members/edctstan/ (last visited March 2, 2017).
[16] FLORIDA STATE UNIVERSITY COLLEGE OF MUSIC, *Music Therapy*, http://music.fsu.edu/programs/music-therapy (last visited March 2, 2017).
[17] FROST SCHOOL OF MUSIC UNIVERSITY OF MIAMI, *Music Therapy Program*, http://www.miami.edu/frost/index.php/music_therapy/ (last visited March 2, 2017).
[18] *Supra*, notes 16, 17.
[19] *Supra*, note 1.

training program and have passed a written objective national examination.[20] Currently, a majority of music therapists hold the MT-BC credential.[21]

The National Music Therapy Registry previously qualified music therapy professionals with the following designations: Registered Music Therapist (RMT), Certified Music Therapist (CMT), or Advanced Certified Music Therapist (ACMT).[22] While new RMT, CMT, and ACMT designations are no longer awarded, individuals who have received and continue to maintain these designations have met certain educational and clinical training standards.[23]

The Florida Music Therapy State Task Force estimates that there are 253 MT-BCs, four RMTs, and four CMTs in Florida.[24]

Regulation of Music Therapists

Music therapists are bound by the AMTA Code of Ethics, AMTA Standards of Clinical Practice, CBMT Code of Professional Practice, CBMT Board Certification Domains, and other applicable state and federal laws.[25] Both AMTA and CBMT have mechanisms to investigate violations of safe and ethical practice, which can result in disciplinary action pursuant to their codes of professional practice, including revocation of certification.[26]

Regulation of music therapists is a recent development at the state level. Wisconsin uses voluntary registration,[27] while Rhode Island has a mandatory music therapy registry.[28] Two states regulate music therapy through certification: Utah requires state certification for board-certified music therapists,[29] and Connecticut limits the provision of music therapy services to music therapists holding the MT-BC credential, and prohibits anyone without that credential from using the title of "music therapist" or "certified music therapist."[30] In addition, five states license music therapists. The first states to license music therapists were North Dakota[31] and Nevada[32] in 2011, and Georgia[33] in 2012. Oregon initiated licensure in 2015,[34] and Oklahoma was the most recent state to license music therapists, in 2016.[35]

Music therapists are not presently regulated in Florida.

<u>The Sunrise Act and Sunrise Questionnaire</u>

The Sunrise Act (the act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors in determining whether to regulate a new profession or occupation. The legislative intent in the act provides that:

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[20] THE CERTIFIED BOARD FOR MUSIC THERAPISTS, *About Certification,* http://www.cbmt.org/about-certification/ (last visited March 2, 2017).
[21] *Supra*, note 1. Over 6,638 music therapists currently maintain the MT-BC credential.
[22] AMERICAN MUSIC THERAPY ASSOCIATION, *How to Find a Music Therapist*, http://www.musictherapy.org/about/find/ (last visited March 2, 2017).
[23] Id. These designations were granted prior to 1998 and will expire in 2020. *Supra*, note 6.
[24] *Supra*, note 6.
[25] *Supra*, note 9.
[26] Id., *see also*, THE CERTIFIED BOARD FOR MUSIC THERAPISTS, *Code of Professional Practice,* http://www.cbmt.org/about-certification/code-of-professional-practice/ (last visited March 3, 2017).
[27] Wis. Stat. s. 440.03.
[28] R.I. Gen. Laws s. 23-20.8.1 et seq.
[29] Utah Code Ann. s. 58-84-102 et seq.
[30] 2016 Conn. Pub. Act page no. 66 s. 35.
[31] N.D. Cent. Code s. 43-59-01 et seq.
[32] Nev. Rev. Stat. s. 640D.010 et seq.
[33] Ca. Code Ann. 43-25A-1 et seq.
[34] Ss. 681.700 – .730, Or. Rev. Stat.
[35] Okla. Stat. tit. 59 s. 889 et seq.

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the state's police power be exercised only to the extent necessary for that purpose; and
- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.[36]

The Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.[37]

The act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees of reference.[38] This required information is traditionally compiled in a "Sunrise Questionnaire."

Music Therapist Sunrise Questionnaire

The Sunrise Questionnaire was completed by the Florida Music Therapy State Task Force (the Task Force); the Task Force was created nu the AMTA and CBMT.[39]

Florida music therapists are seeking regulation to protect the public, including certain vulnerable populations treated by music therapists, and to increase consumer access to music therapy services.[40] The Task Force claims that regulating music therapy would protect clients from the misuse of terms and techniques by unqualified individuals and to ensure competent practice.[41] According to the Task Force, there are a growing number of unqualified individuals in the state claiming to be music therapists who do not hold a music therapy degree from an accredited institution or carry the national credential of MT-BC, which has the potential to cause harm, because these individuals provide services that are not based upon evidence-based practice.[42] Their lack of formalized training and credentials may pose unnecessary and unintended risks to clients.[43] For example, the Task Force states that:

- "If the music stimulus is too complex for one's neurological system, it may cause increased agitation and dysregulation.

[36] S. 11.62(2), F.S.
[37] S. 11.62(3), F.S.
[38] S. 11.62(4), F.S.
[39] *Supra*, note 6 at 4.
[40] Id. at 6.
[41] Id. at 7.
[42] Id.
[43] Id.

- Noncompliance with safety protocols and guidelines in the clinical environment, including those related to appropriate sound environment, can result in loss, injury, infection, regression, or even death.
- Music has the potential to elicit or evoke intense emotions. The lack of, or ineffective therapeutic responses to, or processing of, these emotions may lead to short- or long- term social and psychological damage."[44]

The Task Force does not present any clinical or scientific studies to support these assertions. There is research to suggest that music therapy may be beneficial in a number of circumstances;[45] but there is only anecdotal evidence on the harms of music therapy, whether by a board-certified music therapist or not.[46] There are no studies on the outcomes of patients treated by someone who is a board-certified music therapist as compared to someone who is not.

The Task Force asserts that regulation would prevent unqualified individuals from having access to clients' confidential information and potentially compromising clients' health and wellness issues.[47]

According to the Task Force, access to medically, behaviorally, or educationally necessary music therapy services would be improved by regulation, as residents would be able to locate qualified providers recognized by the state.[48] There are some settings where the Task Force believes regulation is necessary, as with school districts; where lack or regulation prevents individuals from accessing services, because a license is required to provide services.[49] Furthermore, the Task Force claims that access to qualified music therapists would also be made easier for employers and that facilities interested in providing music therapy services would be able to utilize the state system to locate qualified professionals.

Other states have rejected proposals to regulate music therapy. For example, a sunrise review in Washington found that that while there is a therapeutic benefit of music to address the cognitive, emotional, physical, social, or functional needs of clients, there is no a clear and easily recognizable threat to public health and safety from the unregulated practice of music therapy.[50] It noted that anecdotal incidents or generalized examples of harm that even if verified would not rise to the level requiring state regulation.[51] Washington also recognized that the lack of a state credential may prevent music therapists from being employed in certain educational and state mental health facilities, or may prevent them from being compensated for services by insurance or some government programs; however, it found those barriers to be outside the scope of the sunrise review criteria.[52]

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[44] Id.
[45] Music interventions may have beneficial effects on anxiety, pain, fatigue, and quality of life in people with cancer. Bradt, Dileo, Magill, and Teague. *Music interventions for improving psychological and physical outcomes in cancer patients*, COCHRANE DATABASE SYSTEM REV. Aug. 15, 2016, https://www.ncbi.nlm.nih.gov/pubmed/27524661 (last visited March 4, 2017). Instrument-based music interventions can improve fine motor dexterity and gross motor functions in stroke. Moumgjian, Sarkamo, Leone, Leman, and Feys, *Effectiveness of music-based interventions on motricity or cognitive functioning in neurological populations: a systematic review.*, EUR. J PHYS. REHABIL. MED., Nov. 23, 2016, https://www.ncbi.nlm.nih.gov/pubmed/27879960 (last visited March 4, 2017).
[46] *See, e.g.,* Steve Swayne, *The Dangers of Overestimating Music Therapy*, THE ATLANTIC, Jul. 15, 2014, https://www.theatlantic.com/health/archive/2014/07/the-dangers-of-overestimating-music-therapy/374402/ (last visited March 4, 2017) (using music to awaken memories in a patient suffering from dementia can cause the patient to have negative feelings, such as anxiety, sadness, or terror); and Lillieth, *Can music be dangerous? YES!*, MILESTONE MUSIC THERAPY, Mar. 29, 2012, http://milestone-musictherapy.com/can-music-be-dangerous-yes/ (last visited March 4, 2017) (teenager in a coma following a traumatic brain injury experienced increased agitation and heart rate, and decreased oxygen saturation rates when someone who claimed to be a music therapist, but was not, played classical music in an attempt to help the teen relax; the teen only relaxed when someone trained as a music therapist found out his favorite music from his parents and played that for him).
[47] Id. at 7.
[48] Id. at 6.
[49] Id.
[50] WASHINGTON STATE DEPARTMENT OF HEALTH, *Information Summary and Recommendations: Music Therapy Sunrise Review*, Dec. 2012, *available at* http://www.doh.wa.gov/Portals/1/Documents/2000/MusicTherapy.pdf (last visited March 4, 2017).
[51] Id.
[52] Id.

Effect of Proposed Changes

Regulation of Music Therapists

HB 729 requires DOH to register music therapists. This creates a new regulated profession. The bill provides that it is the intent of the Legislature to regulate music therapy to protect the public from the practice of it by unregistered individuals. The bill grants title protection, such that an individual may not practice music therapy or represent himself or herself as being able to practice music therapy in Florida unless he or she registers with DOH.

The bill defines "music therapy" as the clinical and evidence based use of music interventions to accomplish individualized goals for people of all ages and ability levels within a therapeutic relationship by a board-certified music therapist. Music therapy interventions include:

- Music improvisation;
- Receptive music listening;
- Song writing;
- Lyric discussion;
- Music and imagery;
- Singing;
- Music performance;
- Learning through music;
- Music combined with other arts;
- Music-assisted relaxation;
- Music-based patient education;
- Electronic music technology;
- Adapted music intervention; and
- Movement to music.

The bill authorizes a music therapist to:

- Accept referrals for music therapy services from other professionals involved and authorized with provision of client services;
- Collaborate with the client's primary care provider and treatment team before and while providing music therapy services to the client;
- Conduct a music therapy assessment of a client to determine whether music therapy is necessary, and if so, collecting required information to provide the appropriate type of music therapy services to the client;
- Develop an individualized music therapy treatment plan for the client based on the music therapy assessment and ensure that the plan that is consistent with any other services being provided to the client;
- Evaluate the client's response to music therapy and suggesting modifications to the music therapy treatment plan, as appropriate;
- Develop a plan for determining when music therapy services are no longer needed, in collaboration with certain persons;
- Minimize any barriers to ensure that the client receives music therapy services in the least restrictive environment;
- Collaborate with and educating the client, and the family or caregiver of the client, or any other appropriate person, about the client's needs that are being addressed in music therapy and the manner in which the music therapy treatment addresses those needs; and
- Utilize appropriate knowledge and skills to maintain an informed practice of music therapy.

The bill states that the practice of music therapy does not include the diagnosis or assessment of any physical, mental, or communication disorder.

Registration of Music Therapists

The bill directs DOH to register an applicant as a music therapist when the applicant submits:

- A completed application form issued by DOH;
- Application and registration fees;
- Proof of passing the examination for board certification; and
- Proof that the applicant is currently a board-certified music therapist.

The bill requires biennial renewal, conditioned on payment of a renewal fee and proof that the registrant continues to hold an active certificate as a board-certified music therapist. A registered music therapist must inform DOH within 10 days of a change in his or her address or status as a board certified music therapist.

DOH may deny or revoke registration or renewal of registration for failing to meet the registration requirements.

The bill authorizes DOH to establish application, registration, and renewal fees not to exceed $50 per fee, and to adopt rules necessary to administer the registration of music therapists.

Exemptions from Registration

The bill specifies it does not prohibit or restrict the practice, services, or activities of any person:

- Licensed, certified, or regulated under the laws of this state in another profession or occupation or personnel supervised by a licensed professional in this state performing work, including the use of music, incidental to the practice of his or her licensed, certified, or regulated profession or occupation, if that person does not represent himself or herself as a music therapist;
- Whose training and national certification attests to the individual's preparation and ability to practice his or her certified profession or occupation, if that person does not represent himself or herself as a music therapist;
- Practicing music therapy as an integral part of a program of study for students enrolled in an accredited music therapy program, if the student does not represent himself or herself as a music therapist; or
- Practicing music therapy under the supervision of a registered music therapist, if the person does not represent himself or herself as a music therapist.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Creates s. 491.017, relating to registered music therapists.
Section 2: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

DOH/MQA will experience an increase in revenues associated with music therapy registration and renewal fees.

DOH estimates revenues of $28,787 for the first biennium, using the maximum, $50, fees provided by the bill.[53] DOH estimates revenues $15,079 for the second biennium, using the maximum, $50, fees provided by the bill.[54]

2. Expenditures:

DOH/MQA will incur a recurring increase in workload and costs associated with the regulation of music therapists. DOH anticipates that .5 FTE will be required to carry out the provisions of this bill.[55]

DOH currently contracts services for processing of initial and renewal applications and related fees; the cost of the contracted service is based on a $7.69 per application rate. DOH projects 298 new applications will be processed for a biennial cost of $2,230.[56]

Additional costs associated with increase in workload associated the development and maintenance of a new website, online renewals, and online applications can be absorbed within DOH's existing resources.[57]

The total estimated costs are:

Estimated Cost	First Biennium	Second Biennium
Salary	$18,850/Recurring	$18,850/Recurring
Expense	$5,948/Recurring $4,296/Non-Recurring	$5,948/Recurring
Contracted Services	$2,292/Recurring Biennially	$2,292/Recurring Biennially
Human Resources	$339/Recurring	$339/Recurring
TOTAL	**$56,862**	**$52,566**

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Music therapists currently maintaining MT-BC credentials, will be required to pay registration and renewal fees to become registered and maintain their registration in Florida.

D. FISCAL COMMENTS:

None.

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[53] Department of Health, Agency Bill Analysis of 2017 House Bill 729, (February 7, 2017) (on file with Health Quality Subcommittee Staff). First biennium revenues are calculated based on 298 estimated applicants for licensure. The estimated revenue for application fees is $14,900 (298 x $50) and the estimated revenue for initial registration fees is $14,900 (298 x $50). The unlicensed activity revenues are calculated based on 298 initial licensees for a total of $1,490 (298 x $5). The fees collected are subject to the 8% general revenue surcharge and $2,503 ($14,900 + $14,900 + $1,490 * .08) is deducted from the estimated amounts to be collected.

