Tab 1	**SPB 7050** by **HP**; Marijuana

693990	A	S	FAV	HP, Burton	Delete L.49:	02/06 03:46 PM

Tab 2	**SB 338** by **Berman (CO-INTRODUCERS) Rodriguez**; (Compare to CS/H 00165) Safe Waterways Act

440740	D	S	RCS	HP, Berman	Delete everything after	02/06 03:46 PM

Tab 3	**SB 1582** by **Rodriguez**; (Similar to CS/H 01441) Department of Health

879888	A	S	RCS	HP, Rodriguez	Delete L.748 - 902.	02/06 03:46 PM

Tab 4	**SB 768** by **Stewart**; (Compare to CS/H 01653) Duty to Report Certain Deaths

581312	D	S	RCS	HP, Stewart	Delete everything after	02/06 03:46 PM

Tab 5	**SB 1442** by **Grall**; (Identical to H 01609) Pregnancy Support Services

Tab 6	**SB 1474** by **Trumbull**; (Similar to CS/H 01063) Chiropractic Medicine

194076	A	S	RCS	HP, Trumbull	Delete L.43:	02/06 03:46 PM

Tab 7	**SB 1798** by **Trumbull**; (Compare to CS/H 00935) Home Health Care Services

477550	D	S	RCS	HP, Trumbull	Delete everything after	02/06 03:46 PM

Tab 8	**SB 962** by **Hooper**; (Similar to CS/H 00883) Student Health

194644	A	S	RCS	HP, Hooper	Delete L.95 - 242:	02/06 03:46 PM

Tab 9	**SB 1632** by **Collins (CO-INTRODUCERS) Avila**; (Similar to H 01391) Public Records/Personnel of the Agency for Health Care Administration

Tab 10	**SB 1188** by **Garcia**; (Identical to H 01561) Office Surgeries

860118	A	S	RCS	HP, Garcia	Delete L.47 - 293:	02/06 03:46 PM

Tab 11	**SB 1118** by **Harrell**; (Similar to H 01069) Nursing Education Programs

Tab 12	**SB 1612** by **Brodeur**; (Compare to CS/H 01259) Adult Cardiovascular Care Standards

471432	D	S	RCS	HP, Brodeur	Delete everything after	02/06 03:46 PM

Tab 13	**CS/SB 238** by **JU, Burton**; (Identical to CS/H 00995) Claims Against Assisted Living Facilities

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Burton, Chair
Senator Brodeur, Vice Chair

MEETING DATE: Tuesday, February 6, 2024
TIME: 11:30 a.m.—2:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Burton, Chair; Senator Brodeur, Vice Chair; Senators Albritton, Avila, Book, Calatayud, Davis, Garcia, Harrell, and Osgood

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	Consideration of proposed bill:		
1	**SPB 7050**	Marijuana; Prohibiting medical marijuana treatment centers from selling, delivering, or distributing marijuana with greater than a specified potency; providing an exception for edibles; prohibiting edibles for personal use from containing more than a specified amount of tetrahydrocannabinol, etc. **(Preliminary Draft Available - final draft will be made available at least 24 hours prior to the meeting)**	Submitted and Reported Favorably as Committee Bill Yeas 7 Nays 3
2	**SB 338** Berman (Compare CS/H 165)	Safe Waterways Act; Citing this act as the "Safe Waterways Act"; requiring the Department of Health and the Department of Environmental Protection to submit to the Governor and the Legislature, by a specified date, certain recommendations relating to the transfer of duties related to the bacteriological sampling of beach waters and public bathing places; specifying that the Department of Environmental Protection is solely responsible for adopting and enforcing rules related to the bacteriological sampling of beach waters and public bathing places; requiring municipalities and counties to immediately notify the department of any incident that may affect the quality of beach waters or public bathing places within their respective jurisdictions, etc. HP 02/06/2024 Fav/CS AEG FP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
3	**SB 1582** Rodriguez (Similar CS/H 1441, Compare H 1549, CS/S 7016)	Department of Health; Exempting environmental health technicians from certain certification requirements under certain circumstances; creating the Andrew John Anderson Rare Pediatric Disease Grant Program within the department for a specified purpose; providing that any health care practitioner present at a birth or responsible for primary care during the neonatal period has the primary responsibility of administering certain screenings; revising hearing loss screening requirements to include infants and toddlers, etc. HP 02/06/2024 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
4	**SB 768** Stewart (Compare CS/H 1653)	Duty to Report Certain Deaths; Reclassifying the criminal penalty for failure or refusal to report certain deaths and information to the district medical examiner or for engaging in specified conduct related to such deaths, etc. CJ 01/16/2024 Favorable HP 02/06/2024 Fav/CS FP	Fav/CS Yeas 10 Nays 0
5	**SB 1442** Grall (Identical H 1609)	Pregnancy Support Services; Establishing the Florida State Maternity Housing Grant Program within the Department of Health; requiring the program to provide certain resources; requiring the department to use grant funds for specified expenses; providing a limitation on the amount of grants awarded under the program, etc. HP 02/06/2024 Favorable AHS FP	Favorable Yeas 10 Nays 0
6	**SB 1474** Trumbull (Similar CS/H 1063)	Chiropractic Medicine; Revising the definition of the term “practice of chiropractic medicine” to include a specified treatment that a chiropractic physician may use; revising education requirements for licensure as a chiropractic physician, etc. HP 02/06/2024 Fav/CS AHS RC	Fav/CS Yeas 9 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 1798** Trumbull (Compare CS/H 935)	Home Health Care Services; Authorizing contract staff to provide specified visits for a home health agency under certain circumstances; authorizing an advanced practice registered nurse to order or write prescriptions for certain Medicaid services, etc. HP 02/06/2024 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0
8	**SB 962** Hooper (Similar CS/H 883)	Student Health; Revising a provision to authorize asthmatic students to carry a short-acting bronchodilator, rather than a metered dose inhaler; authorizing licensed pharmacists to dispense short-acting bronchodilators and components in the name of a public school; requiring certain public schools to adopt a protocol developed by a licensed physician for the administration of a short-acting bronchodilator and components by school personnel; authorizing certain students to carry a short-acting bronchodilator at school under certain conditions, etc. ED 01/30/2024 Favorable HP 02/06/2024 Fav/CS RC	Fav/CS Yeas 9 Nays 0
9	**SB 1632** Collins (Similar H 1391)	Public Records/Personnel of the Agency for Health Care Administration; Providing an exemption from public records requirements for the personal identifying and location information of certain current or former personnel of the Agency for Health Care Administration and their spouses and children; providing for future legislative review and repeal of the exemption; providing for retroactive application; providing a statement of public necessity, etc. HP 02/06/2024 Favorable GO RC	Favorable Yeas 10 Nays 0
10	**SB 1188** Garcia (Identical H 1561)	Office Surgeries; Revising the types of procedures for which a medical office must register with the Department of Health to perform office surgeries; revising standards of practice for office surgeries; specifying notification and inspection procedures for the department and the Agency for Health Care Administration in the event that, during the reregistration process, the department determines that the performance of specified procedures in an office creates a risk of patient safety such that the office should instead be regulated as an ambulatory surgical center, etc. HP 02/06/2024 Fav/CS AHS FP	Fav/CS Yeas 10 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
11	**SB 1118** Harrell (Similar H 1069)	Nursing Education Programs; Revising application requirements for nursing education program approval; revising requirements for annual reports approved programs are required to submit to the board; authorizing agents of the Department of Health to conduct onsite evaluations and inspections of approved and accredited nursing education programs; deleting a provision authorizing approved nursing education programs to request an extension to meet the board's accreditation requirements, etc. HP 02/06/2024 Favorable AHS RC	Favorable Yeas 9 Nays 1
12	**SB 1612** Brodeur (Compare CS/H 1259)	Adult Cardiovascular Care Standards; Deleting the requirement for the Agency for Health Care Administration to adopt certain rules for adult inpatient diagnostic cardiac catheterization programs; requiring the agency to update its rules as often as necessary to remain consistent with new standards and guidelines published by certain entities, etc. HP 02/06/2024 Fav/CS AHS RC	Fav/CS Yeas 10 Nays 0
13	**CS/SB 238** Judiciary / Burton (Identical CS/H 995)	Claims Against Assisted Living Facilities; Providing requirements for the bringing of an exclusive cause of action for residents' rights violations or negligence against specified individuals; providing certain individuals with immunity from liability for such claims; revising requirements for recovery of certain damages and liability for such damages, etc. JU 01/29/2024 Fav/CS HP 02/06/2024 Favorable RC	Favorable Yeas 6 Nays 3
	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 Health Policy

BILL:	SB 7050
INTRODUCER:	Health Policy Committee
SUBJECT:	Marijuana
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown		**HP Submitted as Comm. Bill/Fav**

I. Summary:

SB 7050 creates s. 381.9861, F.S., to limit the potency of personal use marijuana to 30 percent tetrahydrocannabinol (THC) for marijuana in a form for smoking, 60 percent THC in all other forms except for edibles, and 200 milligrams of THC for whole edibles and 10 milligrams of THC per serving of an edible. The bill allows for a potency variance of up to 15 percent for edibles.

The bill also repeals a provision of ch. 2017-232, L.O.F.,[1] which would automatically cause that chapter of Florida law to expire six months after the effective date of a constitutional amendment that alters the current constitutional authority for medical marijuana or is related to marijuana or cannabis.

The bill provides an effective date 30 days after the passage of a state constitutional amendment allowing the adult personal use of marijuana.

II. Present Situation:

Research on the Health Effects of THC

Although there are more than 100 cannabinoids in a marijuana plant, the two main cannabinoids are Delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD).[2] THC is a mind-altering chemical that increases appetite and reduces nausea and may also decrease pain, anxiety, and muscle control problems.[3] Though CBD may also have an effect on the mind, it does not produce the "high" or sense of euphoria associated with THC. CBD has been shown to help with anxiety,

[1] Chapter 2017-232, L.O.F., is the act creating the majority of the statutory authority for Florida's medical marijuana program.
[2] U.S. Department of Health & Human Services, National Center for Complementary and Integrative Health, *Cannabis (Marijuana) and Cannabinoids: What You Need To Know*, available at https://www.nccih.nih.gov/health/cannabis-marijuana-and-cannabinoids-what-you-need-to-know (last visited Feb. 4, 2024).
[3] Healthline, *CBD vs. THC: What's the Difference?*, https://www.healthline.com/health/cbd-vs-thc (last visited Feb. 4, 2024).

depression, reducing pain and inflammation, controlling epileptic seizures, and possibly treating psychosis or mental disorders.[4]

Marijuana has changed over time. The THC concentration in commonly cultivated marijuana plants increased three-fold between 1995 and 2014 (4 percent and 12 percent respectively).[5] Conversely, the CBD content decreased from 0.28 percent in 2001 to 0.15 percent in 2014. In 1995, the level of THC was 14 times higher than its CBD level. In 2014, the THC level was 80 times the CBD level.[6] The marijuana available today is much stronger than previous versions.

A 2014 New England Journal of Medicine study warned that long-term marijuana use can lead to addiction and that adolescents are more vulnerable to adverse long-term outcomes from marijuana use.[7] Specifically, the study found that, as compared to persons who begin to use marijuana in adulthood, those who begin in adolescence are approximately two to four times as likely to have symptoms of marijuana dependence within two years after first use.[8] The study also found that marijuana-based treatments with THC may have irreversible effects on brain development in adolescents as the brain's endocannabinoid system undergoes development in childhood and adolescence.[9]

Heavy use of marijuana by adolescents is associated with impairments in attention, learning, memory, poor grades, high drop-out rates, and I.Q. reduction.[10] Though the full extent of the health impact of consuming products with high concentration of THC is unknown, research indicates that use of such products significantly increases the risk of marijuana-associated psychosis,[11] regardless of age at first use or the type of marijuana used.[12] A 2019 European study showed that the use of high-potency marijuana (greater than 10 percent THC) only modestly increased the odds of a psychotic disorder compared to never using it; however, individuals who

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[4] *Id*.
[5] *U.S. Surgeon General's Advisory: Marijuana Use and the Developing Brain*, https://www.hhs.gov/surgeongeneral/reports-and-publications/addiction-and-substance-misuse/advisory-on-marijuana-use-and-developing-brain/index.html (last visited Feb. 4, 2024).
[6] ElSohly, M.A., Mehmedic, Z., Foster, S., Gon, C., Chandra, S. and Church, J.C. *Changes in Cannabis Potency Over the Last 2 Decades (1995-2014): Analysis of Current Data in the United States,* Biological Psychiatry. April 1, 2016; 79(7):613-619.
[7] Volkow, N.D., Baler, R.D., Compton, W.M. and Weiss, S.R., *Adverse Health Effects of Marijuana Use,* NEW ENG. J. MED., June 5, 2014, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4827335/ (last viewed on Feb. 4, 2024).
[8] *Id*.
[9] *Id*.
[10] *Supra* note 7. *See* also *The Influence of Marijuana Use on Neurocognitive Functioning in Adolescents*, Schweinsburg AD, Brown SA, Tapert SF, Curr Drug Abuse Rev. 2008;1(1):99-111, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2825218/ (last viewed on Feb. 4, 2024).
[11] Robin Murray, Harriet Quigley, Diego Quattrone, Amir Englund and Marta Di Forti, *Traditional Marijuana, High-Potency Cannabis and Cannabinoids: Increasing Risk for Psychosis*, World Psychiatry, 2016 Oct; 15(3): 195–204, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5032490/ (last viewed Feb. 4, 2024).
[12] Di Forti et al. *The Contribution of Cannabis Use to Variation in the Incidence of Psychotic Disorder Across Europe (EU-GEI): A Multicenter Case-control Study*. Lancet Psychiatry. 2019; 6:427-36, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7646282/ (last viewed on Feb. 4, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption*, The Lancet, Volume 6, Issue 6, June 2019, available at https://doi.org/10.1016/S2215-0366(19)30174-9 (last viewed Feb. 4, 2024); *High-Potency Cannabis and Incident Psychosis: Correcting the Causal Assumption – Author's Reply*, The Lancet, Volume 6, Issue 6, June 2019, available at https://doi.org/10.1016/S2215-0366(19)30176-2 (last viewed Feb. 4, 2024).

started using high-potency marijuana by age 15 showed a doubling of risk.[13] The European study also found that daily use of high-potency cannabis increased the risk of psychotic disorder nearly five times compared with never having used marijuana.[14]

Another study found that frequent use of marijuana or use of marijuana with high THC potency increased the risk of schizophrenia six-fold.[15] According to a literature review of studies on the impact of marijuana use on mental health published in the Journal of the American Medical Association Psychiatry, there is strong physiological and epidemiological evidence supporting a link between marijuana use and schizophrenia.[16] High doses of THC can cause acute, transient, dose-dependent psychosis, which are schizophrenia-like symptoms.[17] Additionally, prospective, longitudinal, and epidemiological studies have consistently found an association between marijuana use and schizophrenia in which marijuana use precedes psychosis, independent of alcohol consumption, and even after removing or controlling for those individuals who had used other drugs.[18]

Even though marijuana use may have been discontinued long before the onset of psychosis, studies have found that the age at which marijuana use begins appears to correlate with the age of onset of psychosis, which suggests that early marijuana use plays a role in initiating psychosis that is independent of actual use.[19] Overall, studies have found that the association between marijuana use and chronic psychosis (including a schizophrenia diagnosis) is stronger in those individuals who have had heavy or frequent marijuana use, use marijuana during adolescence, or use marijuana with high THC potency.[20]

While studies have not shown that marijuana use alone is either necessary or sufficient for the development of schizophrenia, studies suggests that marijuana use may initiate the emergence of a lasting psychotic illness in some individuals, especially those with a genetic vulnerability to develop a psychotic illness.[21]

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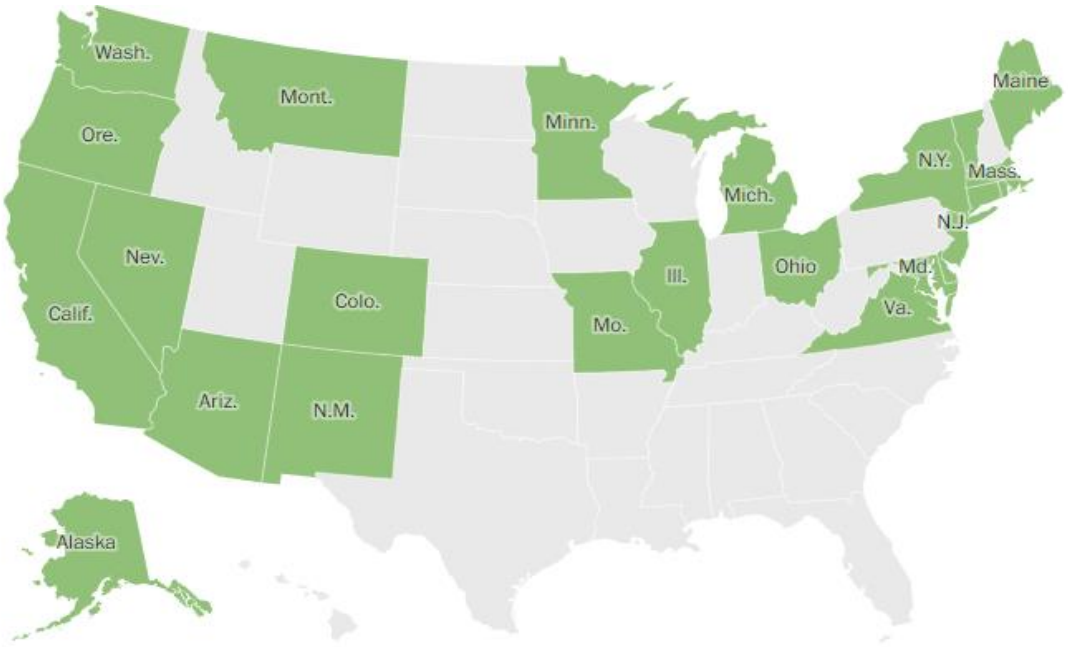
[13] *Id*. at 430.
[14] *Id*. at 431. The odds were lower for those who use low-potency marijuana daily.
[15] Nora D. Volkow, MD; James M. Swanson, PhD; A. Eden Evins, MD; Lynn E. DeLisi, MD; Madeline H. Meier, PhD; Raul Gonzalez, PhD; Michael A. P. Bloomfield, MRCPsych; H. Valerie Curran, PhD; Ruben Baler, PhD., *Effects of Cannabis Use on Human Behavior, Including Cognition, Motivation, and Psychosis: A Review.* JAMA Psychiatry. 2016; 73(3):292-297, available at https://core.ac.uk/reader/79505094?utm_source=linkout (last viewed Feb. 4, 2024).
[16] *Id*.
[17] *Id*.
[18] *Id*.
[19] *Id*.
[20] *Id*.
[21] *Id*.

State Legalization of Adult Use of Marijuana

Currently, 24 states and the District of Columbia (depicted as green in the illustration below) have legalized the adult use of marijuana:[22, 23]



State Potency Limits for Adult Use Marijuana

Two states, Connecticut and Vermont, currently have potency limits for adult use marijuana products. Both states prohibit cannabis flower with a total THC concentration greater than 30 percent and solid or liquid concentrate cannabis products with a total THC concentration of greater than 60 percent from being cultivated, produced or sold in the adult use market.[24] Both states provided an exception to these potency limits for pre-filled cartridges for vape pens.[25]

Florida: Adult Personal Use of Marijuana

Adult personal use of marijuana is not legal in Florida. However, there is a pending ballot initiative to authorize adult personal use. The proponents of the initiative were required to obtain 891,523 valid signatures to qualify the initiative for the ballot. The proponents have met this

[22] California, Alaska, Nevada, Oregon, Washington, Maine, Colorado, Montana, Vermont, Rhode Island, New Mexico, Michigan, Arizona, New Jersey, Delaware, Connecticut, Massachusetts, Illinois, Maryland, Minnesota, New York, Ohio, Missouri, Virginia.
[23] *More Than Half of Americans Live in Places Where Recreational Marijuana is Legal,* Tim Meko and Adrian Blanco, The Washington Post, Nov. 8, 2023, available at https://www.washingtonpost.com/politics/2023/legal-weed-states-map/ (last viewed Feb. 4, 2024).
[24] See CT ST s. 21a-421j and VT ST T.7 s. 868.
[25] *Id.*

requirement as there are currently 1,033,770 valid signatures for the initiative, according to the Florida Secretary of State's Division of Elections.[26] The ballot summary of the initiative states:[27]

> Allows adults 21 years or older to possess, purchase, or use marijuana products and marijuana accessories for non-medical personal consumption by smoking, ingestion, or otherwise; allows Medical Marijuana Treatment Centers, and other state licensed entities, to acquire, cultivate, process, manufacture, sell, and distribute such products and accessories. Applies to Florida law; does not change, or immunize violations of, federal law. Establishes possession limits for personal use. Allows consistent legislation. Defines terms. Provides effective date.

The Florida Attorney General requested an advisory opinion from the Florida Supreme Court as to the validity of the initiative, specifically seeking guidance on whether the initiative and the ballot title and summary comply with applicable Florida law.[28] Oral arguments occurred in November 2023, and the issue remains pending before the court.[29]

Florida Potency of Medical Marijuana Products

Although Florida does not have an adult personal use program, it does have a well-established medical marijuana program. Section 381.986, F.S., authorizes patients with any of the following debilitating medical conditions to legally obtain medical marijuana from licensed medical marijuana treatment centers (MMTC):

- Cancer
- Epilepsy
- Glaucoma
- Positive status for human immunodeficiency virus
- Acquired immune deficiency syndrome
- Post-traumatic stress disorder
- Amyotrophic lateral sclerosis
- Crohn's disease
- Parkinson's disease
- Multiple sclerosis
- Medical conditions of the same kind or class as or comparable to those enumerated above

[26] Adult Personal Use of Marijuana 22-05, Florida Division of Elections, available at https://dos.elections.myflorida.com/initiatives/initdetail.asp?account=83475&seqnum=2 (last viewed Feb. 5, 2024).
[27] Constitutional Amendment Full Text, available at https://initiativepetitions.elections.myflorida.com/InitiativeForms/Fulltext/Fulltext_2205_EN.pdf (last viewed January 31, 2024).
[28] *Advisory Opinion to the Attorney General Re: Adult Personal Use of Marijuana*, SC2023-0682, 2023, available at https://acis.flcourts.gov/portal/court/68f021c4-6a44-4735-9a76-5360b2e8af13/case/85dca015-d108-4595-8cdb-d4488890aa88 (last viewed Feb. 4, 2024).
[29] *Id.*

To obtain marijuana for medical use from an MMTC, and maintain the immunity from criminal prosecution, the patient must obtain a physician certification from a qualified physician[30] and an identification card from the Department of Health.

As of February 2, 2024, there are 872,376 qualified patients, 2,781 qualified physicians, and 25 MMTCs with 618 dispensing locations.[31]

Currently-licensed MMTCs would be eligible to acquire, cultivate, process, manufacture, sell, and distribute adult personal use marijuana products if the ballot initiative were to pass. The THC concentration of the products offered by MMTCs varies based on the route of administration as evidenced by the table below.[32]

Route of Administration	Range in Potency Tetrahydrocannabinol (THC) Content as a Percentage of Volume	
	Lower Threshold	Upper Threshold
Inhalation	60.0%	90.0%
Oral	0.5%	4.0%
Smoking	10.0%	28.0%
Sublingual	0.5%	90.0%
Suppository	1.3%	3.0%
Topical	0.4%	90.0%
Edibles	A multi-serving edible may not contain more than 200 mg of THC, and a single-serving edible, or a single serving portion of a multi-serving edible, may not exceed 10 mg of THC.	

Edibles are the only medical marijuana products currently subject to THC potency limits under Florida law.

III. Effect of Proposed Changes:

SB 7050 creates s. 381.9861, F.S., to provide limitations on the potency of marijuana for personal use. The bill defines the terms:

- "Edibles" to mean commercially produced food items made with marijuana oil, but no other form of marijuana
- “Marijuana” to mean all parts of any plant of the genus Cannabis, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin, including low-THC cannabis.

[30] To certify patients for medical use of marijuana, a physician must hold an active, unrestricted license as an allopathic physician under chapter 458 or as an osteopathic physician under chapter 459 and comply with certain physician education requirements. See ss. 381.986(1)(m), F.S. and 381.986(3)(a), F.S.

[31] *Office of Medical Marijuana Use Weekly Updates, Feb. 2, 2024*, DOH, Office of Medical Marijuana Use, available at https://knowthefactsmmj.com/wp-content/uploads/ommu_updates/2024/020224-OMMU-Update.pdf (last visited on Feb. 4, 2024).

[32] *Florida’s Medical Marijuana Program Update,* Office of Medical Marijuana Use, presented to the Florida House Health Care Regulation Subcommittee on December 13, 2023.

- "Marijuana delivery device" to mean an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing marijuana into the human body.
- "Personal use" to mean possession, purchase, or use of marijuana or a marijuana delivery device by an adult 21 years of age or older for nonmedical consumption.
- "Potency" to mean the relative strength of cannabinoids, and the total amount, in milligrams, of tetrahydrocannabinol as the sum of delta-9-tetrahydrocannabinol, plus 0.877 multiplied by tetrahydrocannabinolic acid, plus delta-8-tetrahydrocannabinol and cannabidiol as the sum of cannabidiol, plus 0.877 multiplied by cannabidiolic acid in the final product.

The bill provides that an MMTC may not sell, deliver, or distribute marijuana for personal use that has a potency, by weight or volume, of greater than 30 percent THC for marijuana in a form for smoking or greater than 60 percent THC in the final product for all other forms of marijuana, other than edibles. For edibles, a total edible may not contain more than 200 milligrams of THC and a single serving may not exceed 10 milligrams of THC. The bill allows for a potency variance of up to 15 percent for edibles.

The bill also amends s. 1 of ch. 2017-232, L.O.F., to repeal a provision that would cause that chapter of Florida law (which contains significant portions of the statutory authority for Florida's medical marijuana program) to expire six months after the effective date of any constitutional amendment which amends s. 29, Art. X, of the State Constitution or is related to cannabis or marijuana.

The bill provides that its provisions will take effect 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends chapter 2017-232 of the Laws of Florida.

This bill creates section 381.9861 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.)

None.

B. Amendments:

None.

693990

LEGISLATIVE ACTION

Senate	.	House
Comm: FAV	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Burton) recommended the following:

Senate Amendment (with title amendment)

Delete line 49

and insert:

tetrahydrocannabinol. Edibles may have a potency variance of no greater than 15 percent.

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

And the title is amended as follows:

Delete line 8

693990

and insert:

more than a specified amount of tetrahydrocannabinol or from having a potency variance greater than a specified percentage;

FOR CONSIDERATION By the Committee on Health Policy

588-02755A-24 20247050pb

A bill to be entitled

An act relating to marijuana; creating s. 381.9861, F.S.; defining terms; prohibiting medical marijuana treatment centers from selling, delivering, or distributing marijuana with greater than a specified potency; providing an exception for edibles; prohibiting edibles for personal use from containing more than a specified amount of tetrahydrocannabinol; amending chapter 2017-232, Laws of Florida; abrogating the contingent future repeal of specified provisions; providing a contingent effective date.

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

Section 1. Section 381.9861, Florida Statutes, is created to read:

381.9861 Limitations on the personal use of marijuana.—

(1) As used in this section, the term:

(a) "Edibles" means commercially produced food items made with marijuana oil, but no other form of marijuana.

(b) "Marijuana" means all parts of any plant of the genus *Cannabis*, whether growing or not; the seeds thereof; the resin extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant or its seeds or resin, including low-THC cannabis.

(c) "Marijuana delivery device" means an object used, intended for use, or designed for use in preparing, storing, ingesting, inhaling, or otherwise introducing marijuana into the human body.

(d) "Personal use" means possession, purchase, or use of marijuana or a marijuana delivery device by an adult 21 years of age or older for nonmedical consumption.

(e) "Potency" means the relative strength of cannabinoids, and the total amount, in milligrams, of tetrahydrocannabinol as the sum of delta-9-tetrahydrocannabinol, plus 0.877 multiplied by tetrahydrocannabinolic acid, plus delta-8-tetrahydrocannabinol and cannabidiol as the sum of cannabidiol, plus 0.877 multiplied by cannabidiolic acid in the final product.

(2) A medical marijuana treatment center may not sell, deliver, or distribute marijuana for personal use which has a potency, by weight or volume, of greater than 30 percent tetrahydrocannabinol for marijuana in a form for smoking or greater than 60 percent tetrahydrocannabinol in the final product for all other forms of marijuana, excluding edibles. Edibles for personal use may not contain more than 200 milligrams of tetrahydrocannabinol, and a single serving portion of an edible may not exceed 10 milligrams of tetrahydrocannabinol.

Section 2. Section 1 of chapter 2017-232, Laws of Florida, is amended to read:

Section 1. Legislative intent.—It is the intent of the Legislature to implement s. 29, Article X of the State Constitution by creating a unified regulatory structure. ~~If s. 29, Article X of the State Constitution is amended or a constitutional amendment related to cannabis or marijuana is adopted, this act shall expire 6 months after the effective date of such amendment.~~

Section 3. This act shall take effect 30 days after passage of an amendment to the State Constitution authorizing adult personal use of marijuana.

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

2/6/24
Meeting Date

The Florida Senate
APPEARANCE RECORD

Deliver both copies of this form to
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7050
Bill Number or Topic

Health Policy
Committee

693990
Amendment Barcode (if applicable)

Name Melissa Villar

Phone (850) 354-8424

Address PO Box 11284
Street

Email melissa@nomhallahassee.org

Tlh FL 32302
City State Zip

Speaking: [ ] For [x] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[x] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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02/06/24
Meeting Date

Senate Health
Committee

7050
SB [redacted]8
Bill Number or Topic

Amendment Barcode (if applicable)

Name Will Clark - Libertarian Party of Florida Phone 850-590-0023

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Street

Quincy FL 32351
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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2.5.2024
Meeting Date

Health Policy
Committee

7050
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jodi James

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Melbourne FL 32935
City State Zip

Email jodi@FLCAN.org

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:
Florida Cannabis Action Network

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

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2/6/24
Meeting Date

Health Policy
Committee

7050
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melissa Villar

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Street

Email MelissaV@thcc.ntally.org

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City *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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2/6/24
Meeting Date

Health Policy
Committee

7050
Bill Number or Topic

Amendment Barcode (if applicable)

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Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☒ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

Medical Marijuana Business Association of Florida

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

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2/6/24
Meeting Date

Health Policy
Committee

7050 and
Bill Number or Topic

Amendment Barcode (if applicable)

Name Melissa Miller

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TLH FL 32302
City State Zip

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

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2/6/24
Meeting Date

Health Policy
Committee

7050
Bill Number or Topic

Amendment Barcode (if applicable)

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TLH fla 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☑ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
AYR Wellness

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 338
INTRODUCER:	Health Policy Committee and Senators Berman and Rodriguez
SUBJECT:	Safe Waterways Act
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.			AEG	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 338 amends s. 514.023, F.S., to require the Department of Health (DOH) to adopt and enforce rules to protect the health, safety, and welfare of persons using beach waters and public bathing places. At a minimum the rules must require owners of beach waters and public bathing places to notify the DOH and retest waters within 24 hours after a test result indicates that a sample fails to meet bacteriological standards. The DOH is required by the bill, rather than allowed, to issue a health advisory, within 24 hours or the next business day, if water quality does not meet standards and must require the closure of beach waters and public bathing places if necessary to protect public health, safety, and welfare. The closure must remain in effect until the water quality is restored.

Additionally, the DOH must adopt by rule a sign that must be used when it issues a health advisory due to elevated fecal coliform, Escherichia Coli (E. coli), or enterococci bacteria, in tested waters which must be a specific size and be maintained by municipalities and counties around waters they own and by the Department of Environmental Protection (DEP) around state waters.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Bacteria

Water is full of bacteria, some of which are beneficial and others which are not.[1] Fecal coliform are naturally occurring bacteria found in the digestive tracts of most animals and they are shed from the body with excrement.[2] While infections from fecal coliform bacteria are typically not fatal, severe symptoms may lead to death.[3] *Escherichia coli* (*E. coli*), a type of fecal coliform bacteria, are found in the environment, intestines of people and animals, and foods.[4] Some strains of *E. coli* may cause illnesses such as intestinal and urinary tract infections, meningitis[5], and septicemia[6].[7] Enterococci are bacteria that live in the intestinal tracts of humans and warm-blooded animals.[8] These bacteria can sicken swimmers and other potential health effects can include diseases of the skin, eyes, ears and respiratory tract.[9]

Sources of fecal indicator bacteria such as enterococci include wastewater treatment plant effluent, leaking septic systems, storm water runoff, sewage discharged or dumped from recreational boats, domestic animal and wildlife waste, improper land application of manure or sewage, and runoff from manure storage areas, pastures, rangelands, and feedlots. There are also natural, non-fecal sources of fecal indicator bacteria, including plants, sand, soil and sediments, that contribute to a certain background level in ambient waters and vary based on local environmental and meteorological conditions.[10]

Beach Waters and Public Bathing Places

Beach waters are the salt waters and brackish waters along the coastal and intracoastal beaches.[11] A public bathing place is a body of water, including artificial impoundments, waters along the coastal and intracoastal beaches and shores of the state, lakes, streams, and rivers that are used by the public for swimming and recreational bathing.[12]

---

[1] United States Geological Survey (USGS), *Bacteria and E. Coli in Water*, https://www.usgs.gov/special-topics/water-science-school/science/bacteria-and-e-coli-water (last visited Feb. 2, 2024).
[2] Jesse Minor, Encyclopedia of Environment and Society - Fecal Coliform Bacteria, https://www.researchgate.net/publication/285400656_Fecal_Coliform_Bacteria , p. 3 (2007).
[3] *Id*.
[4] *Id.*
[5] Some people with meningitis caused by bacteria "die and death can occur in as little as a few hours. However, most people recover from bacterial meningitis. Those who do recover can have permanent disabilities, such as brain damage, hearing loss, and learning disabilities." CDC, *Bacterial Meningitis* (last updated July 15, 2021), https://www.cdc.gov/meningitis/bacterial.html (last visited Feb. 2, 2024).
[6] Septicemia is an infection that occurs when bacteria enter the bloodstream and spread. It can lead to sepsis, the body's reaction to the infection, which can cause organ damage and even death.
[7] USGS, *supra* note 3.
[8] Environmental Protection Agency (EPA), National Aquatic Resource Surveys, *Indicators: Enterococci, What are enterococci?* (last updated June 9, 2023), https://www.epa.gov/national-aquatic-resource-surveys/indicators-enterococci (last visited Feb. 2, 2024).
[9] *Id*.
[10] *Id*.
[11] Section 514.023(1), F.S.
[12] Section 514.011(4), F.S.

The Department of Health (DOH) may, but is not required to, adopt and enforce rules to protect the health, safety, and welfare of individuals using beach waters and public bathing places in Florida.[13] If adopted, "[t]he rules must establish health standards and prescribe procedures and timeframes to conduct bacteriological sampling of beach waters and public bathing places."[14] The issuance of health advisories related to such sampling is preempted to the state, and the DOH is authorized to issue health advisories when beach waters or a public bathing place fail to meet health standards.[15]

DOH Regulation of Beach Waters and Public Bathing Places

The regulation of bathing places is important to prevent disease and sanitary nuisances which may threaten or impair the health or safety of individuals.[16] The DOH has adopted and enforces rules requiring the owners or managers of public bathing places to monitor for water quality, report the results to the DOH and the relevant county health department, and provide notice to the DOH and the public whenever there are water quality violations of the adopted bacteriological standards for fecal coliform, *E. coli*, or enterococci.[17] The owner or manager of a public bathing place is required to collect and test bacteriological samples each month.[18]

If test results exceed standards established by the DOH, then the owner or manager must, within 24 hours of receipt of the results, notify the relevant county health department and re-sample the water.[19] The county health department must also inspect the waters upon receipt of the test results.[20] If the 24-hour samples confirm an exceedance of standards, the owner or manager must immediately post a no swimming advisory[21]; if the owner or manager does not post the advisory, the DOH is required to post it.[22] Once re-sampling confirms that the bathing water again meets the standards, the owner or manager may rescind the posted no-swimming advisory.[23]

When the DOH issues a health advisory against swimming in beach waters or a public bathing place because elevated levels of fecal coliform, *E. coli*, or enterococci bacteria have been detected in a water sample, it must "concurrently notify the municipality or county in which the affected beach waters are located, whichever has jurisdiction, and the local office of the Department of Environmental Protection (DEP), of the advisory."[24] The local DEP office is required to "promptly investigate" all wastewater treatment facilities located within 1 mile of the affected area(s) to determine whether a facility may have contributed to the contamination.[25] The

[13] Section 514.023(2), F.S.
[14] *Id*.
[15] Section 514.023(3), F.S.
[16] Rule 64E-9.001(1), F.A.C.
[17] Rule 64E-9.013(1)-(3), F.A.C.
[18] Rule 64E-9.013(2)(a), F.A.C.
[19] Rule 64E-9.013(2)(a)1., F.A.C.
[20] Rule 64E-9.013(2)(b), F.A.C.
[21] Form DH 4158, Bathing Place Public Health Advisory Sign – Poor Water Quality, 02/13, is incorporated in rule 64E-0.013(a)2., F.A.C. by reference and available at http://www.flrules.org/Gateway/reference.asp?No=Ref-06899.
[22] Rule 64E-9.013(2)(a)2., F.A.C.
[23] *Id*.
[24] Section 514.023(4), F.S.
[25] *Id*.

local DEP office is also required to provide the results of its investigation to the local government with jurisdiction over the affected area.[26]

Florida Healthy Beaches Program

The Florida Healthy Beaches Program was created to monitor salt and brackish water beaches[27] for enterococci bacteria and to more accurately determine whether beaches are safe for recreational uses.[28] In 1998, a grant-funded pilot program allowed 5 of Florida's coastal counties to monitor for enterococci bacteria.[29] In 2000, the program was expanded to 30 counties and also provided for sampling of fecal coliform.[30] In 2002, the Environmental Protection Agency (EPA) provided funding which enabled sampling on a weekly basis; however, in 2011 funding levels decreased, which resulted in a return to bi-weekly sampling.[31] "The goal of the Healthy Beaches Program is to prevent waterborne illness by advising Florida residents and visitors against recreating in waters potentially contaminated with human pathogens."[32]

III. Effect of Proposed Changes:

CS/SB 338 amends s. 514.023, F.S., to require:

- Rather than allow, the DOH to adopt and enforce rules to protect the health, safety, and welfare of persons using beach waters and public bathing places. Such rules must require owners of beach waters and public bathing places to notify the DOH and resample water within 24 hours after a tested sample fails to meet standards established by the DOH.
- Rather than allow, the DOH to issue health advisories within 24 hours or the next business day when waters fail to meet established standards and to require closures of beach waters and public bathing places that fail to meet the DOH's standards if deemed necessary to protect the health, safety, and welfare of the public. These closures must remain in effect until the quality of the water is restored and the DOH has removed any related health advisories.
- Require the DOH to notify, within 24 hours or the next business day of issuing a health advisory, affected local governments, the local DEP office, and local affiliates of national television networks.
- Municipalities and counties or the owners of public boat docks, marinas, and piers, depending on the location of the water, to, within 24 hours or the next business day, notify the DOH immediately of any incident that may affect the quality of beach waters or public bathing places within their jurisdictions.
- The DEP to adopt in rule a sign that must be used when it issues a health advisory against swimming in beach waters or public bathing places due to elevated fecal coliform, *E. Coli*, or enterococci bacteria in the water. The sign:

---

[26] *Id*.
[27] DOH Lee County, *Healthy Beaches* (last updated Feb. 4, 2016), https://lee.floridahealth.gov/programs-and-services/environmental-health/healthy-beaches/index.html (last visited Feb. 2, 2024).
[28] Coastal & Heartland National Estuary Partnership (CHNEP), *Learn More: Healthy Beaches*, https://chnep.wateratlas.usf.edu/library/learn-more/learnmore.aspx?toolsection=lm_healthybeach (last visited Feb. 2, 2024).
[29] DOH, *Florida Healthy Beaches Program* (last updated Feb. 1, 2022), https://www.floridahealth.gov/environmental-health/beach-water-quality/index.html (last visited Feb. 2, 2024).
[30] CHNEP, *supra* note 30.
[31] *Id*.
[32] DOH, *supra* note 31.

  - Must be at least 20 inches by 20 inches; and
  - Must be displayed at beach access points and in conspicuous areas around affected beach waters and public bathing places until subsequent testing of the water demonstrates that the bacteria levels meet the standards established by the DOH.
- Municipalities and counties to post and maintain health advisory signs around affected beach waters and public bathing places that they own.
- The DEP coordinate with the DOH and the Fish and Wildlife Conservation Commission to post and maintain health advisory signs around state beach waters and public bathing places.
- The signage must remain in place until the health advisory is no longer in effect.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have an indeterminate fiscal impact on local area businesses should a beach or public bathing place be closed under the provisions in the bill.

C. Government Sector Impact:

The bill may have an indeterminate fiscal impact on the DOH related to additional duties required of the DOH by the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 514.023 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute:

- Eliminates the underlying bill's transfer of the beach water and public bathing places testing program from the DOH to the DEP;
- Specifies that reporting and health advisory requirements established and amended by the bill must be initiated within 24 hours or the next business day, whichever is sooner;
- Eliminates specific language for signage requirements established in the bill and adds that the sign must be a specific size;
- Eliminates the requirement that the DOH monitor affected water bodies to ensure signage requirements are met; and
- Eliminates the requirement to create an interagency database for reporting specified data.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Berman) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 514.023, Florida Statutes, is amended to read:

514.023 Sampling of beach waters~~;~~ and public bathing places; health advisories; signage.—

(1) As used in this section, the term "beach waters" means the waters along the coastal and intracoastal beaches and shores

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of this ~~the~~ state~~,~~ and includes salt water and brackish water.

(2) The department shall ~~may~~ adopt and enforce rules to protect the health, safety, and welfare of persons using the beach waters and public bathing places of this ~~the~~ state. The rules must establish health standards and prescribe procedures and timeframes for bacteriological sampling of beach waters and public bathing places. At a minimum, the rules must require owners of beach waters and public bathing places to both notify the department and resample the water within 24 hours after a test result indicates that a sample of the beach waters or public bathing place fails to meet standards established by the department.

(3) The department shall, within 24 hours or the next business day, whichever occurs first, ~~may~~ issue health advisories if the quality of beach waters or a public bathing place fails to meet standards established by the department and shall require closure of beach waters and public bathing places that fail to meet the department's standards if it deems closure is necessary to protect the health, safety, and welfare of the public. Closures must remain in effect until the quality of the beach waters or public bathing place is restored in accordance with the department's standards and until the department has removed any related health advisories that it issued. The issuance of health advisories related to the results of bacteriological sampling of beach waters and public bathing places is preempted to the state.

(4)(a) When the department issues a health advisory against swimming in beach waters or a public bathing place on the basis of finding elevated levels of fecal coliform, *Escherichia coli*,

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or enterococci bacteria in a water sample, the department shall, within 24 hours or the next business day, whichever occurs first, concurrently notify the municipality or county in which the affected beach waters or public bathing place is ~~are~~ located, whichever has jurisdiction, ~~and~~ the local office of the Department of Environmental Protection, and the local affiliates of national television networks in the affected area of the advisory.

(b) Municipalities and counties shall, within 24 hours or the next business day, whichever occurs first, notify the department of any incident that negatively impacts the quality of beach waters or public bathing places within their respective jurisdictions. Owners of public boat docks, marinas, and piers shall, within 24 hours or the next business day, whichever occurs first, notify the jurisdictional municipality or county of any incident that negatively impacts the quality of beach waters in which the dock, marina, or pier is located.

(c) The local office of the Department of Environmental Protection shall promptly investigate wastewater treatment facilities within 1 mile of the affected beach waters or public bathing place to determine if a facility experienced an incident that may have contributed to the contamination and provide the results of the investigation in writing or by electronic means to the municipality or county, as applicable.

(d) The department shall adopt by rule a sign that must be used when it issues a health advisory against swimming in affected beach waters or public bathing places due to elevated levels of fecal coliform, *Escherichia coli*, or enterococci bacteria in the water. The department shall require that the

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health advisory sign be no less than 20 inches by 20 inches in diameter and posted at beach access points and in conspicuous areas around affected beach waters and public bathing places until subsequent testing of the water demonstrates that the bacteria levels meet the standards established by the department.

(e) Municipalities and counties are responsible for posting and maintaining health advisory signs as described in paragraph (d) around affected beach waters and public bathing places owned by them. The Department of Environmental Protection is responsible for posting and maintaining health advisory signs around affected beach waters and public bathing places owned by the state. The department shall coordinate with the Department of Environmental Protection and the Fish and Wildlife Conservation Commission as necessary to implement the signage requirements of this subsection. Such signage must be posted and maintained in compliance with this subsection until the health advisory is no longer in effect.

Section 2. This act shall take effect July 1, 2024.

================ 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 sampling of beach waters and public bathing spaces; amending s. 514.023, F.S.; requiring, rather than authorizing, the Department of Health to adopt and enforce certain rules; revising requirements

for such rules; requiring, rather than authorizing, the department to issue certain health advisories within a specified timeframe; directing the department to require closure of beach waters and public bathing places under certain circumstances; requiring that such closures remain in effect for a specified period; preempting the issuance of certain health advisories for public bathing places to the state; specifying a timeframe within which the department must notify the municipality or county, the local office of the Department of Environmental Protection, and the local affiliates of national television networks of areas affected by a health advisory against swimming issued by the department; requiring municipalities and counties to notify the department of certain incidents within a specified timeframe; requiring owners of public boat docks, marinas, and piers to notify the jurisdictional municipality or county of certain incidents within a specified timeframe; requiring the department to adopt by rule a health advisory sign; providing requirements for such sign; providing that municipalities and counties are responsible for posting and maintaining such signs around certain affected beach waters and public bathing places; providing that the Department of Environmental Protection is responsible for posting and maintaining such signs around certain affected beach waters and public bathing places; requiring the Department of Health to coordinate with the Department of

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Environmental Protection and the Fish and Wildlife Conservation Commission to implement signage requirements; providing an effective date.

By Senator Berman

26-00136A-24 2024338__

A bill to be entitled

An act relating to the Safe Waterways Act; providing a short title; requiring the Department of Health to provide a report of specified information to the Governor and the Legislature by a specified date; requiring the Department of Health and the Department of Environmental Protection to submit to the Governor and the Legislature, by a specified date, certain recommendations relating to the transfer of duties related to the bacteriological sampling of beach waters and public bathing places; requiring the departments to enter into an interagency agreement, by a specified date, that meets certain requirements; transferring the duties related to the bacteriological sampling of beach waters and public bathing places from the Department of Health to the Department of Environmental Protection by a type two transfer by a specified date; providing that certain employees retain and transfer certain types of leave upon the transfer; amending s. 514.021, F.S.; specifying that the Department of Environmental Protection is solely responsible for adopting and enforcing rules related to the bacteriological sampling of beach waters and public bathing places; amending s. 514.023, F.S.; defining the term "department"; requiring, rather than authorizing, the department to adopt and enforce certain rules; revising requirements for such rules; requiring, rather than authorizing, the department to issue health advisories under certain circumstances;

directing the department to require closure of beach waters and public bathing places under certain circumstances; requiring that such closures remain in effect for a specified period; including public bathing places in an existing preemption of authority to the state pertaining to the issuance of such health advisories and an existing notification requirement; requiring municipalities and counties to immediately notify the department of any incident that may affect the quality of beach waters or public bathing places within their respective jurisdictions; requiring the department to promptly investigate outfall pipes, in addition to wastewater treatment facilities, within municipalities adjoining affected beach waters or public bathing places; requiring the department to adopt by rule a certain health advisory sign; providing requirements for the sign; requiring that the sign be posted in a specified manner and maintained until subsequent testing demonstrates that the water's bacteria levels meet the standards established by the department; providing that municipalities and counties are responsible for maintaining the health advisory signs around affected beach waters and public bathing places that they own; providing that the department is responsible for maintaining the health advisory signs around affected beach waters and public bathing places owned by the state; requiring the department to coordinate with the Department of Health and the Fish and Wildlife

Conservation Commission as necessary to implement such signage requirements; requiring the department to monitor affected beach waters and public bathing places for compliance with the signage requirements; requiring the department to establish a public statewide interagency database for a specified purpose; requiring the department, in coordination with the Department of Health, to adopt certain rules and procedures; providing requirements for the publication of certain data; amending s. 514.0231, F.S.; conforming a provision to changes made by the act; providing effective dates.

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

Section 1. This act may be cited as the "Safe Waterways Act."

Section 2. (1) By July 1, 2024, the Department of Health shall provide a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives detailing all of the following information regarding the department's bacteriological sampling of beach waters and public bathing places:

(a) The average number of bacteriological samples collected each year, differentiated by those collected by the department and those submitted by owners of beach waters or public bathing places.

(b) The average number of health advisories issued each year, including their average duration.

(c) The number of department employees conducting work on or related to the bacteriological sampling of beach waters and public bathing places, including enforcement duties.

(d) The costs associated with fulfilling the department's duties, including, but not limited to, salaries and benefits, operational costs, and equipment costs.

(2) By December 31, 2024, the Department of Health and the Department of Environmental Protection shall submit recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives regarding the transfer of bacteriological sampling of beach waters and public bathing places from the Department of Health to the Department of Environmental Protection. The recommendations must address all aspects of the transfer, including the continued role, if any, of the county health departments in the collection and tracking of data relating to bacteriological sampling of beach waters and public bathing places and enforcement of posted signage requirements imposed under s. 514.023, Florida Statutes, which would be conducted under the direction of the Department of Environmental Protection.

