Tab 1	**CS/SB 474** by **HP, Grimsley**; (Similar to CS/H 00539) Hospice Care

417868	A	S	CF, Grimsley	Delete L.38 - 107:	04/14 01:17 PM

Tab 2	**CS/SB 552** by **CJ, Bracy**; (Identical to CS/H 00313) Child Support

Tab 3	**SB 1580** by **Gibson**; (Compare to CS/H 01183) Admission of Children and Adolescents to Mental Health Facilities

960350	D	S	CF, Gibson	Delete everything after	04/14 01:17 PM

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Garcia, Chair
Senator Torres, Vice Chair

MEETING DATE: Monday, April 17, 2017
TIME: 1:30—3:30 p.m.
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Garcia, Chair; Senator Torres, Vice Chair; Senators Artiles, Broxson, Campbell, and Stargel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**CS/SB 474** Health Policy / Grimsley (Similar CS/H 539, Compare S 1294)	Hospice Care; Requiring the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, to adopt national hospice outcome measures by a specified date and to make such measures available to the public; authorizing certain hospice personnel to assist in the disposal of certain prescribed controlled substances; requiring a hospice to maintain an up-to-date interdisciplinary record of care, etc. HP 03/27/2017 Fav/CS CF 04/17/2017 RC	
2	**CS/SB 552** Criminal Justice / Bracy (Identical CS/H 313)	Child Support; Citing this act as the "Florida Responsible Parent Act"; providing additional circumstances under which an obligor who fails to pay child support may avoid suspension of his or her driver license and motor vehicle registration, etc. CJ 03/06/2017 Temporarily Postponed CJ 03/27/2017 Fav/CS CF 04/17/2017 AP	
3	**SB 1580** Gibson (Compare CS/H 1183)	Admission of Children and Adolescents to Mental Health Facilities; Requiring a receiving facility or a mental health treatment facility to refer the case of a minor admitted to such facility for a mental health assessment to the clerk of the court for the appointment of a public defender within a specified timeframe; granting the minor's attorney access to relevant records, etc. CF 04/17/2017 JU AP	
4	Presentation on Characteristics of Children in Foster Homes and Group Homes by Office of Program Policy Analysis and Government Accountability (OPPAGA)		

Other Related Meeting Documents

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 474
INTRODUCER:	Health Policy Committee and Senator Grimsley
SUBJECT:	Hospice Care
DATE:	April 14, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.	Hendon	Hendon	CF	**Pre-meeting**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE – Substantial Changes

I. Summary:

CS/SB 474 amends and creates several sections of the Florida Statutes related to the provision of hospice care. The bill:

- Requires the Department of Elder Affairs (DOEA) and the Agency for Health Care Administration (AHCA) to adopt federal guidelines for hospice outcome measures by December 31, 2019, and to develop a system for reporting hospice outcomes to consumers;
- Creates new requirements for hospices that choose to assist in the disposal of prescribed controlled substances after in a patient's home after his or her death; and
- Expands the ways a person may be authorized to receive a hospice patient's medical records both before the patient's death and afterwards.

The bill is not expected to have a fiscal impact on the state and has an effective date of July 1, 2017.

II. Present Situation:

Hospice Care

Hospice care is a continuum of care for the terminally ill[1] patient and his or her family members.[2] Hospice care is provided by a team which includes physicians, nurses, medical social workers, spiritual/pastoral counselors, home health aides, therapists, bereavement counselors, and specially trained volunteers.[3] Currently there are 45 licensed hospice providers in Florida.[4] Hospices can be for-profit or non-profit and provide four levels of care:

- **Routine care** provides the patient with hospice services at home or in a home-like setting. The patient's family provides the primary care with the assistance of the hospice team.
- **Continuous care** provides the patient with skilled nursing services in his or her home during a crisis.
- **Inpatient care** is provided in a healthcare facility for symptoms of a crisis that cannot be managed in the patient's home. Inpatient care is provided on a temporary basis as determined by the patient's physician and the hospice team.
- **Respite care** is provided in a healthcare facility and is primarily to provide the patient's family members and caretakers with a period of relief.[5]

Disposal of Prescription Medication by a Hospice

While there is no statutory provision related to hospice care that addresses the disposal of prescribed controlled substances in a hospice patient's home, Rule 58A-2.005(3)(a)7 of the Florida Administrative Code, requires hospices to have policies and procedures in place for disposal of Schedule II Controlled Substances upon the patient's death. Similarly, federal Medicare standards require hospices to dispose of controlled drugs in accordance with state and federal law.[6]

Hospice Outcome Measures

Current Florida Requirements

Rule 58A-2.005(4) of the Florida Administrative Code, requires hospice providers to annually report outcome measures to the DOEA including:

- Facility demographic information;
- The effectiveness of the hospice's pain management program;[7]
- Patient and family satisfaction including:
  - Whether or not the patient received the right amount of medicine for pain; and

[1] "Terminally ill" means that the patient has a medical prognosis that his or her life expectancy is 1 year or less if the illness runs its normal course. s. 400.601, F.S.
[2] Fla. Admin. Code R. 59C-1.0355.
[3] Florida Hospice and Palliative Care Association, *About Hospice* http://www.floridahospices.org/hospice-palliative-care/about-hospice/ (last visited April 12, 2017).
[4] Agency for Health Care Administration, *Senate Bill 474 Analysis* (January 27, 2017) (on file with the Senate Committee on Health Policy).
[5] Supra note 3
[6] Supra note 4. See 21 CFR s. 1317, for the federal regulations controlling the disposal of controlled substances.
[7] Section 400.60501, F.S., requires 50 percent of patients who report severe pain at the time of admission to a hospice must report a reduction in pain to a level of five or less (on a ten point scale) by the end of the fourth day of hospice care.

  - Would the patient recommend hospice services to others; and
- Aggregate patient data including:
  - Age;
  - Race;
  - Payor source;
  - Total number of patient days by location; and
  - The number of discharges by disposition.[8]

Federal Requirements

As a condition of participation for Medicare and Medicaid certification, 42 C.F.R. 418.54(e), requires that, as a part of a comprehensive assessment of each patient, the hospice must collect data elements that allow for measurement of outcomes for each patient. The hospice is required to document and measure the data elements in the same way for each patient and the data must take into consideration all aspects of care related to hospice and palliation. Additionally, the data must be documented in a systematic and retrievable way for each patient and must be used in individual patient care planning, in coordination of services, and must be used for each hospice's quality assessment and performance improvement program.[9]

Hospice Patient Records

Currently, s. 400.611, F.S., restricts a hospice from releasing a patient's record, or any portion thereof, unless:

- The patient or legal guardian has given express written informed consent;
- A court of competent jurisdiction has ordered the record released; or
- A state or federal agency, acting under its statutory authority, requires the submission of aggregate statistical data.

Legal Guardians, Health Care Surrogacies, and Health Care Proxies.

A legal guardian is a person who is designated by a court pursuant to ch. 744, F.S., to act on the behalf of a ward's person or property. In most cases, in order to have a guardian appointed, a court must determine that the ward is incapacitated. Chapter 744, F.S., defines an incapacitated person as a person who has been judicially determined to lack the capacity to manage at least some of the property or to meet at least some of the essential health and safety requirements of the person.

Section 765.101, F.S., defines a health care surrogate as any competent adult expressly designated by a principal to make health care decisions and to receive health information. The principal may stipulate whether the authority of the surrogate to make health care decisions or to receive health information can be exercised immediately without a determination of incapacity or only upon the principal's incapacity as provided in s. 765.204, F.S. In the case of a patient who is

[8] DOEA Form H-002, *Hospice Demographic and Outcome Measures Report* (August 2008) *available at* http://elderaffairs.state.fl.us/english/hospice/DOEAformH002.xls (last visited on April 12, 2017).
[9] The details of the quality assessment and performance improvement program requirements are in 42 C.F.R. 418.58.

incapacitated and has not designated a health care surrogate, the authority to make health care decisions for a patient rests in the patient's proxy.

Section 765.101, F.S., defines a proxy as a competent adult who has not been expressly designated to make health care decisions for a particular incapacitated individual, but who, nevertheless, is authorized pursuant to s. 765.401, F.S., to make health care decisions for such individual and s. 765.401, F.S., lists in descending order of priority persons who may be considered the patient's proxy.[10]

III. Effect of Proposed Changes:

Section 1 amends s. 400.60501, F.S., to require the DOEA and the AHCA adopt outcome measures for quality and effectiveness of hospice care by December 31, 2019. The bill requires that the DOEA and the AHCA adopt national hospice outcome measures in 42 C.F.R. part 418 and develop a system for publicly reporting these measures identified as useful consumer information. The bill also eliminates a quality standard pertaining to reducing a patient's severe pain by the end of the fourth day after admission.

Section 2 creates s. 400.6096, F.S., to establish requirements for a hospice that chooses to assist with the disposal of prescribed controlled substances after the death of a patient in his or her home. The bill requires a hospice that assists in the disposal of prescribed controlled substances in a patient's home to establish clearly defined policies, procedures, and systems for acceptable disposal methods. Disposal procedures must be carried out in the home and hospice staff and volunteers are not permitted to remove controlled substances from the patient's home. The bill permits hospice physicians, nurses, and social workers to assist family members with the disposal of controlled substances in the patient's home after a patient's death pursuant to regulations in 21 C.F.R. s. 1317 (related to the disposal of controlled substances) and pursuant to the hospice's written policy, procedure, or system for disposal methods.

Section 3 amends s. 400.611, F.S., to expand the ways a person may be authorized to receive a hospice patient's record of care both before and after the patient's death. The bill:

- Increases the length of time a hospice must keep a patient's record from 5 to 6 years after termination of hospice services;
- Restricts a hospice from releasing a patient's interdisciplinary record of care unless the person requesting the record provides:
  - A patient authorization executed by the patient;
  - For incapacitated patients, a patient authorization executed before the patient's death by the patient's legal guardian, health care surrogate, health care proxy, or agent under power of attorney;
  - A court order appointing the person as the administrator, curator, executor, or personal representative of the patient's estate with authority to obtain the patient's medical records;

[10] Proxies may include, in descending order of priority: a judicially appointed guardian, the patient's spouse, an adult child of the patient, the patient's parent, an adult sibling of the patient (or majority of adult siblings if he or she has more than one), an adult relative of the patient who is close to the patient, a close friend of the patient, and a clinical social worker who meets specified criteria.

