SB 24 by **Soto**; (Identical to H 3503) Relief of J.D.S. by the Agency for Persons with Disabilities

CS/SB 40 by **JU, Ring**; (Identical to H 3551) Relief of L.T. by the Department of Children and Families

CS/SB 58 by **JU, Simpson**; (Identical to H 3537) Relief of C.M.H. by the Department of Children and Families

CS/SB 80 by **JU, Flores**; (Similar to H 3555) Relief of Michael and Patricia Rardin by the North Broward Hospital District

CS/SB 512 by **HP, Thompson (CO-INTRODUCERS) Soto**; (Similar to CS/CS/H 0321) HIV Testing

CS/SB 950 by **HP, Hukill**; (Similar to CS/H 0697) Public Health Emergencies

SB 1040 by **Braynon**; (Identical to H 0475) Infectious Disease Elimination Pilot Program

CS/SB 1526 by **HP, Legg**; (Similar to CS/H 0541) Athletic Trainers

SB 816 by **Grimsley**; (Identical to H 0441) Home Health Agencies

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

APPROPRIATIONS SUBCOMMITTEE ON HEALTH AND HUMAN SERVICES
Senator Garcia, Chair
Senator Smith, Vice Chair

MEETING DATE: Wednesday, April 8, 2015
TIME: 10:00 a.m.—12:00 noon
PLACE: *James E. "Jim" King, Jr. Committee Room,* 401 Senate Office Building

MEMBERS: Senator Garcia, Chair; Senator Smith, Vice Chair; Senators Abruzzo, Bean, Benacquisto, Grimsley, Richter, and Sobel

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	**SB 24** Soto (Identical H 3503)	Relief of J.D.S. by the Agency for Persons with Disabilities; Providing for the relief of J.D.S. by the Agency for Persons with Disabilities; providing an appropriation from the General Revenue Fund to compensate J.D.S. for injuries and damages sustained as a result of negligence by the Agency for Persons with Disabilities, as successor agency of the Department of Children and Family Services; providing a limitation on the payment of fees and costs, etc. SM 02/09/2015 Recommendation: Favorable JU 02/17/2015 Favorable AHS 04/08/2015 Favorable AP	Favorable Yeas 5 Nays 0
2	**CS/SB 40** Judiciary / Ring (Identical H 3551)	Relief of L.T. by the Department of Children and Families; Providing an appropriation to compensate L.T. for injuries and damages sustained as a result of the negligence of employees of the Department of Children and Families, formerly known as the Department of Children and Family Services; providing for a waiver of specified lien interests held by the state; providing a limitation on the payment of fees and costs, etc. SM 02/09/2015 Recommendation: Favorable JU 02/17/2015 Fav/CS AHS 04/08/2015 Favorable AP	Favorable Yeas 5 Nays 0
3	**CS/SB 58** Judiciary / Simpson (Identical H 3537)	Relief of C.M.H. by the Department of Children and Families; Providing for the relief of C.M.H.; providing an appropriation to compensate C.M.H. for injuries and damages sustained as a result of the negligence of the Department of Children and Families, formerly known as the Department of Children and Family Services; providing a limitation on the payment of fees and costs, etc. SM 02/26/2015 Recommendation: Fav/1 Amendment JU 03/03/2015 Fav/CS AHS 04/08/2015 Favorable AP	Favorable Yeas 5 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**CS/SB 80** Judiciary / Flores (Similar H 3555)	Relief of Michael and Patricia Rardin by the North Broward Hospital District; Providing for the relief of Michael and Patricia Rardin by the North Broward Hospital District; providing for an appropriation to compensate Michael and Patricia Rardin for injuries sustained as a result of the negligence of the North Broward Hospital District; providing a limitation on the payment of fees and costs, etc. SM 03/19/2015 Recommendation: Fav/1 Amendment JU 03/24/2015 Fav/CS AHS 04/08/2015 Favorable AP	Favorable Yeas 5 Nays 0
5	**CS/SB 512** Health Policy / Thompson (Similar CS/CS/H 321)	HIV Testing; Revising and providing definitions; specifying the notification and consent procedures for performing an HIV test in a health care setting and a nonhealth care setting, etc. HP 03/17/2015 Fav/CS AHS 04/08/2015 Favorable FP	Favorable Yeas 7 Nays 0
6	**CS/SB 950** Health Policy / Hukill (Similar CS/H 697)	Public Health Emergencies; Requiring certain state and local officers to assist in enforcing rules and orders issued by the Department of Health under ch. 381, F.S.; authorizing the State Health Officer to issue orders to isolate individuals; specifying that any order the department issues is immediately enforceable by a law enforcement officer; providing a penalty for violating an isolation order, etc. HP 03/10/2015 Fav/CS AHS 04/08/2015 Favorable FP	Favorable Yeas 5 Nays 0
7	**SB 1040** Braynon (Identical H 475)	Infectious Disease Elimination Pilot Program; Creating the “Miami-Dade Infectious Disease Elimination Act (IDEA)”; authorizing the University of Miami and its affiliates to establish a sterile needle and syringe exchange pilot program in Miami-Dade County; providing that the distribution of needles and syringes under the pilot program is not a violation of the Florida Comprehensive Drug Abuse Prevention and Control Act or any other law; requiring the Office of Program Policy Analysis and Government Accountability to submit a report and recommendations regarding the pilot program to the Legislature; providing for severability, etc. HP 03/23/2015 Favorable AHS 04/08/2015 Favorable FP	Favorable Yeas 6 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
8	**CS/SB 1526** Health Policy / Legg (Similar CS/H 541)	Athletic Trainers; Deleting the requirement for the Governor to appoint the initial members of the Board of Athletic Training; revising the board's authorization to adopt certain rules relating to communication between an athletic trainer and a supervising physician; revising responsibilities of athletic trainers to include requirements that a trainer must practice under the direction of a physician; revising general background screening provisions to include athletic trainers, etc. HP 03/23/2015 Fav/CS AHS 04/08/2015 Favorable FP	Favorable Yeas 5 Nays 0
9	**SB 816** Grimsley (Identical H 441)	Home Health Agencies; Revising the information that a home health agency is required to submit to the Agency for Health Care Administration for license renewal; removing the requirement that a home health agency submit quarterly reports, etc. HP 03/23/2015 Favorable AHS 04/08/2015 Favorable FP	Favorable Yeas 5 Nays 0
	Other Related Meeting Documents		

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
302 Senate Office Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
2/9/15	SM	Favorable
02/17/15	JU	Favorable
4/7/15	AHS	Favorable

February 9, 2015

The Honorable Andy Gardiner
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **SB 24 (2015)** – Senator Darren Soto
Relief of J.D.S., by the Agency for Persons with Disabilities

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $950,000 PAYABLE TO THE AGED POOLED SPECIAL NEEDS TRUST ON BEHALF OF J.D.S., BASED ON A SETTLEMENT AGREEMENT BETWEEN PATTI R. JARRELL, AS PLENARY GUARDIAN OF J.D.S. AND THE STATE OF FLORIDA, AGENCY FOR PERSONS WITH DISABILITIES. THE CLAIM AROSE FROM THE NEGLIGENT SUPERVISION OF A GROUP HOME BY THE AGENCY.

FINDINGS OF FACT:

In 1980, J.D.S. was born with severe disabilities, including cerebral palsy, autism, and mental retardation. J.D.S. has a 31 IQ and has been nonverbal her entire life. J.D.S. was placed in the custody of the State of Florida, Department of Children and Families (DCF) and considered to be a "ward" of DCF. Due to her condition, J.D.S. was dependent upon DCF for the provision of her care, treatment, and daily needs.

At the age of 4, J.D.S., as a developmentally-disabled dependent ward of the State of Florida, was placed in the Strong Group Home. J.D.S. was totally dependent on the Strong Group Home to provide the care for her needs. She was incapable of performing even the most basic functions of life. The Strong Group Home was licensed by DCF to operate the group home, and the home was monitored through face

to face visits on a monthly basis with the exception of a short interval when, due to budget cuts, visits occurred either every other month or quarterly. The Strong Group Home was also visited monthly by the Medicaid Waiver Support Coordinator who had the responsibility of ensuring J.D.S. was receiving her care plan services. Hester Strong was the administrator/owner of the Strong Group Home and was assisted by her husband, Phillip Strong. In addition to caring for 4 - 6 developmentally disabled persons, Ms. Strong cared for her elderly parents who also resided in the home.

Beginning in late 2001 and into 2002, J.D.S.'s behavior became more aggressive. She began to resist getting into a car which had not been an exhibited behavior in the past. And, although she was previously toilet trained, she began exhibiting regular incontinence. Ms. Strong did not report these changes in J.D.S.'s behaviors, and the DCF monitoring reports of the Strong Group Home did not contain any reference to them.

In December 2002, J.D.S. became pregnant while a resident in the Strong Group Home. J.D.S. was 5 months pregnant when her doctor discovered her pregnancy.

Upon the discovery of J.D.S.'s pregnancy, DCF revoked the Strong Group Home's license and J.D.S. was moved to another group home. J.D.S. gave birth to a baby girl on August 30, 2003. The newborn was immediately removed from J.D.S. and placed for adoption. Following the birth, the Florida Department of Law Enforcement took DNA samples from Phillip Strong and the newborn. The results of the DNA testing confirmed that Phillip Strong was the biological father of the infant.

DCF was responsible for the oversight of the Strong Group Home and providing care to J.D.S. when the events related to the claim bill occurred. However, in 2004, the responsibility to oversee group homes for the disabled was transferred to the Agency for Persons with Disabilities along with DCF's related liabilities.

Based on the foregoing, the State of Florida, Agency for Persons with Disabilities, stipulated to the entry of a judgment in the amount of $1,150,000. The Agency for Persons' with Disabilities paid $200,000 to the AGED Pooled Special Needs

Trust on behalf of J.D.S., leaving $950,000, which is the amount sought through this claim bill.

CLAIMANT'S POSITION: The Agency for Persons with Disabilities is directly and vicariously liable for the rape and subsequent pregnancy of J.D.S. The claimant also alleges that the rape of J.D.S. was foreseeable by the agency. It should be noted that Mr. Strong was determined incompetent and never charged with the rape of J.D.S.

RESPONDENT'S POSITION: The Agency for Persons with Disabilities settled this claim before a jury trial and is neutral in this proceeding and will take no action adverse to the passage of a claim bill.

CONCLUSIONS OF LAW: As provided in s. 768.28, F.S. (2002), sovereign immunity shields the State of Florida and its agencies against tort liability in excess of $200,000 per occurrence. The parties settled the case for $1.15 million, and the Agency for Persons with Disabilities paid $200,000 to the AGED Pooled Special Needs Trust on behalf of J.D.S. The claimant alleged APD is liable for the sexual molestation of J.D.S. under two separate legal precepts: vicarious liability and direct liability. The claimant alleged APD had a "non-delegable" duty to protect J.D.S. from harm and sexual assault. At all times material to this matter J.D.S. was a resident of the Strong Group Home.

APD is a governmental agency that licenses, monitors, and places clients in residential living facilities. APD does not undertake to provide direct services to any particular client. Instead, the Florida Legislature, in s. 393.066, F.S. (2002), has mandated that the day-to-day operational level duties of care and maintenance of a client are to be delegated by APD.

Duty

Whether there is a jury verdict or a settlement agreement, as there is in this case, every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. DCF had a duty to protect and care for J.D.S. while she was in the care of the Strong Group Home. This duty included ensuring the administrator and staff of the Strong Group Home were properly trained to detect and prevent sexual abuse of the developmentally-disabled individuals placed in their care; adequate staffing was in place at all times and the staff met training requirements; the number of placements in the home did not exceed the limit established by DCF; and the

home complied with the Bill of Rights of Persons with Developmental Disabilities as set forth under s. 393.13, F.S. (2002). Such Bill of Rights guarantees that developmentally disabled individuals have the right to be free from sexual abuse in a residential facility, the right to be free from harm, and the right to receive prompt and appropriate medical care and treatment.

The Strong Group Home administrator and staff did not meet the educational and training requirements set forth in Rule 65G-2.012, F.A.C., and s. 393.067, F.S. (2002). There was no evidence presented that the administrator met the educational requirements for licensing or that she or any staff member had received any training on how to detect, report, or prevent sexual abuse of the group home's residents and clients.

The Strong Group Home was licensed for and housed 4 - 6 developmentally disabled clients. Nevertheless, at one point while J.D.S. was in the home, DCF placed two foster children in the home. As a result of the placement of additional clients, not enough bedrooms were available and the dining room was converted into J.D.S.'s bedroom. The placement of her bed in the dining room area did not provide J.D.S. the privacy she was entitled to under the Bill of Rights of Persons with Developmental Disabilities set out in s. 393.13, F.S.

Additionally, the Strong Group Home had a duty to exercise reasonable care to protect J.D.S. from abuse and neglect, including sexual abuse; to exercise reasonable care to discover abuse and neglect, to provide J.D.S. with a reasonable, safe living environment that afforded her with privacy, and to exercise reasonable care to ensure she received prompt and appropriate medical care and treatment.

Breach

A preponderance of the evidence establishes that The Strong Group Home did not meet the educational and training requirements to be licensed as a group home initially by DCF and subsequently by APD. APD and the Strong Group Home as licensed by APD, breached their duty to properly care for and protect J.D.S. Further, APD and the Strong Group Home breached their duty to J.D.S. with respect to compliance with the rights and privileges afforded the developmentally disabled pursuant to the Bill of Rights of the Developmentally Disabled.

Causation
The failure of the Department of Children and Families and subsequently the Agency for Persons with Disabilities to ensure the staff of the Strong Group Home was properly trained, possessed the required levels of education and credentials likely led to the rape of J.D.S.

Damages
The claim bill awards $950,000 for the benefit of J.D.S. No evidence was presented or available indicating that the damages authorized by the settlement are excessive or inappropriate.

ATTORNEYS FEES: Section 768.28(8), F.S., provides that "[n]o attorney may charge, demand, receive, or collect, for services rendered, fees in excess of 25 percent of any judgment or settlement." The claimant's attorneys have agreed to limit their fees to 25 percent of any amount awarded in compliance with the statutes. Lobbyists' fees are included with the attorneys' fees.

RECOMMENDATIONS: For the reasons set forth above, I recommend that Senate Bill 24 be reported FAVORABLY.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

The Florida Senate

Committee Agenda Request

To: Senator Rene Garcia
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: February 23, 2015

I respectfully request that **Senate Bill # 40**, relating to Relief of L.T. by the Department of Children and Families, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Jeremy Ring

Senator Jeremy Ring
Florida Senate, District 29

File signed original with committee office

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
302 Capitol Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
12/31/14	SM	Favorable
02/17/15	JU	Fav/CS
4/7/15	AHS	Favorable

December 31, 2014

The Honorable Andy Gardiner
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 40** – Judiciary Committee and Senator Ring
Relief of L.T.

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED EQUITABLE CLAIM FOR $800,000 FROM GENERAL REVENUE BASED ON A SETTLEMENT AGREEMENT BETWEEN THE LEGAL GUARDIAN OF L.T. AND THE DEPARTMENT OF CHILDREN AND FAMILIES FOR THE SEXUAL ABUSE SUFFERED BY L.T. WHEN SHE WAS LEFT BY THE DEPARTMENT IN THE FOSTER CARE OF A REGISTERED SEX OFFENDER

CURRENT STATUS:

On December 14, 2010, an administrative law judge from the Division of Administrative Hearings, serving as a Senate special master, held a de novo hearing on a previous version of this bill, SB 18 (2012). After the hearing, the judge issued a report containing findings of fact and conclusions of law and recommended that the bill be reported favorably with an amendment to correct an erroneous claim amount. (The 2012 bill failed to account for the $200,000 that DCF had already paid; therefore, the proper claim amount was $800,000 rather than $1,000,000.) The 2012 report is attached as an addendum to this report. The amount claimed in SB 40 (2015) on the date of this report is $800,000.

Due to the passage of time since the hearing, the Senate President reassigned the claim to me, Mary K. Kraemer. My

responsibilities were to review the records relating to the claim bill, be available for questions from the members, and determine whether any changes have occurred since the hearing, which if known at the hearing, might have significantly altered the findings or recommendation in the previous report.

According to counsel for the claimant, no changes have occurred since the hearing which might have altered the findings and recommendations in the report. There was no response provided to me by the Department of Children and Families.

The provisions of SB 40 (2015) address and update the circumstances (with additional detail) upon which the claim for relief is based, but it should be noted that the prior claim bill, SB 18 (2012), sought relief sought for the relief of the claimant **as a minor.** The record reflects that the claimant is now over the age of eighteen. There are no longer references to the claimant's "Permanent Custodian." Online public records in Pasco County indicate that a Plenary Guardianship of Minor Person and Property was terminated in 2013 prior to the claimant's 19th birthday (Case No. 51-2009-GA-000006-GAAX-WS). The bill provides that the funds are to be paid to the claimant directly (Section 3, lines 127-132).

In a letter dated October 31, 2014, claimant's counsel stated that the claimant:

1. Is now 20 years old and living with her fiancée, the father of her baby;
2. Intends to attend school in Leon County, with a career goal of specializing in the psychiatric treatment and care of trauma patients;
3. Continues to have the same diagnoses; and
4. Remains on medication.

SB 40 (2015) includes language similar to the above (lines 94-99), and further indicates that the claimant is employed part-time and attending a university in Florida.

Respectfully submitted,

Mary K. Kraemer
Senate Special Master

cc: Debbie Brown, Secretary of the Senate

CS by Judiciary on February 17, 2015:
The committee substitute provides for the proceeds of the claim bill to be paid into a special needs trust, the remainder of which will revert to the claimant when she reaches 30 years of age. Under the underlying bill, the proceeds of the claim bill would have remained in the trust for the duration of the claimant's life. The committee substitute also waives any applicable medical liens held by the state.

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
402 Senate Office Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

	COMM	ACTION
12/1/11	SM	Fav/1 amendment

December 1, 2011

The Honorable Mike Haridopolos
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-110

Re: **SB 18 (2012)** Senator Jeremy Ring
Relief of L.T., a Minor

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED EQUITABLE CLAIM FOR $800,000 FROM GENERAL REVENUE BASED ON A SETTLEMENT AGREEMENT BETWEEN THE LEGAL GUARDIAN OF L.T. AND THE DEPARTMENT OF CHILDREN AND FAMILIES FOR THE SEXUAL ABUSE SUFFERED BY L.T. WHEN SHE WAS LEFT BY THE DEPARTMENT IN THE FOSTER CARE OF A REGISTERED SEX OFFENDER.

FINDINGS OF FACT:

In August 1995, when LT. was less than two years old, the Department of Children and Families (DCF) removed LT. and her brother from their mother and placed them in the foster care of their great uncle, Eddie Thomas, and his wife, who lived in Gadsden County. Less than a year after the placement, Thomas was charged with sexually molesting a 13-year-old girl. He plead no contest to lewd, lascivious,' or indecent assault upon a child and was sentenced to five years' probation and required to receive sex abuse counseling. He was also registered as a sex offender.

Despite the fact that DCF was aware of Thomas' conviction and his registration as a sex offender, it

decided that the risk of harm to L.T. was low and did not remove L.T. from Thomas' care and custody. DCF also terminated protective supervision of L.T., meaning that a social worker no longer visited the Thomas home from time to time to see how L.T. was doing. Protective supervision is often terminated by DCF when a child is placed with a relative and DCF is satisfied that supervision is unnecessary.