(3) By June 30, 2025, the Department of Health and the Department of Environmental Protection shall enter into an interagency agreement, based on the report and recommendations submitted pursuant to subsections (1) and (2), respectively, which must address all aspects of cooperation between the two agencies for a period of at least 5 years after the date of the transfer, including, but not limited to, all of the following:

(a) Any continued role of the county health departments in the collection and tracking of data relating to bacteriological

sampling of beach waters and public bathing places and enforcement of posted signage requirements imposed under s. 514.023, Florida Statutes.

(b) The proportionate number of administrative, auditing, inspector general, attorney, and operational support positions, and their respective related funding levels and sources and assigned property, that is appropriate to be transferred from the Office of General Counsel, the Office of Inspector General, and the Division of Administrative Services or other relevant offices or divisions within the Department of Health to the Department of Environmental Protection.

(c) The development of a recommended plan to address the transfer or shared use of buildings, regional offices, and other facilities used or owned by the Department of Health.

(d) Any operating budget adjustments that are necessary to implement the requirements of this act. Adjustments made to the operating budgets of the agencies in the implementation of this act must be made in consultation with the appropriate substantive and fiscal committees of the Senate and the House of Representatives. The adjustments to the approved operating budgets for the 2025-2026 fiscal year which are necessary to reflect the organizational changes made by this act must be implemented pursuant to s. 216.292(4)(d), Florida Statutes, and are subject to s. 216.177, Florida Statutes. Subsequent adjustments between the Department of Health and the Department of Environmental Protection that are determined necessary by the respective agencies and approved by the Executive Office of the Governor are authorized and subject to s. 216.177, Florida Statutes. Before such adjustments are made, the appropriate

substantive committees of the Senate and the House of Representatives must be notified of the proposed adjustments to ensure their consistency with legislative policy and intent.

(4) Effective July 1, 2025, all powers, duties, functions, records, offices, personnel, associated administrative support positions, property, pending issues, administrative authority, administrative rules, and unexpended balances of appropriations, allocations, and other funds for the regulation of bacteriological sampling of beach waters and public bathing places of the Department of Health are transferred by a type two transfer, as defined in s. 20.06(2), Florida Statutes, to the Department of Environmental Protection.

(5) Notwithstanding chapter 60L-34, Florida Administrative Code, or any law to the contrary, employees transferred from the Department of Health to the Department of Environmental Protection to fill positions transferred by this act retain and transfer any accrued annual leave, sick leave, and regular and special compensatory leave balances.

Section 3. Effective July 1, 2025, subsection (1) of section 514.021, Florida Statutes, is amended to read:

514.021 Department authorization.—

(1) With the exception of rules related to the bacteriological sampling of beach waters and public bathing places under s. 514.023, for which the adoption and enforcement are solely the responsibility of the Department of Environmental Protection, the department may adopt and enforce rules to protect the health, safety, or welfare of persons by setting sanitation and safety standards for public swimming pools and public bathing places. The department shall review and revise

such rules as necessary, but not less than biennially. Sanitation and safety standards must ~~shall~~ be limited to matters relating to source of water supply; microbiological, chemical, and physical quality of water in the pool or bathing area; method of water purification, treatment, and disinfection; lifesaving apparatus; and measures to ensure safety of bathers.

Section 4. Effective July 1, 2025, section 514.023, Florida Statutes, is amended to read:

514.023 Sampling of beach waters~~,~~ and public bathing places; health advisories; signage; database.—

(1) As used in this section, the term:

(a) "Beach waters" means the waters along the coastal and intracoastal beaches and shores of this ~~the~~ state~~,~~ and includes salt water and brackish water.

(b) "Department" means the Department of Environmental Protection.

(2) The department shall ~~may~~ adopt and enforce rules to protect the health, safety, and welfare of persons using the beach waters and public bathing places of this ~~the~~ state. The rules must establish health standards and prescribe procedures and timeframes for bacteriological sampling of beach waters and public bathing places. At a minimum, the rules must require owners of beach waters and public bathing places to both notify the department and resample the water within 24 hours after a test result indicates that a sample of the beach waters or public bathing place fails to meet standards established by the department.

(3) The department must ~~may~~ issue health advisories if the quality of beach waters or a public bathing place fails to meet

standards established by the department and must require closure of beach waters and public bathing places that fail to meet the department's standards if it deems closure is necessary to protect the health, safety, and welfare of the public. Closures must remain in effect until the quality of the beach waters or public bathing place is restored in accordance with the department's standards and until the department has removed any related health advisories that it issued. The issuance of health advisories related to the results of bacteriological sampling of beach waters and public bathing places is preempted to the state.

(4)(a) When the department issues a health advisory against swimming in beach waters or a public bathing place on the basis of finding elevated levels of fecal coliform, *Escherichia coli*, or enterococci bacteria in a water sample, the department must ~~shall~~ concurrently notify the municipality or county in which the affected beach waters or public bathing place is ~~are~~ located, whichever has jurisdiction, and the local office of the Department of Health ~~Environmental Protection,~~ of the advisory.

(b) Municipalities and counties shall immediately notify the department of any incident that may affect the quality of beach waters or public bathing places within their respective jurisdictions.

(c) The ~~local office of the~~ department ~~of Environmental Protection~~ shall promptly investigate wastewater treatment facilities and outfall pipes within municipalities adjoining ~~1 mile of~~ the affected beach waters or public bathing place to determine whether ~~if~~ a facility experienced an incident that may have contributed to the contamination and provide the results of

the investigation in writing or by electronic means to the municipality or county, as applicable.

(d) The department shall adopt by rule a sign that must be used when it issues a health advisory against swimming in affected beach waters or public bathing places due to elevated levels of fecal coliform, *Escherichia coli*, or enterococci bacteria in the water. The sign must include the following language: "THIS WATER BODY HAS BEEN VERIFIED TO BE CONTAMINATED WITH FECAL BACTERIA. RESTORATION IN COMPLIANCE WITH STATE WATER QUALITY STANDARDS IS REQUIRED. THIS WATER BODY PRESENTS A RISK OF INFECTION OR ILLNESS. AVOID SWIMMING AND USE CAUTION TO AVOID INGESTING THE WATER OR EXPOSING OPEN WOUNDS. SECTION 514.023, FLORIDA STATUTES." The department shall require that health advisory signs be displayed at beach access points and in conspicuous areas around affected beach waters and public bathing places until subsequent testing of the water demonstrates that the bacteria levels meet the standards established by the department.

(e) Municipalities and counties are responsible for posting and maintaining health advisory signs as described in paragraph (d) around affected beach waters and public bathing places that they own. The department is responsible for posting and maintaining health advisory signs around affected beach waters and public bathing places owned by the state. The department shall coordinate with the Department of Health and the Fish and Wildlife Conservation Commission as necessary to implement the signage requirements of this subsection.

(f) The department shall monitor affected beach waters and public bathing places for compliance with the signage

requirements of this subsection, ensuring that only department-approved health advisory signs are used and that such signage is posted and maintained in compliance with this subsection until the health advisory is no longer in effect.

(5) The department shall establish a public statewide interagency database for the reporting of fecal indicator bacteria data for beach waters and public bathing places in this state. The department, in coordination with the Department of Health, shall adopt rules and procedures for the sharing of fecal indicator bacteria data between agencies and for the reporting of such data in the database. Fecal indicator bacteria data relating to sampled beach waters and public bathing places must be published in the database within 1 business day after receipt and confirmation of the data.

Section 5. Effective July 1, 2025, section 514.0231, Florida Statutes, is amended to read:

514.0231 Advisory committee to oversee sampling of beach waters.—The Department of Environmental Protection ~~Health~~ shall form an interagency technical advisory committee to oversee the performance of the study required in s. 514.023 and to advise it in rulemaking pertaining to standards for public bathing places along the coastal and intracoastal beaches and shores of the state. Membership on the committee must ~~shall~~ consist of equal numbers of staff of the Department of Environmental Protection and the Department of Health ~~and the Department of Environmental Protection~~ with expertise in the subject matter of the study. Members shall be appointed by the Secretary of Environmental Protection and the State Surgeon General ~~and the Secretary of Environmental Protection~~. The committee shall be chaired by a

representative from the Department of Environmental Protection ~~Health~~.

Section 6. Except as otherwise expressly provided in this act, this act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: November 16, 2023

I respectfully request that **Senate Bill #338**, relating to the Safe Waterways Act, be placed on the:

☒ Committee agenda at your earliest possible convenience.

☐ Next committee agenda.

Senator Lori Berman
Florida Senate, District 26

File signed original with committee office

S-020 (03/2004)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24 11:30
Meeting Date

Health Policy 412 kb
Committee

338
Bill Number or Topic

Amendment Barcode (if applicable)

Name DAVID CULLEN

Phone 941-323-2404

Address 816 W THARPE ST
Street

TALLAHASSEE FL 32303
City *State* *Zip*

Email CULLENASEA@GMAIL.COM

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
SIERRA CLUB FLORIDA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/6/2024
Meeting Date

Health Policy
Committee

338
Bill Number or Topic

Amendment Barcode (if applicable)

Name Emma Haydocy

Phone 786 572 7051

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Street

Email ehaydocy@surfrider.org

Tavernier FL 33070
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Surfrider Foundation

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2-6-24
Meeting Date

Health Policy
Committee

SB 0338
Bill Number or Topic

Amendment Barcode (if applicable)

Name Rick Myers

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Address 940 17th Ave N
Street

Email

Jacksonville Beach FL 32250
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 1582
INTRODUCER:	Health Policy Committee and Senator Rodriguez
SUBJECT:	Department of Health
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1582 amends numerous statutory provisions relating to the Department of Health (DOH) and creates a new program within the department. The bill:

- Amends s. 381.0101, F.S., to create a new profession, the environmental health technician (EHT) and requires the DOH, in conjunction with the Department of Environmental Protection (DEP), to adopt rules that establish minimum standards for education, training, and experience required for certification relating to supervised employment in a department in the areas of onsite sewage treatment and disposal, septic inspection, permitting, examinations, continuing education, and renewals;
- Creates the Andrew John Anderson Pediatric Rare Disease Grant Program to advance research and cures for rare pediatric diseases by awarding grants through a competitive, peer-reviewed process;
- Amends s. 383.14, F.S., to require defined health care practitioners present at a birth, or responsible for primary care during the neonatal period, to administer newborn metabolic screenings. The bill requires that health care practitioners responsible for administering newborn screenings to send all specimen cards to the State Public Health Laboratory, adds genetic counselors to health care practitioners who may receive state lab results, and deletes obsolete provisions;
- Amends s. 383.145, F.S., to standardize the requirements for newborn, infant, and toddler hearing screening at hospitals, licensed birth facilities, and birth centers; expands physician-ordered screening to include infants and toddlers to ensure timely congenital

cytomegalovirus (CMV) screening; and defines toddlers as a child from 12 to 36 months of age;
- Amends s. 383.147, F.S., to require the DOH to notify parents or guardians of the ability to opt-out of the state's sickle cell registry by submitting a DOH form and adds a provision for allowing Florida residents to opt-in to the registry; and
- Creates s. 383.148, F,S., to standardize requirements, and clarify the purpose, of prenatal high-risk pregnancy and postnatal infant mortality and morbidity screening for environmental risk factors unless the pregnant woman or parent/guardian, as applicable, objects to the screening manner prescribed the DOH.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

The Department of Health

The Department of Health (DOH) is responsible for the state's public health system, which must be designed to promote, protect, and improve the health of all people in the state.[1]

Environmental Health Professionals

Environmental health is that segment of public health work which deals with the examination of those factors in the human environment which may adversely impact on the health status of an individual or the public.[2] An environmental health professional (EHP) is a person employed or assigned the responsibility of assessing the environmental health or sanitary conditions, as defined by the DOH, within a building, on an individual's property, or within the community at large, and who has the knowledge, skills, and abilities to carry out these tasks. An EHP may be field, supervisory, or an administrative staff member.[3]

A person may not perform environmental health or sanitary evaluations in any primary program area of environmental health without being certified by the DOH as competent to perform such evaluations, with several exceptions.[4] Those exceptions include:
- Persons performing inspections of public food service establishments licensed under ch. 509, F.S., or
- Persons performing site evaluations in order to determine proper placement and installation of onsite wastewater treatment and disposal systems who have successfully completed a DOH-approved soils morphology course and who are working under the direct responsible charge of an engineer licensed under ch. 471, F.S.

[1] Section 381.001, F.S.
[2] Section 381.010,(1)(c), F.S.
[3] Section 381.010,(1)(d), F.S.
[4] Section 381.010,(2), F.S. This section does not apply to persons performing inspections of public food service establishments licensed under ch. 509, F.S.; or persons performing site evaluations in order to determine proper placement and installation of onsite wastewater treatment and disposal systems who have successfully completed a DOH-approved soils morphology course and who are working under the direct responsible charge of an engineer licensed under ch. 471, F.S.

A person seeking certification as an EHP in any primary program area must:[5]

- Be employed or assigned to provide environmental health services in any primary environmental health program;[6]
- Submit the application and application fee to the DOH for the primary environmental health program in which the applicant seeks certification; and
- Submit an official college transcript evidencing a bachelor's degree from an accredited college or university with major coursework in environmental health, environmental science, or a physical or biological science.

Within 45 days of the DOH's receipt of the completed application, the applicant will receive notice of whether he or she meets the general requirements and is eligible for certification and if eligible, will receive a schedule for classes and program examinations.

Applicants seeking certification in the Onsite Sewage Treatment and Disposal System Program must:

- Complete 24 hours of the DOH-provided pre-certification coursework which includes training and testing on soil classification, system design and theory, system material and construction standards, and regulatory requirements; and
- Pass the examinations administered by the DOH with a minimum passing score of 70 percent.[7]

Applicants seeking certification in the Food Protection Program must:

- Complete 24 hours of the DOH-provided pre-certification coursework which includes training and testing on food microbiology, foodborne illness investigations, and basic hazard analysis and critical control points (HACCP); and
- Pass the pre-certification coursework and certification examinations administered by the DOH with a minimum passing score of 70 percent.[8]

The DOH currently employs 448 certified environmental health professionals (CEHP), most of whom are housed in county health departments (CHD) to perform health evaluations at public food establishments and sanitary evaluations on private and business properties where onsite wastewater treatment and disposal systems are in use. Other CEHPs supervise CHD environmental health teams or work within the Bureau of Environmental Public Health to direct statewide programs.[9]

Section 381.0065, F.S., gives the DEP authority to inspect onsite sewage treatment and disposal systems (OSTDS), which CHD staff complete for DEP as outlined in a five-year interagency agreement required by Section 2 of Chapter 2020-150, Laws of Florida. It also authorizes four

[5] Fla. Admin. Code R. 64E-18.003(2023).
[6] Section 381.0101(2), F.S.
[7] Fla. Admin. Code R. 64E-18.003(6)(2023).
[8] Fla. Admin. Code R. 64E-18.003(7)(2023).
[9] This excludes establishments licensed under ch. 509, F.S., which operate under separate standards. *See*, Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).

groups to complete private provider septic inspections, including two that do not require a four-year degree.[10]

Section 381.0101(4), F.S., sets out the standards for certification and grants the DOH the authority to adopt rules that establish definitions of terms and minimum standards of education, training, or experience for those seeking certification. CEHPs must earn certification from the DOH to perform evaluations of environmental or sanitary conditions in any program area of environmental health. However, due to the four-year degree requirement for environmental health professionals under section 381.0101(4)(e), F.S., CHDs are experiencing a shortage of qualified applicants for the OSTDS and food hygiene programs.[11]

Rare Diseases

The federal Orphan Drug Act defines a rare disease as any condition that nationally affects fewer than 200,000 people. Over 7,000 rare diseases affect more than 30 million people in the U.S. Many rare conditions are life-threatening and most do not have treatments. Drug, biologic, and device development in rare diseases is challenging for many reasons, including the complex biology and the lack of understanding of the natural history of many rare diseases. The inherently small population of patients with a rare disease can also make conducting clinical trials difficult.

Since the Orphan Drug Act was signed into law in 1983, the federal Food and Drug Administration (FDA) has approved hundreds of drugs for rare diseases, but most rare diseases do not have FDA-approved treatments. The FDA works with many people and groups, such as patients, caregivers, and drug and device manufactures, to support rare disease product development. So, while the individual diseases may be rare, the total number of people impacted by a rare disease is larger.[12]

Rare diseases include genetic disorders, infectious diseases, cancers, and various other pediatric and adult conditions. A rare disease can affect anyone at any point in their life, and can be acute or chronic. It is estimated that 80 percent or more of rare diseases are genetic. For genetic rare diseases, genetic testing is often the only way to make a definitive diagnosis.

Rare diseases present a fundamentally different array of challenges compared to those of more common diseases Often patients are set on a "diagnostic odyssey," in order to determine the cause of their symptoms as they seek treatment in health care settings where their condition may have never been seen before.[13]

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[10] Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).
[11] *Id.*
[12] United States Food and Drug Administration, *Rare Diseases at FDA*, available at https://www.fda.gov/patients/rare-diseases-fda (last visited Jan. 31, 2024).
[13] Department of Health, *Rare Disease Advisory Council: Legislative Report, Fiscal Year 2022-2023* (2023). Available at https://www.floridahealth.gov/provider-and-partner-resources/rdac/_documents/RDACLegislativeReport2023Final_Draft.pdf (last visited Jan. 31, 2024).

Rare Pediatric Disease (RPD) Designation and Voucher Programs

Under Section 529 of the Federal Food, Drug, and Cosmetic Act (FD&C Act), the FDA will award priority review vouchers to sponsors of rare pediatric disease product applications that meet certain criteria. Under this program, a sponsor who receives an approval for a drug or biologic for a "rare pediatric disease" may qualify for a voucher that can be redeemed to receive a priority review of a subsequent marketing application for a different product.[14]

On December 27, 2020, the Rare Pediatric Disease Priority Review Voucher Program was extended. Under the current statutory sunset provisions, after September 30, 2024, the FDA may only award a voucher for an approved rare pediatric disease product application if the sponsor has rare pediatric disease designation for the drug and that designation was granted by September 30, 2024. After September 30, 2026, the FDA may not award any rare pediatric disease priority review vouchers.[15]

Rare Disease Advisory Council

In June 2021, the Rare Disease Advisory Council (Council) was created as an adjunct to the DOH. The Council comprises representatives from state agencies, health care providers, researchers, advocacy groups, insurance, and pharmaceutical industries, as well as individuals with rare diseases and caregivers of individuals with rare diseases. Council members hold a shared vision: to improve health outcomes for individuals residing in Florida who have rare diseases. The Council reports annually to the Governor, Senate President and Speaker of the House of Representatives[16] The DOH is responsible for four research grant programs and will implement the proven strategies and processes for awarding highly meritorious grants that will support advancements for the prevention, treatment, and cures of pediatric rare diseases.[17]

Newborn Metabolic Screening Program

The Legislature created the Florida Newborn Screening Program (NBS Program) in 1965 within the DOH, to promote the screening of all newborns for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect.[18] The NBS Program also promotes the identification and screening of all newborns in the state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services.[19]

The Legislature established the Florida Genetics and Newborn Screening Advisory Council to advise the DOH on disorders to be included in the NBS Program panel of screened disorders and

[14] United States Food and Drug Administration, *Rare Pediatric Disease (RPD) Designation and Voucher Programs,* available at https://www.fda.gov/industry/medical-products-rare-diseases-and-conditions/rare-pediatric-disease-rpd-designation-and-voucher-programs (last visited Jan. 31, 2024).
[15] *Id.*
[16] Section 381.99, F.S.
[17] *Supra* note 13.
[18] Section 383.14(1), F.S.
[19] *Id.*

the procedures for collecting and transmitting specimens.[20] The NBS Program began with the screening for phenylketonuria and now screens for 58 conditions prior to discharge. Of the conditions screened, 55 conditions are screened through the collection of blood spots. Screening of the three remaining conditions – hearing (hearing screening), critical congenital heart defect (CCHD) (pulse oximetry) and congenital cytomegalovirus (CMV) targeted screening – are completed at the birthing facility through point of care (POC) testing.[21]

The NBS Program involves coordination across several entities, including the Bureau of Public Health Laboratories Newborn Screening Laboratory in Jacksonville (state laboratory), The DOH Children's Medical Services (CMS) Newborn Screening Follow-up Program in Tallahassee, referral centers, birthing centers, and physicians throughout the state.[22] Health care providers in hospitals, birthing centers, perinatal centers, county health departments, and school health programs provide screening as part of the multilevel NBS Program screening process.[23] This includes a risk assessment for prenatal women, and risk factor analysis and screening for postnatal women and newborns as well as laboratory screening for select disorders in newborns.[24] The NBS Program attempts to screen all newborns for hearing impairment and to identify, diagnose, and manage newborns at risk for select disorders that, without detection and treatment, can lead to permanent developmental and physical damage or death.[25] The NBS Program is intended to screen all prenatal women and newborns, however, parents and guardians may choose to decline the screening.[26]

Health care providers perform non-laboratory NBS Program screening, such as hearing and risk factor analysis, and report the results to the Office of Vital Statistics. If necessary, health care providers refer patients to the appropriate health, education, and social services.[27]

Health care providers in hospitals and birthing centers perform specimen collection for laboratory analysis for the NBS Program screening by collecting a few drops of blood from the newborn's heel on a standardized specimen collection card. [28] The specimen card is then sent to the state laboratory for testing and the results are released to the newborn's health care provider. In the event that a newborn screen has an abnormal result, the newborn's health care

[20] Section 383.14(5), F.S.
[21] Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).
[22] Section 383.14, F.S.
[23] *Id*.
[24] *Id*.
[25] Florida Department of Health, *Florida Newborn Screening Guidelines, a*vailable at https://floridanewbornscreening.com/wp-content/uploads/NBS-Protocols-2022-FINAL.pdf (last visited Jan. 31, 2024).
[26] Section 383.14(4), F.S.; Fla. Admin. Code R. 64C-7.008, (2023). The health care provider must attempt to get a written statement of objection to be placed in the medical record.
[27] *Id*.
[28] Florida Newborn Screening, *What is Newborn Screening?* available at https://floridanewbornscreening.com/parents/what-is-newborn-screening/ (last visited Jan. 31, 2024). *See also,* Florida Newborn Screening, *Specimen Collection Card,* available at http://floridanewbornscreening.com/wp-content/uploads/Order-Form.png (last visited Jan. 31, 2024).

practitioner,[29] or a nurse or specialist from the NBS Program's "Follow-up Program" provides follow-up services and referrals for the child and his or her family.[30]

To administer the NBS Program, the DOH is authorized to charge and collect a fee, not to exceed $15 per live birth, occurring in a hospital or birth center.[31] The DOH must calculate the annual assessment for each hospital and birth center, and then quarterly generate and mail each hospital and birth center a statement of the amount due.[32] The DOH bills hospitals and birth centers quarterly using vital statistics data to determine the amount to be billed.[33] The DOH is authorized to bill third-party payers for the NBS Program tests and bills insurers directly for the cost of the screening.[34] The DOH does not bill families that do not have insurance coverage.[35]

The newborn screening report includes the screening results for all 58 conditions currently screened. Newborn screening is part of the standard of care for all infants. Florida law allows for a parent to opt-out of newborn screening prior to collection. This opt-out is documented in the medical record maintained by the collection facility. The NBS Program maintains the results of the newborn screenings, in addition to diagnostic results for newborns identified with a condition on the screening panel. Data are available from January 2006 forward. The DOH's retention schedule requires newborn screening records to be permanently maintained.[36]

Newborn Hearing Screening

Section 383.145, F.S., requires newborn hearing screening for all newborns in hospitals before discharge. The newborn hearing screening program (NBHS) is housed within the DOH, which is responsible for coordinating the statewide hearing screening and follow-up referral system. The NBHS program is funded through a donations trust and federal grants from the federal Centers for Disease Control and Prevention and the Health Resources and Services Administration (HRSA).[37]

Before a newborn is discharged from a hospital or other state-licensed birthing facility, and unless objected to by the parent or legal guardian, the newborn must be screened for the detection of hearing loss to prevent the consequences of unidentified disorders.[38] For births occurring in a non-hospital setting, specifically a licensed birth center or private home, the facility or attending health care provider is responsible for providing a referral to an audiologist,

[29] Current law allows for the screening results to be released to specified health care practitioners including: allopathic and osteopathic physicians and physician assistants licensed under chs. 458 and 459, F.S., advanced practice registered nurses, registered nurses, and licensed practical nurses licensed under ch. 464, F.S., a midwife licensed under ch. 467, F.S., a speech-language pathologist or audiologist licensed under part I of ch. 468, F.S., or a dietician or nutritionist licensed under part X of ch. 468, F.S.
[30] *Id*.
[31] Section 383.145(3)(g)1., F.S.
[32] *Id*.
[33] Section 383.145(3)(g), F.S.
[34] Section 383.145(3)(h), F.S.
[35] Section 383.14, F.S.
[36] Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).
[37] *Id*.
[38] Section 383.145(3), F.S. If the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 21 days after the birth.

a hospital, or other newborn hearing screening provider within seven days after the birth or discharge from the facility.[39]

All screenings must be conducted by a licensed audiologist, a licensed physician, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening.[40] When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the FDA.[41]

NBHS staff provide follow-up to parents of infants who do not pass the newborn hearing screen to ensure timely diagnosis and enrollment in early intervention for children diagnosed with hearing loss.[42] A child who is diagnosed as having a permanent hearing impairment must be referred by the licensee or individual who conducted the screening to the primary care physician for medical management, treatment, and follow-up services. Furthermore, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program by the licensee or individual who conducted the screening serving the geographical area in which the child resides.

Hearing loss is one of the most common birth defects in the U.S., with approximately two newborns per 1,000 born having hearing loss each year. It is estimated that only half of early childhood hearing loss is detected through newborn hearing screening. To further support early identification of hearing loss prior to school entry to prevent the consequences of unidentified disorders, the federal Health Resources & Services Administration grants also requires collection of hearing screening data for infants and toddlers up to age 36 months.[43]

Sickle Cell Disease

Sickle cell disease (SCD) affects approximately 100,000 Americans and is the most prevalent inherited blood disorder in the U.S.[44] SCD affects mostly, but not exclusively, persons of African ancestry. SCD is a group of inherited disorders in which abnormal hemoglobin cause red blood cells to buckle into a sickle shape. The deformed red blood cells damage blood vessels and over time contribute to a cascade of negative health effects beginning in infancy, such as intense vaso-occlusive pain episodes, strokes, organ failure, and recurrent infections.[45] The severity of

[39] Section 383.145(3)(d), F.S.
[40] Section 383.145(3)(f), F.S.
[41] Section 383.145(3)(i), F.S.
[42] .Section 383.14, F.S.
[43] *Id.*
[44] National Institutes of Health ,National Heart, Lung, and Blood Institute, *What is Sickle Cell Disease?*, available at https://www.nhlbi.nih.gov/health/sickle-cell-disease (last visited Jan. 31, 2024).
[45] Centers for Disease Control and Prevention, *What is Sickle Cell Disease?* available at https://www.cdc.gov/ncbddd/sicklecell/facts.html (last visited Jan. 31, 2024). See also, AHCA (2023) *Florida Medicaid Study of Enrollees with Sickle Cell Disease*. available at https://ahca.myflorida.com/content/download/20771/file/Florida_Medicaid_Study_of_Enrollees_with_Sickle_Cell_Disease.pdf (last visited Jan., 2024).

complications generally worsens as people age, but treatment and prevention strategies can mitigate complications and lengthen the lives of people with SCD.[46]

A person who carries a single gene for SCD has sickle cell trait. People with sickle cell trait do not have SCD, and under normal conditions they are generally asymptomatic. However, they are carriers of SCD and have an increased likelihood of having a child with SCD. It is estimated that eight to ten percent of African Americans carry sickle cell trait.[47]

While SCD is the most common inherited blood disorder in the U.S., and is often diagnosed at birth through newborn screening programs,[48] patients with SCD experience many of the other trials associated with treating a rare disease. Until recently there was very little research development in the areas of managing, treating, or curing SCD.[49]

The NBS Program has included screening for sickle cell disease since 1988.

Sickle Cell Disease Registry

In 2023, the DOH was required under s. 383.147, F.S., to contract with a community-based sickle cell disease medical treatment and research center to establish and maintain a registry for newborns and infants who are identified as carrying a sickle cell hemoglobin variant. If a screening provider detects that a newborn or an infant is carrying a sickle cell hemoglobin variant, it must notify the child's primary care physician and submit the results to the DOH for inclusion in the sickle cell registry The registry must track sickle cell disease outcome measures. A parent or guardian of a newborn or an infant in the registry may request to have his or her child removed from the registry by submitting a form prescribed by the DOH in rule.

Based on a review of the 2022 provisional data, the DOH identified 137 newborns with SCD and 5,800 with sickle cell trait. For any newborn identified with sickle cell trait, notification letters are sent to both the family and physician on file for each newborn. NBS Program results are returned to the submitting provider. It is the responsibility of the submitting entity to forward the results to the newborn's primary care provider.[50]

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[46] Centers for Disease Control and Prevention, *Complications of Sickle Cell Disease*. available at https://www.cdc.gov/ncbddd/sicklecell/complications.html (last visited Jan. 31, 2024).
[47] American Society of Hematology. *ASH Position on Sickle Cell Trait* (2021). available at https://www.hematology.org/advocacy/policy-news-statements-testimony-and-correspondence/policy-statements/2021/ash-position-on-sickle-cell-trait (last visited Jan. 31, 2024).
[48] Centers for Disease Control and Prevention. *Newborn Screening (NBS) Data* (2023). available at https://www.cdc.gov/ncbddd/hemoglobinopathies/scdc-state-data/newborn-screening/index.html#:~:text=Newborn%20screening%20(NBS)%20for%20sickle,SCD%20living%20in%20a%20state. (last visited Jan. 31, 2024).
[49] *See*, American Society of Hematology. *ASH Sickle Cell Disease Initiative*. available at https://www.hematology.org/advocacy/sickle-cell-disease-initiative (last visited Jan. 31, 2024). See also Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).
[50] *Id.*

Environmental Risk Screening

In 2022, 223,833 women gave birth in Florida.[51] Adverse birth outcomes, such as preterm birth and low birthweight, are major public health concerns due to the associated risks of morbidity and mortality throughout an individual's lifespan.[52,53] Risk assessment in pregnancy can assist with identifying pregnant women who are most likely to experience adverse health events and enables providers to administer risk-appropriate prenatal and postnatal care.[54] Research has also shown that the use of risk screening tools significantly reduces risk of low birth weight, preterm birth, and fetal and infant morbidity.[55] Some researchers have found that the risk of low birth weight and preterm birth is reduced by as much as thirty percent in underserved communities, when a risk screen is completed.[56]

The DOH develops and oversees the prenatal risk screening process to assess for environmental risk factors that put a pregnant woman at risk for a preterm birth or other high-risk condition. The prenatal risk screen is completed by the pregnant woman's health care provider at her first prenatal appointment. If the prenatal risk screen identifies a pregnant woman is at-risk, she is referred to home visiting services, and other services, as necessary, to improve prenatal and birth outcomes.

III. Effect of Proposed Changes:

Section 1. - Environmental Health Professionals

The bill amends s. 381.0101, F.S., to create a new profession, the environmental health technician (EHT). The bill provides that an EHT is a person employed or assigned the responsibility for conducting septic inspections under the supervision of a CEHP. An EHT must have completed training approved by the DOH and have the knowledge, skills, and abilities to carry out these tasks.

The bill also creates an additional exemption for to the certification requirements in s. 381.010(2), F.S., which requires a bachelor's degree in science for EHTs employed by a department[57] who are assigned the responsibility of conducting septic tank inspections under the supervision of a CEHP in onsite sewage treatment and disposal.

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[51] FloridaHealthCHARTS: *Resident Live Births*, available at https://www.flhealthcharts.gov/ChartsDashboards/rdPage.aspx?rdReport=BirthMonthly.Dataviewer&cid=25 (last visited Feb. 1, 2024).
[52] Risnes KR, Vatten LJ, Baker JL, et al..*Birthweight and mortality in adulthood: A systematic review and meta-analysis, Int J Epidemiol* 2011;40:647–661, available at https://pubmed.ncbi.nlm.nih.gov/21324938/ (last visited Feb. 1, 2024).
[53] Raju TNK, Pemberton VL, Saigal S, et al.. *Long-Term Healthcare Outcomes Of Preterm Birth: An Executive Summary of a Conference Sponsored By The National Institutes of Health*. *J Pediatr* 2017;181:309–318.e1. available at https://pubmed.ncbi.nlm.nih.gov/27806833/ (last visited Feb. 1, 2024).
[54] Board on Children, Youth, and Families; Institute of Medicine; National Research Council. (2013). An Update on Research Issues in the Assessment of Birth Settings. *Workshop Summary*. *Washington (DC): National Academies Press (US)*., available at https://www.ncbi.nlm.nih.gov/books/NBK201935/ (last visited Feb. 1, 2024).
[55] Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).
[56] *Id*.
[57] Section 20.03(8), F.S., defines "department" as the principal administrative unit within the executive branch of state government.

The bill requires:

- The DOH, in conjunction with the DEP, to adopt rules that establish definitions and minimum standards of education, training, and experience for the certification of EHTs, and the rules must address the following:
  - Education required;
  - Training required;
  - Experience necessary;
  - Application process;
  - Examinations to be taken;
  - Process of certification issuance;
  - Certification expiration;
  - Certification renewal; and
  - Ethical standards of practice for the profession.
- The DOH to establish standards for an EHT in the areas of onsite sewage treatment and disposal;
- A person conducting septic inspections must be certified by examination to be knowledgeable in the area of onsite sewage treatment and disposal;
- An applicant for certification as an EHT to have received a high school diploma or its equivalent;
- An applicant for certification as an EHT to be employed by a department;
- An applicant for certification as an EHT to complete supervised field inspection work as prescribed by DOH rule before examination;
- A CEHT to renew his or her certification biennially by completing at least 24 contact hours of continuing education for each program area in which he or she maintains certification, subject to a maximum of 48 hours for multi-program certification; and
- A CEHT to notify the DOH within 60 days after any change of name or address from that which appears on the current certificate.

According to the DOH, an EHT could perform septic inspections, like a CEHP, but the technician would not be required to have a four-year college degree with certain scientific coursework to be eligible for this certification examination. Technicians would be required to complete an amount of observed field work set by rule, attain a passing score on the certification test, and meet any additional rule requirements. Regulatory work, would include approving permits, and the technician's work would be subject to the supervision and approval of his or her supervising CEHP.[58]

Section 2. - Andrew John Anderson Pediatric Rare Disease Grant Program

The bill creates the Andrew John Anderson Pediatric Rare Disease Grant Program within the DOH under s. 381.991, F.S. The purpose of the grant program is to advance the progress of research and cures for rare pediatric diseases by awarding grants through a competitive, peer-reviewed process. Subject to an annual appropriation by the Legislature, the program must award

[58] Department of Health, 2024 Agency Legislative Bill Analysis, SB 1582 (Sept. 18, 2023) (on file with the Senate Committee on Health Policy).

grants for scientific and clinical research to further the search for new diagnostics, treatments, and cures for rare pediatric diseases.

The bill requires that:

- Applications for the grants may be submitted by any university or established research institute in Florida and that all qualified investigators, regardless of institutional affiliation, will have equal access and opportunity to compete for funding;
- The grants may be awarded by the DOH after consultation with the Rare Disease Advisory Council on the basis of scientific merit, as determined by the competitive, peer-reviewed process to ensure objectivity, consistency, and high quality;
- The DOH must appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score to ensure appropriate and fair evaluation of grant applications based on scientific merit;
- The priority scores must be forwarded to the council and must be considered in determining which proposals will be recommended for funding; and
- The council and the peer review panels must establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest.

The bill authorizes:

- The use of preferences for grant proposals that foster collaboration among institutions, researchers, and community practitioners, on the basis that as such proposals support the advancement of treatments and cures of rare pediatric diseases through basic or applied research;
- The following types of applications to be considered for funding:
  - Investigator-initiated research grants;
  - Institutional research grants; and
  - Collaborative research grants, including those that advance the finding of treatment and cures through basic or applied research.
- The balance of any Legislative appropriation for the Grant Program that is not disbursed, but is obligated pursuant to contract or committed to be expended by June 30 of the fiscal year in which the funds were appropriated, to be carried forward for up to five years after the effective date of the original appropriation.

The bill prohibits any council or panel member from participating in any discussion or decision of the council or panel with respect to a research proposal by any firm, entity, or agency that the member is associated with as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

Section 3. - Newborn Metabolic Screening Program

The bill amends s. 383.14, F.S., to require that any health care practitioner present at a birth or responsible for primary care during the neonatal period has the primary responsibility of administering newborn screenings as required in ss. 383.14 and 383.145, F.S. The bill defines the term “health care practitioner” to mean physicians or physician assistants (PAs) licensed under chs. 458 or 459, F.S., advanced practice registered nurses (APRNs) licensed under ch. 464, F.S, and a midwife licensed under ch. 467, F.S., and requires those practitioners to prepare and send all newborn screening specimen cards to the State Public Health Laboratory.

The bill removes language related to risk screening for environmental risk factors from s. 383.14, F.S., and relocates it to s. 383.148, F.S., later in the bill. The bill also repeals the following:

- Obsolete requirements for the NBS Program and Healthy Start to coordinate with the Florida Department of Education (DOE) for consultation; and
- Language referencing the initial newborn screening condition (phenylketonuria) and multiple other screening methods to allow the NBS Program to apply principles to all conditions on the NBS Program screening panel.

The bill authorizes:

- Licensed genetic counselors to receive NBS Program results;
- The NBS Program to implement systemic improvements for diagnostic reporting and submission of NBS Program specimens and point of contact screening results.

Section 4. - Newborn Hearing Screening

The bill amends s. 383,145, F.S., to add the definition of "toddler" to mean a child from 12 months to 36 months of age. The bill requires that:

- Both infants and toddlers are added to the hearing screening program when a treating physician orders a hearing screening which must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the FDA;
- All licensed birth centers that provide maternity and newborn care services must ensure that all newborns are, before discharge, screened for the detection of hearing loss and that within seven days after the birth, the licensed birth center must ensure that all newborns who do not pass the hearing screening are referred for an appointment for a test to screen for congenital cytomegalovirus (CMV) before the newborn becomes 21 days of age; and
- For home births, the newborn's primary health care provider must refer the newborn for administration of a test approved by the FDA or another diagnostically equivalent test on the newborn to screen for congenital CMV before the newborn becomes 21 days of age.

Section 5 – Sickle Cell Disease Registry

The bill amends s. 383.147, F.S., to provide that:

- If a newborn is identified as having sickle cell disease or carrying a sickle cell trait through the NBS Program, the results will be included in the statewide SCD registry unless the parent or guardian provides an opt-out form obtained from the DOH, or otherwise indicates in writing of his or her objection to having the newborn included in the registry; and
- Persons living in this state who have been identified as having sickle cell disease or carrying a sickle cell trait may choose to be included in the registry by providing the DOH with notification as prescribed by rule.

Section 6 – Environmental Risk Screening

The bill creates s. 383.148, F.S., to house the DOH's requirements relating to screening pregnant women and infants in this state for environmental risk factors, which are being relocated to this new statute from s. 383.14, F.S.

The bill also amends ss. 383.318, 395.1053, and 456.0496, F.S., to make conforming cross reference changes.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the DOH, The Rare Pediatric Disease Research Program is currently funded at $500,000. This funding will be used exclusively for research grants. To assure the proper evaluation of the research grants, peer reviewers will be required.

VI. Technical Deficiencies:

None.

VII. Related Issues:

A child's SCD test results are required to be automatically included in the statewide SCD registry under current law. On lines 672-688, the bill allows a parent or guardian to opt-out of having a child's SCD test results included in the registry by submitting an opt-out form "obtained from the department" or by otherwise indicating in writing to the DOH of his or her objections to having the child included in the registry. However, there is no requirement in the opt-out procedure created by the bill for the parent or guardian to be informed of the existence of the opt-out form or of his or her ability to opt-out.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0101, 383.14, 383.145, 383.147, 383.318, 395.1053, and 456.0496.

This bill creates the following sections of the Florida Statutes: 381.991 and 383.148.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute removes the Telehealth Minority Maternity Care Program from the bill.

B. Amendments:

None.

879888

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
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The Committee on Health Policy (Rodriguez) recommended the following:

Senate Amendment (with title amendment)

Delete lines 748 - 902.

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

And the title is amended as follows:

Delete lines 86 - 91

and insert:

screening; amending ss. 383.318, 395.1053, and 456.0496,

By Senator Rodriguez

40-00964C-24 20241582__

A bill to be entitled

An act relating to the Department of Health; amending s. 381.0101, F.S.; defining the term "environmental health technician"; exempting environmental health technicians from certain certification requirements under certain circumstances; requiring the department, in conjunction with the Department of Environmental Protection, to adopt rules that establish certain standards for environmental health technician certification; requiring the Department of Health to adopt by rule certain standards for environmental health technician certification; revising provisions related to exemptions and fees to conform to changes made by the act; creating s. 381.991, F.S.; creating the Andrew John Anderson Rare Pediatric Disease Grant Program within the department for a specified purpose; subject to an appropriation by the Legislature, requiring the program to award grants for certain scientific and clinical research; specifying entities eligible to apply for the grants; specifying the types of applications that may be considered for grant funding; providing for a competitive, peer-reviewed application and selection process; providing that the remaining balance of appropriations for the program as of a specified date may be carried forward for a specified timeframe under certain circumstances; amending s. 383.14, F.S.; providing that any health care practitioner present at a birth or responsible for primary care during the neonatal period has the

primary responsibility of administering certain screenings; defining the term "health care practitioner"; deleting identification and screening requirements for newborns and their families for certain environmental and health risk factors; deleting certain related duties of the department; revising the definition of the term "health care practitioner" to include licensed genetic counselors; requiring that blood specimens for screenings of newborns be collected before a specified age; requiring that newborns have a blood specimen collected for newborn screenings, rather than only a test for phenylketonuria, before a specified age; deleting certain rulemaking authority of the department; deleting a requirement that the department furnish certain forms to specified entities; deleting the requirement that such entities report the results of certain screenings to the department; making technical and conforming changes; deleting a requirement that the department submit certain certifications as part of its legislative budget request; requiring certain health care practitioners to prepare and send all newborn screening specimen cards to the State Public Health Laboratory; defining the term "health care practitioner"; amending s. 383.145, F.S.; defining the term "toddler"; revising hearing loss screening requirements to include infants and toddlers; revising hearing loss screening requirements for licensed birth centers; revising the

timeframe in which a newborn's primary health care provider must refer a newborn for congenital cytomegalovirus screening after the newborn fails the hearing loss screening; requiring licensed birth centers to complete newborn hearing loss screenings before discharge, with an exception; amending s. 383.147, F.S.; revising sickle cell disease and sickle cell trait screening requirements; requiring screening providers to notify a newborn's parent or guardian, rather than the newborn's primary care physician, of certain information; authorizing the parents or guardians of a newborn to opt out of the newborn's inclusion in the sickle cell registry; specifying the manner in which a parent or guardian may opt out; authorizing certain persons other than newborns who have been identified as having sickle cell disease or carrying a sickle cell trait to choose to be included in the registry; creating s. 383.148, F.S.; requiring the department to promote the screening of pregnant women and infants for specified environmental risk factors; requiring the department to develop a multilevel screening process for prenatal and postnatal risk screenings; specifying requirements for such screening processes; providing construction; requiring persons who object to a screening to give a written statement of such objection to the physician or other person required to administer and report the screening; amending s. 383.2163, F.S.; expanding the telehealth minority maternity care pilot program to a

full program available in any county in this state, contingent upon available funding; making conforming changes; revising the source of funding for the program; amending ss. 383.318, 395.1053, and 456.0496, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Present subsections (5), (6), and (7) of section 381.0101, Florida Statutes, are redesignated as subsections (6), (7), and (8), respectively, a new subsection (5) is added to that section, and subsections (1), (2), and (4) and present subsections (5) and (6) of that section are amended, to read:

381.0101 Environmental health professionals.—

(1) DEFINITIONS.—As used in this section, the term:

(a) "Board" means the Environmental Health Professionals Advisory Board.

(c) ~~(b)~~ "Department" means the Department of Health.

(d) ~~(c)~~ "Environmental health" means that segment of public health work which deals with the examination of those factors in the human environment which may impact adversely on the health status of an individual or the public.

(e) ~~(d)~~ "Environmental health professional" means a person who is employed or assigned the responsibility for assessing the environmental health or sanitary conditions, as defined by the department, within a building, on an individual's property, or within the community at large, and who has the knowledge, skills, and abilities to carry out these tasks. Environmental

health professionals may be either field, supervisory, or administrative staff members.

(b) ~~(c)~~ "Certified" means a person who has displayed competency to perform evaluations of environmental or sanitary conditions through examination.

(f) "Environmental health technician" means a person who is employed or assigned the responsibility for conducting septic inspections under the supervision of a certified environmental health professional. An environmental health technician must have completed training approved by the department and have the knowledge, skills, and abilities to carry out these tasks.

(h) ~~(f)~~ "Registered sanitarian," "R.S.," "Registered Environmental Health Specialist," or "R.E.H.S." means a person who has been certified by either the National Environmental Health Association or the Florida Environmental Health Association as knowledgeable in the environmental health profession.

(g) "Primary environmental health program" means those programs determined by the department to be essential for providing basic environmental and sanitary protection to the public. At a minimum, these programs shall include food protection program work.

(2) CERTIFICATION; EXEMPTIONS ~~REQUIRED~~.—A person may not perform environmental health or sanitary evaluations in any primary program area of environmental health without being certified by the department as competent to perform such evaluations. This section does not apply to any of the following:

(a) Persons performing inspections of public food service

establishments licensed under chapter 509.~~; or~~

(b) Persons performing site evaluations in order to determine proper placement and installation of onsite wastewater treatment and disposal systems who have successfully completed a department-approved soils morphology course and who are working under the direct responsible charge of an engineer licensed under chapter 471.

(c) Environmental health technicians employed by a department as defined in s. 20.03 who are assigned the responsibility for conducting septic tank inspections under the supervision of an environmental health professional certified in onsite sewage treatment and disposal.

(4) STANDARDS FOR CERTIFICATION.—The department shall adopt rules that establish definitions of terms and minimum standards of education, training, or experience for those persons subject to this subsection ~~section~~. The rules must also address the process for application, examination, issuance, expiration, and renewal of certification and ethical standards of practice for the profession.

(a) Persons employed as environmental health professionals shall exhibit a knowledge of rules and principles of environmental and public health law in Florida through examination. A person may not conduct environmental health evaluations in a primary program area unless he or she is currently certified in that program area or works under the direct supervision of a certified environmental health professional.

1. All persons who begin employment in a primary environmental health program on or after September 21, 1994,

must be certified in that program within 6 months after employment.

2. Persons employed in the primary environmental health program of a food protection program or an onsite sewage treatment and disposal system prior to September 21, 1994, shall be considered certified while employed in that position and shall be required to adhere to any professional standards established by the department pursuant to paragraph (b), complete any continuing education requirements imposed under paragraph (d), and pay the certificate renewal fee imposed under subsection (7) ~~(6)~~.

3. Persons employed in the primary environmental health program of a food protection program or an onsite sewage treatment and disposal system prior to September 21, 1994, who change positions or program areas and transfer into another primary environmental health program area on or after September 21, 1994, must be certified in that program within 6 months after such transfer, except that they will not be required to possess the college degree required under paragraph (e).

4. Registered sanitarians shall be considered certified and shall be required to adhere to any professional standards established by the department pursuant to paragraph (b).

(b) At a minimum, the department shall establish standards for professionals in the areas of food hygiene and onsite sewage treatment and disposal.

(c) Those persons conducting primary environmental health evaluations shall be certified by examination to be knowledgeable in any primary area of environmental health in which they are routinely assigned duties.

(d) Persons who are certified shall renew their certification biennially by completing not less than 24 contact hours of continuing education for each program area in which they maintain certification, subject to a maximum of 48 hours for multiprogram certification.

(e) Applicants for certification shall have graduated from an accredited 4-year college or university with a degree or major coursework in public health, environmental health, environmental science, or a physical or biological science.

(f) A certificateholder shall notify the department within 60 days after any change of name or address from that which appears on the current certificate.

(5) STANDARDS FOR ENVIRONMENTAL HEALTH TECHNICIAN CERTIFICATION.—The department, in conjunction with the Department of Environmental Protection, shall adopt rules that establish definitions of terms and minimum standards of education, training, and experience for those persons subject to this subsection. The rules must also address the process for application, examination, issuance, expiration, and renewal of certification, and ethical standards of practice for the profession.

(a) At a minimum, the department shall establish standards for technicians in the areas of onsite sewage treatment and disposal.

(b) A person conducting septic inspections must be certified by examination to be knowledgeable in the area of onsite sewage treatment and disposal.

(c) An applicant for certification as an environmental health technician must, at a minimum, have received a high

school diploma or its equivalent.

(d) An applicant for certification as an environmental health technician must be employed by a department as defined in s. 20.30.

(e) An applicant for certification as an environmental health technician must complete supervised field inspection work as prescribed by department rule before examination.

(f) A certified environmental health technician must renew his or her certification biennially by completing at least 24 contact hours of continuing education for each program area in which he or she maintains certification, subject to a maximum of 48 hours for multiprogram certification.