- If a judicial appointment has not been made, a last will that is self-proved pursuant to s. 732.503, F.S., and designates the person to act as the patient's personal representative; or
- An order by a court of competent jurisdiction mandating the release of the records.[11]

For the purposes of this section, the bill defines the term "patient authorization" as an unrevoked written statement by the patient or an oral statement by the patient, or, in the case of incapacitated patients, the patient's legal guardian, health care surrogate, health care proxy, or agent under power of attorney which has been reduced to writing in the patient's record of care and gives the patient's permission to release the record to the person.

The effective date of the bill is July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

CS/SB 474 may have a positive fiscal impact on persons who would be authorized under the bill to receive a hospice patient's records without the need to obtain a court order.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill amends s. 400.611, F.S., to allow a hospice to release a patient's record of care to a person if the person has a "patient authorization" executed after the patient becomes

[11] Currently a hospice may only provide records pursuant to the patient's consent, the patient's legal guardian's consent, or a court order.

incapacitated but before the patient's death by the patient's acting legal guardian, health care surrogate, health care proxy, or agent under power of attorney. However, the definition provided in the bill for "patient authorization" only allows the patient him or herself to provide a written authorization and requires that a "patient authorization" from a patient's representative (as listed above) be provided as an oral statement that is reduced to writing in the patient's record of care. The bill should be clarified to allow a patient's representative to provide a written authorization as well as an oral authorization for the release of the patient's record of care.

VII. Related Issues:

The bill amends s. 400.611, F.S., to allow a hospice patient's record of care to be released to a person providing a last will that is self-proved under s. 732.503, F.S., and which designates the person to act as the patient's personal representative. Although the language implies that such person should only receive the patient's record of care after the patient's death by stating that the provision is effective if there is no court order appointing the person as the administrator, curator, executor, or personal representative of the patient's estate, as written, the language may technically allow the person to receive the patient's record prior to the patient's death.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.60501 and 400.611.

This bill creates section 400.6096 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:

(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on March 27, 2017:
The CS amends SB 474 to:

- Remove all portions of the bill related to a hospice providing palliative care to seriously ill persons;
- Amend s. 400.611, F.S., to expand the ways a person may be authorized to receive a hospice patient's record of care while the patient is still alive and after the patient's death;
- Require that hospice staff adhere to 21 C.F.R. s. 1317, when assisting with the disposal of controlled substances; and
- Make other technical and clarifying changes.

B. Amendments:

None.

417868

LEGISLATIVE ACTION

Senate . House

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. .

. .

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The Committee on Children, Families, and Elder Affairs (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete lines 38 - 107

and insert:

measures and survey data in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state. ~~At a minimum, these outcome measures shall include a requirement that 50 percent of patients who report severe pain on a 0-to-10 scale must report a reduction to 5 or less by the end of the 4th day of care on the hospice program.~~

(2) ~~For hospices licensed in the state,~~ The department ~~of Elderly Affairs~~, in conjunction with the agency ~~for Health Care Administration~~, shall:

(a) Make available to the public the national hospice outcome measures and survey data in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices ~~Consider and adopt national initiatives, such as those developed by the national hospice and Palliative Care Organization, to set benchmarks for measuring the quality of hospice care provided in the state~~.

(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.

Section 2. Section 400.6096, Florida Statutes, is created to read:

400.6096 Disposal of prescribed controlled substances following the death of a patient in the home.—

(1) A hospice physician, nurse, or social worker is authorized to assist in the disposal of a controlled substance prescribed to a patient at the time of the patient’s death pursuant to the disposal regulations in 21 C.F.R. s. 1317.

(2) A hospice that assists in the disposal of a prescribed controlled substance found in the patient’s home at the time of the patient’s death must establish a written policy, procedure, or system for acceptable disposal methods.

(3) A hospice physician, nurse, or social worker, upon the patient’s death and with the permission of a family member or a caregiver of the patient, may assist in the disposal of an unused controlled substance prescribed to the patient, pursuant

to the written policy, procedure, or system established under subsection (2).

(4) The prescribed controlled substance disposal procedure must be carried out in the patient's home. Hospice staff and volunteers are not authorized to remove a prescribed controlled substance from the patient's home.

Section 3. Section 400.611, Florida Statutes, is amended to read:

400.611 Interdisciplinary records of care; confidentiality; release of records.—

(1) A hospice shall maintain an up-to-date, interdisciplinary record of care being given and patient and family status ~~shall be kept~~. Records shall contain pertinent past and current medical, nursing, social, and other therapeutic information and such other information that is necessary for the safe and adequate care of the patient. Notations regarding all aspects of care for the patient and family shall be made in the record. When services are terminated, the record shall show the date and reason for termination.

(2) Patient records shall be retained for a period of 6 ~~5~~ years after termination of hospice services, unless otherwise provided by law. In the case of a patient who is a minor, the 6-year ~~5-year~~ period shall begin on the date the patient reaches or would have reached the age of majority.

(3) The interdisciplinary record of patient ~~records of~~ care and billing records are confidential.

(4) A hospice may not release a patient's interdisciplinary record or any portion thereof, unless the person requesting the information provides to the hospice:

417868

(a) A patient authorization executed by the patient; ~~or legal guardian has given express written informed consent;~~

(b) In the case of an incapacitated patient, a patient authorization executed prior to the patient's death by the patient's then acting legal guardian, health care surrogate as defined in s. 765.101(21), health care proxy as defined in s. 765.101(19), or agent under power of attorney;

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete line 6

and insert:

measures and survey data by a specified date and to make such measures

By the Committee on Health Policy; and Senator Grimsley

588-02952A-17 2017474c1

A bill to be entitled

An act relating to hospice care; amending s. 400.60501, F.S.; requiring the Department of Elderly Affairs, in conjunction with the Agency for Health Care Administration, to adopt national hospice outcome measures by a specified date and to make such measures available to the public; creating s. 400.6096, F.S.; authorizing certain hospice personnel to assist in the disposal of certain prescribed controlled substances; requiring a hospice that chooses to assist in the disposal of certain prescribed controlled substances to establish policies, procedures, and systems for the disposal; authorizing a hospice physician, nurse, or social worker to assist in the disposals of certain prescribed controlled substances; providing requirements for such disposals; amending s. 400.611, F.S.; requiring a hospice to maintain an up-to-date interdisciplinary record of care; revising the patient records retention period; providing for the confidentiality of the interdisciplinary record of patient care; specifying to whom and under what conditions a hospice may release a patient's interdisciplinary record of care; defining a term; requiring a hospice to release patient statistical data to certain agencies; specifying that information from patient records is confidential and exempt from certain provisions; providing an effective date.

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

588-02952A-17 2017474c1

Section 1. Section 400.60501, Florida Statutes, is amended to read:

400.60501 Outcome measures; adoption of federal quality measures; public reporting ~~national initiatives~~; annual report.—

(1) No later than December 31, 2019 ~~2007~~, the department ~~of Elderly Affairs~~, in conjunction with the agency ~~for Health Care Administration~~, shall adopt the national hospice ~~develop~~ outcome measures in 42 C.F.R. part 418 to determine the quality and effectiveness of hospice care for hospices licensed in the state. ~~At a minimum, these outcome measures shall include a requirement that 50 percent of patients who report severe pain on a 0 to 10 scale must report a reduction to 5 or less by the end of the 4th day of care on the hospice program.~~

(2) ~~For hospices licensed in the state,~~ The department ~~of Elderly Affairs~~, in conjunction with the agency ~~for Health Care Administration~~, shall:

(a) Make available to the public the national hospice outcome measures in a format that is comprehensible by a layperson and that allows a consumer to compare such measures of one or more hospices ~~Consider and adopt national initiatives, such as those developed by the national hospice and Palliative Care Organization, to set benchmarks for measuring the quality of hospice care provided in the state~~.

(b) Develop an annual report that analyzes and evaluates the information collected under this act and any other data collection or reporting provisions of law.

Section 2. Section 400.6096, Florida Statutes, is created to read:

400.6096 Disposal of prescribed controlled substances following the death of a patient in the home.—

(1) A hospice physician, nurse, or social worker is authorized to assist in the disposal of a controlled substance prescribed to a patient at the time of the patient's death pursuant to the disposal regulations in 21 C.F.R. s. 1317.

(2) A hospice that assists in the disposal of a prescribed controlled substance found in the patient's home at the time of the patient's death must establish a written policy, procedure, or system for acceptable disposal methods.

(3) A hospice physician, nurse, or social worker, upon the patient's death and with the permission of a family member or a caregiver of the patient, may assist in the disposal of an unused controlled substance prescribed to the patient, pursuant to the written policy, procedure, or system established under subsection (2).

(4) The prescribed controlled substance disposal procedure must be carried out in the patient's home. Hospice staff and volunteers are not authorized to remove a prescribed controlled substance from the patient's home.

Section 3. Section 400.611, Florida Statutes, is amended to read:

400.611 Interdisciplinary records of care; confidentiality; release of records.—

(1) A hospice shall maintain an up-to-date, interdisciplinary record of care being given and patient and family status ~~shall be kept~~. Records shall contain pertinent past and current medical, nursing, social, and other therapeutic information and such other information that is necessary for the

safe and adequate care of the patient. Notations regarding all aspects of care for the patient and family shall be made in the record. When services are terminated, the record shall show the date and reason for termination.

(2) Patient records shall be retained for a period of ~~5~~ 6 years after termination of hospice services, unless otherwise provided by law. In the case of a patient who is a minor, the ~~5~~ 6-year period shall begin on the date the patient reaches or would have reached the age of majority.

(3) The interdisciplinary record of patient ~~records of~~ care and billing records are confidential.

(4) A hospice may not release a patient's interdisciplinary record or any portion thereof, unless the person requesting the information provides to the hospice:

(a) A patient authorization executed by the patient; ~~or legal guardian has given express written informed consent;~~

(b) If the patient is incapacitated, a patient authorization executed before the patient's death by the patient's then acting legal guardian, health care surrogate, health care proxy, or agent under power of attorney;

(c) A court order appointing the person as the administrator, curator, executor, or personal representative of the patient's estate with authority to obtain the patient's medical records;

(d) If a judicial appointment has not been made pursuant to paragraph (c), a last will that is self-proved under s. 732.503 and designates the person to act as the patient's personal representative; or

(e) An order by a court of competent jurisdiction to

release the interdisciplinary record to the person ~~has so ordered; or~~

~~(c) A state or federal agency, acting under its statutory authority, requires submission of aggregate statistical data. Any information obtained from patient records by a state agency pursuant to its statutory authority is confidential and exempt from the provisions of s. 119.07(1)~~.