[54] Id. Second biennium revenues are calculated based on 298 estimated registration renewals. The estimated revenue for renewal fees is $14,900 (298 x $50) The unlicensed activity revenues are calculated based on 298 initial licensees for a total of $1,490 (298 x $5). The fees collected are subject to the 8% general revenue surcharge and $1,311 ($14,900 + $1,490 * .08) is deducted from the estimated amounts to be collected.

[55] Id.

[56] Id.

[57] Id.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

   None.

B. RULE-MAKING AUTHORITY:

The bill provides rulemaking authority DOH to develop new rules relates to the registration of music therapists.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to music therapists; creating s.
3 491.017, F.S.; providing legislative intent; providing
4 definitions; establishing requirements for
5 registration as a music therapist; providing
6 responsibilities of a music therapist; requiring
7 biennial renewal of registration; prohibiting the
8 practice of music therapy unless registered; providing
9 exemptions to registration; authorizing the Department
10 of Health to adopt rules, to establish application,
11 registration, and renewal fees, and to take
12 disciplinary action against an applicant or registrant
13 who violates the act; providing an effective date.
14
15 Be It Enacted by the Legislature of the State of Florida:
16
17 Section 1. Section 491.017, Florida Statutes, is created
18 to read:
19 491.017 Registration of music therapists.—
20 (1) LEGISLATIVE INTENT.—It is the intent of this section
21 to recognize that music therapy affects the health, safety, and
22 welfare of the public and that the practice of music therapy
23 should be subject to regulation to protect the public from the
24 practice of music therapy by unregistered persons.
25 (2) DEFINITIONS.—As used in this section, the term:

26 (a) "Board-certified music therapist" means a person who
27 has completed the education and clinical training requirements
28 established by the American Music Therapy Association and who
29 holds current board certification from the national
30 Certification Board for Music Therapists.
31 (b) "Music therapist" means a person registered to
32 practice music therapy pursuant to this section.
33 (c) "Music therapy" means the clinical and evidence-based
34 use of music interventions by a board-certified music therapist
35 to accomplish individualized goals for people of all ages and
36 ability levels within a therapeutic relationship. The music
37 therapy interventions may include music improvisation, receptive
38 music listening, song writing, lyric discussion, music and
39 imagery, singing, music performance, learning through music,
40 music combined with other arts, music-assisted relaxation,
41 music-based patient education, electronic music technology,
42 adapted music intervention, and movement to music. The practice
43 of music therapy does not include the diagnosis or assessment of
44 any physical, mental, or communication disorder.
45 (3) REGISTRATION.—
46 (a) The department shall register an applicant as a music
47 therapist when the applicant submits to the department:
48 1. A completed application on a form issued by the
49 department;
50 2. Application and registration fees; and

51 3. Proof of passing the examination for board
52 certification offered by the national Certification Board for
53 Music Therapists, or any successor organization, or proof of
54 being transitioned into board certification and provides proof
55 that the applicant is currently a board-certified music
56 therapist.
57 (b) A registration issued under this section must be
58 renewed biennially by submitting to the department a renewal fee
59 and proof that the applicant holds an active certificate as a
60 board-certified music therapist.
61 (c) A registrant shall inform the department within 10
62 days after a change of the registrant's address or a change in
63 the registrant's status as a board-certified music therapist.
64 (4) RESPONSIBILITIES OF A MUSIC THERAPIST.—A music
65 therapist is authorized to:
66 (a) Accept referrals for music therapy services from
67 medical, developmental, mental health, or education
68 professionals; family members; clients; caregivers; or other
69 persons authorized to provide client services.
70 (b) Collaborate with a client's primary care provider to
71 review the client's diagnosis, treatment needs, and treatment
72 plan before providing services to a client with an identified
73 clinical or developmental need or collaborate with the client's
74 treatment team while providing music therapy services to the
75 client.

76 (c) Conduct a music therapy assessment of a client to
77 determine if treatment is indicated and, if treatment is
78 indicated, collect systematic, comprehensive, and accurate
79 information to determine the appropriateness and type of music
80 therapy services to provide for the client.
81 (d) Develop an individualized music therapy treatment
82 plan, including individualized goals, objectives, and specific
83 music therapy approaches or interventions, for the client that
84 is based on the results of the music therapy assessment and is
85 consistent with any other developmental, rehabilitative,
86 habilitative, medical, mental health, preventive, wellness, or
87 educational services being provided to the client.
88 (e) Evaluate the client's response to music therapy and
89 the music therapy treatment plan, documenting change and
90 progress and suggesting modifications, as appropriate.
91 (f) Develop a plan for determining when music therapy
92 services are no longer needed, in collaboration with the client
93 and the client's physician or other provider of health care or
94 education to the client, family members of the client, and any
95 other appropriate person upon whom the client relies for
96 support.
97 (g) Minimize barriers to ensure that the client receives
98 music therapy services in the least restrictive environment.
99 (h) Collaborate with and educate the client and the
100 client's family members, caregivers, and any other appropriate

101 persons regarding the needs of the client which are being
102 addressed in music therapy and the manner in which the music
103 therapy treatment addresses those needs.
104 (i) Use appropriate knowledge and skills to inform
105 practice, including the use of research, reasoning, and problem-
106 solving skills to determine appropriate actions in the context
107 of each specific clinical setting.
108 (5) PROHIBITED ACTS; EXEMPTIONS.—A person may not practice
109 music therapy or represent himself or herself as being able to
110 practice music therapy in this state unless the person is
111 registered pursuant to this section. This section does not
112 prohibit or restrict the practice, services, or activities of
113 the following:
114 (a) A person licensed, certified, or regulated under the
115 laws of this state in another profession or occupation, or
116 personnel supervised by a licensed professional in this state
117 performing work, including the use of music, incidental to the
118 practice of his or her licensed, certified, or regulated
119 profession or occupation, if that person does not represent
120 himself or herself as a music therapist;
121 (b) A person whose training and national certification
122 attests to the person's preparation and ability to practice his
123 or her certified profession or occupation, if that person does
124 not represent himself or herself as a music therapist;
125 (c) Any practice of music therapy as an integral part of a

126 program of study for students enrolled in an accredited music
127 therapy program, if the student does not represent himself or
128 herself as a music therapist; or
129 (d) A person who practices music therapy under the
130 supervision of a registered music therapist, if the person does
131 not represent himself or herself as a music therapist.
132 (6) DEPARTMENT AUTHORITY.—
133 (a) The department is authorized to establish application,
134 registration, and renewal fees estimated necessary to implement
135 this section, but each fee may not exceed $50.
136 (b) The department is authorized to adopt rules to
137 implement this section.
138 (c) The department may deny or revoke registration or
139 renewal of registration for violations of this section.
140 Section 2. This act shall take effect July 1, 2017.
141

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ___ (Y/N)

ADOPTED AS AMENDED ___ (Y/N)

ADOPTED W/O OBJECTION ___ (Y/N)

FAILED TO ADOPT ___ (Y/N)

WITHDRAWN ___ (Y/N)

OTHER ______

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1 Committee/Subcommittee hearing bill: Health Quality
2 Subcommittee
3 Representative Ponder offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 17-19 and insert:
7 Section 1. Part XVII of chapter 468, Florida Statutes,
8 consisting of section 468.85 Florida Statutes, is created to
9 read:
10 PART XVII MUSIC THERAPISTS
11 468.85 Registration of music therapists.-
12
13 ---
14 **T I T L E A M E N D M E N T**
15 Remove lines 2-3 and insert:

16 An act relating to music therapists; creating part XVII of ch.
17 468, F.S.; creating s. 468.85, F.S.; providing legislative
18 intent; providing

HB 763

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 763 Access to Health Care Practitioner Services
SPONSOR(S): Grant
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Siples	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

HB 763 incentivizes physicians to provide pro bono health care services to certain low-income individuals and provides an opportunity for physicians from other jurisdictions and retired physicians to provide health services to low-income and medically underserved individuals in this state.

The bill requires Department of Health (DOH) to waive the renewal fee of an allopathic or osteopathic physician who demonstrates to DOH, provision at least 160 hours of pro bono medical services to certain populations within the biennial licensure renewal period. Demonstration of 120 hours of pro bono medical services, gains an exemption from the 40 hours of continuing medical education required for license renewal. A physician is eligible to receive both a waiver of the renewal fee and an exemption from continuing education requirements.

The bill authorizes both the Board of Medicine and the Board of Osteopathic Medicine to issue restricted licenses to physicians not licensed in Florida who contract to practice for 36 months solely in the employ of the state, a federally funded community health center, a migrant health center, a free clinic, or a health provider in a health professional shortage area or medical underserved areas, as designated by the U.S. Department of Health and Human Services. An applicant for a restricted license must hold an active, unencumbered license to practice medicine in another jurisdiction of the United States or Canada and pass a background screening. Each board may issue up to 300 restricted licenses and an unlimited number to physicians who hold active, unencumbered licenses in Canada. Prior to the end of the 36-month contract, the physician must take and pass the appropriate licensing exam to become fully licensed in this state. Breach of contract precludes full licensure.

The bill also creates a registration process for retired physicians to provide volunteer health care services if the physician held an active licensed status to practice and maintained such license in good standing in this state or in another jurisdiction of the United States or Canada for at least 20 years and contracts with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in a health professional shortage area or medically underserved area. Such a physician must work under the supervision of a nonretired physician who holds an active, unencumbered license, only provide medical services of the type and within the specialty performed by the physician prior to retirement, and does not perform surgery or prescribe controlled substances. These physicians are exempt from any application, licensure, and unlicensed activity fees. Registration must be renewed biennially to demonstrate compliance with registration requirements.

The "Access to Health Care Act" (Act) was enacted in 1992 to encourage health care providers to provide care to low-income persons. The bill redefines low-income persons to include individuals that do not have health insurance and have a family income that does not exceed 400 percent of the federal poverty level, rather than the 200 percent in current law.

The bill may have an indeterminate positive impact and an indeterminate negative fiscal impact on DOH. The bill will have no impact on local governments.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Present Situation

Licensure and Regulation of Physicians

Allopathic Physicians

Chapter 458, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Medicine (allopathic board) in conjunction the Department of Health (DOH). The chapter provides, among other things, licensure requirements by examination for medical school graduates and licensure by endorsement requirements.

Allopathic Licensure by Examination

An individual seeking to be licensed by examination as an allopathic physician, must meet the following requirements:[1]

- Pay an application fee;[2]
- Be at least 21 years of age;
- Be of good moral character;
- Has not committed an act or offense that would constitute the basis for disciplining a physician, pursuant to s. 458.331, F.S.;
- Complete 2 years of post-secondary education which includes, at a minimum, courses in fields such as anatomy, biology, and chemistry prior to entering medical school;
- Meets one of the following medical education and postgraduate training requirements:
  - Is a graduate of an allopathic medical school recognized and approved by an accrediting agency recognized by the U.S. Office of Education or recognized by an appropriate governmental body of a U.S. territorial jurisdiction, and has completed at least one year of approved residency training;
  - Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to statute as meeting the standards required to accredit U.S. medical schools, and has completed at least one year of approved residency training; or
  - Is a graduate of an allopathic foreign medical school that has not been certified pursuant to statute; has an active, valid certificate issued by the Educational Commission for Foreign Medical Graduates (ECFMG),[3] has passed that commission's examination; and has completed an approved residency or fellowship of at least 2 years in one specialty area;
- Has submitted to a background screening by the DOH; and
- Has obtained a passing score on:
  - The United States Medical Licensing Examination (USMLE);

[1] Section 458.311(1), F.S.
[2] Pursuant to r. 64B8-3.002(5), F.A.C., the application fee for a person desiring to be licensed as a physician by examination is $500. The applicant must pay an initial license fee of $429. Section 766.314(4), F.S., assesses a fee to be paid with at time of an initial license to finance the Florida Birth-Related Neurological Injury Compensation Plan. The current assessment amount is $250 for most practitioners and $5,000 for obstetricians. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of licensure.
[3] A graduate of a foreign medical school does not need to present an ECFMG certification or pass its exam if the graduate received his or bachelor's degree from an accredited U.S. college or university, studied at a medical school recognized by the World Health Organization, and has completed all but the internship or social service requirements, has passed parts I and II of the National Board Medical Examiners licensing examination or the ECFMG equivalent examination. (Section 458.311, F.S.)

- A combination of the USMLE, the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or
- The Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX), if the applicant was licensed on the basis of a state board examination, is currently licensed in at least one other jurisdiction of the United States or Canada, and has practiced for a period of at least 10 years.

Allopathic Licensure by Endorsement

An individual who holds an active license to practice medicine in another jurisdiction may seek licensure by endorsement to practice medicine in Florida.[4] The applicant must meet the same requirements for licensure by examination. To qualify for licensure by endorsement, the applicant must also submit evidence of the licensed active practice of medicine in another jurisdiction for at least 2 of the preceding 4 years, or evidence of successful completion of either a board-approved postgraduate training program within 2 years preceding filing of an application or a board-approved clinical competency examination within the year preceding the filing of an application for licensure.

When the allopathic board determines that any applicant for licensure by endorsement has failed to meet, to the allopathic board's satisfaction, each of the appropriate requirements for licensure by endorsement, it may enter an order requiring one or more of the following terms:

- Refusal to certify to the DOH an application for licensure, certification, or registration;
- Certification to the DOH of an application for licensure, certification, or registration with restrictions on the scope of practice of the licensee; or
- Certification to the DOH of an application for licensure, certification, or registration with placement of the physician on probation for a period of time and subject to such conditions as the allopathic board may specify, including, but not limited to, requiring the physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another physician.

Allopathic License Renewal

Physician licenses are renewed biennially. The current fee for the timely renewal of a license is $389; this fee also applies to restricted licenses and temporary certificates for practice in areas of critical need.[5] However, if a physician holding a restricted license or temporary certificate for practice in areas of critical need submits a notarized statement from his or her employer stating that the physician will not receive monetary compensation for the provision of medical services, the renewal fees are waived.[6]

Within each biennial licensure renewal period, a physician must complete 40 hours of continuing medical education (CME) courses approved by the allopathic board. As a part of the 40 hours of CME, a licensee must also complete the following:

- A two-hour course regarding domestic violence every third biennial;[7]
- A one-hour course addressing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome no later than upon the first biennial licensure renewal;[8] and
- Two hours of CME relating to the prevention of medical errors.[9]

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[4] Section 458.313, F.S.
[5] Rule 64B8-3.003, F.A.C. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of renewal.
[6] Id.
[7] Section 456.031, F.S.
[8] Section 456.033, F.S.
[9] Section 456.013(7), F.S.

The allopathic board authorizes up to 5 hours of the required CME hours to be fulfilled by the performance of pro bono services to indigent or underserved persons or in areas of critical need.[10] The allopathic board has approved as pro bono service sites, federally funded community and migrant health centers, volunteer health care provider programs contracted to provide uncompensated care with DOH, and DOH. If pro bono services are to be provided to any other entity, the licensee must obtain prior approval for such services to apply against the CME requirement.