In 2004, when L.T. was 10 years old, DCF placed an adolescent girl in the foster care of the Thomases. A few months after the placement, this minor girl ran away from the house in the middle of the night, claiming that Thomas had attempted to sexually molest her. DCF removed this girl from the Thomas home, but DCF did not re-evaluate the placement of LT. with Thomas.

In March 2005, when L.T. was 11 years old (and Thomas was 44), she ran away from home and told authorities that she had been repeatedly sexually abused by Thomas. She also said that Thomas and his wife used drugs. DCF then removed L.T. from the Thomas home.

It was later revealed by L.T. that she was roughly disciplined by the Thomases and that they were verbally abusive to her, frequently calling her derogatory names and telling her that she was worthless.

L.T. is now 17 years old and in a good foster home. However, as a result of the sexual abuse she endured while living with Thomas, L.T. suffers from post-traumatic stress disorder, depression, and low self-esteem. She has occasionally attempted suicide and for 10 months was a resident of Tampa Bay Academy, a mental health facility. She is receiving psychological counseling and will likely need counseling for many years. A trial consultant projected her future lost earnings as $540,000. Her projected future medical expenses are $760,000 to $11,580,000, depending on the degree of psychological therapy and supervision she might need, the higher figure reflecting the costs of institutionalization. A conservative estimate of her total future economic losses is around $2 million.

LITIGATION HISTORY:

In 2009, a lawsuit against DCF was filed in the Second Judicial Circuit by L.T.'s aunt and legal guardian. The case was successfully mediated and the parties entered into a settlement agreement pursuant to which L.T. would receive $1,000,000. The sovereign immunity limit of $200,000 was paid and the balance of $800,000 is sought through this claim bill. The court order approving the settlement agreement requires that the net proceeds to L.T. be placed in a special needs trust. After deducting legal fees and costs from the $200,000, and accounting for a Medicaid lien, $11,084 remained to be placed in a special needs trust for L.T.

CONCLUSIONS OF LAW:

The claim bill hearing was a *de novo* proceeding for the purpose of determining, based on the evidence presented to the Special Master, whether DCF is liable in negligence for the injuries suffered by L.T., and, if so, whether the amount of the claim is reasonable.

DCF has a duty to exercise reasonable care when it places foster children and to protect them from known dangers. DCF breached that duty when it learned that Thomas had been convicted of a sexual offense on a child, but did not remove L.T. from the Thomas home. DCF acted negligently again when it did not remove L.T. following the charge of sexual abuse against Thomas made by another foster child in 2004. DCF knew or should have known that Thomas posed a serious risk of harm to L.T. These breaches of duty were the proximate cause of the injuries that L.T. suffered.

The amount of the claim is fair and reasonable.

ATTORNEY'S FEES:

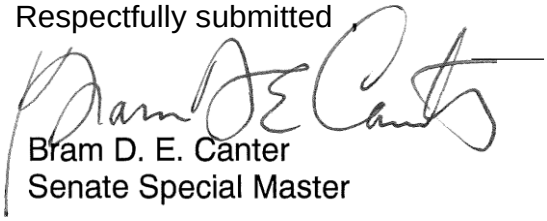
In compliance with s. 768.28(8), Florida Statutes, LT.'s attorneys have agreed to limit their fees to 25 percent of any amount awarded by the Legislature.

OTHER ISSUES:

The bill erroneously states that the claim is for $1 million, failing to account for the $200,000 that DCF has already paid. The bill should be amended to state that the claim is for $800,000.

RECOMMENDATIONS: For the reasons set forth above, I recommend that Senate Bill 18 (2012) be reported FAVORABLY, as amended.

Respectfully submitted



Bram D. E. Canter
Senate Special Master

cc: Senator Ring
Debbie Brown, Secretary of the Senate
Counsel of Record

Bar Code
815506
(2012)

e

LEGISLATIVE ACTION

Senate House

The Special Master on Claim Bills recommended the following:

Senate Amendment

Delete line 147
and insert:
a warrant in the sum of $800,000, payable to L.T., by and

THE FLORIDA SENATE

SPECIAL MASTER ON CLAIM BILLS

Location
302 Capitol

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
12/18/14	SM	Fav/1 amendment
3/3/15	JU	Fav/CS
4/7/15	AHS	Favorable

December 18, 2014

The Honorable Andy Gardiner
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB/SB 58** – Judiciary Committee and Senator Wilton Simpson
Relief of C.M.H. by the Department of Children and Families

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $5,000,000 PREDICATED ON THE ENTRY OF A JURY AWARD IN FAVOR OF CHRISTOPHER HANN AND THERESA HANN, INDIVIDUALLY, AND AS NATURAL GUARDIANS OF C.M.H., A MINOR CHILD, DUE TO THE NEGLIGENCE OF THE DEPARTMENT OF CHILDREN AND FAMILIES.

FINDINGS OF FACT:

The Department of Children and Families, placed J.W., a 10 year old foster child with a history of violence and sexual assaults against younger children, in the home of Christopher and Theresa Hann. The Hanns had young children of their own, and because the Hanns were not trained to handle a child with J.W.'s propensity for violence, the department should not have placed J.W. in the Hann's home. Making matters worse, the department concealed J.W.'s violent past from the Hanns when it had a duty to disclose it. Ultimately, the department's placement of J.W. in the Hann's home led to the emotional, physical, and sexual abuse of C.M.H., the Hann's 8 year old son, by J.W.

The Department of Children and Families knew of J.W.'s propensity for violence toward other children.

J.W. was born January 23, 1992, in Florida, to a teenage mother who had a history of mental illness and homelessness. She did not receive prenatal care and attempted suicide during the third month of her pregnancy by inhaling butane. J.W.'s mother was living in a shelter for homeless and runaway youth at his birth. J.W.'s biological father had a history of drug abuse and played no major role in his life.

J.W. lived with his mother until the age of 4. During this time he was subjected to extreme neglect, cruelty, and physical and sexual abuse by his mother, her boyfriends, and her extended family members. J.W., at age 1, was subjected to sexual abuse for approximately 2-3 years by males visiting his mother. He was severely beaten at age 2 while in the care of his mother's boyfriend.

As a result of his repeated abuse and neglect, J.W. began to exhibit symptoms of post-traumatic stress disorder. Due to aggressive behaviors, he was dismissed from two daycare centers. At age 3, he attempted suicide. He was subsequently diagnosed as having attention deficit hyperactivity disorder with psychotic behavior and suicidal tendencies and treated with anti-psychotic medication.

J.W. was returned to his mother's care at age 5. He was severely psychotic and began setting fires. In June 1997, J.W. was admitted to the Columbia Hospital Inpatient Psychiatric Program for a week due to self-mutilation, violent behavior, homicidal ideation, auditory hallucinations, and multiple suicide attempts. J.W. would continue receiving intensive outpatient psychiatric treatment for 7 months following his initial hospitalization.

After receiving a report that J.W. was again sexually molested by another of his mother's male friends, the department placed J.W. back into foster care where he resided on and off for approximately 5 years. He was involuntarily hospitalized at least two more times by age 9. One hospitalization was due to aggressive behavior, an attempt to stab his uncle and his babysitter with a knife. Later he was hospitalized for planning to bring a gun and knife to school to kill a teacher and himself. In 2002, J.W. was living with his mother who had married several years earlier and had given birth to a daughter with her new husband. The department and the family entered into

a voluntary case plan to address continuing allegations of abuse, neglect, and domestic violence in the home. During this time, J.W. began to exhibit sexually aggressive behavior towards other children. Multiple reports indicated that J.W. performed anal penetration on a neighborhood girl. He also continued to display severe psychotic behavior. On one occasion he attempted to cut his stepfather's throat while he slept.

On June 14, 2002, DCF family services counselor, Suzy Parchment, referred J.W. to Camelot Community Care, a DCF provider of child welfare and behavioral health services, for intensive therapeutic in-home services. Realizing the severity of J.W.'s behavior, in a communication with Camelot on June 24, Ms. Parchment noted that J.W. needed to be in a residential treatment facility as soon as possible.

As an emergency, temporary solution and noting that J.W. was a danger in the home, Camelot accepted the referral to provide mental health services to J.W. in his natural home while the department sought residential placement. Camelot noted on its admission form that J.W. was a sexual predator and engaged in sexually inappropriate behavior. It was also noted that J.W. suffered from non-specified psychosis, major depression with psychotic features, adjustment disorder and attention deficit hyperactivity disorder. The in-home counselor assigned to J.W.'s case did not have experience with sexual trauma, and Camelot's initial treatment plan did not include any specific goals or specialized treatment for sexual abuse.

J.W.'s mother informed Camelot and the department that J.W. was giving his 3 year old sister hickies, bouncing her on his lap in a sexual manner, and having her fondle his genitals. Camelot performed a child safety determination and found that based on J.W.'s history, a sibling was likely to be in immediate danger of moderate to severe harm if J.W. was not supervised. Camelot recommended that J.W.'s parents separate him from his younger sister at night and closely watch him when he interacts with his sister.

On or about August 2002, the department removed J.W. and his younger sister from their mother's care after she abandoned them at a friend's house. J.W. was sheltered in the home of a family friend, Luz Cruz, a non-relative

placement while his younger half-sister was placed with family members.

J.W. underwent a Comprehensive Behavioral Health Assessment on August 30, 2002, at the request of DCF. The assessment concluded that J.W. "should not have unsupervised access to [his younger sister], or to any younger, or smaller children wherever he resides." The Assessment also states: "***J.W.'s caregiver must be informed about these issues and must be able to demonstrate that they can provide adequate levels of supervision in order to prevent further victimization. These issues should be strongly considered in terms of making decisions about both temporary and long term care and supervision of J.W.***"

Based upon the findings and recommendations in the Assessment, J.W. was referred to Father Flanagan's Boys' Home d/b/s Girls and Boys Town, a DCF service provider, for case management services.

The Department of Children and Families knew that J.W., should not have been placed in a home with younger children.

Ms. Parchment removed J.W. from the Cruz home on September 6, 2002, due to allegations of sexual abuse by a member of the Cruz family; however, she did not report the abuse allegation as required by Florida law. It was also on September 6, 2002, that J.W. was placed with the Hanns.

Mr. and Mrs. Hann were former neighbors of J.W. and his natural family. The Hanns lived with their two children, a daughter, age 16, and a son, C.M.H., age 8. They were not licensed or trained foster parents. In the past, J.W. had often sought shelter in the Hann home when left alone by his mother. Theresa Hann had offered to care for J.W. and his mother lobbied Camelot and the department to have J.W. placed with the Hann family instead of Luz Cruz.

Ms. Parchment recalled her first impressions of the Hann family were of nice people who maintained a very organized and clean home. She believed Theresa Hann's main purpose was to care for J.W. and that she had no ulterior motives. However, despite the willingness of the Hanns to care for

J.W., the removal of J.W. from the Cruz home and placement in the Hann home violated DCF rules.

Under the department's rules, it is required to obtain prior court approval for all non-relative placements. This requirement eliminates non-relative placements for use in lieu of emergency shelter care. Ms. Parchment did not obtain the required court approval prior to placing J.W. in the Hann home. She also failed to notify the department's legal team, who is responsible for court filings, of the allegation of sexual abuse of J.W. in the Cruz home or his subsequent placement in the Hann home for two months.

Additionally, the placement directly conflicted with previous recommendations by department providers regarding placement for J.W. due to his sexually aggressive behaviors. J.W. was placed in a home with an 8 year old child even though 2 months earlier Camelot had warned that a sibling would be in danger in a home with J.W. One week prior to the placement, St. Mary's Medical Center had recommended that J.W. not have unsupervised access to younger children. The Hanns were not provided any information about J.W.'s ongoing inappropriate behavior with younger children and the Hanns allowed J.W. to share a bedroom with their son, C.M.H. Department rules expressly prohibit placing a sexually aggressive child in a bedroom with another child. Ms. Parchment knew of the planned sleeping arrangements prior to placing J.W. in the Hann home but did not tell them that the arrangement was prohibited under the department's rules.

The Department of Children and Families failed to inform the Hanns of J.W.'s background.

Christopher Hann specifically requested information about J.W., but the department failed to provide any information regarding J.W.'s troubled history of child-on-child sexual abuse or on his background generally. Florida law requires DCF to share psychological, psychiatric and behavioral histories, comprehensive behavioral assessments and other social assessments found in the child's resource record with caregivers. The department acknowledged during litigation that no evidence of a child resource record for J.W. was found. Additionally, for the purpose of preventing the reoccurrence of child-on-child sexual abuse, the department must provide caregivers of sexual abuse victims and aggressors with

written, complete, and detailed information and strategies related to such children, including the date of the sexual abuse incident(s), type of abuse, type of treatment received, and outcome of the treatment in order to "provide a safe living environment for **all** the children living in the home."

Not only did the department fail to comply with its own requirements, Ms. Parchment told Mr. Hann that she was not allowed to give him such information about J.W. because the placement was temporary. Nevertheless, J.W. remained in the Hann home for approximately 3 years during which his behavioral problems continued and quickly escalated.

The Department of Children and Families knew it should have removed J.W. from the Hann home as his violent behaviors increased.

Within a few weeks after J.W.'s placement in the Hann home, Mrs. Hann reported to Camelot that J.W. was playing with matches in the presence of C.M.H.; exhibited extreme anger and hostility towards C.M.H., including yelling, screaming "shut up" at the smallest aggravation or noise, and kicking C.M.H. Among J.W.'s behavioral problems, he stabbed himself with a straightened paper clip after being grounded for leaving the neighborhood without permission; threatened to jump out of a window after it was discovered he stole a roll of felt from school; and attacked Ms. Hann, biting and scratching her when she grounded him for cursing.

Camelot recommended to Ms. Parchment that the Hanns place a one way monitor in the bedroom shared by J.W. and C.M.H. While Ms. Parchment agreed to pass the recommendation on to the Hanns, there is no evidence that the information was shared or that the Hanns ever obtained the monitor.

J.W.'s behavior further deteriorated and on October 24, 2002, after a physical altercation with C.M.H., he pulled a knife on the younger child but was stopped from further assaulting him by Mr. Hann. Camelot was immediately informed of the incident by Mr. Hann, and J.W. was again involuntarily committed into Columbia Hospital for a mental health assessment. Camelot's notes indicate Ms. Parchment was informed of J.W.'s escalating behavior in the Hann home. Ms. Parchment later acknowledged that at this point she should

have considered removing J.W. from the Hann home due to the danger he posed to himself, the Hanns and their son.

A week after the mental health assessment was performed, J.W. sexually assaulted a 4 year old girl who was visiting the Hann home. The children were watching a movie when J.W. exposed his genitals and began "humping" the young girl. Ms. Hann reported the incident to DCF. During the course of the investigation, the department learned the children were not under the direct supervision of any adult at the time of the incident – a failure that DCF providers warned would lead to harm of other children when left alone with J.W. Again, DCF was required to give immediate consideration to the safety of C.M.H. Despite, the inability of the Hanns, who both worked outside the home, to adequately supervise J.W. and his continuing access to young children, DCF did not remove J.W. from the Hann home.

Camelot began pressuring Ms. Parchment to schedule a psychosexual evaluation of J.W. which she was required to do months earlier pursuant to DCF's operating procedures. The evaluation had in fact been requested by Camelot when J.W. was placed with the Hanns and again just 2 days before he sexually assaulted the 4 year old girl visiting the Hann home. Camelot's notes indicate that it told Ms. Parchment that "[J.W.] needed specific sexual counseling by a specialist in this area." Ms. Parchment took no action so Camelot advised Mr. Hann that a new safety plan would be implemented which prohibited J.W. and C.M.H. from sharing a bedroom and requiring J.W. to be under close adult supervision when other children were present. Such recommendations had already been a complete failure at preventing J.W. from perpetuating sexual abuse on other children. Further, still without knowledge of J.W.'s extensive history of sexual abuse as a victim and aggressor, Mr. Hann informed Camelot that the family disagreed with and would not follow the safety plan.

The Department of Children and Families ignored repeated warnings from its service providers.

Beginning in November 2002, Girls and Boys Town began providing services to J.W. in conjunction with Camelot. The assessment of J.W.'s case and his current behaviors, which was performed by Girls and Boys Town, found that despite his

escalating violence and suicidal and sexually aggressive actions, no additional interventions or therapies had been put in place.

Camelot again requested a psychosexual evaluation of J.W. on November 6, 2002.

Additionally, in November 2002, C.M.H. began to exhibit behavioral problems which Camelot directly attributed to J.W. being in the home. C.M.H.'s grade dropped. In one school year he went from being an "A", "B", or "C" student to failing grades and was ultimately retained in the fourth grade.

In December 2002, the Hanns, overwhelmed with the number of providers involved in J.W.'s care and the disruption to their family, canceled the services of Camelot. Camelot recommended in its discharge form, signed by Ms. Parchment, that J.W. be placed in a residential treatment facility; however, DCF did not initiate a change in placement.

In June 2003, J.W. began expressing sexually inappropriate behavior towards C.M.H., asking him if he wanted to "see what sperm looks like" before masturbating to completion in front of him and attempting to hand him the semen. Due to this new escalation of J.W.'s behavior now directed at C.M.H., the department finally secured the psychosexual evaluation of J.W. but still did not remove him from the Hann home.

The department received the results of the psychosexual evaluation of J.W. performed by The Chrysalis Center on September 18, 2003. The Center found that J.W. "fit the profile of a sexually aggressive child due to the fact that he continues to engage in extensive sexual behaviors with children younger than himself." Further, it was found that J.W. "[presented] a risk of potentially becoming increasing more aggressive" and "continuing sexually inappropriate behaviors." The Center warned that J.W. "may seek out victims who are children and coerce them to engage in sexual activity." And again the Center recommended specific counseling for J.W. and appropriate training for his caregivers, the Hanns.

Finally, in October 2003, the Hanns requested J.W. be placed in a therapeutic treatment facility as they did not feel equipped to provide him with services and interventions he needed.

Therapeutic placement was authorized for J.W. and he was referred to Alternate Family Care in Jupiter, Florida. The Hanns were told that if J.W. was removed from their home they would not be permitted visitation privileges with him at the facility. The Hanns did not want to be the next in a series of parental figures that abandoned J.W. so they ultimately made the decision to maintain him in their home with a request for additional services to treat his ongoing issues. At this time the Hanns begin training to become therapeutic foster parents.

C.M.H.'s problems due to J.W.'s presence in the home continued at school. Beginning in late 2003 to early 2004, C.M.H. began to act out and have more conflicts in school. He received a student discipline referral for ongoing behavioral problems in the classroom. Additionally, in early 2004 he began gaining weight and would subsequently gain about 40 pounds over the next two years.

The Department of Children and Families failed to remove a dangerous child it had placed in the Hann home when requested by the Hanns.

Mrs. Hann was diagnosed with terminal cancer on March 3, 2004. As a result, Mr. Hann contacted DCF within 48 hours of the diagnosis and requested the process of having J.W.'s placement with them as "long-term non-relative care" be stopped and asked that J.W. be placed elsewhere. Ms. Parchment visited the Hann home within 24 hours after the request and advised the family that "we'll get on it."

Nothing was done and contrary to the express request and wishes of the Hanns and without their knowledge, DCF had the Hanns declared as "long term non-relative caregivers" of J.W. The department subsequently closed the dependency case, leaving J.W. him the care of the Hanns.

The Department of Children and Family Services withdrew support for the Hann family when it was needed most.

The Hanns were not part of the foster care system so when DCF closed its dependency case, the Hann family lost approximately 50 percent of their services and counseling. Father Flanagan's suspended services to J.W. and the Hann family in April 2004. The Hanns would later directly attribute

the resurgence in J.W.'s inappropriate sexual behavior to the loss of counseling services.