(g) A certified environmental health technician shall notify the department within 60 days after any change of name or address from that which appears on the current certificate.

(6) ~~(5)~~ EXEMPTIONS.—A person who conducts primary environmental evaluation activities and maintains a current registration or certification from another state agency which examined the person's knowledge of the primary program area and requires comparable continuing education to maintain the certificate shall not be required to be certified by this section. ~~Examples of persons not subject to certification are physicians, registered dietitians, certified laboratory personnel, and nurses.~~

(7) ~~(6)~~ FEES.—The department shall charge fees in amounts necessary to meet the cost of providing environmental health professional certification. Fees for certification shall be not less than $10 or more than $300 and shall be set by rule. Application, examination, and certification costs shall be

included in this fee. Fees for renewal of a certificate shall be no less than $25 nor more than $150 per biennium.

Section 2. Section 381.991, Florida Statutes, is created to read:

381.991 Andrew John Anderson Pediatric Rare Disease Grant Program.—

(1)(a) There is created within the Department of Health the Andrew John Anderson Rare Pediatric Disease Grant Program. The purpose of the program is to advance the progress of research and cures for rare pediatric diseases by awarding grants through a competitive, peer-reviewed process.

(b) Subject to an annual appropriation by the Legislature, the program shall award grants for scientific and clinical research to further the search for new diagnostics, treatments, and cures for rare pediatric diseases.

(2)(a) Applications for grants for rare pediatric disease research may be submitted by any university or established research institute in the state. All qualified investigators in the state, regardless of institutional affiliation, shall have equal access and opportunity to compete for the research funding. Preference may be given to grant proposals that foster collaboration among institutions, researchers, and community practitioners, as such proposals support the advancement of treatments and cures of rare pediatric diseases through basic or applied research. Grants shall be awarded by the department, after consultation with the Rare Disease Advisory Council, pursuant to s. 381.99, on the basis of scientific merit, as determined by the competitive, peer-reviewed process to ensure objectivity, consistency, and high quality. The following types

of applications may be considered for funding:

1. Investigator-initiated research grants.

2. Institutional research grants.

3. Collaborative research grants, including those that advance the finding of treatment and cures through basic or applied research.

(b) To ensure appropriate and fair evaluation of grant applications based on scientific merit, the department shall appoint peer review panels of independent, scientifically qualified individuals to review the scientific merit of each proposal and establish its priority score. The priority scores shall be forwarded to the council and must be considered in determining which proposals shall be recommended for funding.

(c) The council and the peer review panels shall establish and follow rigorous guidelines for ethical conduct and adhere to a strict policy with regard to conflicts of interest. A member of the council or panel may not participate in any discussion or decision of the council or panel with respect to a research proposal by any firm, entity, or agency that the member is associated with as a member of the governing body or as an employee or with which the member has entered into a contractual arrangement.

(d) Notwithstanding s. 216.301 and pursuant to s. 216.351, the balance of any appropriation from the General Revenue Fund for the Andrew John Anderson Pediatric Rare Disease Grant Program that is not disbursed but that is obligated pursuant to contract or committed to be expended by June 30 of the fiscal year in which the funds are appropriated may be carried forward for up to 5 years after the effective date of the original

appropriation.

Section 3. Present subsection (5) of section 383.14, Florida Statutes, is redesignated as subsection (6), a new subsection (5) is added to that section, and subsections (1), (2), and (3) of that section are amended, to read:

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.—

(1) SCREENING REQUIREMENTS.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. Any health care practitioner present at a birth or responsible for primary care during the neonatal period has the primary responsibility of administering screenings as required in ss. 383.14 and 383.145. As used in this subsection, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458, an osteopathic physician or physician assistant licensed under chapter 459, an advanced practice registered nurse licensed under part I of chapter 464, or a midwife licensed under chapter 467 ~~The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention~~

~~services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.~~

~~(a) *Prenatal screening.*—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify women at risk for a preterm birth or other high-risk condition. The primary health care provider shall complete the risk assessment instrument and report the results to the Office of Vital Statistics so that the woman may immediately be notified and referred to appropriate health, education, and social services.~~

~~(b) *Postnatal screening.*—A risk factor analysis using the department's designated risk assessment instrument shall also be conducted as part of the medical screening process upon the birth of a child and submitted to the department's Office of Vital Statistics for recording and other purposes provided for in this chapter. The department's screening process for risk assessment shall include a scoring mechanism and procedures that establish thresholds for notification, further assessment, referral, and eligibility for services by professionals or paraprofessionals consistent with the level of risk. Procedures for developing and using the screening instrument, notification, referral, and care coordination services, reporting~~

~~requirements, management information, and maintenance of a computer-driven registry in the Office of Vital Statistics which ensures privacy safeguards must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter. Procedures established for reporting information and maintaining a confidential registry must include a mechanism for a centralized information depository at the state and county levels. The department shall coordinate with existing risk assessment systems and information registries. The department must ensure, to the maximum extent possible, that the screening information registry is integrated with the department's automated data systems, including the Florida On-line Recipient Integrated Data Access (FLORIDA) system~~.

(a) *Blood specimens for newborn screenings.*—Newborn ~~Tests and~~ screenings must be performed by the State Public Health Laboratory, in coordination with Children's Medical Services, at such times and in such manner as is prescribed by the department after consultation with the Genetics and Newborn Screening Advisory Council ~~and the Department of Education~~.

(b) ~~(c)~~ *Release of screening results.*—Notwithstanding any law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's ~~hearing and metabolic tests or~~ screenings to the newborn's health care practitioner, the newborn's parent or legal guardian, the newborn's personal representative, or a person designated by the newborn's parent or legal guardian. As used in this paragraph, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458; an osteopathic physician or

physician assistant licensed under chapter 459; an advanced practice registered nurse, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a midwife licensed under chapter 467; a speech-language pathologist or audiologist licensed under part I of chapter 468; ~~or~~ a dietician or nutritionist licensed under part X of chapter 468; or a genetic counselor licensed under part III of chapter 483.

(2) RULES.—

(a) After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall:

1. Before becoming 1 week of age, have a blood specimen collected for newborn screenings ~~be subjected to a test for phenylketonuria~~;

2. Be tested for any condition included on the federal Recommended Uniform Screening Panel which the council advises the department should be included under the state's screening program. After the council recommends that a condition be included, the department shall submit a legislative budget request to seek an appropriation to add testing of the condition to the newborn screening program. The department shall expand statewide screening of newborns to include screening for such conditions within 18 months after the council renders such advice, if a test approved by the United States Food and Drug Administration or a test offered by an alternative vendor is available. If such a test is not available within 18 months after the council makes its recommendation, the department shall implement such screening as soon as a test offered by the United States Food and Drug Administration or by an alternative vendor

is available; and

3. At the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary ~~from time to time~~.

~~(b) After consultation with the Department of Education, the department shall adopt and enforce rules requiring every newborn in this state to be screened for environmental risk factors that place children and their families at risk for increased morbidity, mortality, and other negative outcomes.~~

(b) ~~(c)~~ The department shall adopt such additional rules as are found necessary for the administration of this section and ss. 383.145 and 383.148 ~~s. 383.145~~, including rules providing definitions of terms, rules relating to the methods used and time or times for testing as accepted medical practice indicates, rules relating to charging and collecting fees for the administration of the newborn screening program authorized by this section, rules for processing requests and releasing test and screening results, and rules requiring mandatory reporting of the results of tests and screenings for these conditions to the department.

(3) DEPARTMENT OF HEALTH; POWERS AND DUTIES.—The department shall administer and provide certain services to implement the provisions of this section and shall:

(a) Assure the availability and quality of the necessary laboratory tests and materials.

(b) ~~Furnish all physicians, county health departments, perinatal centers, birthing centers, and hospitals forms on which environmental screening and the results of tests for phenylketonuria and such other disorders for which testing may~~

~~be required from time to time shall be reported to the department.~~

~~(c)~~ Promote education of the public about the prevention and management of metabolic, hereditary, and congenital disorders ~~and dangers associated with environmental risk factors~~.

(c)~~(d)~~ Maintain a confidential registry of cases, including information of importance for the purpose of follow-up ~~followup~~ services to prevent intellectual disabilities, to correct or ameliorate physical disabilities, and for epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1).

(d)~~(e)~~ Supply the necessary dietary treatment products where practicable for diagnosed cases of ~~phenylketonuria and other~~ metabolic diseases for as long as medically indicated when the products are not otherwise available. Provide nutrition education and supplemental foods to those families eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children as provided in s. 383.011.

(e)~~(f)~~ Promote the availability of genetic studies, services, and counseling in order that the parents, siblings, and affected newborns may benefit from detection and available knowledge of the condition.

(f)~~(g)~~ Have the authority to charge and collect fees for the administration of the newborn screening program. ~~authorized in this section, as follows:~~

~~1.~~ A fee not to exceed $15 will be charged for each live birth, as recorded by the Office of Vital Statistics, occurring in a hospital licensed under part I of chapter 395 or a birth

center licensed under s. 383.305 ~~per year~~. The department shall calculate the ~~annual~~ assessment for each hospital and birth center, and this assessment must be paid ~~in equal amounts~~ quarterly. ~~Quarterly,~~ The department shall generate and issue ~~mail to~~ each hospital and birth center a statement of the amount due.

~~2. As part of the department's legislative budget request prepared pursuant to chapter 216, the department shall submit a certification by the department's inspector general, or the director of auditing within the inspector general's office, of the annual costs of the uniform testing and reporting procedures of the newborn screening program. In certifying the annual costs, the department's inspector general or the director of auditing within the inspector general's office shall calculate the direct costs of the uniform testing and reporting procedures, including applicable administrative costs. Administrative costs shall be limited to those department costs which are reasonably and directly associated with the administration of the uniform testing and reporting procedures of the newborn screening program.~~

(g) ~~(h)~~ Have the authority to bill third-party payors for newborn screening tests.

(h) ~~(i)~~ Create and make available electronically a pamphlet with information on screening for, and the treatment of, preventable infant and childhood eye and vision disorders, including, but not limited to, retinoblastoma and amblyopia.

All provisions of this subsection must be coordinated with the provisions and plans established under this chapter, chapter

411, and Pub. L. No. 99-457.

(5) SUBMISSION OF NEWBORN SCREENING SPECIMEN CARDS.—Any health care practitioner whose duty it is to administer screenings under this section shall prepare and send all newborn screening specimen cards to the State Public Health Laboratory in accordance with rules adopted under this section. As used in this subsection, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458, an osteopathic physician or physician assistant licensed under chapter 459, an advanced practice registered nurse licensed under part I of chapter 464, or a midwife licensed under chapter 467.

Section 4. Paragraph (k) is added to subsection (2) of Section 383.145, Florida Statutes, and subsection (3) of that section is amended, to read:

383.145 Newborn, ~~and~~ infant, and toddler hearing screening.—

(2) DEFINITIONS.—As used in this section, the term:

(k) "Toddler" means a child from 12 months to 36 months of age.

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS, INFANTS, AND TODDLERS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.—

(a) Each hospital or other state-licensed birth ~~birthing~~ facility that provides maternity and newborn care services shall ensure that all newborns are, before discharge, screened for the detection of hearing loss to prevent the consequences of unidentified disorders. If a newborn fails the screening for the detection of hearing loss, the hospital or other state-licensed birth ~~birthing~~ facility must administer a test approved by the

United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age or before discharge, whichever occurs earlier.

(b) Each licensed birth center that provides maternity and newborn care services shall ensure that all newborns are, before discharge, screened for the detection of hearing loss. Within 7 days after the birth, the licensed birth center must ensure that all newborns who do not pass the hearing screening are referred for ~~to~~ an appointment ~~audiologist, a hospital, or another newborn hearing screening provider~~ for a test to screen for congenital cytomegalovirus before the newborn becomes 21 days of age ~~screening for the detection of hearing loss to prevent the consequences of unidentified disorders. The referral for appointment must be made within 7 days after discharge~~. Written documentation of the referral must be placed in the newborn's medical chart.

(c) If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such case, the physician, midwife, or other person attending the newborn shall maintain a record that the screening has not been performed and attach a written objection that must be signed by the parent or guardian.

(d) For home births, the health care provider in attendance is responsible for coordination and referral to an audiologist, a hospital, or another newborn hearing screening provider. The health care provider in attendance must make the referral for appointment within 7 days after the birth. In cases in which the home birth is not attended by a health care provider, the

newborn's primary health care provider is responsible for coordinating the referral.

(e) For home births and births in a licensed birth center, if a newborn is referred to a newborn hearing screening provider and the newborn fails the screening for the detection of hearing loss, the newborn's primary health care provider must refer the newborn for administration of a test approved by the United States Food and Drug Administration or another diagnostically equivalent test on the newborn to screen for congenital cytomegalovirus before the newborn becomes 21 days of age.

(f) All newborn and infant hearing screenings must be conducted by an audiologist, a physician, or an appropriately supervised individual who has completed documented training specifically for newborn hearing screening. Every hospital that provides maternity or newborn care services shall obtain the services of an audiologist, a physician, or another newborn hearing screening provider, through employment or contract or written memorandum of understanding, for the purposes of appropriate staff training, screening program supervision, monitoring the scoring and interpretation of test results, rendering of appropriate recommendations, and coordination of appropriate follow-up services. Appropriate documentation of the screening completion, results, interpretation, and recommendations must be placed in the medical record within 24 hours after completion of the screening procedure.

(g) The screening of a newborn's hearing must be completed before the newborn is discharged from the hospital or licensed birth center. However, if the screening is not completed before discharge due to scheduling or temporary staffing limitations,

the screening must be completed within 21 days after the birth. Screenings completed after discharge or performed because of initial screening failure must be completed by an audiologist, a physician, a hospital, or another newborn hearing screening provider.

(h) Each hospital shall formally designate a lead physician responsible for programmatic oversight for newborn hearing screening. Each birth center shall designate a licensed health care provider to provide such programmatic oversight and to ensure that the appropriate referrals are being completed.

(i) When ordered by the treating physician, screening of a newborn's, infant's, or toddler's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.

(j) The results of any test conducted pursuant to this section, including, but not limited to, newborn hearing loss screening, congenital cytomegalovirus testing, and any related diagnostic testing, must be reported to the department within 7 days after receipt of such results.

(k) The initial procedure for screening the hearing of the newborn or infant and any medically necessary follow-up reevaluations leading to diagnosis shall be a covered benefit for Medicaid patients covered by a fee-for-service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health

maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(30), except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental policies, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers are eligible to bill Medicaid for the professional and technical component of each procedure code.

(l) A child who is diagnosed as having permanent hearing loss must be referred to the primary care physician for medical management, treatment, and follow-up services. Furthermore, in accordance with Part C of the Individuals with Disabilities Education Act, Pub. L. No. 108-446, Infants and Toddlers with Disabilities, any child from birth to 36 months of age who is diagnosed as having hearing loss that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program serving the geographical area in which the child resides.

Section 5. Section 383.147, Florida Statutes, is amended to read:

383.147 ~~Newborn and infant screenings for~~ Sickle cell disease and sickle cell trait ~~hemoglobin variants;~~ registry.—

(1) If ~~a screening provider detects that~~ a newborn as ~~or an infant, as those terms are~~ defined in s. 383.145(2)~~,~~ is identified as having sickle cell disease or carrying a sickle cell trait through the newborn screening program as described in s. 383.14, the department ~~hemoglobin variant, it~~ must:

(a) Notify the parent or guardian of the newborn and provide information regarding the availability and benefits of

genetic counseling. ~~primary care physician of the newborn or infant and~~

(b) Submit the results of such screening ~~to the Department of Health~~ for inclusion in the sickle cell registry established under paragraph (2)(a), unless the parent or guardian of the newborn provides an opt-out form obtained from the department, or otherwise indicates in writing to the department his or her objection to having the newborn included in the sickle cell registry. ~~The primary care physician must provide to the parent or guardian of the newborn or infant information regarding the availability and benefits of genetic counseling.~~

(2)(a) The Department of Health shall contract with a community-based sickle cell disease medical treatment and research center to establish and maintain a registry for individuals ~~newborns and infants~~ who are identified as having sickle cell disease or carrying a sickle cell trait ~~hemoglobin variant~~. The sickle cell registry must track sickle cell disease outcome measures, except as provided in paragraph (1)(b). ~~A parent or guardian of a newborn or an infant in the registry may request to have his or her child removed from the registry by submitting a form prescribed by the department by rule.~~

(b) In addition to newborns identified and included in the registry under subsection (1), persons living in this state who have been identified as having sickle cell disease or carrying a sickle cell trait may choose to be included in the registry by providing the department with notification as prescribed by rule.

(c) The Department of Health shall also establish a system to ensure that the community-based sickle cell disease medical

treatment and research center notifies the parent or guardian of a child who has been included in the registry that a follow-up consultation with a physician is recommended. Such notice must be provided to the parent or guardian of such child at least once during early adolescence and once during late adolescence. The department shall make every reasonable effort to notify persons included in the registry who are 18 years of age that they may request to be removed from the registry by submitting a form prescribed by the department by rule. The department shall also provide to such persons information regarding available educational services, genetic counseling, and other beneficial resources.

(3) The Department of Health shall adopt rules to implement this section.

Section 6. Section 383.148, Florida Statutes, is created to read:

383.148 ENVIRONMENTAL RISK SCREENING.—

(1) RISK SCREENING.—To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all pregnant women and infants in this state for environmental risk factors, such as low income, poor education, maternal and family stress, mental health, substance use disorder, and other high-risk conditions, and promote education of the public about the dangers associated with environmental risk factors.

(2) PRENATAL RISK SCREENING REQUIREMENTS.—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify women at risk for a preterm birth or other high-risk condition.

(a) A primary health care provider must complete the risk screening at a pregnant woman's first prenatal visit using the form and in the manner prescribed by rules adopted under this section, so that the woman may immediately be notified and referred to appropriate health, education, and social services.

(b) This subsection does not apply if the pregnant woman objects to the screening in a manner prescribed by department rule.

(3) POSTNATAL RISK SCREENING REQUIREMENTS.—The department shall develop a multilevel screening process that includes a risk assessment instrument to identify factors associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management.

(a) A hospital or birth center must complete the risk screening immediately following the birth of the infant, before discharge from the hospital or birth center, using the form and in the manner prescribed by rules adopted under this section.

(b) This subsection does not apply if a parent or guardian of the newborn objects to the screening in a manner prescribed by department rule.

Section 7. Section 383.2163, Florida Statutes, is amended to read:

383.2163 Telehealth minority maternity care program ~~pilot programs~~. ~~By July 1, 2022,~~ The department shall establish a telehealth minority maternity care ~~pilot~~ program ~~in Duval County and Orange County~~ which uses telehealth to expand the capacity for positive maternal health outcomes in racial and ethnic

minority populations. The department shall ~~direct and assist the county health departments in Duval County and Orange County to~~ implement local ~~the~~ programs contingent upon available funding.

(1) DEFINITIONS.—As used in this section, the term:

(a) "Department" means the Department of Health.

(b) "Eligible pregnant woman" means a pregnant woman who is receiving, or is eligible to receive, maternal or infant care services from the department under chapter 381 or this chapter.

(c) "Health care practitioner" has the same meaning as in s. 456.001.

(d) "Health professional shortage area" means a geographic area designated as such by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(e) "Indigenous population" means any Indian tribe, band, or nation or other organized group or community of Indians recognized as eligible for services provided to Indians by the United States Secretary of the Interior because of their status as Indians, including any Alaskan native village as defined in 43 U.S.C. s. 1602(c), the Alaska Native Claims Settlement Act, as that definition existed on the effective date of this act.

(f) "Maternal mortality" means a death occurring during pregnancy or the postpartum period which is caused by pregnancy or childbirth complications.

(g) "Medically underserved population" means the population of an urban or rural area designated by the United States Secretary of Health and Human Services as an area with a shortage of personal health care services or a population group designated by the United States Secretary of Health and Human

Services as having a shortage of such services.

(h) "Perinatal professionals" means doulas, personnel from Healthy Start and home visiting programs, childbirth educators, community health workers, peer supporters, certified lactation consultants, nutritionists and dietitians, social workers, and other licensed and nonlicensed professionals who assist women through their prenatal or postpartum periods.

(i) "Postpartum" means the 1-year period beginning on the last day of a woman's pregnancy.

(j) "Severe maternal morbidity" means an unexpected outcome caused by a woman's labor and delivery which results in significant short-term or long-term consequences to the woman's health.

(k) "Technology-enabled collaborative learning and capacity building model" means a distance health care education model that connects health care professionals, particularly specialists, with other health care professionals through simultaneous interactive videoconferencing for the purpose of facilitating case-based learning, disseminating best practices, and evaluating outcomes in the context of maternal health care.

(2) PURPOSE.—The purpose of the program ~~pilot programs~~ is to:

(a) Expand the use of technology-enabled collaborative learning and capacity building models to improve maternal health outcomes for the following populations and demographics:

1. Ethnic and minority populations.

2. Health professional shortage areas.

3. Areas with significant racial and ethnic disparities in maternal health outcomes and high rates of adverse maternal

health outcomes, including, but not limited to, maternal mortality and severe maternal morbidity.

4. Medically underserved populations.

5. Indigenous populations.

(b) Provide for the adoption of and use of telehealth services that allow for screening and treatment of common pregnancy-related complications, including, but not limited to, anxiety, depression, substance use disorder, hemorrhage, infection, amniotic fluid embolism, thrombotic pulmonary or other embolism, hypertensive disorders relating to pregnancy, diabetes, cerebrovascular accidents, cardiomyopathy, and other cardiovascular conditions.

(3) TELEHEALTH SERVICES AND EDUCATION.—The program ~~pilot programs~~ shall adopt the use of telehealth or coordinate with prenatal home visiting programs to provide all of the following services and education to eligible pregnant women up to the last day of their postpartum periods, as applicable:

(a) Referrals to Healthy Start's coordinated intake and referral program to offer families prenatal home visiting services.

(b) Services and education addressing social determinants of health, including, but not limited to, all of the following:

1. Housing placement options.

2. Transportation services or information on how to access such services.

3. Nutrition counseling.

4. Access to healthy foods.

5. Lactation support.

6. Lead abatement and other efforts to improve air and

water quality.

7. Child care options.

8. Car seat installation and training.

9. Wellness and stress management programs.

10. Coordination across safety net and social support services and programs.

(c) Evidence-based health literacy and pregnancy, childbirth, and parenting education for women in the prenatal and postpartum periods.

(d) For women during their pregnancies through the postpartum periods, connection to support from doulas and other perinatal health workers.

(e) Tools for prenatal women to conduct key components of maternal wellness checks, including, but not limited to, all of the following:

1. A device to measure body weight, such as a scale.

2. A device to measure blood pressure which has a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

3. A device to measure blood sugar levels with a verbal reader to assist the pregnant woman in reading the device and to ensure that the health care practitioner performing the wellness check through telehealth is able to hear the reading.

4. Any other device that the health care practitioner performing wellness checks through telehealth deems necessary.

(4) TRAINING.—The program ~~pilot programs~~ shall provide training to participating health care practitioners and other perinatal professionals on all of the following:

(a) Implicit and explicit biases, racism, and discrimination in the provision of maternity care and how to eliminate these barriers to accessing adequate and competent maternity care.

(b) The use of remote patient monitoring tools for pregnancy-related complications.

(c) How to screen for social determinants of health risks in the prenatal and postpartum periods, such as inadequate housing, lack of access to nutritional foods, environmental risks, transportation barriers, and lack of continuity of care.

(d) Best practices in screening for and, as needed, evaluating and treating maternal mental health conditions and substance use disorders.

(e) Information collection, recording, and evaluation activities to:

1. Study the impact of the ~~pilot~~ program;

2. Ensure access to and the quality of care;

3. Evaluate patient outcomes as a result of the pilot program;

4. Measure patient experience; and

5. Identify best practices for the future expansion of the ~~pilot~~ program.

(5) FUNDING.—The program ~~pilot programs~~ shall be funded using funds appropriated by the Legislature ~~for the Closing the Gap grant program~~. The department's Division of Community Health Promotion and Office of Minority Health and Health Equity shall also work in partnership to apply for federal funds that are available to assist the department in accomplishing the program's purpose and successfully implementing the program

through community-based organizations ~~pilot programs~~.

(6) RULES.—The department may adopt rules to implement this section.

Section 8. Paragraph (i) of subsection (3) of section 383.318, Florida Statutes, is amended to read:

383.318 Postpartum care for birth center clients and infants.—

(3) The birth center shall provide a postpartum evaluation and followup care that includes all of the following:

(i) Provision of the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~.

Section 9. Section 395.1053, Florida Statutes, is amended to read:

395.1053 Postpartum education.—A hospital that provides birthing services shall incorporate information on safe sleep practices and the possible causes of Sudden Unexpected Infant Death into the hospital's postpartum instruction on the care of newborns and provide to each parent the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~.

Section 10. Section 456.0496, Florida Statutes, is amended to read:

456.0496 Provision of information on eye and vision disorders to parents during planned out-of-hospital births.—A health care practitioner who attends an out-of-hospital birth must ensure that the informational pamphlet on infant and childhood eye and vision disorders created by the department pursuant to s. 383.14(3)(h) ~~s. 383.14(3)(i)~~ is provided to each

parent after such a birth.

Section 11. This act shall take effect July 1, 2024.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 10, 2024

I respectfully request that **Senate Bill #1582**, relating to Department of Health, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 40

File signed original with committee office

S-020 (03/2004)

Florida Senate Sunrise Questionnaire
For Environmental Health Technicians

The Department of Health submits these answers for the proposal in Section 1 of SB 1582. The environmental health technician (EHT) certification created under this proposal is not a “health care practitioner” or a “professional” as those terms are defined in Chapter 456, Florida Statutes, and therefore would not be subject to regulation under that chapter.

The proposal creates a lower-level certification for those who would complete septic inspections as employees of a state agency. Section 381.0101, Florida Statutes, currently outlines the regulation of certified environmental health professionals (CEHPs) to complete that work and requires a CEHP to have graduated from an accredited 4-year college or university with a degree or major coursework in public health, environmental health, environmental science, or a physical or biological science. The proposed legislation would allow for those individuals who do not hold the required educational background to undergo the same training and examination and complete the same tasks as CEHPs, with two key exceptions: EHTs will be required to have completed a minimum of supervised hours (to be adopted in rule) prior to certification and their work will always be reviewed and authorized by a supervising CEHP, even after certification.

Legislative History

1. There is no prior legislation or attempts to create an environmental health technician (EHT). Section 381.0101, Florida Statutes, currently sets forth the regulation of the profession of “certified environmental health professional.” The intent here is to create a lower-level certification for persons who would conduct work under the supervision of a certified environmental health professional.

Applicant Group Identification

2. There is no group external to the Department of Health (Department) and the Department of Environmental Protection (DEP) seeking this regulation.

3. There are approximately 550 CEHPs in Florida.

4. CEHPs have no distinct organization representing them, nor would EHTs.

5. CEHPs are largely state employees and have not been polled directly as to their advocacy of any legislation. There is no practical way to poll prospective EHTs.

6. The Department and the DEP Onsite Sewage Program support the legislation to expand the workforce into those without a bachelor’s degree with significant science.

7. Yes

Consumer Group Identification

8. EHTs would deal with the same consumer populations as CEHPs: individual property owners with septic tanks, septic tank contractors, home builders, and contractors.

9. There is no known advocacy group specifically for this population.

10. If regulation is approved, all the consumer populations using CEHP services may use EHT services, if either state agency assigns an EHT to their specific case.

11. There are no known opponents of expanding the available workforce for septic inspections.

Need for Regulation?

12. The current standard of requiring a CEHP for many tasks related to septic regulation is adequate. However, the challenge of recruitment and retention for those with the applicable degree has caused delays across the state, and particularly in areas with accelerated building like Lee County. It was due to the demand for services that the Legislature passed SB 856 in 2022 to create private provider inspectors in section 381.0065(8), Florida Statutes. Two categories of private provider inspectors aren't required to have a bachelor's degree with significant science. Even with this new class of inspectors in law, some customers are frustrated with the time it takes for either a private or public employee to complete related tasks, and so the Department and DEP are seeking to reduce wait times by careful expansion of the regulatory workforce.

13. No harm to the public has occurred as inspections are currently handled by CEHPs or private providers who are regulated under existing statute and rules.

14. There is no significant likelihood of any harm. EHTs will receive appropriate training before beginning work, will always have their work checked by a supervising CEHP, and must renew certification through documented continuing education as rule will outline.

15. In the last 12 months, there have been three complaints against CEHPs (none of whom are currently employed by the state).

16. The Department will be required to adopt rules that will establish the necessary education and training to ensure that EHTs have the knowledge, skills, and abilities to complete the assigned work. Further, the Department has existing authority in section 381.0101(7), Florida Statutes, to deny, suspend, or revoke a certification or impose an administrative fine of up to $500 for each violation of the section or a rule adopted under the section. Any person with a revoked certificate may not perform the work for at least 5 years from the date of revocation.

17. There is no national certification or registration for an EHT.

18. If there are private provider inspectors in the area, consumers generally have the choice between them or public sector inspectors. But they do not always select from among the inspectors the way one would select a health care provider; the entity assigns one to the task. Where there are no private provider inspectors, the CHD will always respond.

19. As the work is enforcing regulations, versus providing health care, there is no "referral" to inspectors except in a case where a consumer is advised by someone familiar with relevant law that they need to have a permit.

20. Inspectors "refer" consumers to other professionals that will help them complete a construction or repair task, such as a master septic tank contractor, so that the final product can be legally permitted.

21. The Department has adopted Rules 64E-18.006 – 18.008, Florida Administrative Code, to address standards of practice for CEHPs, as well as providing for suspension,

revocation, or denial of a certification, and to provide for disciplinary guidelines. If a CEHP makes a mistake, it is investigated and remedied.

22. The Department has existing statutory authority under section 381.0101(7), Florida Statutes, and Rules 64E-18.006, 18.007 and 18.008, Florida Administrative Code, to address complaints of violations by CEHPs. These complaints may come from consumers. In addition, if a consumer believes a public sector employee has behaved improperly, they can contact that employee's Office of Inspector General.

23. The available remedies are sufficient.

24. There are no applicable market controls to assure consumer protection in the regulation of septic tanks.

25. No other states are known to have a certified EHT. All those surveyed only have educational requirements comparable to CEHP and disallow any applicants or employees without those requirements from regulating septic tanks.

26. CEHPs have been regulated by the state pursuant to section 381.0101, Florida Statutes, and Chapter 64E-18, Florida Administrative Code, since September 1994. The educational standards that exist in section 381.0101, Florida Statutes, prevent the Department and DEP from allowing those without the statutorily required educational background from completing the work. The Department cannot implement a code of ethics or other approach short of statutory change and rule adoption to allow any other public sector employees to perform work now reserved for CEHPs. There is no national certification or code of ethics for CEHPs or EHTs.

27. There is no grandfather clause.

28. The public will realize improved septic regulatory timeframes through the implementation of an EHT certification.

29. Owners and operators of septic tanks and their neighbors will benefit most from this legislation.

30. This proposal does not create restrictions of opportunities to practice or of supply, it increases opportunities for both. It does not increase costs of services and is neutral in the amount of governmental intervention as the public sector already performs most regulatory tasks for septic tanks.

31. EHTs judgments will always have review and oversight by CEHPs in the proposal.

32. EHTs will never operate fully independently. Once certified, they will visit the site and draft permitting or citation findings, but those will all be reviewed and authorized by a supervising CEHP.

33. There is no high degree of skill or knowledge to avoid harm. Training and supervision are required to ensure appropriate regulation and minimize inconvenience.

34. The proposed regulatory scheme sets up a lower-level certification to allow EHTs to perform functions and tasks of a CEHP but will require approval of a supervising CEHP.

35. EHTs would complete all relevant regulatory tasks outlined in rule Chapter 62-6, Florida Administrative Code, as CEHPs currently do.

36. EHTs would have to complete supervised field hours set by rule prior to taking and passing the same exam as CEHP candidates. EHTs must maintain certification through documented continuing education as CEHPs do. The proposal will also require the Department to establish ethical standards of practice for the profession.

37. Competent practice is assessed by the exam, and then through continuing education.

38. Any violation listed in Rule 64E-18.007, Florida Administrative Code, would demonstrate incompetence and/or dishonesty.

39. CEHPs are currently certified according to section 381.0101, Florida Statutes, and Chapter 64E-18, Florida Administrative Code; EHTs would perform the same or similar tasks as a CEHP but would require supervisory review and approval.

40. EHTs would perform the same or similar functions as a CEHP but would require supervisory review and approval by the CEHP.

41. EHTs should be considered a branch of the currently certified occupation.

42. The only impact from this proposal to the authority or scope of CEHPs is to add responsibility for authorizing the work products of subordinate EHTs.

43. There are no unregulated occupations performing similar services. The closest parallel would be private provider inspectors without a scientific degree. DEP maintains a registry of those inspectors but does not regulate them. Section 381.0065(8)(d)2., Florida Statutes, includes a required attestation for any private provider inspection work that the owner or authorized agent has “made inquiry regarding the competence of the licensed or certified private provider” and they are satisfied that their “interests are adequately protected.”

44. There would be no substantive difference between EHTs and private provider inspectors without a scientific degree, other than it will allow the DEP and DOH to hire public sector employees to perform the tasks associated with septic inspections without requiring a 4-year degree.

45. The legislation should create no confusion in the marketplace as to who is certified, as the Department assigns inspectors based on their available workforce; consumers do not actively pick an individual, only the entity (CHD or private provider).

46. The proposal will not generate scope or practice or unlicensed activity complaints.

47. The general accepted core set of knowledge, skills, and abilities (KSAs) without which a regulator may ineffectively apply laws and rules is the material covered in the required training and certification exam.

48. DEP administers the septic training and certification exam.

49. The KSAs are tested through written certification exam.

50. There are no accredited or nonaccredited preparatory programs for CEHPs or EHTs.

51. EHTs will acquire the required KSAs through on-the-job training and supervised inspections proposed in the legislation. There is no formal apprenticeship or internship option.

52. All (100% of) EHTs will acquire the required KSAs through that route.

53. DEP administers the septic exam and further information can be provided as needed.

54. DEP administers the septic exam and further information can be provided as needed.

55. No alternate exam is available or proposed for EHTs.

Economic Impact

56. There is no firm figure for the number of septic system owners and operators, as it fluctuates constantly as new systems come online and others are abandoned. Adding a certified EHT occupation will not affect the number of septic system owners or operators.

57. Fees for septic systems are set in Rule 62-6.30, Florida Administrative Code. CHDs would charge the same fees if an EHT completed the work or if a CEHP completed the work.

58. The major governmental activities needed to appropriately regulate EHTs are to create a new rule, evaluate applicants' test scores and supervised hours, renew certifications, follow up on complaints, and assess continuing education.

59. The number of EHTs likely to be certified is difficult to estimate, as the occupation will simply be an option for CHDs who need additional help and wish to consider applicants without a scientific degree. Additionally, all CHDs will have to maintain CEHPs to review EHT work products, and some EHTs may pursue the necessary degree while employed to promote out of the function into a CEHP. It is unlikely that there will be more than EHTs 50 statewide in any given year.

60. The number of applicants expected to apply is also difficult to estimate as the framework is new and not all CHDs need to consider it to manage their workload.

61. Though the workforce is expected to be relatively small, there are minimal costs incurred by the Department and DEP to certify this addition occupation. Recruitment and retention are expected to improve, which will also offset extra certification costs.

62. Adoption of the requested certification represents the only form of regulating it, as previously explained by the degree requirement prohibiting any consideration without a statutory change.

Proposed Legislation

63. SB 1582 (Department of Health) creates no new board, establishes education and experience requirements to be adopted by rule, establishes a required examination, creates no grandfather clause, and makes no change to existing authority in section

381.0101(7), Florida Statutes, or Rules 64E-18.006, 18.007 and 64E-18.008, Florida Administrative Code, regarding prohibited actions, standards of practice, and disciplinary measures.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

SB 1582
Bill Number or Topic

Amendment Barcode (if applicable)

Name Nancy Lawther, Ph.D.

Phone 407 855-7604

Address 174 Orlando Central Pkwy
Street

Email legislation@floridapta.org

Orlando FL 32809
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by: Florida PTA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 768
INTRODUCER:	Health Policy Committee and Senator Stewart
SUBJECT:	Duty to Report Certain Deaths
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Wyant	Stokes	CJ	**Favorable**
2.	Brown	Brown	HP	**Fav/CS**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 768 revises current law that requires a person who becomes aware of a death under specified circumstances to report the death to the medical examiner in the district where the death occurred. The bill allows such person the option of making the report to a law enforcement agency having jurisdiction over the location.

The bill also revises current law's criminal penalties associated with a person's failure to make the report or the person's unlawful behavior after becoming aware of the death and elevates certain offenses to third degree felonies, as opposed to first degree misdemeanors as under current law.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Duty to Report

Section 406.12, F.S., requires any person in the district where a death occurs, including all municipalities and unincorporated and federal areas, who becomes aware of the death of a person due to circumstances listed under s. 406.11, F.S., to report such death and circumstances forthwith[1] to the district medical examiner.

[1] Merriam-Webster defines "forthwith" to mean "without any delay."

A person commits a first degree misdemeanor[2] if he or she:

- Knowingly fails or refuses to report such death and circumstances;
- Refuses to make available prior medical records or other information pertinent to the death investigation; or
- Without an order from the office of the district medical examiner, willfully touches, removes, or disturbs the body, clothing, or any article upon or near the body, with the intent to alter evidence or circumstances surrounding the death.

Section 406.11, F.S., provides the following circumstances that require the medical examiner of the district in which the death occurred or the body was found, to determine the cause of death and, for that purpose, make or perform such examinations, investigations, and autopsies as he or she deems necessary or as requested by the state attorney:

- When a person dies in this state:
  - Of criminal violence.
  - By accident.
  - By suicide.
  - Suddenly, when in apparent good health.
  - Unattended by a practicing physician or other recognized practitioner.
  - In any prison or penal institution.
  - In police custody.
  - In any suspicious or unusual circumstance.
  - By criminal abortion.
  - By poison.
  - By disease constituting a threat to public health.
  - By disease, injury, or toxic agent resulting from employment.[3]
- When a dead body is brought into this state without proper medical certification.[4]
- When a body is to be cremated, dissected, or buried at sea.[5]

III. Effect of Proposed Changes:

The bill amends s. 406.12, F.S., to specify that a person who becomes aware of the death of any person occurring under the circumstances described in s. 406.11, F.S., must report such death and circumstances forthwith to the district medical examiner or to a law enforcement agency having jurisdiction over the location. Current law does not provide the option of reporting to a law enforcement agency.

The bill increases, from a first degree misdemeanor to a third degree felony,[6] the criminal penalty for any person who, with the intent to conceal such death or alter the evidence or circumstances surrounding such death, does any of the following:

---

[2] A first degree misdemeanor is punishable by a term of imprisonment not exceeding one year and a fine of up to $1,000. *See* ss. 775.082 and 775.083, F.S.
[3] Section 406.12(1)(a), F.S.
[4] Section 406.12(1)(b), F.S.
[5] Section 406.12(1)(c), F.S.
[6] A third degree felony is generally punishable by no more than five years in state prison and a fine not exceeding $5,000. *See* ss. 775.082 and 775.083, F.S.

- Knowingly fails or refuses to report such death and circumstances;
- Refuses to make available prior medical records or other information pertinent to the death investigation; or
- Without an order from the office of the district medical examiner, willfully touches, removes, or disturbs the body, clothing, or any article upon or near the body.

The bill applies current law's penalty of a first degree misdemeanor when the following offenses are committed without the intent to conceal or alter evidence or circumstances:

- The knowing failure or refusal to report such death and circumstances; or
- The refusal to make available prior medical records or other information pertinent to the death investigation.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

Unknown.[7]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill amends section 406.12 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute:

- Creates the option for a person to report a death covered under the bill to a law enforcement agency having jurisdiction over the location where the body was found.
- Revises current law's criminal penalties associated with a person's failure to make the report or the person's unlawful behavior after becoming aware of the death and elevates certain offenses to third degree felonies, as opposed to first degree misdemeanors as under current law.

B. Amendments:

None.

[7] As of this writing, the Criminal Justice Estimating Conference has not yet forecast a fiscal impact for this CS.

581312

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Stewart) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 406.12, Florida Statutes, is amended to read:

406.12 Duty to report; prohibited acts.—

(1) It is the duty of any person in the district where a death occurs, including all municipalities and unincorporated and federal areas, who becomes aware of the death of any person

581312

occurring under the circumstances described in s. 406.11 to report such death and circumstances forthwith to the district medical examiner or to a law enforcement agency having jurisdiction over the location.

(2) Any person who knowingly fails or refuses to report such death and circumstances as required under subsection (1) or~~,~~ who refuses to make available prior medical or other information pertinent to the death investigation commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(3) Any person~~, or~~ who, with the intent to conceal such death or to alter the evidence or circumstances surrounding such death:

(a) Violates subsection (2); or

(b) Without an order from the office of the district medical examiner, willfully touches, removes, or disturbs the body, clothing, or any article upon or near the body, ~~with the intent to alter the evidence or circumstances surrounding the death, shall be guilty of a misdemeanor of the first~~

commits a felony of the third degree, punishable as provided in s. 775.082, ~~or~~ s. 775.083, or s. 775.084.

Section 2. This act shall take effect July 1, 2024.

========== 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

581312

An act relating to duties and prohibited acts associated with death; amending s. 406.12, F.S.; authorizing that a report regarding specified deaths and circumstances be made to a certain law enforcement agency in addition to the district medical examiner; increasing the criminal penalty for persons who fail or refuse to report a death or who refuse to make available certain information with the intent to conceal the death or alter the evidence and circumstances surrounding the death; increasing the criminal penalty for persons who willfully touch, remove, or disturb a body without an order from the office of the district medical examiner with the intent to conceal the death or alter the evidence and circumstances surrounding the death; providing an effective date.

By Senator Stewart

17-00940-24 2024768__

A bill to be entitled

An act relating to the duty to report certain deaths; amending s. 406.12, F.S.; reclassifying the criminal penalty for failure or refusal to report certain deaths and information to the district medical examiner or for engaging in specified conduct related to such deaths; providing an effective date.

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

Section 1. Section 406.12, Florida Statutes, is amended to read:

406.12 Duty to report; prohibited acts.—It is the duty of any person in the district where a death occurs, including all municipalities and unincorporated and federal areas, who becomes aware of the death of any person occurring under the circumstances described in s. 406.11 to immediately report such death and circumstances ~~forthwith~~ to the district medical examiner. Any person who knowingly fails or refuses to report such death and circumstances, who refuses to make available prior medical or other information pertinent to the death investigation, or who, without an order from the office of the district medical examiner, willfully touches, removes, or disturbs the body, clothing, or any article upon or near the body, with the intent to alter the evidence or circumstances surrounding the death, commits ~~shall be guilty of~~ a felony ~~misdemeanor~~ of the third ~~first~~ degree, punishable as provided in s. 775.082 or s. 775.083.

Section 2. This act shall take effect July 1, 2024.

The Florida Senate

Committee Agenda Request

To: Senator, Chair Burton
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 18, 2024

I respectfully request that **Senate Bill #768**, Duty to Report Certain Deaths be placed on:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Linda Stewart

Senator Linda Stewart
Florida Senate, District 17

File signed original with committee office

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

HEALTH POLICY
Committee

SB 768
Bill Number or Topic

—
Amendment Barcode (if applicable)

Name ANTONIO WRIGHT

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Street

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ORLANDO, FL 32804
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: ORANGE COUNTY SHERIFF'S OFFICE

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	SB 1442
INTRODUCER:	Senator Grall
SUBJECT:	Pregnancy Support Services
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Favorable**
2.			AHS	
3.			FP	

I. Summary:

SB 1442 creates s. 381.97, F.S., to establish a Florida State Maternity Housing Grant Program (program) within the Department of Health (DOH) to provide approved living arrangements and resources to Florida's women and families experiencing homelessness during the prenatal period.

The program is designed to assist approved persons in achieving residency via an alternative living arrangement for a period not to exceed eight months, and includes a maximum of six weeks of postpartum care.

The bill requires the DOH to use grant funds specifically appropriated for the program in order to cover expenses identified in the bill and provides that the total amount of grants awarded may not exceed the funding appropriated for the grant program.

The bill authorizes the DOH to adopt rules necessary to administer the program.

The bill provides an effective date of July 1, 2024.

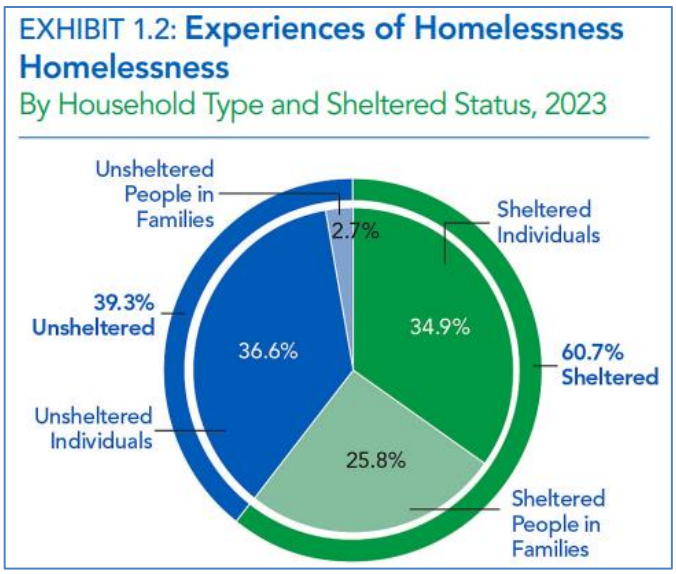
II. Present Situation:

Homelessness in the United States

Homeless persons are defined as those who lack a fixed, regular, and adequate nighttime residence, or those living in shelters and temporary housing, or public and private places not designed for sleeping accommodations. While many homeless individuals are alone, others are couples, families with children, or unaccompanied youth.[1]

[1] Florida Department of Children and Families, *Homelessness Frequently Asked Questions, available at* https://www.myflfamilies.com/services/public-assistance/homelessness/homelessness-frequently-asked-questions (last visited Feb. 1, 2024).