DOH may not renew a license until a licensee complies with all CME requirements.[11] The allopathic board may also take action against a license for failure to comply with CME requirements.

Osteopathic Physicians

Chapter 459, F.S., provides for the licensure and regulation of the practice of medicine by the Florida Board of Osteopathic Medicine (osteopathic board) in conjunction the Department of Health (DOH). The chapter provides, among other things, general licensure requirements, including by examination for medical school graduates and licensure by endorsement requirements.

Osteopathic General Licensure

An individual seeking to be licensed as an osteopathic physician must meet the following requirements:[12]

- Pay an application fee;[13]
- Be at least 21 years of age;
- Be of good moral character;
- Complete at least 3 years of preprofessional post-secondary education;
- Has not committed, or be under investigation in any jurisdiction for, an act or offense that would constitute the basis for disciplining an osteopathic physician, unless the osteopathic board determines such act does not adversely affect the applicant's present ability and fitness to practice osteopathic medicine;
- Has not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against by the licensing authority in any jurisdiction;
- Has not received less than a satisfactory evaluation from an internship, residency, or fellowship training program;
- Has submitted to a background screening by the DOH;
- Is a graduate of a medical college recognized and approved by the American Osteopathic Association;
- Successfully completes a resident internship of at least 12 months in a hospital approved by the Board of Trustees of the American Osteopathic Association or any other internship approved by the osteopathic board; and
- Obtains a passing score, as established by rule of the osteopathic board, on the examination conducted by the National Board of Osteopathic Medical Examiners or other examination approved by the osteopathic board, no more than five years prior to applying for licensure.[14]

[10] Rule 64B8-13.005(9), F.A.C. Indigency is persons of low-income (no greater than 150 percent of the federal poverty level) or uninsured persons.
[11] Section 456.031, F.S.
[12] Section 459.0055(1), F.S.
[13] Pursuant to r. 64B15-10.002, F.A.C., the application fee for a person desiring to be licensed as an osteopathic physician by examination is $200. The applicant must pay an initial license fee of $305. Section 766.314(4), F.S., assesses a fee to be paid with at time of an initial license to finance the Florida Birth-Related Neurological Injury Compensation Plan. The current assessment amount is $250.
[14] However, if an applicant has been actively licensed in another state, the initial licensure in the other state must have occurred no more than five years after the applicant obtained the passing score on the licensure examination.

Osteopathic Licensure by Endorsement

If an applicant for a license to practice osteopathic medicine is licensed in another state, the applicant must have actively practiced osteopathic medicine within the two years prior to applying for licensure in this state. If it has been more than two years since the active practice of osteopathic medicine and more than two years since completion of a resident internship, residency, or fellowship and if the osteopathic board determines that the disruption in practice has adversely affected the osteopathic physician's present ability to practice, the osteopathic board may:

- Deny the application;
- Issue the license with reasonable restrictions or conditions; or
- Issue the license upon receipt of documentation confirming the applicant has met any reasonable conditions of the osteopathic board.

Osteopathic License Renewal

Osteopathic physician licenses are renewed biennially. The current fee for the timely renewal of a license is $429; this fee also applies to restricted licenses and temporary certificates for practice in areas of critical need.[15] However, if an osteopathic physician holding a restricted license or temporary certificate for practice in areas of critical need submits a notarized statement from his or her employer stating that the physician will not receive monetary compensation for the provision of medical services, the renewal fees are waived.[16]

Within each biennial licensure renewal period, an osteopathic physician must complete 40 hours of continuing medical education (CME) courses approved by the osteopathic board. As a part of the 40 hours of CME, a licensee must also complete the following:

- A two-hour course regarding domestic violence every third biennial;[17]
- A one-hour course addressing the Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome no later than upon the first biennial licensure renewal;[18]
- Two hours of CME relating to the prevention of medical errors;[19]
- A one-hour course on profession and medical ethics education; and
- A one-hour course on the federal and state laws related to the prescribing of controlled substances.[20]

The osteopathic board authorizes up to 10 hours of the required CME hours to be fulfilled by the performance of pro bono medical services to indigent or underserved persons or in areas of critical need.[21] The osteopathic board has approved federally-funded community and migrant health centers, volunteer health care provider programs contracted to provide uncompensated care with DOH, and DOH as pro bono sites. If pro bono services are to be provided to any other entity, the licensee must obtain prior approval for such services to apply to the CME requirement.

DOH may not renew a license until a licensee complies with all CME requirements.[22] The osteopathic board may also take action against a license for failure to comply with CME requirements.

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[15] Rule 64B8-3.003, F.A.C. If a practitioner dispenses medicinal drugs, an additional fee of $100 must be paid at the time of renewal.
[16] Id.
[17] Section 456.031, F.S.
[18] Section 456.033, F.S.
[19] Section 456.013(7), F.S.
[20] Rule 64B15-13.001, F.A.C.
[21] Rule 64B15-13.005, F.A.C. Indigency is persons of low-income (no greater than 150 percent of the federal poverty level) or uninsured persons.
[22] Section 456.031, F.S.

Financial Responsibility

Both allopathic and osteopathic physicians must carry malpractice insurance or demonstrate proof of financial responsibility as a condition of licensure or prior renewal of licensure. A physician may meet this requirement by:

- Maintaining financial liability coverage in an amount of at least $100,000 per claim, with a minimum annual aggregate of at least $300,000 if the licensee does not have hospital privileges;
- Maintaining financial liability coverage in an amount of at least $250,000 per claim, with a minimum annual aggregate of at least $750,000 if the licensee does have hospital privileges;
- Maintaining an unexpired, irrevocable letter of credit or an escrow account in an amount of at least $100,000 per claim, with a minimum aggregate availability of at least $300,000 if the licensee does not have hospital privileges;
- Maintaining an unexpired, irrevocable letter of credit or an escrow account in an amount of at least $250,000 per claim, with a minimum aggregate availability of at least $750,000 if the licensee does have hospital privileges; or
- Not obtaining malpractice insurance or demonstrating financial ability but agreeing to satisfy any adverse judgments and prominently posting a notice in the reception area to notify all patients of such decision.[23]

Physician Licensure for Volunteer and Low-Income Practice

Allopathic Restricted Licenses

Current law authorizes the allopathic board to issue restricted licenses to practice medicine in this state, without examination, for physicians who contracts to practice for 24 months solely in the employ of the state or a federally funded community health center or migrant health center. An applicant for a restricted license must also:

- Meet the requirements for licensure by examination; and
- Have actively practiced medicine in another jurisdiction for at least two years of the immediately preceding four years or has completed board-approved postgraduate training within the year preceding submission of the application.[24]

A restricted licensee must take and pass the licensure examination prior to completion of the 24-month practice period. A restricted licensee who breaches the terms of his or her contract is prohibited from being licensed as a physician in this state.[25]

The allopathic board may issue up to 100 restricted licenses annually.

Osteopathic Limited Licenses

Current law authorizes the osteopathic board to issue limited licenses to certain osteopathic physicians who will only practice in areas of critical need or in medically underserved areas. Such a limited license may be issued to an individual who:

- Submits the licensure application and required application fee of $100;
- Provides proof that he or she has been licensed to practice osteopathic medicine in any jurisdiction of the United States in good standing for at least 10 years;

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[23] Sections 458.320, F.S., and 459.0085, F.S.
[24] Section 458.310, F.S.
[25] Id.

- Has completed at least 40 hours of continuing education within the preceding two year period; and
- Will only practice in the employ of public agencies, nonprofit entities, or agencies or institutions in areas of critical need or in medically underserved areas.[26]

If it has been more than three years since the applicant has actively practiced osteopathic medicine, the full-time director of the local county health department must supervise the applicant for at least six months after issuance of the limited license.

The osteopathic board must review the practice of each physician who holds a limited license at least biennially to ensure that he or she is in compliance with the practice act and rules adopted thereunder.

Temporary Certificate for Practice in Areas of Critical Need

Current law authorizes the boards to issue a temporary certificate to practice in areas of critical need to an allopathic or osteopathic physician who will practice in an area of critical need. An applicant for a temporary certificate must:

- Be actively licensed to practice medicine in any jurisdiction of the U.S.;
- Be employed by or practice in a county health department, correctional facility, Department of Veterans' Affairs clinic, federally-funded community health care center, or any other agency or institution designated by the State Surgeon General and provides health care to underserved populations; or
- Practice for a limited time to address critical physician-specialty, demographic, or geographic needs for this state's workforce as determined by the Surgeon General.[27]

The allopathic and osteopathic boards are authorized to administer an abbreviated oral examination to determine a physician's competency, but a written examination is not required.[28] If it has been more than three years since the applicant has actively practiced and the board determines the applicant lacks clinical competency, adequate skills, necessary medical knowledge, or sufficient clinical decision-making, the boards may deny the application, issue the temporary certificate with reasonable restrictions, or require the applicant to meet any reasonable conditions of the allopathic or osteopathic board prior to issuing the temporary certificate.

Fees for the temporary certificate for practice in areas of critical need include a $300 application fee and $429 initial licensure fee; however, these fees may be waived if the individual is not compensated for his or her practice.[29] The temporary certificate is only valid for as long as the Surgeon General determines that critical need remains an issue in this state.[30] However, the allopathic and osteopathic boards must review the temporary certificateholder at least annually to ensure that he or she is in compliance with the practice act and rules adopted thereunder. If noncompliance is found, the allopathic board may revoke or restrict the temporary certificate for practice in areas of critical need.

Florida Volunteer Protection Act

The Florida Volunteer Protection Act (FVPA), s. 768.1355, F.S., limits the civil liability for volunteers. Under the FVPA, any person who volunteers to perform any service for any nonprofit organization, without compensation from the nonprofit organization, regardless of whether the person is receiving compensation from another source, is an agent of the nonprofit organization when acting within the

[26] Section 459.0075, F.S., and r. 64B15-12.005, F.A.C.
[27] Sections 458.315, and 459.0076, F.S.F.S.
[28] Id.
[29] Rules 64B8-3.003 and 64B15-10.002, F.A.C.
[30] Sections 458.315(3), and 459.0076(3), F.S.

scope of any official duties.[31] The FVPA exempts volunteers from civil liability for any act or omission which results in personal injury or property damage if:

- The volunteer was acting in good faith within the scope of any official duties;
- The volunteer was acting as an ordinary reasonably prudent person would have acted under the same or similar circumstances; and
- The injury or damage was not caused by any wanton or willful misconduct of the volunteer in the performance of such duties.

If a volunteer is determined not to be liable pursuant to these provisions, the nonprofit organization for which the volunteer was performing services when the damages were caused is liable for the damages to the same extent as the nonprofit organization would have been liable if the liability limitation under the Act had not been provided.[32]

Access to Health Care Act

"The Access to Health Care Act" (Act), s. 766.1115, F.S., was enacted in 1992 to encourage health care providers to provide care to low-income persons.[33] Health care providers under the Act include, among others, allopathic and osteopathic physicians.[34] DOH administers the Act through the Volunteer Health Services Program, which works with DOH entities and community and faith-based health care providers to promote access to quality health care for the medically underserved and uninsured in this state.[35]

The Act grants sovereign immunity[36] to health care providers who execute a contract with a governmental contractor[37] and who, as agents of the state, provide volunteer, uncompensated health care services to low-income individuals. These health care providers are considered agents of the state under s.768.28(9), F.S., so have sovereign immunity while acting within the scope of duties required under the Act.[38] Therefore, the state will defend the a health care provider covered under the Act in any

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[31] Section 766.1355, F.S. Compensation does not include reimbursement for actual expenses, a stipend under the Domestic Service Volunteer Act of 1973 (i.e. Americorps and SeniorCorps), or other financial assistance that is valued at less than two-thirds of the federal minimum wage.
[32] Section 768.1355(3), F.S.
[33] Section 766.115, F.S. Low-income persons include a person who is Medicaid-eligible, a person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level, or any eligible client of the DOH who voluntarily chooses to participate in a program offered or approved by the department. A single individual whose annual income does not exceed $24,120 is at 200 percent of the federal poverty level. U.S. Department of Health and Human Services, *HHS Poverty Guidelines for 2017,* (January 26, 2017), *available at* https://aspe.hhs.gov/poverty-guidelines (last visited March 3, 2017).
[34] Section 766.1115(3)(d), F.S.,
[35] DOH, *Volunteer Health Services*, *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/index.html (last visited March 3. 2017).
[36] The legal doctrine of sovereign immunity prevents a government from being sued in its own courts without its consent. According to United States Supreme Court Justice Oliver Wendell Holmes, citing the noted 17th century Hobbes work, *Leviathan*, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." State governments in the United States, as sovereigns, inherently possess sovereign immunity. Article X, section 13 of the Florida Constitution recognizes the concept of sovereign immunity and gives the Legislature the power to waive immunity in part or in full by general law. Section 768.28, F.S., contains the limited waiver of sovereign immunity applicable to the state. Under this statute, officers, employees, and agents of the state will not be held personally liable in tort or named as a party defendant in any action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of her or his employment or function. However, personal liability may result from actions committed in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property. When an officer, employee, or agency of the state is sued, the state steps in as the party litigant and defends against the claim. A person may recover no more than $200,000 for one incident and the total for all recoveries related to one incident is limited to $300,000. The sovereign immunity recovery caps do not prevent a plaintiff from obtaining a judgment in excess of the caps, but the plaintiff cannot recover the excess damages without action by the Legislature. *See* Black's Law Dictionary, 3rd Pocket Edition, 2006; *Kawananakoa v Polyblank*, 205 U.S. 349, 353 (1907); Fla. Jur. 2d, Government Tort Liability, Sec. 1.; Section 768.28, F.S.
[37] A governmental contractor is the DOH, a county health department, a special taxing district having health care responsibilities, or a hospital owned and operated by a governmental entity. Section 766.1115(3)(c), F.S.
[38] Section 766.1115(4), F.S.

action alleging harm or injury, and any recovery would be limited to $200,000 for one incident and a total of $300,000 for all recoveries related to one incident.