With almost no support from DCF, the Hanns grew more desperate as they tried to deal with Mrs. Hann's illness and J.W.'s escalating behavior.

C.M.H.'s troubles also continued. An April 2005 treatment plan from St. Mary's Child Development Center's Children's Provider Network noted that he began to have nightmares and was easily frustrated. The report also noted that his mother's diagnosis of terminal cancer and intensive chemotherapy treatments were contributing to C.M.H.'s increasing separation anxiety and grief issues. He was diagnosed with post-traumatic stress disorder.

In April 2005, Mr. Hann wrote DCF and the juvenile judge requesting help in placing J.W. in a residential placement. There was no response to his request, and J.W. remained in the Hann home.

A report from Child & Family Connections, the lead agency for community-based care in Palm Beach County, dated June 16, 2005, provided a description of J.W.'s personality and behavior, the high risk of sexual behavior problems and increasing aggression, his excessive masturbation, seeking out younger children, lies, and refusal to take responsibility for his actions. The reported stated that the Hanns "[had] been told that it is not a matter of will J.W. perpetrate on their son again, but a matter of when the perpetration would occur. [J.W. was] in need of a more restrictive setting with intensive services specializing in sexual specific treatment." The report also noted that J.W.'s previous therapist, current therapist, and a psychosexual evaluation all recommended a full-time group home facility specializing in sexual specific treatment. The report concluded that J.W.'s condition was "so severe and the situation so urgent that treatment [could not] be safely attempted in the community."

Predictably, the numerous failures of the Department and its Family Services resulted in the sexual assault of another child.

On June 29, 2005, after a physical altercation between J.W. and Mrs. Hann, C.M.H., then 10 years old, told his parents

that 2 years prior, J.W. had forced him to engage in oral sex while the boys were at a sleepover at this cousin's house. Mr. Hann called Girls & Boys Town and demanded that J.W. be removed from the home immediately. Later that same day, the department finally removed J.W. from the Hann home, and he was taken to an emergency shelter until a placement could be determined.

The court entered an order on August 11, 2005, authorizing the placement of J.W. into a residential treatment center. The court found that although a previous court order authorized placement in a specialized therapeutic group home, due to another incident that occurred while in emergency shelter, J.W. required a higher level of care.

Theresa Hann passed away the next year shortly after initiating litigation against DCF and its providers.

CLAIMANT'S POSITION:

The lawsuit was filed against the department, Camelot Community Care, Inc., Elaine Beckwith, Chrysalis Center, and Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida. The suit alleged the defendants were negligent and directly liable for the injuries suffered by C.M.H. as a result of the sexual abuse due to:

1. The initial placement of J.W. in the Hann home;
2. The failure of DCF to follow its own rules and operating procedures to provide the necessary treatment and services for J.W.;
3. The failure of DCF to provide the required information to the Hanns regarding J.W.'s history of sexual abuse and sexual aggressiveness, including the failure to formulate a safety plan for J.W. and all the children residing in the Hann home;
4. The failure of DCF to maintain the safety of J.W. and any children residing in the placement;
5. The failure of the DCF employee to report the allegations of sexual abuse of J.W. as mandated by s. 39.201, F.S.; and
6. DCF moving forward with having the court declare the Hanns "long-term non-relative caregivers," closing the case file, and leaving J.W. in the custody of the Hanns without notice to them and despite their request to stop the process.

RESPONDENT'S POSITION: The Department of Children and Families defended the lawsuit. On November 18, 2013, after a 4-week jury trial, a judgment was entered in the amount of $10,000,000. DCF was found to be 50 percent liable ($5,000,000) and Mr. and Mrs. Hann were found to be 50 percent liable ($5,000,000). The jury attributed no liability to the remaining defendants.

CONCLUSIONS OF LAW: Every claim bill must be based on facts sufficient to meet the preponderance of evidence standard. With respect to this claim bill, which is based on a negligence claim, the claimant proved that the state had a duty to the claimant, the state breached that duty, and that the breach caused the claimant's damages.

Duty
The Department of Children and Families had a duty pursuant to exercise reasonable care when placing a child involved in child-on-child sexual abuse or sexual assault in substitute care; to provide caregivers of children with sexual aggression and sexual abuse with written, detailed and complete information of the child's history; to establish appropriate safeguards and strategies to protect all children living in the foster or temporary care; to ensure the foster family is properly trained and equipped to meet the serious needs of the foster child; and to exercise reasonable care under the circumstances.

Breach
A preponderance of the evidence establishes that DCF breached its duties by failing to follow its governing statutes, rules, and internal operating procedures by:

- Placing J.W., a known sexually aggressive, severely emotionally disturbed, and dangerous child in the Hann home without legal authority and in direct conflict with recommendations of DCF service providers that J.W. not have access to young children;
- Failing to ensure that Mr. and Mrs. Hann were duly licensed and trained as required by department rule, making them capable of safely caring for a child with J.W.'s extensive needs;
- Failing to fully and completely inform the Hanns of J.W.'s history, and the risk and danger he posed to C.M.H. as required by department rule; and

- Failing to remove J.W. from the Hann home when it became clear that the placement was inappropriate and dangerous to the Hanns and C.M.H. particularly.

Causation
The sexual, physical and emotional abuse suffered by C.M.H. was the direct and proximate result of DCF's failure to fulfill its duties regarding the foster placement of a known sexually aggressive child.

Damages
At the conclusion of a 2-week trial, the jury found DCF and Mr. and Mrs. Hann each 50 percent responsible for the negligence that resulted in the injuries suffered by C.M.H. The jury awarded C.M.H. $6 million for past pain and suffering, $3.5 million for future pain and suffering, $250,000.00 for future treatment and services and $250,000.00 for future loss of earning capacity for a total award of $10 million. The department and Mr. and Mrs. Hann were each responsible for $5 million. The jury did not assess any liability for negligence against the remaining 6 defendants.

C.M.H. was initially diagnosed with post-traumatic stress disorder in 2005. Thomas N. Dikel, Ph.D., reaffirmed the diagnosis in 2010, finding that C.M.H.'s severe PTSD was cause by his "experiences of child-on-child sexual abuse, exacerbated and magnified by his mother's diagnosis of stage 4, metastatic colon cancer."

He was re-evaluated by Dr. Stephen Alexander in October 2014. Dr. Alexander found C.M.H. to continue to suffer from PTSD and major depression, but had become even more dysfunctional since his initial evaluation due to lack of services. Dr. Alexander attributed the majority of C.M.H.'s psychological trauma to this mother's illness and death; however, he did note that due to J.W.'s presence in the home during her illness, the two events have become inextricably intertwined in this psyche.

Comprehensive Rehabilitation Consultants, Inc., created a life plan for C.M.H. to determine the funds necessary to provide the support needed by C.M.H. as a direct consequence of the sexual abuse he experienced. It was determined the cost for medical, psycho-therapies, educational and support services

as well as ancillary services of transportation, housing and personal items would be $2.23 million over C.M.H.'s life.

As a result of the judgment entered by the court against DCF, the state paid $100,000 (the maximum allowed under the state's sovereign immunity waiver) with the remaining $4.9 million to be paid if this claim bill is passed by the Legislature and signed into law by the Governor.

COLLATERAL SOURCES OF RECOVERY:

Father Flanagan's Boys' Home d/b/a Girls and Boys Town of South Florida (Father Flanagan) was a named defendant in the lawsuit. Father Flanagan executed a settlement agreement with Claimants on July 30, 2013, in the amount of $340,000. However, in October 2013, the jury found that Father Flanagan was not negligent for any loss, injury or damage to C.M.H.

ATTORNEY FEES:

Claimant's attorneys have acknowledged in writing that nothing in excess of 25 percent of the gross recovery will be withheld or paid as attorneys' fees.

RECOMMENDATIONS:

The negligence of the department and the Hanns were the legal proximate cause of the damages suffered by C.M.H. However, The jury award of $9.5 million for non-economic damages or pain and suffering is not supported by the weight of the evidence. According to Dr. Alexander's October 2014 report, C.M.H. continues to suffer from PTSD but attributes a majority of C.M.H.'s psychological trauma to the illness and death of his mother. The department should not be held financially liable for C.M.H.'s psychological trauma that occurred due to the illness and death of his mother.

Damages awarded by the jury in the amount of $500,000 for future treatment and services and lost wages due to the sexual abuse are reasonable under the circumstances and are fully supported by the weight of the evidence. C.M.H. requires intensive and long-term psychotherapy, psychiatric evaluation and treatment and possible psychotropic mediations to assist him in dealing with his PTSD.

It should be noted that since receiving the settlement from Father Flanagan's in 2013, C.M.H. has only sought psychiatric treatment one time.

Accordingly, I recommend that SB 58 be reported FAVORABLY, with the amount to be paid amended to $2.5 million. The jury awarded $9.5 million ($4.75 million assessed to DCF) for past and future pain and suffering. Based on a lack of objective evidence in the record, a 50 percent reduction of DCF's obligation or $2.375 million may be a more appropriate amount to be paid for the non-economic damages. A corresponding reduction of 50 percent of DCF's share of the economic damages ($125,000) would be appropriate.

I further recommend that the funds be paid into a trust established for C.M.H. in equal installments over 10 years to pay for expenses related to education, psycho-therapies and living expenses. Any funds remaining in the trust after 10 years should be distributed in full to C.M.H.

Respectfully submitted,

Barbara M. Crosier
Senate Special Master

cc: Debbie Brown, Secretary of the Senate

CS by Judiciary:
The committee substitute revises a factual finding in a "whereas clause" to declare that the claimant's family did not receive information known to the Department of Children and Families about the risks associated with J.W. The committee substitute also provides for the proceeds of the claim bill to be paid into a revocable trust instead of directly to the claimant as in the underlying bill.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

April 8, 2015
Meeting Date

80
Bill Number (if applicable)

Topic Michael and Patricia Rardin claim bill

Amendment Barcode (if applicable)

Name Jason Unger

Job Title GrayRobinson

Address 301 South Bronough Street, Suite 600
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Phone 577-9090

Tallahassee FL 32301
City *State* *Zip*

Email junger@gray-robinson.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing North Broward Hospital District

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

SPECIAL MASTER ON CLAIM BILLS

Location
302 Senate Office Building

Mailing Address
404 South Monroe Street
Tallahassee, Florida 32399-1100
(850) 487-5237

DATE	COMM	ACTION
12/31/14	SM	Fav/1 amendment
03/24/15	JU	Fav/CS
4/7/15	AHS	Favorable
	AP	

December 31, 2014

The Honorable Andy Gardiner
President, The Florida Senate
Suite 409, The Capitol
Tallahassee, Florida 32399-1100

Re: **CS/SB 80** – Judiciary Committee and Senator Anitere Flores
Relief of Michael Rardin

SPECIAL MASTER'S FINAL REPORT

THIS IS AN UNCONTESTED CLAIM FOR $2,000,000 AGAINST THE NORTH BROWARD HOSPITAL DISTRICT FOR AN INCIDENT OF MEDICAL MALPRACTICE.

FINDINGS OF FACT:

In 2011, Michael Rardin was a 42-year old construction company employee. He acted in a general contractor role on high value projects and earned a high salary. On July 14, 2011, Mr. Rardin went to his primary care physician complaining of fatigue and shortness of breath. His primary care physician sent Mr. Rardin to the emergency room. Mr. Rardin was triaged as a priority 1/critical patient. Mr. Rardin was seen by Dr. Susan Nesselroth at 2:04 pm. Dr. Nesselroth noted his complaints and ordered an oxygen saturation monitor. Mr. Rardin had an oxygen saturation level of 53%. A normal oxygen saturation level is 95% or greater. Dr. Nesselroth ordered a non-rebreather mask with supplemental oxygen. Mr. Rardin was to be monitored in the emergency department.

Mr. Rardin was not intubated nor placed on a centrally monitored respiratory or cardiac monitor. A chest x-ray was then performed, indicating a left lower lobe infiltrate, and Dr. Nesselroth's diagnostic impression was left lower lobe

pneumonia and hypoxia. Over the next two hours, Mr. Rardin's condition deteriorated.

At 3:57 pm, Dr. Nesselroth was called to Mr. Rardin's bedside. A nurse noted increased respiratory distress and difficulty in arousing Mr. Rardin. Dr. Nesselroth evaluated Mr. Rardin as unresponsive, diaphoretic, and with agonal respirations. Dr. Nesselroth decided to intubate Mr. Rardin. There were two attempts to intubate Mr. Rardin. The first attempt at 4:05 pm, resulted in an "esophageal intubation" where oxygen was being delivered to his stomach rather than his lungs. Mr. Rardin became asystolic. A code was called and CPR and other live saving efforts were administered. By the time the physicians and staff successfully intubated Mr. Rardin, a sufficient period of time had passed with inadequate oxygen to the brain, resulting in a serious and permanent hypoxic brain injury. The second intubation attempt occurred at 4:15 pm, resulting in approximately 10 minutes of time of no heart rate, no blood pressure, and no oxygen being delivered to Mr. Rardin's brain.

The Rardins filed a lawsuit against the North Broward Hospital District. The minor children were subsequently dropped from the lawsuit and the matter continued with Mr. and Mrs. Rardin as plaintiffs. North Broward Hospital District, which owns and operates North Broward Medical Center, reached a settlement agreement with the Rardins by mediation in the amount of $2.2 million dollars, $200,000 of which has been paid in partial satisfaction of the final judgment. As a condition of the settlement, North Broward Hospital District agreed to support passage of a claim bill. If the bill passes, the claim will be paid through a combination of money the North Broward Hospital District has set aside for the payment of claims and insurance.

The Rardins also settled a claim against Dr. Nesselroth for an undisclosed amount. Counsel for the claimants did not disclose the amount of the settlement to the Special Master, citing a confidentiality agreement.

CONCLUSIONS OF LAW:

The claim bill hearing was a *de novo* proceeding to determine whether the North Broward Hospital District was liable in negligence for the damages suffered by Michael and Patricia Rardin. The undersigned finds that the staff of the North Broward Hospital District had a duty to treat Mr. Rardin

according to the standard of care and that it failed to do so. In waiting approximately two hours to intubate, despite an initial evaluation indicating critical oxygen values, Dr. Nesselroth and the hospital staff violated the standard of care. The failure of the staff was the cause of Mr. Rardin's injuries.

Due to the failure of hospital personnel to properly monitor and timely intubate Mr. Rardin, he suffers from a permanent brain injury, including but not limited to visual disturbances, short term memory loss and severe depression. Mr. Rardin's catastrophic injuries have rendered him unable to work. Furthermore, Mr. Rardin's injuries render him unable to provide the services, comfort, attention, and affection that he otherwise would have provided to his wife, Patricia Rardin, and his two minor children, Kayla and Emily Rardin The amount of damages agreed to by the parties is reasonable.

ATTORNEYS FEES: Mr. Rardin's attorneys have agreed to limit their fees to 25 percent of any amount awarded by the Legislature. Lobbyist fees are included with the attorney fees.

RECOMMENDATIONS: SB 80 names the Rardin's children as claimants when they were dropped from the litigation. The attached amendment names only Michael and Patricia Rardin as the claimants, removing the names of the children. The undersigned recommends that the bill be reported favorably with the suggested amendment.

Respectfully submitted,

L. Michael Billmeier, Jr.
Senate Special Master

cc: Debbie Brown, Secretary of the Senate

CS by Judiciary on March 24. 2015:
The committee substitute revises the underlying bill to clearly identify Patricia Rardin as a claimant. Additionally, the committee substitute also deletes references to the children of Michael and Patricia Rardin.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-8-2015
Meeting Date

SB 512
Bill Number (if applicable)

Topic HIV TESTING

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

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TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] 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 the Senator or Senate Professional Staff conducting the meeting)

April 8, 2015
Meeting Date

512
Bill Number (if applicable)

Topic CS/SB 512 by Health Policy / Thompson—HIV Testing

Amendment Barcode (if applicable)

Name Jesse Fry

Job Title Policy Analyst

Address 641 E College Ave Unit 2
Street

Phone (850) 339-6395

Tallahassee FL 32301
City *State* *Zip*

Email jfry@theaidsinstitute.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The AIDS Institute

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 the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

512
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic HIV Testing

Name Avery Coleman

Job Title lobbyist

Address 2340 Hansen Lane
Street

Tall FL 32301
City *State* *Zip*

Phone 321.228.7389

Email avery@fachc.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Assoc of Community Health Centers

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

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 512
Bill Number (if applicable)

Topic HIV Testing

Amendment Barcode (if applicable)

Name Michael Rajner

Job Title —

Address PO Box 2133
Street

Phone 954 566-0144

Ft. Lauderdale, FL 33303
City *State* *Zip*

Email mrajner@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☒ Against
(The Chair will read this information into the record.)

Representing —

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 the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

512
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 1000 Riverside Ave
Street
Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Health Association

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 the Senator or Senate Professional Staff conducting the meeting)

4-8-15
Meeting Date

SB512
Bill Number (if applicable)

Topic HIV

Amendment Barcode (if applicable)

Name Rich Rasmussen

Job Title V.P. Florida Hospital Assn

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Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-222-9800

Email Rich@fha.org

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Fla. Hospital Assn

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] 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

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 512
INTRODUCER:	Health Policy Committee and Senator Thompson and others
SUBJECT:	HIV Testing
DATE:	April 7, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harper	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 512 defines "health care setting" and "nonhealth care setting" for the purposes of human immunodeficiency virus (HIV) testing, and differentiates between the notification and informed consent procedures for performing an HIV test in such settings.

Regardless of the setting, the test subject must be informed that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject. The test subject shall also be informed of the availability and location of sites that perform anonymous testing.

The bill authorizes hospitals to release HIV test results contained in hospital medical records, in accordance with standard patient record protections. The bill removes the need for hospitals to obtain informed consent before releasing these records.

The bill revises and clarifies provisions to address the occurrence of a significant exposure to medical personnel and nonmedical personnel.

The bill updates the definition of "preliminary HIV test" to reflect current advances in HIV testing.

The bill has no fiscal impact.

The effective date of the bill is July 1, 2015.

II. Present Situation:

Human Immunodeficiency Virus

HIV is an immune system virus that can lead to the fatal acquired immunodeficiency syndrome (AIDS). HIV affects specific cells of the immune system and, over time, the virus can destroy so many of these cells that the body cannot fight off infections and disease. However, with proper medical care, HIV can be controlled for most patients.[1]

In the United States, HIV is spread mainly by having unprotected sex with someone who has HIV or by sharing needles, syringes, or other equipment used to prepare injection drugs with someone who has HIV.[2] The U.S. Centers for Disease Control and Prevention (CDC) estimates that more than 1.2 million persons 13 years of age and older in the United States are living with HIV infection, including 168,300 (14 percent) who are unaware of their infection.[3] Approximately 50,000 people get infected with HIV each year.[4]

HIV in Florida

The Florida Department of Health (DOH) estimates that approximately 130,000 individuals are living with HIV in Florida.[5] In 2013, Florida ranked first nationally in the number of new HIV infection cases diagnosed, with over 5,300 new cases.[6] Additionally, in 2013, all six of Florida's large metropolitan statistical areas reported more cases individually than many states as a whole.[7] In 2014, there were more than 6,000 people newly reported with HIV infections in Florida.[8]

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[1] U.S. Centers for Disease Control and Prevention, *About HIV/AIDS* (updated January 16, 2015), *available at* http://www.cdc.gov/hiv/basics/whatishiv.html#panel0, (last visited Mar. 11, 2015).
[2] U.S. Centers for Disease Control and Prevention, *HIV Transmission* (updated January 16, 2015), *available at* http://www.cdc.gov/hiv/basics/transmission.html, (last visited Mar. 11, 2015).
[3] U.S. Centers for Disease Control and Prevention, *HIV in the United States: At a Glance* (updated November 25, 2014), *available at* http://www.cdc.gov/hiv/statistics/basics/ataglance.html, (last visited Mar. 11, 2015).
[4] *Id*.
[5] Florida Department of Health, *HIV AIDS*, *available at* http://www.floridahealth.gov/diseases-and-conditions/aids/, (last visited Mar. 11, 2015).
[6] Florida Department of Health, *HIV Disease: United States vs. Florida*, *available at* http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/fact-sheet/2014/2014-us-vs-fl-fact-sheet.pdf, (last visited Mar. 11, 2015).
[7] *Id*. For example, Miami reported more cases than all but four other states in the U.S. Miami-Ft. Lauderdale-West Palm Beach, Tampa-St. Petersburg-Clearwater, Orlando-Kissimmee-Sanford, and Jacksonville ranked among the top 30 *states* for new HIV cases in 2013.
[8] *Id*.