There are two types of homelessness: "sheltered" and "unsheltered." Unsheltered homeless persons live on the streets or live in tents, cars, or abandoned buildings. Sheltered homeless persons stay in emergency or transitional housing temporarily. Sheltered homeless persons are still considered homeless due to a lack of stable permanent housing.[2]



On a single night in 2023, roughly 653,100 people, about 20 of every 10,000 people in the U.S., were experiencing homelessness. This is the highest number reported since the inception of point-in-time count reporting in 2007. The data indicated that six in ten people were experiencing sheltered homelessness, while the remaining four in ten were experiencing unsheltered homelessness in places not meant for human habitation.[3]

Reporting has also shown experiences of homelessness increased nationwide across all household types. Between 2022 and 2023, the number of people experiencing homelessness increased by 12 percent, roughly 70,650 more people. Nearly three of every ten people experiencing homelessness (28 percent or approximately 186,100 people) did so as part of a family with children. Between 2022 and 2023, the number of people in families with children who were experiencing homelessness increased by more than 25,000 people (or 16 percent), ending a downward trend in families experiencing homelessness that began in 2012.[4]

The following exhibits demonstrate the approximate U.S. homeless population by state, as well as the people in families with children experiencing homelessness by sheltered status from 2007 to 2023.[5]

[2] *Id.*
[3] U.S. Department of Housing and Urban Development's Office of Community Planning and Development, *The 2023 Annual Homelessness Assessment Report (AHAR) to Congress – Part 1: Point-in-Time Estimates of Homelessness (December 2023), available at* https://www.huduser.gov/portal/sites/default/files/pdf/2023-AHAR-Part-1.pdf (last visited Feb. 1, 2024).
[4] *Id.*
[5] *Id.*

EXHIBIT 1.6: **Estimates of People Experiencing Homelessness**
By State, 2023

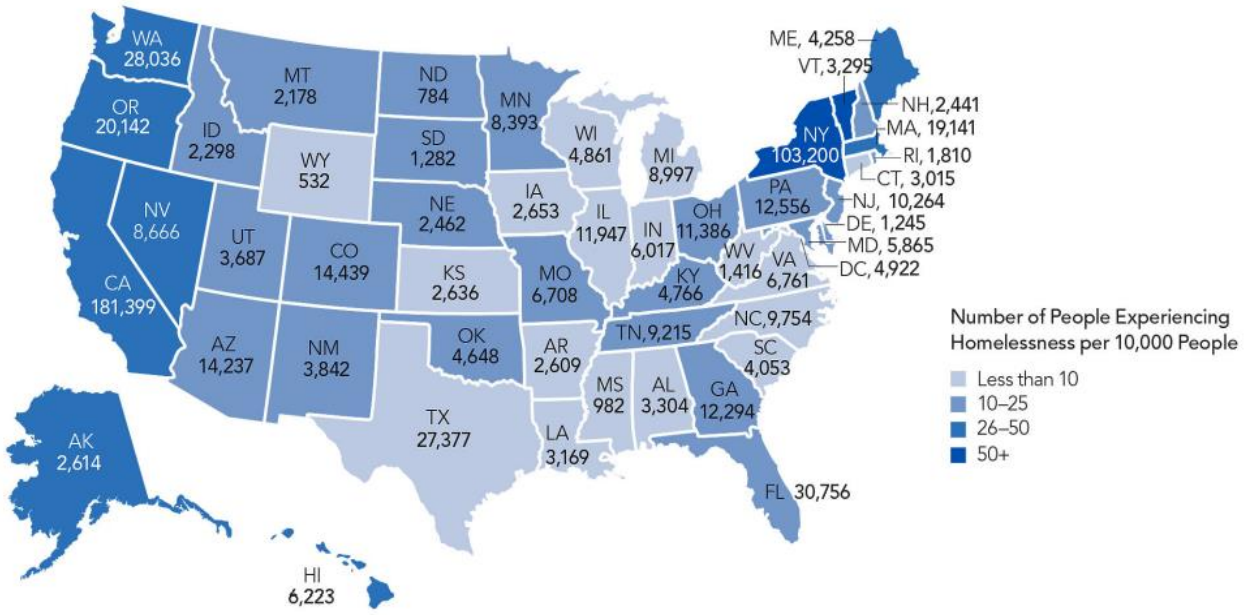
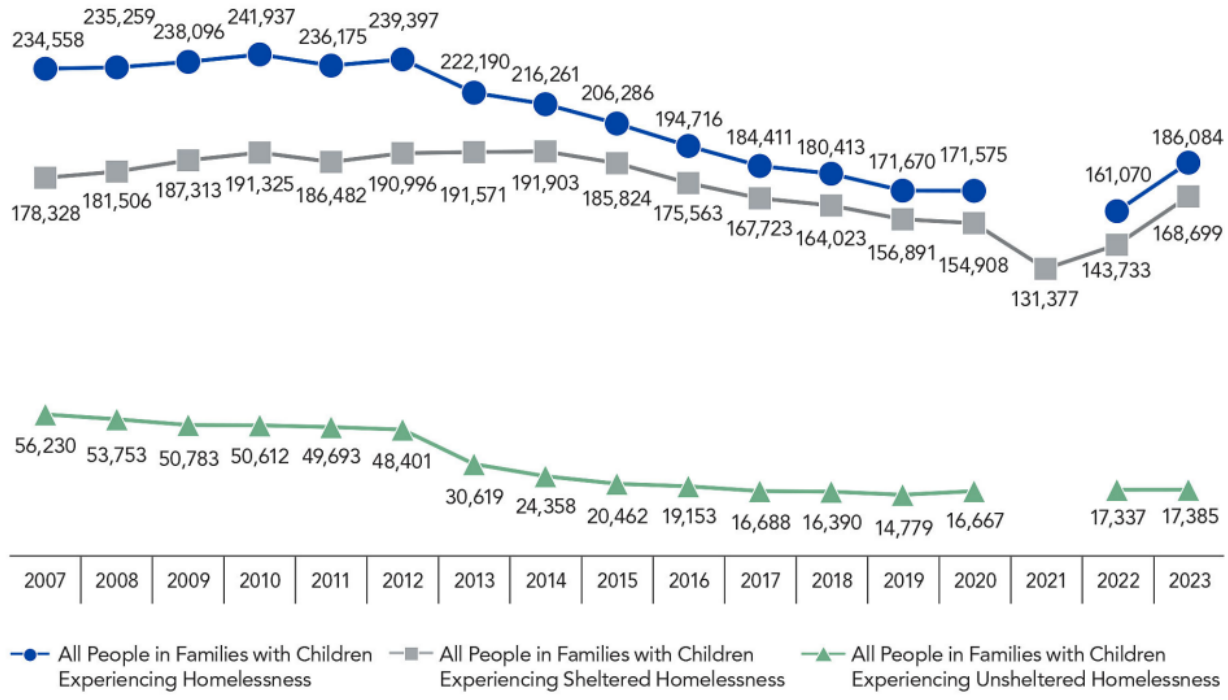


EXHIBIT 3.1: **PIT Estimates of People in Families with Children Experiencing Homelessness**
By Sheltered Status, 2007-2023



Note: The data for 2021 does not display the total count of people in families with children experiencing homelessness or the count of all people in families with children experiencing unsheltered homelessness because of pandemic-related disruptions to counts. Also, estimates of the number of people in families with children experiencing sheltered homelessness at a point in time in 2021 should be viewed with caution, as the number could be artificially reduced compared with non-pandemic times, reflecting reduced capacity in some communities or safety concerns regarding staying in shelters.

Homelessness in Florida

On a given night in January 2023, more than half of all people experiencing homelessness in the U.S. were in four states:[6]

- California (28 percent of all people experiencing homelessness in the U.S., or 181,399 people);
- New York (16 percent or 103,200 people);
- Florida (5 percent or 30,756 people); and
- Washington (4 percent or 28,036 people).

Between 2022 and 2023, the states with the largest absolute increases in homelessness were:[7]

- New York (29,022 more people);
- California (9,878);
- Florida (4,797);
- Colorado (4,042); and
- Massachusetts (3,634).

Over a longer period, from 2007 to 2023, the number of people experiencing homelessness declined in 25 states and the District of Columbia. The largest absolute decreases were in Florida (17,313 fewer people) and Texas (12,411 fewer people).[8]

Between 2022 and 2023, the number of people in families with children experiencing homelessness increased in 34 states and the District of Columbia. The largest increases were in:[9]

- New York (18,890 more people, a 54 percent increase);
- Massachusetts (2,906 more people or 29 percent);
- Colorado (1,490 more people or 69 percent);
- Florida (1,391 more people or 22 percent); and
- Illinois (1,077 more people or 36 percent).

Pregnant Women Experiencing Homelessness

Due to the very transient nature of homelessness, the exact number of pregnant homeless women is difficult to determine. This represents a significant gap in knowledge that could be used to inform social and health policy, as well as service delivery, thus researchers have continued in their attempts to identify the extent of pregnancy among the homeless population.[10]

In the U.S., one study estimated that one in five homeless women are pregnant at any given time, almost twice the rate of the general population. Other research uncovered even higher rates of

[6] *Id*.
[7] *Id*.
[8] *Id*.
[9] *Id*.
[10] Council to Homeless Persons, *The Extent, Nature and Impact of Homelessness on Pregnant Women and Their Babies, available at* https://chp.org.au/parity/the-extent-nature-and-impact-of-homelessness-on-pregnant-women-and-their-babies/ (last visited Feb. 1, 2024).

pregnancy among homeless women, finding that while ten percent of women in the U.S. were pregnant in 2009, 50 to 60 percent of homeless women were pregnant.[11]

Another study conducted in Florida determined about 183 pregnant homeless women live in Northeast Florida in any given month.[12]

The Impact of Homelessness on Maternal and Infant Health

Stable housing has been identified as one of the most important predictors of health as housing instability or homelessness lessens access to health care. This is more pressing during pregnancy, a time when access to affordable, high-quality health care is crucial. Although prenatal care is available, pregnant mothers and parents experiencing homelessness face barriers (e.g., lack of transportation, site-related factors, provider-client relationship, inconvenience, fear, cost, etc.).[13] For some, these obstacles bar them from accessing care altogether. Additionally, people experiencing housing instability or homelessness are more likely to live in conditions that are hazardous to their health.[14]

A number of studies have shown that homelessness has a negative impact on the health of pregnant mothers and infants:[15]

- Pregnant mothers experiencing homelessness are significantly less likely to have a prenatal visit during the first trimester, breastfeed, and have a well-baby checkup than their housed counterparts.
- In comparison with a housing-secure group with similar characteristics, pregnant mothers experiencing homelessness are significantly more likely to have various pregnancy-related conditions and complications, including high blood pressure, iron deficiency and other anemia, nausea and vomiting, hemorrhage, placental problems, and abdominal pain.
- One in five mothers who experienced homelessness in the year prior to giving birth had an infant with a low birthweight, a nearly 50 percent increase in risk compared to consistently housed people with otherwise similar characteristics.
- Newborn infants of people experiencing homelessness have longer stays in the hospital and are more likely to require intensive care than infants of consistently housed people.
- People who were homeless as infants are more likely to have upper respiratory infection, other respiratory disease, fever, allergy, injuries, developmental disorders, and asthma, compared to people who were stably housed during infancy. These individuals also show a propensity for increased emergency department visits, hospitalizations, and health care costs.

[11] *Id*.
[12] Journal of Obstetric, Gynecologic, and Neonatal Nursing, Bloom, K. C., Bednarzyk, M. S., Devitt, D. L., Renault, R. A., Teaman, V., & Van Loock, D. M., *Barriers to prenatal care for homeless pregnant women (2004), available at* https://www.jognn.org/article/S0884-2175(15)34192-7/fulltext (last visited Feb. 1, 2024).
[13] *Id*.
[14] National Partnership for Women & Families, *Homelessness Hurts Moms and Babies, available at* https://nationalpartnership.org/report/homelessness-hurts-moms-and-babies/ (last visited Feb. 1, 2024).
[15] *Id*.

The Department of Children and Families (DCF)

Office on Homelessness

The Office on Homelessness (office), through the DCF, oversees policy and funding toward ending and serving persons experiencing homelessness. The office recognizes and designates local Continuum of Care (CoC) entities to serve as lead agencies for the homeless assistance system throughout the state of Florida.[16]

CoCs are organizations composed of representatives of nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, among other stakeholders.[17]

Services offered through CoCs and their providers include operation and maintenance of emergency shelters, outreach to individuals who are homeless, rental assistance to prevent individuals from becoming homeless, and rapid rehousing of individuals from shelters or homelessness.[18]

The CoC model creates a framework for a comprehensive array of emergency, transitional, and permanent housing, and supportive services to address the varying needs of the persons who are homeless or at-risk of becoming homeless. The purpose of the CoC is to help communities envision, plan, and implement coordinated, long-term solutions to address homelessness.[19]

Currently, Florida has 28 CoCs.[20]

Council on Homelessness

The Council on Homelessness (council) was created in 2001 to develop and coordinate policy to reduce the prevalence and duration of homelessness, and work toward ending homelessness in Florida.[21] With this goal in mind, the council annually produces a report documenting its findings and recommendations, which offers insight on homelessness among special populations not captured by the federal point-in-time count, such as parenting youth.[22]

Parenting youth are a percentage of youth who experience homelessness and are pregnant or parenting. While lack of permanent housing can be traumatic in itself, these youth are also

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[16] Florida Department of Children and Families, *Homelessness, available at* https://www.myflfamilies.com/services/public-assistance/homelessness (last visited Feb. 1, 2024).
[17] *Id*.
[18] *Id*.
[19] *Id*.
[20] *Id*.
[21] Florida Department of Children and Families, *Council on Homelessness, available at* https://www.myflfamilies.com/services/public-assistance/homelessness/council-homelessness (last visited Feb. 1, 2024).
[22] Florida Department of Children and Families, Florida's Council on Homelessness, *Annual Report (June 2023), available at* https://www.myflfamilies.com/sites/default/files/2023-07/Florida%27s%20Council%20On%20Homelessness%20Annual%20Report%202023.pdf#:~:text=The%20number%20of%20people%20experiencing%20unsheltered%20homelessness%20in%20Florida%20increased,the%20number%20of%20unsheltered%20homeless. (last visited Feb. 1, 2024).

burdened with concerns of trying to provide stable and safe housing for their children. One hundred and ninety-four parenting youth were accounted for in the council's 2023 report. Data from 2018 also indicated that about 1.1 million children had a young parent who experienced homelessness during the past year. The challenges faced by this segment of the homeless youth population requires systems of care to support developmentally appropriate services that address the unique needs of young homeless parents.[23]

Affordable Housing

Affordable housing is defined in terms of household income. Housing is considered affordable when it costs less than 30 percent of a family's gross income.[24] A family paying more than 30 percent of its income for housing is considered "cost burdened," while those paying more than 50 percent are considered "extremely cost burdened."[25] Severely cost burdened households are more likely to sacrifice other necessities such as healthy food and healthcare to pay for housing, and to experience unstable housing situations such as eviction.[26]

Resident eligibility for Florida's state and federally funded housing programs is typically governed by area median income (AMI) levels. These levels are published annually by the federal Department of Housing and Urban Development (HUD) for every county and metropolitan area. The following are standard household income level definitions and their relationship to the 2023 Florida state AMI of $85,500[27] for a family of four (as family size increases or decreases, the income range also increases or decreases):[28]

- Extremely low income – earning up to 30 percent AMI (at or below $25,650);[29]
- Very low income – earning from 30.01 to 50 percent AMI ($25,651 to $42,750);[30]
- Low income – earning from 50.01 to 80 percent AMI ($42,751 to $68,400);[31] and
- Moderate income – earning from 80.01 to 120 percent of AMI ($68,401 to $102,600).[32]

Housing costs reflect what people are willing to pay to live in an area, which may make it difficult for growing families to find affordable homes and apartments. The government helps make housing affordable through decreased monthly rent or mortgage payments so that income eligible families are able to pay less for housing than it would otherwise cost at "market rate."

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[23] *Id*.
[24] Florida Housing Coalition, *Affordable Housing in Florida, available at* https://www.flhousing.org/wp-content/uploads/2019/03/Affordable-Housing-in-Florida-Book-WEB.pdf (last visited Feb. 2, 2024).
[25] *Id*.
[26] The Florida Senate Staff Analysis of SB 102, February 24, 2023, *available at* https://www.flsenate.gov/Session/Bill/2023/102/Analyses/2023s00102.ap.PDF (last visited Feb. 2, 2024).
[27] U.S. Department of Housing and Urban Development's Office of Policy Development and Research, *FY 2023 Median Family Income for States, Metropolitan and Nonmetropolitan Portions of States Attachment, available at* https://www.huduser.gov/portal/datasets/il/il23/FY23-Median-Attachment-State-Medians.pdf (last visited Feb. 1, 2024).
[28] U.S. Department of Housing and Urban Development's Office of Policy Development and Research, *Income Limits, Access Individual Income Limits Areas – Click Here for FY 2023 IL Documentation, available at* https://www.huduser.gov/portal/datasets/il.html#query_2023 (last visited Feb. 1, 2024).
[29] Section 420.0004(9), F.S.
[30] Section 420.0004(17), F.S.
[31] Section 420.0004(11), F.S.
[32] Section 420.0004(12), F.S.

Lower monthly payments or down payment assistance is a result of affordable housing financing.[33]

Impact on Homelessness

Over the last 30 years, lack of affordable rental housing for low-income households has fostered homelessness in the U.S. In 1970, there were 6.5 million low-cost rental units in the U.S. and 6.2 million low-income renter households with 300,000 available units. By 1985, the number of low-cost units fell to 5.6 million and the number of low-income renter households grew to 8.9 million, a disparity of 3.3 million units. In 2019, the National Low Income Housing Coalition reported that the State of Florida had a shortage of 428,622 affordable rental units.[34]

In 2017, the median rent, including utilities, for an apartment in Florida was $1,130 per month, a 16 percent increase since 2001, while income only increased by a disproportionate one percent[35]. As a result, 1,666,000 people in 769,400 low-income Florida households paid more than half their income in rent. Often low-income individuals and families forego necessities, like food or medicine, to keep a roof over their heads.[36]

According to the Center on Budget and Policy Priorities, 50 percent of low-income people in Florida are homeless or pay over half their income in rent. Currently, most do not receive federal rental assistance due to limited funding, but research has shown that rental assistance has helped 286,700 people in families with children in Florida avoid homelessness.[37]

Florida Housing Finance Corporation

The 1997 Legislature created the Florida Housing Finance Corporation (FHFC) as a public-private entity to assist in providing a range of affordable housing opportunities for Floridians.[38] The FHFC is a corporation held by the state and housed within the Department of Commerce. The FHFC is a separate budget entity, and its operations, including those relating to personnel, purchasing, transactions involving real or personal property, and budgetary matters, are not subject to control, supervision, or direction by the Department of Commerce.[39]

The goal of the FHFC is to increase the supply of safe, affordable housing for individuals and families with very low to moderate incomes by stimulating investment of private capital and encouraging public and private sector housing partnerships. As a financial institution, the FHFC administers federal and state resources to finance the development and preservation of affordable rental housing and assist homebuyers with financing and down payment assistance.[40]

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[33] *Supra* note 26.
[34] Florida Coalition to End Homelessness, *The Issue – The Fight to End Homelessness: Past, Present, and Future, available at* https://fchonline.org/the-issue/ (last visited Feb. 1, 2024).
[35] *Id*.
[36] Center on Budget and Policy Priorities, *Florida Federal Rental Assistance Fact Sheet, available at* https://apps.cbpp.org/4-3-19hous/PDF/4-3-19hous-factsheet-fl.pdf (last visited Feb. 1, 2024).
[37] *Id*.
[38] Chapter 97-167, Laws of Fla. From 1980 through 1997, the former Florida Housing Finance Agency, placed within the former Department of Community Affairs, performed similar duties.
[39] Section 420.504(1), F.S.
[40] *Supra* note 26.

State Apartment Incentive Loan Program

The State Apartment Incentive Loan (SAIL) Program is administered by the FHFC and provides low-interest loans on a competitive basis to multifamily affordable housing developers.[41] These funds often serve to bridge the gap between the developments' primary financing and the total cost of the development. SAIL dollars are available for developers proposing to construct or substantially rehabilitate multifamily rental housing.[42]

At a minimum, developments financed by SAIL must set aside 20 percent of units for households at or below 50 percent of AMI, or if the development also receives Low Income Housing Tax Credits[43] (LIHTC), 40 percent of units for households up to 60 percent of AMI.[44] Loan interest rates are set at zero percent for those developments that maintain 80 percent of their occupancy for farmworkers, commercial fishing workers or homeless people. The interest rates are set at one percent for all other developments. Generally, loans are issued for 15 years and cover approximately 25 to 35 percent of the total development cost.[45]

State Housing Initiatives Partnership Program

The State Housing Initiatives Partnership (SHIP) Program was created in 1992[46] to provide funds to local governments as an incentive to create partnerships that produce and preserve affordable homeownership and multifamily housing. The SHIP program provides funds to all 67 counties and 52 Community Development Block Grant[47] entitlement cities on a population-based formula to finance and preserve affordable housing based on locally adopted housing plans.[48] The program was designed to serve very-low, low-, and moderate-income families and is administered by the FHFC. SHIP funds may be used to pay for emergency repairs, rehabilitation, down payment and closing cost assistance, impact fees, construction and gap financing, mortgage buy-downs, acquisition of property for affordable housing, matching dollars for federal housing grants and programs, and homeownership counseling.[49]

Funds are expended per each local government's adopted Local Housing Assistance Plan (LHAP), which details the housing strategies that will be utilized, such as helping those affected by mobile home park closures, encouraging innovative housing design to reduce long-term housing costs, preserving assisted housing, and reducing homelessness.[50] Local governments

[41] Section 420.5087, F.S.
[42] Florida Housing Finance Corporation, *State Apartment Incentive Loan, available at* https://floridahousing.org/programs/developers-multifamily-programs/state-apartment-incentive-loan (last visited Feb. 1, 2024).
[43] Low Income Housing Tax Credits are a financial instrument administered by the Department of Housing and Urban Development that provide financing for low income housing developments. Credits are allocated to states on a per capita basis and state-level administration is performed by FHFC. Eligible developments are income-limited similarly to SAIL requirements.
[44] Section 420.5087(2), F.S.
[45] *Supra* note 26.
[46] Chapter 92-317, Laws of Fla.
[47] The Community Development Block Grant program is a federal program created in 1974 that provides funding for housing and community development activities.
[48] *See* ss. 420.907-420.9089, F.S.
[49] Section 420.9072(7), F.S.
[50] Section 420.9075(3), F.S.

submit their LHAPs to the FHFC for review to ensure that they meet the broad statutory guidelines and the requirements of the program rules. The FHFC must approve an LHAP before a local government may receive the SHIP funding.[51]

Certain statutory requirements restrict a local government's use of funds made available under the SHIP program (excluding amounts set aside for administrative costs):[52]

- At least 75 percent of SHIP funds must be reserved for construction, rehabilitation, or emergency repair of affordable, eligible housing; and
- Up to 25 percent of SHIP funds may be reserved for allowed rental services.[53]

III. Effect of Proposed Changes:

Section 1 creates s. 381.97, F.S., to establish the Florida State Maternity Housing Grant Program (program) within the DOH, to provide approved living arrangements and resources to Florida's women and families experiencing homelessness during the prenatal period. The bill provides Legislative intent that the provisions of this bill assist those whose financial resources have been determined inadequate to meet residential costs, regardless of age or marital status.

The bill designs the program to support approved persons in achieving residency via an alternative living arrangement for a period not to exceed eight months, and includes a maximum of six weeks of postpartum care.

The bill identifies the types of expenses program funds can be utilized towards:

- Housing in an authorized living arrangement for a period of time determined by the mother's estimated delivery date.
- Services recommended by the DOH for women and families approved for the program to encourage economic independence and positive health outcomes for participants.
- Staffing and reimbursements for providers of authorized living arrangements.
- All other related costs for the administration of the program, not to exceed five percent of the total grant funds.

The bill specifies that the total amount of grants awarded cannot exceed the state allocation, as its provisions are subject to appropriated funds.

The bill authorizes the DOH to adopt rules necessary to administer the program, which may include:

- A framework for the payment or reimbursement of funds to the mother for authorized living arrangements.
- Eligibility criteria for pregnant mothers and expecting families seeking maternity housing services, including a sliding fee scale for participants.
- Requirements for program applications.

[51] *Supra* note 26.
[52] Section 420.9075(5), F.S.
[53] Section 420.9075(5)(b), F.S. However, a local government may not expend money distributed to it to provide ongoing rent subsidies, except for: security and utility deposit assistance; eviction prevention not to exceed six months' rent; or a rent subsidy program for very-low-income households with at least one adult who is a person with special needs or is homeless, not to exceed 12 months' rental assistance.

- Guidelines for assessing the appropriateness of authorized living arrangements and for a determination of approval for authorized living arrangements.

Section 2 provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Since funding has not been appropriated under this bill, no fiscal impact exists at this time. However, should the Legislature appropriate funding for the program, the program's implementation may have an impact to community partners and Florida residents that receive grant funds.

Additionally, health care providers that treat the homeless women and families identified in the bill may also be positively impacted. Through the provision of stable housing, illnesses and injuries can be better prevented, and conditions can be improved or better maintained. This could result in a decrease in potentially preventable emergency department visits, reducing costs and allowing facilities such as hospitals to utilize limited funds on others in need.

C. Government Sector Impact:

As funding has not been appropriated under this bill, no fiscal impact exists at this time. However, similar to private entities, should the Legislature appropriate funds, the government sector may also experience the same positive fiscal impact as a result of this bill. Potentially, state expenditures could decrease in relation to government funded health care previously spent on ailments worsened as a result of homelessness.

The DOH indicates that SB 1442 will have a significant fiscal impact on the department, with an estimated cost of approximately $5,969,693 total:[54]

- Expense: $70,846 recurring and $26,636 non-recurring;
- Salary and Benefits: $396,772 recurring;
- Contracted Services: $5,474,000 recurring;
- Human Resources: $1,439 recurring.

The additional costs for authorized living arrangements are indeterminate, but the DOH anticipates they will be significant.[55]

VI. Technical Deficiencies:

None.

VII. Related Issues:

The DOH staff analysis indicates that the department does not have programs or an established infrastructure to address homelessness in Florida. At a minimum, the DOH will require one year to establish the framework for the program, as the department will need to procure staff for authorized living arrangements and develop rules, an administrative system, the application process, and the payment methodology for eligible pregnant women and families.[56]

SB 1442 does not define "postpartum care," leaving its meaning unclear as used in the bill. For better understanding as to the intent, it is recommended that an amendment be filed to provide further clarity.

The bill may duplicate services currently provided by the DCF and the FHFC.[57] The bill may also duplicate pregnancy support and wellness services provided by the DOH under s. 381.96, F.S.[58]

While the bill does not directly impact Medicaid, postpartum care as used in ch. 409, F.S., is a service provided to eligible low-income mothers via Medicaid, potentially suggesting there could be a duplication of services already reimbursed by the Agency for Health Care Administration and the federal government.

[54] DOH Staff Analysis of SB 1442, January 12, 2024. On file with Senate Health Policy Committee staff.
[55] *Id*.
[56] *Id*.
[57] *Id*.
[58] *Id*.

VIII. Statutes Affected:

This bill creates section 381.97 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.)

None.

B. Amendments:

None.

By Senator Grall

29-00938C-24 20241442__

A bill to be entitled

An act relating to pregnancy support services; creating s. 381.97, F.S.; providing legislative intent; establishing the Florida State Maternity Housing Grant Program within the Department of Health; requiring the program to provide certain resources; requiring the department to use grant funds for specified expenses; providing a limitation on the amount of grants awarded under the program; authorizing the department to adopt rules necessary to administer the program; providing an effective date.

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

Section 1. Section 381.97, Florida Statutes, is created to read:

381.97 Florida State Maternity Housing Grant Program.—

(1) It is the intent of the Legislature to provide housing resources for resident women and families experiencing homelessness during the prenatal period, regardless of age or marital status, whose financial resources have been determined inadequate to meet residential costs.

(2) There is created within the department the Florida State Maternity Housing Grant Program to provide approved living arrangements for residents experiencing homelessness during the prenatal period.

(3) The grant program shall provide resources for approved persons to reside in an alternative living arrangement for a period not to exceed 8 months, which includes a maximum of 6

weeks of postpartum care.

(4) The department shall use grant funds specifically appropriated for the grant program to cover expenses related to any of the following:

(a) Housing in an authorized living arrangement for a period of time determined by the mother's estimated delivery date.

(b) Services recommended by the department for women and families approved for the grant program to encourage economic independence and positive health outcomes for participants.

(c) Staffing and reimbursements for providers of authorized living arrangements.

(d) All other related costs for the administration of the program, not to exceed five percent of the total grant funds.

(5) The total amount of grants awarded may not exceed the funding appropriated for the grant program.

(6) The department may adopt rules necessary to administer the program. The rules may include, but need not be limited to:

(a) A framework for the payment or reimbursement of funds to the mother for authorized living arrangements.

(b) Eligibility criteria for pregnant mothers and expecting families seeking maternity housing services, including a sliding fee scale for participants.

(c) Requirements for maternity housing grant program applications.

(d) Guidelines for assessing the appropriateness of authorized living arrangements and for a determination of approval for authorized living arrangements.

Section 2. This act shall take effect July 1, 2024.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 10, 2024

I respectfully request that **Senate Bill #1442**, relating to Pregnancy Support Services, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Erin K. Grall

Senator Erin Grall
Florida Senate, District 29

File signed original with committee office

S-020 (03/2004)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

SB 1442
Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Madonna Finney

Phone 850 677 3077

Address PO Box 10728
Street

Email MMFinney@aol.com

Tallahassee FL 32302
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

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02/06/24
Meeting Date

HEALTH POLICY
Committee

SB 1442
Bill Number or Topic

Amendment Barcode (if applicable)

Name JAMMY FECCI (PRONOUNCES "FECHY")

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FLORIDA CONFERENCE CATHOLIC BISHOPS
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FLORIDA CONFERENCE OF CATHOLIC BISHOPS

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

Pat Thrasy S-412 Pregnancy Support Services

The Florida Senate

APPEARANCE RECORD

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2/6/24
Meeting Date

HEALTH
Committee

SB 1442
Bill Number or Topic

Amendment Barcode (if applicable)

Name DR. JOHN FRANK

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Email jwfrank904@gmail.com

St. Johns FL 32259
City State Zip

Reset Form

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☑ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

PAX CHRISTI - FLORIDA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 1474
INTRODUCER:	Health Policy Committee and Senator Trumbull
SUBJECT:	Chiropractic Medicine
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1474 expands the scope of practice for chiropractic physicians to treat the human body by the use of monofilament intramuscular stimulation, also known as dry needling, for trigger points or myofascial pain after demonstrating to the satisfaction of the Board of Chiropractic Medicine (BCM) the completion of training in the modality of a board-approved number of credit hours in a board-approved education program.

The bill gives the BCM the authority to recognize chiropractic physician applicants for licensure if they provide a credential evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree from a college or university accredited by an institutional accrediting agency recognized and approved by the U.S. Department of Education. The effect of this change is to create a licensure pathway for chiropractic physicians to practice in Florida when they obtained their bachelor's degree at a non-U.S. educational institution of higher education.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

The Practice of Chiropractic Medicine

The BCM, in conjunction with the Department of Health (DOH), regulates the practice of chiropractic medicine pursuant to chs. 456 and 460, F.S.

Florida law defines the practice of chiropractic medicine as a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that are interfering with the normal generation, transmission, and expression of nerve impulses between the brain, organs, and tissue cells of the body, thereby causing disease, are adjusted, manipulated, or treated, thus restoring the normal flow of nerve impulse which produces normal function and consequent health by chiropractic physicians using specific chiropractic adjustment or manipulation techniques taught in chiropractic colleges accredited by the Council on Chiropractic Education (CCE).[1]

Licensed chiropractic physicians may examine, analyze, and diagnose the human living body and its diseases by the use of:[2]

- Any physical, chemical, electrical, or thermal method;
- X-ray for diagnosing;
- Phlebotomizing; and
- Any other general method of examination for diagnosis and analysis taught in any school of chiropractic.

Chiropractic physicians may adjust, manipulate, or treat the human body by:[3]

- Manual, mechanical, electrical, or natural methods;
- The use of physical means or physiotherapy, including light, heat, water, or exercise;
- The use of acupuncture, if certified;
- The administration of foods, food concentrates, food extracts, and items for which a prescription is not required and may apply first aid and hygiene;
- Analyze and diagnose abnormal bodily functions and to adjust the physical representative of the primary cause of disease;
- Caring for the sick and advising and instructing patients in all matters pertaining to hygiene and sanitary measures as taught and approved by recognized chiropractic schools and colleges.

Chiropractic physicians are expressly prohibited from:[4]

- Ordering, storing, or administering to any person any legend drug, except medical oxygen for emergency purposes only at the chiropractic physician's office or place of business, and the following topical aesthetics in aerosol form:

[1] Section 460.403(9)(a), F.S.
[2] Section 460.403(9)(b), F.S.
[3] Section 460.403(9)(c)(f), F.S.
[4] *Id.*

  - Any solution consisting of 25 percent ethylchloride and 75 percent dichlorodifluoromethane; and
  - Any solution consisting of 15 percent dichlorodifluoromethane and 85 percent trichloromonofluoromethane.
- Performing any surgery except as otherwise provided in the practice act;
- Practicing obstetrics;
- Using diagnostic or treatment instruments the use of which are not taught in the regular course of instruction in a college recognized by the Board of Chiropractic;[5]
- Treating Cancer, Leukemia, Tuberculosis, Syphilis, Gonorrhea, Hepatitis, Anthrax, Diphtheria, Hansen's Disease, Hookworm Disease, Malaria, Rabies, Typhoid Fever, and AIDS.[6]

The Board of Chiropractic Medicine

The BCM is created within the DOH and consist of seven members, appointed by the Governor and confirmed by the Senate. Five members must be licensed chiropractic physicians who are residents of the state and who have been licensed chiropractic physicians engaged in the practice of chiropractic medicine for at least four years. The remaining two members must be residents of the state who are not, and have never been, licensed chiropractic physicians or members of any closely related profession. At least one member of the board must be 60 years of age or older. As the terms of the members expire, the Governor appoint successors for terms of four years, and such members must serve until their successors are appointed.[7]

Chiropractic Education

The National Board of Chiropractic Examiners

The National Board of Chiropractic Examiners (NBCE), including the International Board of Chiropractic Examiners (IBCE), is the international testing agency for the chiropractic profession. The NBCE develops, administers and scores standardized exams that assess knowledge, higher-level cognitive abilities and problem-solving in various basic science and clinical science subjects.[8]

The purpose of the NBCE is to establish and maintain uniform high standards of excellence in the chiropractic profession and chiropractic education, primarily but not exclusively by preparing and administering to qualified applicants examinations of superior quality, whereby those legal agencies which govern the practice of chiropractic within each state and other countries may accept, at their discretion, those individuals who have successfully completed any part of the examinations of the NBCE, and by providing test and measurement services to the chiropractic profession in all areas of demonstrated need, and to advance the chiropractic profession when in the best interests of the corporation and chiropractic testing.[9]

[5] Fla. Admin. Code R. 64B2-17.001 (2023).
[6] Fla. Admin. Code R. 64B2-17.002 (2023).
[7] Section 460.404, F.S.
[8] National Board of Chiropractic Examiners, *About the NBCE*, available at https://www.nbce.org/about-nbce/ (last visited Feb. 1, 2024).
[9] *Id.*

In addition, chiropractors may earn post-doctoral diplomate certifications from the International Chiropractors Association as well as various subspecialties, such as acupuncture, radiology, and neurology, through the American Chiropractic Association. Certifications are also available in veterinary chiropractic, spinal trauma, sport science and other niche disciplines.[10]

In the U.S., there are 15 NBCE-accredited chiropractic colleges and universities on 18 campus:[11]

- Campbellsville University School of Chiropractic in Harrodsburg, Kentucky;
- Cleveland Chiropractic College in Overland Park, Kansas;
- D'Youville College in Buffalo, New York;
- Keiser University in West Palm Beach, Florida;
- Life University, College of Chiropractic in Marietta, Georgia, and Hayward, California;
- National University of Health Sciences in Seminole, Florida;
- Northeast College of Health Sciences in Seneca Falls, New York;
- Northwestern Health Sciences University in Bloomington, Minnesota;
- Palmer College of Chiropractic in Port Orange, Florida, and San Jose, California;
- Parker College of Chiropractic in Dallas, Texas;
- Sherman College of Chiropractic in Spartanburg, South Carolina;
- Southern California University of Health Sciences in Whittier, California;
- Texas Chiropractic College in Pasadena, Texas;
- University of Bridgeport, School of Chiropractic in Bridgeport, Connecticut;
- University of Western States in Portland, Oregon.

To earn and maintain accreditation, chiropractic colleges must meet a variety of requirements. Each program's curriculum must include at least 4,200 instructional hours of course credits. Once a student is accepted into an accredited program, chiropractic students typically follow a curriculum similar to the following:[12]

- **First year**
  - General anatomy;
  - Histology;
  - Chiropractic principles;
  - Palpation;
  - Human physiology;
  - Chiropractic procedures;
  - Embryology;
  - Introduction to physical examination;
  - Human biochemistry;
  - Clinical chiropractic;
  - Neuroanatomy and neurophysiology;
  - Normal radiographic anatomy;

[10] National Board of Chiropractic Examiners, *Certification and Licensure*, available at https://www.nbce.org/about-nbce/chiropractic-care/certification-and-licensure/ (last visited Feb. 1, 2024).
[11] National Board of Chiropractic Examiners, *Links to Chiropractic Colleges*, available at https://www.nbce.org/links-to-chiropractic-colleges/ (last visited Feb. 1, 2024).
[12] National Board of Chiropractic Examiners, *Chiropractic Education*, available at https://www.nbce.org/about-nbce/chiropractic-care/chiropractic-education/ (last visited Feb. 1, 2024).

- Fundamentals of nutrition;
- Functional anatomy/biomechanics; and
- Spinal anatomy.

- **Second year**
  - Pharmatoxicology;
  - Pathology;
  - Chiropractic procedures;
  - Clinical orthopedics and neurology;
  - Community and public health;
  - Clinical nutrition;
  - Practice management;
  - Differential diagnosis;
  - Emergency care;
  - Clinical microbiology;
  - Chiropractic principles;
  - Physics of clinical imaging;
  - Nutritional assessment;
  - Physiological therapeutics;
  - Research methods;
  - Imaging interpretation; and
  - Applied clinical chiropractic.
- **Third year**
  - Integrated chiropractic clinical application;
  - Chiropractic principles;
  - Radiologic positioning and technique;
  - Clinical application of manual procedures;
  - Clinical internship;
  - Clinical psychology;
  - Pediatrics;
  - Clinical laboratory clerkship;
  - Original research project;
  - Physiological therapeutics;
  - Practice management;
  - Diagnostic imaging interpretation;
  - Differential diagnosis;
  - Dermatology;
  - Obstetrics and gynecology;
  - Geriatrics; and
  - Ethics and jurisprudence.

In the fourth year of chiropractic college, students work a clinical internship in a chiropractor's office. In addition to treating patients under the supervision of an experienced chiropractor, many students also complete a clinical rotation at a hospital or veterans clinic.

Chiropractic Licensure by Examination

Any person desiring to be licensed as a chiropractic physician in Florida must apply to the DOH to take the licensure examination. The nonrefundable application fee is capped at $100, and the NBCE administers the examination. The examination fee must not exceed $500 plus the actual per applicant cost to the DOH for purchase of portions of the examination from NBCE.[13]

The DOH examines each applicant whom the BCM certifies has met all of the following criteria:[14]

- Completed the application form and remitted the appropriate fee;
- Submitted proof that the applicant is 18 years of age or older;
- Submitted proof that the applicant is a graduate of a chiropractic college which is accredited by CCE or its predecessor agency;
- Successfully completed the NBCE certification examination in parts I, II, III, and IV, and the physiotherapy examination of the NBCE and the NBCE Physiotherapy Examination with a score 375 on each section;[15]
- Successfully completed the NBCE Florida Laws and Rules examination with a score of 75 percent;[16]
- Submitted to the DOH a set of fingerprints on a form specified by the DOH and the fee for the criminal background check of the applicant.

For an applicants who have matriculated in a chiropractic college before July 2, 1990, to take the NBCE certification examination, he or she must have completed at least two years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor's degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the U.S. Department of Education (DOE).[17]

For an applicants who have matriculated in a chiropractic college after July 1, 1990, to take the NBCE certification examination, he or she must have: [18]

- Been granted a bachelor's degree, based upon four academic years of study, by a college or university accredited by an institutional accrediting agency that is a member of the Commission on Recognition of Postsecondary Accreditation;
- Effective July 1, 2000, completed, before matriculation in a chiropractic college, at least three years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the U.S. DOE;
- Been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional accrediting agency that is recognized by the U.S. DOE. The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

[13] Section 460.406(1), F.S.
[14] Section 460.406(1), F.S.
[15] Fla. Admin. Code R. 64B2-11.001(2023).
[16] *Id.*
[17] Section 460.406(1)(d)1., F.S.
[18] Section 460.406(1)(d)2., F.S.

The above matriculation requirements for applicants to have a bachelor's degree from a school accredited by an agency recognized and approved by the U.S. DOE may prevent persons who have obtained their bachelor's degree at a non-U.S. educational institution of higher education from being considered for licensure in Florida, even if they graduated from a U.S. chiropractic college or university.

An application for a license to practice chiropractic medicine may not be denied solely because the applicant is a graduate of a chiropractic college that subscribes to one philosophy of chiropractic medicine as distinguished from another.[19]

The BCM may require an applicant who graduated from an institution accredited by the CCE more than 10 years before the date of application to the BCM to take the NBCE Special Purposes Examination for Chiropractic, or its equivalent, and determine the passing score by board rule.[20]

Dry Needling

Monofilament intermuscular stimulation treatment, a.k.a. dry needling, is a technique that acupuncturists, physical therapists, and other trained health care providers use to treat musculoskeletal pain and movement issues. Health care providers may incorporate dry needling as a part of a larger pain management treatment plan that could include exercise, stretching, massage, and other techniques. With dry needling, a health care provider inserts thin, sharp needles through a patient's skin, through the subcutaneous tissue, through the fascia, and into the muscle underlying the myofascial[21] trigger points. Trigger points are knotted, tender areas that develop in muscles which are highly sensitive and can be painful when touched.[22]

When health providers apply dry needling to muscles and tissues, the needles may decrease tightness, increase blood flow, and reduce local and referred pain. Providers use solid needles that do not contain any kind of medication – hence "dry" needling. Dry needling may also be known as intramuscular stimulation.[23]

When a patient overexerts a muscle, the muscle experiences an energy crisis where the muscle fibers cannot access an adequate supply of blood. Without normal blood supply to the muscle, the muscle cannot get the oxygen and nutrients that allow the muscle to return to its normal resting state. Dry needling may stimulate the trigger point to help draw normal blood supply back to flush out the area and release tension.[24]

Dry needling may help relieve pain and increase range of motion. Conditions that dry needling may treat include:[25]

[19] Section 460.406(1)(c), F.S.
[20] Section 460.406(1)(f), F.S.
[21] In the word "myofascial," "myo" means "muscle." Fascia is the thin, white connective tissue that wraps around muscles.
[22] The Cleveland Clinic, *Dry Needling*, (last reviewed Feb. 20, 2023) available at https://my.clevelandclinic.org/health/treatments/16542-dry-needling (last visited Feb. 1, 2024).
[23] *Id.*
[24] *Id.*
[25] *Id.*

- Joint issues;
- Disk issues;
- Tendonitis;
- Migraine and tension-type headaches;
- Jaw and mouth problems, such as temporomandibular joint (TMJ) disorders;
- Whiplash;
- Repetitive motion disorders, such as carpal tunnel syndrome;
- Spinal issues;
- Pelvic pain;
- Night cramps; and
- Phantom limb pain; and
- Postherpetic neuralgia, a complication of shingles.

There are certain groups of people who should not receive dry needling. Providers do not recommend the procedure for children under the age of 12 because it can be painful. Other groups who should consult with their physician before receiving dry needling include people who:[26]

- Are pregnant;
- Are not able to understand the treatment;
- Are very afraid of needles (trypanophobia);
- Have compromised immune systems;
- Have just had surgery; and
- Are on blood thinners.

The most common side effect of dry needling is soreness during and after treatment. Other side effects may include:[27]

- Stiffness;
- Bruising at or near the insertion site;
- Fainting;
- Fatigue; and
- Infection.

Dry Needling Versus Acupuncture

While both dry needling and acupuncture use needles to treat pain, acupuncture treats musculoskeletal pain along meridians, or nerve pathways, and dry needling treats deeper muscle tissue with the goal of pain mitigation, deactivating trigger points, and improving movement.[28] Depending on the state, dry needling is performed by licensed physical therapists, athletic trainers, chiropractors, or medical doctors who have been trained in the procedure.

According to a 2020 Montana Department of Labor and Industry survey of chiropractic colleges regarding dry needling instruction, of the 14 chiropractic colleges surveyed, only one provided instruction in dry needling in the D.C. degree program (Parker University) and only three

[26] *Id.*
[27] *Id.*
[28] *Id.*

universities offered continuing education or graduate courses in the modality (Western States, Texas, and National University of Health Sciences).[29]

Florida BCM rules expressly provide that "Chiropractors in Florida are not authorized by law to use diagnostic instruments or instruments for treatment, the use of which are not taught in the regular course of instruction in a college recognized by the Board of Chiropractic."[30]

On November 9, 2023, the BCM convened a board meeting to discuss, in part, the Florida Chiropractic Association's (FCA) petition for a declaratory statement[31] asking whether dry needling is within the scope of practice for chiropractic physicians. The Florida Chiropractic Physician Association (FCPA) appeared in support of adding drying needling to the scope of practice. The Florida Chiropractic Society (FCS) appeared in opposition to adding dry needling to the scope of practice.

The question before the BCM, presented by board counsel was, " [I]f a chiropractor is competent to do so, and they are properly trained in dry needling, is that a permitted activity within the scope of your practice act?"

The vote was four to two that it was not within the scope of practice of chiropractic medicine, as follows:

- "Yes, it is." – Walter Melton, Jr. D.C.; and Michael Roberts, D.C.
- "No, it is not." – Jason Comerford, D.C., Board Chair; Gretchen Saunders, Consumer Member and Vice-Chair; Todd Cielo, D.C.; and Anthony Oliverio, D.C.

Board counsel then advised the board that it was required to specify the reason why dry needling is not within the scope of practice of chiropractic medicine, but was interrupted by counsel for the FCA with a request to withdraw the Petition for Declaratory Statement. A motion was made to permit the withdrawal, which was seconded and unanimously approved.[32, 33]

III. Effect of Proposed Changes:

CS/SB 1474 expands the scope of practice for chiropractic physicians to treat the human body by the use of monofilament intramuscular stimulation, also known as dry needling, for trigger points or myofascial pain and allows a chiropractor to lawfully perform dry needling after demonstrating to the BCM's satisfaction the completion of training in the modality which includes a board-approved number of credit hours in a board-approved education program.

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[29] Bragg, Kevin, EO, Montana Department of Labor and Industry, *Dry Needling, Survey of Chiropractic Colleges*, (Mar. 12, 2020), available at https://leg.mt.gov/content/Committees/Interim/2019-2020/Economic-Affairs/Meetings/June-July2020/CHIRO-course-research2020.pdf (last visited Feb. 1, 2024).

[30] Fla. Admin. Code R. 64B2-17.001 (2023).

[31] *Florida Chiropractic Association's Petition for Declaratory Statement Before the Department of Health / Board of Chiropractic Medicine* (Oct. 30, 2023) available at https://www.fcachiro.org/wp-content/uploads/2023/08/Petition-for-Declaratory-Statement-dry-needling-1.pdf (last visited Feb. 1, 2024).

[32] Florida Board of Chiropractic Medicine, *Board Meeting Minutes, November 9, 2023*, Florida Department of Health (Nov. 9, 2023) available at https://ww10.doh.state.fl.us/pub/hcpr/Chiropractor/2023/Chiro%20Draft%20Minutes%2011.9.23.pdf (last visited Feb. 1, 2024).

[33] Board of Chiropractic Medicine, Recording of the Board meeting, Nov. 9, 2023, at 1:23:48 through 1:47:01, available at https://floridaschiropracticmedicine.gov/meeting-information/past-meetings/ (last visited Feb. 7, 2024).

The bill also gives the BCM authority to recognize chiropractic physician applicants for licensure if they provide a credential evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree from a college or university accredited by an institutional accrediting agency recognized and approved by the U.S. DOE. The effect of this change is to create a licensure pathway for chiropractic physicians to practice in Florida when they obtained their bachelor's degree at a non-U.S. educational institution of higher education.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 460.403 and 460.406.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute provides that a chiropractic physician may treat patients with the use of monofilament intramuscular stimulation after demonstrating to the satisfaction of the BCM the completion of training in the modality of a board-approved number of credit hours in a board-approved education program.

B. Amendments:

None.

194076

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
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	.	
	.	

The Committee on Health Policy (Trumbull) recommended the following:

Senate Amendment (with title amendment)

Delete line 43

and insert:

stimulation treatment for trigger points or myofascial pain, after demonstrating to the board's satisfaction the completion of training in such modality which includes a board-approved number of credit hours in a board-approved education program; or

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

194076

And the title is amended as follows:

Delete line 6

and insert:

use after demonstrating to the Board of Chiropractic Medicine's satisfaction completion of certain training; amending s. 460.406, F.S.; revising education

By Senator Trumbull

2-01588-24 20241474__

A bill to be entitled

An act relating to chiropractic medicine; amending s. 460.403, F.S.; revising the definition of the term "practice of chiropractic medicine" to include a specified treatment that a chiropractic physician may use; amending s. 460.406, F.S.; revising education requirements for licensure as a chiropractic physician; providing an effective date.

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

Section 1. Subsection (9) of section 460.403, Florida Statutes, is amended to read:

460.403 Definitions.—As used in this chapter, the term:

(9)(a) "Practice of chiropractic medicine" means a noncombative principle and practice consisting of the science, philosophy, and art of the adjustment, manipulation, and treatment of the human body in which vertebral subluxations and other malpositioned articulations and structures that are interfering with the normal generation, transmission, and expression of nerve impulse between the brain, organs, and tissue cells of the body, thereby causing disease, are adjusted, manipulated, or treated, thus restoring the normal flow of nerve impulse which produces normal function and consequent health by chiropractic physicians using specific chiropractic adjustment or manipulation techniques taught in chiropractic colleges accredited by the Council on Chiropractic Education. No person other than a licensed chiropractic physician may render chiropractic services, chiropractic adjustments, or chiropractic

manipulations.

(b) Any chiropractic physician who has complied with the provisions of this chapter may examine, analyze, and diagnose the human living body and its diseases by the use of any physical, chemical, electrical, or thermal method; use the X ray for diagnosing; phlebotomize; and use any other general method of examination for diagnosis and analysis taught in any school of chiropractic.

(c)1. Chiropractic physicians may adjust, manipulate, or treat the human body by manual, mechanical, electrical, or natural methods; by the use of physical means or physiotherapy, including light, heat, water, or exercise; by the use of acupuncture; by the use of monofilament intramuscular stimulation treatment for trigger points or myofascial pain; or by the administration of foods, food concentrates, food extracts, and items for which a prescription is not required and may apply first aid and hygiene, but chiropractic physicians are expressly prohibited from prescribing or administering to any person any legend drug except as authorized under subparagraph 2., from performing any surgery except as stated herein, or from practicing obstetrics.

2. Notwithstanding the prohibition against prescribing and administering legend drugs under subparagraph 1. or s. 499.83(2)(c), pursuant to board rule chiropractic physicians may order, store, and administer, for emergency purposes only at the chiropractic physician’s office or place of business, prescription medical oxygen and may also order, store, and administer the following topical anesthetics in aerosol form:

a. Any solution consisting of 25 percent ethylchloride and

75 percent dichlorodifluoromethane.

b. Any solution consisting of 15 percent dichlorodifluoromethane and 85 percent trichloromonofluoromethane.

However, this paragraph does not authorize a chiropractic physician to prescribe medical oxygen as defined in s. 499.82(10) ~~chapter 499~~.

(d) Chiropractic physicians shall have the privileges of services from the department's laboratories.

(e) The term "chiropractic medicine," "chiropractic," "doctor of chiropractic," or "chiropractor" shall be synonymous with "chiropractic physician," and each term shall be construed to mean a practitioner of chiropractic medicine as the same has been defined herein. Chiropractic physicians may analyze and diagnose the physical conditions of the human body to determine the abnormal functions of the human organism and to determine such functions as are abnormally expressed and the cause of such abnormal expression.