A contract under the Act must pertain to volunteer, uncompensated services for which the provider may not receive compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient or any public or private third-party payor for the specific services provided to the low-income recipients covered by the contract.[39]

The Act establishes several contractual requirements for government contractors and health care providers. The contract must require the government contractor to retain the right of dismissal or termination of any health care provider delivering services under the contract[40] and to have access to the patient records of any health care provider delivering services under the contract.[41] The health care provider must, under the contract, report adverse incidents and information on treatment outcomes to the governmental contractor.[42] The governmental contractor or the health care provider must make patient selection and initial referrals.[43] The health care provider is subject to supervision and regular inspection by the governmental contractor.[44]

The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is covered under s. 768.28, F.S., for purposes of legal actions alleging medical negligence.[45]

In Fiscal Year 2015-2016, 13,195 licensed health care professionals (plus an additional 10,991 clinic staff volunteers) provided 478,511 health care services with a total value of donated goods and services of more than $298 million, under the Act.[46]

Since February 15, 2000, 10 claims have been filed against the Volunteer Health Services Program.[47]

Effect of Proposed Changes

Restricted Licenses to Practice Medicine or Osteopathic Medicine

The bill amends the criteria for the allopathic board to issue restricted licenses to practice allopathic medicine, and authorizes the osteopathic board to issue restricted licenses to practice osteopathic medicine to physicians who contract to practice for 36 months in certain settings. The contract must be for employment by:

- This state;
- A federally funded community health center;
- A migrant health center:
- A free clinic that only delivers medical diagnostic services or nonsurgical medical treatment free of charge to all low-income residents; or
- A health provider in a health professional shortage area or medical underserved areas, as designated by the U.S. Department of Health and Human Services.[48]

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[39] Section 766.1115(3)(a), F.S.
[40] Section 766.1115(4)(a), F.S
[41] Section 766.1115(4)(b), F.S
[42] Section 766.1115(4)(c), F.S
[43] Section 766.1115(4)(d), F.S
[44] Section 766.1115(4)(f), F.S.
[45] Section 766.1115(5), F.S.
[46] DOH, *Volunteer Health Services 2015-2016 Annual Report* (December 2016), *available at* http://www.floridahealth.gov/provider-and-partner-resources/getting-involved-in-public-health/volunteer-health-services-opportunities/Volunteer%20Health%20Services%20Annual%20Report%202016.pdf (last visited March 3, 2017).
[47] Id as A-1. As of April 2016.
[48] As of March 2017, Florida has 655 health professional shortage areas and 128 medically underserved areas. *See* https://datawarehouse.hrsa.gov/topics/shortageAreas.aspx (last visited March 3, 2017) (hover over Florida on the map to get the

To obtain a restricted license, an applicant must:

- Submit a completed application, along with a nonrefundable fee not to exceed $50;
- Be at least 21 years old;
- Be of good moral character;
- Have not committed an act or offense that would constitute the basis for disciplining a physician pursuant to s. 458.331, F.S., or an osteopathic physician pursuant to ch. 459, F.S.;
- Submits to a background screening by DOH, except that a Canadian applicant may provide the applicable board with a printed or electronic copy of his or her Canadian criminal history records check;
- Submits evidence of the active licensed practice of medicine or osteopathic medicine, as appropriate in another jurisdiction for at least two of the immediately preceding four years, or completion of postgraduate training approved by the appropriate board within the year preceding the filing of an application;
- Enters into a contract to practice for 36 months solely in the employ of

Additionally, an osteopathic physicians applying for a restricted license must demonstrate completion of at least three years of preprofessional postsecondary education, that he or she is not under investigation in any jurisdiction that would constitute a violation of the osteopathic medicine practice act, and that he or she has not had an application for a license to practice osteopathic medicine denied or a license to practice osteopathic medicine revoked, suspended, or otherwise acted against, by the licensing authority in any jurisdiction.

Each board may issue no more than 300 restricted licenses; however, the boards may issue an unlimited number of restricted licenses to physicians who hold active unencumbered licenses in Canada.

Prior to the conclusion of the contracted practice period, an allopathic or osteopathic physician must take the appropriate licensure examination to become fully licensed in this state. However, a physician who breaches the terms of the employment contract may not be licensed as a physician in this state.

The bill also repeals the authority of the Board of Medicine to adopt rules related to the criteria for the issuance of restricted licenses. However, both the allopathic and osteopathic boards have broad grants of rulemaking authority to adopt rules implementing statutes related to the licensure and regulation of physicians.[49] Therefore, the boards may adopt any rules necessary to implement the restricted licenses.

The bill maintains current law authorizing limited licenses for osteopathic physicians.

Volunteer Retired Physician Registration

The bill creates a registration program to allow retired physicians to practice medicine under contact with a health care provider to provide free, volunteer health care services to indigent persons or medically underserved populations in a health professional shortage area or medically underserved area as designated by the U.S. Department of Health and Human Services.

The bill authorizes a retired physician to register as a volunteer retired physician if the physician:

- Submits an application to the board within two years of changing the license to practice from active status to retired status for an allopathic physician, of if he or submits an application to

number of health professional shortage areas and click on the State Summary of Medically Underserved Areas/Populations to obtain the number of medically underserved areas).

[49] *See* s. 458.309 and 459.005, F.S.

board no more than six months before the license permanently expires and no later than two years after such expiration for an osteopathic physician;
- Provides proof of active practice medical practice for at least three of the five years immediately preceding the date on which the license changed from active status to retired status for an allopathic physician;
- Has held an active licensed status to practice and maintained such license in good standing in this state or in another jurisdiction or the United States or Canada for at least 20 years;
- Works under the supervision of a nonretired allopathic physician or osteopathic physician, as applicable, who holds an active unencumbered license; and
- Only provides medical services of the type and within the specialty performed by the physician prior to retirement and does not perform surgery or prescribe controlled substances.

DOH must waive application fee, licensure fee, and unlicensed activity fee for retired physicians who qualify for registration under the provisions of the bill. Registration must be renewed biennially to demonstrate compliance with registration requirements. If the registrant is found to be in noncompliant, the registration may be revoked or denied.

Licensure Renewals

The bill requires DOH to waive the licensure renewal fee of an allopathic or osteopathic physician who demonstrates to DOH, in a manner provided by board rule, that he or she has provided at least 160 hours of pro bono medical services to indigent persons or medically underserved populations within the biennial renewal period.

If an allopathic or osteopathic physician provides documentation to DOH that he or she has provided at least 120 hours of pro bono medical services within the biennial licensure period, he or she is exempt from the 40 hours of continuing medical education required for license renewal. This exemption would also apply to any of the specific courses, such as the courses on domestic violence and prevention of medical errors, that are calculated as a part of as a part of the required 40 hours of continuing medical education.

A physician may receive both the waiver of the licensure renewal fee and an exemption from the continuing medical education requirements if the required number of pro bono hours are provided.

Physician Licensure by Examination

Currently, allopathic physicians who hold an active unencumbered license to practice medicine in Canada who have practiced at least 10 years may use a passing score the Special Purpose Examination of the Federation of State Medical Boards of the United States to qualify for licensure in this state. The bill removes the requirement that allopathic physicians licensed in Canada must practice for 10 years to use the Special Purpose Examination of the Federation of State Medical Boards of the United States to qualify for licensure.

Access to Health Care Act

The bill increases the eligibility for services under the Act by amending the definition of low-income to mean a person without health insurance and whose family income does not exceed 400 percent of the federal poverty level, rather than the 200 percent in current law.

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 456.013, F.S., relating to department; general licensing provisions.
Section 2: Amends s. 458.310, F.S., relating to restricted licenses.

Section 3: Creates s. 458.3105, F.S., relating to registration of volunteer retired physicians.
Section 4: Amends s. 458.311, F.S., relating to licensure by examination; requirements; fees.
Section 5: Amends s. 458.319, F.S., relating to renewal of license.
Section 6: Creates s. 459.00751, F.S., relating to restricted licenses.
Section 7: Creates s. 459.00752, F.S., relating to registration of volunteer retired osteopathic physicians.
Section 8: Amends s. 459.008, F.S., relating to renewal of licenses and certificates.
Section 9: Amends s. 766.1115, F.s., relating to health care providers; creation of agency relationship with governmental contractors.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill may have an indeterminate positive fiscal impact on DOH associated with the new application fees for restricted licenses.

2. Expenditures:

   The bill may have an insignificant, indeterminate negative fiscal impact on DOH associated with the loss of licensure renewal fees for those physicians who qualify for the waiver of such fees.

   Additionally, DOH may experience an insignificant, indeterminate negative fiscal impact for rulemaking activities, and labor costs associated with processing the restricted licenses and registrations authorized under the provisions of the bill. However, current resources are sufficient to absorb such costs.[50]

   DOH may experience an indeterminate, nonrecurring negative fiscal impact for modifications to its Licensing and Enforcement Information Database to accommodate requirements of the bill.[51]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

   Physicians performing pro bono activities may not have to pay licensure renewal fees or pay for continuing education activities.

D. FISCAL COMMENTS:

   None.

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[50] DOH, "2017 Agency Bill Analysis: House Bill 763," (February 10, 2017), on file with the Health Quality Subcommittee.
[51] Id.

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:

   None.

B. RULE-MAKING AUTHORITY:

Both the allopathic and osteopathic boards have broad grants of rulemaking authority to adopt rules under their respective practice acts; therefore, no additional rulemaking authority is needed.[52]

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

[52] *See* ss. 458.309 and 459.005, F.S.

1 A bill to be entitled
2 An act relating to access to health care practitioner
3 services; amending s. 456.013, F.S.; exempting
4 physicians who provide a certain number of hours of
5 pro bono services from continuing education
6 requirements; amending s. 458.310, F.S.; revising the
7 eligibility criteria for a restricted license;
8 prohibiting licensure if a restricted licensee
9 breaches the terms of an employment contract; creating
10 s. 458.3105, F.S.; establishing a registration program
11 for volunteer retired physicians; providing
12 eligibility criteria for such registration; requiring
13 biennial renewal of registration; authorizing the
14 Department of Health to waive certain fees;
15 authorizing the Board of Medicine to deny or revoke
16 registration for noncompliance with certain
17 requirements; amending s. 458.311, F.S.; revising the
18 physician licensure criteria applicable to Canadian
19 applicants; amending s. 458.319, F.S.; requiring the
20 department to waive a physician's license renewal fee
21 under certain circumstances; creating s. 459.00751,
22 F.S.; providing legislative intent; authorizing the
23 Board of Osteopathic Medicine to issue a restricted
24 license to qualified applicants; providing eligibility
25 criteria for such license; prohibiting licensure if a

26 restricted licensee breaches the terms of an
27 employment contract; creating s. 459.00752, F.S.;
28 establishing a registration program for volunteer
29 retired osteopathic physicians; providing eligibility
30 criteria for such registration; requiring biennial
31 renewal of registration; authorizing the Department of
32 Health to waive certain fees; authorizing the Board of
33 Osteopathic Medicine to deny or revoke registration
34 for noncompliance with certain requirements; amending
35 s. 459.008, F.S.; requiring the department to waive an
36 osteopathic physician's license renewal fee under
37 certain circumstances; amending s. 766.1115, F.S.;
38 revising the definition of the term "low-income" for
39 purposes of the Access to Health Care Act; providing
40 an effective date.
41
42 Be It Enacted by the Legislature of the State of Florida:
43
44 Section 1. Subsection (9) of section 456.013, Florida
45 Statutes, is amended to read:
46 456.013 Department; general licensing provisions.—
47 (6) As a condition of renewal of a license, the Board of
48 Medicine, the Board of Osteopathic Medicine, the Board of
49 Chiropractic Medicine, and the Board of Podiatric Medicine shall
50 each require licensees which they respectively regulate to

51 periodically demonstrate their professional competency by
52 completing at least 40 hours of continuing education every 2
53 years. The boards may require by rule that up to 1 hour of the
54 required 40 or more hours be in the area of risk management or
55 cost containment. This provision shall not be construed to limit
56 the number of hours that a licensee may obtain in risk
57 management or cost containment to be credited toward satisfying
58 the 40 or more required hours. This provision shall not be
59 construed to require the boards to impose any requirement on
60 licensees except for the completion of at least 40 hours of
61 continuing education every 2 years. Each of such boards shall
62 determine whether any specific continuing education requirements
63 not otherwise mandated by law shall be mandated and shall
64 approve criteria for, and the content of, any continuing
65 education mandated by such board. Notwithstanding any other
66 provision of law, the board, or the department when there is no
67 board, may approve by rule alternative methods of obtaining
68 continuing education credits in risk management. The alternative
69 methods may include attending a board meeting at which another
70 licensee is disciplined, serving as a volunteer expert witness
71 for the department in a disciplinary case, or serving as a
72 member of a probable cause panel following the expiration of a
73 board member's term. Other boards within the Division of Medical
74 Quality Assurance, or the department if there is no board, may
75 adopt rules granting continuing education hours in risk

76 management for attending a board meeting at which another
77 licensee is disciplined, for serving as a volunteer expert
78 witness for the department in a disciplinary case, or for
79 serving as a member of a probable cause panel following the
80 expiration of a board member's term.
81 (9) Any board that currently requires continuing education
82 for renewal of a license, or the department if there is no
83 board, shall adopt rules to establish the criteria for
84 continuing education courses. The rules may provide that up to a
85 maximum of 25 percent of the required continuing education hours
86 can be fulfilled by the performance of pro bono services to the
87 indigent or to underserved populations or in areas of critical
88 need within the state where the licensee practices. However, a
89 physician licensed under chapter 458 or chapter 459 who submits
90 to the department documentation proving that he or she has
91 completed at least 120 hours of pro bono services within a
92 biennial licensure period is exempt from the continuing
93 education requirements established by board rule under
94 subsection (6). The board, or the department if there is no
95 board, must require that any pro bono services be approved in
96 advance in order to receive credit for continuing education
97 under this subsection. The standard for determining indigency
98 shall be that recognized by the Federal Poverty Income
99 Guidelines produced by the United States Department of Health
100 and Human Services. The rules may provide for approval by the

101 board, or the department if there is no board, that a part of
102 the continuing education hours can be fulfilled by performing
103 research in critical need areas or for training leading to
104 advanced professional certification. The board, or the
105 department if there is no board, may make rules to define
106 underserved and critical need areas. The department shall adopt
107 rules for administering continuing education requirements
108 adopted by the boards or the department if there is no board.
109 Section 2. Subsections (2) and (3) of section 458.310,
110 Florida Statutes, are amended to read:
111 458.310 Restricted licenses.—
112 (2) The board ~~of Medicine~~ may annually~~, by rule, develop~~
113 ~~criteria and, without examination,~~ issue restricted licenses
114 authorizing the practice of medicine in this state to not more
115 than 300 persons and to an unlimited number of physicians who
116 hold active unencumbered licenses to practice medicine in Canada
117 if such applicants ~~annually to up to 100 persons to practice~~
118 ~~medicine in this state who~~:
119 (a) Submit to the department a completed application form
120 and a nonrefundable application fee not to exceed $50;
121 (b)~~(a)~~ Meet the requirements of s. 458.311(1)(b), (c),
122 (d), and (g). However, a Canadian applicant shall satisfy the
123 requirement of s. 458.311(1)(g) by providing the board with a
124 printed or electronic copy of his or her Canadian criminal
125 history records check;