HIV Testing

In 2006, the CDC revised its recommendations for HIV testing after a comprehensive review of literature, a consensus of medical opinions, input of community organizations, and the opinion of persons living with HIV.[9] The CDC's updated recommendations include the following:[10]

- Opt-out HIV screening[11] in all health-care settings;[12]
- Tests for all high-risk patients at least annually;
- No requirement for separate written consent for testing;
- No prevention counseling required in conjunction with HIV screening; and
- Inclusion in all routine prenatal screening, with repeat screening in the third trimester, for high-risk pregnant women.

The most common type of HIV test is the antibody screening test (immunoassay), which tests for the antibodies the human body makes against HIV. A "rapid test" is an immunoassay used for screening that produces quick results (in 30 minutes or less). Rapid tests use blood or oral fluid to look for antibodies to HIV. Antibody tests are considered "preliminary." If the result is positive, follow-up diagnostic testing is required to confirm the presence of HIV. Other HIV tests can detect both antibodies and antigen (part of the virus itself). These antibody-antigen tests can find recent HIV infection earlier than tests that detect only antibodies, but antibody-antigen combination tests are only available for testing blood, not oral fluid.[13]

HIV Testing in Florida

Section 381.004, F.S., governs HIV testing in Florida and was enacted to create an environment in Florida in which people will agree to or seek HIV testing because they are sufficiently informed about HIV infection and assured about the privacy of a decision to be tested.[14] Under s. 381.004, F.S., "HIV test" means a test ordered after July 6, 1988, to determine the presence of the antibody or antigen to human immunodeficiency virus or the presence of human immunodeficiency virus infection.[15] "Test subject" means the person upon whom an HIV test is

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[9] *See Revised CDC Recommendations: HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings* (September 12, 2006), accessible at: U.S. Centers for Disease Control and Prevention, *HIV Screening & Testing* (updated December 16, 2014), http://www.cdc.gov/hiv/guidelines/testing.html (last visited Mar. 11, 2015).

[10] U.S. Centers for Disease Control and Prevention, *Revised CDC Recommendations: HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings, Annotated Guide* (September 2006), *available at* http://www.cdc.gov/hiv/testing/HIVStandardCare/resources/brochures/MMWR-Annotated%20508C_Full.pdf (last visited Mar. 11, 2015).

[11] Opt-out screening means the patient must be notified that the screening will be done; the patient may decline the test.

[12] U.S. Centers for Disease Control and Prevention, *Assessment of 2010 CDC-funded Health Department HIV Testing Spending and Outcomes* (February 2013), *available at* http://www.cdc.gov/hiv/pdf/evaluation_HIVTesting_BudgetAllocation.pdf (last visited Mar. 11, 2015). The CDC refers to "health care settings" as a place where both medical diagnostic and treatment services are provided. A nonhealth care setting does not provide these services. Examples of nonhealth care settings include community-based organization and outreach venues.

[13] U.S. Center for Disease Control and Prevention, *Testing, available at* http://www.cdc.gov/hiv/basics/testing.html (last visited Mar. 12, 2015).

[14] Jack P. Hartog, Esq., *Florida's Omnibus AIDS Act: A Brief Legal Guide for Health Care Professionals* (August 2013), Florida Department of Health, *available at* http://www.floridahealth.gov/diseases-and-conditions/aids/operations_managment/_documents/Omnibus-booklet-update-2013.pdf (last visited Mar. 12, 2015).

[15] Section 381.004(1)(a), F.S.

performed, or the person who has legal authority to make health care decisions for the test subject.[16]

In Florida, county health departments (CHDs) are the primary sources for state-sponsored HIV programs. In 2013, CHD programs administered more than 428,000 HIV tests which resulted in 4,200 positive test results.[17] No other person in Florida may legally conduct HIV testing services without first registering with the DOH and complying with the statutory requirements listed in s. 381.004(4), F.S., such as providing opportunities for pre-test and post-test counseling specifically designed to address the needs of persons who may receive positive test results.

Informed Consent

Currently in Florida, every person who is tested for HIV must first give his or her informed consent before a test is administered, except as specified in s. 381.004(2)(h), F.S. Informed consent for HIV testing is defined under DOH rule and requires:[18]

- An explanation that the information identifying the test subject and the results of the test are confidential and protected against further disclosure to the extent permitted by law;
- Notice that persons who test positive will be reported to the local CHD;
- Notice that anonymous testing is available and the locations of the anonymous sites;
- Written informed consent only for the following:
  - From the potential donor or donor's legal representative prior to first donation of blood, blood components, organs, skin, semen, or other human tissue or body part;
  - For insurance purposes; and
  - For contract purposes in a health maintenance organization, pursuant to s. 641.3007, F.S.

Exceptions to informed consent include:[19]

- When testing for sexually transmitted diseases is required by state or federal law or rule;
- Transfer of human tissue pursuant to s. 381.0041, F.S.;
- Performance of an HIV-related test by licensed medical personnel in bona fide medical emergencies if the patient is unable to consent or for the medical diagnosis of acute illness and if the attending physician believes obtaining informed consent would be detrimental to the patient;
- When the HIV testing is performed as part of an autopsy for which consent was obtained;
- The testing of a defendant for any type of sexual battery crime, pursuant to the victim's request, if the blood sample is taken from the defendant voluntarily;
- When mandated by court order;
- For research purposes, if the identity of the test subject is not known and may not be retrieved by the researcher;
- When human tissue is collected lawfully without consent of the donor for corneal removal or enucleation of the eyes;
- Performance of an HIV test upon an individual who comes into contact with medical personnel in such a way that a significant exposure has occurred to the medical personnel

[16] Section 381.004(1)(e), F.S.
[17] *Supra* note 6.
[18] Rule 64D-2.004, F.A.C.
[19] Section 381.004(2)(h), F.S.

during the course of employment or within the scope of practice and where a blood sample is available that was taken from the individual voluntarily by medical personnel for other purposes;
- Performance of an HIV test upon an individual who comes into contact with medical personnel or nonmedical personnel in such a way that a significant exposure has occurred to the individual during emergency medical treatment or assistance during a medical emergency;
- Performance of an HIV test by a medical examiner or attending physician upon an individual who died while receiving emergency medical assistance or care and who was the source of significant exposure to medical or nonmedical personnel providing assistance or care;
- Performance of an HIV-related test medically indicated by licensed medical personnel for medical diagnosis of a hospitalized infant when, after a reasonable attempt, a parent cannot be contacted to provide consent;
- Testing conducted to monitor the clinical progress of a patient previously diagnosed to be HIV positive; and
- Performance of repeated HIV testing conducted to monitor possible conversion from a significant exposure.

Another exception to informed consent for HIV testing in Florida relates to pregnancy. Prior to testing, a health care practitioner must inform a pregnant woman that the HIV test will be conducted and of her right to refuse the test. If declined, the refusal will be noted in the medical record.[20]

Minors meeting certain requirements, such as being married, pregnant, or able to demonstrate maturity to make an informed judgment, can be tested for HIV without parental consent if the minor provides informed consent.[21]

III. Effect of Proposed Changes:

Section 1 amends s. 381.004, F.S., by adding definitions of "health care setting" and "nonhealth care setting," differentiating between notification and informed consent requirements for the two settings, and making technical and conforming changes.

"Health care setting" is defined by the bill to mean, for the purposes of HIV testing, a setting devoted to the diagnosis and care of persons or the provision of medical services to persons, such as:
- County health department clinics;
- Hospitals;
- Urgent care clinics;
- Substance abuse treatment clinics;
- Primary care settings;
- Community clinics;
- Blood banks;
- Mobile medical clinics; and

[20] Sections 381.004(2)(h) and 384.31, F.S.
[21] Section 384.30, F.S. and Rule 64D-2.004(4), F.A.C.

- Correctional health care facilities.

"Nonhealth care setting" is defined by the bill to mean, for the purposes of HIV testing, a site that conducts HIV testing for the sole purpose of identifying HIV infection. A nonhealth care setting does not provide medical treatment. A nonhealth care setting may include:
- Community-based organizations;
- Outreach settings;
- County health department HIV testing programs; and
- Mobile vans.

The bill updates the definition of "preliminary HIV tests" to reflect advances in HIV testing and deletes obsolete language.

The bill specifies that before performing an HIV test in a health care setting, the person to be tested must be notified orally or in writing that the HIV test is planned and that he or she has the right to decline the HIV test. If the person to be tested declines the HIV test in a health care setting, the decision will be documented in the person's medical record. A person who has signed a general consent form for medical care is not required to sign or otherwise provide a separate consent for an HIV test during the period in which the general consent form is in effect.

The bill specifies that before performing an HIV test in a nonhealth care setting, a provider must obtain the informed consent of the person upon whom the test is being performed. Informed consent shall be preceded by an explanation of the right to confidential treatment of information that identifies the test subject and the test result as provided by law.

The bill provides that, regardless of setting, the test subject of an HIV test must also be informed that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject. The test subject must also be provided with the availability and location of sites that perform anonymous testing.

The bill authorizes hospitals licensed under ch. 395, F.S., to release HIV test results contained in hospital medical records in accordance with standard patient record provisions. The bill removes the current-law requirement that a hospital must obtain written informed consent for the HIV test before releasing these records.

The bill provides that notification in a health care setting or informed consent in a nonhealth care setting is not required before performing an HIV test if the test is being performed for the following reasons:
- When testing for sexually transmitted diseases is required by state or federal law or by rule, including HIV testing of inmates before their release from prison;
- Transfer of human tissue pursuant to s. 381.0041, F.S.;
- Performance of an HIV-related test by licensed medical personnel in bona fide medical emergencies if the patient is unable to consent or for the medical diagnosis of acute illness and if the attending physician believes obtaining notification would be detrimental to the patient;
- If HIV testing is performed as part of an autopsy for which consent was obtained;

- The testing of a defendant for any type of sexual battery crime, pursuant to the victim's request, if the blood sample is taken from the defendant voluntarily;
- If an HIV test is mandated by court order;
- For research purposes, if the identity of the test subject is not known and may not be retrieved by the researcher;
- If human tissue is collected lawfully without consent of the donor for corneal removal or enucleation of the eyes;
- Performance of an HIV test upon an individual who comes into contact with medical personnel in such a way that a significant exposure has occurred to the medical personnel during the course of employment, within the scope of practice, or during the course of providing emergency medical assistance to the individual;
- Performance of an HIV test upon an individual who comes into contact with nonmedical personnel in such a way that a significant exposure has occurred to the nonmedical personnel while the nonmedical personnel provides emergency medical assistance during a medical emergency;
- Performance of an HIV test by a medical examiner or attending physician upon an individual who died while receiving emergency medical assistance or care and who was the source of significant exposure to medical or nonmedical personnel providing assistance or care;
- Performance an HIV-related test medically indicated by licensed medical personnel for medical diagnosis of a hospitalized infant when, after a reasonable attempt, a parent cannot be contacted to provide consent;
- Testing conducted to monitor the clinical progress of a patient previously diagnosed to be HIV positive; and
- Performance of repeated HIV testing conducted to monitor possible conversion from a significant exposure.

The bill clarifies procedures for testing when a significant exposure to medical personnel occurs. Specifically, the bill requires that the occurrence of a significant exposure to medical personnel must be documented by medical personnel under the supervision of a licensed physician and recorded only in the personal record of the medical personnel. Costs of an HIV test shall be covered by the medical personnel or the employer of the medical personnel. To fall under this provision of the bill, the medical personnel must be tested for HIV or provide the results of an HIV test taken within six months before the significant exposure if such test results are negative. The results of the HIV test will be released to the source of the exposure and to the person who experienced the exposure.

The bill directs that, if the source of the exposure is not available and will not voluntarily present to a health facility for testing, the medical personnel or the employer of the medical personnel may seek a court order directing the source of the exposure to submit to HIV testing. The bill provides that a sworn statement by a physician licensed under chs. 458 or 459, F.S., that a significant exposure has occurred and that testing is medically necessary, constitutes probable cause for the issuance of an order by the court.

The bill provides substantially similar procedures for nonmedical personnel when a significant exposure has occurred while the nonmedical personnel provides emergency medical assistance during a medical emergency.

The bill provides that a county health department and any other person in Florida offering HIV tests in a nonhealth care setting may not conduct or hold themselves out to the public as conducting a testing program for HIV or AIDS without first registering with the DOH. The bill provides that a program in a nonhealth care setting must meet the informed consent criteria as contained in the bill.

Section 2 amends s. 456.032(2), F.S., to conform a cross-reference.

Section 3 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

Section 1 of this bill contains a stand-alone flush-left paragraph that contains language inconsistent with the preceding paragraph. The bill amends s. 381.004(2)(a), F.S., to provide the condition of "*Before* performing an HIV test" (emphasis added); however, the stand-alone paragraph after s. 381.004(2)(a)2, F.S., refers to "the test subject." Test subject, as currently defined in s. 381.004(e), F.S., means the person upon whom an HIV test is performed. Technically, a person would not be considered a test subject until during or *after* the HIV test is performed. Therefore, the proposed bill language under this section is inconsistent as to when and to whom information should be given regarding reporting a positive HIV test result to a county health department. The bill language in the stand-alone paragraph may be revised to refer

to "the person to be tested" instead of "test subject," or the phrase "After performing an HIV test" may be substituted for "Before performing an HIV test" if the condition continues to apply to a test subject.

VII. Related Issues:

The proposed stand-alone paragraph in section 1 of the bill makes vague reference to "the county health department." The bill does not provide specificity as to which county health department a positive HIV test result will be reported. For example, the language used in Florida Administrative Code Rule 64D-2.004, more specifically refers to the "local county health department." A revision may be needed for this bill to further clarify that a positive HIV test result will be reported to the *local* county health department or to the county health department *in the county in which the HIV test was performed*.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.004 and 456.032 of the.

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 March 17, 2015:
The CS revises the definitions of "health care setting" and "nonhealth care setting" for the purposes of HIV testing, and further clarifies the notification and informed consent procedures for performing an HIV test in such settings. The CS revises and clarifies provisions to address the occurrence of a significant exposure to medical personnel and nonmedical personnel. The CS provides that a county health department and any other person in Florida offering HIV tests in a nonhealth care setting may not conduct testing without first registering with DOH.

B. Amendments:

None.

By the Committee on Health Policy; and Senators Thompson and Soto

588-02385-15 2015512c1

A bill to be entitled

An act relating to HIV testing; amending s. 381.004, F.S.; revising and providing definitions; specifying the notification and consent procedures for performing an HIV test in a health care setting and a nonhealth care setting; amending s. 456.032, F.S.; conforming a cross-reference; providing an effective date.

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

Section 1. Subsection (1) of section 381.004, Florida Statutes, is reordered and amended, and paragraphs (a), (b), (g), and (h) of subsection (2) and paragraph (d) of subsection (4) of that section are amended, to read:

381.004 HIV testing.—

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

(a) "Health care setting" means a setting devoted to the diagnosis and care of persons or the provision of medical services to persons, such as county health department clinics, hospitals, urgent care clinics, substance abuse treatment clinics, primary care settings, community clinics, blood banks, mobile medical clinics, and correctional health care facilities.

(b) ~~(a)~~ "HIV test" means a test ordered after July 6, 1988, to determine the presence of the antibody or antigen to human immunodeficiency virus or the presence of human immunodeficiency virus infection.

(c) ~~(b)~~ "HIV test result" means a laboratory report of a human immunodeficiency virus test result entered into a medical record on or after July 6, 1988, or any report or notation in a

588-02385-15 2015512c1

medical record of a laboratory report of a human immunodeficiency virus test. ~~As used in this section,~~ The term ~~"HIV test result"~~ does not include test results reported to a health care provider by a patient.

(d) "Nonhealth care setting" means a site that conducts HIV testing for the sole purpose of identifying HIV infection but does not provide medical treatment. The term includes community-based organizations, outreach settings, county health department HIV testing programs, and mobile vans.

(f) ~~(c)~~ "Significant exposure" means:

1. Exposure to blood or body fluids through needlestick, instruments, or sharps;

2. Exposure of mucous membranes to visible blood or body fluids, to which universal precautions apply according to the National Centers for Disease Control and Prevention, including, without limitations, the following body fluids:

a. Blood.

b. Semen.

c. Vaginal secretions.

d. Cerebrospinal ~~Cerebro-spinal~~ fluid (CSF).

e. Synovial fluid.

f. Pleural fluid.

g. Peritoneal fluid.

h. Pericardial fluid.

i. Amniotic fluid.

j. Laboratory specimens that contain HIV (e.g., suspensions of concentrated virus); or

3. Exposure of skin to visible blood or body fluids, especially when the exposed skin is chapped, abraded, or

afflicted with dermatitis or the contact is prolonged or involving an extensive area.

(e) ~~(d)~~ "Preliminary HIV test" means an antibody or antibody-antigen screening test, such as the ~~enzyme-linked~~ immunosorbent assays (IA), or a rapid test approved by the United States Food and Drug Administration ~~(ELISAs) or the Single-Use Diagnostic System (SUDS)~~.

(g) ~~(e)~~ "Test subject" or "subject of the test" means the person upon whom an HIV test is performed, or the person who has legal authority to make health care decisions for the test subject.

(2) HUMAN IMMUNODEFICIENCY VIRUS TESTING; INFORMED CONSENT; RESULTS; COUNSELING; CONFIDENTIALITY.—

(a) Before performing an HIV test:

1. In a health care setting, the person to be tested must be notified orally or in writing that the HIV test is planned and that he or she has the right to decline the test. If the person to be tested declines the test, such decision shall be documented in the person's medical record. A person who has signed a general consent form for medical care is not required to sign or otherwise provide a separate consent for an HIV test during the period in which the general consent form is in effect ~~No person in this state shall order a test designed to identify the human immunodeficiency virus, or its antigen or antibody, without first obtaining the informed consent of the person upon whom the test is being performed, except as specified in paragraph (h). Informed consent shall be preceded by an explanation of the right to confidential treatment of information identifying the subject of the test and the results~~

~~of the test to the extent provided by law. Information shall also be provided on the fact that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject and on the availability and location of sites at which anonymous testing is performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites at which anonymous testing is performed, including the locations, phone numbers, and hours of operation of the sites. Consent need not be in writing provided there is documentation in the medical record that the test has been explained and the consent has been obtained~~.