(f) Any chiropractic physician who has complied with the provisions of this chapter is authorized to analyze and diagnose abnormal bodily functions and to adjust the physical representative of the primary cause of disease as is herein defined and provided. As an incident to the care of the sick, chiropractic physicians may advise and instruct patients in all matters pertaining to hygiene and sanitary measures as taught and approved by recognized chiropractic schools and colleges. A chiropractic physician may not use acupuncture until certified by the board. Certification shall be granted to chiropractic

physicians who have satisfactorily completed the required coursework in acupuncture and after successful passage of an appropriate examination as administered by the department. The required coursework shall have been provided by a college or university which is recognized by an accrediting agency approved by the United States Department of Education.

Section 2. Paragraph (d) of subsection (1) of section 460.406, Florida Statutes, is amended to read:

460.406 Licensure by examination.—

(1) Any person desiring to be licensed as a chiropractic physician must apply to the department to take the licensure examination. There shall be an application fee set by the board not to exceed $100 which shall be nonrefundable. There shall also be an examination fee not to exceed $500 plus the actual per applicant cost to the department for purchase of portions of the examination from the National Board of Chiropractic Examiners or a similar national organization, which may be refundable if the applicant is found ineligible to take the examination. The department shall examine each applicant whom the board certifies has met all of the following criteria:

(d)1. For an applicant who has matriculated in a chiropractic college before July 2, 1990, completed at least 2 years of residence college work, consisting of a minimum of one-half the work acceptable for a bachelor’s degree granted on the basis of a 4-year period of study, in a college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education. However, before being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college

after July 1, 1990, must have been granted a bachelor's degree, based upon 4 academic years of study, by a college or university accredited by an institutional accrediting agency that is a member of the Commission on Recognition of Postsecondary Accreditation or have produced a credentials evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree.

2. Effective July 1, 2000, completed, before matriculation in a chiropractic college, at least 3 years of residence college work, consisting of a minimum of 90 semester hours leading to a bachelor's degree in a liberal arts college or university accredited by an institutional accrediting agency recognized and approved by the United States Department of Education or produced a credentials evaluation report from a board-approved organization that deems the applicant's education equivalent to a bachelor's degree. However, before being certified by the board to sit for the examination, each applicant who has matriculated in a chiropractic college after July 1, 2000, must have been granted a bachelor's degree from an institution holding accreditation for that degree from an institutional accrediting agency that is recognized by the United States Department of Education. The applicant's chiropractic degree must consist of credits earned in the chiropractic program and may not include academic credit for courses from the bachelor's degree.

The board may require an applicant who graduated from an institution accredited by the Council on Chiropractic Education more than 10 years before the date of application to the board

to take the National Board of Chiropractic Examiners Special Purposes Examination for Chiropractic, or its equivalent, as determined by the board. The board shall establish by rule a passing score.

Section 3. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Appropriations Committee on Transportation, Tourism, and Economic Development, *Vice Chair*
Appropriations Committee on Agriculture, Environment, and General Government
Banking and Insurance
Fiscal Policy
Judiciary
Transportation

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR JAY TRUMBULL
2nd District

January 10, 2024

Re: SB 1474

Dear Chair Burton,

I am respectfully requesting that Senate Bill 1474, related to Chiropractic Medicine, be placed on the agenda for your next meeting of the Health Policy Committee.

I appreciate your consideration of this bill. If there are any questions or concerns, please do not hesitate to call my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull
District 2

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 320 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

1474
Bill Number or Topic

194076
Amendment Barcode (if applicable)

Name Kim Daggers, FL Chiropract Assn

Phone 850.597.1355

Address 1009 SE 9th St.
Street

Email Kdaggers@daggers-law.com

Ft. Lauderdale, FL 33316
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: FL Chiropractic Assn

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

1474
Bill Number or Topic

Amendment Barcode (if applicable)

Name Kim Driggers, FL Chiropractic Assn. Phone 850-597-1355

Address 1009 SE 9th St. Email kdriggers@driggers-law.com
Street

Ft. Lauderdale, FL 33316
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[X] I am a registered lobbyist, representing: FL Chiropractic Assn.

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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6 FEB 2024
Meeting Date

HEALTH POLICY
Committee

SB 1474
Bill Number or Topic

Amendment Barcode (if applicable)

Name Amanda Sellers

Phone (407) 756-5550

Address 306 Riverbend Blvd.
Street

Email amandasellers407@gmail.com

Longwood. FL. 32779
City State Zip

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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APPEARANCE RECORD

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2/6/24
Meeting Date

Health Policy
Committee

SB 1474
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr Eduardo Martinez

Phone 786-281-0698

Address 3400 Coral Way, #101
Street

Email Coconutgrovechiro@gmail.com

Miami FL 33145
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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2-6-24
Meeting Date

Health Policy
Committee

SB 1474
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Brian Moriarty

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Address 6632 SE Monterey Rd
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Stuart FL 34994
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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The Florida Senate

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2/6/2024
Meeting Date

Health Policy
Committee

1474
Bill Number or Topic

Amendment Barcode (if applicable)

Name Amanda Stewart Phone (813) 404-5216

Address 101 E. College Avenue, Ste. 502 Email amanda@johnstonstewart.com
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Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Palmer College of Chiropractic

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 1798
INTRODUCER:	Health Policy Committee and Senator Trumbull
SUBJECT:	Home Health Care Services
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Morgan	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1798 amends s. 409.905, F.S., to authorize an advanced practice registered nurse (APRN) or a physician assistant to order or write prescriptions for Medicaid home health services.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

The Florida Medicaid Program

The Medicaid program is a voluntary, joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[1] The Centers for Medicare & Medicaid Services within the U.S. Department of Health and Human Services is responsible for administering the Medicaid program at the federal level. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the Agency for Health Care Administration (AHCA) and financed through state and federal funds.[2]

[1] Medicaid.gov, Medicaid, available at https://www.medicaid.gov/medicaid/index.html (last visited Feb. 3, 2024).
[2] Section 20.42, F.S.

Medicaid Home Health Care Services

States that elect to participate in the Medicaid program agree to cover a host of mandatory Medicaid services in accordance with Title XIX of the Social Security Act. As the single-state agency responsible for the administration of Florida's Medicaid program, the AHCA is required to provide reimbursement for these services, including home health care, when furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were rendered. Medicaid services are only provided as medically necessary.[3]

Under Medicaid's home health care services benefit, the AHCA reimburses for nursing and home health aide[4] services, supplies, appliances, and durable medical equipment necessary to assist a recipient who is living at home. The AHCA requires prior authorization to determine the medical necessity for these services. A home health agency (HHA) must submit the recipient's plan of care and documentation that support the diagnosis to the AHCA when requesting prior authorization.[5]

The AHCA cannot pay for home health services unless the services are medically necessary and:[6]

- The services are ordered by a physician.
- The written prescription for the services is signed and dated by the recipient's physician before the development of a plan of care and any request requiring prior authorization.
- Outside of any exclusions, the physician ordering the services is not employed, under contract with, or otherwise affiliated with the HHA rendering the services.
- The physician ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.
- The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

The Coronavirus Aid, Relief, and Economic Security Act

The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provided fast and direct economic assistance for American workers, families, small businesses, and industries through the implementation of a variety of programs[7] to address issues related to the onset of the

[3] Section 409.905, F.S.
[4] Under s. 400.462(14), F.S., a home health aide is a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation or exercises, assists in administering medications as permitted in rule and for which the person has received training established by the Agency for Health Care Administration, or performs tasks delegated to him or her under ch. 464, F.S.
[5] Section 409.905(4), F.S.
[6] *Id*.
[7] Centers for Medicare & Medicaid Services, *Home Health Agencies: CMS Flexibilities to Fight COVID-19, available at* https://www.cms.gov/files/document/home-health-agencies-cms-flexibilities-fight-covid-19.pdf (last visited Feb. 3, 2024).

COVID-19 pandemic. The CARES Act was passed by Congress on March 25, 2020, and signed into law on March 27, 2020.[8]

Improving Care Planning for Medicare and Medicaid Home Health Services

Prior to the CARES Act, federal law allowed only a physician to order home health services for Medicare and Medicaid recipients.[9] Section 3708 of the CARES Act[10] expanded the allowable ordering provider type to include a nurse practitioner, a clinical nurse specialist, or a physician assistant.[11]

III. Effect of Proposed Changes:

CS/SB 1798 amends s. 409.905, F.S., to authorize an APRN or a physician assistant to order or write prescriptions for Medicaid home health services. The APRN or physician assistant ordering the services may not be employed, under contract with, or otherwise affiliated with the HHA rendering the services.[12]

In order for the AHCA to reimburse when an APRN or a physician assistant orders or writes prescriptions for HHA services, the bill also requires that:

- The examination of the recipient by the APRN or the physician assistant must happen within the 30 days preceding the initial request for the services and biannually thereafter, which are the same current-law requirements for physicians.
- The national provider identifier, Medicaid identification number, or medical practitioner license number of the APRN or the physician assistant must be listed on the written prescription, the claim for reimbursement, and the prior authorization request, which is also required of physicians under current law.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

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[8] U.S. Department of the Treasury, *About the CARES Act and the Consolidated Appropriations Act, available at* https://home.treasury.gov/policy-issues/coronavirus/about-the-cares-act (last visited Feb. 3, 2024).
[9] Congress.gov, *H.R.748 – CARES Act, Summary, available at* https://www.congress.gov/bill/116th-congress/house-bill/748 (last visited Feb. 3, 2024).
[10] Kaiser Family Foundation, *The Coronavirus Aid, Relief, and Economic Security Act: Summary of Key Health Provisions, available at* https://www.kff.org/coronavirus-covid-19/issue-brief/the-coronavirus-aid-relief-and-economic-security-act-summary-of-key-health-provisions/ (last visited Feb. 3, 2024).
[11] Congress.gov, *H.R.748 – CARES Act, Text, available at* https://www.congress.gov/bill/116th-congress/house-bill/748/text (last visited Feb. 3, 2024).
[12] Section 409.905(4)(c)3., F.S. However, this subparagraph does not apply to an HHA affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 CFR part 491, subpart A, ss. 1-11, a nursing home licensed under part II of ch. 400, F.S., or an apartment or single-family home for independent living. For purposes of this subparagraph, the AHCA may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

By allowing an APRN or a physician assistant to order Medicaid home health services that only physicians may order under current law, the bill might streamline the provision of such services in the Medicaid program.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.905 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute removes Section 1 and Section 2 of the underlying bill and further amends s. 409.905, F.S., to authorize both APRNs and physician assistants to order and prescribe Medicaid home health services in the same capacity as a physician.

B. Amendments:

None.

477550

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Trumbull) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (c) of subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be

477550

eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

(4) HOME HEALTH CARE SERVICES.—The agency shall pay for nursing and home health aide services, supplies, appliances, and durable medical equipment, necessary to assist a recipient living at home. An entity that provides such services must be licensed under part III of chapter 400. These services, equipment, and supplies, or reimbursement therefor, may be limited as provided in the General Appropriations Act and do not include services, equipment, or supplies provided to a person residing in a hospital or nursing facility.

(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician, an advanced practice registered nurse, or a physician assistant.

2. The written prescription for the services is signed and dated by the recipient's physician, advanced practice registered nurse, or physician assistant before the development of a plan of care and before any request requiring prior authorization.

3. The physician, advanced practice registered nurse, or

477550

physician assistant ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician, advanced practice registered nurse, or physician assistant ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician, advanced practice registered nurse, or physician assistant ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 2. This act shall take effect July 1, 2024.

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

And the title is amended as follows:

477550

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to home health care services; amending s. 409.905, F.S.; authorizing advanced practice registered nurses and physician assistants to order or write prescriptions for certain Medicaid services; providing an effective date.

By Senator Trumbull

2-00712A-24 20241798__

A bill to be entitled

An act relating to home health care services; amending s. 400.487, F.S.; authorizing contract staff to provide specified visits for a home health agency under certain circumstances; amending s. 408.032, F.S.; revising the definition of "health care facility" to include a home health agency; amending s. 409.905, F.S.; authorizing an advanced practice registered nurse to order or write prescriptions for certain Medicaid services; providing an effective date.

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

Section 1. Subsection (5) of section 400.487, Florida Statutes, is amended to read:

400.487 Home health service agreements; physician's, physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.—

(5) When nursing services are ordered, the home health agency to which a patient has been admitted for care must provide the initial admission visit, all service evaluation visits, and the discharge visit by a direct employee <u>or contract staff</u>. Services provided by others under contractual arrangements to a home health agency must be monitored and managed by the admitting home health agency. The admitting home health agency is fully responsible for ensuring that all care

provided through its employees or contract staff is delivered in accordance with this part and applicable rules.

Section 2. Subsection (8) of section 408.032, Florida Statutes, is amended to read:

408.032 Definitions relating to Health Facility and Services Development Act.—As used in ss. 408.031-408.045, the term:

(8) "Health care facility" means a skilled nursing facility, hospice, ~~or~~ intermediate care facility, or home health agency for the developmentally disabled. A facility relying solely on spiritual means through prayer for healing is not included as a health care facility.

Section 3. Paragraph (c) of subsection (4) of section 409.905, Florida Statutes, is amended to read:

409.905 Mandatory Medicaid services.—The agency may make payments for the following services, which are required of the state by Title XIX of the Social Security Act, furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any service under this section shall be provided only when medically necessary and in accordance with state and federal law. Mandatory services rendered by providers in mobile units to Medicaid recipients may be restricted by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, number of services, or any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216.

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(c) The agency may not pay for home health services unless the services are medically necessary and:

1. The services are ordered by a physician or an advanced practice registered nurse.

2. The written prescription for the services is signed and dated by the recipient's physician or an advanced practice registered nurse before the development of a plan of care and before any request requiring prior authorization.

3. The physician or advanced practice registered nurse ordering the services is not employed, under contract with, or otherwise affiliated with the home health agency rendering the services. However, this subparagraph does not apply to a home health agency affiliated with a retirement community, of which the parent corporation or a related legal entity owns a rural health clinic certified under 42 C.F.R. part 491, subpart A, ss. 1-11, a nursing home licensed under part II of chapter 400, or an apartment or single-family home for independent living. For purposes of this subparagraph, the agency may, on a case-by-case basis, provide an exception for medically fragile children who are younger than 21 years of age.

4. The physician or advanced practice registered nurse ordering the services has examined the recipient within the 30 days preceding the initial request for the services and biannually thereafter.

5. The written prescription for the services includes the recipient's acute or chronic medical condition or diagnosis, the home health service required, and, for skilled nursing services, the frequency and duration of the services.

6. The national provider identifier, Medicaid identification number, or medical practitioner license number of the physician or advanced practice registered nurse ordering the services is listed on the written prescription for the services, the claim for home health reimbursement, and the prior authorization request.

Section 4. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Commerce and Tourism, *Chair*
Appropriations Committee on Transportation, Tourism, and Economic Development, *Vice Chair*
Appropriations Committee on Agriculture, Environment, and General Government
Banking and Insurance
Fiscal Policy
Judiciary
Transportation

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR JAY TRUMBULL
2nd District

January 11, 2024

Re: SB 1798

Dear Chair Burton,

I am respectfully requesting that Senate Bill 1798, related to Home Health Services, be placed on the agenda for your next meeting of the Health Policy Committee.

I appreciate your consideration of this bill. If there are any questions or concerns, please do not hesitate to call my office at (850) 487-5002.

Thank you,

Senator Jay Trumbull
District 2

REPLY TO:
❒ 840 West 11th Street, Panama City, Florida 32401 (850) 747-5454
❒ 320 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5002

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

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2/6/2024
Meeting Date

Health Policy
Committee

1798
Bill Number or Topic

477550
Amendment Barcode (if applicable)

Name Chris Floyd

Phone 813-624-5117

Address
Street

Email chris@clrcanselthy.com

Tampa
City

State

33606
Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: FL Assoc of Nurse Practitioners

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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2/6/24
Meeting Date

1798
Bill Number or Topic

477558
Amendment Barcode (if applicable)

Committee

Name Corinne (core-in) Mixon Phone

Address 511 N. Adams Email corinnemixon@gmail.com
Street

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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2/6/24
Meeting Date

HEALTH POLICY
Committee

SB 1798
Bill Number or Topic

Amendment Barcode (if applicable)

Name KYLE SIMON

Phone 850. 222. 8967

Address 2236 CAPITAL CIR NE #206
Street

Email KSIMON@HOMECAREFLA.ORG

TALLAHASSEE FL 32308
City State Zip

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [ ] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[ ] I am appearing without compensation or sponsorship.

[X] I am a registered lobbyist, representing:
HOME CARE ASSOCIATION OF FLORIDA

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

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02/06/24
Meeting Date

Health Policy
Committee

SB 1798
Bill Number or Topic

Amendment Barcode (if applicable)

Name E. Ivonne Fernandez

Phone 954-850-7262

Address 215 S. Monroe Street
Street

Email lfernandez@aarp.org

Tallahassee FL
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

AARP

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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2/6/24
Meeting Date

S. Health Policy
Committee

1798
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jennifer Ungria

Phone 850 214 5100

Address 106 E College Ave
Street

Email jungria@joneswalker.com

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Home Care Association of America

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 962
INTRODUCER:	Health Policy Committee and Senator Hooper
SUBJECT:	Student Health
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brick	Bouck	ED	**Favorable**
2.	Brown	Brown	HP	**Fav/CS**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 962 amends the Education Code to provide a framework for public and private schools to treat students with asthma or otherwise in respiratory distress. The bill authorizes:

- Trained staff to administer bronchodilators to students in respiratory distress and includes civil immunity for good-faith administration.
- Schools to acquire and safely maintain a supply of bronchodilators.
- Allopathic and osteopathic physicians, physician assistants, and advanced practice registered nurses to prescribe bronchodilators and components in the name of a public or private school.
- Licensed pharmacists to dispense bronchodilators and components pursuant to a prescription issued in the name of a public or private school.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Asthma is a chronic condition that involves inflammation of the airways.[1] In Florida, approximately one in eight adults and one in nine children have asthma.[2] As children with

[1] Florida Health, *What is Asthma?*, https://www.floridahealth.gov/diseases-and-conditions/asthma/what-is-asthma.html (last visited Feb. 1, 2024).
[2] *Id*.

asthma attend school, their safety and the management of their condition becomes the shared responsibility of the family, their healthcare providers, and school personnel.[3]

As approximately 10 percent of school children have asthma and spend a significant amount of time at school, having access to a rescue inhaler is important.[4] Rescue inhalers, known as short-acting bronchodilators, are used for sudden, acute asthma symptoms and includes short-acting beta 2-agonists, which quickly open airways to stop asthma symptoms. Referred to as "reliever" or "rescue" medicines, they are the most effective for treating sudden, severe, or new asthma symptoms, working within 15 to 20 minutes and lasting for four to six hours.[5]

In a 2021 joint policy statement on ensuring access to albuterol in schools, the American Thoracic Society, the Allergy and Asthma Network Mothers of Asthmatics, the American Lung Associations, and the National Association of School Nurses stated that for children with asthma, access to quick-relief medications is critical to minimizing morbidity and mortality.[6] The statement concluded that stock albuterol in schools is a safe, practical, and potentially life-saving option for children with asthma, whether asthma is diagnosed or undiagnosed, who lack access to their personal quick-relief medication.[7]

Bronchodilator Regulation

The Federal Food, Drug, and Cosmetic Act governs the sale of drugs[8] in the United States.[9] When approving applications for the approval of new drugs, the Secretary of Health and Human Services indicates whether the drug is approved for over-the-counter or for prescription use.[10]

A short-acting beta-2 agonist contains albuterol or a derivative thereof[11] and is only available with a prescription.[12] A common metered-dose inhaler costs between $20 to $100.[13]

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[3] American Lung Association, *Improving Access to Asthma Medications in Schools* (Sept. 2014), *available at* https://www.lung.org/getmedia/872c9b6a-5379-4321-8913-102d53182e29/improving-access-to-asthma.pdf.pdf, at 1.
[4] American Academy of Allergy, *Asthma & Immunology, School stock inhaler program* (2021), https://www.aaaai.org/tools-for-the-public/latest-research-summaries/the-journal-of-allergy-and-clinical-immunology/2021/school-inhaler (last visited Feb. 1, 2024).
[5] Cleveland Clinic, *Bronchodilator*, https://my.clevelandclinic.org/health/treatments/17575-bronchodilator (last visited Feb. 1, 2024).
[6] Anna Volerman, et al., *Ensuring Access to Albuterol in Schools: From Policy to Implementation. An official ATS/AANMA/ALA/NASN Policy Statement*, 204 American Journal of Respiratory and Critical Care Medicine 5 (Sept. 2021), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8491259/pdf/rccm.202106-1550ST.pdf.
[7] *Id.*
[8] The term 'drug' is broadly defined in federal law and includes any article intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals. 21 U.S.C. s. 321(g)(1).
[9] 21 U.S.C. s. 355(a).
[10] 21 U.S.C. s. 353(b)(1).
[11] Cleveland Clinic, *Bronchodilator*, https://my.clevelandclinic.org/health/treatments/17575-bronchodilator (last visited Feb. 1, 2024).
[12] Mayo Clinic, *Beta-2 Adrenergic Agonist (Oral Route, Injection Route)*, https://www.mayoclinic.org/drugs-supplements/beta-2-adrenergic-agonist-oral-route-injection-route/description/drg-20069364 (last visited Feb. 1, 2024).
[13] Anna Volerman, et al., *Ensuring Access to Albuterol in Schools: From Policy to Implementation. An official ATS/AANMA/ALA/NASN Policy Statement*, 204 American Journal of Respiratory and Critical Care Medicine 5 (Sept. 2021), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8491259/pdf/rccm.202106-1550ST.pdf, at 518.

Subject to statutory exceptions, it is illegal for a drug manufacturer or wholesale distributor in Florida to distribute a prescription drug to a person without a prescription.[14] One such statutory exception authorizes a public school to purchase a supply of epinephrine auto-injectors from a wholesale distributor or manufacturer.[15] In addition, a manufacturer or wholesale distributor of a short-acting beta-2 agonist may sell a prescription drug to:[16]

- A licensed pharmacist or any person under the licensed pharmacist's supervision while acting within the scope of the licensed pharmacist's practice;
- A licensed practitioner authorized by law to prescribe prescription drugs or any person under the licensed practitioner's supervision while acting within the scope of the licensed practitioner's practice;
- A qualified person who uses prescription drugs for lawful research, teaching, or testing, and not for resale;
- A licensed hospital or other institution that procures such drugs for lawful administration or dispensing by practitioners;
- An officer or employee of a federal, state, or local government; or
- A person that holds a valid permit issued by the Department of Business and Professional Regulation, which authorizes that person to possess prescription drugs.

School Health

District school board personnel may assist students in the administration of certain medication and medical services.[17] County health departments, district school boards, and local school health advisory committees jointly develop school health services plans, which must include provisions for meeting emergency needs at each school.[18] Each school must ensure that at least two school staff members are currently certified by nationally recognized certifying agencies to provide first aid and cardiopulmonary resuscitation.[19]

In Florida, asthmatic students may carry a metered dose inhaler at school if both their parent and physician approve and provide written authorization to the school principal.[20]

III. Effect of Proposed Changes:

CS/SB 962 provides a framework for public and private schools to treat students in respiratory distress.

Definitions

The bill amends ss. 1002.20 and 1002.42, F.S., to modify the rights for asthmatic student to carry devices to treat asthma at a public or private school, respectively. For consistency, the bill defines:

[14] Section 499.005(14), F.S.
[15] Section 1002.20(3)(i), F.S.
[16] Section 499.03(1), F.S.
[17] Section 1006.062, F.S.
[18] Sections 381.0056(4)(a)12. and 1006.062(6), F.S.
[19] Rule 64F-6.004, F.A.C.
[20] Section 1002.20(3)(h), F.S.

- "Administer" to mean to give or directly apply a short-acting bronchodilator to a student.
- "Asthma" to mean a chronic lung disease that inflames and narrows the airways and can manifest wheezing, chest tightness, shortness of breath, and coughing.
- "Authorized health care practitioner" to mean an allopathic physician licensed under chapter 458, an osteopathic physician licensed under chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.
- "Components" to mean devices used as part of clinically recommended use of short-acting bronchodilators, including spacers, valved holding chambers, or nebulizers.
- "Respiratory distress" to mean difficulty breathing by an individual, which can be caused by several medical factors, including chronic diseases such as asthma.
- "Short-acting bronchodilator" to mean any beta-2 agonist, such as albuterol, which is used for the quick relief of asthma symptoms and is recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. Such bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured metered dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a bronchodilator recommended by the Guidelines for the Treatment of Asthma.

Bronchodilator Supply

The bill facilitates the provision and use of short-acting bronchodilators in public and private schools. The bill authorizes:

- Allopathic or osteopathic physicians, physician assistants, and advanced practice registered nurses to prescribe short-acting bronchodilators and components in the name of a public or private school for use in accordance with ss. 1002.20 or 1002.42, F.S., respectively.
- Licensed pharmacists to dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a public or private school for use in accordance with ss. 1002.20 or 1002.42, F.S., respectively.
- A school nurse or a trained school personnel member to administer short-acting bronchodilators or components to students only if the personnel member has successfully completed training and believes in good faith that the student is experiencing respiratory distress or asthma-related distress, regardless of whether the student has a prescription for a short-acting bronchodilator or has previously been diagnosed with asthma.

The bill provides a pathway for schools to purchase and maintain a supply of bronchodilators. The bill authorizes schools to:

- Acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor or enter into an arrangement with a wholesale distributor or manufacturer, for short-acting bronchodilators and components at no charge, a fair market price, or a reduced price for use in the event a student experiences an anaphylactic reaction or respiratory distress.

- Accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.
- Supply short-acting bronchodilators and components for use by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator or components.

The bill provides safeguards for the use of bronchodilators in schools. The bill requires:
- The short-acting bronchodilators and components to be maintained in a secure location on a school's premises.
- The participating school district or school to adopt a protocol developed by a licensed allopathic or osteopathic physician for administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The school district and the protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with a known diagnosis of asthma and, if approved by the school district, for students with no known diagnosis of asthma.
- The school district or school to provide written notice of the district's or school's adopted protocol to each parent or guardian.
- The school to receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

Bronchodilator Administration

The bill provides that a school district or private school and its employees and agents who act in good faith are not liable for any injury arising from the use or nonuse of a short-acting bronchodilator or components administered by a trained school personnel member or nurse who follows the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:
- Unless the trained school personnel member's or nurse's action is willful and wanton;
- Notwithstanding that the parent or guardian of the student to whom the short-acting bronchodilator is administered has not been provided notice or has not signed a statement acknowledging that the school district is not liable; and
- Regardless of whether authorization has been given by the student's parent or guardian or by the student's physician, physician assistant, or advanced practice registered nurse.

The bill provides that an authorized health care practitioner or dispensing pharmacist who prescribes short-acting bronchodilators and components for use by a public or private school is immune from civil liability for any act or omission related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 1002.20 and 1002.42.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute:

- Modifies the underlying bill's definition of "authorized health care practitioner" to include APRNs, instead of registered nurses, so that APRNs, not registered nurses, are authorized under the bill to issue prescriptions for bronchodilators;
- Modifies the underlying bill's definition of "short-acting bronchodilator" to require recommendation by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma, as opposed to recommendation by the Institute itself;
- Specifies that the physician protocol required to be adopted by public or private school under the bill must be developed by an allopathic or osteopathic physician; and
- Provides that a school district and its protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with no known diagnosis of asthma, if such administration is approved by the school district.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Hooper) recommended the following:

Senate Amendment

Delete lines 95 - 242
and insert:
licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.

d. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, including spacers, valved holding chambers, or nebulizers.

e. "Respiratory distress" means difficulty breathing by an

individual, which can be caused by several medical factors, including chronic diseases such as asthma.

f. "Short-acting bronchodilator" means any beta-2 agonist, such as albuterol, which is used for the quick relief of asthma symptoms and is recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. Such bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured metered dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a bronchodilator recommended in the Guidelines for the Treatment of Asthma.

2. Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator ~~metered dose inhaler~~ on their person while in school. The school principal must ~~shall~~ be provided a copy of the parent's and physician's approval.

3. An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a public school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a public school for use in accordance with this section.

4.a. A public school may acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor as defined in s. 499.003 or may enter into an

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arrangement with a wholesale distributor or manufacturer, as those terms are defined in s. 499.003, for short-acting bronchodilators and components at no charge, a fair market price, or a reduced price for use in the event a student experiences an anaphylactic reaction or respiratory distress. The short-acting bronchodilators and components must be maintained in a secure location on a school's premises.

b. A participating public school must adopt a protocol developed by a physician licensed under chapter 458 or chapter 459 for the administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The school district and the protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with a known diagnosis of asthma and if approved by the school district for students with no known diagnosis of asthma.

c. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator or components.

d. A public school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

e. A school nurse or a trained school personnel member may administer short-acting bronchodilators or components to students only if the personnel member has successfully completed

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training and believes in good faith that the student is experiencing respiratory distress or asthma-related distress, regardless of whether the student has a prescription for a short-acting bronchodilator or has previously been diagnosed with asthma.

f. The school district or public school shall provide written notice of the district's or school's adopted protocol to each parent or guardian. The public school must receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

g. A school district and its employees and agents who act in good faith are not liable for any injury arising from the use or nonuse of a short-acting bronchodilator or components administered by a trained school personnel member or nurse who follows the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

(I) Unless the trained school personnel member's or nurse's action is willful and wanton;

(II) Notwithstanding that the parent or guardian of the student to whom the short-acting bronchodilator is administered has not been provided notice or has not signed a statement acknowledging that the school district is not liable; and

(III) Regardless of whether authorization has been given by the student's parent or guardian or by the student's physician, physician assistant, or advanced practice registered nurse.

h. An authorized health care practitioner or dispensing pharmacist who prescribes short-acting bronchodilators and components for use by a public school is immune from civil liability for any act or omission related to the administration

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of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

Section 2. Subsection (19) is added to section 1002.42, Florida Statutes, to read:

1002.42 Private schools.—

(19) SHORT-ACTING BRONCHODILATOR USE.—

(a) As used in this subsection, the term:

1. "Administer" means to give or directly apply a short-acting bronchodilator to a student.

2. "Asthma" means a chronic lung disease that inflames and narrows the airways and can manifest wheezing, chest tightness, shortness of breath, and coughing.

3. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or an advanced practice registered nurse licensed under chapter 464.

4. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, including spacers, valved holding chambers, or nebulizers.

5. "Respiratory distress" means difficulty breathing by an individual, which can be caused by several medical factors, including chronic diseases such as asthma.

6. "Short-acting bronchodilator" means any beta-2 agonist, such as albuterol, which is used for the quick relief of asthma symptoms and is recommended by the National Heart, Lung, and Blood Institute's National Asthma Education and Prevention Program Guidelines for the Treatment of Asthma. Such bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol

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sulfate delivered by a nebulizer or compressor device or by a pressured metered dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a bronchodilator recommended in the Guidelines for the Treatment of Asthma.

(b) Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator on their person while in school. The school principal must be provided a copy of the parent's and physician's approval.

(c) An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a private school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a private school for use in accordance with this section.

(d) A private school may acquire and stock a supply of short-acting bronchodilators and components, as defined in s. 1002.20(3)(h), from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer, as those terms are defined in s. 499.003, for short-acting bronchodilators and components at no charge, a fair market price, or a reduced price for use in the event a student experiences an anaphylactic reaction or respiratory distress. The short-acting bronchodilators and components must be maintained in a secure location on the school premises.

(e) A participating private school must adopt a protocol

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developed by a physician licensed under chapter 458 or chapter 459 for the administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The protocol must provide guidance for administering short-acting bronchodilators in instances of respiratory distress for a student with a known diagnosis of asthma and if approved by the private school for students with no known diagnosis of asthma.

(f) The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator.

By Senator Hooper

21-00831B-24 2024962__

A bill to be entitled

An act relating to student health; amending s. 1002.20, F.S.; defining terms; revising a provision to authorize asthmatic students to carry a short-acting bronchodilator, rather than a metered dose inhaler; authorizing authorized health care practitioners to prescribe short-acting bronchodilators and components in the name of a public school; authorizing licensed pharmacists to dispense short-acting bronchodilators and components in the name of a public school; authorizing a public school to acquire and stock short-acting bronchodilators and components from wholesale distributors; authorizing a public school to enter into certain arrangements with a wholesale distributor or manufacturer; requiring a public school that obtains short-acting bronchodilators and components to maintain them in a secure location on school premises; requiring certain public schools to adopt a protocol developed by a licensed physician for the administration of a short-acting bronchodilator and components by school personnel; providing that a public school's short-acting bronchodilators and components may be provided to and used by trained school personnel or students authorized to self-administer a short-acting bronchodilator and components; authorizing school districts to accept short-acting bronchodilators and components as a donation or transfer if the bronchodilators and components meet specified requirements; providing

requirements for school personnel to administer a short-acting bronchodilator to a student; requiring school districts or public schools to provide written notice of the adopted protocol to each parent or guardian; requiring public schools to receive a parent or guardian's prior permission to administer a short-acting bronchodilator to a student; providing for immunity from liability for specified individuals under certain conditions; amending s. 1002.42, F.S.; defining terms; authorizing certain students to carry a short-acting bronchodilator at school under certain conditions; authorizing authorized health care practitioners to prescribe short-acting bronchodilators and components in the name of a private school; authorizing licensed pharmacists to dispense short-acting bronchodilators and components in the name of a private school; authorizing private schools to acquire and stock short-acting bronchodilators and components from wholesale distributors; authorizing private schools to enter into certain arrangements with a wholesale distributor or manufacturer; requiring private schools that obtain short-acting bronchodilators and components to maintain them in a secure location on school premises; requiring such private schools to adopt a protocol developed by a licensed physician for the administration of a short-acting bronchodilator by school personnel; providing that a private school's bronchodilators may be provided to and used by trained

school personnel and by students authorized to self-administer short-acting bronchodilators; authorizing private schools to accept short-acting bronchodilators and components as a donation or transfer if the bronchodilators and components meet specified requirements; providing requirements for school personnel to administer a short-acting bronchodilator and components to a student; requiring private schools to provide written notice of the adopted protocol to each parent or guardian; requiring private schools to receive a parent or guardian's prior permission to administer a short-acting bronchodilator and components to a student; providing for immunity from liability for specified individuals under certain conditions; providing an effective date.

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

Section 1. Paragraph (h) of subsection (3) of section 1002.20, Florida Statutes, is amended to read:

1002.20 K-12 student and parent rights.—Parents of public school students must receive accurate and timely information regarding their child's academic progress and must be informed of ways they can help their child to succeed in school. K-12 students and their parents are afforded numerous statutory rights including, but not limited to, the following:

(3) HEALTH ISSUES.—

(h) *Short-acting bronchodilator* ~~*Inhaler*~~ *use.*—

1. As used in this paragraph, the term:

a. "Administer" means to give or directly apply a short-acting bronchodilator to a student.

b. "Asthma" means a chronic lung disease that inflames and narrows the airways and can manifest wheezing, chest tightness, shortness of breath, and coughing.

c. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or a registered nurse licensed under chapter 464.

d. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, including spacers, valved holding chambers, or nebulizers.

e. "Respiratory distress" means difficulty breathing by an individual, which can be caused by several medical factors, including chronic diseases such as asthma.

f. "Short-acting bronchodilator" means any beta-2 agonist, such as albuterol, which is used for the quick relief of asthma symptoms and is recommended by the National Heart, Lung, and Blood Institute. Such bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured metered dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a bronchodilator recommended by the National Heart, Lung, and Blood Institute.

2. Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator ~~metered dose inhaler~~ on their person while in

school. The school principal must ~~shall~~ be provided a copy of the parent's and physician's approval.

3. An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a public school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a public school for use in accordance with this section.

4.a. A public school may acquire and stock a supply of short-acting bronchodilators and components from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer, as those terms are defined in s. 499.003, for short-acting bronchodilators and components at no charge, a fair market price, or a reduced price for use in the event a student experiences an anaphylactic reaction or respiratory distress. The short-acting bronchodilators and components must be maintained in a secure location on a school's premises. The participating school district or public school shall adopt a protocol developed by a licensed physician for administration of short-acting bronchodilators or components by school personnel who are trained to recognize symptoms of respiratory distress and to administer a short-acting bronchodilator or components. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator or components.

b. A public school may accept short-acting bronchodilators and components as a donation or transfer if they are new,

unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

c. A school nurse or a trained school personnel member may administer short-acting bronchodilators or components to students only if the personnel member has successfully completed training and believes in good faith that the student is experiencing respiratory distress or asthma-related distress, regardless of whether the student has a prescription for a short-acting bronchodilator or has previously been diagnosed with asthma.

d. The school district or public school shall provide written notice of the district's or school's adopted protocol to each parent or guardian. The public school must receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

e. A school district and its employees and agents who act in good faith are not liable for any injury arising from the use or nonuse of a short-acting bronchodilator or components administered by a trained school personnel member or nurse who follows the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

(I) Unless the trained school personnel member's or nurse's action is willful and wanton;

(II) Notwithstanding that the parent or guardian of the student to whom the short-acting bronchodilator is administered has not been provided notice or has not signed a statement acknowledging that the school district is not liable; and

(III) Regardless of whether authorization has been given by

the student's parent or guardian or by the student's physician, physician assistant, or advanced practice registered nurse.

f. An authorized health care practitioner or dispensing pharmacist who prescribes short-acting bronchodilators and components for use by a public school is immune from civil liability for any act or omission related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

Section 2. Subsection (19) is added to section 1002.42, Florida Statutes, to read:

1002.42 Private schools.—

(19) SHORT-ACTING BRONCHODILATOR USE.—

(a) As used in this subsection, the term:

1. "Administer" means to give or directly apply a short-acting bronchodilator to a student.

2. "Asthma" means a chronic lung disease that inflames and narrows the airways and can manifest wheezing, chest tightness, shortness of breath, and coughing.

3. "Authorized health care practitioner" means a physician licensed under chapter 458 or chapter 459, a physician assistant licensed under chapter 458 or chapter 459, or a registered nurse licensed under chapter 464.

4. "Components" means devices used as part of clinically recommended use of short-acting bronchodilators, including spacers, valved holding chambers, or nebulizers.

5. "Respiratory distress" means difficulty breathing by an individual, which can be caused by several medical factors, including chronic diseases such as asthma.

6. "Short-acting bronchodilator" means any beta-2 agonist,

such as albuterol, which is used for the quick relief of asthma symptoms and is recommended by the National Heart, Lung, and Blood Institute. Such bronchodilators may include an orally inhaled medication that contains a premeasured single dose of albuterol or albuterol sulfate delivered by a nebulizer or compressor device or by a pressured metered dose inhaler used to treat respiratory distress, including, but not limited to, wheezing, shortness of breath, and difficulty breathing, or another dosage of a bronchodilator recommended by the National Heart, Lung, and Blood Institute.

(b) Asthmatic students whose parent and physician provide their approval to the school principal may carry a short-acting bronchodilator on their person while in school. The school principal must be provided a copy of the parent's and physician's approval.

(c) An authorized health care practitioner may prescribe short-acting bronchodilators and components in the name of a private school for use in accordance with this section, and a licensed pharmacist may dispense short-acting bronchodilators and components pursuant to a prescription issued in the name of a private school for use in accordance with this section.

(d) A private school may acquire and stock a supply of short-acting bronchodilators and components, as defined in s. 1002.20(3)(h), from a wholesale distributor as defined in s. 499.003 or may enter into an arrangement with a wholesale distributor or manufacturer, as those terms are defined in s. 499.003, for short-acting bronchodilators and components at no charge, a fair market price, or a reduced price for use in the event a student experiences an anaphylactic reaction or

respiratory distress. The short-acting bronchodilators and components must be maintained in a secure location on the school premises. The participating school shall adopt a protocol developed by a licensed physician for the administration of a short-acting bronchodilator or components by school personnel who are trained to recognize symptoms of respiratory distress. The supply of short-acting bronchodilators and components may be provided to and used by a trained school personnel member or a student authorized to self-administer a short-acting bronchodilator or components.

(e) A private school may accept short-acting bronchodilators and components as a donation or transfer if they are new, unexpired, manufacturer-sealed, not subject to recall, unadulterated, and in compliance with relevant regulations adopted by the United States Food and Drug Administration.

(f) A school nurse or a trained school personnel member may administer short-acting bronchodilators or components to students only if the personnel member has successfully completed training and believes in good faith that the student is experiencing respiratory distress or asthma-related distress, regardless of whether the student has a prescription for a short-acting bronchodilator or has previously been diagnosed with asthma.

(g) A private school shall provide written notice of the school's adopted protocol to each parent or guardian. A private school must receive prior permission from the parent or guardian to administer a short-acting bronchodilator or components to a student.

(h) A private school and its employees and agents who act

in good faith are not liable for any injury arising from the use or nonuse of a short-acting bronchodilator or components administered by a trained school personnel member or nurse who follows the adopted protocol and whose professional opinion is that the student is experiencing respiratory distress:

1. Unless the trained school personnel member's or nurse's action is willful and wanton;

2. Notwithstanding that the parent or guardian of the student to whom the short-acting bronchodilator is administered has not been provided notice or has not signed a statement acknowledging that the school is not liable; and

3. Regardless of whether authorization has been given by the student's parents or guardians or by the student's physician, physician assistant, or advanced practice registered nurse.

(i) An authorized health care practitioner or dispensing pharmacist who prescribes short-acting bronchodilators and components for use by a private school is immune from civil liability for any act or omission related to the administration of a short-acting bronchodilator or components, except for an act of willful or wanton misconduct.

Section 3. This act shall take effect July 1, 2024.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 31, 2024

I respectfully request that **Senate Bill #962**, relating to Student Health, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ed Hooper
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

02/06/24
Meeting Date

Health Policy
Committee

SB 962
Bill Number or Topic

Amendment Barcode (if applicable)

Name Anna Grace Lewis

Phone 850-205-9000

Address 119 S. Monroe St
Street

Email agl@mhdfirm.com

Tallahassee FL 32303
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
The American Lung Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

02-06-24
Meeting Date

Health Policy
Committee

SB 962
Bill Number or Topic

Amendment Barcode (if applicable)

Name Dr. Sumanth Dore MD

Phone

Address 210 SW 6th Ave
Street
Gainesville FL 32601
City State Zip

Email sdore10@gmail.com

Speaking: ☐ For ☐ Against ☒ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

SB 962
Bill Number or Topic

Amendment Barcode (if applicable)

Name Nancy Lawther, Ph.D. Phone 407 855-7604

Address 1747 Orlando Central Pkwy Email legislator@floridapta.org
Street

Orlando FL 32809
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☒ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by: Florida PTA

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	SB 1632
INTRODUCER:	Senators Collins and Avila
SUBJECT:	Public Records/Personnel of the Agency for Health Care Administration
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			GO	
3.			RC	

I. Summary:

SB 1632 creates a new public records exemption for specified personally identifying information of current and former personnel of the Agency for Health Care Administration (AHCA) whose duties include the investigation of complaints filed against health care facilities or the inspection of health care facilities, such personnel's children and spouses' specified personally identifying information, and the names and locations of their children's schools and day care facilities.

The bill provides that the new exemption is subject to the Open Government Sunset Review Act and will be repealed on October 2, 2029, unless saved form repeal by the Legislature. The bill also finds that exempting the specified records from public records requirements is a public necessity to protect the AHCA's current and former personnel from potential danger posed by disgruntled individuals who may have contentious reactions to actions carried out by such personnel.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Access to Public Records – Generally

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[1] The right to inspect or copy applies to the official business of any public body, officer, or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[2]

[1] FLA. CONST. art. I, s. 24(a).
[2] *Id*.

Additional requirements and exemptions related to public records are found in various statutes and rules, depending on the branch of government involved. For instance, s.11.0431, F.S., provides public access requirements for legislative records. Relevant exemptions are codified in s. 11.0431(2)-(3), F.S., and adopted in the rules of each house of the Legislature.[3] Florida Rule of Judicial Administration 2.420 governs public access to judicial branch records.[4] Lastly, ch. 119, F.S., known as the Public Records Act, provides requirements for public records held by executive agencies.

Executive Agency Records – The Public Records Act

The Public Records Act provides that all state, county and municipal records are open for personal inspection and copying by any person, and that providing access to public records is a duty of each agency.[5]

Section 119.011(12), F.S., defines "public records" to include:

> All documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connections with the transaction of official business by any agency.

The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business that are used to "perpetuate, communicate, or formalize knowledge of some type."[6]

The Florida Statutes specify conditions under which public access to public records must be provided. The Public Records Act guarantees every person's right to inspect and copy any public record at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record.[7] A violation of the Public Records Act may result in civil or criminal liability.[8]

The Legislature may exempt public records from public access requirements by passing a general law by a two-thirds vote of both the House and the Senate.[9] The exemption must state

[3] *See* Rule 1.48, *Rules and Manual of the Florida Senate*, (2022-2024) and Rule 14.1, *Rules of the Florida House of Representatives*, Edition 2, (2022-2024)
[4] *State v. Wooten*, 260 So. 3d 1060 (Fla. 4th DCA 2018).
[5] Section 119.01(1), F.S. Section 119.011(2), F.S., defines "agency" as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."
[6] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc., Inc*., 379 So. 2d 633, 640 (Fla. 1980).
[7] Section 119.07(1)(a), F.S.
[8] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.
[9] FLA. CONST. art. I, s. 24(c).

with specificity the public necessity justifying the exemption and must be no broader than necessary to accomplish the stated purpose of the exemption.[10]

General exemptions from the public records requirements are contained in the Public Records Act.[11] Specific exemptions often are placed in the substantive statutes relating to a particular agency or program.[12]

When creating a public records exemption, the Legislature may provide that a record is "exempt" or "confidential and exempt." Records designated as "confidential and exempt" are not subject to inspection by the public and may only be released under the circumstances defined by statute.[13] Records designated as "exempt" may be released at the discretion of the records custodian under certain circumstances.[14]

Open Meetings Laws

The State Constitution provides that the public has a right to access governmental meetings.[15] Each collegial body must provide notice of its meetings to the public and permit the public to attend any meeting at which official acts are taken or at which public business is transacted or discussed.[16] This applies to the meetings of any collegial body of the executive branch of state government, counties, municipalities, school districts or special districts.[17]

Public policy regarding access to government meetings is also addressed in the Florida Statutes. Section 286.011, F.S., known as the "Government in the Sunshine Law,"[18] or the "Sunshine Law,"[19] requires all meetings of any board or commission of any state or local agency or authority at which official acts are to be taken be open to the public.[20] The board or commission must provide the public reasonable notice of such meetings.[21] Public meetings may not be held at any location that discriminates on the basis of sex, age, race, creed, color, origin or economic

[10] *Id*. *See, e.g., Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So. 2d 567 (Fla. 1999) (holding that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption); *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004) (holding that a statutory provision written to bring another party within an existing public records exemption is unconstitutional without a public necessity statement).
[11] *See, e.g.*, s. 119.071(1)(a), F.S. (exempting from public disclosure examination questions and answer sheets of examinations administered by a governmental agency for the purpose of licensure).
[12] *See, e.g.*, s. 213.053(2)(a), F.S. (exempting from public disclosure information contained in tax returns received by the Department of Revenue).
[13] *WFTV, Inc. v. The Sch. Bd. of Seminole County*, 874 So. 2d 48, 53 (Fla. 5th DCA 2004).
[14] *Williams v. City of Minneola*, 575 So. 2d 683 (Fla. 5th DCA 1991).
[15] FLA. CONST., art. I, s. 24(b).
[16] *Id*.
[17] FLA. CONST., art. I, s. 24(b). Meetings of the Legislature are governed by Article III, section 4(e) of the Florida Constitution, which states: "The rules of procedure of each house shall further provide that all prearranged gatherings, between more than two members of the legislature, or between the governor, the president of the senate, or the speaker of the house of representatives, the purpose of which is to agree upon formal legislative action that will be taken at a subsequent time, or at which formal legislative action is taken, regarding pending legislation or amendments, shall be reasonably open to the public."
[18] *Times Pub. Co. v. Williams*, 222 So. 2d 470, 472 (Fla. 2d DCA 1969).
[19] *Board of Public Instruction of Broward County v. Doran*, 224 So. 2d 693, 695 (Fla. 1969).
[20] Section 286.011(1)-(2), F.S.
[21] *Id*.

status or which operates in a manner that unreasonably restricts the public's access to the facility.[22] Minutes of a public meeting must be promptly recorded and open to public inspection.[23] Failure to abide by open meetings requirements will invalidate any resolution, rule or formal action adopted at a meeting.[24] A public officer or member of a governmental entity who violates the Sunshine Law is subject to civil and criminal penalties.[25]

The Legislature may create an exemption to open meetings requirements by passing a general law by at least a two-thirds vote of each house of the Legislature.[26] The exemption must explicitly lay out the public necessity justifying the exemption, and must be no broader than necessary to accomplish the stated purpose of the exemption.[27] A statutory exemption which does not meet these two criteria may be unconstitutional and may not be judicially saved.[28]

Open Government Sunset Review Act

The provisions of s. 119.15, F.S., known as the Open Government Sunset Review Act[29] (the Act), prescribe a legislative review process for newly created or substantially amended[30] public records or open meetings exemptions, with specified exceptions.[31] The Act requires the repeal of such exemption on October 2nd of the fifth year after creation or substantial amendment, unless the Legislature reenacts the exemption.[32]

The Act provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[33] An exemption serves an identifiable purpose if it meets one of the following purposes *and* the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

- It allows the state or its political subdivisions to effectively and efficiently administer a governmental program, and administration would be significantly impaired without the exemption;[34]

[22] Section 286.011(6), F.S.
[23] Section 286.011(2), F.S.
[24] Section 286.011(1), F.S.
[25] Section 286.011(3), F.S.
[26] FLA. CONST., art. I, s. 24(c).
[27] *Id*.
[28] *Halifax Hosp. Medical Center v. New-Journal Corp.,* 724 So. 2d 567 (Fla. 1999). In *Halifax Hospital*, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. *Id*. at 570. The Florida Supreme Court also declined to narrow the exemption in order to save it. *Id.* In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a public records statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional. *Id*. at 196.
[29] Section 119.15, F.S.
[30] An exemption is considered to be substantially amended if it is expanded to include more records or information or to include meetings as well as records. Section 119.15(4)(b), F.S.
[31] Section 119.15(2)(a) and (b), F.S., provides that exemptions required by federal law or applicable solely to the Legislature or the State Court System are not subject to the Open Government Sunset Review Act.
[32] Section 119.15(3), F.S.
[33] Section 119.15(6)(b), F.S.
[34] Section 119.15(6)(b)1., F.S.