126 (c) ~~(b)~~ Show evidence of the active licensed practice of
127 medicine in another jurisdiction for at least 2 years of the
128 immediately preceding 4 years, or completion of board-approved
129 postgraduate training within the year preceding the filing of an
130 application; and
131 (d) ~~(c)~~ Enter into a contract to practice for a period of
132 up to 36 ~~24~~ months ~~solely~~ in the employ of the state, ~~or~~ a
133 federally funded community health center, or a migrant health
134 center; a free clinic that delivers only medical diagnostic
135 services or nonsurgical medical treatment free of charge to all
136 low-income residents; or a health care provider in a health
137 professional shortage area or medically underserved area,
138 designated by the United States Department of Health and Human
139 Services~~, at the current salary level for that position~~. The
140 board may ~~of Medicine shall~~ designate other areas of critical
141 need in the state where these restricted licensees may practice.
142 (3) Before the end of the contracted ~~24-month~~ practice
143 period, the physician must take and successfully complete the
144 licensure examination under s. 458.311 to become fully licensed
145 in this state.
146 Section 3. Section 458.3105, Florida Statutes, is created
147 to read:
148 458.3105 Registration of volunteer retired physicians.—
149 (1) A physician may register under this section to
150 practice medicine as a volunteer retired physician if the

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

151 physician:
152 (a) Submits an application to the board on a form
153 developed by the department within 2 years after the date on
154 which the physician's license changed from active status to
155 retired status;
156 (b) Provides proof to the department that the physician
157 actively practiced medicine for at least 3 of the 5 years
158 immediately preceding the date on which his or her license
159 changed from active status to retired status;
160 (c) Has held an active license to practice medicine and
161 maintained such license in good standing in this state or in at
162 least one other jurisdiction of the United States or Canada for
163 at least 20 years;
164 (d) Contracts with a health care provider to provide free,
165 volunteer health care services to indigent persons or medically
166 underserved populations in health professional shortage areas or
167 medically underserved areas designated by the United States
168 Department of Health and Human Services;
169 (e) Works under the supervision of a nonretired physician
170 who holds an active unencumbered license; and
171 (f) Only provides medical services of the type and within
172 the specialty performed by the physician prior to retirement,
173 and does not perform surgery or prescribe a controlled substance
174 as defined in s. 893.02(4).
175 (2) The registrant shall apply biennially to the board for

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

176 renewal of his or her registration by demonstrating to the board
177 compliance with this section.
178 (3) The department shall waive the application fee,
179 licensure fee, and unlicensed activity fee for qualifying
180 applicants under this section.
181 (4) The board may deny or revoke registration for
182 noncompliance with this section.
183 Section 4. Paragraph (h) of subsection (1) of section
184 458.311, Florida Statutes, is amended to read:
185 458.311 Licensure by examination; requirements; fees.—
186 (1) Any person desiring to be licensed as a physician, who
187 does not hold a valid license in any state, shall apply to the
188 department on forms furnished by the department. The department
189 shall license each applicant who the board certifies:
190 (h) Has obtained a passing score, as established by rule
191 of the board, on the licensure examination of the United States
192 Medical Licensing Examination (USMLE); or a combination of the
193 United States Medical Licensing Examination (USMLE), the
194 examination of the Federation of State Medical Boards of the
195 United States, Inc. (FLEX), or the examination of the National
196 Board of Medical Examiners up to the year 2000; or for the
197 purpose of examination of any applicant who was licensed on the
198 basis of a state board examination and who is currently licensed
199 in at least one other jurisdiction of the United States ~~or~~
200 ~~Canada,~~ and who has practiced pursuant to such licensure for a

201 period of at least 10 years or for the purpose of examination of
202 any applicant who holds an active unencumbered license to
203 practice medicine in Canada, use of the Special Purpose
204 Examination of the Federation of State Medical Boards of the
205 United States (SPEX) upon receipt of a passing score as
206 established by rule of the board. However, for the purpose of
207 examination of any applicant who was licensed on the basis of a
208 state board examination prior to 1974, who is currently licensed
209 in at least three other jurisdictions of the United States or
210 Canada, and who has practiced pursuant to such licensure for a
211 period of at least 20 years, this paragraph does not apply.
212 Section 5. Subsection (1) of section 458.319, Florida
213 Statutes, is amended to read:
214 458.319 Renewal of license.—
215 (1) The department shall renew a license upon receipt of
216 the renewal application, evidence that the applicant has
217 actively practiced medicine or has been on the active teaching
218 faculty of an accredited medical school for at least 2 years of
219 the immediately preceding 4 years, and a fee not to exceed $500;
220 provided, however, that if the licensee is either a resident
221 physician, assistant resident physician, fellow, house
222 physician, or intern in an approved postgraduate training
223 program, as defined by the board by rule, the fee shall not
224 exceed $100 per annum. If the licensee demonstrates to the
225 department in a manner set by department rule that he or she has

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

226 provided at least 160 hours of pro bono medical services to
227 indigent persons or medically underserved populations within the
228 biennial renewal period, the department shall waive the renewal
229 fee. If the licensee has not actively practiced medicine for at
230 least 2 years of the immediately preceding 4 years, the board
231 shall require that the licensee successfully complete a board-
232 approved clinical competency examination prior to renewal of the
233 license. "Actively practiced medicine" means that practice of
234 medicine by physicians, including those employed by any
235 governmental entity in community or public health, as defined by
236 this chapter, including physicians practicing administrative
237 medicine. An applicant for a renewed license must also submit
238 the information required under s. 456.039 to the department on a
239 form and under procedures specified by the department, along
240 with payment in an amount equal to the costs incurred by the
241 Department of Health for the statewide criminal background check
242 of the applicant. The applicant must submit a set of
243 fingerprints to the Department of Health on a form and under
244 procedures specified by the department, along with payment in an
245 amount equal to the costs incurred by the department for a
246 national criminal background check of the applicant for the
247 initial renewal of his or her license after January 1, 2000. If
248 the applicant fails to submit either the information required
249 under s. 456.039 or a set of fingerprints to the department as
250 required by this section, the department shall issue a notice of

251 noncompliance, and the applicant will be given 30 additional
252 days to comply. If the applicant fails to comply within 30 days
253 after the notice of noncompliance is issued, the department or
254 board, as appropriate, may issue a citation to the applicant and
255 may fine the applicant up to $50 for each day that the applicant
256 is not in compliance with the requirements of s. 456.039. The
257 citation must clearly state that the applicant may choose, in
258 lieu of accepting the citation, to follow the procedure under s.
259 456.073. If the applicant disputes the matter in the citation,
260 the procedures set forth in s. 456.073 must be followed.
261 However, if the applicant does not dispute the matter in the
262 citation with the department within 30 days after the citation
263 is served, the citation becomes a final order and constitutes
264 discipline. Service of a citation may be made by personal
265 service or certified mail, restricted delivery, to the subject
266 at the applicant's last known address. If an applicant has
267 submitted fingerprints to the department for a national criminal
268 history check upon initial licensure and is renewing his or her
269 license for the first time, then the applicant need only submit
270 the information and fee required for a statewide criminal
271 history check.
272 Section 6. Section 459.00751, Florida Statutes, is created
273 to read:
274 459.00751 Restricted licenses.—
275 (1) It is the intent of the Legislature to provide medical

276 services to all residents of this state at an affordable cost.
277 (2) The board may annually issue restricted licenses
278 authorizing the practice of osteopathic medicine in this state
279 to not more than 300 persons and to an unlimited number of
280 osteopathic physicians who hold active unencumbered licenses to
281 practice medicine in Canada if such applicants:
282 (a) Submit to the department a completed application form
283 and a nonrefundable application fee not to exceed $50;
284 (b) Meet the requirements of s. 459.0055(1)(b), (c), (d),
285 (e), (f), (g), and (j). However, a Canadian applicant shall
286 satisfy the requirement of s. 459.0055(1)(j) by providing the
287 board with a printed or electronic copy of his or her Canadian
288 criminal history records check;
289 (c) Provide proof to the department that the osteopathic
290 physician has held an active license to practice osteopathic
291 medicine and maintained such license in good standing in this
292 state or in at least one other jurisdiction of the United States
293 or Canada for at least 2 of the immediately preceding 4 years,
294 or completed board-approved postgraduate training within the
295 year immediately preceding the filing of an application; and
296 (d) Enter into a contract to practice osteopathic medicine
297 for a period of up to 36 months in the employ of the state, a
298 federally funded community health center, or a migrant health
299 center; a free clinic that delivers only medical diagnostic
300 services or nonsurgical medical treatment free of charge to all

301 low-income residents; or a health care provider in a health
302 professional shortage area or medically underserved area
303 designated by the United States Department of Health and Human
304 Services. The board may designate other areas of critical need
305 in the state where these restricted licensees may practice.
306 (3) Before the end of the contracted practice period, the
307 osteopathic physician must take and successfully complete the
308 licensure examination under s. 459.0055 to become fully licensed
309 in this state.
310 (4) If the restricted licensee breaches the terms of the
311 employment contract, he or she may not be licensed as an
312 osteopathic physician in this state under any licensing
313 provisions.
314 Section 7. Section 459.00752, Florida Statutes, is created
315 to read:
316 459.00752 Registration of volunteer retired osteopathic
317 physicians.—
318 (1) An osteopathic physician may register under this
319 section to practice medicine as a volunteer retired osteopathic
320 physician if the osteopathic physician:
321 (a) Submits an application to the board on a form
322 developed by the department no earlier than 6 months before the
323 date on which the osteopathic physician's license permanently
324 expires and no later than 2 years after such expiration;
325 (b) Has held an active license to practice osteopathic

326 medicine and maintained such license in good standing in this
327 state or in at least one other jurisdiction of the United States
328 or Canada for at least 20 years;
329 (c) Contracts with a health care provider to provide free,
330 volunteer health care services to indigent persons or medically
331 underserved populations in health professional shortage areas or
332 medically underserved areas designated by the United States
333 Department of Health and Human Services;
334 (d) Works under the supervision of a nonretired
335 osteopathic physician who holds an active unencumbered license;
336 and
337 (e) Only provides medical services of the type and within
338 the specialty performed by the osteopathic physician prior to
339 retirement, and does not perform surgery or prescribe controlled
340 substances as defined in s. 893.02(4).
341 (2) The registrant shall apply biennially to the board for
342 renewal of his or her registration by demonstrating to the board
343 compliance with this section.
344 (3) The department shall waive the application fee,
345 licensure fee, and unlicensed activity fee for qualifying
346 applicants under this section.
347 (4) The board may deny or revoke registration for
348 noncompliance with this section.
349 Section 8. Subsection (1) of section 459.008, Florida
350 Statutes, is amended to read:

351 459.008 Renewal of licenses and certificates.—
352 (1) The department shall renew a license or certificate
353 upon receipt of the renewal application and fee. If the licensee
354 demonstrates to the department that he or she has provided at
355 least 160 hours of pro bono osteopathic medical services to
356 indigent persons or medically underserved populations within the
357 biennial renewal period, the department shall waive the renewal
358 fee. An applicant for a renewed license must also submit the
359 information required under s. 456.039 to the department on a
360 form and under procedures specified by the department, along
361 with payment in an amount equal to the costs incurred by the
362 department ~~of Health~~ for the statewide criminal background check
363 of the applicant. The applicant must submit a set of
364 fingerprints to the Department of Health on a form and under
365 procedures specified by the department, along with payment in an
366 amount equal to the costs incurred by the department for a
367 national criminal background check of the applicant for the
368 initial renewal of his or her license after January 1, 2000. If
369 the applicant fails to submit either the information required
370 under s. 456.039 or a set of fingerprints to the department as
371 required by this section, the department shall issue a notice of
372 noncompliance, and the applicant will be given 30 additional
373 days to comply. If the applicant fails to comply within 30 days
374 after the notice of noncompliance is issued, the department or
375 board, as appropriate, may issue a citation to the applicant and

376 may fine the applicant up to $50 for each day that the applicant
377 is not in compliance with the requirements of s. 456.039. The
378 citation must clearly state that the applicant may choose, in
379 lieu of accepting the citation, to follow the procedure under s.
380 456.073. If the applicant disputes the matter in the citation,
381 the procedures set forth in s. 456.073 must be followed.
382 However, if the applicant does not dispute the matter in the
383 citation with the department within 30 days after the citation
384 is served, the citation becomes a final order and constitutes
385 discipline. Service of a citation may be made by personal
386 service or certified mail, restricted delivery, to the subject
387 at the applicant's last known address. If an applicant has
388 submitted fingerprints to the department for a national criminal
389 history check upon initial licensure and is renewing his or her
390 license for the first time, then the applicant need only submit
391 the information and fee required for a statewide criminal
392 history check.
393 Section 9. Paragraph (e) of subsection (3) of section
394 766.1115, Florida Statutes, is amended to read:
395 766.1115 Health care providers; creation of agency
396 relationship with governmental contractors.—
397 (3) DEFINITIONS.—As used in this section, the term:
398 (e) "Low-income" means:
399 1. A person who is Medicaid-eligible under Florida law;
400 2. A person who is without health insurance and whose

401 family income does not exceed 400 ~~200~~ percent of the federal
402 poverty level as defined annually by the federal Office of
403 Management and Budget; or
404 3. Any client of the department who voluntarily chooses to
405 participate in a program offered or approved by the department
406 and meets the program eligibility guidelines of the department.
407 Section 10. This act shall take effect July 1, 2017.

COMMITTEE/SUBCOMMITTEE ACTION

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

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1 Committee/Subcommittee hearing bill: Health Quality
2 Subcommittee
3 Representative Grant, M. offered the following:
4
5 **Amendment**
6 Remove lines 121-182 and insert:
7 (b)(a) Meet the requirements of s. 458.311(1)(b), (c),
8 (d), and (g). A Canadian applicant must also provide the board
9 with a printed or electronic copy of his or her Canadian
10 criminal history records check;
11 (c)(b) Show evidence of the active licensed practice of
12 medicine in another jurisdiction for at least 2 years of the
13 immediately preceding 4 years, or completion of board-approved
14 postgraduate training within the year preceding the filing of an
15 application; and

16 (d)(c) Enter into a contract to practice for a period of
17 up to 36 24 months solely in the employ of the state, or a
18 federally funded community health center, or a migrant health
19 center; a free clinic that delivers only medical diagnostic
20 services or nonsurgical medical treatment free of charge to all
21 low-income residents; or a health care provider in a health
22 professional shortage area or medically underserved area,
23 designated by the United States Department of Health and Human
24 Services, at the current salary level for that position. The
25 board may of Medicine shall designate other areas of critical
26 need in the state where these restricted licensees may practice.
27 (3) Before the end of the contracted 24-month practice
28 period, the physician must take and successfully complete the
29 licensure examination under s. 458.311 to become fully licensed
30 in this state.
31 Section 3. Section 458.3105, Florida Statutes, is created
32 to read:
33 458.3105 Registration of volunteer retired physicians.—
34 (1) A physician may register under this section to
35 practice medicine as a volunteer retired physician if the
36 physician:
37 (a) Submits an application to the board on a form
38 developed by the department within 2 years after the date on
39 which the physician's license changed from active status to
40 retired status;

41 (b) Provides proof to the department that the physician
42 actively practiced medicine for at least 3 of the 5 years
43 immediately preceding the date on which his or her license
44 changed from active status to retired status;
45 (c) Has held an active license to practice medicine and
46 maintained such license in good standing in this state or in at
47 least one other jurisdiction of the United States or Canada for
48 at least 20 years;
49 (d) Contracts with a health care provider to provide free,
50 volunteer health care services to indigent persons or medically
51 underserved populations in health professional shortage areas or
52 medically underserved areas designated by the United States
53 Department of Health and Human Services;
54 (e) Works under the supervision of a nonretired physician
55 who holds an active unencumbered license; and
56 (f) Only provides medical services of the type and within
57 the specialty performed by the physician prior to retirement,
58 and does not perform surgery or prescribe a controlled substance
59 as defined in s. 893.02(4).
60 (2) The registrant shall apply biennially to the board for
61 renewal of his or her registration by demonstrating to the board
62 compliance with this section.
63 (3) The department shall waive the application fee,
64 licensure fee, and unlicensed activity fee for qualifying
65 applicants under this section.