(5) For purposes of this section, the term "patient authorization" means an unrevoked written statement by the patient, or an oral statement made by the patient which has been reduced to writing in the patient's interdisciplinary record of care, or, in the case of an incapacitated patient, by the patient's then acting legal guardian, health care surrogate, agent under a power of attorney, or health care proxy giving the patient's permission to release the interdisciplinary record to a person requesting the record.

(6) A hospice must release requested aggregate patient statistical data to a state or federal agency acting under its statutory authority. Any information obtained from patient records by a state agency pursuant to its statutory authority is confidential and exempt from s. 119.07(1).

Section 4. This act shall take effect July 1, 2017.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	CS/SB 552
INTRODUCER:	Criminal Justice Committee and Senator Bracy
SUBJECT:	Child Support
DATE:	April 14, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Hrdlicka	Hrdlicka	CJ	**Fav/CS**
2.	Crosier	Hendon	CF	**Pre-meeting**
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE – Substantial Changes

I. Summary:

CS/SB 552 adds a new ground to those already allowed for an obligor to contest a notice of delinquency in support payments issued by the Department of Revenue in circuit court. The obligor may show that he or she has no ability to make payments towards the delinquency due to circumstances that include, but are not limited to:

- Temporary interruption in employment due to a natural disaster.
- Incapacitation as a result of an illness or temporary medical condition
- Temporary, unexpected involuntary unemployment.

II. Present Situation:

Support

Parents have a duty to support[1] their child until the child turns 18 years of age.[2] "Public policy favors imposing on parents an obligation to contribute to the child's support."[3] The obligation

[1] Section 61.046(22), F.S., defines "support" as child support when the Department of Revenue is not enforcing the support obligation and it includes spousal support or alimony for the person with whom the child is living when the Department of Revenue is enforcing the support obligation. The definition applies to the use of the term throughout ch. 61, F.S.

[2] Section 61.29, F.S. *See generally* ss. 744.301 and 744.361, F.S. *See also* 2-33 Florida Family Law s. 33.01 (Parents' Duty to Support Child).

[3] *Mitchell v. Mitchell*, 841 So. 2d 564 570, (Fla. 2nd DCA 2003). In fact, s. 856.04, F.S., provides that it is a third degree felony for a parent to dessert his or her child or to withhold from the child the means of support.

exists even if the parents are not married, and can exist when the parents are married, but the child is not the biological child of the husband or if a person contractually agrees to support the child.[4]

A parent caring for a child can seek a court order for support either through dissolution of marriage or through an order for alimony and support of the child without seeking a dissolution of marriage.[5] Section 61.30, F.S., sets forth guidelines to determine the appropriate amount of support to be provided. A court is permitted to deviate from the guideline amount "after considering all relevant factors, including the needs of the child or children, age, station in life, standard of living, and the financial status and ability of each parent," but the deviation must be part of a written finding in the support order explaining why the guideline amount is unjust or inappropriate.[6]

Failure to Pay Support

There are several options to enforce a support order, including both civil and criminal remedies. In an enforcement action, "the court must determine whether a valid support order exists, the terms of payment contained in the order, and whether the obligor[7] has complied with its terms. If a court determines that arrearages are due under a support order, it may also inquire into the reasons why the payments were not made and whether nonpayment can be legally excused."[8]

Civil remedies include garnishment of the obligor's wages,[9] an order for income deduction,[10] suspension or denial of certain business and professional licenses and certificates,[11] suspension of the person's driver license and motor vehicle registration,[12] and an order to seek employment or job training.[13]

Specifically related to suspension of a driver license, if an obligor is 15 days delinquent in making a support payment, then the Department of Revenue (DOR) can provide notice to the obligor of the delinquency. The notice must state that the DOR will request the Department of Highway Safety and Motor Vehicles to suspend the driver license within 20 days of the date of the notice from the DOR. There are several ways for an obligor to stop suspension of his or her license, including:

- Paying the delinquency in full;
- Contesting the delinquency notice by filing a petition in circuit court;
- Demonstrating that he or she is on reemployment assistance (unemployment compensation);
- Demonstrating that he or she receives temporary cash assistance; or

[4] *See* 2-33 Florida Family Law s. 33.01 (Parents' Duty to Support Child) for a discussion on situations where the duty of providing support arises.
[5] Section 61.09, F.S.
[6] Section 61.30(1)(a), F.S.
[7] Section 61.046(13), F.S., defines "obligor" to mean "a person responsible for making payments pursuant to an order establishing, enforcing, or modifying an obligation for alimony, for child support, or for alimony and child support."
[8] 4-70 Florida Family Law s. 70.23 (Complaint for Enforcement).
[9] Section 61.12, F.S.
[10] Section 61.1301, F.S.
[11] Section 61.13015, F.S.
[12] Section 61.13016, F.S.
[13] Section 61.14(5)(b), F.S.

- Demonstrating that he or she is disabled and incapable of self-support.[14]

If the obligor chooses to contest the delinquency notice in circuit court, the grounds for the petition must be mistake of fact regarding the existence of delinquency or the identity of the obligor. The petition has to be served on the DOR. The court must hear a timely filed petition within 15 days and enter an order resolving the petition within 10 days of the hearing. A timely filed petition stays the notice of delinquency by the DOR until the court enters an order resolving the matter.

The obligor can also petition a court to direct the Department of Highway Safety and Motor Vehicles to issue a license for driving privileges restricted to business purposes only.[15]

III. Effect of Proposed Changes:

Section 1 amends s. 61.13016, F.S., to allow the DOR to request the Department of Highway Safety and Motor Vehicles to suspend an obligor's driver license within 20 days of the date of the notice from the DOR that the obligor is delinquent in making support payments. The bill sets forth additional grounds for an obligor to petition the circuit court to contest the notice of delinquency. The obligor can contest the notice by showing that he or she has no ability to make payments towards the delinquency in support payments due to circumstances that include, but are not limited to:

- Temporary interruption in employment due to a natural disaster.
- Incapacitation as a result of an illness or temporary medical condition.
- Temporary, unexpected involuntary unemployment.

Section 2 provides an effective date of July 1, 2017.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[14] Section 61.13016(1), F.S.

[15] Section 61.13016(2), F.S. The term "a driving privilege restricted to business purposes only" means a driving privilege that is limited to any driving necessary to maintain livelihood, including driving to and from work, necessary on-the-job driving, driving for educational purposes, and driving for church and for medical purposes. Section 322.271(1)(c)1., F.S.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

An obligator who fails to pay child support and is able to show the circumstances provided in the bill will benefit by being able to retain his or her driver license.

C. Government Sector Impact:

The DOR indicates that the bill will have an insignificant fiscal impact on department expenditures.[16]

Any impact on the state court system is unknown at this time.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 61.13016 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Criminal Justice on March 27, 2017:
The committee substitute substantially rewrote the bill. The CS added grounds for an obligor to petition a circuit court to contest a notice of delinquency in support payments. It removed the following provisions:

- Allowing an obligor to demonstrate to the DOR certain conditions in order to stop suspension of his or her driver license.
- Allowing an obligor to avoid being held in contempt of court by demonstrating certain conditions.
- Allowing a court to order an obligor to work release or supervised home confinement without electronic monitoring under certain conditions.
- Requiring the Department of Economic Opportunity to develop and administer a program to provide tax credits to business entities that employ obligors ordered to be

[16] DOR, *2017 Agency Legislative Bill Analysis CS/HB 313*, March 24, 2017.

placed in work release programs or supervised home confinement without electronic monitoring.

B. Amendments:

None.

By the Committee on Criminal Justice; and Senator Bracy

A bill to be entitled

An act relating to child support; creating the "Florida Responsible Parent Act"; amending s. 61.13016, F.S.; providing additional circumstances under which an obligor who fails to pay child support may avoid suspension of his or her driver license and motor vehicle registration; providing an effective date.

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

Section 1. This act may be cited as the "Florida Responsible Parent Act."

Section 2. Subsections (1) and (4) of section 61.13016, Florida Statutes, are amended to read:

61.13016 Suspension of driver licenses and motor vehicle registrations.—

(1) The driver license and motor vehicle registration of a support obligor who is delinquent in payment or who has failed to comply with subpoenas or a similar order to appear or show cause relating to paternity or support proceedings may be suspended. When an obligor is 15 days delinquent making a payment in support or failure to comply with a subpoena, order to appear, order to show cause, or similar order in IV-D cases, the Title IV-D agency may provide notice to the obligor of the delinquency or failure to comply with a subpoena, order to appear, order to show cause, or similar order and the intent to suspend by regular United States mail that is posted to the obligor's last address of record with the Department of Highway

Safety and Motor Vehicles. When an obligor is 15 days delinquent in making a payment in support in non-IV-D cases, and upon the request of the obligee, the depository or the clerk of the court must provide notice to the obligor of the delinquency and the intent to suspend by regular United States mail that is posted to the obligor's last address of record with the Department of Highway Safety and Motor Vehicles. In either case, the notice must state:

(a) The terms of the order creating the support obligation;

(b) The period of the delinquency and the total amount of the delinquency as of the date of the notice or describe the subpoena, order to appear, order to show cause, or other similar order that has not been complied with;

(c) That notification will be given to the Department of Highway Safety and Motor Vehicles to suspend the obligor's driver license and motor vehicle registration unless, within 20 days after the date that the notice is mailed, the obligor:

1.a. Pays the delinquency in full and any other costs and fees accrued between the date of the notice and the date the delinquency is paid;

b. Enters into a written agreement for payment with the obligee in non-IV-D cases or with the Title IV-D agency in IV-D cases; or in IV-D cases, complies with a subpoena or order to appear, order to show cause, or a similar order;

c. Files a petition with the circuit court to contest the delinquency action as provided in subsection (4);

d. Demonstrates that he or she receives reemployment assistance or unemployment compensation pursuant to chapter 443;

e. Demonstrates that he or she is disabled and incapable of

self-support or that he or she receives benefits under the federal Supplemental Security Income program or Social Security Disability Insurance program;

f. Demonstrates that he or she receives temporary cash assistance pursuant to chapter 414; or

g. Demonstrates that he or she is making payments in accordance with a confirmed bankruptcy plan under chapter 11, chapter 12, or chapter 13 of the United States Bankruptcy Code, 11 U.S.C. ss. 101 et seq.; and

2. Pays any applicable delinquency fees.

If an obligor in a non-IV-D case enters into a written agreement for payment before the expiration of the 20-day period, the obligor must provide a copy of the signed written agreement to the depository or the clerk of the court. If an obligor seeks to satisfy sub-subparagraph 1.d., sub-subparagraph 1.e., sub-subparagraph 1.f., or sub-subparagraph 1.g. before expiration of the 20-day period, the obligor must provide the applicable documentation or proof to the depository or the clerk of the court.