- It protects sensitive, personal information, the release of which would be defamatory, cause unwarranted damage to the good name or reputation of the individual, or would jeopardize the individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[35] or
- It protects information of a confidential nature concerning entities, such as trade or business secrets.[36]

The Act also requires specified questions to be considered during the review process. In examining an exemption, the Act directs the Legislature to question the purpose and necessity of reenacting the exemption.

Public Necessity Statement and Two-thirds Vote Requirement

If the exemption is continued and expanded, then a public necessity statement and a two-thirds vote for passage are required.[37] If the exemption is continued without substantive changes or if the exemption is continued and narrowed, then a public necessity statement and a two-thirds vote for passage are *not* required. If the Legislature allows an exemption to expire, the previously exempt records will remain exempt unless otherwise provided by law.

Threats to Agency for Health Care Administration Staff

The AHCA reports that AHCA staff have dealt with numerous instances where disgruntled providers/suppliers and complainants have found staff's personal information and used that information to make threats against the AHCA, the employees, and their families. AHCA investigators are positioned throughout the state to ensure every health care facility the AHCA regulates and licenses maintains required standards. If these standards are not met, the AHCA will fine and/or revoke the facility license. In addition, the AHCA deploys investigators around the state to investigate fraud in the Medicaid program among providers and suppliers.

Such regulatory behavior by AHCA personnel could cause disgruntled providers or suppliers and complainants to threaten the AHCA investigators, as well as their families. An example of a current situation involves the case of a complainant. This situation includes a complainant who has made threats, verbally and in writing, to management staff and their families in one of the AHCA's field offices regarding a complaint investigation. The management staff had to request an injunction and appear in court. The complainant was finally charged with aggravated assault. Injunctions were granted to the management staff and will be in place for five years.[38]

III. Effect of Proposed Changes:

SB 1632 amends s. 119.071, F.S., to make exempt from public records laws the home addresses, telephone numbers, dates of birth, and photographs of current or former AHCA personnel whose duties include the investigation of complaints filed against health care facilities or the inspection of health care facilities licensed or certified by the AHCA. The bill also exempts the names,

[35] Section 119.15(6)(b)2., F.S.
[36] Section 119.15(6)(b)3., F.S.
[37] *See generally* s. 119.15, F.S.
[38] AHCA bill analysis for HB 1391, on file with Senate Health Policy Committee Staff.

home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such AHCA personnel as well as the names and locations of their children's schools and day care facilities.

The bill provides that these exemptions are subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2029, if not reviewed and saved from repeal through reenactment by the Legislature.

The bill also creates one undesignated section of Florida law to provide Legislative findings of the public necessity for the new public records exemption. The bill provides that it is a public necessity to establish the public records exemption in order to protect AHCA's current and former personnel, as well as their families, from potential danger of physical and emotional harm from disgruntled individuals who have contentious reactions to actions carried out by such personnel and that the harm that may result from the release of the information being exempted outweighs any public benefit that may be derived from the disclosure of the information.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Vote Requirement
Article I, section 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records or open meetings requirements. This bill creates public records exemptions and a public meeting exemption; therefore, it requires a two-thirds vote.

Public Necessity Statement
Article I, section 24(a) of the State Constitution and Article I, section 24(b) of the State Constitution require a bill creating or expanding an exemption to the public records or open meetings requirements to state with specificity the public necessity justifying the exemption. Section 2 of the bill contains a statement of public necessity statement for the exemptions.

Breadth of Exemption
Article I, section 24(c), of the State Constitution requires exemptions to the public records and open meetings requirements to be no broader than necessary to accomplish the stated purpose of the law. The purpose of the bill is to protect personal identifying information of certain AHCA personnel and their families. These protections are required of a member state through these compacts and they do not appear to be broader than necessary to accomplish its purpose.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 119.071 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.)

None.

B. Amendments:

None.

By Senator Collins

14-00732-24 20241632__

A bill to be entitled

An act relating to public records; amending s. 119.071, F.S.; providing an exemption from public records requirements for the personal identifying and location information of certain current or former personnel of the Agency for Health Care Administration and their spouses and children; providing for future legislative review and repeal of the exemption; providing for retroactive application; providing a statement of public necessity; providing an effective date.

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

Section 1. Paragraph (d) of subsection (4) of section 119.071, Florida Statutes, is amended to read:

119.071 General exemptions from inspection or copying of public records.—

(4) AGENCY PERSONNEL INFORMATION.—

(d)1. For purposes of this paragraph, the term:

a. "Home addresses" means the dwelling location at which an individual resides and includes the physical address, mailing address, street address, parcel identification number, plot identification number, legal property description, neighborhood name and lot number, GPS coordinates, and any other descriptive property information that may reveal the home address.

b. "Judicial assistant" means a court employee assigned to the following class codes: 8140, 8150, 8310, and 8320.

c. "Telephone numbers" includes home telephone numbers,

personal cellular telephone numbers, personal pager telephone numbers, and telephone numbers associated with personal communications devices.

2.a. The home addresses, telephone numbers, dates of birth, and photographs of active or former sworn law enforcement personnel or of active or former civilian personnel employed by a law enforcement agency, including correctional and correctional probation officers, personnel of the Department of Children and Families whose duties include the investigation of abuse, neglect, exploitation, fraud, theft, or other criminal activities, personnel of the Department of Health whose duties are to support the investigation of child abuse or neglect, and personnel of the Department of Revenue or local governments whose responsibilities include revenue collection and enforcement or child support enforcement; the names, home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

b. The home addresses, telephone numbers, dates of birth, and photographs of current or former nonsworn investigative personnel of the Department of Financial Services whose duties include the investigation of fraud, theft, workers' compensation coverage requirements and compliance, other related criminal activities, or state regulatory requirement violations; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such

personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

c. The home addresses, telephone numbers, dates of birth, and photographs of current or former nonsworn investigative personnel of the Office of Financial Regulation's Bureau of Financial Investigations whose duties include the investigation of fraud, theft, other related criminal activities, or state regulatory requirement violations; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

d. The home addresses, telephone numbers, dates of birth, and photographs of current or former firefighters certified in compliance with s. 633.408; the names, home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of such firefighters; and the names and locations of schools and day care facilities attended by the children of such firefighters are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

e. The home addresses, dates of birth, and telephone numbers of current or former justices of the Supreme Court, district court of appeal judges, circuit court judges, and county court judges, and of current judicial assistants; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of current or

former justices and judges and of current judicial assistants; and the names and locations of schools and day care facilities attended by the children of current or former justices and judges and of current judicial assistants are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This sub-subparagraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2028, unless reviewed and saved from repeal through reenactment by the Legislature.

f. The home addresses, telephone numbers, dates of birth, and photographs of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors; the names, home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors; and the names and locations of schools and day care facilities attended by the children of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

g. The home addresses, dates of birth, and telephone numbers of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division of Administrative Hearings, and child support enforcement hearing officers; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division

of Administrative Hearings, and child support enforcement hearing officers; and the names and locations of schools and day care facilities attended by the children of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division of Administrative Hearings, and child support enforcement hearing officers are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

h. The home addresses, telephone numbers, dates of birth, and photographs of current or former human resource, labor relations, or employee relations directors, assistant directors, managers, or assistant managers of any local government agency or water management district whose duties include hiring and firing employees, labor contract negotiation, administration, or other personnel-related duties; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

i. The home addresses, telephone numbers, dates of birth, and photographs of current or former code enforcement officers; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

j. The home addresses, telephone numbers, places of

employment, dates of birth, and photographs of current or former guardians ad litem, as defined in s. 39.820; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

k. The home addresses, telephone numbers, dates of birth, and photographs of current or former juvenile probation officers, juvenile probation supervisors, detention superintendents, assistant detention superintendents, juvenile justice detention officers I and II, juvenile justice detention officer supervisors, juvenile justice residential officers, juvenile justice residential officer supervisors I and II, juvenile justice counselors, juvenile justice counselor supervisors, human services counselor administrators, senior human services counselor administrators, rehabilitation therapists, and social services counselors of the Department of Juvenile Justice; the names, home addresses, telephone numbers, dates of birth, and places of employment of spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

l. The home addresses, telephone numbers, dates of birth, and photographs of current or former public defenders, assistant public defenders, criminal conflict and civil regional counsel, and assistant criminal conflict and civil regional counsel; the names, home addresses, telephone numbers, dates of birth, and

places of employment of the spouses and children of current or former public defenders, assistant public defenders, criminal conflict and civil regional counsel, and assistant criminal conflict and civil regional counsel; and the names and locations of schools and day care facilities attended by the children of current or former public defenders, assistant public defenders, criminal conflict and civil regional counsel, and assistant criminal conflict and civil regional counsel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

m. The home addresses, telephone numbers, dates of birth, and photographs of current or former investigators or inspectors of the Department of Business and Professional Regulation; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such current or former investigators and inspectors; and the names and locations of schools and day care facilities attended by the children of such current or former investigators and inspectors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

n. The home addresses, telephone numbers, and dates of birth of county tax collectors; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such tax collectors; and the names and locations of schools and day care facilities attended by the children of such tax collectors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

o. The home addresses, telephone numbers, dates of birth, and photographs of current or former personnel of the Department of Health whose duties include, or result in, the determination

or adjudication of eligibility for social security disability benefits, the investigation or prosecution of complaints filed against health care practitioners, or the inspection of health care practitioners or health care facilities licensed by the Department of Health; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

p. The home addresses, telephone numbers, dates of birth, and photographs of current or former impaired practitioner consultants who are retained by an agency or current or former employees of an impaired practitioner consultant whose duties result in a determination of a person's skill and safety to practice a licensed profession; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such consultants or their employees; and the names and locations of schools and day care facilities attended by the children of such consultants or employees are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

q. The home addresses, telephone numbers, dates of birth, and photographs of current or former emergency medical technicians or paramedics certified under chapter 401; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such emergency medical technicians or paramedics; and the names and locations of schools and day care facilities attended by the

children of such emergency medical technicians or paramedics are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

r. The home addresses, telephone numbers, dates of birth, and photographs of current or former personnel employed in an agency's office of inspector general or internal audit department whose duties include auditing or investigating waste, fraud, abuse, theft, exploitation, or other activities that could lead to criminal prosecution or administrative discipline; the names, home addresses, telephone numbers, dates of birth, and places of employment of spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

s. The home addresses, telephone numbers, dates of birth, and photographs of current or former directors, managers, supervisors, nurses, and clinical employees of an addiction treatment facility; the home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. For purposes of this sub-subparagraph, the term "addiction treatment facility" means a county government, or agency thereof, that is licensed pursuant to s. 397.401 and provides substance abuse prevention, intervention, or clinical treatment, including any licensed service component described in s. 397.311(26).

t. The home addresses, telephone numbers, dates of birth, and photographs of current or former directors, managers, supervisors, and clinical employees of a child advocacy center that meets the standards of s. 39.3035(2) and fulfills the screening requirement of s. 39.3035(3), and the members of a Child Protection Team as described in s. 39.303 whose duties include supporting the investigation of child abuse or sexual abuse, child abandonment, child neglect, and child exploitation or to provide services as part of a multidisciplinary case review team; the names, home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of such personnel and members; and the names and locations of schools and day care facilities attended by the children of such personnel and members are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

u. The home addresses, telephone numbers, places of employment, dates of birth, and photographs of current or former staff and domestic violence advocates, as defined in s. 90.5036(1)(b), of domestic violence centers certified by the Department of Children and Families under chapter 39; the names, home addresses, telephone numbers, places of employment, dates of birth, and photographs of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

v. The home addresses, telephone numbers, dates of birth, and photographs of current or former inspectors or investigators of the Department of Agriculture and Consumer Services; the

names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of current or former inspectors or investigators; and the names and locations of schools and day care facilities attended by the children of current or former inspectors or investigators are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This sub-subparagraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2028, unless reviewed and saved from repeal through reenactment by the Legislature.

w. The home addresses, telephone numbers, dates of birth, and photographs of current or former personnel of the Agency for Health Care Administration whose duties include the investigation of complaints filed against health care facilities or the inspection of health care facilities licensed or certified by agency; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This sub-subparagraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2029, unless reviewed and saved from repeal through reenactment by the Legislature.

3. An agency that is the custodian of the information specified in subparagraph 2. and that is not the employer of the officer, employee, justice, judge, or other person specified in subparagraph 2. must maintain the exempt status of that information only if the officer, employee, justice, judge, other

person, or employing agency of the designated employee submits a written and notarized request for maintenance of the exemption to the custodial agency. The request must state under oath the statutory basis for the individual's exemption request and confirm the individual's status as a party eligible for exempt status.

4.a. A county property appraiser, as defined in s. 192.001(3), or a county tax collector, as defined in s. 192.001(4), who receives a written and notarized request for maintenance of the exemption pursuant to subparagraph 3. must comply by removing the name of the individual with exempt status and the instrument number or Official Records book and page number identifying the property with the exempt status from all publicly available records maintained by the property appraiser or tax collector. For written requests received on or before July 1, 2021, a county property appraiser or county tax collector must comply with this sub-subparagraph by October 1, 2021. A county property appraiser or county tax collector may not remove the street address, legal description, or other information identifying real property within the agency's records so long as a name or personal information otherwise exempt from inspection and copying pursuant to this section is not associated with the property or otherwise displayed in the public records of the agency.

b. Any information restricted from public display, inspection, or copying under sub-subparagraph a. must be provided to the individual whose information was removed.

5. An officer, an employee, a justice, a judge, or other person specified in subparagraph 2. may submit a written request

for the release of his or her exempt information to the custodial agency. The written request must be notarized and must specify the information to be released and the party authorized to receive the information. Upon receipt of the written request, the custodial agency must release the specified information to the party authorized to receive such information.

6. The exemptions in this paragraph apply to information held by an agency before, on, or after the effective date of the exemption.

7. Information made exempt under this paragraph may be disclosed pursuant to s. 28.2221 to a title insurer authorized pursuant to s. 624.401 and its affiliates as defined in s. 624.10; a title insurance agent or title insurance agency as defined in s. 626.841(1) or (2), respectively; or an attorney duly admitted to practice law in this state and in good standing with The Florida Bar.

8. The exempt status of a home address contained in the Official Records is maintained only during the period when a protected party resides at the dwelling location. Upon conveyance of real property after October 1, 2021, and when such real property no longer constitutes a protected party's home address as defined in sub-subparagraph 1.a., the protected party must submit a written request to release the removed information to the county recorder. The written request to release the removed information must be notarized, must confirm that a protected party's request for release is pursuant to a conveyance of his or her dwelling location, and must specify the Official Records book and page, instrument number, or clerk's file number for each document containing the information to be

released.

9. Upon the death of a protected party as verified by a certified copy of a death certificate or court order, any party can request the county recorder to release a protected decedent's removed information unless there is a related request on file with the county recorder for continued removal of the decedent's information or unless such removal is otherwise prohibited by statute or by court order. The written request to release the removed information upon the death of a protected party must attach the certified copy of a death certificate or court order and must be notarized, must confirm the request for release is due to the death of a protected party, and must specify the Official Records book and page number, instrument number, or clerk's file number for each document containing the information to be released. A fee may not be charged for the release of any document pursuant to such request.

10. Except as otherwise expressly provided in this paragraph, this paragraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2024, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that the home addresses, telephone numbers, dates of birth, and photographs of current or former personnel of the Agency for Health Care Administration whose duties include the investigation of complaints filed against health care facilities or the inspection of health care facilities licensed or certified by the Agency for Health Care Administration; the names, home addresses, telephone numbers, dates of birth, and

places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. The Legislature finds that the release of such personal identifying and location information might place the agency's current or former personnel and their family members in danger of physical and emotional harm from disgruntled individuals who have contentious reactions to actions carried out by such personnel or whose business or professional practices have come under scrutiny as a result of such investigations and agency actions. The Legislature further finds that the harm that may result from the release of such personal identifying and location information outweighs any public benefit that may be derived from the disclosure of the information.

Section 3. This act shall take effect July 1, 2024.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 17, 2024

I respectfully request that **Senate Bill # 1632**, relating to Public Records/Personnel of the Agency for Health Care Administration, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Jay Collins
Florida Senate, District 14

File signed original with committee office

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/2024
Meeting Date

Health Policy
Committee

SB 1632
Bill Number or Topic

Amendment Barcode (if applicable)

Name Patricia Steele

Phone (904) 955-0331

Address 2727 Mahan Dr.
Street

Email Patricia.Steele@AHCA.myflorida.com

Tallahassee FL 32308
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
AHCA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 1188
INTRODUCER:	Health Policy Committee and Senator Garcia
SUBJECT:	Office Surgeries
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AHS	
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1188 provides additional enforcement authority to the Department of Health (DOH) over physician offices in which physicians perform certain liposuction procedures or gluteal fat grafting procedures, also known as Brazilian Butt Lifts (BBLs).

The bill requires that, in addition to other circumstances that require office registration:

- Physicians must register their offices with the DOH if they perform liposuction procedures in their offices in which more than 1,000 cc of supernatant fat is temporarily or permanently removed. Current law does not specify temporarily or permanently.
- Physicians must register their offices with the DOH if they perform gluteal fat grafting procedures in their offices. Current law does not expressly require registration for the performance of such procedures by name.
- Physicians must register their offices with the DOH if they perform liposuction procedures in their offices during which the patient is rotated 180 degrees or more.

The bill modifies the penalty for performing surgery in an unregistered office, if the surgery requires office registration, from a fine of $5,000 per day to $5,000 per incident, to allow the DOH to fine a physician for multiple offenses committed during the same day.

The bill requires that physicians who have registered their offices prior to July 1, 2024, must re-register, in accordance with a schedule developed by the DOH, if a physician performs gluteal

fat grafting procedures or liposuction procedures in which the patient is rotated 180 degrees or more in that office.

The bill requires that if, during the re-registration process, the DOH determines that the procedures being performed in the office create a significant risk to patient safety and the interests of patient safety would be better served if the office were licensed and regulated as an ambulatory surgical center (ASC), then the DOH must notify the Agency for Health Care Administration (AHCA) and the AHCA must inspect the office and determine, in the interests of patient safety, whether the office is a candidate for ASC licensure. If the AHCA determines the office is a candidate for ASC licensure, then the bill requires the AHCA to notify the office and the DOH. The bill requires that an office so notified must cease performing procedures that require re-registration and prohibits such procedures from being performed there until the office relinquishes its registration and obtains an ASC license.

The bill also applies the heightened inspection procedure (described above for offices required to seek re-registration) to an office seeking initial registration, if the DOH determines that a physician is likely to perform, or will be performing, liposuction procedures during which the patient is rotated 180 degrees or more or gluteal fat grafting procedures in the office.

The bill takes effect upon becoming law.

II. Present Situation:

Regulation of Office Surgeries

The Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) (collectively, the boards)[1], within the DOH[2], have authority to adopt rules to regulate practice of medicine and osteopathic medicine, respectively. The boards have authority to establish, by rule, standards of practice for particular settings.[3] Such standards may include education and training; medications, including anesthetics; assistance of and delegation to other personnel; sterilization; performance of complex or multiple procedures; records; informed consent; and policy and procedures manuals.[4]

The boards set forth the standards of practice that must be met for office surgeries. An office surgery is any surgery that is performed outside a facility licensed under ch. 390, F.S., or ch. 395, F.S.[5] There are several levels of office surgeries governed by rules adopted by the boards, which set forth the scope of each level of office surgeries, the equipment and medications that must be available, and the training requirements for personnel present during the surgery.

[1]Chapter 458, F.S., regulates the practice of allopathic medicine, and ch. 459, F.S., regulates the practice of osteopathic medicine.
[2] The Dept. of Health, Division of Medical Quality Assurance (MQA), serves as the principle administrative unit for the Board of Medicine and the Board of Osteopathic Medicine.
[3] Sections 458.331(v) and 459.015(z), F.S.
[4] *Id.*
[5] Fla. Admin. Code Rs. 64B8-9.009(1)(d) and 64B15-14.007(1)(d), (2023). Abortion clinics are licensed under ch. 390, F.S., and facilities licensed under ch. 395, F.S., include hospitals, ambulatory surgery centers, mobile surgical facilities, and certain intensive residential treatment programs.

Registration

A physician is required to register his or her office with the DOH to perform liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed, a level II office surgery, or a level III office surgery.[6]

Each registered office must designate a physician who is responsible for complying with all laws and regulations establishing safety requirements for such offices.[7] The designated physician is required to notify the DOH within 10 days of hiring any new recovery or surgical team personnel.[8] The office must notify the DOH within 10 calendar days after the termination of a designated physician relationship.[9]

The DOH must inspect any office where office surgeries will be done before the office is registered.[10] If the office refuses such inspection, it will not be registered until the inspection can be completed. If an office that has already been registered with the DOH refuses inspection, its registration will be immediately suspended and remain suspended until the inspection is completed, and the office must close for 14 days.[11]

The DOH must inspect each registered office annually unless the office is accredited by a nationally recognized accrediting agency approved by the respective board. Such inspections may be unannounced.[12]

The DOH's license verification web page indicates there are 1,816 office surgery registrations.[13]

Standards of Practice

Prior to performing any surgery, a physician must evaluate the risks of anesthesia and the surgical procedure to be performed.[14] A physician must maintain a complete record of each surgical procedure, including the anesthesia record, if applicable, and written informed consent.[15] The written consent must reflect the patient's knowledge of identified risks, consent to the procedure, type of anesthesia and anesthesia provider, and that a choice of anesthesia provider exists.[16]

[6] Sections 458.328(1) and 459.0138(1), F.S.
[7] Fla Admin. Code Rs. 64B8-9.0091(1) and 64B15-14.0076(1), (2023).
[8] *Id.*
[9] *Id.*
[10] *Supra* note 5.
[11] *Id.*
[12] *Id.*
[13] Florida Agency for Health Care Administration, House Bill 1561, 2024 Agency Legislative Bill Analysis (Jan. 18, 2024) (on file with the Senate Committee on Health Policy).
[14] Fla. Admin. Code Rs. 64B8-9.009(2) and 64B15-14.007(2), (2023).
[15] *Id.* A physician does not need to obtain written informed consent for minor Level I procedures limited to the skin and mucosa.
[16] *Id.* A patient may use an anesthesiologist, anesthesiologist assistant, another appropriately trained physician, certified registered nurse anesthetist, or physician assistant.

Physicians performing office surgeries must maintain a log of all liposuction procedures in which more than 1,000 cubic centimeters of supernatant fat is removed and Level II and Level III surgical procedures performed, which includes:[17]

- A confidential patient identifier;
- The time the patient arrives in the operating suite;
- The name of the physician who provided medical clearance;
- The surgeon's name;
- The diagnosis;
- The CPT codes for the procedures performed;
- The patient's ASA classification;
- The type of procedure performed;
- The level of surgery;
- The anesthesia provider;
- The type of anesthesia used;
- The duration of the procedure;
- The type of post-operative care;
- The duration of recovery;
- The disposition of the patient upon discharge;
- A list of medications used during surgery and recovery; and
- Any adverse incidents.

Such logs must be maintained for at least six years from the last patient contact and must be provided to the DOH investigators upon request.[18]

For elective cosmetic and plastic surgery procedures performed in a physician's office:[19]

- The maximum planned duration of all planned procedures cannot exceed eight hours.
- A physician must discharge the patient within 24 hours, and overnight stay may not exceed 23 hours and 59 minutes.
- The overnight stay is strictly limited to the physician's office.
- If the patient has not sufficiently recovered to be safely discharged within the 24-hour period, the patient must be transferred to a hospital for continued post-operative care.

Office surgeries are prohibited from:

- Resulting in blood loss greater than ten percent of blood volume in a patient with normal hemoglobin;
- Requiring major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, excluding laparoscopy;
- Involving a major blood vessel with direct visualization by open exposure of the vessel, not including percutaneous endovascular treatment[20]; or
- Being emergent or life threatening.

[17] Fla. Admin. Code Rs. 64B8-9.009(2)(a) and 64B15-14.007(2)(a), (2023).
[18] *Id.*
[19] Fla. Admin. Code Rs. 64B8-9.009(2)(f) and 64B15-14.007(2)(f), (2023).
[20] Such treatment addresses conditions such as peripheral artery disease and other arterial blockages.

Levels of Office Surgeries

Level I

Level I involves the most minor of surgeries, which require minimal sedation[21] or local or topical anesthesia, and have a remote chance of complications requiring hospitalization.[22] Level I procedures include:[23]

- Minor procedures such as excision of skin lesions, moles, warts, cysts, lipomas and repair of lacerations, or surgery limited to the skin and subcutaneous tissue performed under topical or local anesthesia not involving drug-induced alteration of consciousness other than minimal pre-operative tranquilization of the patient;
- Liposuction involving the removal of less than 4,000 cc supernatant fat; and
- Incision and drainage of superficial abscesses, limited endoscopies such as proctoscopies, skin biopsies, arthrocentesis, thoracentesis, paracentesis, dilation of urethra, cryptoscopic procedures, and closed reduction of simple fractures or small joint dislocations (e.g., finger and toe joints).

Level II

Level II office surgeries involve moderate sedation[24] and require the physician office to have a transfer agreement with a licensed hospital that is no more than 30 minutes from the office.[25] Level II office surgeries, include but are not limited to:[26]

- Hemorrhoidectomy, hernia repair, large joint dislocations, colonoscopy, and liposuction involving the removal of up to 4,000 cc supernatant fat; and
- Any surgery in which the patient's level of sedation is that of moderate sedation and analgesia or conscious sedation.

A physician performing a Level II office surgery must:[27]

- Have staff privileges at a licensed hospital to perform the same procedure in that hospital as the surgery being performed in the office setting;
- Demonstrate to the appropriate board that he or she has successfully completed training directly related to and include the procedure being performed, such as board certification or eligibility to become board-certified; or
- Demonstrate comparable background, training, or experience.

[21] Minimal sedation is a drug-induced state during which the patient responds normally to verbal commands. Although cognitive function and physical coordination may be impaired, airway reflexes, and ventilator and cardiovascular functions are not impaired. Controlled substances are limited to oral administration in doses appropriate for the unsupervised treatment of insomnia, anxiety, or pain.
[22] Fla. Admin. Code Rs. 64B8-9.009(3) and 64B15-14.007(3), (2023).
[23] *Id.*
[24] Moderate sedation or conscious sedation is a drug-induced depression of consciousness during which a patient responds purposefully to verbal commands, either alone or accompanied by light tactile stimulations. No interventions are needed to manage the patient's airway and spontaneous ventilation is adequate. Cardiovascular function is maintained. Reflex withdrawal from a painful stimulus is not considered a purposeful response.
[25] Fla. Admin. Code Rs. 64B8-9.009(4) and 64B15-14.007(4), (2023).
[26] *Id.*
[27] *Id.*

A physician, or a facility where the procedure is being performed, must have a transfer agreement with a licensed hospital within a reasonable proximity[28] if the physician performing the procedure does not have staff privileges to perform the same procedure at a licensed hospital within a reasonable proximity.

Anesthesiology must be performed by an anesthesiologist, a certified registered nurse anesthetist (CRNA), or a qualified physician assistant (PA). An appropriately-trained physician, PA, or registered nurse with experience in post-anesthesia care, must be available to monitor the patient in the recovery room until the patient is recovered from anesthesia.[29]

Level IIA

Level IIA office surgeries are those Level II surgeries with a maximum planned duration of five minutes or less and in which chances of complications requiring hospitalization are remote.[30] A physician, physician assistant, registered nurse, or licensed practical nurse must assist the surgeon during the procedure and monitor the patient in the recovery room until the patient is recovered from anesthesia.[31] The assisting health care practitioner must be appropriately certified in advanced cardiac life support, or in the case of pediatric patients, pediatric advanced life support.[32]

Level III

Level III office surgeries are the most complex and require deep sedation or general anesthesia.[33] A physician performing the surgery must have staff privileges to perform the same procedure in a hospital.[34] The physician must also have knowledge of the principles of general anesthesia.

Only patients classified under the American Society of Anesthesiologist's (ASA) risk classification criteria as Class I or II[35] are appropriate candidates for Level III office surgery. For all ASA Class II patients above the age of 50, the surgeon must obtain a complete work-up

[28] Transport time to the hospital must be 30 minutes of less.
[29] *Id.* The assisting practitioner must be trained in advanced cardiovascular life support, or for pediatric patients, pediatric advanced life support.
[30] Fla. Admin. Code Rs. 64B-9.009(5) and 64B15-14.007(5), (2023).
[31] *Id.*
[32] *Id.*
[33] Deep sedation is a drug-induced depression of consciousness during which a patient cannot be easily aroused but responds purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. A patient may require assistance in maintaining a patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. General anesthesia is a drug-induced loss of consciousness during which a patient is not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired. The use of spinal or epidural anesthesia is considered Level III.
[34] Fla. Admin. Code Rs. 64B8-9.009(6) and 64B15-14.007(6), (2023). The physician may also document satisfactory completion of training directly related to and include the procedure being performed.
[35] An ASA Class I patient is a normal, healthy, non-smoking patient, with no or minimal alcohol use. An ASA Class II patient is a patient with mild systemic disease without substantive functional limitations. Examples include current smoker, social alcohol drinker, pregnancy, obesity, well-controlled hypertension with diabetes, or mild lung disease. *See* American Society of Anesthesiologists, *ASA Physical Status Classification System*, (Oct. 15, 2014, last amended Dec. 13, 2020), available at https://www.asahq.org/standards-and-guidelines/asa-physical-status-classification-system (last visited on Feb. 2, 2024).

performed prior to the performance of Level III surgery in a physician office setting.[36] If the patient has a cardiac history or is deemed to be a complicated medical patient, the patient must have a preoperative electrocardiogram and be referred to an appropriate consultant for medical optimization. The referral to a consultant may be waived after evaluation by the patient's anesthesiologist.[37] All Level III surgeries on patients classified as ASA III[38] and higher must be performed in a hospital or an ambulatory surgery center.

During the procedure, the physician must have one assistant who has current certification in advanced cardiac life support. Additionally, the physician must have emergency policies and procedures related to serious anesthesia complications, which address:

- Airway blockage (foreign body obstruction);
- Allergic reactions;
- Bradycardia;
- Bronchospasm;
- Cardiac arrest;
- Chest pain;
- Hypoglycemia;
- Hypotension;
- Hypoventilation;
- Laryngospasm;
- Local anesthetic toxicity reaction; and
- Malignant hypothermia.

Gluteal Fat Grafting Procedure

Gluteal fat grafting (a.k.a. the Brazilian Butt Lift or BBL) is a surgical procedure that takes supernatant fat from one part of a person's body by liposuction, usually from the waist, back, or abdomen, purifies the supernatant fat, and then injects the supernatant fat in tiny droplets back into the patient's buttocks. The amount of supernatant fat that is temporarily removed from one part of the body and then transferred to the buttocks varies greatly between patients, and the patient may be turned 180 degrees while under general anesthesia following harvesting of the supernatant fat.[39]

When a surgeon performs a gluteal fat grafting procedure in an office setting, supernatant fat is removed from various parts of the patient's body but may only be injected into the subcutaneous space of the buttocks and must never cross the gluteal muscle fascia. Intramuscular or submuscular fat injections are prohibited.[40]

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[36] *Id.*
[37] *Id.*
[38] An ASA Class III patient is a patient with severe systemic disease who has substantive functional limitations and/or one or more moderate to severe diseases. This may include poorly controlled diabetes or hypertension, chronic obstructive pulmonary disease, morbid obesity, active hepatitis, alcohol dependence or abuse, implanted pacemaker, premature infant, recent history of myocardial infarction, cerebrovascular disease, transient ischemic attack, or coronary artery disease.
[39] McLintock, Kaitlyn, *Your Comprehensive Guide To The Brazilian Butt Lift*, (Oct. 29, 2021) available at https://plasticsurgerypractice.com/treatment-solutions/innovations/industry-trends/your-comprehensive-guide-to-the-brazilian-butt-lift/ (last visited Feb. 2,, 2024).
[40] Fla. Admin. Code Rs. 64B8-9.009(2)(c) and 64B15-14.007(2)((c) (2023).

The risks associated with a gluteal fat grafting procedure include:[41]

- Excessive bleeding;
- Fat embolism, or fat that gets stuck in a vein and then in the lungs;
- Seroma, or fluid build-up under the skin;
- Necrosis, or large volumes of supernatant fat cells that fail to survive transfer;
- Significant scarring;
- Undesirable results; and
- Death.

The rate of fatal complications from gluteal fat grafting is higher than any other cosmetic procedure.[42] South Florida carries the highest BBL mortality rate, by far, in the nation with 25 deaths occurring between 2010 and 2022.[43] According to a study of the deaths that occurred in South Florida, the surgical setting and the short surgical times for these cases were the most significant contributing factors to the deaths.[44] Of the 25 deaths, 23 of the surgeries were found to have been performed at what the researchers classified as high-volume, low-budget clinics. These clinics were found to have employed a practice model based on minimal patient interaction. All of the deaths resulted from pulmonary fat embolism, which occurs when a vein wall is injured during the injection process, allowing fat to enter the pulmonary vessels.[45]

360 Degree Liposuction Procedures

The 360 degree Liposuction may include liposuction of areas of body, including but not limited to the following, while under general anesthesia:

- Upper back;
- Lower back;
- Hip roll;
- Mid back;
- Flanks;
- Abdomen;
- Arms;
- Thighs; and
- Presacral triangle.

The 360 Degree Liposuction Combined with a BBL

The 360 degree liposuction with the BBL is a new popular cosmetic procedure and is actually two surgical procedures performed at the same time.[46] The 360 degree liposuction harvests

[41] Cleveland Clinic, *Fat Transfer*, available at https://my.clevelandclinic.org/health/treatments/24027-fat-transfer (last visited Feb. 2, 2024).
[42] Pazmiño, Pat; Garcia, Onelio, *Brazilian Butt Lift–Associated Mortality: The South Florida Experience*, Aesthetic Surgery Journal, Vol. 43, (Feb 2023), pps. 162–178, available at https://doi.org/10.1093/asj/sjac224 (last visited Feb. 2, 2024).
[43] *Id.*
[44] *Id.*
[45] *Id.*
[46] Kao, Y.-M.; Chen, K.-T.;Lee, K.-C.; Hsu, C.-C.; Chien, Y.-C., *Pulmonary Fat Embolism Following Liposuction and Fat Grafting: A Review of Published Cases.* Healthcare (May 11 2023), 11, 1391. available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10218620/pdf/healthcare-11-01391.pdf (last visited Feb. 2, 2024).

excess supernatant fat from various areas of the body as noted above and involves turning the patient over 360 degrees while under general anesthesia; and then placing the patient on his or her abdomen, face down, and undergoing a BBL.[47]

The risks associated with the 360 degree liposuction with the BBL includes:

- Hemorrhage;
- Pain;
- Skin discoloration;
- Infections,
- Fluid accumulation;
- Blood building up at the incision or underneath the buttocks;
- Skin loss; and
- Pulmonary embolism.[48]

Adding the BBL to 360 degree liposuction makes the procedure longer and potentially more dangerous, especially regarding the complication of a fat embolism and excessive blood loss, which could lead to death.[49]

The Vasovagal Response

During general anesthesia for a 360 degree liposuction and BBL there is also the possible complication of excessive vasovagal stimulation caused by turning the patient over 180 degrees or 360 degrees, creating life-threatening vasovagal syncope and triggering bradycardia, hypotension, and progressing to cardiac arrest and even death.[50] Painful stimulus of the bronchial, pharyngeal, laryngeal, esophageal mucosa and peritoneum stretch, and reduced blood volume can increase the vagal activity, leading to severe bradycardia, hypotension, and cardiac arrest. Even venous cannulation, neuraxial, and regional anesthesia techniques have been attributed to vasovagal syncope.[51]

Under Florida law, liposuction may be performed in combination with another separate surgical procedure during a single Level II or Level III operations, only in the following circumstances:[52]

- When combined with abdominoplasty, liposuction may not exceed 1,000 cc of supernatant fat;

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[47] McLintock, Kaitlyn, *Your Comprehensive Guide To The Brazilian Butt Lift,* (Oct. 29, 2021) available at https://plasticsurgerypractice.com/treatment-solutions/innovations/industry-trends/your-comprehensive-guide-to-the-brazilian-butt-lift/ (last visited Feb. 2, 2024).

[48] *Id*.

[49] Kaiser HA, Saied NN, Kokoefer AS, Saffour L, Zoller JK, Helwani MA.,PLOS ONE, (Jan. 22, 2020) Incidence and prediction of intraoperative and postoperative cardiac arrest requiring cardiopulmonary resuscitation and 30-day mortality in non-cardiac surgical patients, available at https://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0225939&type=printable (last visited Feb. 2, 2024).

[50] *Id*.

[51] Hosie L, Wood JP, Thomas AN. Vasovagal syncope and anaesthetic practice. Eur. J. Anaesthesiology(Aug. 2001) available at https://journals.lww.com/ejanaesthesiology/fulltext/2001/08000/vasovagal_syncope_and_anaesthetic_practice.11.aspx (last visited Feb. 2, 2024).

[52] Fla. Admin. Code Rs. 64B8-9.009(2)(e) and 64B15-14.007(2)((e) (2023).

- When liposuction is associated and directly related to another procedure, the liposuction may not exceed 1,000 cc of supernatant fat; and
- Major liposuction in excess of 1,000 cc supernatant fat may not be performed in a remote location from any other procedure.

A maximum of 4,000 cc supernatant fat may be removed by liposuction in the office setting.[53]

Standards of Practice for a Gluteal Fat Grafting Procedures in Office Surgery Setting

A physician performing a gluteal fat grafting procedure in an office setting must conduct an in-person examination of the patient while physically present in the same room as the patient, no later than the day before the procedure.[54]

If a surgeon desires to delegate any of his or her duties during a gluteal fat grafting procedure, he or she must obtain the patient's written, informed consent for the delegation. Any delegated duty must be performed under the direct supervision of the physician performing the procedure. The surgeon may not delegate the supernatant extraction or the gluteal fat injections. The supernatant fat may only be injected into the subcutaneous space of the patient's buttocks and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular supernatant fat injections are prohibited.[55]

When the physician performing a gluteal fat grafting procedure injects the supernatant fat into the subcutaneous space of the patient's buttocks, the physician must use ultrasound guidance, or another form of guidance or technology authorized under BOM or BOOM rule, as applicable, which is equal to, or exceeds, the quality of ultrasound, during the placement and navigation of the cannula, to ensure that the supernatant fat is injected into the subcutaneous space above the fascia overlying the gluteal muscle. Ultrasound guidance is not required for other portions of the procedure.[56]

Adverse Incident Reporting

A physician must report any adverse incident that occurs in an office setting to the DOH within 15 days after the occurrence.[57] An adverse incident in an office setting is defined as an event over which the physician or licensee could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:[58]

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

[53] Fla. Admin. Code Rs. 64B8-9.009(2)(d) and 64B15-14.007(2)((d) (2023).
[54] Sections 458.328(2)(c) and 459.0138 (2)(c), F.S.
[55] *Id.*
[56] *Id.*
[57] Sections 458.351 and 459.026, F.S.
[58] Sections 458.351(4) and 459.026(4), F.S.

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

The DOH must review each adverse incident report to determine if discipline against the practitioner's license is warranted.[59]

DOH Regulatory Authority of Office Surgeries

The DOH and the respective boards may deny or revoke an office surgery's registration if any of its physicians, owners, or operators do not comply with any office surgery laws or rules. The DOH may deny a person applying for a facility registration if he or she was named in the registration document of an office whose registration is revoked for five years after the revocation date. The DOH may impose penalties on the designated physician if the registered office is not in compliance with safety requirements, including:[60]

- Suspension or permanent revocation of a license;
- Restriction of license;
- Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board must impose a fine of $10,000 per count or offense;
- Issuance of a reprimand or letter of concern:
- Placement of the licensee on probation for a period of time and subject to such conditions as specified by the board;
- Corrective action;
- Imposition of an administrative fine in accordance with s. 381.0261, F.S., for violations regarding patient rights;
- Refund of fees billed and collected from the patient or a third party on behalf of the patient; or
- Requirement that the licensee undergo remedial education.

The DOH, via the Surgeon General, can also issue an emergency order suspending or restricting the registration of a facility if there is probable cause that:

- The office or its physicians are not in compliance with board rule on the standards of practice or The licensee or registrant is practicing or offering to practice beyond the scope allowed by law or beyond his or her competence to perform; and
- Such noncompliance constitutes an immediate danger to the public.

[59] Sections 458.351(5) and 459.026(5), F.S.
[60] Section 456.072(2), F.S.

The boards must adopt rules establishing the standards of practice for physicians who perform office surgery. The boards must fine physicians who perform office surgeries in an unregistered facility $5,000 per day. Performing office surgery in a facility that is not registered with the DOH is grounds for disciplinary action against a physician's license.

Ambulatory Surgical Centers

An ASC is a facility that is not a part of a hospital, the primary purpose of which is to provide elective surgical care, in which the patient is admitted and discharged within 24 hours.[61] If a provider anticipates or knows that he or she will be discharging patients beyond 24 hours, he or she must self-designate as an ASC by applying for ASC licensure with the AHCA. An ASC is licensed and regulated by the AHCA under the same regulatory framework as hospitals.[62] Currently, there are 520 licensed ASCs in Florida.[63]

III. Effect of Proposed Changes:

CS/SB 1188 requires physicians to register their offices with the DOH if they perform liposuction procedures in their offices in which more than 1,000 cc of supernatant fat is temporarily or permanently removed. Current law does not specify temporarily or permanently.

The bill requires physicians to register their offices with the DOH if they perform gluteal fat grafting procedures in their offices. Current law does not expressly require registration for the performance of such procedures by name.

The bill requires physicians to register their offices with the DOH if they perform liposuction procedures in their offices during which the patient is rotated 180 degrees or more.

The bill modifies the penalty for performing surgery in an unregistered office, if the surgery requires office registration, from a fine of $5,000 per day to $5,000 per incident, to allow the DOH to fine a physician for multiple offenses committed during the same day.

The bill requires that physicians who have registered their offices prior to July 1, 2024, must re-register, in accordance with a schedule developed by the DOH, if a physician performs gluteal fat grafting procedures or liposuction procedures in which the patient is rotated 180 degrees or more in that office.

The bill requires that if, during the re-registration process, the DOH determines that the procedures being performed in the office create a significant risk to patient safety and the interests of patient safety would be better served if the office were licensed and regulated as an ASC, then the DOH must notify the AHCA, and the AHCA must inspect the office and determine, in the interests of patient safety, whether the office is a candidate for ASC licensure, notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding any pertinent exceptions provided in the definition of an

[61] Section 395.002(3), F.S.
[62] Sections 395.001-.1065, F.S., and Part II, Chapter 408, F.S.
[63] Florida Agency for Health Care Administration, House Bill 1561, 2024 Agency Legislative Bill Analysis (Jan. 18, 2024) (on file with the Senate Committee on Health Policy).

ASC under s. 395.002(3), F.S.[64] If the AHCA determines that the office is a candidate for ASC licensure, then the bill requires the AHCA to notify the office and the DOH. The bill requires that an office so notified must cease performing procedures that require re-registration and prohibits such procedures from being performed there until the office relinquishes its registration and obtains an ASC license.

The bill also applies the heightened inspection procedure (described above for offices required to seek re-registration) to an office seeking initial registration, if the DOH determines that a physician is likely to perform, or will be performing, liposuction procedures during which the patient is rotated 180 degrees or gluteal fat grafting procedures in the office.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

A portion of the bill may present an unconstitutional delegation of legislative authority under Article II, Section 3 of the Florida Constitution.

During an office's initial registration process, and the re-registration process required under the bill, the bill requires that *"if the [DOH] determines that the performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:"*

- The DOH must notify the AHCA of its determination;
- The AHCA must inspect the office "*and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure notwithstanding the office's failure to meet all requirements associated with such*

[64] Section 395.002(3), F.S., provides exceptions from the definition of an ASC, including that an office maintained by a physician for the practice of medicine may not be construed to be an ASC.

licensure at the time of inspection and notwithstanding the exceptions provided under s. 395.002(3)"; and

- If the AHCA determines that an office is a *"candidate"* for ASC licensure, then the AHCA must notify the office and the DOH, and the office must cease performing procedures requiring re-registration.

The bill:

- Does not define *"a significant risk to patient safety;"*
- Does not provide criteria for the DOH or the AHCA inspectors to utilize in determining what *"creates a significant risk to patient safety"* such that *"the interests of patient safety would be better served"* if such procedures were instead regulated under the requirements of an ASC; and
- Does not define what is meant by *"a candidate for ambulatory surgical center licensure."*

These missing items in the bill could be interpreted to represent fundamental pieces of state policy that the Legislature may need to create instead of delegating that task to the executive branch.

As such, this portion of the bill may represent an unconstitutional delegation of legislative authority under Article II, Section 3 of the Florida Constitution. *See* Askew v. Cross Key Waterways, 372 So. 2d 913, 925 (Fla. 1978); see also Avatar Dev. Corp. v. State; 723 So. 2d 199, 202 (Fla. 1998) (citing Askew with approval). "…fundamental and primary policy decisions must be made by members of the legislature who are elected to perform those tasks, and administration of legislative programs must be pursuant to some minimal standards and guidelines ascertainable by reference to the enactment establishing the program."

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

According to the DOH, MQA will experience a non-recurring increase in workload and costs associated with updating the Licensing and Enforcement Information Database System (LEIDS) and Iron Data Mobile (IDM) inspection software to update inspection requirements. MQA will also experience a non-recurring workload increase to update the artificial intelligence virtual agent (ELI) for voice and web, Search Services application,

data reporting, and board and DOH websites. Additionally, MQA may be required to create data exchange services with the AHCA.[65]

VI. Technical Deficiencies:

None.

VII. Related Issues:

Under the bill, certain office surgery registrants need to be re-registered and inspected by December 1, 2024. The DOH advises that it currently has five OPS registered nurse consultants to complete such inspections, and it would take approximately six months to re-register and inspect all affected physician offices, if the nurse consultants do no other DOH work. Based on this, DOH requests the re-registration timeframe be extended to June 30, 2025.[66]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.328 and 459.0138.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute applies the bill's heightened inspection procedure (that the bill requires for offices seeking re-registration) to applicants for initial office surgery registration, if the DOH determines that a physician will perform, or is likely to perform, liposuction procedures during which the patient is rotated 180 degrees or more or gluteal fat grafting procedures in the office.

B. Amendments:

None.

[65] Florida Department of Health, House, Senate Bill 1188, 2024 Agency Legislative Bill Analysis (Jan. 11, 2024) (on file with the Senate Committee on Health Policy).
[66] *Id.*

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Garcia) recommended the following:

Senate Amendment (with title amendment)

Delete lines 47 - 293

and insert:

3. If the department determines that an office seeking registration under this section is one in which a physician is likely to perform, or intends to perform, liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician is likely to perform, or intends to perform, gluteal fat grafting procedures, and the

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department determines that the performance of such procedures in the office would create a significant risk to patient safety and the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

a. The department must notify the Agency for Health Care Administration of its determination.

b. The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure, notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding any pertinent exceptions provided under s. 395.002(3).

c. If the agency determines that an office is a candidate for ambulatory surgical center licensure under sub-subparagraph b., the agency must notify the office and the department, and the office may not register under this section and must instead attain ambulatory surgical center licensure under chapter 395 before such surgeries may be conducted in the office.

d. If the agency determines that an office is not a candidate for ambulatory surgical center licensure under sub-subparagraph b., the agency must notify the office and the department, and the department shall resume the office's registration process.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 459.0138 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted hereunder. A designated physician must have a full, active, and


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unencumbered license under this chapter or chapter 459 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend the registration of an office if the office fails to comply with the requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

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3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice under this subsection and rules adopted by the board, which include, but are not limited to, all of the following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and

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navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in hospitalization, the incident must be reported as an adverse incident pursuant to s. 458.351.

~~(c) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs liposuction procedures that include a patient being rotated 180

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degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination; and

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure, notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding any pertinent exceptions provided under s. 395.002(3).

If the agency determines that an office is a candidate for ambulatory surgical center licensure under paragraph (b), the agency must notify the office and the department, and the office must cease performing procedures described in this subsection. The office may not recommence performing such procedures without first relinquishing its registration under this section and attaining ambulatory surgical center licensure under chapter 395.

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Section 2. Paragraphs (a), (b), and (h) of subsection (1) and subsection (2) of section 459.0138, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

459.0138 Office surgeries.—

(1) REGISTRATION.—

(a)1. An office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a liposuction procedure in which the patient is rotated 180 degrees or more during the procedure, a gluteal fat grafting procedure, a Level II office surgery, or a Level III office surgery must register with the department. ~~unless the office is licensed as~~ A facility licensed under chapter 390 or chapter 395 may not be registered under this section.