66 (4) The board may deny, revoke, or impose restrictions or
67 conditions on a registration for any violation of this act or
68 chapter 456, or the rules adopted under this act or chapter 456.
69 (5) The board may deny or revoke registration for
70 noncompliance with this section.
71 Section 4. Paragraph (h) of subsection (1) of section
72 458.311, Florida Statutes, is amended to read:
73 458.311 Licensure by examination; requirements; fees.—
74 (1) Any person desiring to be licensed as a physician, who
75 does not hold a valid license in any state, shall apply to the
76 department on forms furnished by the department. The department
77 shall license each applicant who the board certifies:
78 (h) Has obtained a passing score, as established by rule
79 of the board, on the licensure examination of the United States
80 Medical Licensing Examination (USMLE); or a combination of the
81 United States Medical Licensing Examination (USMLE), the
82 examination of the Federation of State Medical Boards of the
83 United States, Inc. (FLEX), or the examination of the National
84 Board of Medical Examiners up to the year 2000; or for the
85 purpose of examination of any applicant who was licensed on the
86 basis of a state board examination and who is currently licensed
87 in at least one other jurisdiction of the United States ~~or~~
88 ~~Canada,~~ and who has practiced pursuant to such licensure for a
89 period of at least 10 years or for the purpose of examination of
90 any applicant who holds an active unencumbered license to

91 practice medicine in Canada and who has practiced pursuant to
92 such licensure of at least 10 years, use of the Special Purpose
93 Examination of the Federation of State Medical Boards of the
94 United States (SPEX) upon receipt of a passing score as
95 established by rule of the board. However, for the purpose of
96 examination of any applicant who was licensed on the basis of a
97 state board examination prior to 1974, who is currently licensed
98 in at least three other jurisdictions of the United States or
99 Canada, and who has practiced pursuant to such licensure for a
100 period of at least 20 years, this paragraph does not apply.
101 Section 5. Subsection (1) of section 458.319, Florida
102 Statutes, is amended to read:
103 458.319 Renewal of license.—
104 (1) The department shall renew a license upon receipt of
105 the renewal application, evidence that the applicant has
106 actively practiced medicine or has been on the active teaching
107 faculty of an accredited medical school for at least 2 years of
108 the immediately preceding 4 years, and a fee not to exceed $500;
109 provided, however, that if the licensee is either a resident
110 physician, assistant resident physician, fellow, house
111 physician, or intern in an approved postgraduate training
112 program, as defined by the board by rule, the fee shall not
113 exceed $100 per annum. If the licensee demonstrates to the
114 department in a manner set by department rule that he or she has
115 provided at least 160 hours of pro bono medical services to

116 indigent persons or medically underserved populations within the
117 biennial renewal period, the department shall waive the renewal
118 fee. If the licensee has not actively practiced medicine for at
119 least 2 years of the immediately preceding 4 years, the board
120 shall require that the licensee successfully complete a board-
121 approved clinical competency examination prior to renewal of the
122 license. "Actively practiced medicine" means that practice of
123 medicine by physicians, including those employed by any
124 governmental entity in community or public health, as defined by
125 this chapter, including physicians practicing administrative
126 medicine. An applicant for a renewed license must also submit
127 the information required under s. 456.039 to the department on a
128 form and under procedures specified by the department, along
129 with payment in an amount equal to the costs incurred by the
130 Department of Health for the statewide criminal background check
131 of the applicant. The applicant must submit a set of
132 fingerprints to the Department of Health on a form and under
133 procedures specified by the department, along with payment in an
134 amount equal to the costs incurred by the department for a
135 national criminal background check of the applicant for the
136 initial renewal of his or her license after January 1, 2000. If
137 the applicant fails to submit either the information required
138 under s. 456.039 or a set of fingerprints to the department as
139 required by this section, the department shall issue a notice of
140 noncompliance, and the applicant will be given 30 additional

141 days to comply. If the applicant fails to comply within 30 days
142 after the notice of noncompliance is issued, the department or
143 board, as appropriate, may issue a citation to the applicant and
144 may fine the applicant up to $50 for each day that the applicant
145 is not in compliance with the requirements of s. 456.039. The
146 citation must clearly state that the applicant may choose, in
147 lieu of accepting the citation, to follow the procedure under s.
148 456.073. If the applicant disputes the matter in the citation,
149 the procedures set forth in s. 456.073 must be followed.
150 However, if the applicant does not dispute the matter in the
151 citation with the department within 30 days after the citation
152 is served, the citation becomes a final order and constitutes
153 discipline. Service of a citation may be made by personal
154 service or certified mail, restricted delivery, to the subject
155 at the applicant's last known address. If an applicant has
156 submitted fingerprints to the department for a national criminal
157 history check upon initial licensure and is renewing his or her
158 license for the first time, then the applicant need only submit
159 the information and fee required for a statewide criminal
160 history check
161 Section 6. Section 459.00751, Florida Statutes, is created
162 to read:
163 459.00751 Restricted licenses.—
164 (1) It is the intent of the Legislature to provide medical
165 services to all residents of this state at an affordable cost.

166 (2) The board may annually issue restricted licenses
167 authorizing the practice of osteopathic medicine in this state
168 to not more than 300 persons and to an unlimited number of
169 osteopathic physicians who hold active unencumbered licenses to
170 practice medicine in Canada if such applicants:
171 (a) Submit to the department a completed application form
172 and a nonrefundable application fee not to exceed $50;
173 (b) Meet the requirements of s. 459.0055(1)(b), (c), (d),
174 (e), (f), (g), and (j). A Canadian applicant must also provide
175 the board with a printed or electronic copy of his or her
176 Canadian criminal history records check;
177 (c) Provide proof to the department that the osteopathic
178 physician has held an active license to practice osteopathic
179 medicine and maintained such license in good standing in this
180 state or in at least one other jurisdiction of the United States
181 or Canada for at least 2 of the immediately preceding 4 years,
182 or completed board-approved postgraduate training within the
183 year immediately preceding the filing of an application; and
184 (d) Enter into a contract to practice osteopathic medicine
185 for a period of up to 36 months in the employ of the state, a
186 federally funded community health center, or a migrant health
187 center; a free clinic that delivers only medical diagnostic
188 services or nonsurgical medical treatment free of charge to all
189 low-income residents; or a health care provider in a health
190 professional shortage area or medically underserved area

191 designated by the United States Department of Health and Human
192 Services. The board may designate other areas of critical need
193 in the state where these restricted licensees may practice.
194 (3) Before the end of the contracted practice period, the
195 osteopathic physician must take and successfully complete the
196 licensure examination under s. 459.0055 to become fully licensed
197 in this state.
198 (4) If the restricted licensee breaches the terms of the
199 employment contract, he or she may not be licensed as an
200 osteopathic physician in this state under any licensing
201 provisions.
202 Section 7. Section 459.00752, Florida Statutes, is created
203 to read:
204 459.00752 Registration of volunteer retired osteopathic
205 physicians.—
206 (1) An osteopathic physician may register under this
207 section to practice medicine as a volunteer retired osteopathic
208 physician if the osteopathic physician:
209 (a) Submits an application to the board on a form
210 developed by the department no earlier than 6 months before the
211 date on which the osteopathic physician's license permanently
212 expires and no later than 2 years after such expiration;
213 (b) Has held an active license to practice osteopathic
214 medicine and maintained such license in good standing in this

215 state or in at least one other jurisdiction of the United States
216 or Canada for at least 20 years;
217 (c) Contracts with a health care provider to provide free,
218 volunteer health care services to indigent persons or medically
219 underserved populations in health professional shortage areas or
220 medically underserved areas designated by the United States
221 Department of Health and Human Services;
222 (d) Works under the supervision of a nonretired
223 osteopathic physician who holds an active unencumbered license;
224 and
225 (e) Only provides medical services of the type and within
226 the specialty performed by the osteopathic physician prior to
227 retirement, and does not perform surgery or prescribe controlled
228 substances as defined in s. 893.02(4).
229 (2) The registrant shall apply biennially to the board for
230 renewal of his or her registration by demonstrating to the board
231 compliance with this section.
232 (3) The department shall waive the application fee,
233 licensure fee, and unlicensed activity fee for qualifying
234 applicants under this section.
235 (4) The board may deny, revoke, or impose restrictions or
236 conditions on a registration for any violation of this act or
237 chapter 456, or the rules adopted under this act or chapter 456.
238 (5) The board may deny or revoke registration for
239 noncompliance with this section.

HB 785

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 785 Stroke Centers
SPONSOR(S): Magar and others
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Health Quality Subcommittee		Langston	McElroy
2) Health Care Appropriations Subcommittee			
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A stroke is a serious medical condition that occurs when the blood supply to part of the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death. Stroke is one of the leading causes of death in the United States.

The Agency for Health Care Administration (AHCA) establishes criteria for primary and comprehensive stroke centers in Florida. There are 118 Florida hospitals designated as a Primary Stroke Center in 37 counties and 41 Comprehensive Stroke Centers in 16 counties. Additionally, AHCA maintains an inventory of hospitals offering stroke services.

Research indicates that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care. However, many patients with an acute stroke live in areas without ready access to a primary or comprehensive stroke center; more than half the United States population lived more than an hour away from a stroke center. Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke. A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke. Acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.

The Department of Health (DOH) provides a stroke assessment tool to emergency medical service providers, which must use it or another tool that is substantially similar. DOH sends a list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida anually.

HB 785 amends s. 395.3038, F.S. to include a new level of stroke services entitled acute stroke ready centers and adds them to the list of stroke centers DOH supplies to emergency service providers in the state.

The bill also creates a statewide stroke registry. The bill requires DOH to establish a statewide stroke registry. The registry will collect data from stroke centers and make it available for evaluation stoke care system effectiveness, to ensure compliance with standards for stroke centers, and to monitor patient outcomes. DOH may contract with a private entity to establish and maintain the registry.

DOH must adopt rules to implement the registry. AHCA must develop and adopt by rule electronic standardized forms for stroke centers to report data to DOH, including patient care quality assurance proceedings, records, or reports associated with any treatment or service provided to a person suffering a stroke.

The bill has a significant negative fiscal impact on DOH.

The bill provides an effective date of July 1, 2017.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

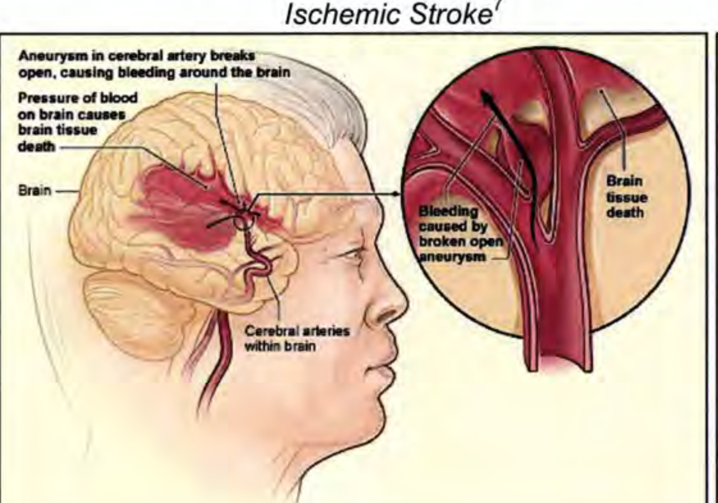
Background

<u>Stroke</u>

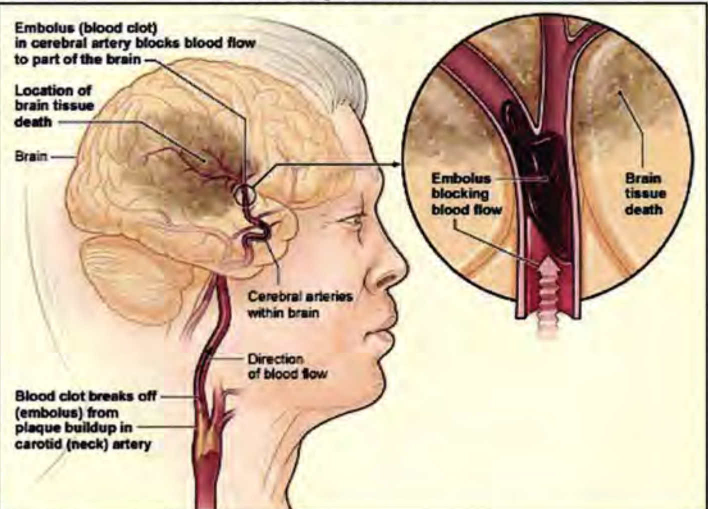
A stroke is a serious medical condition that occurs when the blood supply to part of the brain is interrupted or severely reduced, depriving brain tissue of oxygen and nutrients.[1] The brain needs a constant supply of oxygen and nutrients in order to function.[2] Even a brief interruption in blood supply from a stoke can cause problems; brain cells begin to die after just a few minutes without blood or oxygen.[3] Brain cell death causes loss of brain function, including impaired ability with movement, speech, thinking and memory, bowel and bladder, eating, emotional control, and other vital body functions. A small stroke may result in problems such as weakness in an arm or leg, whereas larger strokes may cause paralysis, loss of speech, or even death.[4] Stroke is one of the leading causes of death in the United States.[5]

There are two main types of stroke: an ischemic stroke, the more common type, which occurs when an artery that supplies oxygenated blood to the brain becomes blocked; and a hemorrhagic stroke, which occurs if an artery in the brain leaks blood or ruptures.[6]

Ischemic Stroke[7]



Hemorrhagic Stoke[8]



The two types of ischemic stroke are thrombotic and embolic.[9] In a thrombotic stroke, a blood clot, called a thrombus, forms in an artery that supplies blood to the brain.[10] In an embolic stroke, a blood clot or other substance, such as plaque, a fatty material, travels through the bloodstream to an artery in