(4)(a) The obligor may, within 20 days after the mailing date on the notice of delinquency or noncompliance and intent to suspend, file in the circuit court a petition to contest the notice of delinquency or noncompliance and intent to suspend on the ground of:

1. Mistake of fact regarding the existence of a delinquency; ~~or~~

2. Mistake of fact regarding the identity of the obligor; or

3. No ability to make payments toward the delinquency due to circumstances including, but not limited to, temporary interruption in employment as the result of a natural disaster, incapacitation as the result of an illness or temporary medical condition, or temporary unexpected involuntary unemployment.

(b) The obligor must serve a copy of the petition on the Title IV-D agency in IV-D cases or depository or clerk of the court in non-IV-D cases. When an obligor timely files a petition to contest, the court must hear the matter within 15 days after the petition is filed. The court must enter an order resolving the matter within 10 days after the hearing, and a copy of the order must be served on the parties. The timely filing of a petition to contest stays the notice of delinquency and intent to suspend until the entry of a court order resolving the matter.

Section 3. This act shall take effect July 1, 2017.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Children, Families, and Elder Affairs

BILL:	SB 1580
INTRODUCER:	Senator Gibson
SUBJECT:	Admission of Children and Adolescents to Mental Health Facilities
DATE:	April 14, 2017
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Crosier	Hendon	CF	**Pre-meeting**
2.			JU	
3.			AP	

I. Summary:

SB 1580 requires a receiving facility or a mental health treatment facility to refer the case of a minor admitted to such a facility for a mental health assessment to the clerk of the court for the appointment of a public defender within a specified timeframe. The bill also requires the child's attorney have access to all records relevant for representation of the child in a judicial hearing and the hearing must be in person and not be held by electronic or video means. A violation of these provisions is a first degree misdemeanor.

The bill has an effective date of July 1, 2017, and an indeterminate but negative fiscal impact on the State Court System.

II. Present Situation:

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 presenting a threat of harm to themselves or others. The Baker Act also establishes procedures for courts, law enforcement, and certain health care practitioners to initiate such examinations and then act in response to the findings.

Individuals in acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[1] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness:[2]

[1] Sections 394.4625 and 394.463, F.S.
[2] Section 394.463(1), F.S.

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; **and**
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by the Department of Children and Families (DCF) as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.3

Within the 72-hour examination period, or if the 72 hours end on a weekend or holiday, no later than the next business day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[4]

Receiving facilities must give prompt notice[5] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[6] guardian advocate,[7] health care surrogate or proxy, attorney, and representative.[8] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has submitted a report to the central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once

[3] Section 394.455(39), F.S. This term does not include a county jail.
[4] Section 394.463(2)(g), F.S.
[5] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means. Section 394.455(2),F.S.
[6] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[7] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455(18), F.S.
[8] Section 394.4599(2)(b), F.S.

every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[9]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[10] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[11] The purpose of a CSU is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[12] Individuals often enter the public mental health system through CSUs. For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by the Legislature in the 1970s to ensure continuity of care for individuals.[13]

During calendar year 2015, 32,882 involuntary examinations were initiated under the Baker Act for individuals under the age of 18. These examinations occur in receiving facilities such as crisis stabilization units and hospitals and must conclude within 72 hours under most circumstances. Residential treatment centers generally provide longer-term assessment and treatment services.

Section 394.467, F.S., defines "residential treatment center for children and adolescents" as a 24-hour residential program, including a therapeutic group home, which provides mental health services to emotionally disturbed children or adolescents and which is a private for-profit or not-for-profit corporation licensed by the agency which offers a variety of treatment modalities in a more restrictive setting. Residential treatment centers provide longer-term treatment services. The purpose of a residential treatment center for children and adolescents is to provide mental health assessment and treatment services to children and adolescents who are experiencing an acute mental or emotional crisis, have a serious emotional disturbance or mental illness, or have an emotional disturbance. The treatment center must provide the least restrictive available treatment that is appropriate to the individual needs of the child or adolescent.[14]

Section 39.407, F.S., details procedures for placing a child who is in the legal custody of the Department of Children and Families due to involvement in the child welfare system in a residential treatment center. Such procedures include an assessment by a qualified evaluator, mandatory appointment of a guardian ad litem, regular reporting by the center to the court on the child's progress, and court review hearings. There are no similar statutory provisions for child who is not in the legal custody of the Department of Children and Families.

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[9] Section 394.4599(c), F.S.
[10] Section 394.875(1)(a), F.S.
[11] *Id.*
[12] *Id.*
[13] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), *available at* http://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited April 12, 2017).
[14] Section 394.4785(2), F.S.

The public defender is elected for a term of four years during a general election by the electors in his or her judicial circuit.[15] The public defender in each judicial circuit may employ, as authorized by the General Appropriations Act, assistant public defenders and other staff needed to fulfill the duties of the office.[16]

Under s. 27.51, a public defender must represent, without additional compensation, any person determined to be indigent[17] and:

- Is under arrest for or charged with:
  - A felony;
  - Certain misdemeanors;
  - Certain traffic violations punishable by imprisonment;
  - A violation of a special law or county or municipal ordinance ancillary to a state charge;
- Alleged to be a delinquent child pursuant to a petition filed before the circuit court;
- Sought by petition filed in such court to be
  - Involuntarily placed as a mentally ill person under part I ch. 394, F.S.
  - Involuntarily committed as a sexually violent predator under part V of ch. 394, F.S., or
  - Involuntarily admitted to residential services as a person with developmental disabilities under ch. 393, F.S.;
- Is convicted or sentenced to death, for purposes of handling an appeal to the Supreme Court; or
- Is appealing a matter for which a public defendant may be appointed.

In September 2016, the 2nd District Court of Appeal issued a ruling in response to a suit brought by 14 patients in Lee County regarding conducting Baker Act hearings via videoconference. The judge and magistrate presiding over Baker Act hearings in that county had decided they would no longer travel to receiving facilities to hold commitment hearings in person. Instead, the judge and magistrate would remain in the courthouse and hold hearings via videoconference while the patients, witnesses, and attorneys would continue to be physically present at the receiving facility. The 2nd DCA ruled that "there is simply no duty 'clearly and certainly established in the aw' requiring the judicial officer to be in the physical presence of the patient, attorneys, and witnesses while presiding over the hearing" and concluded that it was within the court's authority to hold Baker Act hearings through videoconferencing. However, the 2nd DCA certified as a question of great public importance, "Does a judicial officer have an indisputable legal duty to preside over section 394.467 hearings in person?"[18] In December 2016 the Supreme Court initially refused to grant a stay and thus allowed the hearings to continue. However, in February 2017 the Supreme Court vacated that ruling and instead issued a stay.[19] The Supreme Court indicated it will issue an opinion in the future.

[15] Section 27.50, F.S.
[16] Section 27.53, F.S.
[17] Section 27.52, F.S.
[18] Doe v. State, 41 Fla. L. Weekly D2220a (Fla. 2d DCA 2016).
[19] Doe v. State, SC16-1852.

III. Effect of Proposed Changes:

Section 1 amends s. 394.4599, F.S., to require that within 24 hours after a minor arrives at a receiving facility for an involuntary examination under the Baker Act, or is admitted to a crisis stabilization unit or a residential treatment center, the facility must refer the case to the clerk of court for the appointment of a public defender for a potential judicial review hearing. The attorney representing the child must have access to all records relevant to the child's case. All hearings involving the child must be held in physical presence of the child and may not be conducted by an electronic or video means. A person who fails to comply with the requirements of the bill's provisions commits a first degree misdemeanor.

Section 2 amends s. 394.4785, F.S., to require that within 24 hours after a minor arrives at a receiving facility for an involuntary examination under the Baker Act, or is admitted to a crisis stabilization unit or a residential treatment center, the facility must refer the case to the clerk of court for the appointment of a public defender for a potential judicial review hearing. The attorney representing the child must have access to all records relevant to the child's case. All hearings involving the child must be held in physical presence of the child and may not be conducted by an electronic or video means. A person who fails to comply with the requirements of the bill's provisions commits a first degree misdemeanor.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

It is well settled that the interest of parents in the care, custody, and control of their children is perhaps the oldest of the recognized fundamental liberty interests protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution.[20] This fundamental liberty interest is rooted in the fundamental right of privacy from interference in making important decisions relating to things such as marriage, family relationships, and child rearing and education.[21]

[20] *Santosky v. Kramer*, 45 U.S. 745 (1982); *Troxel v. Granville*, 530 U.S. 57, 65 (2000)
[21] See *Carey v. Population Svcs. Int/l*, 431 U.S. 678, 684-685 (1977)

The Florida Supreme Court has likewise recognized that parents have a fundamental liberty interest in determining the care and upbringing of their children.[22] These rights may not be intruded upon absent a compelling state interest.[23]

When it comes to medical decisions, parents generally have the right to be informed about, and give consent for, proposed medical procedures on their children. However, the State also has an obligation to ensure that children receive reasonable medical treatment that is necessary for the preservation of life.[24]

A parent may reject medical treatment for a child and the state may not interfere with such decision if the evidence is not sufficiently compelling to establish the primacy of the state's interest, or that the child's own welfare would be best served by such treatment.[25] In the event the minor's parent or legal guardian are not contacted prior to the appointment of a public defender, under this bill the parent and the minor's legal representative may be at odds regarding medical treatment for a child.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

If review hearings are scheduled in response to any motions by the appointed public defenders, there may be additional costs to facilities to transport minors to the hearings.

C. Government Sector Impact:

The state court system will experience an indeterminate but significant negative fiscal impact associated with the additional duty assigned to the public defenders to represent children under the age of 18 within 24 hours after admission to a public or private facility. Presently, if a person is admitted for evaluation and assessment meets the criteria, within 72 hours a petition for involuntary inpatient treatment must be filed with the court. At the hearing on the petition, a public defender is appointed to represent the person being held if they cannot afford to hire their own attorney.

VI. Technical Deficiencies:

None.

[22] *Beagle v. Beagle*, 678 So. 2d 1271
[23] See, e.g., *Shevin v. Byron, Harless, Schaffer, Reid & Assocs., Inc.* 379 So. 2d 633, 637 (Fla. 1980) and *Belair v. Drew*, 776 So.2d 1105, 1107 (fla. 5th DCA 2001).
[24] *Von Eiff v. Azicri*, 720 So.2d 510 (Fla. 1998).
[25] *M.N. v. S. Baptist Hosp.*, 648 so.2d 769 (Fla. 1st DCA 1994).