2. In a nonhealth care setting, a provider must obtain the informed consent of the person upon whom the HIV test is being performed. Informed consent must be preceded by an explanation of the right to confidential treatment of information identifying the subject of the test and the HIV test results as provided by law.

The test subject must also be informed that a positive HIV test result will be reported to the county health department with sufficient information to identify the test subject and must be provided with the availability and location of sites at which anonymous testing is performed. As required in paragraph (3)(c), each county health department shall maintain a list of sites at which anonymous HIV testing is performed, including the locations, telephone numbers, and hours of operation of the sites.

(b) Except as provided in paragraph (h), informed consent must be obtained from a legal guardian or other person

authorized by law if ~~when~~ the person:

1. Is not competent, is incapacitated, or is otherwise unable to make an informed judgment; or

2. Has not reached the age of majority, except as provided in s. 384.30.

(g) Human immunodeficiency virus test results contained in the medical records of a hospital licensed under chapter 395 may be released in accordance with s. 395.3025 without being subject to ~~the requirements of~~ subparagraph (e)2., subparagraph (e)9., or paragraph (f) ~~; provided the hospital has obtained written informed consent for the HIV test in accordance with provisions of this section~~.

(h) Paragraph (a) does not apply ~~Notwithstanding the provisions of paragraph (a), informed consent is not required~~:

1. When testing for sexually transmissible diseases is required by state or federal law, or by rule including the following situations:

a. HIV testing pursuant to s. 796.08 of persons convicted of prostitution or of procuring another to commit prostitution.

b. HIV testing of inmates pursuant to s. 945.355 before ~~prior to~~ their release from prison by reason of parole, accumulation of gain-time credits, or expiration of sentence.

c. Testing for HIV by a medical examiner in accordance with s. 406.11.

d. HIV testing of pregnant women pursuant to s. 384.31.

2. Those exceptions provided for blood, plasma, organs, skin, semen, or other human tissue pursuant to s. 381.0041.

3. For the performance of an HIV-related test by licensed medical personnel in bona fide medical emergencies if ~~when~~ the

test results are necessary for medical diagnostic purposes to provide appropriate emergency care or treatment to the person being tested and the patient is unable to consent, as supported by documentation in the medical record. Notification of test results in accordance with paragraph (c) is required.

4. For the performance of an HIV-related test by licensed medical personnel for medical diagnosis of acute illness if ~~where~~, in the opinion of the attending physician, providing notification ~~obtaining informed consent~~ would be detrimental to the patient, as supported by documentation in the medical record, and the test results are necessary for medical diagnostic purposes to provide appropriate care or treatment to the person being tested. Notification of test results in accordance with paragraph (c) is required if it would not be detrimental to the patient. This subparagraph does not authorize the routine testing of patients for HIV infection without notification ~~informed consent~~.

5. If ~~When~~ HIV testing is performed as part of an autopsy for which consent was obtained pursuant to s. 872.04.

6. For the performance of an HIV test upon a defendant pursuant to the victim's request in a prosecution for any type of sexual battery where a blood sample is taken from the defendant voluntarily, pursuant to court order for any purpose, or pursuant to ~~the provisions of~~ s. 775.0877, s. 951.27, or s. 960.003; however, the results of an ~~any~~ HIV test performed shall be disclosed solely to the victim and the defendant, except as provided in ss. 775.0877, 951.27, and 960.003.

7. If ~~When~~ an HIV test is mandated by court order.

8. For epidemiological research pursuant to s. 381.0031,

for research consistent with institutional review boards created by 45 C.F.R. part 46, or for the performance of an HIV-related test for the purpose of research, if the testing is performed in a manner by which the identity of the test subject is not known and may not be retrieved by the researcher.

9. If ~~When~~ human tissue is collected lawfully without the consent of the donor for corneal removal as authorized by s. 765.5185 or enucleation of the eyes as authorized by s. 765.519.

10. For the performance of an HIV test upon an individual who comes into contact with medical personnel in such a way that a significant exposure has occurred during the course of employment, ~~or~~ within the scope of practice, or during the course of providing emergency medical assistance to the individual ~~and where a blood sample is available that was taken from that individual voluntarily by medical personnel for other purposes~~. The term "medical personnel" includes a licensed or certified health care professional; an employee of a health care professional or health care facility; employees of a laboratory licensed under chapter 483; personnel of a blood bank or plasma center; a medical student or other student who is receiving training as a health care professional at a health care facility; and a paramedic or emergency medical technician certified by the department to perform life-support procedures under s. 401.23.

a. The occurrence of a significant exposure must be documented by medical personnel under the supervision of a licensed physician and recorded only in the personal record of the medical personnel ~~Prior to performance of an HIV test on a voluntarily obtained blood sample, the individual from whom the~~

~~blood was obtained shall be requested to consent to the performance of the test and to the release of the results. If consent cannot be obtained within the time necessary to perform the HIV test and begin prophylactic treatment of the exposed medical personnel, all information concerning the performance of an HIV test and any HIV test result shall be documented only in the medical personnel's record unless the individual gives written consent to entering this information on the individual's medical record~~.

~~b. Reasonable attempts to locate the individual and to obtain consent shall be made, and all attempts must be documented. If the individual cannot be found or is incapable of providing consent, an HIV test may be conducted on the available blood sample. If the individual does not voluntarily consent to the performance of an HIV test, the individual shall be informed that an HIV test will be performed, and counseling shall be furnished as provided in this section. However, HIV testing shall be conducted only after appropriate medical personnel under the supervision of a licensed physician documents, in the medical record of the medical personnel, that there has been a significant exposure and that, in accordance with the written protocols based on the National Centers for Disease Control and Prevention guidelines on HIV postexposure prophylaxis and in the physician's medical judgment, the information is medically necessary to determine the course of treatment for the medical personnel.~~

b.~~c.~~ Costs of an ~~any~~ HIV test ~~of a blood sample performed with or without the consent of the individual, as provided in this subparagraph,~~ shall be borne by the medical personnel or

the employer of the medical personnel. However, costs of testing or treatment not directly related to the initial HIV tests or costs of subsequent testing or treatment may not be borne by the medical personnel or the employer of the medical personnel.

c.~~d.~~ In order to use ~~utilize~~ the provisions of this subparagraph, the medical personnel must ~~either~~ be tested for HIV pursuant to this section or provide the results of an HIV test taken within 6 months before ~~prior to~~ the significant exposure if such test results are negative.

d. If the source of the exposure is not available and will not voluntarily present to a health facility to be tested for HIV, the medical personnel or the employer of such person acting on behalf of the employee may seek a court order directing the source of the exposure to submit to HIV testing. A sworn statement by a physician licensed under chapter 458 or chapter 459 that a significant exposure has occurred and that, in the physician's medical judgment, testing is medically necessary to determine the course of treatment constitutes probable cause for the issuance of an order by the court. The results of the test shall be released to the source of the exposure and to the person who experienced the exposure.

e. A person who receives the results of an HIV test pursuant to this subparagraph shall maintain the confidentiality of the information received and of the persons tested. Such confidential information is exempt from s. 119.07(1).

~~f. If the source of the exposure will not voluntarily submit to HIV testing and a blood sample is not available, the medical personnel or the employer of such person acting on behalf of the employee may seek a court order directing the~~

~~source of the exposure to submit to HIV testing. A sworn statement by a physician licensed under chapter 458 or chapter 459 that a significant exposure has occurred and that, in the physician's medical judgment, testing is medically necessary to determine the course of treatment constitutes probable cause for the issuance of an order by the court. The results of the test shall be released to the source of the exposure and to the person who experienced the exposure.~~

11. For the performance of an HIV test upon an individual who comes into contact with nonmedical ~~medical~~ personnel in such a way that a significant exposure has occurred ~~during the course of employment or within the scope of practice of the medical personnel~~ while the nonmedical ~~medical~~ personnel provides emergency medical assistance during a medical emergency ~~treatment to the individual; or notwithstanding s. 384.287, an individual who comes into contact with nonmedical personnel in such a way that a significant exposure has occurred while the nonmedical personnel provides emergency medical assistance during a medical emergency~~. For the purposes of this subparagraph, a medical emergency means an emergency medical condition outside of a hospital or health care facility that provides physician care. The test may be performed only during the course of treatment for the medical emergency.

a. The occurrence of a significant exposure shall be documented by medical personnel under the supervision of a licensed physician and recorded only in the personal record of the nonmedical personnel ~~An individual who is capable of providing consent shall be requested to consent to an HIV test prior to the testing. If consent cannot be obtained within the~~

~~time necessary to perform the HIV test and begin prophylactic treatment of the exposed medical personnel and nonmedical personnel, all information concerning the performance of an HIV test and its result, shall be documented only in the medical personnel's or nonmedical personnel's record unless the individual gives written consent to entering this information on the individual's medical record~~.

~~b. HIV testing shall be conducted only after appropriate medical personnel under the supervision of a licensed physician documents, in the medical record of the medical personnel or nonmedical personnel, that there has been a significant exposure and that, in accordance with the written protocols based on the National Centers for Disease Control and Prevention guidelines on HIV postexposure prophylaxis and in the physician's medical judgment, the information is medically necessary to determine the course of treatment for the medical personnel or nonmedical personnel.~~

b.~~c.~~ Costs of any HIV test ~~performed with or without the consent of the individual, as provided in this subparagraph,~~ shall be borne by the nonmedical ~~medical~~ personnel or the employer of the ~~medical personnel or~~ nonmedical personnel. However, costs of testing or treatment not directly related to the initial HIV tests or costs of subsequent testing or treatment may not be borne by the nonmedical ~~medical~~ personnel or the employer of the ~~medical personnel or~~ nonmedical personnel.

c.~~d.~~ For ~~In order to utilize the provisions of~~ this subparagraph to be applicable, the ~~medical personnel or~~ nonmedical personnel must ~~shall~~ be tested for HIV under ~~pursuant~~

~~to~~ this section or must ~~shall~~ provide the results of an HIV test taken within 6 months before ~~prior to~~ the significant exposure if such test results are negative.

d. If the source of the exposure is not available and will not voluntarily present to a health facility to be tested for HIV, the nonmedical personnel or the employer of the nonmedical personnel acting on behalf of the employee may seek a court order directing the source of the exposure to submit to HIV testing. A sworn statement by a physician licensed under chapter 458 or chapter 459 that a significant exposure has occurred and that, in the physician's medical judgment, HIV testing is medically necessary to determine the course of treatment constitutes probable cause for the issuance of an order by the court. The results of the HIV test shall be released to the source of the exposure and to the person who experienced the exposure.

e. A person who receives the results of an HIV test pursuant to this subparagraph shall maintain the confidentiality of the information received and of the persons tested. Such confidential information is exempt from s. 119.07(1).

~~f. If the source of the exposure will not voluntarily submit to HIV testing and a blood sample was not obtained during treatment for the medical emergency, the medical personnel, the employer of the medical personnel acting on behalf of the employee, or the nonmedical personnel may seek a court order directing the source of the exposure to submit to HIV testing. A sworn statement by a physician licensed under chapter 458 or chapter 459 that a significant exposure has occurred and that, in the physician's medical judgment, testing is medically~~

~~necessary to determine the course of treatment constitutes probable cause for the issuance of an order by the court. The results of the test shall be released to the source of the exposure and to the person who experienced the exposure.~~

12. For the performance of an HIV test by the medical examiner or attending physician upon an individual who expired or could not be resuscitated while receiving emergency medical assistance or care and who was the source of a significant exposure to medical or nonmedical personnel providing such assistance or care.

a. HIV testing may be conducted only after appropriate medical personnel under the supervision of a licensed physician documents in the medical record of the medical personnel or nonmedical personnel that there has been a significant exposure and that, in accordance with the written protocols based on the National Centers for Disease Control and Prevention guidelines on HIV postexposure prophylaxis and in the physician's medical judgment, the information is medically necessary to determine the course of treatment for the medical personnel or nonmedical personnel.

b. Costs of an ~~any~~ HIV test performed under this subparagraph may not be charged to the deceased or to the family of the deceased person.

c. For ~~the provisions of~~ this subparagraph to be applicable, the medical personnel or nonmedical personnel must be tested for HIV under this section or must provide the results of an HIV test taken within 6 months before the significant exposure if such test results are negative.

d. A person who receives the results of an HIV test

pursuant to this subparagraph shall comply with paragraph (e).

13. For the performance of an HIV-related test medically indicated by licensed medical personnel for medical diagnosis of a hospitalized infant as necessary to provide appropriate care and treatment of the infant if ~~when~~, after a reasonable attempt, a parent cannot be contacted to provide consent. The medical records of the infant must ~~shall~~ reflect the reason consent of the parent was not initially obtained. Test results shall be provided to the parent when the parent is located.

14. For the performance of HIV testing conducted to monitor the clinical progress of a patient previously diagnosed to be HIV positive.

15. For the performance of repeated HIV testing conducted to monitor possible conversion from a significant exposure.

(4) HUMAN IMMUNODEFICIENCY VIRUS TESTING REQUIREMENTS; REGISTRATION WITH THE DEPARTMENT OF HEALTH; EXEMPTIONS FROM REGISTRATION.—A ~~No~~ county health department and any ~~no~~ other person in this state offering HIV tests in a nonhealth care setting may not ~~shall~~ conduct or hold themselves out to the public as conducting a testing program for acquired immune deficiency syndrome or human immunodeficiency virus status without first registering with the Department of Health, reregistering each year, complying with all other applicable provisions of state law, and meeting the following requirements:

(d) A program in a nonhealth care setting must meet all informed consent criteria provided in subparagraph (2)(a)2 ~~The program must meet all the informed consent criteria contained in subsection (2)~~.

Section 2. Subsection (2) of section 456.032, Florida

Statutes, is amended to read:

456.032 Hepatitis B or HIV carriers.—

(2) Any person licensed by the department and any other person employed by a health care facility who contracts a blood-borne infection shall have a rebuttable presumption that the illness was contracted in the course and scope of his or her employment, provided that the person, as soon as practicable, reports to the person's supervisor or the facility's risk manager any significant exposure, as that term is defined in s. 381.004(1)(f) ~~381.004(1)(c)~~, to blood or body fluids. The employer may test the blood or body fluid to determine if it is infected with the same disease contracted by the employee. The employer may rebut the presumption by the preponderance of the evidence. Except as expressly provided in this subsection, there shall be no presumption that a blood-borne infection is a job-related injury or illness.

Section 3. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Finance and Tax, *Chair*
Communications, Energy, and Public Utilities, *Vice Chair*
Appropriations
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Banking and Insurance
Fiscal Policy

JOINT COMMITTEE:
Joint Committee on Public Counsel Oversight

SENATOR DOROTHY L. HUKILL
8th District

March 10, 2015

The Honorable Rene Garcia
201 The Capitol
404 S. Monroe Street
Tallahassee, FL 32399

Re: Senate Bill 950 – Public Health Emergencies

Dear Chairman Garcia:

Senate Bill 950, relating Public Health Emergencies has been referred to the Appropriations Subcommittee on Health and Human Services. I am requesting your consideration on placing SB 950 on your next agenda. Should you need any additional information please do not hesitate to contact my office.

Thank you for your consideration.

Sincerely,

Dorothy L. Hukill

Dorothy L. Hukill, District 8

cc: Scarlett Pigott, Staff Director of the Appropriations Subcommittee on Health and Human Services
Robin Auber, Administrative Assistant of the Appropriations Subcommittee on Health and Human Services

REPLY TO:
❒ 209 Dunlawton Avenue, Unit 17, Port Orange, Florida 32127 (386) 304-7630 FAX: (888) 263-3818
❒ Ocala City Hall, 110 SE Watula Avenue, 3rd Floor, Ocala, Florida 34471 (352) 694-0160

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4-8-2015
Meeting Date

SB 950
Bill Number (if applicable)

Topic PUBLIC HEALTH EMERGENCIES

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BIRKSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] 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 the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

950
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nland

Job Title _____

Address 1000 Riverside Ave
Street
Jacksonville FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nlandlaw@aol.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Health Association

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

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 950
INTRODUCER:	Health Policy Committee and Senator Hukill
SUBJECT:	Public Health Emergencies
DATE:	April 7, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 950 amends provisions relating to the Department of Health's (DOH) authority to initiate and enforce quarantine orders for persons, animals, and premises. The bill defines the terms "isolation" and "quarantine" and allows the DOH to isolate individuals whenever a quarantine would be allowed under s. 381.00315, F.S. (relating to public health advisories, public health emergencies, and quarantines).

The bill requires law enforcement to assist the DOH in enforcing orders adopted under ch. 381, F.S., related to public health. Quarantine and isolation orders are enacted by the State Surgeon General or by the director of a county health department or his or her designee. The bill also includes a legislative finding that the act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

The bill has no fiscal impact on state government.

The effective date of the bill is July 1, 2015.

II. Present Situation:

Public Health Emergencies in Florida

Currently, s. 381.00315, F.S., allows the State Surgeon General to declare a public health emergency for a period of up to 60 days. The emergency period may be extended if renewed by the Governor. Such declarations can be statewide or localized. During a public health emergency the Surgeon General is granted the power to take actions that are necessary to protect the public, including, but not limited to:

- Directing prescription drug manufacturers to ship specified drugs to pharmacies and health care providers within specified geographic areas;
- Directing DOH-employed pharmacists to compound necessary bulk medications;
- Temporarily reactivating inactive health care practitioner licenses; and
- Ordering individuals to be examined, tested, vaccinated, treated, or quarantined for communicable diseases that have significant morbidity or mortality and present a severe danger to the public health.

Public health emergencies can be declared for various reasons. For example, Governor Charlie Crist directed State Surgeon General Dr. Ana Viamonte Ros to declare a public health emergency for two cases of swine flu in Lee and Broward counties in 2009.[1] Additionally, in 2011, the Florida Legislature passed HB 7095 which directed Surgeon General Frank Farmer to issue a statewide public health emergency in response to the ongoing problem of prescription drug abuse.[2]

Quarantine versus Isolation

Quarantine and isolation are two tools used by public health authorities to separate from the public people, animals, or premises that have a potential to threaten the public health. The U.S. Centers for Disease Control and Prevention (CDC) differentiates between isolation and quarantine in that isolation applies to persons who are known to be ill with a contagious disease whereas quarantine applies to those who have been exposed to a contagious disease but who may or may not become ill. In addition to people, the CDC applies the term quarantine to animals and premises who may have been exposed to a dangerous contagious disease agent and have been closed off or separated from the population.[3] Isolation and quarantine orders can also differ in length. The length of an isolation order is typically determined by the length of the communicability of the illness for which the individual is being isolated while the duration and scope of quarantine orders can vary, depending on their purpose, and can last as long as necessary to protect the public.[4]

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[1] See Florida Declares Health Emergency, available at http://swflorida.blogspot.com/2009/05/florida-declares-health-emergency.html, (last visited Mar. 5, 2015).
[2] See http://newsroom.doh.state.fl.us/2011/07/01/emergency-declaration/ (last visited March 5, 2015).
[3] U.S. Centers for Disease Control and Prevention, *Understand Quarantine and Isolation* (February 10, 2014) available at http://emergency.cdc.gov/preparedness/quarantine/ (last visited Mar. 6, 2015).
[4] U.S. Centers for Disease Control and Prevention, *Understand Quarantine and Isolation: Questions & Answers* (February 10, 2014) available at http://emergency.cdc.gov/preparedness/quarantine/qa.asp, (last visited Mar. 6, 2015).