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[1] MAYO CLINIC, *Stroke*, http://www.mayoclinic.org/diseases-conditions/stroke/home/ovc-20117264 (last visited March 2, 2017).
[2] UCLA STROKE CENTER, *What is a Stroke?*, http://stroke.ucla.edu/what-is-a-stroke (last visited March 2, 2017).
[3] Id.
[4] Id.
[5] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *What Is a Stroke?*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke (last visited March 2, 2017).
[6] Id.
[7] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *Types of Stroke*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/types (last visited March 2, 2017).
[8] Id.
[9] Id.
[10] Id.

the brain.[11] With both types of ischemic stroke, the blood clot or plaque blocks the flow of oxygenated blood to a portion of the brain.[12]

The two types of hemorrhagic stroke are intracerebral and subarachnoid.[13] In an intracerebral hemorrhage, a blood vessel inside the brain leaks blood or ruptures.[14] In a subarachnoid hemorrhage, a blood vessel on the surface of the brain leaks blood or ruptures; when this happens, bleeding occurs between the inner and middle layers of the membranes that cover the brain.[15] In both types of hemorrhagic stroke, the leaked blood causes swelling of the brain and increased pressure in the skull.[16]

Treatment

Time is of the essence for stroke treatment; medical personnel begin treatment in an ambulance on the way to the emergency room.[17] Treatment for a stroke also depends on how much time has passed since symptoms began and on whether it is ischemic or hemorrhagic.[18] Treatment for an ischemic stroke may include medicines, such as antiplatelet medicines and blood thinners, and medical procedures, but a hemorrhagic stroke may be treated with surgery to find and stop the bleeding.[19] In addition to emergency care to treat the stroke, an individual may also receive treatment to prevent another stroke and rehabilitation to treat the side effects of the stroke.[20] According to the United States Centers for Disease Control and Prevention, research indicates that patients receiving care at primary stroke centers have a higher incidence of survival and recovery than those treated in hospitals without this type of specialized care.[21]

Stroke Centers in Florida

Florida was one of the first four states, in 2004, to enact primary stroke center legislation.[22] Pursuant to s. 395.3038, F.S., the Agency for Health Care Administration (AHCA) establishes criteria for primary and comprehensive stroke centers. There are 118 Florida hospitals designated as primary stroke centers in 37 counties and 41 comprehensive stroke centers in 16 counties. [23]

Primary Stroke Centers

A primary stroke center certification recognizes hospitals that meet standards to support better outcomes for stroke care.[24] Such hospitals must have a dedicated stroke-focused program, be staffed by qualified medical professionals trained in stroke care, and provide individualized care to meet stroke patients' needs based on recommendations of the Brain Attack Coalition and guidelines published by

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[11] Id. The blood clot or other substance traveling through the bloodstream is called an embolus.
[12] Id.
[13] Id.
[14] Id.
[15] Id.
[16] Id.
[17] CENTERS FOR DISEASE CONTROL AND PREVENTION, *Stroke Treatment*, https://www.cdc.gov/stroke/treatments.htm (Last visited March 2, 2017).
[18] NATIONAL HEART, LUNG, AND BLOOD INSTITUTE, *How Is a Stroke Treated?*, https://www.nhlbi.nih.gov/health/health-topics/topics/stroke/treatment (last visited March 2, 2017).
[19] Id.
[20] *Supra*, note 17.
[21] Centers for Disease Control and Prevention, A *summary of primary stroke center policy in the United States*, (2011), available at https://www.cdc.gov/dhdsp/pubs/docs/primary_stroke_center_report.pdf (last visited March 2, 2017)
[22] S. 3, ch. 2004-325, Laws of Fla.
[23] Florida Agency for Health Care Administration, Agency Analysis of 2017 House Bill 785, (Feb. 17, 2017) (analysis on file with Health Quality Subcommittee Staff). Although stroke services is dependent upon the availability of qualified health care professionals, the majority of primary stroke centers have fewer than 300 inpatient beds and the majority of comprehensive stroke centers have more than 300 beds.
[24] AMERICAN HEART ASSOCIATION, *Primary Stroke Center Certification*, https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/PrimaryStrokeCenterCertification/Primary-Stroke-Center-Certification_UCM_439155_SubHomePage.jsp (last visited March 7, 2017).

the American Heart Association/American Stroke Association or equivalent guidelines.[25] These hospitals must also collect and utilize performance data to improve quality of care for stroke patients.[26]

In order for AHCA to designate a hospital program as a primary stroke center, the hospital program must be certified by the Joint Commission as a primary stroke center, or meet the criteria applicable to primary stroke centers as outlined in the Joint Commission Disease-Specific Care Certification Manual, 2nd Edition.[27]

Under the Joint Commission, certified primary stroke centers must meet the standards for Disease-Specific Care Certification:[28]

- Use a standardized method of delivering care;
- Support patient self-management activities;
- Tailor treatment and intervention to individual needs;
- Promote the flow of patient information across settings and providers, while protecting patient rights, security and privacy;
- Analyze and use standardized performance measure data to continually improve treatment plans; and
- Demonstrate their application of and compliance with clinical practice guidelines published by the American Heart Association/American Stroke Association or equivalent evidence-based guidelines[29]

Comprehensive Stroke Centers

A comprehensive stroke center certification recognizes hospitals that meet standards to treat the most complex stroke cases.[30] These hospitals must meet all the criteria of a primary stroke center; they must also have advanced imaging techniques and personnel trained in vascular neurology, neurosurgery and endovascular procedures available 24/7, as well as neuroscience ICU facilities and capabilities and experience and expertise treating patients with large ischemic strokes, intracerebral hemorrhage and subarachnoid hemorrhage.

In order for AHCA to designate a hospital program as a compressive stroke center, the hospital program must have received primary stroke center designation and also have personnel with clinical expertise in specified disciplines available,[31] advanced diagnostic capabilities,[32] neurological surgery

[25] Id.
[26] Id.
[27] Rule 59A-3.2085(15)(a), F.A.C. Currently, in lieu of the Joint Commission, hospitals may choose to use the Healthcare Facilities Accreditation Program or DNV GL (formerly known as Det Norske Veritas) for certification.
[28] The standards are published in the Comprehensive Certification Manual for Disease-Specific Care. They incorporate the "Recommendations for the Establishment of Primary Stroke Centers" developed by the Brain Attack Coalition. The chapters address program management, delivering or facilitating clinical care, supporting self-management, clinical information management, and performance improvement and measurement.
[29] THE JOINT COMMISSION, *Facts about Primary Stroke Center Certification*, https://www.jointcommission.org/facts_about_primary_stroke_center_certification/ (last visited March 2, 2017).
[30] AMERICAN HEART ASSOCIATION, *Comprehensive Stroke Center Certification*, https://www.heart.org/HEARTORG/Professional/HospitalAccreditationCertification/ComprehensiveStrokeCenterCertification/Comprehensive-Stroke-Center-Certification_UCM_455446_SubHomePage.jsp (last visited March 7, 2017).
[31] Rule 59A-3.2085(15)(b), F.A.C. This must include designated comprehensive stroke center medical director; neurologists, neurosurgeons, surgeons with expertise performing carotid endartrectomy, diagnostic neuroradiologists, and physicians with expertise in endovascular neuroInterventional procedures and other pertinent physicians; emergency department physicians and nurses trained in the care of stroke patients; nursing staff in the stroke unit with particular neurologic expertise who are trained in the overall care of stroke patients; nursing staff in intensive care unit with specialized training in care of patients with complex and/or severe neurological/neurosurgical conditions; advanced practice nurses with particular expertise in neurological and/or neurosurgical evaluation and treatment, physicians with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions; physicians with specialized expertise in critical care for patients with severe and/or complex neurological/neurosurgical conditions; physicians with expertise in performing and interpreting trans-thoracic echocardiography, transesophageal echocardiography, carotid duplex ultrasound and transcranial Doppler; physicians and therapists with training in rehabilitation, including physical, occupational and speech therapy; and a multidisciplinary team of health care professionals with expertise or experience in stroke, representing clinical or neuropsychology, nutrition services, pharmacy, including a Pharmacy

and endovascular interventions, [33] and specialized infrastructure,[34] and quality improvement and clinical outcomes measurement.[35] The specialized infrastructure includes extensive requirements that emergency medical services (EMS) link to ensure that EMS uses of a stroke triage assessment tool, that EMS assessment/management at the scene is consistent with evidence-based practice, facilitate inter-facility transfers, and to maintain an on-going communication system with EMS providers regarding availability of services; and that a comprehensive stroke center must:

- Maintain an acute stroke team available 24 hours per day, 7 days per week, and a system for facilitating inter-facility transfers, and a defined access telephone numbers in a system for accepting appropriate transfer;
- Maintain specialized inpatient units including an ICU with medical and nursing personnel who have special training, skills and knowledge in the management of patients with all forms of neurological/neurosurgical conditions that require intensive care; and an acute stroke unit with medical and nursing personnel who have training, skills and knowledge sufficient to care for patients with neurological conditions, particularly acute stroke patients, and who are appropriately trained in neurological assessment and management;
- Provide inpatient post-stroke rehabilitation and ensure continuing arrangements post-discharge for rehabilitation needs and medical management;
- Fulfill the educational needs of its medical and paramedical professionals by offering ongoing professional education for all disciplines; and provide education to the public and inpatients and families on risk factor reduction/management, primary and secondary prevention, the warning signs and symptoms of stroke, and medical management and rehabilitation for stroke patients;
- Provide a career development track to develop neuroscience nursing, particularly in the area of cerebrovascular disease; and
- Have the professional and administrative infrastructure necessary to conduct clinical trials and should have participated in stroke clinical trials within the last year and actively participate in ongoing clinical stroke trials.[36]

Stroke Patient Transportation

Section 395.3041(2), F.S., requires the Department of Health (DOH) to develop a stroke assessment tool. The tool is available on DOH's website and is provided to emergency medical service providers.[37] Each licensed emergency medical services provider must use a stroke-triage assessment tool that is

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Doctorate with stroke expertise, case management and social workers. Additionally, medical personnel with neurosurgical expertise must be available in a CSC on a 24 hours per day, 7 days per week basis and in-house within 2 hours, and neurologist(s) with special expertise in the management of stroke patients should be available 24 hours per day, 7 days per week.

[32] Rule 59A-3.2085(15)(b), F.A.C. This includes magnetic resonance imaging and related technologies, catheter angiography, Coaxial Tomography angiography, extracranial ultrasonography, carotid duplex, Transcranial Doppler, transthoracic and trans-esophageal echocardiography, tests of cerebral blood flow and metabolism, and comprehensive hematological and hypercoagulability profile testing.

[33] Rule 59A-3.2085(15)(b), F.A.C. This includes angioplasty and stenting of intracranial and extracranial arterial stenosis, endovascular therapy of acute stroke, endovascular treatment of intracranial aneurysms, endovascular and surgical repair of arteriovenous malformations (AVMs) and arteriovenous fistulae (AVFs), surgical clipping of intracranial aneurysms, intracranial angioplasty for vasospasm, surgical resection of AVMs and AVFs, placement of ventriculostomies and ventriculoperitoneal shunts, evacuation of intracranial hematomas, carotid endarterectomy, and decompressive craniectomy.

[34] Rule 59A-3.2085(15)(b), F.A.C.

[35] Rule 59A-3.2085(15)(b), F.A.C. The purpose of a quality improvement program is analysis of data, correction of errors, systems improvements, and ongoing improvement in patient care and delivery of services. Specific benchmarks, outcomes, and indicators should be defined, monitored, and reviewed on a regular basis for quality assurance purposes. Outcomes for procedures such as carotid endarterectomy, carotid stenting, IVtPA, endovascular/interventional stroke therapy, intracerebral aneurysm coiling, and intracerebral aneurysm clipping should be monitored. A database and/or registry should be established that allows for tracking of parameters such as length of stay, treatments received, discharge destination and status, incidence of complications (such as aspiration pneumonia, urinary tract infection, deep venous thrombosis), and discharge medications and comparing to institutions across the country. Additionally, the comprehensive stroke center must participate in a national and/or state registry (or registries) for acute stroke therapy clinical outcomes, including IVtPA and endovascular/interventional stroke therapy.

[36] Rule 59A-3.2085(15)(b), F.A.C.

[37] S. 395.3041(2), F.S.

substantially similar to DOH's stroke-triage assessment tool.[38] Annually, by June 1, DOH sends the list of primary stroke centers and comprehensive stroke centers to the medical director of each licensed emergency medical services provider in Florida.[39]

Stroke Center Inventory

AHCA must maintain an inventory of hospitals offering stroke services.[40] A listing of hospitals meeting the criteria as either a primary stroke center or comprehensive stroke center, is published on AHCA's website.[41] A list of hospitals with a stroke center designation is also available through the facility locator tool on www.floridahealthfinder.gov.[42]

Currently, there are no data reporting requirements for stroke centers related to quality measures.[43] There are 274 emergency medical service providers, 222 acute care hospitals and 25 medical examiner districts that report patient data to DOH.[44] However, the data is not standardized and much of the data that DOH currently collects comes from voluntary participation in DOH's EMS Tracking and Reporting System (EMSTARS) program[45] and only includes data on response, provider impression, procedures and medication and destination.[46]

The Florida Puerto Rico Stroke Registry

In 2009, the University of Miami Miller School of Medicine created the Florida Puerto Collaboration to Reduce Stroke Disparities (FPCRSD) aims to address stroke disparities among African Americans and Hispanics and to identify the best approaches to eliminate stroke care disparities in these groups.[47] As part of this initiative, it also created a voluntary stroke registry among hospitals in Florida and Puerto Rico currently participating in the American Heart Association's (AHA) quality improvement initiative "Get With The Guidelines Stroke."[48] The Florida Puerto Rico Stroke Registry aims to:

- Leverage the power of data already collected through the AHA's stroke database to identify and address disparities in stroke care;
- Evaluate disparities in stroke care performance metrics by race, ethnicity, and geographic regions;
- Analyze the frequency of disparities at 30-days after a stroke in terms of outcomes (mortality, hospital readmission, stroke recurrence) medication adherence, and lifestyle modifications by race, ethnicity and geographic regions;
- Evaluate the frequency of disparities in longer-term outcomes (mortality, hospital readmission, stroke recurrence) among Medicare patients and the relationship of such outcomes with acute stroke performance metrics; and
- Implement education programs among healthcare stakeholders with a focus on identifying and implementing specific culturally-tailored quality improvement programs to address disparities.[49]

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[38] Id.
[39] S. . 395.3041(1), F.S.
[40] S. 395.3038, F.S.
[41] *Supra*, note 23.
[42] Id.
[43] Id.
[44] Florida Department of Health, Agency Analysis of 2017 House Bill 785, (Feb. 1, 2017) (analysis on file with Health Quality Subcommittee Staff).
[45] The EMSTARS program allows emergency medical providers to capture incident level patient care records for every emergency activation.
[46] *Supra*, note 44.
[47] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *Florida-Puerto Rico Collaboration to Reduce Stroke Disparities: About*, http://spirp.med.miami.edu/about (last visited March 7, 2017).
[48] Id.
[49] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *Florida Puerto Rico Stroke Registry*, http://spirp.med.miami.edu/program-components/florida-puerto-rico-stroke-registry (last visited March 7, 2017).