2. The department must complete an inspection of any office seeking registration under this section before the office may be registered.

3. If the department determines that an office seeking registration under this section is one in which a physician is likely to perform, or intends to perform, liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician is likely to perform, or intends to perform, gluteal fat grafting procedures, and the department determines that the performance of such procedures in the office would create a significant risk to patient safety and the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

a. The department must notify the Agency for Health Care

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Administration of its determination.

b. The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure, notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding any pertinent exceptions provided under s. 395.002(3).

c. If the agency determines that an office is a candidate for ambulatory surgical center licensure under sub-subparagraph b., the agency must notify the office and the department, and the office may not register under this section and must instead attain ambulatory surgical center licensure under chapter 395 before such surgeries may be conducted in the office.

d. If the agency determines that an office is not a candidate for ambulatory surgical center licensure under sub-subparagraph b., the agency must notify the office and the department, and the department shall resume the office's registration process.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 458.328 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted hereunder. A designated physician must have a full, active, and unencumbered license under this chapter or chapter 458 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend a

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registration for an office if the office fails to comply with the requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of

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practice under this subsection and rules adopted by the board, which include, but are not limited to, all of the following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat

grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in hospitalization, the incident must be reported as an adverse incident pursuant to s. 458.351.

~~(c) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the

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performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination;

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding any pertinent exceptions provided under s. 395.002(3).

================ 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:

surgeries; specifying notification and inspection procedures for the department and the Agency for Health Care Administration if, during the registration process, the department determines that the performance of specified procedures in the office would create a risk to patient safety such that the office should instead be regulated as an ambulatory surgical center; deleting obsolete language; making

By Senator Garcia

36-01129-24 20241188__

A bill to be entitled

An act relating to office surgeries; amending ss. 458.328 and 459.0138, F.S.; revising the types of procedures for which a medical office must register with the Department of Health to perform office surgeries; deleting obsolete language; making technical and clarifying changes; revising standards of practice for office surgeries; requiring medical offices already registered with the department to perform certain office surgeries as of a specified date to reregister if such offices perform specified procedures; specifying notification and inspection procedures for the department and the Agency for Health Care Administration in the event that, during the reregistration process, the department determines that the performance of specified procedures in an office creates a risk of patient safety such that the office should instead be regulated as an ambulatory surgical center; requiring an office to cease performing the specified procedures and relinquish its office surgery registration and instead seek licensure as an ambulatory surgical center under such circumstances; requiring the department to develop a schedule for reregistration of medical offices affected by this act, to be completed by a specified date; providing an effective date.

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

Section 1. Paragraphs (a), (b), and (h) of subsection (1) and subsection (2) of section 458.328, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

458.328 Office surgeries.—

(1) REGISTRATION.—

(a)1. An office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a liposuction procedure in which the patient is rotated 180 degrees or more during the procedure, a gluteal fat grafting procedure, a Level II office surgery, or a Level III office surgery must register with the department. ~~unless the office is licensed as~~ A facility licensed under chapter 390 or chapter 395 may not be registered under this section.

2. The department must complete an inspection of any office seeking registration under this section before the office may be registered.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 459.0138 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted hereunder. A designated physician must have a full, active, and unencumbered license under this chapter or chapter 459 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend the registration of an office if the office fails to comply with the

requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice under this subsection and rules adopted by the board,

which include, but are not limited to, all of the following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one

physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in hospitalization, the incident must be reported as an adverse incident pursuant to s. 458.351.

~~(c) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the performance of such procedures in the office creates a

significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination;

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding the exceptions provided under s. 395.002(3).

If the agency determines that an office is a candidate for ambulatory surgical center licensure under paragraph (b), the agency must notify the office and the department, and the office must cease performing procedures described in this subsection. The office may not recommence performing such procedures without first relinquishing its registration under this section and attaining ambulatory surgery center licensure under chapter 395.

Section 2. Paragraphs (a), (b), and (h) of subsection (1) and subsection (2) of section 459.0138, Florida Statutes, are amended, and subsection (4) is added to that section, to read:

459.0138 Office surgeries.—

(1) REGISTRATION.—

(a)1. An office in which a physician performs a liposuction procedure in which more than 1,000 cubic centimeters of supernatant fat is temporarily or permanently removed, a liposuction procedure in which the patient is rotated 180

degrees or more during the procedure, a gluteal fat grafting procedure, a Level II office surgery, or a Level III office surgery must register with the department. ~~unless the office is licensed as~~ A facility licensed under chapter 390 or chapter 395 may not be registered under this section.

2. The department must complete an inspection of any office seeking registration under this section before the office may be registered.

(b) ~~By January 1, 2020,~~ Each office registered under this section or s. 458.328 must designate a physician who is responsible for the office's compliance with the office health and safety requirements of this section and rules adopted hereunder. A designated physician must have a full, active, and unencumbered license under this chapter or chapter 458 and shall practice at the office for which he or she has assumed responsibility. Within 10 calendar days after the termination of a designated physician relationship, the office must notify the department of the designation of another physician to serve as the designated physician. The department may suspend a registration for an office if the office fails to comply with the requirements of this paragraph.

~~(h) A physician may only perform a procedure or surgery identified in paragraph (a) in an office that is registered with the department. The board shall impose a fine of $5,000 per day on a physician who performs a procedure or surgery in an office that is not registered with the department.~~

(2) STANDARDS OF PRACTICE.—

(a) A physician may not perform any surgery or procedure identified in paragraph (1)(a) in a setting other than an office

registered under this section or a facility licensed under chapter 390 or chapter 395, as applicable. The board shall impose a fine of $5,000 per incident on a physician who violates this paragraph ~~performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice pursuant to this subsection and rules adopted by the board~~.

(b) Office surgeries may not:

1. Be a type of surgery that generally results in blood loss of more than 10 percent of estimated blood volume in a patient with a normal hemoglobin level;

2. Require major or prolonged intracranial, intrathoracic, abdominal, or joint replacement procedures, except for laparoscopic procedures;

3. Involve major blood vessels and be performed with direct visualization by open exposure of the major blood vessel, except for percutaneous endovascular intervention; or

4. Be emergent or life threatening.

(c) A physician performing a gluteal fat grafting procedure in an office surgery setting shall adhere to standards of practice under this subsection and rules adopted by the board, which include, but are not limited to, all of the following:

1. A physician performing a gluteal fat grafting procedure must conduct an in-person examination of the patient while physically present in the same room as the patient no later than the day before the procedure.

2. Before a physician may delegate any duties during a gluteal fat grafting procedure, the patient must provide written, informed consent for such delegation. Any duty delegated by a physician during a gluteal fat grafting procedure

must be performed under the direct supervision of the physician performing such procedure. Fat extraction and gluteal fat injections must be performed by the physician and may not be delegated.

3. Fat may only be injected into the subcutaneous space of the patient and may not cross the fascia overlying the gluteal muscle. Intramuscular or submuscular fat injections are prohibited.

4. When the physician performing a gluteal fat grafting procedure injects fat into the subcutaneous space of the patient, the physician must use ultrasound guidance, or guidance with other technology authorized under board rule which equals or exceeds the quality of ultrasound, during the placement and navigation of the cannula to ensure that the fat is injected into the subcutaneous space of the patient above the fascia overlying the gluteal muscle. Such guidance with the use of ultrasound or other technology is not required for other portions of such procedure.

5. An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.

(d) If a procedure in an office surgery setting results in hospitalization, the incident must be reported as an adverse

incident pursuant to s. 458.351.

~~(c) An office in which a physician performs gluteal fat grafting procedures must at all times maintain a ratio of one physician to one patient during all phases of the procedure, beginning with the administration of anesthesia to the patient and concluding with the extubation of the patient. After a physician has commenced, and while he or she is engaged in, a gluteal fat grafting procedure, the physician may not commence or engage in another gluteal fat grafting procedure or any other procedure with another patient at the same time.~~

(4) REREGISTRATION.—An office that registered under this section before July 1, 2024, in which a physician performs liposuction procedures that include a patient being rotated 180 degrees or more during the procedure or in which a physician performs gluteal fat grafting procedures must seek reregistration with the department consistent with the parameters of initial registration under subsection (1) according to a schedule developed by the department. During the reregistration process, if the department determines that the performance of such procedures in the office creates a significant risk to patient safety and that the interests of patient safety would be better served if such procedures were instead regulated under the requirements of ambulatory surgical center licensure under chapter 395:

(a) The department must notify the Agency for Health Care Administration of its determination;

(b) The agency must inspect the office and determine, in the interest of patient safety, whether the office is a candidate for ambulatory surgical center licensure

notwithstanding the office's failure to meet all requirements associated with such licensure at the time of inspection and notwithstanding the exceptions provided under s. 395.002(3).

If the agency determines that an office is a candidate for ambulatory surgical center licensure under paragraph (b), the agency must notify the office and the department, and the office must cease performing procedures described in this subsection. The office may not recommence performing such procedures without first relinquishing its registration under this section and attaining ambulatory surgery center licensure under chapter 395.

Section 3. The Department of Health shall develop a schedule for reregistration of offices affected by the amendments made to s. 458.328(1) or s. 459.0138(1), Florida Statutes, by this act. Registration of all such offices must be completed by December 1, 2024.

Section 4. This act shall take effect upon becoming a law.

The Florida Senate

Committee Agenda Request

To: Senator Colleen Burton, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 8, 2024

I respectfully request that **Senate Bill #1188**, relating to Office Surgeries, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ileana Garcia
Florida Senate, District 36

File signed original with committee office

S-020 (03/2004)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

1188
Bill Number or Topic

Amendment Barcode (if applicable)

Name Chris Nuland

Phone 904-233-3051

Address 4427 Herschel St
Street

Email nulandlaw@aol.com

Jacksonville FL 32210
City State Zip

Speaking: ☐ For ☑ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:

Florida Society of Plastic Surgeons

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

SB 1188
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jeff Scott

Phone 850-224-6456

Address 1430 Piedmont Dr. E
Street

Tall FL 32308
City State Zip

Email JScott@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☑ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
FMA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2.6.24
Meeting Date

Health Care
Committee

1188
Bill Number or Topic

Amendment Barcode (if applicable)

Name Albert Balido

Phone 8502513440

Address 201 W Park Ave
Street

Tall FL 32301
City State Zip

Email

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☒ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Dr. Scott Moradian DO, PA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	SB 1118
INTRODUCER:	Senator Harrell
SUBJECT:	Nursing Education Programs
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Favorable**
2.			AHS	
3.			RC	

I. Summary:

SB 1118 adds the following requirements to the application process for approval of nursing education programs:

- The legal name of the nursing education program director must be included;
- The nursing educational program's annual report to the Board of Nursing (BON) must be submitted by the program director;
- The nursing education program must have evaluation and standardized admission criteria that identify students likely to need additional educational support and a student academic support plan; and
- The nursing education program must have a comprehensive examination, i.e., an exit exam, to prepare nursing students for the National Council of State Boards of Nursing Licensing Examination (NELEX), which cannot be the sole basis of exclusion from graduation.

The bill requires the BON to:

- Terminate a nursing education program's approval if the annual report is not submitted, or the required elements are not included;
- Deny an application, or revoke an approval, of a nursing education program that has had adverse action taken against it by another regulatory jurisdiction in the U.S.;
- Terminate a nursing education program if, during the calendar year following being placed on probation, the program does not achieve the required passage rate; and
- Terminate a nursing education program if the nursing education program director fails to submit a required written remediation plan or fails to appear before the BON to present the remediation plan.

The bill requires the nursing education program director to do the following or be subject to professional discipline:

- Provide the written statements or official program transcripts of the institution and to certify them as true and accurate;
- Be responsible for ensuring that the average exit exam results of the nursing education program are placed on the program's website and reported to the BON along with the annual report; and
- Submit to the BON a written remediation plan if an approved program's graduate NELEX passage rates are not equal to, or do not exceed, the required passage rates for one calendar year and to present the plan to the BON.

The bill reduces the time period for which an approved nursing education program's graduate passage rates are permitted to go below the required passage rates before the BON must place the program on probation, from two consecutive calendar years to one calendar year.

The bill authorizes DOH agents or employees to conduct onsite inspections at reasonable times to ensure that approved programs or accredited programs are in full compliance with ch. 464, F.S., or to determine whether ch. 464, F.S., or s. 456.072, F.S., are being violated.

The bill grants rule making authority to the BON to enforce and administer s. 464.019 (5), F.S.; and repeals the BON's rule making authority to establish criteria for nursing education programs to qualify for an extension of time to meet accreditation requirements. The bill repeals the BON's rule making authority to grant an extension of the accreditation deadline.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Florida Postsecondary Nursing Education Programs

The number of approved pre-licensure licensed practical nurse (LPN) and registered nurse (RN) nursing education programs in Florida continues to grow from 482 programs in 2020 to 515 in August, 2023.[1] Pre-licensure nursing programs include pre-licensure programs offered by Florida state universities, colleges, public school districts, private institutions licensed by the Florida Commission for Independent Education (CIE), private institutions that are members of the Independent Colleges and Universities of Florida (ICUF), and religious institutions authorized by law to offer nursing programs.[2]

Post-licensure nursing programs advance the training of licensed RNs and include Registered Nurse to Bachelor of Science in Nursing (RN to BSN), Master of Science in Nursing (MSN), Doctor of Nursing Practice (DNP), Doctor of Philosophy (Ph.D.) programs, and nursing certificates. Upon completion of some masters and doctorate programs, RNs transition to an advanced practice registered nurse (APRN) license. These roles include nurse practitioner (NP), certified nurse midwife (CNM), clinical nurse specialist (CNS), psychiatric mental health nurse practitioner, and certified registered nurse anesthetists (CRNA).[3]

[1] Florida Center for Nursing (2023), *Florida's Nursing Education Program Report Academic Year 2022-2023*, Tampa, Fla., available at https://issuu.com/flcenterfornursing/docs/nursing_education_report-interactive (last visited Feb. 1, 2024).
[2] *Id.*
[3] *Id.*

Pre-license Nursing Education Programs

Educational institutions that wish to conduct a program in Florida for the pre-licensure education of RNs or LPNs must meet specific requirements to be approved by the BON.[4] The program application must include the legal name of the educational institution, the legal name of the nursing education program, and, if such institution is accredited, the name of the accrediting agency. The application must also document:[5]

- For an RN education program, the program director and that at least 50 percent of the program's faculty members must be RNs who have a master's degree or higher in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing;
- For an LPN education program, the program director and at least 50 percent of the program's faculty members must be RNs who have a bachelor's degree or higher in nursing;
- The program's nursing major curriculum consists of at least:
  - Fifty percent clinical training in the U.S., the District of Columbia (D.C.), or a possession or territory of the U.S. for an LPN, ARN or a diploma RN;
  - Forty percent clinical training in a U.S. state, D.C., or a possession or territory of the U.S. for a B.S. degree RN education program, and no more than 50 percent of the program's clinical training may consist of clinical simulation;
- The RN and LPN educational degree requirements may be documented by an official transcript or by a written statement from the educational institution verifying that the institution conferred the degree;
- The program must have signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites;
- The program must have written policies for faculty which include provisions for direct or indirect supervision by faculty or clinical preceptors for students in clinical training consistent with the following standards;
  - The number of program faculty members must equal at least one faculty member directly supervising every 12 students unless the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18, to be directly supervised by one program faculty member;
  - For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor and a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility;
  - For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility;
  - For community-based clinical experiences not involving student participation in invasive or complex nursing activities, indirect supervision may occur only when a supervising program faculty member is available to the student by telephone; and

[4] Section. 464.019, F.S. and Florida Board of Nursing, *Education and Training Programs*, available at https://floridasnursing.gov/education-and-training-programs/ (last visited Feb. 1, 2024).
[5] Section 464.019(1), F.S.

- A program's clinical training policies must require that a clinical preceptor who is supervising students in an RN education program be an RN or, if supervising students in an LPN education program, be an RN or LPN;

- The RN or LPN nursing curriculum plan must document clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing. An RN curriculum plan must also document clinical experience and theoretical instruction in psychiatric nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings;
- An RN or LPN education programs must provide theoretical instruction and clinical application in the following:
  - Personal, family, and community health concepts;
  - Nutrition;
  - Human growth and development throughout the lifespan;
  - Body structure and function;
  - Interpersonal relationship skills;
  - Mental health concepts;
  - Pharmacology and administration of medications; and
  - Legal aspects of practice; and
- An RN nursing education program must also provide theoretical instruction and clinical experience in:
  - Interpersonal relationships and leadership skills;
  - Professional role and function; and
  - Health teaching and counseling skills.

Program Approval Process

Upon receipt of a program application and the required fee, the DOH must examine the application to determine if it is complete. If the application is not complete, the DOH must notify the educational institution in writing of any errors or omissions within 30 days after the DOH's receipt of the application. A program application is deemed complete upon the DOH's receipt of:

- The initial application, if the DOH does not notify the educational institution of any errors or omissions within the initial 30-day period after receipt; or
- Upon receipt of a revised application that corrects each error and omission that the DOH has notified the applicant of within the initial the 30-day period after receipt of the application.[6]

Once a complete application is received, the BON may conduct an onsite evaluation if necessary to document the applicant's curriculum and staffing. Within 90 days after the DOH's receipt of the complete program application, the BON must:

- Approve the application; or
- Provide the educational institution with a Notice of Intent to Deny if information or documents are missing.[7]

[6] Sections 464.019(2) and 464.003(4), F.S.
[7] *Id*.

The notice must specify in writing the reasons for the BON's denial of the application, and the BON may not deny an application because of an educational institution's failure to correct an error or omission that the DOH failed to notify the institution of within the 30-day notice period. The educational institution may request a hearing on the Notice of Intent to Deny the application pursuant to ch. 120, F.S. A program application is deemed approved if the BON does not act within the 90-day review period. Upon the BON's approval of a program application, the program becomes an "approved" program.[8]

Approved Nursing Pre-licensure Education Programs Annual Report

Each approved pre-licensure education program must submit to the BON an annual report by November 1, which must include:

- An affidavit certifying continued compliance with s. 465.019(1), F.S;
- A summary description of the program's compliance with s. 465.019(1), F.S; and
- Documentation for the previous academic year that describes:
  - The number of student applications received, qualified applicants, applicants accepted, accepted applicants who enroll in the program, students enrolled in the program, and program graduates;
  - The program's retention rates for students tracked from program entry to graduation; and
  - The program's accreditation status, including identification of the accrediting agency.[9]

If an approved program fails to submit the required annual report, the BON must notify the program director and president or chief executive officer of the institution in writing within 15 days after the due date. The program director must appear before the BON to explain the delay. If the program director fails to appear, or if the program does not submit the annual report within six months after the due date, the BON must terminate the program.[10]

Approved Nursing Pre-licensure Education Programs Accountability

Graduate Passage Rates

An approved nursing pre-licensure education program must achieve a graduate NELEX passage rate of first-time test takers which is not more than ten percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are U.S. educated, first-time test takers, as calculated by the contracted testing service of the National Council of State Boards of Nursing.[11]

For purposes of s. 464.019(5), F.S., an approved program is comparable to all degree programs of the same program type from among the following program types:[12]

- RN nursing education programs that terminate in a bachelor's degree;
- RN nursing education programs that terminate in an associate degree;
- RN nursing education programs that terminate in a diploma; and

[8] *Id*.
[9] Section 464.019(3), F.S.
[10] Section 464.019(5). F.S.
[11] *Id*.
[12] *Id*.

- LPN nursing education programs.

If an approved program's graduate passage rates do not equal or exceed the required passage rates for two consecutive calendar years, the BON must place the program on probationary status and the program director must appear before the BON to present a plan for remediation, which must include specific benchmarks to identify progress toward a graduate passage rate goal. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for any one calendar year.[13]

The BON must deny a program application for a new pre-licensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the BON must remove the program's probationary status.

If the program, during the two calendar years following its placement on probation, does not achieve the required passage rate for any one calendar year, the BON may extend the program's probationary status for one additional year if certain criteria are met. If the program is not granted the one-year extension or fails to achieve the required passage rate by the end of the extension, the BON must terminate the program. If students from a program that is terminated transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the BON must recalculate the passage rates of the programs receiving the transfer students and exclude the test scores of those students transferring more than 12 credits.[14]

An "accredited" nursing education program is a program for the pre-licensure education of RNs or LPNs that is conducted at a U.S. educational institution, whether in Florida, another state, or D.C., and that is accredited by a specialized nursing accrediting agency that is nationally recognized by the U.S. Secretary of Education to accredit nursing education programs.[15] Accredited programs do not have to meet requirements related to program application, approval, or submission of annual reports to the BON.[16]

All approved and accredited programs must meet accountability requirements related to graduate passage rate on the NELEX.

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[13] *Id.*
[14] *Id.*
[15] Section 464.003(1), F.S. Eligible institutional and accrediting Agencies available to Florida Nursing Programs are: Accreditation Commission for Education in Nursing (ACEN), Inc., formerly, National League for Nursing Accrediting Commission; Commission on Collegiate Nursing Education (CCNE)); National League for Nursing Commission for Nursing Education Accreditation (NLN CNEA); National Nurse Practitioner Residency and Fellowship Training Consortium;. and Florida Board of Nursing, *See* U.S. Department of Education, Accreditation in the U.S., available at https://www2.ed.gov/print/admins/finaid/accred/accreditation.html# (last visited Feb. 1, 2024); and Florida Board of Nursing, *What is the difference between an "approved" and an "accredited" pre-licensure nursing education program in Florida?* available at https://floridasnursing.gov/help-center/what-is-the-difference-between-an-approved-and-an-accredited-pre-licensure-nursing-education-program-in-florida/ (last visited Feb. 1, 2024).
[16] Section 464.019(9), F.S.

All approved nursing programs, except those specifically excluded,[17] must seek accreditation within five years of enrolling the program's first students.[18] An approved program which has been placed on probation must disclose its probationary status in writing to the program's students and applicants.[19] If an accredited program ceases to be accredited, the educational institution conducting the program must provide written notice to that effect to the BON, the program's students and applicants, and each entity providing clinical training sites or experiences. It may then apply to be an approved program.[20]

The BON does not have rulemaking authority to administer s. 464.019, F.S., except:

- The BON must adopt rules that prescribe the format for submitting program applications and annual reports, and to administer the documentation of the accreditation of nursing education programs.[21]
- The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology, and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements.[22]

Under these rulemaking requirements and authority, the BON may not impose any condition or requirement on an educational institution submitting a program application, an approved program, or an accredited program, except as expressly provided in s. 464.019, F.S.[23]

III. Effect of Proposed Changes:

SB 1118 adds the following requirements to the application process for nursing education program approval:

- The legal name of the nursing education program director must be included;
- The nursing educational program's annual report to the Board of Nursing (BON) must be submitted by the program director;
- The nursing education program must have evaluation and standardized admission criteria that identify students who are likely to need additional educational support and a student academic support plan; and
- The nursing education program must have a comprehensive examination to prepare nursing students for the NELEX;
    - This type of comprehensive examination:
        - Must be termed an "exit examination" that all nursing education programs will administer;
        - May not be the sole exclusion to graduation if the student has otherwise successfully completed all coursework required by the program; and

[17] Excluded institutions are those exempt from licensure by the Commission of Independent Education under ss. 1005.06(1) and 464.019(11)(d), F.S.
[18] Section 464.019(11)(a)-(d), F.S.
[19] *Id.*
[20] Section 464.019(9)(b), F.S.
[21] Section 464.019(8), F.S.
[22] *Id.*
[23] *Id.*

- The program director must be responsible for ensuring that the program's average exit exam results are placed on the program's website and reported to the BON along with the annual report.

The nursing education program must submit to the BON established criteria for remediation that will be offered to students who do not successfully pass the exit examination. A program with NELEX passage rates at least ten percentage points below the average passage rate for the most recent calendar year must offer remediation at no additional cost or refer the student to an approved remedial program and pay for that program for the student.

The bill requires the BON to deny an application from a nursing education program that has had adverse action taken against it by another regulatory jurisdiction in the U.S. The BON may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the U.S.

The bill reduces the time period for which an approved nursing education program's graduate passage rates are permitted to go below the required passage rates before the BON must place the program on probation, from two consecutive calendar years to one calendar year.

The bill requires the program director to submit to the BON a written remediation plan with specific nationally-recognized benchmarks to identify progress toward a graduate passage rate goal, and to present that plan to the BON. If the program director fails to submit the required written remediation plan, or fails to appear before the BON to present the remediation plan no later than six months after the date of the program being placed on probation, the bill requires the BON to terminate the nursing education program and the program director is subject to professional discipline for failing to perform any statutory or legal obligation placed upon a licensee.

The bill requires that if a nursing education program, during the calendar year following being placed on probation, does not achieve the required passage rate, the BON must terminate the program.

The bill authorizes agents or employees of the DOH to conduct onsite evaluations or inspections at reasonable hours to ensure that approved programs or accredited programs are in full compliance with ch. 464, F.S., or to determine whether ch. 464, F.S., or s. 456.072, F.S., is being violated. The DOH may collect any evidence necessary or as required to ensure compliance with ch. 464, F.S. or for prosecution. A refusal by a nursing education program to allow an onsite evaluation or inspection is deemed a violation of a legal obligation imposed by the BON and the DOH.

The bill grants rulemaking authority to the BON to enforce and administer s. 464.019(5), F.S.; and repeals the BON rulemaking authority to establish the criteria for nursing education programs to qualify for an extension of time to meet the accreditation requirements under s. 464.019(11), F.S., and repeals s. 464.019(11)(f), F.S., which gives the BON authority to grant an extension of the accreditation deadline.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 464.019 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.)

None.

B. Amendments:

None.

By Senator Harrell

31-00960A-24 20241118__

A bill to be entitled

An act relating to nursing education programs; amending s. 464.019, F.S.; revising application requirements for nursing education program approval; requiring the Board of Nursing to deny an application under certain circumstances; authorizing the board to revoke a program's approval under certain circumstances; revising requirements for annual reports approved programs are required to submit to the board; providing for the revocation of a program's approval, and discipline of its program director, under certain circumstances; revising remediation procedures for approved programs with graduate passage rates that do not meet specified requirements; subjecting program directors of approved programs to specified disciplinary action under certain circumstances; deleting a provision authorizing the board to extend a program's probationary status; authorizing agents of the Department of Health to conduct onsite evaluations and inspections of approved and accredited nursing education programs; authorizing the department to collect evidence as part of such evaluations and inspections; deeming failure or refusal of a program to allow such evaluation or inspection as a violation of a legal obligation; revising rulemaking authority of the board; deleting a provision authorizing approved nursing education programs to request an extension to meet the board's accreditation requirements; providing an effective

date.

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

Section 1. Subsections (1), (2), (3), (5), and (8) and paragraph (f) of subsection (11) of section 464.019, Florida Statutes, are amended to read:

464.019 Approval of nursing education programs.—

(1) PROGRAM APPLICATION.—An educational institution that wishes to conduct a program in this state for the prelicensure education of professional or practical nurses must submit to the department a program application and review fee of $1,000 for each prelicensure nursing education program to be offered at the institution's main campus, branch campus, or other instructional site. The program application must include the legal name of the educational institution, the legal name of the nursing education program, the legal name of the nursing education program director, and, if such institution is accredited, the name of the accrediting agency. The application must also document that:

(a)1. For a professional nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a master's or higher degree in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing.

2. For a practical nursing education program, the program director and at least 50 percent of the program's faculty members are registered nurses who have a bachelor's or higher degree in nursing.

The educational degree requirements of this paragraph must ~~may~~ be documented by an official transcript or by a written statement from the program director of the educational institution verifying that the institution conferred the degree. The program director shall certify the official transcript or written statement as true and accurate.

(b) The program's nursing major curriculum consists of at least:

1. Fifty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a practical nursing education program, an associate degree professional nursing education program, or a professional diploma nursing education program.

2. Forty percent clinical training in the United States, the District of Columbia, or a possession or territory of the United States for a bachelor's degree professional nursing education program.

(c) No more than 50 percent of the program's clinical training consists of clinical simulation.

(d) The program has signed agreements with each agency, facility, and organization included in the curriculum plan as clinical training sites and community-based clinical experience sites.

(e) The program has written policies for faculty which include provisions for direct or indirect supervision by program faculty or clinical preceptors for students in clinical training consistent with the following standards:

1. The number of program faculty members equals at least one faculty member directly supervising every 12 students unless

the written agreement between the program and the agency, facility, or organization providing clinical training sites allows more students, not to exceed 18 students, to be directly supervised by one program faculty member.

2. For a hospital setting, indirect supervision may occur only if there is direct supervision by an assigned clinical preceptor, a supervising program faculty member is available by telephone, and such arrangement is approved by the clinical facility.

3. For community-based clinical experiences that involve student participation in invasive or complex nursing activities, students must be directly supervised by a program faculty member or clinical preceptor and such arrangement must be approved by the community-based clinical facility.

4. For community-based clinical experiences not subject to subparagraph 3., indirect supervision may occur only when a supervising program faculty member is available to the student by telephone.

A program's policies established under this paragraph must require that a clinical preceptor who is supervising students in a professional nursing education program be a registered nurse or, if supervising students in a practical nursing education program, be a registered nurse or licensed practical nurse.

(f) The professional or practical nursing curriculum plan documents clinical experience and theoretical instruction in medical, surgical, obstetric, pediatric, and geriatric nursing. A professional nursing curriculum plan shall also document clinical experience and theoretical instruction in psychiatric

nursing. Each curriculum plan must document clinical training experience in appropriate settings that include, but are not limited to, acute care, long-term care, and community settings.

(g) The professional or practical nursing education program provides theoretical instruction and clinical application in personal, family, and community health concepts; nutrition; human growth and development throughout the life span; body structure and function; interpersonal relationship skills; mental health concepts; pharmacology and administration of medications; and legal aspects of practice. A professional nursing education program must also provide theoretical instruction and clinical application in interpersonal relationships and leadership skills; professional role and function; and health teaching and counseling skills.

(h) The professional or practical nursing education program has established evaluation and standardized admission criteria. The admission criteria must, at a minimum, identify those students who are likely to need additional educational support to be successful program graduates. The program shall maintain documentation of the individualized student academic support plan for those students identified as in need of additional preparation and educational support.

(i) The professional or practical nursing education program has an established comprehensive examination to prepare students for the National Council of State Boards of Nursing Licensing Examination (NCLEX). This type of comprehensive examination must be termed an exit examination that all programs will administer and may not be the sole exclusion to graduation if the student has otherwise successfully completed all coursework required by

the program. The program director is responsible for ensuring that the average exit exam results of the program are placed on the program's website and reported to the board along with the annual report required in subsection (3).

(j) The program shall submit to the board established criteria for remediation that will be offered to students who do not successfully pass the exit examination. A program with NCLEX passage rates at least 10 percentage points below the average passage rate for the most recent calendar year must offer remediation at no additional cost or refer the student to an approved remedial program and pay for that program for the student.

(2) PROGRAM APPROVAL.—

(a) Upon receipt of a program application and review fee, the department shall examine the application to determine if it is complete. If the application is not complete, the department shall notify the educational institution in writing of any errors or omissions within 30 days after the department's receipt of the application. A program application is deemed complete upon the department's receipt of:

1. The initial application, if the department does not notify the educational institution of any errors or omissions within the 30-day period; or

2. A revised application that corrects each error and omission of which the department notifies the educational institution within the 30-day period.

(b) Following the department's receipt of a complete program application, the board may conduct an onsite evaluation if necessary to document the applicant's compliance with

subsection (1). Within 90 days after the department's receipt of a complete program application, the board shall:

1. Approve the application if it documents compliance with subsection (1); or

2. Provide the educational institution with a notice of intent to deny the application if it does not document compliance with subsection (1). The notice must specify written reasons for the board's denial of the application. The board may not deny a program application because of an educational institution's failure to correct an error or omission that the department failed to provide notice of to the institution within the 30-day notice period under paragraph (a). The educational institution may request a hearing on the notice of intent to deny the program application pursuant to chapter 120.

(c) A program application is deemed approved if the board does not act within the 90-day review period provided under paragraph (b).

(d) Upon the board's approval of a program application, the program becomes an approved program.

(e) The board shall deny an application from a program that has had adverse action taken against it by another regulatory jurisdiction in the United States. The board may also revoke the approval of an existing approved program that has had adverse action taken against it by another regulatory jurisdiction in the United States.

(3) ANNUAL REPORT.—By November 1 of each year, each approved program's director ~~program~~ shall submit to the board an annual report comprised of an affidavit certifying continued compliance with subsection (1), a summary description of the

program's compliance with subsection (1), and documentation for the previous academic year that, to the extent applicable, describes:

(a) The number of student applications received, qualified applicants, applicants accepted, accepted applicants who enroll in the program, students enrolled in the program, and program graduates.

(b) The program's retention rates for students tracked from program entry to graduation.

(c) The program's accreditation status, including identification of the accrediting agency.

<u>The board shall terminate the program pursuant to chapter 120 if the requirements of this subsection are not met. The program director is also subject to discipline under s. 456.072(1)(k).</u>

(5) ACCOUNTABILITY.—

(a)1. An approved program must achieve a graduate passage rate for first-time test takers which is not more than 10 percentage points lower than the average passage rate during the same calendar year for graduates of comparable degree programs who are United States educated, first-time test takers on the National Council of State Boards of Nursing Licensing Examination, as calculated by the contract testing service of the National Council of State Boards of Nursing. For purposes of this subparagraph, an approved program is comparable to all degree programs of the same program type from among the following program types:

a. Professional nursing education programs that terminate in a bachelor's degree.

b. Professional nursing education programs that terminate in an associate degree.

c. Professional nursing education programs that terminate in a diploma.

d. Practical nursing education programs.

2. If an approved program's graduate passage rates do not equal or exceed the required passage rates for 1 calendar year ~~2 consecutive calendar years~~, the board shall place the program on probationary status pursuant to chapter 120 and the program director shall submit a written remediation plan to the board. The program director shall appear before the board to present the ~~a~~ plan for remediation, which shall include specific nationally recognized benchmarks to identify progress toward a graduate passage rate goal. The board shall terminate a program pursuant to chapter 120 if the program director fails to submit a written remediation plan or fails to appear before the board and present the remediation plan no later than 6 months after the date of the program being placed on probation. The program's director is also subject to discipline under s. 456.072(1)(k) for such failure. The program must remain on probationary status until it achieves a graduate passage rate that equals or exceeds the required passage rate for ~~any~~ 1 calendar year. The board shall deny a program application for a new prelicensure nursing education program submitted by an educational institution if the institution has an existing program that is already on probationary status.

3. Upon the program's achievement of a graduate passage rate that equals or exceeds the required passage rate, the board, at its next regularly scheduled meeting following release

of the program's graduate passage rate by the National Council of State Boards of Nursing, shall remove the program's probationary status. If the program, during the ~~2~~ calendar year ~~years~~ following its placement on probationary status, does not achieve the required passage rate ~~for any 1 calendar year~~, the board must ~~may extend the program's probationary status for 1 additional year, provided the program has demonstrated adequate progress toward the graduate passage rate goal by meeting a majority of the benchmarks established in the remediation plan. If the program is not granted the 1-year extension or fails to achieve the required passage rate by the end of such extension, the board shall~~ terminate the program pursuant to chapter 120.

(b) If an approved program fails to submit the annual report required in subsection (3), the board must ~~shall~~ notify the program director and president or chief executive officer of the educational institution in writing within 15 days after the due date of the annual report. The program director shall appear before the board at the board's next regularly scheduled meeting to explain the reason for the delay. The board shall terminate the program pursuant to chapter 120 if the program director fails to appear before the board, as required under this paragraph, or if the program does not submit the annual report within 6 months after the due date.

(c) A nursing education program, whether accredited or nonaccredited, which has been placed on probationary status shall disclose its probationary status in writing to the program's students and applicants. The notification must include an explanation of the implications of the program's probationary status on the students or applicants.

(d) If students from a program that is terminated pursuant to this subsection transfer to an approved or an accredited program under the direction of the Commission for Independent Education, the board must ~~shall~~ recalculate the passage rates of the programs receiving the transferring students, excluding the test scores of those students transferring more than 12 credits.

(e) Duly authorized agents or employees of the department may conduct onsite evaluations or inspections at all reasonable hours to ensure that approved programs or accredited programs are in full compliance with this chapter, or to determine whether this chapter or s. 456.072 is being violated. The department may collect any necessary evidence needed to ensure compliance with this chapter or for prosecution as deemed necessary. A failure of a program to refuse or allow an onsite evaluation or inspection is deemed as violating a legal obligation imposed by the board or the department.

(8) RULEMAKING.—The board does not have rulemaking authority to administer this section, except that the board shall adopt rules that prescribe the format for submitting program applications under subsection (1) and annual reports under subsection (3), to enforce and administer subsection (5), and to administer the documentation of the accreditation of nursing education programs under subsection (11). The board may adopt rules relating to the nursing curriculum, including rules relating to the uses and limitations of simulation technology~~,~~ ~~and rules relating to the criteria to qualify for an extension of time to meet the accreditation requirements under paragraph (11)(f)~~. The board may not impose any condition or requirement on an educational institution submitting a program application,

an approved program, or an accredited program, except as expressly provided in this section.

(11) ACCREDITATION REQUIRED.—

~~(f) An approved nursing education program may, no sooner than 90 days before the deadline for meeting the accreditation requirements of this subsection, apply to the board for an extension of the accreditation deadline for a period which does not exceed 2 years. An additional extension may not be granted. In order to be eligible for the extension, the approved program must establish that it has a graduate passage rate of 60 percent or higher on the National Council of State Boards of Nursing Licensing Examination for the most recent calendar year and must meet a majority of the board's additional criteria, including, but not limited to, all of the following:~~

~~1. A student retention rate of 60 percent or higher for the most recent calendar year.~~

~~2. A graduate work placement rate of 70 percent or higher for the most recent calendar year.~~

~~3. The program has applied for approval or been approved by an institutional or programmatic accreditor recognized by the United States Department of Education.~~

~~4. The program is in full compliance with subsections (1) and (3) and paragraph (5)(b).~~

~~5. The program is not currently in its second year of probationary status under subsection (5).~~

~~The applicable deadline under this paragraph is tolled from the date on which an approved program applies for an extension until the date on which the board issues a decision on the requested~~

~~extension.~~

Section 2. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Health and Human Services, *Chair*
Environment and Natural Resources, *Vice Chair*
Appropriations
Appropriations Committee on Education
Education Postsecondary
Health Policy
Judiciary

SELECT COMMITTEE:
Select Committee on Resiliency

SENATOR GAYLE HARRELL
31st District

January 16, 2023

Senator Burton
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Chair Burton,

I respectfully request that SB 1118 – Nursing Education Programs be placed on the next available agenda for the Health Policy Meeting.

Should you have any questions or concerns, please feel free to contact my office. Thank you in advance for your consideration.

Thank you,

Senator Gayle Harrell
Senate District 25

Cc: Allen Brown, Staff Director
Anhar AlAsadi, Committee Administrative Assistant

REPLY TO:
❒ 215 SW Federal Highway, Suite 203, Stuart, Florida 34994 (772) 221-4019 FAX: (888) 263-7895
❒ 414 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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02/06/24
Meeting Date

Health Policy
Committee

1118
Bill Number or Topic

N/A
Amendment Barcode (if applicable)

Name Allen Mortham Jr

Phone (850) 566-3760

Address 150 South Monroe Suite 306
Street

Email Allen@FAPSC.org

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Assoc. of Postsecondary Schools

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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02/06/24
Meeting Date

Health Policy
Committee

SB 1118
Bill Number or Topic

Amendment Barcode (if applicable)

Name Teye Carmichael

Phone 850-224-5081

Address 311 E Park Avenue
Street

Email tcarmichael@smithbryanandmyers.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
National Council of State Boards of Nursing

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

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02/06/24
Meeting Date

1118
Bill Number or Topic

Committee

N/A
Amendment Barcode (if applicable)

Name Bob Harris

Phone (850) 222-0720

Address 2618 Centennial Place
Street
Tallahassee FL 32308
City State Zip

Email BHarris@lawFL.com

Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Assoc. of Independent Nursing Students

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/6
Meeting Date

Health
Committee

SB 1118
Bill Number or Topic

Amendment Barcode (if applicable)

Name JACK CORR Phone

Address 730 E. Park Ave
Street

Tal
City State Zip

Email

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing: Florida Nursing Assoc

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 1612
INTRODUCER:	Health Policy Committee and Senator Brodeur
SUBJECT:	Adult Cardiovascular Care Standards
DATE:	February 7, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.			AHS	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1612 amends s. 395.1055, F.S., to amend requirements in that section related to the Agency for Health Care Administration's (AHCA) rules governing adult cardiovascular services (ACS) to specify that Level I services include rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions.

II. Present Situation:

Adult Cardiovascular Services

Section 395.1055(18), F.S., establishes requirements that the AHCA must adopt in rule governing the provision of ACS. The section divides ACS into two levels, Level I and Level II, with Level I ACS providers authorized to provide adult percutaneous cardiac intervention (PCI) without cardiac surgery and with Level II providers being authorized to perform PCI with cardiac surgery.

Percutaneous Coronary Intervention

Percutaneous coronary intervention (PCI), also commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease, including unstable angina, acute myocardial infarction, and multi-vessel coronary artery disease.[1]

PCI uses a catheter to insert a small structure called a stent to reopen blood vessels in the heart that have been narrowed by plaque build-up, a condition known as atherosclerosis. Using a special type of X-ray called fluoroscopy, the catheter is threaded through blood vessels into the heart where the coronary artery has narrowed. When the tip is in place, a balloon tip covered with a stent is inflated. The balloon tip compresses the plaque and expands the stent. Once the plaque is compressed and the stent is in place, the balloon is deflated and withdrawn. The stent stays in the artery, holding it open.[2]

Rotational Atherectomy

Rotational atherectomy (RA) is an atheroablative technology that enables percutaneous coronary intervention for complex, calcified coronary lesions. RA works on the principle of 'differential cutting' and preferentially ablates hard, inelastic, calcified plaque. The objective of RA use has evolved from plaque debulking to plaque modification to enable balloon angioplasty and optimal stent expansion.[3]

Electrophysiological Study

An electrophysiological study (EP study) is a test used to evaluate the heart's electrical system and to check for abnormal heart rhythms. Natural electrical impulses coordinate contractions of the different parts of the heart. This helps keep blood flowing the way it should. This movement of the heart creates the heartbeat, or heart rhythm. During an EP study, a doctor inserts small, thin wire electrodes into a vein in the groin (or neck, in some cases). He or she will then thread the wire electrodes through the vein and into the heart. To do this, he or she uses a special type of X-ray called fluoroscopy. Once in the heart, the electrodes measures the heart's electrical signals. Electrical signals are also sent through the electrodes to stimulate the heart tissue to try to cause the abnormal heart rhythm. This is done so that it can be evaluated and its cause can be found. It may also be done to help evaluate how well a medicine is working.[4]

Chronic Total Occlusion

A Chronic total occlusion (CTO) is a complete or nearly complete blockage of one or more coronary arteries. The blockage, typically present for at least three months, is caused by a

[1] Medscape: Percutaneous cardiac intervention, *available at* http://emedicine.medscape.com/article/161446-overview, (last visited Feb. 2, 2024).
[2] Heart and Stroke Foundation, *available at* https://www.heartandstroke.ca/heart/treatments/surgery-and-other-procedures/percutaneous-coronary-intervention, (last visited Feb. 2, 2024).
[3] Gupta T, Weinreich M, Greenberg M, Colombo A, Latib A. Rotational Atherectomy: A Contemporary Appraisal. Interv Cardiol. 2019 Nov 18;14(3):182-189. doi: 10.15420/icr.2019.17.R1. PMID: 31867066; PMCID: PMC6918488.
[4] What is an electrophysiological study? Johns Hopkins Medicine, available at https://www.hopkinsmedicine.org/health/treatment-tests-and-therapies/electrophysiological-studies#:~:text=An%20electrophysiological%20study%20(EP%20study,flowing%20the%20way%20it%20should., (last visited Feb. 2, 2024).

buildup of plaque within a coronary artery. When this happens, blood flow to the heart is compromised. CTO is a common heart disorder in patients with coronary artery disease. Between 20 and 25 percent of patients with coronary artery disease also have a chronically blocked artery.[5]

III. Effect of Proposed Changes:

CS/SB 1612 amends s. 395.1055, F.S., to specify that Level I ACS includes PCI with rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions.

The bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

[5] Chronic Total Occlusion (CTO), University of Michigan Health, available at https://www.uofmhealth.org/conditions-treatments/chronic-total-occlusion-cto, (last visited Feb. 2, 2024).

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 395.1055 of the Florida Statutes.

IX. Additional Information:

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

CS by Health Policy on February 6, 2024:
The committee substitute eliminates all provisions of the bill other than the provision specifying rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions to services that may be provided by Level I ACS providers.

B. Amendments:

None.

471432

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/06/2024	.	
	.	
	.	
	.	

The Committee on Health Policy (Brodeur) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Paragraph (a) of subsection (18) of section 395.1055, Florida Statutes, is amended to read:

395.1055 Rules and enforcement.—

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that allow for:

(a) The establishment of two hospital program licensure

471432

levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions, and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

Section 2. This act shall take effect July 1, 2024.

========== 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 adult cardiovascular care standards; amending s. 395.1055, F.S.; revising requirements for rules the Agency for Health Care Administration is required to adopt, to allow a Level I Adult Cardiovascular Services program to use certain additional tools in the treatment of adult percutaneous cardiac intervention; providing an effective date.

By Senator Brodeur

10-01555-24 20241612__

A bill to be entitled

An act relating to adult cardiovascular care standards; amending s. 395.1055, F.S.; deleting the requirement for the Agency for Health Care Administration to adopt certain rules for adult inpatient diagnostic cardiac catheterization programs; revising standards for rules relating to adult cardiovascular services; requiring the agency to update its rules as often as necessary to remain consistent with new standards and guidelines published by certain entities; providing an effective date.

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

Section 1. Subsections (16), (18), and (19) of section 395.1055, Florida Statutes, are amended to read:

395.1055 Rules and enforcement.—

~~(16) Each provider of diagnostic cardiac catheterization services shall comply with rules adopted by the agency which establish licensure standards governing the operation of adult inpatient diagnostic cardiac catheterization programs. The rules must ensure that such programs:~~

~~(a) Comply with the most recent guidelines of the American College of Cardiology and American Heart Association Guidelines for Cardiac Catheterization and Cardiac Catheterization Laboratories.~~

~~(b) Perform only adult inpatient diagnostic cardiac catheterization services and will not provide therapeutic cardiac catheterization or any other cardiology services.~~

~~(c) Maintain sufficient appropriate equipment and health care personnel to ensure quality and safety.~~

~~(d) Maintain appropriate times of operation and protocols to ensure availability and appropriate referrals in the event of emergencies.~~

~~(e) Demonstrate a plan to provide services to Medicaid and charity care patients.~~

(18) In establishing rules for adult cardiovascular services, the agency shall include provisions that provide ~~allow~~ for all of the following:

(a) The establishment of two hospital program licensure levels, a Level I program that authorizes the performance of adult percutaneous cardiac intervention without onsite cardiac surgery, including rotational or other atherectomy devices, electrophysiology, and treatment of chronic total occlusions, and a Level II program that authorizes the performance of percutaneous cardiac intervention with onsite cardiac surgery.

(b)1. ~~For~~ A hospital seeking a Level I program must have a~~,~~ ~~demonstration that, for the most recent 12-month period as reported to the agency, the hospital has provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations or, for the most recent 12-month period, has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease and that it has a formalized,~~ written transfer agreement with a hospital that has a Level II program, including written transport protocols to ensure safe and efficient transfer of a patient ~~within 60 minutes.~~

~~2.a. A hospital located more than 100 road miles from the~~

~~closest Level II adult cardiovascular services program is not required to meet the diagnostic cardiac catheterization volume and ischemic heart disease diagnosis volume requirements in subparagraph 1. if the hospital demonstrates that it has, for the most recent 12-month period as reported to the agency, provided a minimum of 100 adult inpatient and outpatient diagnostic cardiac catheterizations or that, for the most recent 12-month period, it has discharged or transferred at least 300 patients with the principal diagnosis of ischemic heart disease~~.

2.~~b.~~ A hospital located more than 100 road miles from the closest Level II adult cardiovascular services program must have a ~~does not need to meet the 60-minute transfer time protocol requirement in subparagraph 1. if the hospital demonstrates that it has a formalized,~~ written transfer agreement with a hospital that has a Level II program which includes~~. The agreement must include~~ written transport protocols to ensure the safe and efficient transfer of a patient, taking into consideration the patient's clinical and physical characteristics, road and weather conditions, and viability of ground and air ambulance service to transfer the patient.