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 394.4599, 394.4785.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate . House

. . . . .

The Committee on Children, Families, and Elder Affairs (Gibson) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraphs (g) and (h) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(g) The examination period may last for up to 72 hours for

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an adult. For a minor, the examination must be initiated within 12 hours after the patient's arrival at the facility and completed within 24 hours unless the attending physician, clinical psychologist, or psychiatric nurse performing within the framework of an established protocol with a psychiatrist determines that additional time is required to stabilize and assess the minor. Within the ~~72-hour~~ examination period or, if the examination period ~~72 hours~~ ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on the individual needs of the patient:

1. The patient shall be released, unless he or she is charged with a crime, in which case the patient shall be returned to the custody of a law enforcement officer;

2. The patient shall be released, subject to ~~the provisions of~~ subparagraph 1., for voluntary outpatient treatment;

3. The patient, unless he or she is charged with a crime, shall be asked to give express and informed consent to placement as a voluntary patient and, if such consent is given, the patient shall be admitted as a voluntary patient; or

4. A petition for involuntary services shall be filed in the circuit court if inpatient treatment is deemed necessary or with the criminal county court, as defined in s. 394.4655(1), as applicable. When inpatient treatment is deemed necessary, the least restrictive treatment consistent with the optimum improvement of the patient's condition shall be made available. When a petition is to be filed for involuntary outpatient placement, it shall be filed by one of the petitioners specified in s. 394.4655(4)(a). A petition for involuntary inpatient

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placement shall be filed by the facility administrator.

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g) ~~72 hours~~. The examination ~~72-hour~~ period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.4655(2) or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary services or placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient services or involuntary outpatient placement must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been met.

Section 2. (1) There is created a task force within the Department of Children and Families to address the issue of involuntary examinations under s. 394.463, Florida Statutes, of children age 17 and younger. The task force shall, at a minimum, analyze data on the initiation of involuntary examinations of

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children, research the root causes of trends in such involuntary examinations, and identify recommendations for encouraging alternatives to these examinations. The task force shall submit a report on its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before December 1, 2017.

(2) The task force shall consist of the following members:

(a) The Secretary of the Department of Children and Families, or his or her designee, who shall chair the task force.

(b) The Commissioner of the Department of Education, or his or her designee.

(c) A representative of the Florida Public Defender Association.

(d) A representative of the Florida Association of District School Superintendents.

(e) A representative of the Florida Sheriffs Association.

(f) A representative of the Florida Police Chiefs Association.

(g) A representative of the Florida Council for Community Mental Health.

(h) A representative of the Florida Alcohol and Drug Abuse Association.

(i) A representative of the Behavioral Health Care Council of the Florida Hospital Association.

(j) A representative of the Florida Psychiatric Society.

(k) A representative of the National Alliance on Mental Illness.

(l) One individual who is a family member of a minor who

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has been subject to an involuntary examination.

(m) Other members as deemed appropriate by the Secretary of the Department of Children and Families.

(3) The department shall use existing and available resources to administer and support the activities of the task force. Members of the task force shall serve without compensation and are not entitled to reimbursement for per diem or travel expense. The task force may conduct its meetings via teleconference.

(4) This section expires March 31, 2018.

Section 3. This act shall take effect July 1, 2017.

================ T I T L E A M E N D M E N T ================

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to admission of children and adolescents to mental health facilities; amending s. 394.463, F.S.; requiring a facility to initiate an involuntary examination of a minor within 12 hours and complete the examination within 24 hours after the patient’s arrival; providing an exception; creating a task force within the Department of Children and Families; requiring the task force to analyze certain data and make recommendations in a report to the Governor and the Legislature by a specified date; specifying task force membership; specifying operation of the task force; providing for expiration of the

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task force; providing an effective date.

By Senator Gibson

6-01010B-17 20171580__

A bill to be entitled

An act relating to admission of children and adolescents to mental health facilities; amending ss. 394.4599 and 394.4785, F.S.; requiring a receiving facility or a mental health treatment facility to refer the case of a minor admitted to such facility for a mental health assessment to the clerk of the court for the appointment of a public defender within a specified timeframe; granting the minor's attorney access to relevant records; requiring a hearing involving a child under a specified age to be conducted in the physical presence of the child; providing penalties; providing an effective date.

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

Section 1. Paragraph (c) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(c)1.a. A receiving facility shall give notice of the whereabouts of a minor who is being involuntarily held for examination pursuant to s. 394.463 to the minor's parent, guardian, caregiver, or guardian advocate, in person or by telephone or other form of electronic communication, immediately after the minor's arrival at the facility. The facility may delay notification for no more than 24 hours after the minor's arrival if the facility has submitted a report to the central abuse hotline, pursuant to s. 39.201, based upon knowledge or

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suspicion of abuse, abandonment, or neglect and if the facility deems a delay in notification to be in the minor's best interest.

b. If the minor is under the age of 18, the receiving facility shall refer the case to the clerk of the court for the appointment of a public defender within the first 24 hours after the minor's arrival for potential initiation of a judicial review hearing. An attorney who represents the minor shall have access to all records relevant to the presentation of the minor's case. All hearings involving children under the age of 18 shall be conducted in the physical presence of the child and not by electronic or video means. A person who violates this sub-subparagraph commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

2. The receiving facility shall attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until the receiving facility receives confirmation from the parent, guardian, caregiver, or guardian advocate, verbally, by telephone or other form of electronic communication, or by recorded message, that notification has been received. Attempts to notify the parent, guardian, caregiver, or guardian advocate must be repeated at least once every hour during the first 12 hours after the minor's arrival and once every 24 hours thereafter and must continue until such confirmation is received, unless the minor is released at the end of the 72-hour examination period, or until a petition for involuntary services is filed with the court pursuant to s. 394.463(2)(g). The receiving facility may seek assistance from a law enforcement agency to notify the minor's parent, guardian, caregiver, or

guardian advocate if the facility has not received within the first 24 hours after the minor's arrival a confirmation by the parent, guardian, caregiver, or guardian advocate that notification has been received. The receiving facility must document notification attempts in the minor's clinical record.

Section 2. Section 394.4785, Florida Statutes, is amended to read:

394.4785 Children and adolescents; admission and placement in mental health facilities.—

(1) A child or adolescent as defined in s. 394.492 may not be admitted to a state-owned or state-operated mental health treatment facility. A child may be admitted pursuant to s. 394.4625 or s. 394.467 to a crisis stabilization unit or a residential treatment center licensed under this chapter or a hospital licensed under chapter 395. The treatment center, unit, or hospital must provide the least restrictive available treatment that is appropriate to the individual needs of the child or adolescent and must adhere to the guiding principles, system of care, and service planning provisions contained in part III of this chapter.

(2) A person under the age of 14 who is admitted to any hospital licensed pursuant to chapter 395 may not be admitted to a bed in a room or ward with an adult patient in a mental health unit or share common areas with an adult patient in a mental health unit. However, a person 14 years of age or older may be admitted to a bed in a room or ward in the mental health unit with an adult if the admitting physician documents in the case record that such placement is medically indicated or for reasons of safety. Such placement shall be reviewed by the attending

physician or a designee or on-call physician each day and documented in the case record.

(3) Within 24 hours after a person under the age of 18 is admitted to a crisis stabilization unit or a residential treatment center licensed under this chapter or a hospital licensed under chapter 395, the facility administrator must refer the case to the clerk of the court for the appointment of a public defender for potential initiation of a judicial review hearing. An attorney who represents the minor shall have access to all records relevant to the presentation of the minor's case. All hearings involving children under the age of 18 shall be conducted in the physical presence of the child and not by electronic or video means. A person who violates this subsection commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. This act shall take effect July 1, 2017.

Characteristics of Children in Foster Homes and Group Homes

A presentation to the Senate Committee on Children, Families, and Elder Affairs

Megan Smernoff
Senior Legislative Analyst

April 17, 2017

Family Foster Homes and Residential Group Care[1]

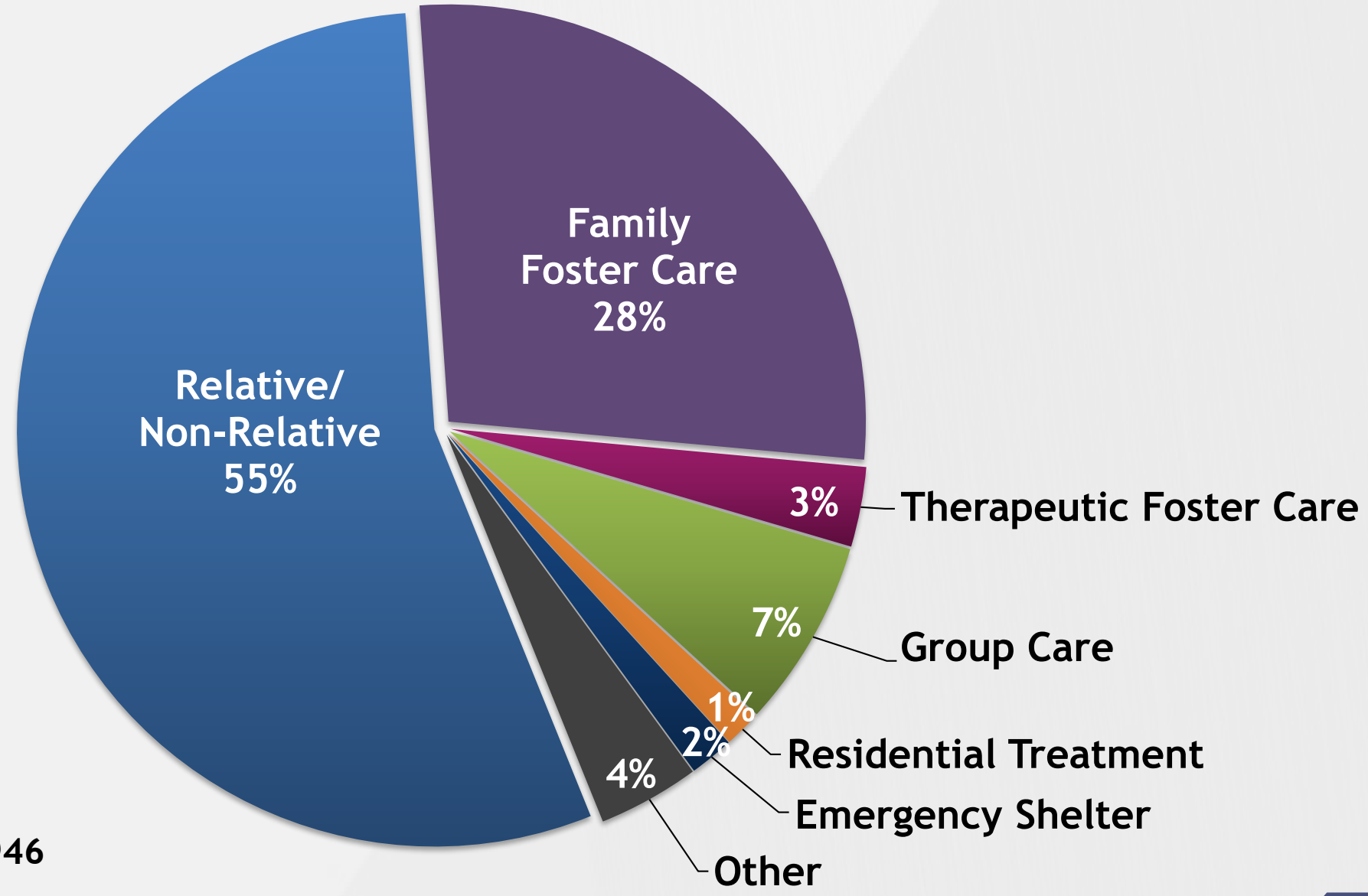
- Characteristics of children in family foster homes and residential group care
- Costs associated with family foster homes and residential group care
- Required activities and services for family foster homes and residential group care

[1] Information gathered by OPPAGA during Fiscal Years 2013-14 and 2014-15.