Quarantines in Florida

Section 64D-3.038, F.A.C., details how the DOH may initiate and lift a quarantine. Quarantine orders are issued by the Surgeon General or a county health department director or their designee and must include an expiration date or specific conditions for the end of the quarantine. The quarantine order must also restrict or compel the movement or actions, including isolation, closure of premises, testing, destruction, disinfection, treatment, and immunization of a person, animal, or a premises. The DOH must have access to the quarantined individual or premises and any transportation or removal of quarantined persons or animals must be in accordance with written orders issued by the Surgeon General or the county health department director.

The state has used its quarantine power on several occasions. In 1988, the Miami-Dade County health department declared a quarantine of a building in downtown Miami due to a major fire spreading dangerous PCB chemicals within the building. Also, in 2003, a six-year-old was placed in home isolation by the Okaloosa County health department under suspicion of having SARS, and the Miami-Dade County health department persuaded a jewelry salesman who was suspected of having SARS to sequester himself for 10 days. Additionally, a building in Boca Raton was quarantined after an anthrax attack killed a photojournalist in 2001.[5] For these examples, however, no formal involuntary orders were issued. The last involuntary order that was issued in Florida occurred in 1947.[6]

The most recent example of a quarantine order is from October 2014 when Governor Rick Scott issued executive order number 14-280. That order directed the DOH to monitor all people leaving an Ebola-affected country for 21 days after their departure and to quarantine for 21 days any high-risk traveler from an Ebola-affected country in West Africa. The order allowed the DOH to make its own determinations on quarantine and other necessary public health interventions.[7]

Law Enforcement

Section 381.0012, F.S., currently requires law enforcement officials and other city and county officials to enforce DOH laws and rules. Orders are not included in this enforcement mandate. However, s. 381.00315(1), F.S., states that all orders by the state health officer (State Surgeon General) are immediately enforceable by a law enforcement officer under s. 381.0012, F.S. The conflict in these sections may create some ambiguity for law enforcement officials who are tasked with enforcing quarantine orders.

III. Effect of Proposed Changes:

The bill amends s. 381.00315, F.S., to define the terms:

[5] Wm. Robert Johnston, *Review of Fall 2001 Anthrax Attacks*, (last modified March 16, 2005), available at http://www.cdc.gov/niosh/nas/rdrp/appendices/chapter6/a6-45.pdf, (last visited on March 9, 2015).
[6] Florida Department of Health, *White Paper on the Law of Florida Human Quarantine*, (January 2007), available at http://biotech.law.lsu.edu/cphl/articles/others/Florida-Quarantine-07.pdf, (Last visited March. 5, 2015).
[7] Exec Order No. 14-280, (October 25, 2014), available at http://www.flgov.com/wp-content/uploads/2014/10/SKMBT_C35314102515490.pdf, (last visited on Mar. 5, 2015).

- "Isolation" as the separation of an individual who is reasonably believed to be infected with a communicable from those who are not infected with the disease to prevent the spread of the disease; and
- "Quarantine" as the separation of an asymptomatic individual or a premises reasonably believed to have been exposed to a communicable disease from others who have not been exposed to the disease to prevent the possible spread of the disease.

The bill allows the DOH to use isolation as a preventative measure with similar authority to the authority the DOH currently has to order a quarantine and makes any isolation and quarantine order immediately enforceable by law enforcement. In addition, the bill amends s. 381.0012, F.S., to require law enforcement, as well as other city and county officials, to assist the DOH in enforcing state health orders (in addition to state laws and DOH rules). The bill also contains a legislative finding that the act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

The DOH is required to adopt rules regarding the imposition and lifting of isolation orders.

The bill has an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

To the extent this bill requires a local government to expend funds to comply with its terms, the provisions contained in Article VII, section 18(a) of the Florida Constitution, may apply. If those provisions do apply, in order for the law to be binding upon the cities and counties, the Legislature must find that the law fulfills an important state interest, and one of the following relevant exceptions must apply:

- The expenditure is required to comply with a law that applies to all persons similarly situated; or
- The law must be approved by two-thirds of the membership of each house of the Legislature.

The municipality/county mandates provision of the Florida Constitution may apply because this bill requires local law enforcement agencies, county attorneys, and other appropriate city and county officials to use their own resources to assist the DOH or its agents in enforcing isolation and quarantine orders upon the request of the DOH or its agents. However, it is likely that the costs to the cities or counties of enforcing the isolation and quarantine orders would be insignificant due to the rarity of the DOH invoking its quarantine authority.

Since the bill requires the assistance of both state and local law enforcement, as well as other officials, in enforcing such orders, it appears the bill applies to all persons similarly situated. Additionally, the bill contains a finding of important state interest. Thus it appears the bill is binding upon city and county law enforcement and other appropriate city and county officials.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

The bill defines the term quarantine to include individuals and premises; however, the DOH also has the authority in s. 381.0012, F.S., to quarantine animals. The definition of quarantine in the bill should be amended to include animals as well as individuals and premises.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0012 and 381.00315.

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 March 10, 2015:
The CS amends the definition of "quarantine" to include premises and adds section 3 of the bill which provides a legislative finding that the bill fulfills an important state interest.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Hukill

588-02132-15 2015950c1

A bill to be entitled

An act relating to public health emergencies; amending s. 381.0012, F.S.; requiring certain state and local officers to assist in enforcing rules and orders issued by the Department of Health under ch. 381, F.S.; amending s. 381.00315, F.S.; authorizing the State Health Officer to issue orders to isolate individuals; defining terms; clarifying the responsibilities of the department for isolation and quarantine; specifying that any order the department issues is immediately enforceable by a law enforcement officer; requiring the department to adopt rules for the imposing and lifting of isolation orders; providing a penalty for violating an isolation order; providing a legislative finding of important state interest; providing an effective date.

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

Section 1. Subsection (5) of section 381.0012, Florida Statutes, is amended to read:

381.0012 Enforcement authority.—

(5) It shall be the duty of every state and county attorney, sheriff, police officer, and other appropriate city and county officials upon request to assist the department or any of its agents in enforcing the state health laws, rules, and orders ~~the rules~~ adopted under this chapter.

Section 2. Section 381.00315, Florida Statutes, is amended to read:

588-02132-15 2015950c1

381.00315 Public health advisories; public health emergencies; isolation and quarantines.—The State Health Officer is responsible for declaring public health emergencies, issuing public health advisories, and ordering isolation or ~~and~~ quarantines ~~and issuing public health advisories~~.

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

(a) "Isolation" means the separation of an individual who is reasonably believed to be infected with a communicable disease from those who are not infected with the disease to prevent the spread of the disease.

(b) ~~(a)~~ "Public health advisory" means any warning or report giving information to the public about a potential public health threat. Prior to issuing any public health advisory, the State Health Officer must consult with any state or local agency regarding areas of responsibility which may be affected by such advisory. Upon determining that issuing a public health advisory is necessary to protect the public health and safety, and prior to issuing the advisory, the State Health Officer must notify each county health department within the area which is affected by the advisory of the State Health Officer's intent to issue the advisory. The State Health Officer is authorized to take any action appropriate to enforce any public health advisory.

(c) ~~(b)~~ "Public health emergency" means any occurrence, or threat thereof, whether natural or manmade ~~man made~~, which results or may result in substantial injury or harm to the public health from infectious disease, chemical agents, nuclear agents, biological toxins, or situations involving mass casualties or natural disasters. Prior to declaring a public health emergency, the State Health Officer shall, to the extent

possible, consult with the Governor and shall notify the Chief of Domestic Security. The declaration of a public health emergency shall continue until the State Health Officer finds that the threat or danger has been dealt with to the extent that the emergency conditions no longer exist and he or she terminates the declaration. However, a declaration of a public health emergency may not continue for longer than 60 days unless the Governor concurs in the renewal of the declaration. The State Health Officer, upon declaration of a public health emergency, may take actions that are necessary to protect the public health. Such actions include, but are not limited to:

1. Directing manufacturers of prescription drugs or over-the-counter drugs who are permitted under chapter 499 and wholesalers of prescription drugs located in this state who are permitted under chapter 499 to give priority to the shipping of specified drugs to pharmacies and health care providers within geographic areas that have been identified by the State Health Officer. The State Health Officer must identify the drugs to be shipped. Manufacturers and wholesalers located in the state must respond to the State Health Officer's priority shipping directive before shipping the specified drugs.

2. Notwithstanding chapters 465 and 499 and rules adopted thereunder, directing pharmacists employed by the department to compound bulk prescription drugs and provide these bulk prescription drugs to physicians and nurses of county health departments or any qualified person authorized by the State Health Officer for administration to persons as part of a prophylactic or treatment regimen.

3. Notwithstanding s. 456.036, temporarily reactivating the

inactive license of the following health care practitioners, when such practitioners are needed to respond to the public health emergency: physicians licensed under chapter 458 or chapter 459; physician assistants licensed under chapter 458 or chapter 459; licensed practical nurses, registered nurses, and advanced registered nurse practitioners licensed under part I of chapter 464; respiratory therapists licensed under part V of chapter 468; and emergency medical technicians and paramedics certified under part III of chapter 401. Only those health care practitioners specified in this paragraph who possess an unencumbered inactive license and who request that such license be reactivated are eligible for reactivation. An inactive license that is reactivated under this paragraph shall return to inactive status when the public health emergency ends or prior to the end of the public health emergency if the State Health Officer determines that the health care practitioner is no longer needed to provide services during the public health emergency. Such licenses may only be reactivated for a period not to exceed 90 days without meeting the requirements of s. 456.036 or chapter 401, as applicable.

4. Ordering an individual to be examined, tested, vaccinated, treated, isolated, or quarantined for communicable diseases that have significant morbidity or mortality and present a severe danger to public health. Individuals who are unable or unwilling to be examined, tested, vaccinated, or treated for reasons of health, religion, or conscience may be subjected to isolation or quarantine.

a. Examination, testing, vaccination, or treatment may be performed by any qualified person authorized by the State Health

Officer.

b. If the individual poses a danger to the public health, the State Health Officer may subject the individual to isolation or quarantine. If there is no practical method to isolate or quarantine the individual, the State Health Officer may use any means necessary to vaccinate or treat the individual.

Any order of the State Health Officer given to effectuate this paragraph shall be immediately enforceable by a law enforcement officer under s. 381.0012.

(d) "Quarantine" means the separation of an asymptomatic individual or a premises reasonably believed to have been exposed to a communicable disease from individuals who have not been exposed to the disease to prevent its possible spread.

(2) Individuals who assist the State Health Officer at his or her request on a volunteer basis during a public health emergency are entitled to the benefits specified in s. 110.504(2), (3), (4), and (5).

(3) To facilitate effective emergency management, when the United States Department of Health and Human Services contracts for the manufacture and delivery of licensable products in response to a public health emergency and the terms of those contracts are made available to the states, the department shall accept funds provided by counties, municipalities, and other entities designated in the state emergency management plan required under s. 252.35(2)(a) for the purpose of participation in those contracts. The department shall deposit those funds in the Grants and Donations Trust Fund and expend those funds on behalf of the donor county, municipality, or other entity for

the purchase of the licensable products made available under the contract.

(4) The department has the duty and the authority to declare, enforce, modify, and abolish the isolation or quarantine ~~quarantines~~ of persons, animals, and premises as the circumstances indicate for controlling communicable diseases or providing protection from unsafe conditions that pose a threat to public health, except as provided in ss. 384.28 and 392.545-392.60. Any order the department issues pursuant to this subsection is immediately enforceable by a law enforcement officer under s. 381.0012.

(5) The department shall adopt rules to specify the conditions and procedures for imposing and lifting an order for isolation or ~~and releasing a~~ quarantine. The rules must include provisions related to:

(a) The closure of premises.

(b) The movement of persons or animals exposed to or infected with a communicable disease.

(c) The tests or treatment, including vaccination, for communicable disease required prior to employment or admission to the premises or to comply with an isolation or ~~a~~ quarantine order.

(d) Testing or destruction of animals with or suspected of having a disease transmissible to humans.

(e) Access by the department to persons in isolation or quarantine or to premises housing persons in isolation or in quarantine ~~quarantined premises~~.

(f) The disinfection of isolated or quarantined animals, persons, or premises.

(g) Methods of isolation or quarantine.

(6) The rules adopted under this section and actions taken by the department pursuant to a declared public health emergency, isolation, or quarantine shall supersede all rules enacted by other state departments, boards or commissions, and ordinances and regulations enacted by political subdivisions of the state. Any person who violates any rule adopted under this section, any order of isolation or quarantine, or any requirement adopted by the department pursuant to a declared public health emergency, commits a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

Section 3. The Legislature finds that this act fulfills an important state interest by providing measures for the control of communicable diseases and the protection of public health.

Section 4. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

APPEARANCE RECORD

4/8/15
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1040
Bill Number (if applicable)

Topic Infectious Disease Elimination Act

Amendment Barcode (if applicable)

Name Holly Miller

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Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FMA

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] 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

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

1040
Bill Number (if applicable)

Topic Infectious Disease Elim. Pilot Program
Amendment Barcode (if applicable)

Name Avery Coleman

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Assoc. of Community Health Centers

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

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

April 8, 2015
Meeting Date

1040
Bill Number (if applicable)

Topic SB 1040 by Braynon—Infectious Disease Elimination Pilot Program

Amendment Barcode (if applicable)

Name Jesse Fry

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The AIDS Institute

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

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 1040
Bill Number (if applicable)

Topic HIV Infections Disease Elimination Pilot Program

Amendment Barcode (if applicable)

Name Christian Minor

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Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Florida Smart Justice Alliance

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

1040
Bill Number (if applicable)

Topic Infectious Disease Elimination Act

Amendment Barcode (if applicable)

Name Hansel Tookes

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Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

4-8-2015
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

SB 1040
Bill Number (if applicable)

Topic INFECTIOUS DISEASE ELIMINATION PILOT PROGRAM

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

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Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [ ] Yes [ ] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 1040
Bill Number (if applicable)

Topic IDEA

Amendment Barcode (if applicable)

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Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing —

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

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 1040
Bill Number (if applicable)

Topic SYRINGE EXCHANGE SB 1040-"IDEA"
Amendment Barcode (if applicable)

Name PAUL ARONS

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Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing SELF

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

1040
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

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Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Health Association

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)

APPEARANCE RECORD

4-8
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1040
Bill Number (if applicable)

Topic Needle Exchange by Braynon

Amendment Barcode (if applicable)

Name Martha DeCastro

Job Title

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Phone

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital Assoc

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

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 Appropriations Subcommittee on Health and Human Services

BILL:	SB 1040
INTRODUCER:	Senator Braynon
SUBJECT:	Infectious Disease Elimination Pilot Program
DATE:	April 7, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Harper	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

I. Summary:

SB 1040 creates the Miami-Dade Infectious Disease Elimination Act (IDEA), which authorizes the University of Miami and its affiliates to establish a single sterile needle and syringe exchange pilot program in Miami-Dade County as a means to prevent the transmission of blood-borne diseases. The bill provides duties and requirements for the operation of the pilot program.

The bill specifies that state funds may not be used to operate the pilot program. Instead, the pilot program must be funded through grants and donations from private resources and funds.

The bill directs the Office of Program Policy Analysis and Government Accountability (OPPAGA) to submit a report with specified data and a recommendation regarding continuance of the pilot program six months before the pilot program's expiration, which, under the bill, is July 1, 2020.

The bill has no fiscal impact. The bill has an effective date of July 1, 2015.

II. Present Situation:

Intravenous Drug Use in Florida

The majority of Florida counties with high rates of persons living with HIV/AIDS (PLWHA), and with a high injection-drug-user (IDU)-associated risk, in 2013 were in the southeast or central parts of the state.[1] The Department of Health (DOH) reports that 50 to 90 percent of HIV-

[1] Department of Health, *HIV Infection Among Those with an Injection Drug Use-Associated Risk, Florida, 2014* (power point slide) (revised Jan. 29, 2015), *available at* http://www.floridahealth.gov/diseases-and-conditions/aids/surveillance/_documents/hiv-aids-slide-sets/2014/idu-2014.pdf (last visited Mar. 19, 2015).

infected IDUs are also co-infected with Hepatitis C Virus.[2] The chart below displays data from 2013 of the 11 Florida counties with the highest incidence of PLWHA with an IDU-associated risk.[3]

County	Total PLWHA Cases	Total IDU	Percent IDU
Miami-Dade	26,445	3,240	12%
Broward	17,214	2,132	12%
Palm Beach	7,964	1,481	19%
Orange	7,508	1,304	17%
Hillsborough	6,262	1,198	19%
Duval	5,584	999	18%
Pinellas	3,675	728	20%
Lee	1,777	310	18%
St. Lucie	1,550	309	20%
Volusia	1,408	340	24%
Brevard	1,300	273	21%
STATE TOTAL	101,977	17,368	17%

Intravenous Drug Use in Miami-Dade County

In a 2011 study, researchers from the University of Miami estimated that there are more than 10,000 IDUs in Miami and that one in five of these IDUs are HIV positive while one in three are Hepatitis C Virus positive.[4] The researchers also found that IDUs in Miami—a city without a needle and syringe exchange program—had over 34 times the adjusted odds of disposal of a used syringe in a public location relative to IDUs in San Francisco—a city with multiple exchange programs.[5]

Needle and Syringe Exchange Programs

In the mid-1980s, the National Institute on Drug Abuse (NIDA) undertook a research program to develop, implement, and evaluate the effectiveness of intervention strategies to reduce risk behaviors and prevent the spread of HIV/AIDS, particularly among IDUs, their sexual partners, and offspring. The studies found that comprehensive strategies—in the absence of a vaccine or cure for AIDS—are the most cost effective and reliable approaches to prevent new blood-borne infections. The strategies NIDA recommends are community-based outreach, drug abuse treatment, and sterile syringe access programs, including needle and syringe exchange programs (NSEPs). In general, these strategies are referred to as harm reduction. [6]

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[2] Department of Health, *HIV Disease and Hepatitis C Virus (HCV) Co-Infection – Florida, 2013* (Revised Sept. 3, 2014) (on file with the Senate Committee on Health Policy).
[3] *Supra* note 1. Percent IDU adjusted to conform with previous data charts.
[4] Hansel E. Tookes, et al. "A comparison of syringe disposal practices among injection drug users in a city with versus a city without needle and syringe programs." Drug and Alcohol Dependence, June 2012, Vol. 123, Issue 1, pp. 255-259, *available at* http://www.ncbi.nlm.nih.gov/pubmed/22209091 (last visited Mar. 19, 2015).
[5] *Id*.
[6] National Institute of Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, *Principles of HIV Prevention in Drug-Using Populations: A Research-Based Guide* (March 2002), *available at* http://www.nhts.net/media/Principles%20of%20HIV%20Prevention%20(17).pdf (last visited Mar. 19, 2015).

Needle and syringe exchange programs provide free sterile needles and syringe units and collect used needles and syringes from IDUs to reduce transmission of blood-borne pathogens, including HIV, hepatitis B virus, and hepatitis C virus (HCV). In addition, the programs help to:

- Increase the number of drug users who enter and remain in available treatment programs;
- Disseminate HIV risk reduction information and referrals for HIV testing and counseling and drug treatment;
- Reduce injection frequency and needle-sharing behaviors;
- Reduce the number of contaminated syringes in circulation in a community; and
- Increase the availability of sterile needles, thereby reducing the risk that new infections will spread.[7]

The first sanctioned NSEP in the world began in Amsterdam, the Netherlands, in 1984. The first sanctioned program to operate in North America originated in Tacoma, Washington, in 1988. Programs have since developed throughout the United States.[8] As of June 2014, there are 194 NSEPs in 33 states, the District of Columbia, the Commonwealth of Puerto Rico, and the Indian Nations.[9]

Federal Ban on Funding Needle and Syringe Exchange Programs

In 1988, Congress enacted an initial ban on the use of federal funds for NSEPs which remained in place until 2009. In 2009, Congress passed the 2010 Consolidated Appropriations Act, which removed the ban on federal funding of NSEPs. In July 2010, the U.S. Department of Health and Human Services issued implementation guidelines for programs interested in using federal dollars for NSEPs.[10]

However, on December 23, 2011, President Barack Obama signed the 2012 omnibus spending bill that reinstated the ban on the use of federal funds for NSEPs, which reversed the 111th Congress's 2009 decision to allow federal funds to be used for NSEPs.[11] The ban on federal funding for NSEPs remains in effect.