~~3. At a minimum, the rules for adult cardiovascular services must require nursing and technical staff to have demonstrated experience in handling acutely ill patients requiring intervention, based on the staff member's previous experience in dedicated cardiac interventional laboratories or surgical centers. If a staff member's previous experience is in a dedicated cardiac interventional laboratory at a hospital that does not have an approved adult open heart surgery program, the staff member's previous experience qualifies only if, at the~~

~~time the staff member acquired his or her experience, the dedicated cardiac interventional laboratory:~~

~~a. Had an annual volume of 500 or more percutaneous cardiac intervention procedures.~~

~~b. Achieved a demonstrated success rate of 95 percent or greater for percutaneous cardiac intervention procedures.~~

~~c. Experienced a complication rate of less than 5 percent for percutaneous cardiac intervention procedures.~~

~~d. Performed diverse cardiac procedures, including, but not limited to, balloon angioplasty and stenting, rotational atherectomy, cutting balloon atheroma remodeling, and procedures relating to left ventricular support capability.~~

(c) For a hospital seeking a Level II program, demonstration that, for the most recent 12-month period as reported to the agency, the hospital has performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations, or, for the most recent 12-month period, has discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

(d) Compliance with the most recent guidelines of the American College of Cardiology, ~~and~~ the American Heart Association, and the Society for Cardiac Angiography and Intervention guidelines for staffing, physician training and experience, operating procedures, equipment, physical plant, and patient selection criteria, to ensure patient quality and safety.

(e) The establishment of appropriate hours of operation and protocols to ensure availability and timely referral in the event of emergencies.

(f) The demonstration of a plan to provide services to Medicaid and charity care patients.

(g) For a hospital licensed for adult diagnostic cardiac catheterization that provides Level I or Level II adult cardiovascular services, demonstration that the hospital is participating in the American College of Cardiology's National Cardiovascular Data Registry or the American Heart Association's Get with the Guidelines-Coronary Artery Disease registry and documentation of an ongoing quality improvement plan ensuring that the licensed cardiac program meets or exceeds national quality and outcome benchmarks reported by the registry in which the hospital participates. A hospital licensed for Level II adult cardiovascular services must also participate in the clinical outcome reporting systems operated by the Society for Thoracic Surgeons.

(19) The agency may adopt rules to administer the requirements of part II of chapter 408 and shall update agency rules as often as necessary to remain consistent with new standards and guidelines published by federal health agencies and nationally recognized medical organizations.

Section 2. This act shall take effect July 1, 2024.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Appropriations Committee on Agriculture, Environment, and General Government, *Chair*
Health Policy, *Vice Chair*
Appropriations
Appropriations Committee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs
Regulated Industries
Rules

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR JASON BRODEUR
10th District

January 11, 2024

The Honorable Colleen Burton
Chair, Committee on Health Policy
312 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Burton,

I respectfully request that **Senate Bill 1612**, **Adult Cardiovascular Care Standards**, be placed on the agenda of the Health Policy Committee meeting to be considered at your earliest convenience.

If you have any questions or concerns, please do not hesitate to reach out to me or my office.

Sincerely,

Jason Brodeur

Senator Jason Brodeur – District 10

CC: Allen Brown – Staff Director
Daniel Looke – Deputy Staff Director
Anhar Al-Asadi – Administrative Assistant

REPLY TO:
❒ 110 Timberlachen Circle, Suite 1012, Lake Mary, Florida 32746 (407) 333-1802
❒ 405 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5010

Senate's Website: *www.flsenate.gov*

KATHLEEN PASSIDOMO
President of the Senate

DENNIS BAXLEY
President Pro Tempore

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Feb 6, 2024	1612/Brodeur
Meeting Date	Bill Number or Topic
Senate Health Policy Committee	
Committee	Amendment Barcode (if applicable)

Name Dr. Charles Lambert Phone

Address AdventHealth Tampa, 3100 East Fletcher Avenue Email charles.lambert@adventhealth.com
Street

Tampa FL 33613
City *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☑ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

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 Health Policy

BILL:	CS/SB 238
INTRODUCER:	Judiciary Committee and Senator Burton
SUBJECT:	Claims Against Assisted Living Facilities
DATE:	February 5, 2024
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Collazo	Cibula	JU	**Fav/CS**
2.	Brown	Brown	HP	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 238 amends the Assisted Living Facilities Act to extend assisted living facilities (ALFs) the same substantive and procedural protections that apply to nursing homes.

The bill amends s. 429.29, F.S., which authorizes civil actions to enforce ALF residents' rights, to provide that actions brought for a residents' rights violation or for negligence, which allege direct or vicarious liability for the personal injury or death of a resident, and which seek damages for such injury or death, may be brought only against:

- The licensee.
- The licensee's management or active participant.
- The licensee's managing employees.
- Any direct caregivers, whether employees or contractors.

Passive investors, as defined in the bill, may no longer be found liable. The bill also amends the statute allowing legal actions resulting from the death of an ALF resident to specify the point in the proceedings when the plaintiff must elect survival damages or wrongful death damages. As specified, the election must occur between the rendition of the verdict and the rendition of the judgment.

The bill also amends s. 429.297, F.S., which currently authorizes the award of punitive damages under certain circumstances, to require courts to hold a hearing to determine whether there is sufficient admissible evidence to ensure there is a reasonable basis for a punitive damages award.

The bill defines the terms "licensee," "management company or active participant," and "passive investor." The bill's provisions only apply to causes of action that accrue on or after July 1, 2024.

The bill provides an effective date of July 1, 2024.

II. Present Situation:

Assisted Living Facilities

According to the Assisted Living Facilities Act (the Act),[1] an assisted living facility (ALF) is a residential establishment, or part of a residential establishment, providing housing, meals, and one or more personal services, for periods exceeding 24 hours, to one or more adults who are not relatives of the owner or the administrator.[2] "Personal service" means direct physical assistance with, or supervision of, the activities of daily living and the self-administration of medication.[3] "Activities of daily living" include ambulation, bathing, dressing, eating, grooming, toileting, and other similar tasks.[4]

There are approximately 3,000 licensed ALFs in the state, having more than 106,000 beds. In contrast, there are only about 700 licensed nursing homes in the state, having 84,000 beds.[5] ALFs must have a standard license issued by the Agency for Health Care Administration (AHCA) under part I of chapter 429, F.S., and part II of chapter 408, F.S. In addition to the standard license, ALFs may have one or more specialty licenses allowing them to provide additional care. Specialty licenses include limited nursing services,[6] limited mental health,[7] and extended congregate care licenses.[8]

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[1] Chapter 429, part II, F.S. According to s. 429.01(2), F.S., the purpose of the Act is to:
- Promote the availability of appropriate services for elderly persons and adults with disabilities in the least restrictive and most homelike environment.
- Encourage the development of facilities that promote the dignity, individuality, privacy, and decisionmaking ability of such persons.
- Provide for the health, safety, and welfare of residents of assisted living facilities in the state.
- Promote continued improvement of such facilities.
- Encourage the development of innovative and affordable facilities, particularly for persons with low to moderate incomes.
- Ensure that all agencies of the state cooperate in the protection of such residents.
- Ensure that needed economic, social, mental health, health, and leisure services are made available to residents of such facilities through the efforts of the Agency for Health Care Administration, the Department of Elderly Affairs, the Department of Children and Families, the Department of Health, assisted living facilities, and other community agencies.

[2] Section 429.02(5), F.S. An ALF does not include an adult family-care home or a non-transient public lodging establishment.
[3] Section 429.02(17), F.S.
[4] Section 429.02(1), F.S.
[5] University of South Florida, School of Aging Studies, Florida Policy Exchange Center on Aging, *Exploring Assisted Living Communities in Florida*, https://www.usf.edu/cbcs/aging-studies/fpeca/research/alf.aspx (last visited Jan. 24, 2024).
[6] Section 429.07(3)(c), F.S.
[7] Section 429.075, F.S.
[8] Section 429.07(3)(b), F.S.

ALFs are required to provide care and services appropriate to the needs of the residents accepted for admission to the facility.[9] The owner or facility administrator determines whether an individual is appropriate for admission to the facility based on a number of criteria.[10] If, as determined by the facility administrator or the health care provider, a resident no longer meets the criteria for continued residency, or the facility is unable to meet the resident's needs, the resident must be discharged in accordance with the Resident Bill of Rights.

The Resident Bill of Rights

The Act includes a "Resident Bill of Rights."[11] The Resident Bill of Rights provides that no resident of a facility may be deprived of any civil or legal rights, benefits, or privileges guaranteed by law, the State Constitution, or the U.S. Constitution.[12]

Under the Resident Bill of Rights, every resident of a facility has the right to:[13]

- Live in a safe and decent living environment, free from abuse and neglect.
- Be treated with consideration and respect and with due recognition of personal dignity, individuality, and the need for privacy.
- Retain and use his or her own clothes and other personal property in his or her immediate living quarters, so as to maintain individuality and personal dignity, except when the facility can demonstrate that doing so would be unsafe, impractical, or an infringement upon the rights of other residents.
- Unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any time between the hours of 9:00 a.m. and 9:00 p.m. at a minimum. Upon request, the facility must make provisions to extend visiting hours for caregivers and out-of-town guests.
- Freedom to participate in, and benefit from, community services and activities, and to pursue the highest possible level of independence, autonomy, and interaction within the community.
- Manage his or her financial affairs unless the resident or, if applicable, the resident's representative, designee, surrogate, guardian, or attorney in fact authorizes the administrator of the facility to provide safekeeping for funds.[14]
- Share a room with his or her spouse, if both are residents of the facility.
- Reasonable opportunity for regular exercise several times a week, and to be outdoors at regular and frequent intervals, except when prevented by inclement weather.
- Exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor any attendance at religious services, may be imposed upon any resident.
- Assistance with obtaining access to adequate and appropriate health care.
- At least 45 days' notice of relocation or termination of residency from the facility unless, for medical reasons, the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or the resident engages in a pattern of conduct that is harmful or offensive to other residents.

[9] *See* Fla. Admin. Code R. 59A-36.007, F.A.C. (providing specific minimum standards).
[10] Section 429.26, F.S., and Fla. Admin. Code R. 59A-36.006, F.A.C.
[11] Section 429.28, F.S.
[12] Section 429.28(1), F.S.
[13] *Id.*
[14] *See* s. 429.27, F.S.

- Present grievances and recommend changes in policies, procedures, and services to the staff of the facility, governing officials, or any other person without restraint, interference, coercion, discrimination, or reprisal.[15]

Training

Administrators and other ALF staff must meet minimum training and education requirements established by rule.[16] These requirements are intended to assist ALFs in responding appropriately to the needs of residents; maintaining resident care and facility standards; and meeting licensure requirements.[17]

ALF core training requirements established by the AHCA currently consist of a minimum of 26 hours of training, and passing a competency test. Administrators and managers must successfully complete the core training requirements within three months after becoming an ALF administrator or manager. The minimum passing score for the competency test is 75 percent.[18]

Administrators and managers must participate in 12 hours of continuing education in assisted living-related topics every two years.[19] Newly-hired administrators or managers, who have successfully completed the ALF core training and continuing education requirements, are not required to retake the core training. Administrators or managers who have successfully completed the core training, but have not maintained the continuing education requirements, must retake both the ALF core training and the competency test.[20]

Facility administrators or managers are required to facilitate six hours of in-service training for facility staff who provide direct care to residents. Generally, staff training requirements must be completed within 30 days after staff begin employment at the facility; however, staff must have at least one hour of infection control training before providing direct care to residents. Nurses, certified nursing assistants, and home health aides who are on staff with an ALF are exempt from many of the training requirements. In addition to the standard six hours of in-service training, staff must complete one hour of elopement training and one hour of training on "do not resuscitate" orders. Staff may be required to also complete training on special topics such as self-administration of medication and Alzheimer's disease, if applicable.[21]

Inspections and Surveys

The AHCA is required to conduct a survey, investigation, or monitoring visit of an ALF:

- Prior to the issuance of a license.
- Prior to biennial renewal of a license.

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[15] *Id.*
[16] Fla. Admin. Code R. 59A-36.011, F.A.C.
[17] Section 429.52(1), F.S.
[18] Fla. Admin. Code R. 59A-36.011(1)(a)-(b). Administrators who have attended core training prior to July 1, 1997, and managers who attended the core training program prior to April 20, 1998, are not required to take the competency test. Administrators licensed as nursing home administrators in accordance with part II of ch. 468, F.S., are exempt from this requirement. *Id.*
[19] Fla. Admin. Code R. 59A-36.011(1)(c).
[20] Fla. Admin. Code R. 59A-36.011(1)(d).
[21] Fla. Admin. Code R. 59A-36.011(3), (10)-(11).

- When there is a change of ownership.
- To monitor ALFs licensed to provide limited nursing services or extended congregate care services.
- To monitor ALFs cited in the previous year for a class I or class II violation or for four or more uncorrected class III violations.
- Upon receipt of an oral or written complaint of practices that threaten the health, safety, or welfare of residents.
- If the AHCA has reason to believe an ALF is violating a provision of part III of chapter 429, F.S., relating to adult day care centers, or an administrative rule.
- To determine if cited deficiencies have been corrected.
- To determine if an ALF is operating without a license.[22]

An applicant for licensure renewal is eligible for an abbreviated biennial survey by the AHCA if the applicant does not have any:

- Class I, class II, or uncorrected class III violations.
- Confirmed complaints from the long-term care ombudsman program.[23]
- Confirmed licensing complaints within the two licensing periods immediately preceding the current renewal date.[24]

Causes of Action under the Assisted Living Facilities Act

Generally

The Act authorizes any person or resident whose rights under the Act have been violated by a licensee, person, or entity to bring a cause of action against them. The action may be brought by the resident or his or her guardian, or by a person or organization acting on behalf of the resident, with the resident's consent, or the consent of his or her guardian or the personal representative of the deceased resident's estate, regardless of the cause of death.[25]

If the action alleges a claim for a resident's rights violation or for negligence that caused the death of the resident, the claimant must elect either survival damages[26] or wrongful death damages.[27] If the action alleges a claim for a resident's rights violation or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.[28]

The action may be brought in any court of competent jurisdiction, to enforce such rights and to recover actual, as well as punitive, damages, for violations of the resident's rights or negligence.

[22] *See generally* ss. 429.34 and 408.811, F.S.
[23] Florida's Long-Term Care Ombudsman Program was founded in 1975 as a result of the federal Older Americans Act, which grants a special set of residents' rights to individuals who live in long-term care facilities such as nursing homes, assisted living facilities and adult family care homes. Volunteer ombudsmen seek to ensure the health, safety, welfare and rights of these residents throughout Florida. Florida Department of Elder Affairs, *Florida Long-Term Care Ombudsman Program*, http://ombudsman.myflorida.com/AboutUs.php (last visited on Jan. 24, 2024).
[24] Fla. Admin. Code R. 59A-36.023(1)(a), F.A.C.
[25] Section 429.29(1), F.S.
[26] *See* s. 46.021, F.S.
[27] *See* s. 768.21, F.S.
[28] Section 429.29(1), F.S.

Any resident who prevails in seeking injunctive relief or a claim for an administrative remedy, is entitled to recover the costs of the action and reasonable attorneys' fees up to $25,000. Fees may be awarded only for the injunctive or administrative relief, and not for any claim or action for damages, regardless of whether the claim or action is brought together with a request for an injunction or administrative relief or as a separate action, except as otherwise provided under state law.[29]

The resident, or the resident's legal representative, must serve a copy of any complaint alleging a violation of the Resident Bill of Rights to the AHCA at the time he or she files the initial complaint. This requirement does not impair the resident's legal rights or ability to seek relief for his or her claim.[30]

The ALF civil enforcement statutes[31] provide the exclusive remedy for the recovery of damages due to the personal injury or death of a resident arising out of negligence or a violation of the Resident Bill of Rights. The statute does not preclude theories of recovery not arising out of negligence or violations of the Resident Bill of Rights that may be available to a resident or to the agency. The provisions of chapter 766, F.S., which govern medical malpractice and related matters, do not apply to causes of action brought under the ALF civil enforcement statutes.[32]

Punitive Damages

In order for a plaintiff to bring a claim for punitive damages, there must be a reasonable showing, based upon evidence in the record or proffered by the claimant, that there is a reasonable basis for the recovery of punitive damages.[33]

Claimants may move to amend their complaints to assert a claim for punitive damages, as allowed by the rules of civil procedure. The rules must be liberally construed so as to allow the claimant to discover evidence that is reasonably calculated to lead to admissible evidence on the issue.[34] Discovery of financial information for the purpose of determining the value of punitive damages may not be had unless the plaintiff shows the court, by proffer or evidence in the record, that a reasonable basis exists to support the claim for punitive damages.[35]

Punitive damages may only be imposed against a defendant if the trier of fact, based on clear and convincing evidence, finds that the defendant was personally guilty of intentional misconduct or gross negligence. In this context, "intentional misconduct" means that the defendant had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage. "Gross negligence" means that the defendant's conduct

[29] *Id.* (referencing s. 768.79, F.S., which is the offer of judgment and demand for judgment statute, and the Florida Rules of Civil Procedure).
[30] Section 429.29(7), F.S.
[31] Sections 429.29-429.298, F.S.
[32] Section 429.29(1), F.S.
[33] Section 429.297(1), F.S.
[34] *Id.*
[35] Sections 429.297(1) and 429.29(5), F.S.

was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.[36]

In the case of an employer, principal, corporation, or other legal entity, punitive damages may be imposed for the conduct of an employee or agent only if the conduct of the employee or agent meets the criteria specified in the previous paragraph, and:

- The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;
- The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or
- The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant.[37]

Plaintiffs must establish at trial, by clear and convincing evidence, their entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.[38] Any award of punitive damages under the Act must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.[39]

Comparisons to Nursing Home Civil Enforcement Statutes

The nursing home civil enforcement statutes[40] are similar, but not identical, to the ALF civil enforcement statutes.

Unlike in the ALF civil enforcement context, which does not limit who may be sued,[41] an exclusive cause of action for negligence or for a violation of residents' rights,[42] which alleges direct or vicarious liability for the personal injury or death of a nursing home resident arising from such negligence or violation of rights, and which seeks damages for such injury and death, may be brought only against:

- The licensee.
- The licensee's management or consulting company.
- The licensee's managing employees.
- Any direct caregivers, whether employees or contractors.[43]

Passive investors may not be held liable under the nursing home civil enforcement statutes.[44]

[36] Section 429.297(2), F.S.
[37] Section 429.297(3), F.S.
[38] Section 429.297(4), F.S.
[39] Section 429.29(6), F.S.
[40] Sections 400.023-400.0239, F.S.
[41] *See* s. 429.29(1), F.S.
[42] Chapter 400, part II, F.S., governing nursing homes, contains a "residents' rights" statute that is similar, but not identical, to the Resident Bill of Rights. *See generally* s. 400.022, F.S.
[43] Section 400.023(1), F.S.
[44] *Id.*

An action against an individual or entity not falling within any of the above four categories may only be brought after a hearing on a motion for leave to amend, and after the court or an arbitration panel determines that there is sufficient evidence in the record, or proffered by the claimant, to establish a reasonable showing that:

- The individual or entity owned a duty of reasonable care to the resident and that the individual or entity breached that fiduciary duty.
- The breach of that duty is a legal cause of loss, injury, death, or damage to the resident.[45]

Unlike the ALF civil enforcement statute, which does not specify when an election must be made,[46] if a nursing home civil enforcement action alleges a claim for a resident's rights violation or for negligence that caused the death of the resident, the claimant must elect survival damages[47] or wrongful death damages[48] after the verdict, but before the judgment is entered.[49]

With respect to punitive damages, a claim may not be brought under the nursing home civil enforcement statute unless the parties submit admissible evidence providing a reasonable basis for the recovery of such damages.[50] The court must conduct a hearing to determine whether the recovery of punitive damages is warranted under a claim for direct liability or vicarious liability as provided by statute.[51] In contrast, the ALF civil enforcement statute only requires a reasonable showing by evidence in the record, but no hearing.[52]

A defendant may be held liable for punitive damages only if the trier of fact, by clear and convincing evidence, finds that a specific person or corporate defendant actively and knowingly participated in intentional misconduct or engaged in conduct that constitutes gross negligence and contributed to the loss, damages, or injury suffered by the claimant. In this context, "intentional misconduct" means that the defendant against whom punitive damages are sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage. Gross negligence" means that a defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of persons exposed to such conduct.[53]

In the case of vicarious liability of an individual, employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless his or her conduct meets the criteria above and an officer, director, or a manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to that conduct.[54]

[45] Section 400.023(3), F.S.
[46] *See* s. 429.29(1), F.S.
[47] *See* s. 46.021, F.S.
[48] *See* s. 768.21, F.S.
[49] Section 400.023(1)(b), F.S.
[50] Section 400.0237, F.S.
[51] Section 400.0237(1)(b), F.S.
[52] Section 429.297(1), F.S.
[53] Section 400.0237(2), F.S.
[54] Section 400.0237(3), F.S.

III. Effect of Proposed Changes:

The bill amends two sections of the Assisted Living Facilities Act to extend certain substantive and procedural protections that are already enjoyed by nursing homes to ALFs.

Section 1 of the bill amends s. 429.29, F.S., which currently authorizes civil actions to enforce ALF residents' rights, in the following ways.

The bill amends the statute to include the following definitions:

- "Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency and is legally responsible for all aspects of the operation of the facility.
- "Management company or active participant" means an individual or entity that contracts or receives a fee to provide any of the following services for a facility:
  - Hiring or firing the administrator or director of nursing.
  - Controlling or having control over staffing levels at the facility.
  - Having control over the budget of the facility.
  - Implementing and enforcing the policies and procedures of the facility.
  - Receiving and controlling a line of credit, loan, or other credit instrument that is used either in whole or in part by, or for the benefit of, the subject facility where a resident resides or resided during the subject residency.
- "Passive investor" means an individual or entity that has an interest in a facility but does not participate in the decision-making or operations of the facility.

The bill provides that an exclusive cause of action for an ALF residents' rights violation or for negligence, which alleges direct or vicarious liability for the personal injury or death of a resident arising from such rights violation or negligence, and which seeks damages for such injury or death, may be brought only against:

- The licensee.
- The licensee's management company or active participant.
- The licensee's managing employees.
- Any direct caregivers, whether employees or contractors.

The bill provides that passive investors are not liable under the statute. Additionally, an action against any other individual or entity may be brought only pursuant to a new provision in the bill, described below.

Currently, for ALFs, the law does not limit who can initially be sued.[55] For example, a plaintiff can sue the licensee, managing company, managing employees, direct caregivers, building owner, real property owner, and passive investors. However, for nursing homes, the initial cause of action is limited to being filed against the licensee, the licensee's management company or consulting company, the licensee's managing employees, and direct caregivers, whether employees or contractors.[56] The bill makes it so causes of action against ALFs involve similar potential defendants as causes of actions against nursing homes.

[55] *See* s. 429.29(1), F.S.
[56] Section 400.023(1), F.S.

With respect to actions alleging a claim for an ALF residents' rights violation or for negligence that caused the death of the resident, the bill amends the statute to require the claimant to elect survival damages[57] or wrongful death damages[58] after the verdict but before the judgment is entered. In cases involving the death of a resident, current law requires the claimant to elect either survival damages or wrongful death damages but does not specify when the election must be made.[59] For nursing homes, state law requires this election to be made after the verdict but before the judgment is entered.[60] The bill aligns this election in the ALF context with the same election in the nursing home context.

The bill provides that a cause of action for a residents' rights violation or for negligence may not be asserted against an individual or entity other than the licensee, the licensee's management company or active participant, the licensee's managing employees, and any direct caregivers, whether employees or contractors, unless, after a motion for leave to amend hearing, the court or an arbitration panel determines that there is sufficient evidence in the record or proffered by the claimant to establish a reasonable showing that:

- The individual or entity owed a duty of reasonable care to the resident and breached that duty.
- The breach of that duty is a legal cause of loss, injury, death, or damage to the resident.

The bill provides that for purposes of these causes of action against others, if it is asserted in a proposed amended pleading that they arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the proposed amendment relates back to the original pleading.

Section 2 of the bill amends s. 429.297, F.S., regarding punitive damages, in the following ways.

The bill clarifies that, in any action brought under the Act, no claim for punitive damages may be brought unless there is admissible evidence submitted by the parties providing a reasonable basis for recovery pursuant to the statute. Claimants may move to amend their complaints to assert a claim for punitive damages, as allowed by the rules of civil procedure, but only if in accordance with the evidentiary requirements in the bill.

The bill requires the court to conduct a hearing to determine whether there is sufficient admissible evidence submitted by the parties to ensure that there is a reasonable basis for a punitive damages award. The claimant, at trial, will need to demonstrate by clear and convincing evidence that the recovery of punitive damages is warranted under a claim for direct liability or vicarious liability as specified in the statute.

Currently, for ALFs, a plaintiff may claim punitive damages by a reasonable showing based on evidence in the record (*e.g.* an affidavit) or proffered by the claimant that would provide a reasonable basis for recovery of such damages.[61] However, for nursing homes, the court must

[57] *See* s. 46.021, F.S.
[58] *See* s. 768.21, F.S.
[59] *See* s. 429.29(1), F.S.
[60] Section 400.023(1)(b), F.S.
[61] *See* s. 429.297(1), F.S.

conduct a hearing where the plaintiff must demonstrate that there is admissible evidence providing a reasonable basis for the recovery of punitive damages.[62] The bill aligns the statute with the corresponding statute for nursing homes.

The bill provides that a defendant may be held liable for punitive damages only if the trier of fact, by clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct, or actively and knowingly engaged in conduct that constitutes gross negligence and contributed to the loss, damages, or injury suffered by the claimant. The bill also clarifies that in this context, "intentional misconduct" means that the defendant *against whom punitive damages are sought* had actual knowledge of the wrongfulness of the conduct, and the high probability that injury or damage to the claimant would result and, despite that knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

The bill also provides that in the case of vicarious liability of an individual, employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless the conduct of the employee or agent meets the criteria described above, and an officer, director, or manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to that specific conduct.

Section 3 of the bill provides that the bill's provisions apply to causes of action that accrue on or after July 1, 2024.

Section 4 of the bill provides an effective date of July 1, 2024.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[62] Section 400.0237(1)(b), F.S.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill will benefit passive investors of ALFs by exempting them from lawsuits under the civil enforcement provisions of the Assisted Living Facilities Act. Because passive investors will no longer be named as defendants in ALF lawsuits, they will avoid potential liability under the Act as well as the costs associated with defending themselves in court. Additionally, by reducing liability risks, ALFs may be better positioned to attract passive investors.

Additionally, the bill makes it more difficult for plaintiffs under the Act to seek punitive damages against defendants, by requiring the court to hold a hearing determining whether sufficient admissible evidence providing a reasonable basis for the recovery of punitive damages exists. If the plaintiff cannot make this demonstration, the defendant will not incur the costs associated with defending the claim.

C. Government Sector Impact:

The bill is likely to improve judicial economy by reducing the number of lawsuits filed under the civil enforcement provisions of the Act.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 429.29 and 429.297.

IX. Additional Information:

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

CS by Judiciary on January 29, 2024:

- Replaces the definition of "management or consulting company" with a new but similar definition for "management company or active participant."
- Provides that "management company or active participant" means an individual or entity that contracts or receives a fee to provide the same services included in the definition for "management or consulting company," but also the service of receiving

and controlling a line of credit, loan, or other credit instrument that is used in whole or in part by, or for the benefit of, the subject facility where a resident resides or resided during the subject tenancy.

- Replaces all references to "management or consulting company" in the bill with "management company or active participant."

B. Amendments:

None.

By the Committee on Judiciary; and Senator Burton

590-02612-24 2024238c1

A bill to be entitled

An act relating to claims against assisted living facilities; amending s. 429.29, F.S.; defining terms; providing requirements for the bringing of an exclusive cause of action for residents' rights violations or negligence against specified individuals; providing certain individuals with immunity from liability for such claims; providing exceptions; amending s. 429.297, F.S.; revising requirements for recovery of certain damages and liability for such damages; revising definitions; deleting obsolete language; providing applicability; providing an effective date.

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

Section 1. Section 429.29, Florida Statutes, is amended to read:

429.29 Civil actions to enforce rights.—

(1) As used in this section, the term:

(a) "Licensee" means an individual, corporation, partnership, firm, association, governmental entity, or other entity that is issued a permit, registration, certificate, or license by the agency and is legally responsible for all aspects of the operation of the facility.

(b) "Management company or active participant" means an individual or entity that contracts or receives a fee to provide any of the following services for a facility:

1. Hiring or firing the administrator or director of

nursing;

2. Controlling or having control over staffing levels at the facility;

3. Having control over the budget of the facility;

4. Implementing and enforcing the policies and procedures of the facility; or

5. Receiving and controlling a line of credit, loan, or other credit instrument that is used either in whole or in part by, or for the benefit of, the subject facility where a resident resides or resided during the subject residency.

(c) "Passive investor" means an individual or entity that has an interest in a facility but does not participate in the decisionmaking or operations of the facility.

(2) An exclusive cause of action for a residents' ~~Any person or resident whose~~ rights violation or for negligence as specified under ~~in~~ this part which alleges direct or vicarious liability for the personal injury or death of a resident arising from such rights violation or negligence and which seeks damages for such injury or death may be brought only against the licensee, the licensee's management company or active participant, the licensee's managing employees, or any direct caregivers, whether employees or contractors. A passive investor is not liable under this section. An action against any other individual or entity may be brought only pursuant to subsection (3) ~~are violated shall have a cause of action~~.

(a) The action may be brought by the resident or his or her guardian, or by an individual ~~a person~~ or organization acting on behalf of a resident with the consent of the resident or his or her guardian, or by the personal representative of the estate of

a deceased resident regardless of the cause of death.

(b) If the action alleges a claim for a residents' ~~the resident's~~ rights violation or for negligence that caused the death of the resident, the claimant, after the verdict, but before the judgment is entered, must ~~shall be required to~~ elect ~~either~~ survival damages pursuant to s. 46.021 or wrongful death damages pursuant to s. 768.21. If the action alleges a claim for a residents' ~~the resident's~~ rights violation or for negligence that did not cause the death of the resident, the personal representative of the estate may recover damages for the negligence that caused injury to the resident.

(c) The action may be brought in any court of competent jurisdiction to enforce such rights and to recover actual ~~damages,~~ and punitive damages for the residents' rights violation ~~of the rights of a resident~~ or negligence.

(d) A ~~Any~~ resident who prevails in seeking injunctive relief or ~~a claim for~~ an administrative remedy is entitled to recover the costs of the action and ~~a~~ reasonable attorney fees ~~attorney's fee~~ assessed against the defendant of up ~~not~~ to ~~exceed~~ $25,000. Such attorney fees must ~~shall~~ be awarded solely for the injunctive or administrative relief and not for any claim or action for damages whether such claim or action is brought ~~together~~ with a request for an injunction or administrative relief or as a separate action, except as provided under s. 768.79 or the Florida Rules of Civil Procedure. ~~Sections 429.29-429.298 provide the exclusive remedy for a cause of action for recovery of damages for the personal injury or death of a resident arising out of negligence or a violation of rights specified in s. 429.28.~~

(e) This section does not preclude theories of recovery not arising out of negligence or s. 429.28 which are available to a resident or to the agency. ~~The provisions of~~ Chapter 766 does ~~do~~ not apply to any cause of action brought under ss. 429.29-429.298.

(3) A cause of action for a residents' rights violation or for negligence may not be asserted against an individual or entity other than the licensee, the licensee's management company or active participant, the licensee's managing employees, and any direct caregivers, whether employees or contractors, unless, after a motion for leave to amend hearing, the court or an arbitration panel determines that there is sufficient evidence in the record or proffered by the claimant to establish a reasonable showing that:

(a) The individual or entity owed a duty of reasonable care to the resident and breached that duty; and

(b) The breach of that duty is a legal cause of loss, injury, death, or damage to the resident.

For purposes of this subsection, if it is asserted in a proposed amended pleading that such cause of action arose out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the proposed amendment relates back to the original pleading.

(4) ~~(2)~~ In any claim brought pursuant to this part alleging a violation of residents' ~~resident's~~ rights or negligence causing injury to or the death of a resident, the claimant has ~~shall have~~ the burden of proving, by a preponderance of the evidence, that:

(a) The defendant owed a duty to the resident;

(b) The defendant breached the duty to the resident;

(c) The breach of the duty is a legal cause of loss, injury, death, or damage to the resident; and

(d) The resident sustained loss, injury, death, or damage as a result of the breach.

~~Nothing in~~ This part does not ~~shall be interpreted to~~ create strict liability. A violation of the rights provided ~~set forth~~ in s. 429.28 or in any other standard or guidelines specified in this part or in any applicable administrative standard or guidelines of this state or a federal regulatory agency may ~~shall~~ be evidence of negligence but is ~~shall~~ not ~~be~~ considered negligence per se.

(5) ~~(3)~~ In a ~~any~~ claim brought pursuant to this section, a licensee, individual ~~person~~, or entity has ~~shall have~~ a duty to exercise reasonable care. Reasonable care is that degree of care which a reasonably careful licensee, individual ~~person~~, or entity would use under like circumstances.

(6) ~~(4)~~ In a ~~any~~ claim for a residents' ~~resident's~~ rights violation or for negligence by a nurse licensed under part I of chapter 464, such nurse has ~~shall have~~ the duty to exercise care consistent with the prevailing professional standard of care for a nurse. The prevailing professional standard of care for a nurse is ~~shall be~~ that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar nurses.

(7) ~~(5)~~ Discovery of financial information for the purpose

of determining the value of punitive damages may not be conducted ~~had~~ unless the plaintiff shows the court by proffer or evidence in the record that a reasonable basis exists to support a claim for punitive damages.

(8) ~~(6)~~ In addition to any other standards for punitive damages, any award of punitive damages must be reasonable in light of the actual harm suffered by the resident and the egregiousness of the conduct that caused the actual harm to the resident.

(9) ~~(7)~~ The resident or the resident's legal representative shall serve a copy of a ~~any~~ complaint alleging in whole or in part a violation of any rights specified in this part to the agency ~~for Health Care Administration~~ at the time of filing the initial complaint with the clerk of the court for the county in which the action is pursued. The requirement of providing a copy of the complaint to the agency does not impair the resident's legal rights or ability to seek relief for his or her claim.

Section 2. Section 429.297, Florida Statutes, is amended to read:

429.297 Punitive damages; pleading; burden of proof.—

(1) A ~~In any action for damages brought under this part, no~~ claim for punitive damages may not be brought under this part ~~shall be permitted~~ unless there is a ~~reasonable~~ showing by admissible evidence submitted by the parties which provides ~~in the record or proffered by the claimant which would provide~~ a reasonable basis for recovery of such damages pursuant to this section.

(a) The claimant may move to amend her or his complaint to assert a claim for punitive damages as allowed by the rules of

civil procedure in accordance with evidentiary requirements provided in this section.

(b) The court shall conduct a hearing to determine whether there is sufficient admissible evidence submitted by the parties to ensure that there is a reasonable basis to believe that the claimant, at trial, will be able to demonstrate by clear and convincing evidence that the recovery of such damages is warranted under a claim for direct liability as specified in subsection (2) or under a claim for vicarious liability as specified in subsection (3).

(c) The rules of civil procedure must ~~shall~~ be liberally construed so as to allow the claimant discovery of evidence which appears reasonably calculated to lead to admissible evidence on the issue of punitive damages. ~~No~~ Discovery of financial worth may not ~~shall~~ proceed until ~~after~~ the pleading concerning punitive damages is approved by the court ~~permitted~~.

(2) A defendant may be held liable for punitive damages only if the trier of fact, by ~~based on~~ clear and convincing evidence, finds that a specific individual or corporate defendant actively and knowingly participated in intentional misconduct or actively and knowingly engaged in conduct that constitutes gross negligence and contributed to the loss, damages, or injury suffered by the claimant ~~the defendant was personally guilty of intentional misconduct or gross negligence~~. As used in this section, the term:

(b) ~~(a)~~ "Intentional misconduct" means that the defendant against whom punitive damages are sought had actual knowledge of the wrongfulness of the conduct and the high probability that injury or damage to the claimant would result and, despite that

knowledge, intentionally pursued that course of conduct, resulting in injury or damage.

(a) ~~(b)~~ "Gross negligence" means that the defendant's conduct was so reckless or wanting in care that it constituted a conscious disregard or indifference to the life, safety, or rights of individuals ~~persons~~ exposed to such conduct.

(3) In the case of vicarious liability of an individual, employer, principal, corporation, or other legal entity, punitive damages may not be imposed for the conduct of an employee or agent unless ~~only if~~ the conduct of the employee or agent meets the criteria specified in subsection (2) and an officer, director, or manager of the actual employer, corporation, or legal entity condoned, ratified, or consented to the specific conduct as provided in subsection (2) ~~:~~

~~(a) The employer, principal, corporation, or other legal entity actively and knowingly participated in such conduct;~~

~~(b) The officers, directors, or managers of the employer, principal, corporation, or other legal entity condoned, ratified, or consented to such conduct; or~~

~~(c) The employer, principal, corporation, or other legal entity engaged in conduct that constituted gross negligence and that contributed to the loss, damages, or injury suffered by the claimant~~.

(4) The plaintiff must establish at trial, by clear and convincing evidence, its entitlement to an award of punitive damages. The "greater weight of the evidence" burden of proof applies to a determination of the amount of damages.

~~(5) This section is remedial in nature and shall take effect upon becoming a law.~~

Section 3. The amendments to ss. 429.29 and 429.297, Florida Statutes, made by this act apply to causes of action that accrue on or after July 1, 2024.

Section 4. This act shall take effect July 1, 2024.

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
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2/6/2024
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name Janann S. Holt

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Ponte Vedra FL 32081
City State Zip

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

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2/6/2024
Meeting Date

Health Policy
Committee

SB 238
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jennifer McConnell

Phone 727-742-0189

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Land O Lakes FL 34637
City *State* *Zip*

Email JMcConnell@Sencare management.net

Speaking: [X] For [ ] Against [ ] Information **OR** Waive Speaking: [X] In Support [ ] Against

PLEASE CHECK ONE OF THE FOLLOWING:

[✓] I am appearing without compensation or sponsorship.

[ ] I am a registered lobbyist, representing:

[ ] I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

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2-6-24
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name Jason Hand

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City State Zip

Email

Speaking: ☒ For ☐ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
FSLA

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

2-6-24

Meeting Date

The Florida Senate
APPEARANCE RECORD

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238

Bill Number or Topic

Committee

Amendment Barcode (if applicable)

Name Rey Contreras

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Speaking: ☐ For ☒ Against ☐ Information **OR** Waive Speaking: ☐ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☒ I am appearing without compensation or sponsorship.

☐ I am a registered lobbyist, representing:

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

THE FLORIDA SENATE

APPEARANCE RECORD

2/6/24
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

238
Bill Number (if applicable)

Topic ALF BILL (BURTON)

Amendment Barcode (if applicable)

Name BRECHT HEUCHAN

Job Title GOV'T AFFAIRS

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TALLAHASSEE FL 32302
City *State* *Zip*

Phone 850.345.2937

Email

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FJA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

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S-001 (10/14/14)

The Florida Senate

APPEARANCE RECORD

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02.06.24
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name William Large

Phone 850-222-0170

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Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** **Waive Speaking:** ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
Florida Justice Reform Institute

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name Sarah Massey

Phone 850 545 0543

Address 136 S. Bronough St.
Street

Email rmassey@flchamber.com

City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Chamber of Commerce

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

THE FLORIDA SENATE

APPEARANCE RECORD

~~2/65/2024~~ 2/6/24 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) 238

Meeting Date *Bill Number (if applicable)*

Topic Claims Against Assisted Living Facilities *Amendment Barcode (if applicable)*

Name Adam Basford

Job Title VP-Government Relations

Address 516 N Adams St Phone 850-224-7173

Street

Tallahassee FL 32301 Email abasford@aif.com

City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information Waive Speaking: ☑ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Associated Industries of Florida

Appearing at request of Chair: ☐ Yes ☐ No Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2/6/24
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name ADAM POTTS

Phone 850 841-1726

Address 113 E. College Ave Ste 400
Street

Email adam@libertypartnersfl.com

Tallahassee FL 32302
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing: Florida Assisted Living Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

Feb. 6, 2024
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name Hayden Dempsey

Phone 850-222-6891

Address 101 E College Ave
Street

Email dempseyh@gtlaw.com

Tallahassee FL 32301
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☑ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☑ I am a registered lobbyist, representing:
LeadingAge Florida

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

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S-001 (08/10/2021)

The Florida Senate

APPEARANCE RECORD

Deliver both copies of this form to
Senate professional staff conducting the meeting

2-6-24
Meeting Date

Health Policy
Committee

238
Bill Number or Topic

Amendment Barcode (if applicable)

Name James McFaddin

Phone 850-671-4401

Address 123 S. Adams St
Street

Email mcfaddin@thesoutherngroup.com

Tallahassee FL 32301
City State Zip

Speaking: ☐ For ☐ Against ☐ Information **OR** Waive Speaking: ☒ In Support ☐ Against

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I am appearing without compensation or sponsorship.

☒ I am a registered lobbyist, representing:
Florida Senior Living Association

☐ I am not a lobbyist, but received something of value for my appearance (travel, meals, lodging, etc.), sponsored by:

While it is a tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this hearing. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard. If you have questions about registering to lobby please see Fla. Stat. §11.045 and Joint Rule 1. 2020-2022JointRules.pdf (flsenate.gov)

This form is part of the public record for this meeting.

S-001 (08/10/2021)

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 2/6/2024 11:16:18 AM
Ends: 2/6/2024 1:59:54 PM Length: 02:43:37

11:34:08 AM Chair Burton calls meeting to order
11:35:19 AM roll call - quorum present
11:35:30 AM tab 8 - SB 962 by Sen. Hooper
11:36:56 AM amend. barcode 194644 explained by sponsor
11:37:48 AM amendment adopted
11:37:57 AM Dr. Nancy Lawther waives in support
11:38:11 AM Dr. Sylvan Dore speaks for informational purposes
11:39:44 AM Anna Grace Lewis waives in support
11:39:57 AM Sen. Hooper closes on bill
11:40:07 AM roll call - SB 962 reported favorably as a CS
11:40:58 AM tab 5 - SB 1442 by Sen. Grall
11:42:11 AM Madonna Finney waives in support
11:42:19 AM Tammy Fecci waives in support
11:42:35 AM Dr. John Frank w/ Pax Christi Fla., speaks in favor
11:44:23 AM Sen. Osgood in debate
11:46:14 AM Sen. Davis in debate
11:47:29 AM Sen. Garcia in debate
11:48:03 AM Sen. Grall closes on bill
11:50:10 AM roll call - SB 1442 reported favorable
11:50:31 AM tab 9 - SB 1632 by Sen. Collins and Sen. Avila
11:50:57 AM Sen. Avila presents bill on behalf of Sen. Collins
11:52:31 AM Patrick Steele w/ AHCA, waives in support
11:52:35 AM Sen. Avila waives close
11:52:46 AM roll call - SB 1442 reported favorably
11:53:01 AM tab 2 - SB 338 by Sen. Berman
11:53:50 AM Sen. Berman explains bill
11:55:26 AM Strike All amend. 440740 adopted
11:55:56 AM Sen. Harrell has question
11:57:19 AM David Cullen w/ Sierra Club, waives in support
11:57:29 AM Emma Hayday w/ Surfrider Fndn., speaks for the bill
11:58:51 AM Rick Myers waives in support
12:00:01 PM Sen. Burton waives close on bill
12:00:12 PM roll call - SB 338 reported favorably as a CS
12:00:46 PM tab 3 - SB 1582 by Sen. Rodriguez
12:01:03 PM Sen. Rodriguez explains bill
12:01:30 PM amend. barcode 879888
12:01:57 PM amendment adopted
12:02:08 PM Nancy Lawther waives in support
12:02:22 PM roll call - SB 1582 reported favorably as a CS
12:02:52 PM tab 4 - SB 768 by Sen. Stewart
12:02:58 PM Sen. Stewart explains Late-filed Strike All amend. 581312 first
12:04:47 PM amendment adopted
12:05:05 PM Antorrio Wright waives in support
12:05:33 PM Sen. Book asks question of Captain Antorrio Wright
12:07:09 PM Sen. Davis w/ a question of Cap. Wright
12:08:22 PM Sen. Osgood w/ a question of speaker
12:09:32 PM Sen. Stewart closes on bill
12:09:46 PM roll call - SB 768 reported favorably as a CS
12:10:09 PM tab 6 - SB 1474 by Sen. Trumbull
12:10:18 PM Sen. Trumbull explains bill
12:11:55 PM Sen. Harrell has question
12:14:11 PM couple of follow-ups

12:14:42 PM late-filed amend. 194076 taken up
12:15:25 PM Kim Driggers waives in support
12:15:54 PM Kim Driggers w/ Fla. Chiropractic Assn., again to speak in favor of bill
12:22:13 PM Sen. Davis has question for speaker
12:22:47 PM Dr. Amanda Sellers speaks in favor of bill
12:24:57 PM Dr. Eduardo Martinez speaks against bill
12:27:59 PM Sen. Osgood has question for speaker
12:30:28 PM Dr. Brian Moriarty speaks against bill
12:33:18 PM Sen. Osgood w/ a question of speaker
12:34:12 PM Amanda Stewart waives in support
12:34:29 PM Sen. Brodeur in debate
12:36:03 PM Sen. Harrell debates
12:38:07 PM Sen. Osgood debates
12:38:47 PM Sen. Trumbull closes on bill
12:41:01 PM roll call - SB 1474 reported favorably as a CS
12:41:35 PM tab 7 - SB 1798 by Sen. Trumbull
12:41:47 PM Strike All amend. 477550 taken up
12:43:11 PM Chris Floyd waives in support of amend.
12:43:28 PM Corinne Mixon waives in support of amend.
12:43:34 PM amendment adopted
12:43:42 PM Kyle Simon waives in support of bill
12:43:55 PM Ivonne Fernandez w/ AARP, waives in support
12:43:56 PM Jennifer Ungru waives in support
12:44:09 PM sponsor waives close
12:44:15 PM roll call - SB 1798 reported favorably as a CS
12:44:34 PM tab 10 - SB 1188 by Sen. Garcia
12:46:49 PM Sen. Garcia explains bill
12:48:00 PM amend. 860118 explained
12:48:06 PM sponsor waives close on amend. -adopted
12:48:17 PM Chris Nuland representing Fla. Society of Plastic Surgeons, speaks against bill
12:50:31 PM Jeff Scott w/ FMA, waives in opposition
12:50:44 PM Albert Balido waives in opposition
12:52:54 PM sponsor closes on bill
12:53:01 PM roll call - SB 1188 reported favorably as a CS
12:53:27 PM gavel passes to vice-chair Brodeur
12:53:37 PM tab 1 - SPB 7050
12:54:03 PM Sen. Burton explains bill
12:55:03 PM amend. barcode 693990 explained
12:55:35 PM Melissa Villar speaks against the amendment
12:56:15 PM Sen. Burton closes on amend. - adopted
12:56:26 PM Sen. Davis in questions
12:59:19 PM Will Clark, Libertarian Party of Fla., speaks against bill
1:00:53 PM Jodi James w/ Fl. Cannabis Action Network, speaks against bill
1:05:38 PM Jeff Sharkey waives against
1:05:46 PM Melissa Villar speaks for informational purposes
1:12:54 PM Ron Book waives in opposition
1:13:04 PM Sen. Harrell in debate
1:14:39 PM Sen. Davis in debate
1:17:54 PM Sen. Osgood in debate
1:23:50 PM Sen. Burton closes on bill
1:26:45 PM SPB becomes a committee bill
1:27:03 PM roll call - SPB 7050 reported favorably as a committee bill
1:27:34 PM tab 11 - SB 1118 by Sen. Harrell
1:27:40 PM Sen. Harrell explains bill
1:31:41 PM Allen Mortham, Jr., representing Fla. Assn. of Postsecondary Schools, speaks against
1:32:38 PM Teye Carmichael waives in support
1:32:47 PM Bob Harris, representing Fla. Assn. of Ind. Nursing Students, speaks against
1:33:46 PM Jack Cory waives in support
1:33:57 PM Sen. Harrell closes on bill
1:34:14 PM roll call - SB 1118 reported favorably
1:34:43 PM tab 12 - SB 1612 by Sen. Brodeur
1:34:52 PM Sen. Brodeur explains Strike All amend. 471432

1:35:38 PM amendment adopted
1:35:45 PM Dr. Chas. Lambert speaks in favor of bill
1:36:41 PM Sen. Brodeur closes
1:36:56 PM roll call - SB 1612 reported favorably as a CS
1:37:15 PM gavel turned over to vice-chair Brodeur
1:37:36 PM tab 13 - CS/SB 238 by Sen. Burton
1:37:50 PM Sen. Burton explains bill
1:40:58 PM Sen. Davis asks a question
1:45:25 PM Sen. Osgood w/ questions
1:48:40 PM Janann Holt speaks for the bill
1:49:25 PM Jennifer McConnell speaks for the bill
1:50:49 PM Jason Hand w/ FSLA, waives in support
1:51:55 PM Rey Contreras speaks against bill
1:53:20 PM Brecht Heuchan representing FJA, speaks against bill
1:54:20 PM Wm. Large waives in support
1:54:27 PM Sarah Massey waives in support
1:54:31 PM Adam Basford waives in support
1:54:34 PM Adam Potts waives in support
1:54:37 PM Hayden Dempsey waives in support
1:54:50 PM Jms. McFaddin waives in supoort
1:55:03 PM Sen. Garcia in debate
1:55:51 PM Sen. Burton closes on bill
1:56:38 PM roll call - CS/SB 238 reported favorably
1:57:14 PM motion by Sen. Book to vote in affirmative on the bills that she missed
1:57:23 PM motion by Sen. Calatayud to vote in affirmative for tabs 8, 2, 5, 9, 3, 4, 6, 7, 10
1:57:37 PM comment by Sen. Davis to confirm that she voted a Yea on tab 11
1:57:47 PM motion by Sen. Avila to vote in affirmative for tabs 3, 2, 4, 6, 7, 10
1:58:29 PM closing statements from Chair Burton
1:59:40 PM Sen. Brodeur moves to adjourn