Out-of-Home Care Placements

- Legislative intent is that children are placed in the least restrictive environment

21,946 Children in Out-of-Home Care on June 1, 2015



N = 21,946

Family Foster Homes and Residential Group Care

Family Foster Homes

- DCF licensed family-based settings; up to 5 children, including foster parents' biological and adopted children

Residential Group Care

- DCF licensed residential child-caring agencies; shift-care and house parent models

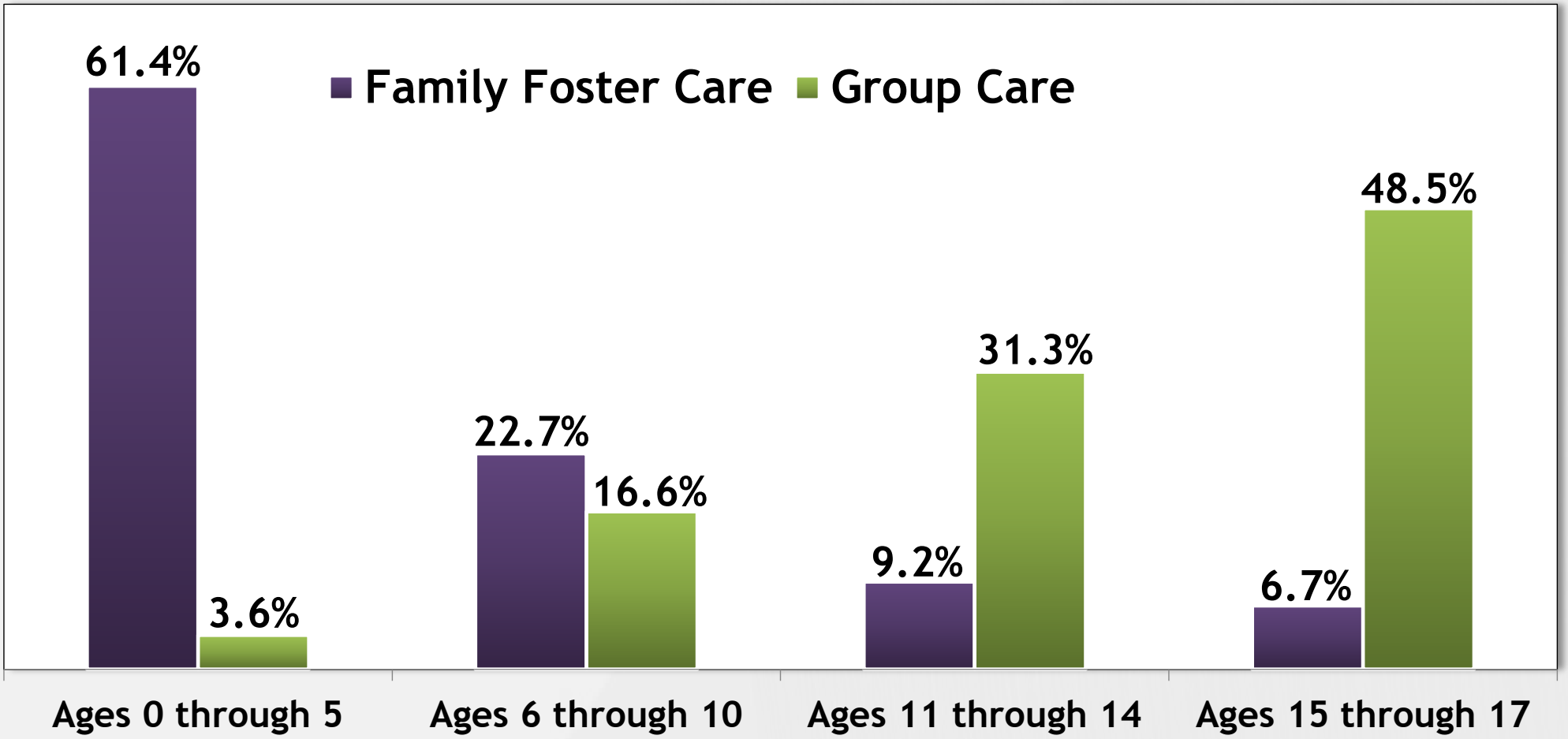
How Is Placement in Residential Group Care Determined?

- Placement in group care must be considered when the child
  - Is age 11 or older,
  - Has been in licensed family foster care for more than six months and removed more than once, AND
  - Has serious behavioral problems
- Other factors to consider
  - Placement of siblings
  - Availability of more family-like settings