Florida Comprehensive Drug Abuse Prevention and Control Act

In Florida, the term "drug paraphernalia" is defined as all equipment, products, and materials of any kind which are used, intended for use, or designed for use in planting, propagating, cultivating, growing, harvesting, manufacturing, compounding, converting, producing,

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[7] *Id*, at 18. *See also* World Health Organization, *Effectiveness of Sterile Needle and Syringe Programming in Reducing HIV/AIDS Among Injecting Drug Users* (2004) 28 – 29, *available at* http://www.who.int/hiv/pub/idu/pubidu/en/ (last visited Mar. 19, 2015).

[8] Sandra D. Lane, R.N., Ph.D., M.P.H., *Needle Exchange: A Brief History, a Publication from The Kaiser Forums*, *available at* http://hpcpsdi.rutgers.edu/facilitator/SAP/downloads/articles%20and%20data/History+of+Needle+Exchange.pdf (last visited Mar. 19, 2015).

[9] North American Syringe Exchange Network, *Syringe Services Program Coverage in the United States* (June 2014), *available at* http://www.amfar.org/uploadedFiles/_amfarorg/On_the_Hill/2014-SSP-Map-7-17-14.pdf (last visited Mar. 19, 2015).

[10] Matt Fisher, Center for Strategic and International Studies, *A History of the Ban on Federal Funding for Syringe Exchange Programs*, SmartGlobalHealth.org (Feb. 6, 2012), *available at* http://www.smartglobalhealth.org/blog/entry/a-history-of-the-ban-on-federal-funding-for-syringe-exchange-programs/ (last visited Mar. 19, 2015).

[11] *Id*.

processing, preparing, testing, analyzing, packaging, repackaging, storing, containing, concealing, transporting, injecting, ingesting, inhaling, or otherwise introducing into the human body, a controlled substance in violation of ch. 893, F.S., or s. 877.111, F.S.[12]

Section 893.147, F.S., regulates the use or possession of drug paraphernalia. Currently, it is unlawful for any person to use, or to possess with intent to use, drug paraphernalia:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this chapter; or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of ch. 893, F.S.

Any person who violates this provision commits a first degree misdemeanor.[13]

It is unlawful for any person to deliver, possess with intent to deliver, or manufacture with intent to deliver drug paraphernalia, knowing, or under circumstances where one reasonably should know, that it will be used:

- To plant, propagate, cultivate, grow, harvest, manufacture, compound, convert, produce, process, prepare, test, analyze, pack, repack, store, contain, or conceal a controlled substance in violation of this act, or
- To inject, ingest, inhale, or otherwise introduce into the human body a controlled substance in violation of this act.

Any person who violates this provision commits a third degree felony.[14]

A court, jury, or other authority, when determining in a criminal case whether an object constitutes drug paraphernalia, must consider specified facts surrounding the connection between the item and the individual arrested for possessing drug paraphernalia. A court or jury is required to consider a number of factors in determining whether an object is drug paraphernalia, such as proximity of the object in time and space to a controlled substance, the existence of residue of controlled substances on the object, and expert testimony concerning its use.[15]

Federal Law Exemption

Any person authorized by local, state, or federal law to manufacture, possess, or distribute drug paraphernalia is exempt from the federal drug paraphernalia statute.[16]

III. Effect of Proposed Changes:

Section 1 titles the bill as the "Miami-Dade Infectious Disease Elimination Act (IDEA)."

[12] Section 893.145, F.S.
[13] A first degree misdemeanor is punishable by up to 1-year imprisonment in a county jail, a fine of up to $1,000, or both. *See* ss. 775.082 and 775.083, F.S.
[14] A third degree felony is punishable by up to 5 years in state prison, a fine not to exceed $5,000, or both. *See* ss. 775.082 and 775.083, F.S.
[15] Section 893.146, F.S.
[16] 21 U.S.C. § 863(f)(1).

Section 2 amends s. 381.0038, F.S., to create a sterile needle and syringe exchange pilot program in Miami-Dade County.

The bill authorizes the University of Miami and its affiliates to establish a single sterile needle and syringe exchange pilot program in Miami-Dade County. The pilot program may operate at a fixed location or through a mobile health unit. The pilot program is designed to offer the free exchange of clean, unused needles and hypodermic syringes for used needles and hypodermic syringes as a means to prevent the transmission of HIV, AIDS, viral hepatitis, or other blood-borne diseases.

The bill provides that the pilot program must provide for maximum security of exchange sites and equipment, including:

- An accounting of the number of needles and syringes in use;
- The number of needles and syringes in storage;
- Safe disposal of returned needles; and
- Any other measure required to control the use and dispersal of needles and syringes.

The bill provides that the pilot program must operate a one-to-one exchange, whereby participants receive one sterile needle and syringe unit in exchange for each used one. In addition to the needle and syringe exchange, the pilot program must make available:

- Educational materials;
- HIV and viral hepatitis counseling and testing;
- Referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and
- Drug-abuse prevention and treatment counseling and referral services.

The bill specifies that the possession, distribution, or exchange of needles or syringes as part of the pilot program is not a violation of any law. However, a pilot program staff member, volunteer, or participant is not immune for criminal prosecution for:

- Possession of needles or syringes that are not a part of the pilot program; or
- Redistribution of needles or syringes in any form, if acting outside the pilot program.

The bill provides that the pilot program collect data for annual and final reporting purposes, including information on:

- The number of participants served;
- The number of needles and syringes exchanged and distributed;
- The demographic profiles of the participants served;
- The number of participants entering drug counseling and treatment;
- The number of participants receiving HIV, AIDS, or viral hepatitis testing; and
- Other data deemed necessary for the pilot program.

The bill specifies that personal identifying information may not be collected from a participant for any purpose.

The bill provides that state funds may not be used to operate the pilot program and that the pilot program must be funded through grants and donations from private resources and funds.

The bill provides that the pilot program will expire July 1, 2020. The bill directs the OPPAGA to submit a report to the President of the Senate and the Speaker of the House of Representatives six months before the pilot program expires. The OPPAGA report must include:

- The data collection requirements established in the bill;
- The rates of HIV, AIDS, viral hepatitis, and other blood-borne diseases before the pilot program began and every subsequent year thereafter; and
- A recommendation on whether to continue the pilot program.

The bill also revises current law to clarify that the DOH education program about the threat of AIDS must use all forms of media with emphasis on materials that can be used in the regular course of business for businesses, schools, and health care providers.

Section 3 creates an undesignated section of Florida law to provide a severability clause, providing that if any provision of this act or its application to any person or circumstances is held invalid, the invalidity does not affect other provisions or applications of the bill that can be given effect without the invalid provision or application, and to this end the provisions of the bill are severable.

Section 4 provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under SB 1040, the University of Miami will be responsible for securing funding through grants and donations from private sources.

C. Government Sector Impact:

The OPPAGA will incur additional workload demands to submit the report required under the bill.

The pilot program may reduce state and local government expenditures for the treatment of blood-borne diseases associated with intravenous drug use.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill requires the pilot program to collect various data for the purpose of annual reports and the program's final report, including "other data deemed necessary for the pilot program." The bill does not provide guidance as to standards under which data may be deemed necessary or which entity may deem data to be necessary.

VIII. Statutes Affected:

This bill substantially amends section 381.0038 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 Braynon

36-00220B-15 20151040__

A bill to be entitled

An act relating to an infectious disease elimination pilot program; creating the "Miami-Dade Infectious Disease Elimination Act (IDEA)"; amending s. 381.0038, F.S.; authorizing the University of Miami and its affiliates to establish a sterile needle and syringe exchange pilot program in Miami-Dade County; establishing pilot program criteria; providing that the distribution of needles and syringes under the pilot program is not a violation of the Florida Comprehensive Drug Abuse Prevention and Control Act or any other law; providing conditions under which a pilot program staff member or participant may be prosecuted; prohibiting the collection of participant identifying information; providing for the pilot program to be funded through private grants and donations; providing for expiration of the pilot program; requiring the Office of Program Policy Analysis and Government Accountability to submit a report and recommendations regarding the pilot program to the Legislature; providing for severability; providing an effective date.

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

Section 1. This act may be cited as the "Miami-Dade Infectious Disease Elimination Act (IDEA)."

Section 2. Section 381.0038, Florida Statutes, is amended to read:

36-00220B-15 20151040__

381.0038 Education; sterile needle and syringe exchange pilot program.—The Department of Health shall establish a program to educate the public about the threat of acquired immune deficiency syndrome.

(1) The acquired immune deficiency syndrome education program shall:

(a) Be designed to reach all segments of Florida's population;

(b) Contain special components designed to reach non-English-speaking and other minority groups within the state;

(c) Impart knowledge to the public about methods of transmission of acquired immune deficiency syndrome and methods of prevention;

(d) Educate the public about transmission risks in social, employment, and educational situations;

(e) Educate health care workers and health facility employees about methods of transmission and prevention in their unique workplace environments;

(f) Contain special components designed to reach persons who may frequently engage in behaviors placing them at a high risk for acquiring acquired immune deficiency syndrome;

(g) Provide information and consultation to state agencies to educate all state employees; ~~and~~

(h) Provide information and consultation to state and local agencies to educate law enforcement and correctional personnel and inmates;~~.~~

(i) Provide information and consultation to local governments to educate local government employees;~~.~~

(j) Make information available to private employers and

encourage them to distribute this information to their employees;~~.~~

(k) Contain special components which emphasize appropriate behavior and attitude change; and~~.~~

(l) Contain components that include information about domestic violence and the risk factors associated with domestic violence and AIDS.

(2) The education program designed by the Department of Health shall use ~~utilize~~ all forms of the media and shall place emphasis on the design of educational materials that can be used by businesses, schools, and health care providers in the regular course of their business.

(3) The department may contract with other persons in the design, development, and distribution of the components of the education program.

(4) The University of Miami and its affiliates may establish a single sterile needle and syringe exchange pilot program in Miami-Dade County. The pilot program may operate at a fixed location or through a mobile health unit. The pilot program shall offer the free exchange of clean, unused needles and hypodermic syringes for used needles and hypodermic syringes as a means to prevent the transmission of HIV, AIDS, viral hepatitis, or other blood-borne diseases among intravenous drug users and their sexual partners and offspring.

(a) The pilot program shall:

1. Provide for maximum security of exchange sites and equipment, including an accounting of the number of needles and syringes in use, the number of needles and syringes in storage, safe disposal of returned needles, and any other measure that

may be required to control the use and dispersal of sterile needles and syringes.

2. Operate a one-to-one exchange, whereby the participant shall receive one sterile needle and syringe unit in exchange for each used one.

3. Make available educational materials; HIV and viral hepatitis counseling and testing; referral services to provide education regarding HIV, AIDS, and viral hepatitis transmission; and drug-abuse prevention and treatment counseling and referral services.

(b) The possession, distribution, or exchange of needles or syringes as part of the pilot program established under this subsection is not a violation of any part of chapter 893 or any other law.

(c) A pilot program staff member, volunteer, or participant is not immune from criminal prosecution for:

1. The possession of needles or syringes that are not a part of the pilot program; or

2. Redistribution of needles or syringes in any form, if acting outside the pilot program.

(d) The pilot program shall collect data for annual and final reporting purposes, which shall include information on the number of participants served, the number of needles and syringes exchanged and distributed, the demographic profiles of the participants served, the number of participants entering drug counseling and treatment, the number of participants receiving HIV, AIDS, or viral hepatitis testing, and other data deemed necessary for the pilot program. However, personal identifying information may not be collected from a participant

for any purpose.

(e) State funds may not be used to operate the pilot program. The pilot program shall be funded through grants and donations from private resources and funds.

(f) The pilot program shall expire July 1, 2020. Six months before the pilot program expires, the Office of Program Policy Analysis and Government Accountability shall submit a report to the President of the Senate and the Speaker of the House of Representatives that includes the data collection requirements established in this subsection; the rates of HIV, AIDS, viral hepatitis, or other blood-borne diseases before the pilot program began and every subsequent year thereafter; and a recommendation on whether to continue the pilot program.

Section 3. If any provision of this act or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act that can be given effect without the invalid provision or application, and to this end the provisions of this act are severable.

Section 4. This act shall take effect July 1, 2015.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 1526
Bill Number (if applicable)

Topic Athletic Trainers

Amendment Barcode (if applicable)

Name Jerry Stevens, ATC, LAT

Job Title Athletic Trainer

Address 4396 Allenwood Ct
Street

Phone (904) 208-0713

Jacksonville FL 32258
City *State* *Zip*

Email gasate828@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Athletic Trainers Assoc. 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

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 Appropriations Subcommittee on Health and Human Services

BILL:	CS/SB 1526
INTRODUCER:	Health Policy Committee and Senator Legg
SUBJECT:	Athletic Trainers
DATE:	April 7, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1526 updates the regulation of athletic trainers. The bill authorizes the practice of athletic training under the direction of a physician. The direction must be communicated through an oral or written prescription or protocols. An allopathic, osteopathic, or chiropractic physician is authorized to make the determination as to the appropriate method for communicating his or her direction for the provision of services and care by the athletic trainer. The Board of Athletic Training is directed to adopt rules pertaining to mandatory requirements and guidelines for such communication.

The bill revises legislative intent relating to athletic trainers, updates definitions, and revises the requirements for licensure as an athletic trainer. Applicants must pass the national examination to be certified by the Board of Certification (BOC). Background screening requirements for new applicants, applicants whose licenses have expired, and licensees undergoing disciplinary action, go into effect on July 1, 2016.

The bill has no fiscal impact for Fiscal Year 2015-2016. However, the Florida Department of Law Enforcement (FDLE) estimates a positive fiscal impact of $92,880 to the Operating Trust Fund in Fiscal Year 2016-2017 due to the anticipated collection of additional fees for level 2 background checks.

The bill's effective date is January 1, 2016.

II. Present Situation:

Athletic trainers are regulated by the Department of Health (DOH) and the Board of Athletic Training (board) within the DOH pursuant to part XIII of ch. 468, F.S. The Legislature created part XIII of ch. 468, F.S., in 1994.[1] The stated legislative intent was for athletes to be assisted by persons who are adequately trained to recognize, prevent, and treat physical injuries suffered during athletic activities, and to protect the public by licensing and fully regulating these trainers.[2]

The board consists of nine members appointed by the Governor and confirmed by the Senate. Five of the members must be licensed athletic trainers, one must be a physician licensed under ch. 458, F.S., or ch. 459, F.S., one must be a physician licensed under ch. 460, F.S., and the remaining two members must be consumers who have never worked or have had a financial interest in athletic training or been a licensed health care practitioner.[3]

Services provided by athletic trainers include prevention, emergency care, clinical diagnosis, therapeutic intervention, and rehabilitation of injuries and medical conditions.[4] State law defines athletic training to mean the recognition, prevention, and treatment of athletic injuries.[5] An athletic injury is defined as an injury that is sustained which affects the athlete's ability to participate or perform in an athletic activity.[6] An athletic activity means participation in an activity conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation, requiring any of the physical attributes of strength, agility, range of motion, speed, and stamina.[7]

Licensing Process

To be licensed as an athletic trainer in Florida today, an applicant must:

- Be at least 21 years of age;
- Have a bachelor's degree from a college or university accredited by a specified accrediting agency;
- If graduated after 2004, have completed an approved athletic training curriculum from a college or university accredited by a program recognized by the Board of Certification (BOC);
- Have a current certification in cardiovascular pulmonary resuscitation (CPR) with an automated external defibrillator (AED) from the American Red Cross, the American Heart Association, American Safety and Health Institute, the National Safety Council, or an entity approved by the board as equivalent;
- Have passed the BOC Entry Level Certification examination and submit a certified copy of certificate;

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[1] Chapter 94-119, Laws of Fla., and s. 468.70, F.S..
[2] Id.
[3] Section 468.703(2), F.S.
[4] Board of Certification for the Athletic Trainer, *Defining Athletic Training*, (January 2013) http://www.bocatc.org/about-us/defining-athletic-training (last visited Mar. 18, 2015).
[5] Section 468.701(5), F.S.
[6] Section 468.701(3), F.S.
[7] Section 468.701, (2), F.S.

- Submit proof of taking a two-hour course on the prevention of medical errors; and
- If licensed in another state, territory or jurisdiction of the United States, have a license verification form sent directly to the board office from the office that issued the license or certification.[8]

The biennial licensure fee is $230 for new applicants if the applicant is applying in the first year of the biennium or $180 if the applicant is applying in the second year of the biennium. The fees include a $100 application fee and an initial licensure fee of $125 for a two-year licensure period or $75 for a one-year licensure period.[9]

Currently there are 1,935 in-state athletic trainers in Florida.[10] There are an additional 196 active, out-of-state licensees and three active-military licensees.[11] During 2013-2014, the DOH reports 356 initial applications were received and 324 initial licensed were issued.[12]

Exemptions from licensure are made for those individuals who are acting within the professional scope of their DOH-issued license, an athletic training student under the direct supervision of a licensed athletic director; a person administering standard first aid to an athlete; a person licensed under ch. 548, F.S.,[13] if acting within the scope of such license; and a person providing personal training instructions for exercise, aerobics, or weightlifting, if the person does not represent himself or herself as an "athletic trainer."

All licenses expire on September 30 of even-numbered years. To renew, a licensee needs to complete a renewal application, pay the renewal fees and show proof of current certification from the BOC.[14] The cost to renew an active license for each biennium is $130.[15]

Continuing education requirements may not exceed 24 hours biennially and must include a current certification in CPR with an AED from the American Red Cross or the American Heart Association or an equivalent training as determined by the board.[16]

Board of Certification

To become a certified athletic trainer, a student must earn a degree from a school with an athletic training curriculum accredited by the Commission on Accreditation of Athletic Training

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[8] Section 468.707, F.S., and Department of Health, Board of Athletic Training, *Licensing and Regulation,* (updated July 23, 2014) http://floridasathletictraining.gov/licensing/ (last visited Mar. 18, 2015).
[9] Department of Health, Board of Athletic Training, *Licensing and Registration - Fees,* http://floridasathletictraining.gov/licensing/, (last visited Mar. 18, 2015) and Rule 64B33-3001, F.A.C. The fees listed in the administrative rule do not match the fees on the board's website.
[10] Department of Health, *Senate Bill 1526 Analysis*, pg. 2 (February 26, 2015), (on file with the Senate Committee on Health Policy).
[11] Department of Health, *2013-14 Annual Report and Long Range Plan,* pg. 13 http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/annual-reports.html, (last visited Mar. 18, 2015).
[12] Id at pg. 17.
[13] Chapter 548 regulates pugilistic exhibitions, including the attendance of a physician who serves as an agent of the Florida State Boxing Commission for each event.
[14] Department of Health, Board of Athletic Training, *Renewal Information - Requirements,* http://floridasathletictraining.gov/renewals/#tab-requirements (last visited Mar. 18, 2015).
[15] Id at Fees. *See also* Rule 64B33-3.001, F.A.C., which shows the biennial renewal fee as $125.
[16] Rule 64B33-2.003, F.A.C.