Hospitals submit data on measures established by the AHA's "Get With The Guidelines Stroke." These reporting measures include:

- Demographic information for patients;
- Patient arrival mode;
- Time from last known well to triage (ED arrival);
- Time from ED arrival to initial imaging work-up;
- Time from hospital arrival to initiation of specified therapies;
- Types of complications seen with specified therapies;
- Reasons why eligible stroke patients were not treated with specified services;
- Rate of prescription of different types of anti-hypertensive medications, antithrombotic medication, or diabetic medications prescribed at discharge;
- In-hospital mortality and risk-adjusted mortality measures;
- Percent of patient records that are saved as complete;
- Percent of patients where the "Get With The Guidelines" criteria are met; and
- Joint Commission core measures for primary stroke centers.[50]

As of March 2014, there were 64 Florida hospitals, and nine Puerto Rican hospitals participating in the Florida-Puerto Rico Stroke Registry.[51]

Acute Stroke Ready Centers

Many patients with an acute strokes live in areas without ready access to a primary or comprehensive stroke center; more than half the United States population lives more than an hour away from a stroke center.[52] Hospitals in areas with low population densities and relatively small numbers of patients with strokes may be less likely to have the resources to become a stroke center and may lack the experience and expertise to provide ongoing care for a stroke.[53] In such settings, there is a need to distinguish between those that offer enhanced care and expertise for acute stroke versus those with only basic or no organized abilities and expertise.[54]

A recent study by the American Stroke Association proposed a new designation for hospitals that are not primary stroke centers, but can provide timely, evidence-based care to most patients with an acute stroke; these acute stroke-ready hospitals provide initial diagnostic services, stabilization, emergent care and therapies to patients with an acute stroke who are seen in their emergency department, and would then transfer these patients to a primary or comprehensive stroke center.[55]

The Joint Commission, the Healthcare Facilities Accreditation Program, and DNV GL (formerly known as Det Norske Veritas) offer certification as acute stroke ready centers.[56]

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[50] AMERICAN HEART ASSOCIATION/ AMERICAN STROKE ASSOCIATION, *Get With The Guidelines: Stroke Fact Sheet*, available at http://www.heart.org/idc/groups/heart-public/@wcm/@gwtg/documents/downloadable/ucm_310976.pdf (last visited March 7, 2017).
[51] THE UNIVERSITY OF MIAMI MILLER SCHOOL OF MEDICINE, *FL-PR Stroke Registry Participants*, http://spirp.med.miami.edu/registry-participants (last visited March 7, 2017).
[52] Mark J. Alberts, et a., *Formation and Function of Acute Stroke–Ready Hospitals Within a Stroke System of Care Recommendations From the Brain Attack Coalition*, STROKE, Vol. 44, Issue 12 (Nov. 25, 2013), http://stroke.ahajournals.org/content/44/12/3382.full (last visited March 2, 2017).
[53] Id.
[54] Id.
[55] Id.
[56] *Supra*, note 23.

Effect of the Bill

Acute Stroke Ready Centers

HB 785 amends s. 395.3038, F.S. to include a new level of stroke services, acute stroke ready centers. A hospital that meets the certification standards for acute stroke ready centers would receive the acute stroke ready center designation from AHCA in the same manner as primary and comprehensive stroke centers currently do. Currently, there are approximately 60 acute care hospitals do not have primary or comprehensive stroke center designation and may be eligible for acute stroke ready center designation.[57]

This bill also adds acute stroke ready centers in the list of stroke centers DOH supplies to emergency service providers in the state.

Stroke Center Accreditation

The bill removes language requiring AHCA to base stroke center rules solely on criteria established by the Joint Commission and expands criteria to all nationally recognized accreditation organizations.

Statewide Stroke Registry

This bill creates a statewide stroke registry, established by DOH, and requires all stroke centers, emergency medical providers, and medical examiners to submit data to DOH for the registry. The information stroke centers must submit to the registry includes quality assurance proceedings, records, and reports associated with any treatment or service provided to a person suffering a stroke. The bill does not define quality assurance proceedings or specify particular information to be provided from patient records.

DOH must ensure that the records submitted are available to be used to evaluate stroke care system effectiveness, improve or modify the stroke care systems, ensure compliance with standards for stroke centers, and monitor and improve patient outcomes. AHCA must develop and adopt by rule electronic standardized forms for stroke centers to report the data to DOH.

The bill gives DOH the option to contract with a private entity to establish and maintain the registry. Additionally, DOH must adopt rules to implement the registry.

The bill grants liability protection from damages or any other relief for any entity that provides information required by the registry.

Stroke centers that do not comply with the reporting requirements to the registry will be subject to licensure denial, modification, suspension, or revocation by AHCA. Section 395.003(7)(a), F.S., authorizes AHCA to deny, modify, suspend, and revoke a license for the substantial failure to comply with any requirements of Part I of Chapter 395, F.S., which is where the statute establishing the stroke registry is located.

The bill removes obsolete deadlines for DOH to implement the stroke-triage assessment tool..

The bill provides an effective date of July 1, 2017.

B. SECTION DIRECTORY:

Section 1: Amends s. 395.3038, F.S., relating to state-listed stroke centers; notification of hospitals.
Section 2: Creates s. 395.30381, F.S., relating to statewide stroke registry.

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[57] *Supra*, note 23.

Section 3: Amends s. 395.3041, F.S, relating to emergency medical services providers; triage and transportation of stroke victims to a stroke center.
Section 4: Provides an effective date of July 1, 2017.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   DOH estimates the need for of one to three full-time equivalents depending upon whether DOH establishes and maintains the registry itself or contracts out those responsibilities.[58]

   If DOH establishes and maintains the registry, it estimates expenditures of $11,997 in nonrecurring funds and $188,775 in recurring funds.[59] If DOH contracts with a private entity to establish and maintain the registry, it estimates expenditures of $3,999 in nonrecurring funds and $68,425 in recurring funds.[60]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   Public hospitals, emergency medical service providers, and medical examiner offices that would be required to submit data to DOH may be required the purchase of new software and incur labor costs to collect, maintain and send required data to DOH.[61] The estimated cost of this is unknown at this time.[62]

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private hospitals, emergency medical service providers, and medical examiner offices that would be required to submit data to DOH may be required the purchase of new software and incur labor costs to collect, maintain and send required data to DOH.[63] The estimated cost of this is unknown at this time.[64]

D. FISCAL COMMENTS:

None.

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[58] *Supra*, note 44. If DOH establishes a state stroke registry, it would require 3.00 FTEs to run the program: one project manager, one support/training staff, and one staff member to perform compliance functions. If it contracts with a private entity to establish and maintain the registry, it would require a minimum of 1.0 FTE to act as a stroke registry coordinator.
[59] Id.
[60] Id.
[61] Id.
[62] Id.
[63] Id.
[64] Id.

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:

   None.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

1 A bill to be entitled
2 An act relating to stroke centers; amending s.
3 395.3038, F.S.; directing the Agency for Health Care
4 Administration to include hospitals that meet the
5 criteria for acute stroke ready centers on a list of
6 stroke centers; directing the agency to adopt rules
7 governing such criteria and the development of certain
8 electronic forms to provide reports to the Department
9 of Health; creating s. 395.30381, F.S.; requiring
10 stroke centers to provide certain information to the
11 department; requiring the department to establish a
12 statewide stroke registry; providing immunity from
13 liability under certain circumstances; requiring the
14 department to adopt rules; amending s. 395.3041,
15 F.S.; conforming a provision and deleting obsolete
16 dates; providing an effective date.
17
18 Be It Enacted by the Legislature of the State of Florida:
19
20 Section 1. Section 395.3038, Florida Statutes, is amended
21 to read:
22 395.3038 State-listed ~~primary stroke centers and~~
23 ~~comprehensive~~ stroke centers; notification of hospitals.—
24 (1) The agency shall make available on its website and to
25 the department a list of the name and address of each hospital

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

26 that meets the criteria for an acute stroke ready center, a
27 primary stroke center, or ~~and the name and address of each~~
28 ~~hospital that meets the criteria for~~ a comprehensive stroke
29 center. The list of ~~primary and comprehensive~~ stroke centers
30 must include only those hospitals that attest in an affidavit
31 submitted to the agency that the hospital meets the named
32 criteria, or those hospitals that attest in an affidavit
33 submitted to the agency that the hospital is certified as an
34 acute stroke ready center, a primary stroke center, or a
35 comprehensive stroke center by a nationally recognized ~~an~~
36 accrediting organization.
37 (2)(a) If a hospital no longer chooses to meet the
38 criteria for an acute stroke ready center, a primary stroke
39 center, or a comprehensive stroke center, the hospital shall
40 notify the agency and the agency shall immediately remove the
41 hospital from the list of stroke centers.
42 (b)1. This subsection does not apply if the hospital is
43 unable to provide stroke treatment services for a period of time
44 not to exceed 2 months. The hospital shall immediately notify
45 all local emergency medical services providers when the
46 temporary unavailability of stroke treatment services begins and
47 when the services resume.
48 2. If stroke treatment services are unavailable for more
49 than 2 months, the agency shall remove the hospital from the
50 list of ~~primary or comprehensive~~ stroke centers until the

51 hospital notifies the agency that stroke treatment services have
52 been resumed.
53 (3) The agency shall adopt by rule criteria for an acute
54 stroke ready center, a primary stroke center, and a
55 comprehensive stroke center which are substantially similar to
56 the certification standards for the same categories of ~~primary~~
57 stroke centers of a nationally recognized accrediting
58 organization ~~the Joint Commission~~.
59 ~~(4) The agency shall adopt by rule criteria for a~~
60 ~~comprehensive stroke center. However, if the Joint Commission~~
61 ~~establishes criteria for a comprehensive stroke center, agency~~
62 ~~rules shall be substantially similar.~~
63 (4)~~(5)~~ This act is not a medical practice guideline and
64 may not be used to restrict the authority of a hospital to
65 provide services for which it is licensed under chapter 395. The
66 Legislature intends that all patients be treated individually
67 based on each patient's needs and circumstances.
68 (5) The agency shall adopt by rule standardized electronic
69 forms for each acute stroke ready center, primary stroke center,
70 and comprehensive stroke center to report to the department such
71 information as required in s. 395.30381.
72 Section 2. Section 395.30381, Florida Statutes, is created
73 to read:
74 395.30381 Statewide stroke registry.—
75 (1) Each acute ready stroke center, primary stroke center,

76 comprehensive stroke center, emergency medical service provider,
77 and medical examiner shall submit to the department patient care
78 quality assurance proceedings, records, or reports associated
79 with any treatment or service provided to a person suffering a
80 stroke. Such information shall be used to evaluate stroke care
81 system effectiveness, ensure compliance with standards
82 established pursuant to s. 395.3038, and monitor patient
83 outcomes.
84 (2) The department shall establish a statewide stroke
85 registry to ensure that patient care quality assurance
86 proceedings, records, and reports required to be submitted under
87 subsection (1) are maintained and available for use to improve
88 or modify the stroke care system, ensure compliance with
89 standards, and monitor stroke patient outcomes. The department
90 may contract with a private entity to establish and maintain the
91 registry. No liability of any kind or character for damages or
92 other relief shall arise or be enforced against any acute ready
93 stroke center, primary stroke center, comprehensive stroke
94 center, emergency medical service provider, or medical examiner
95 by reason of having provided such information to the department.
96 (3) The department shall adopt rules to administer this
97 section.
98 Section 3. Subsections (1), (2), and (4) of section
99 395.3041, Florida Statutes, are amended to read:
100 395.3041 Emergency medical services providers; triage and

101 transportation of stroke victims to a stroke center.—
102 (1) By June 1 of each year, the department shall send the
103 list of acute stroke ready centers, primary stroke centers, and
104 comprehensive stroke centers to the medical director of each
105 licensed emergency medical services provider in this state.
106 (2) The department shall develop a sample stroke-triage
107 assessment tool. The department must post this sample assessment
108 tool on its website and provide a copy of the assessment tool to
109 each licensed emergency medical services provider ~~no later than~~
110 ~~June 1, 2005~~. Each licensed emergency medical services provider
111 must use a stroke-triage assessment tool that is substantially
112 similar to the sample stroke-triage assessment tool provided by
113 the department.
114 (4) Each emergency medical services provider licensed
115 under chapter 401 must comply with all sections of this act ~~by~~
116 ~~July 1, 2005~~.
117 Section 4. This act shall take effect July 1, 2017.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED __ (Y/N)

ADOPTED AS AMENDED __ (Y/N)

ADOPTED W/O OBJECTION __ (Y/N)

FAILED TO ADOPT __ (Y/N)

WITHDRAWN __ (Y/N)

OTHER ____

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1 Committee/Subcommittee hearing bill: Health Quality
2 Subcommittee
3 Representative Magar offered the following:
4
5 **Amendment (with title amendment)**
6 Remove lines 68-97 and insert:
7 Section 2. Section 395.30381, Florida Statutes, is created
8 to read:
9 395.30381 Statewide stroke registry.—
10 (1) Each acute ready stroke center, primary stroke center,
11 and comprehensive stroke center shall report to the department
12 information specified in department rule, including, but not
13 limited to, demographic information, stroke severity
14 assessments, diagnostic and examination results, time from
15 symptom onset to hospital arrival, in-hospital treatments and

16 events, mortality, and discharge destination for each stroke
17 patient treated by a stroke center.
18 (2) The department shall contract with a recognized
19 medical organization in this state and its affiliated
20 institutions to establish and maintain a statewide stroke
21 registry. The medical organization shall maintain and make
22 available the reports required under this section for use in the
23 course of any study for the purpose of reducing morbidity or
24 mortality or improving the stroke care system. Such reports
25 shall be used to evaluate stroke care system effectiveness,
26 monitor patient outcomes, and improve or modify the stroke care
27 system.
28 (3) No liability of any kind or character for damages or
29 other relief shall arise or be enforced against any acute ready
30 stroke center, primary stroke center, or comprehensive stroke
31 center, by reason of having provided such information to the
32 department.
33 (4) The department shall develop electronic forms for each
34 acute ready stroke center, primary stroke center, and
35 comprehensive stroke center to report required information to
36 the registry. The department must post these forms on its
37 website.
38 (5) The department may adopt rules to administer this
39 section.
40

41 ---

42 **T I T L E A M E N D M E N T**

43 Remove lines 6-9 and insert:

44 stroke centers; creating s. 395.30381, F.S.; requiring