Characteristics of Children in Family Foster Homes and Residential Group Care

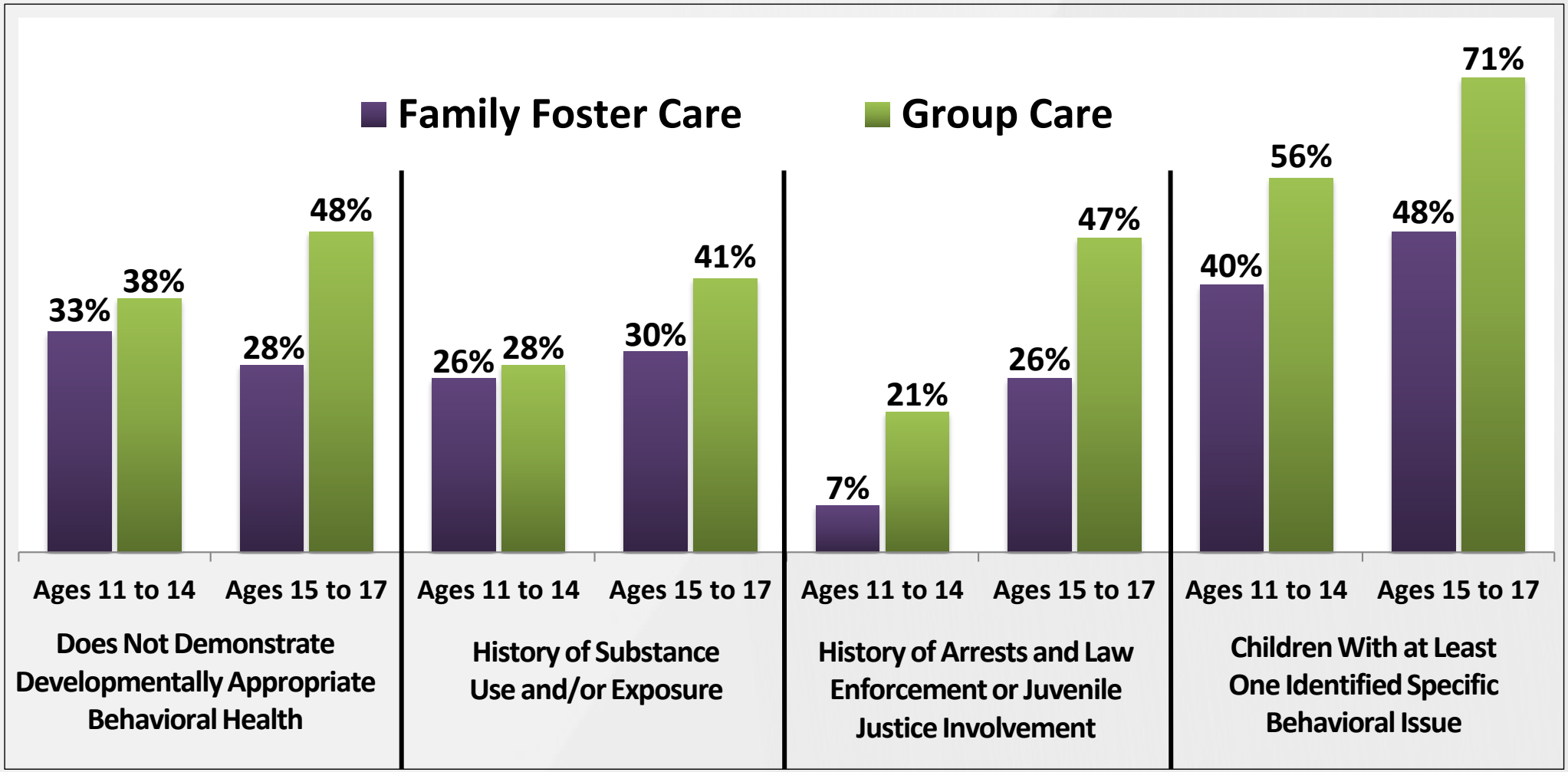
Children in Group Care Were Older

79.8% of children in group care were ages 11 through 17

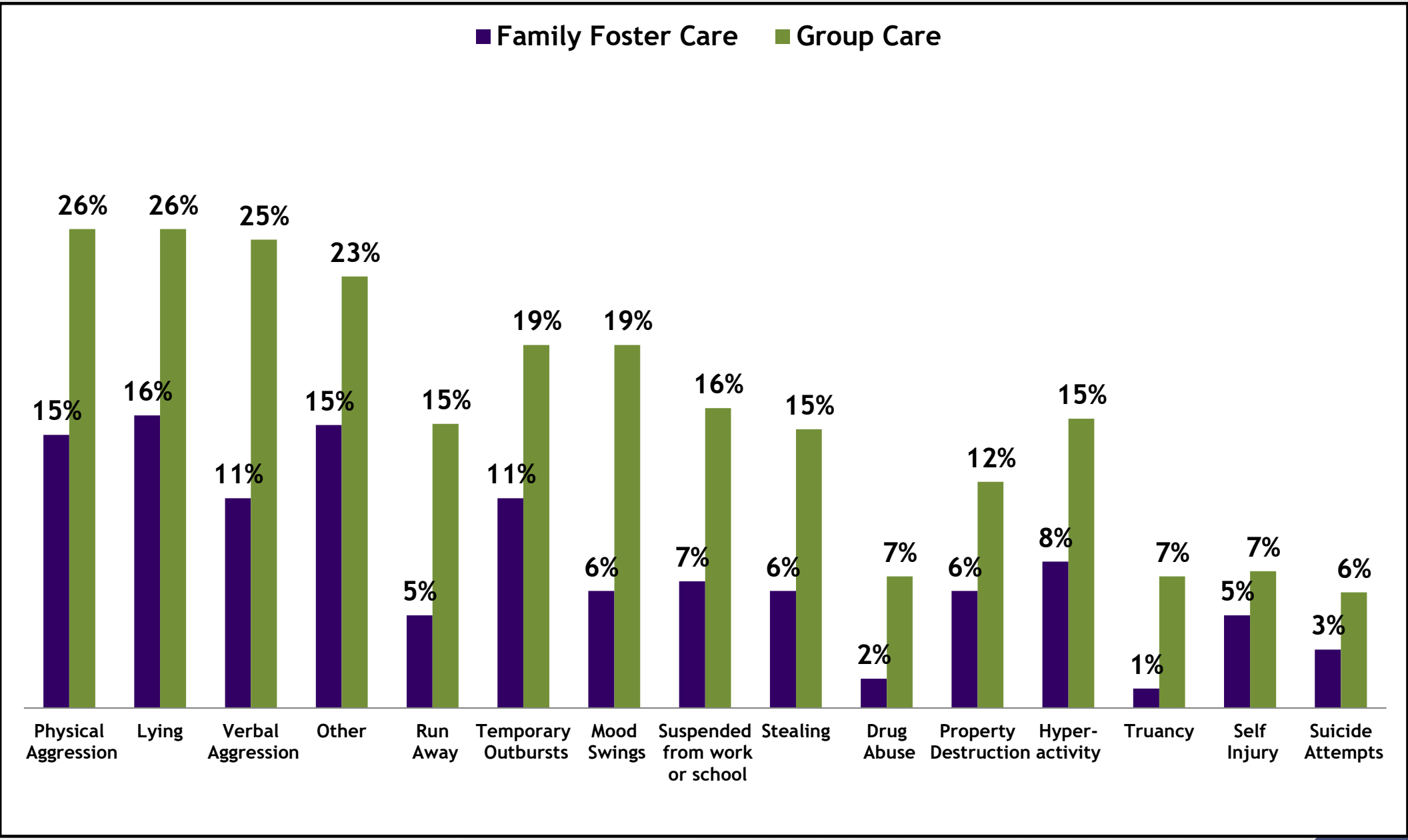


Children in Group Care Had More Behavioral Issues

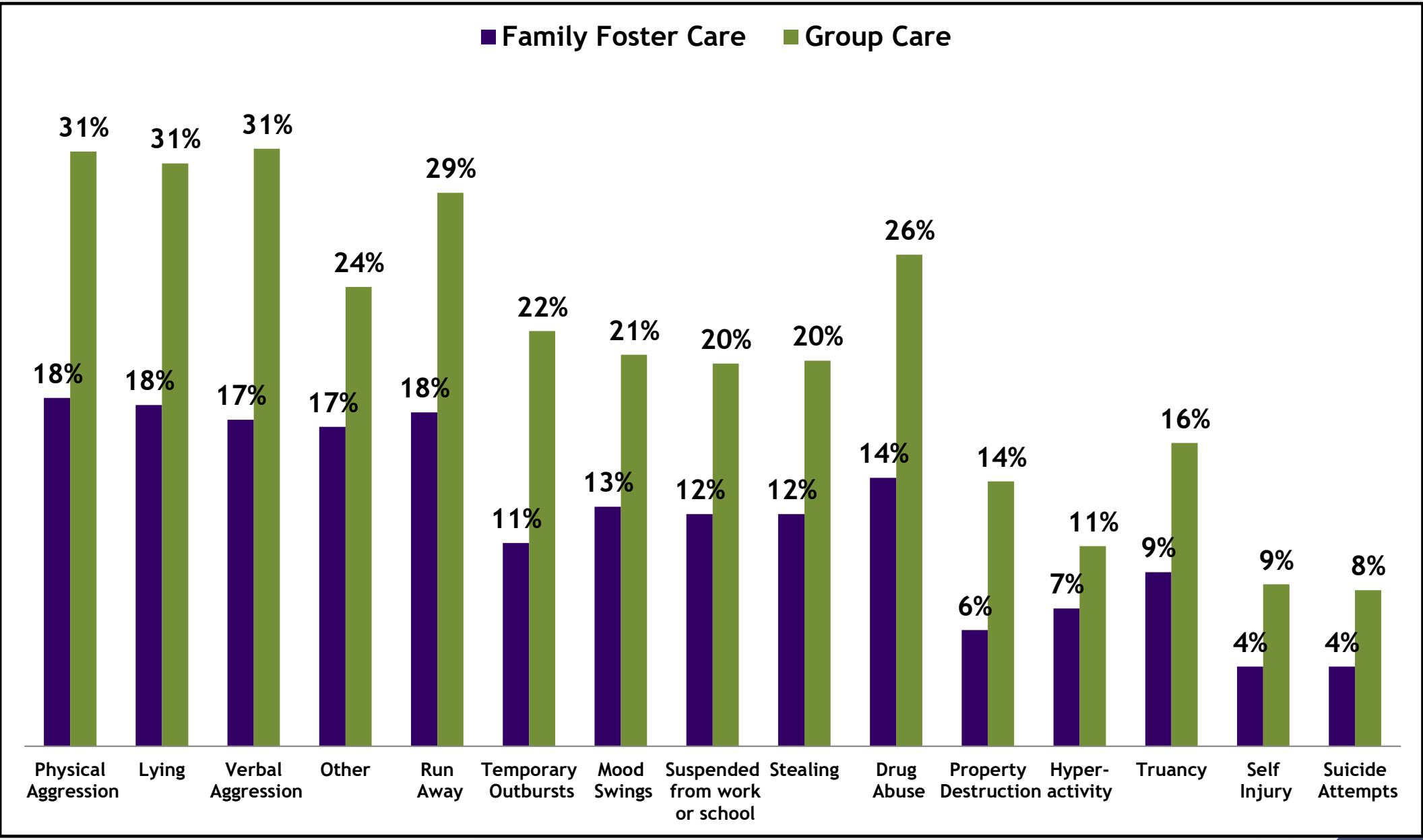
A larger percentage of children in group care had behavioral issues



Percentage of Children Ages 11 to 14 With Specific Behavioral Issues



Percentage of Children Ages 15 to 17 With Specific Behavioral Issues



Costs Associated With Family Foster Homes and Residential Group Care

Foster Parent Room and Board Rates

Foster parents received an average daily rate of $16

Calendar Year 2015 Monthly Foster Care Rate		
Children Ages 0 Through 5	Children Ages 6 Through 12	Children Ages 13 Through 21
$439	$451	$527

Source: Section 409.145, *F.S.*, provides base monthly rates of $429, $440, and $515, respectively; the department provides an annual cost of living increase.

Fiscal Year 2013-14 Residential Group Care Daily Rates

- Shift-care model daily costs ranged from $52 to $283
- Shift-care average daily rate $124; median daily rate $115
- House-parent model daily costs ranged from $17 to $175
- House-parent average daily rate $97; median daily rate $97

Group Care Expenditures Through Fiscal Year 2014-15

State Fiscal Year	Average Number of Children in Out-of-Home Care (Percentage Change from Prior Fiscal Year)[1]	Average Number of Children in Residential Group Care (Percentage Change from Prior Fiscal Year)[2]	Residential Group Care Expenditures[3]	Percentage Change in Residential Group Care (Expenditures from Prior Fiscal Year)
2007-08	24,755	3,075	$112,240,934	
2008-09	21,020 (-15%)	2,696 (-12%)	$98,411,631	-12%
2009-10	18,936 (-10%)	2,389 (-11%)	$88,778,416	-10%
2010-11	18,704 (-1%)	2,223 (-7%)	$87,941,722	-1%
2011-12	19,761 (6%)	2,268 (2%)	$86,840,671	-1%
2012-13	18,854 (-5%)	2,135 (-6%)	$84,482,158	-3%
2013-14	18,464 (-2%)	2,052 (-4%)	$88,710,648	5%
2014-15	20,520 (11%)	2,230 (9%)	$89,778,347	1%

[1] This figure is calculated by averaging the number of children in care at the end of each month in the fiscal year.

[2] This figure is calculated by averaging the number of children in care at the end of each month in the fiscal year. Children in all types of residential group care were used in this calculation.

[3] Fiscal Year 2014-15 residential group care expenditures are year-to-date expenditures from the Department of Children and Families.

Source: OPPAGA analysis of Department of Children and Families data.

Fiscal Year 2014-15 Group Care Expenditures Accounted for 60% of All Licensed Care Expenditures

Community-Based Care Lead Agency	Foster Care Expenditures	Residential Group Care Expenditures	Other Licensed Care Expenditures	Percentage of Licensed Care Expenditures Spent on Residential Group Care
Big Bend CBC	$1,347,954	$3,236,695	$124,477	69%
Brevard Family Partnerships	2,140,572	2,233,708	122,335	50%
CBC of Central Florida (Orange-Osceola)	2,881,675	4,516,097	0	61%
CBC of Central Florida (Seminole)	747,749	2,055,688	0	73%
Childnet (Broward)	8,933,230	10,317,774	2,709,449	47%
Childnet (Palm Beach)	3,058,949	8,674,408	1,322,192	66%
Children's Network of Southwest Florida	2,357,510	3,553,280	0	60%
Community Partnership for Children	1,941,694	2,218,983	294,666	50%
Devereux	981,195	5,145,187	289,779	80%
Eckerd (Hillsborough)	3,641,636	7,497,008	0	67%
Eckerd (Pasco-Pinellas)	3,938,083	5,833,173	0	60%
Families First Network	3,056,071	2,337,549	83,425	43%
Family Integrity Program	241,288	522,319	0	68%
Family Support Services of North Florida	2,877,920	2,536,005	3,675	47%
Heartland for Children	1,711,467	5,532,589	445,581	72%
Kids Central	2,415,986	2,708,094	1,221,885	43%
Kids First of Florida	611,354	451,480	1,224	42%
Our Kids	6,672,112	15,064,529	0	69%
Partnership for Strong Families	1,387,891	1,914,202	0	58%
Sarasota Family YMCA	1,263,390	3,429,679	0	73%
Total[1]	$52,207,725	$89,778,347	$6,618,688	60%

Required Services and Activities for Family Foster Homes and Residential Group Care

Group Care Services

Group care must provide or ensure access to a minimum range of activities and services

Group Care Activities and Services

- Recreation and leisure activities
- Cultural enrichment
- Transportation
- Medical and dental care
- Work activities
- Clothing and hygiene items
- Behavioral management program
- Assessments and service plans
- Educational and vocational services
- Budget training
- Life skills training

Medical services, including behavioral health care, are provided by Medicaid

Foster Parents' Roles and Responsibilities

Foster parents are expected to provide quality parenting and fulfill certain roles and responsibilities

Roles and Responsibilities of Foster Parents

- Assist with child's case plan
- Complete trauma training
- Support child's ties to biological family
- Advocate for the child
- Participate in health care services
- Support educational success
- Maintain important records
- Ensure independent living skills
- Enable child to maintain mentoring relationships

Medical services, including behavioral health care, are provided by Medicaid

Contact Information

Megan Smernoff, J.D.
Senior Legislative Analyst
(850) 717-0532
smernoff.megan@oppaga.fl.gov

Mary Alice Nye, Ph.D.
Health and Human Services Staff Director
(850) 717-0567
nye.maryalice@oppaga.fl.gov

Questions?

Residential Group Care in Florida
Scale and Scope

Ginger Griffeth, Child Welfare Director of Performance and Quality Management

Senate Children, Families and Elder Affairs Committee

April 17, 2017

Residential Group Care (RGC) as a Part of Florida's Continuum of Care

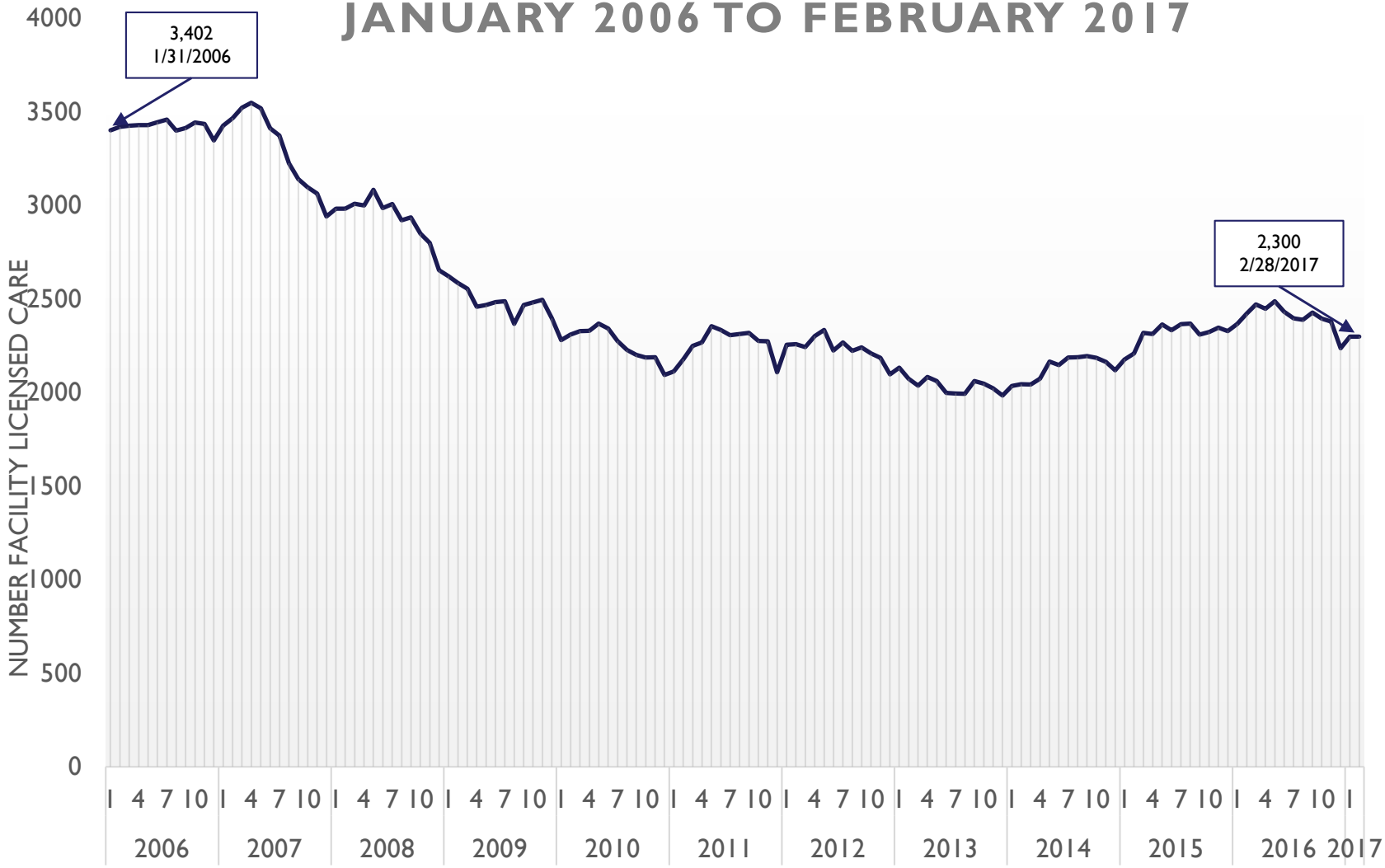
- Most Family-like settings are best
- RGC should never be a default
- Assessment and placement should be based on specific behavioral or mental health need or clinical disability
- RGC should be time limited based on the needs of the child

Working Towards Solutions

Appropriate Utilization:
Enhancing Service Array
Increasing FH Capacity
Rethinking How RGC is Used

Ensuring Quality RGC:
Quality Standards
Innovative Practices
Worker skill enhancement

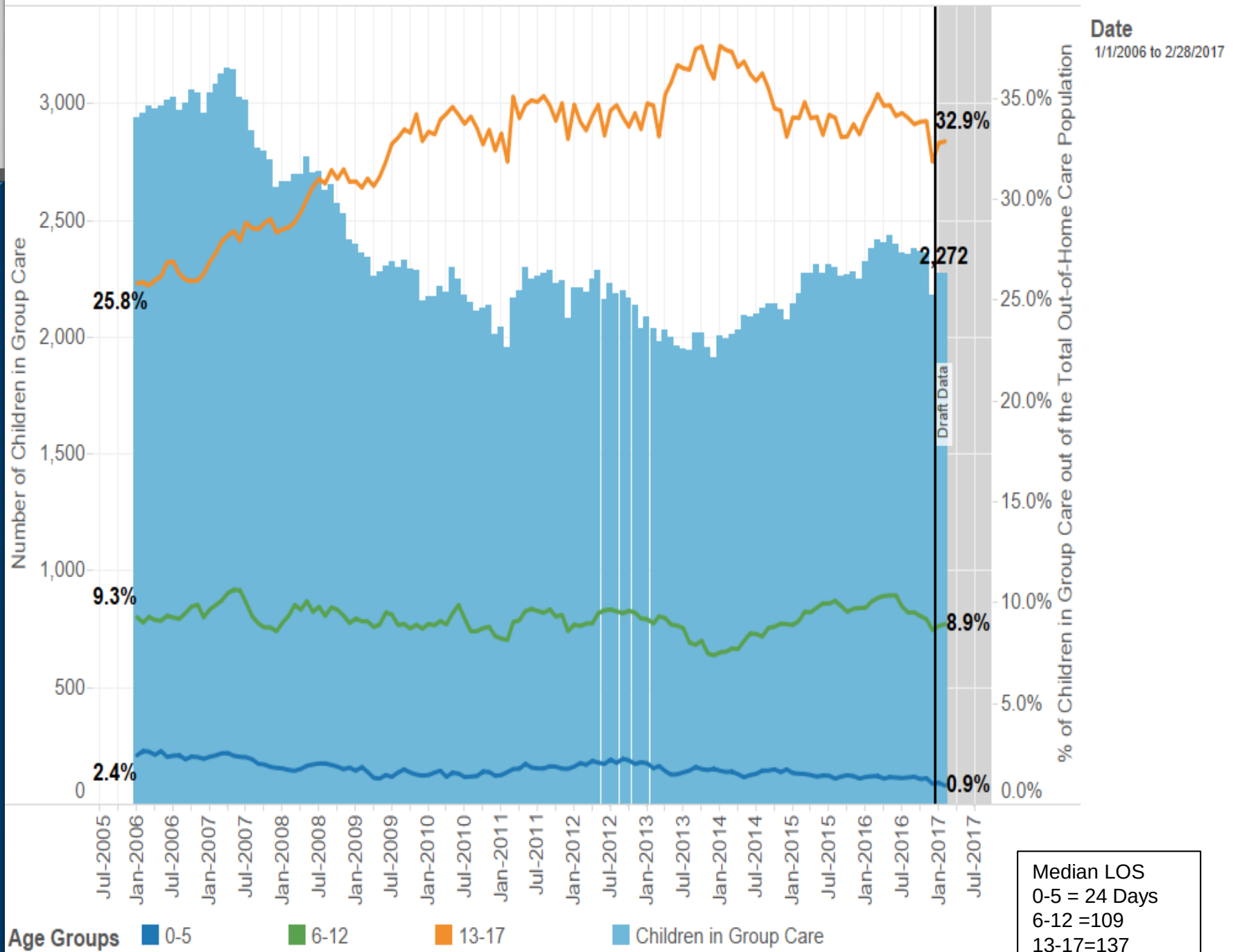
CHILDREN IN RGC
AS OF THE LAST DAY OF THE MONTH
STATEWIDE
JANUARY 2006 TO FEBRUARY 2017



RGC represents 10% of the Total OOHC Population

National Rankings
24th in 2010
13th in 2015

Count of Children in Group Care and Percent of Children in Group Care of Total Out-of-Home Care Population



Median LOS
0-5 = 24 Days
6-12 =109
13-17=137

Data Source: FSFN Data Repository, Tableau Data Source
Group care includes children placed in group homes and residential treatment centers.

Last Updated: 3/4/2017

Questions?