Education (CAATE).[17] The curriculum includes both formal instruction in injury/illness prevention, first aid and emergency care, assessment of injury/illness, human anatomy, and physiology, therapeutic modalities and nutrition, as well as clinical education in practice settings.[18]

The BOC was incorporated in 1989 to provide a certification program for entry-level athletic trainers. The BOC has been certifying athletic trainers since 1969 and is the only accredited certification program available.[19] The program is accredited through the National Commission for Certifying Agencies and undergoes reaccreditation by that agency every five years.[20]

The exam fee through the BOC is $300 for first-time candidates and registration occurs through the BOC directly.[21]

Athletic Trainer Responsibilities

An athletic trainer practices under a written protocol with a licensed supervising physician or, if at an athletic event, under the direction of a licensed physician. A physician is defined as a provider licensed under chapters 458 (medical), 459 (osteopathic), 460 (chiropractic), F.S., or an individual otherwise authorized to practice medicine.[22]

The written protocol must require the athletic trainer to notify the supervising physician of new injuries as soon as practicable.

Violations, Penalties and Discipline

Sexual misconduct between an athletic trainer and an athlete is a violation of the mutual trust needed for an athletic trainer-athlete relationship and is prohibited.[23]

An athletic trainer is guilty of a first degree misdemeanor, punishable as provided under ss. 775.082 or 775.083, F.S., if any of the following occur:[24]

- The practice of athletic training for compensation without holding an active license;
- The use or attempted use of an athletic trainer license that has been suspended or revoked;
- The act of knowingly employing an unlicensed person in the practice of athletic training;
- The act of obtaining or attempting to obtain an athletic trainer license by misleading statements or knowing misrepresentation; and

[17] Board of Certification for the Athletic Trainer, *Defining Athletic Training*, (January 2013) http://www.bocatc.org/about-us/defining-athletic-training (last visited Mar. 18, 2015).
[18] National Athletic Trainers' Association, *Athletic Training*, http://www.nata.org/about_AT/docs/GuideToAthleticTrainingServices.pdf (last visited Mar. 18, 2015).
[19] Board of Certification, *BOC Vision and Mission*, http://www.bocatc.org/about-us/boc-vision-mission (last visited: Mar. 18, 2015).
[20] Id.
[21] Board of Certification, *Register for Exam*, http://www.bocatc.org/candidates/register-for-exam (last visited Mar. 18, 2015).
[22] Section 468.713, F.S.
[23] Section 468.715, F.S.
[24] A first degree misdemeanor conviction under s. 775.082(4), F.S., is punishable by a definite term of imprisonment not to exceed 1 year. Under s. 775.083, F.S., a first degree misdemeanor conviction is punishable by a not to exceed $1,000, in addition to any punishment under s. 775.082, F.S.

- The use of the title "athletic trainer" without being licensed.[25]

Disciplinary measures covered under current law provide actions which constitute grounds for denial of a license, imposition of a penalty, or disciplinary action. Examples of such acts in the practice of athletic training include:

- Failing to follow advertising guidelines;
- Committing incompetency or misconduct;
- Committing fraud or deceit;
- Committing negligence, gross negligence, or repeated negligence;
- Showing an inability to practice with reasonable skill and safety by reason of illness or use of alcohol or drugs, or as a result of any mental or physical condition;
- Violating any provision of chapter 468, F.S., or adopted rules; or
- Violating any provision of s. 456.072, F.S.[26]

The rules promulgated under ch. 468, F.S., provide more detail as to the recommended penalties for the violations and the discipline a licensee can expect on a first through third offense.[27] Recommended penalties can range from a letter of concern to large fines to revocation of a license, depending on the nature of the violation or how many times the licensee has offended on the same type of violation.

III. Effect of Proposed Changes:

The bill modifies the legislative intent to focus on athletic trainers meeting minimum requirements for the safe practice of athletic training and to protect the public by ensuring that athletic trainers who fall below the minimum standards are prohibited from practicing in this state.

In **Section 2,** the definitions under s. 468.701, F.S., are updated to reference current accrediting entities and to delete "athlete," "athlete activity," "athletic injury," "direct supervision," and "supervision." Focus is shifted from an athlete to a physically active person.

For "athletic trainer," the education requirements of the CAATE and the BOC are added. A licensed athletic trainer is also expressly prohibited from offering to provide any care or services for which he or she lacks the education, training, or experience to provide or that he or she is prohibited by law from providing.

"Athletic training" is updated to mean service and care provided under the direction of a physician licensed under s. 468.713, F.S. Service and care are further specified to mean prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition while involved in exercise, sport, recreation, or another physical activity. An athletic trainer may use physical modalities, including but not limited to, heat, light, sound, cold, electricity, and mechanical

[25] Section 468.717, F.S.
[26] Sections 468.717 and 468.719, F.S; and Rule 64B33-5.001, F.A.C.
[27] Rule 64B33-5.001, F.A.C.

devices. Under current law, the definition of "athletic training" is limited to the recognition, prevention, and treatment of athletic injuries.

Section 3 deletes obsolete provisions of s. 468.703, F.S., relating to provisions for the initial staggered terms for members of the Board of Athletic Training (board).

Section 4 amends s. 468.705, F.S., relating to the board's authority on rulemaking to delete a requirement for a written protocol between the athletic trainer and a supervising physician. The bill authorizes the DOH to develop rules for requirements and guidelines addressing communication between the athletic trainer and a physician, including the reporting to the physician of new or recurring injuries or conditions. Existing requirements of the protocol require the athletic trainer to notify the supervising physician of new injuries as soon as practicable.

Section 5 amends the licensure requirements under s. 468.707, F.S. An applicant is required to submit information to the board and complete an application, in addition to meeting other qualifications.

Under the bill, the DOH must license each applicant who:
- Has completed an application form and remitted the required fees;
- Has submitted to a background screening under s. 456.0135, F.S., if the applicant applied after July 1, 2016;
- Has obtained a bachelor's degree or higher from a college or university professional athletic training degree program accredited by CAATE or its successor recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, and passed the national examination to be certified by the BOC;
- Has a current certification from the BOC if graduated before 2004;
- Has current certification in both CPR and the use of an AED as set forth in the continuing education requirements as determined by the board; and
- Has completed any other requirements as determined by the department and approved by the board.

Under the bill, the board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action. The current law requirement that an applicant be at least 21 years of age is removed under the bill.

Fingerprinting will be handled by FDLE for state processing and then by the Federal Bureau of Investigation (FBI) for national processing.[28] The cost for fingerprint processing is borne by the applicant under s. 456.0135, F.S.

The bill adds a provision requiring the applicant to provide records or other evidence to prove he or she has met the bill's requirements. The bill leaves open to the board the ability to determine other records or requirements that are not specifically listed in statute. Broad authority to require

[28] Section 456.0135, F.S.

additional components or elements to the licensing or renewal process is also granted to the board.

Section 6 deletes the examination fee from s. 468.709, F.S., because the examinations are now handled through the BOC.

Section 7 removes references to specific entities for the continuing education requirements for CPR and AED training under s. 468.711, F.S.

Section 8 amends s. 468.713, F.S., to require athletic trainers to practice under the direction of a physician licensed under chapters 458, 459, 460, F.S., or a physician otherwise permitted to practice medicine under Florida law. References to practicing at an athletic event pursuant to direction of an authorized practitioner, a written protocol, and requirements for the athletic trainer to notify the supervising physician of new injuries as soon as practicable, are deleted.

The physician may communicate his or her direction to the athletic trainer through an oral or written prescription or protocol, as deemed appropriate by the physician. The athletic trainer is to provide care and service in the manner dictated by the physician.

Section 9 amends s. 468.715, F.S., to remove the description of sexual misconduct and to prohibit sexual misconduct in the practice of athletic training with a cross reference to s. 456.063, F.S., which provides more extensive protections applicable to all licensed health care professions.

Section 10 amends s. 468.717, F.S., relating to violations and penalties for athletic trainers. Two violations which are first degree misdemeanor violations pertaining to unlicensed practice and the use of certain credentials, are revised.

Section 11 amends s. 468.719, F.S., relating to disciplinary actions and removes as grounds for denial of a license or disciplinary action, the failure to adhere to certain advertising guidelines. Current law requires that an athletic trainer's name and license number be included in any advertising, including letterhead and business cards, but not clothing or novelty items.

The disciplinary action related to an athletic trainer who is unable to practice with reasonable skill and safety is modified to add reasons related to the licensee's mental or physical condition, use of controlled substances, and any other substance that may impair one's ability to practice.

Section 12 amends s. 468.723, F.S., relating to exemptions from part XIII of ch. 468, F.S. The bill clarifies that a person licensed in this state under another chapter is not prohibited from engaging in the practice for which he or she is licensed.

"Direct supervision" is defined for the purposes of supervising an athletic training student. It means the physical presence of an athletic trainer who is immediately available to an athletic trainer student and able to intervene in accordance with the standards set by CAATE.

An exemption from licensure is granted to a person authorized to practice athletic training in another state when such person is employed by or a volunteer for an out-of-state secondary or

post-secondary educational institution, or a recreation, competitive, or professional organization that is temporarily present in this state. The exemption does not further define what would be a recreation, competitive or professional organization or what length of time would be considered temporary. An exemption specific only to pugilistic exhibitions is deleted.

An exemption is also provided to third party payers to permit such organizations to reimburse employers of athletic trainers for covered services rendered by licensed athletic trainers.

Section 13 modifies the general background screening provisions of s. 456.0135, F.S., to include athletic trainers.

Section 14 provides an effective date of January 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. Other Constitutional Issues:

Broad authority is given to the Department of Health, which must be approved by the board, concerning additional requirements for licensure on lines 177 and 178 of the bill. This authority may raise the issue of unlawful delegation of legislative authority to an entity of the executive branch.

Article II, section 3 of the Florida Constitution, establishes a doctrine of separation of powers, providing that no branch may exercise powers pertaining to the other branches. Interpreting this doctrine in the context of the Legislature delegating authority to the executive branch, the Florida Supreme Court has stated that, "where the Legislature makes the fundamental policy decision and delegates to some other body the task of implementing that policy under adequate safeguards, there is no violation of the doctrine." *Askew v. Cross Key Waterways,* 372 So.2d 913 (Fla. 1978). However, "[w]hen the statute is couched in vague and uncertain terms or is so broad in scope that no one can say with certainty, from the terms of the law itself, what would be deemed an infringement of the law, it must be held unconstitutional as attempting to grant to the administrative body the power to say what the law shall be." *Conner v. Joe Hatton, Inc.* 216 So.2d 209 (Fla. 1968).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under CS/SB 1526, for a person who applies for licensure after July 1, 2016, a background screening through the FDLE will be required. According to the FDLE, the costs for all aspects of the screening amount to $75.75, which is borne by the applicant. The FDLE estimates that 1,935 record checks will be requested in Fiscal Year 2016-2017.[29]

Each applicant and licensee is also required to have CPR and AED certification. The fiscal impact to the applicants and licensees is unknown.

Similarly, the applicant may be required to provide records or other evidence or complete any other requirements as determined by the DOH and approved by the board for licensing. The fiscal impact to applicants and renewing licensees is indeterminate since such requirements are unknown at present.

C. Government Sector Impact:

The DOH will incur non-recurring costs for rulemaking and modification of the application and forms which current budget authority is adequate to absorb. The DOH may incur a recurring increase in workload associated with additional complaints which current resources are adequate to absorb.[30]

The FDLE anticipates no fiscal impact for Fiscal Year 2015-2016 but estimates an increase in fees collected in Fiscal Year 2016-2017 of $92,880 if 1,935 applicants pay the $48 combined cost of a state background check and five-year up-front inclusion in the state fingerprint retention program. Such fees are deposited into the FDLE's Operating Trust Fund.

No additional FTEs or other resources are anticipated for this bill. However, the FDLE advises that the combined effect of this bill and other legislation being considered in the 2015 Regular Session that require the FDLE to perform additional background screenings, could cause the FDLE to need additional human resources to meet the cumulative demand over time.

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[29] Florida Department of Law Enforcement, *2015 FDLE Legislative Bill Analysis of SB 1526,* March 23, 2015, on file with staff of the Appropriations Subcommittee on Health and Human Services. The cost for a state background check is $24, and the cost of the five-year up-front inclusion in the state fingerprint retention program is $24. The cost for a national background check is $14.75, and inclusion in the national fingerprint retention program is $13. Total cost for initial background check and retention per applicant is $75.75.

[30] Department of Health, Board of Athletic Trainers, *Senate Bill 1526 Analysis,* (February 27, 2015), pg. 5, (on file with the Senate Committee on Health Policy).

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill adds as a first degree misdemeanor for the use of the title "licensed athletic trainer," the abbreviation "AT," or "LAT," or a similar title or abbreviation that suggests licensure as an athletic trainer. It is unclear how it could be known what similar title or abbreviation, now or in the future, might suggest to an individual that someone is a licensed athletic trainer.

To better facilitate level 2 background checks, fingerprint retention, and inclusion in the clearinghouse, the FDLE recommends inserting language acknowledging that:

- The applicant is to submit a full set of fingerprints to the FDLE or to an authorized vendor;
- Costs for the screening shall be borne by the applicant;
- The FDLE will handle fingerprints for state processing and forward them to the FBI for national processing;
- Fingerprints shall be retained by the FDLE in accordance with state law and, when enrolled with the national program, the FBI;
- Any arrest record identified will be reported to the FDLE; and
- All fingerprints received shall be entered into the Care Provider Background Screening Clearinghouse.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 468.70, 468.701, 468.703, 468.705, 468.707, 468.709, 468.711, 468.713, 468.715, 468.717, 468.719, 468.723, and 456.0135.

IX. Additional Information:

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

CS by Health Policy on March 23, 2015:
The committee substitute includes two technical amendments to provide clarity relating to care and services. No substantive changes were included.

B. Amendments:

None.

By the Committee on Health Policy; and Senator Legg

588-02731-15 20151526c1

A bill to be entitled

An act relating to athletic trainers; amending s. 468.70, F.S.; revising legislative intent; amending s. 468.701, F.S.; revising definitions; amending s. 468.703, F.S.; deleting the requirement for the Governor to appoint the initial members of the Board of Athletic Training; amending s. 468.705, F.S.; revising the board's authorization to adopt certain rules relating to communication between an athletic trainer and a supervising physician; amending s. 468.707, F.S.; requiring certain applicants for licensure to submit fingerprints; revising requirements for licensure; authorizing the board to require a background screening for an applicant in certain circumstances; amending s. 468.709, F.S.; deleting the requirement for the board to establish an examination fee; amending s. 468.711, F.S.; revising continuing education requirements for license renewal; amending s. 468.713, F.S.; revising responsibilities of athletic trainers to include requirements that a trainer must practice under the direction of a physician; amending s. 468.715, F.S.; prohibiting sexual misconduct by an athletic trainer; amending s. 468.717, F.S.; prohibiting unlicensed persons from practicing athletic training or representing themselves as athletic trainers; prohibiting an unlicensed person from using specified titles; amending s. 468.719, F.S.; revising grounds for disciplinary action; amending s. 468.723, F.S.;

588-02731-15 20151526c1

providing exemptions; amending s. 456.0135, F.S.; revising general background screening provisions to include athletic trainers; providing an effective date.

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

Section 1. Section 468.70, Florida Statutes, is amended to read:

468.70 Legislative intent.—It is the intent of the Legislature that athletic trainers practicing in this state meet minimum requirements for safe practice and that an athletic trainer who falls below minimum competency or who otherwise presents a danger to the public be prohibited from practicing in this state ~~athletes be assisted by persons adequately trained to recognize, prevent, and treat physical injuries sustained during athletic activities~~. ~~Therefore,~~ It is the further intent of the Legislature to protect the public by licensing and fully regulating athletic trainers.

Section 2. Section 468.701, Florida Statutes, is amended to read:

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

~~(1) "Athlete" means a person who participates in an athletic activity.~~

~~(2) "Athletic activity" means the participation in an activity, conducted by an educational institution, a professional athletic organization, or an amateur athletic organization, involving exercises, sports, games, or recreation requiring any of the physical attributes of strength, agility,~~

~~flexibility, range of motion, speed, and stamina.~~

~~(3) "Athletic injury" means an injury sustained which affects the athlete's ability to participate or perform in athletic activity.~~

(1)~~(4)~~ "Athletic trainer" means a person licensed under this part who has met the requirements under this part, including education requirements as set forth by the Commission on Accreditation of Athletic Training Education or its successor and necessary credentials from the Board of Certification. An individual who is licensed as an athletic trainer may not provide, offer to provide, or represent that he or she is qualified to provide any care or services that he or she lacks the education, training, or experience to provide, or that he or she is otherwise prohibited by law from providing.

(2)~~(5)~~ "Athletic training" means service and care provided by an athletic trainer under the direction of a physician licensed as specified in s. 468.713. Such service and care must relate to the prevention, recognition, evaluation, management, disposition, treatment, or rehabilitation of a physically active person who sustained an injury, illness, or other condition involving exercise, sport, recreation, or related physical activity. For the provision of such care and services, an athletic trainer may use physical modalities, including, but not limited to, heat, light, sound, cold, electricity, and mechanical devices ~~the recognition, prevention, and treatment of athletic injuries~~.

(3)~~(6)~~ "Board" means the Board of Athletic Training.

(4)~~(7)~~ "Board of Certification" means the nationally accredited certifying body for athletic trainers or its

successor agency.

(5)~~(8)~~ "Department" means the Department of Health.

~~(9) "Direct supervision" means the physical presence of the supervisor on the premises so that the supervisor is immediately available to the trainee when needed.~~

~~(10) "Supervision" means the easy availability of the supervisor to the athletic trainer, which includes the ability to communicate by telecommunications.~~

Section 3. Section 468.703, Florida Statutes, is amended to read:

468.703 Board of Athletic Training.—

(1) The Board of Athletic Training is created within the department and shall consist of nine members appointed by the Governor and confirmed by the Senate.

(2) Five members of the board must be licensed athletic trainers, certified by the Board of Certification. One member of the board must be a physician licensed under chapter 458 or chapter 459. One member of the board must be a physician licensed under chapter 460. Two members of the board shall be consumer members, each of whom must be a resident of this state who has never worked as an athletic trainer, who has no financial interest in the practice of athletic training, and who has never been a licensed health care practitioner as defined in s. 456.001(4).

~~(3) For the purpose of staggering terms, the Governor shall appoint the initial members of the board as follows:~~

~~(a) Three members for terms of 2 years each.~~

~~(b) Three members for terms of 3 years each.~~

~~(c) Three members for terms of 4 years each.~~

(3) ~~(4)~~ As the terms of the members expire, the Governor shall appoint successors for terms of 4 years and such members shall serve until their successors are appointed.

(4) ~~(5)~~ All provisions of chapter 456 relating to activities of the board shall apply.

(5) ~~(6)~~ The board shall maintain its official headquarters in Tallahassee.

Section 4. Section 468.705, Florida Statutes, is amended to read:

468.705 Rulemaking authority.— The board is authorized to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement provisions of this part conferring duties upon it. The provisions of s. 456.011(5) shall apply to the board's activity. Such rules shall include, but not be limited to, the allowable scope of practice regarding the use of equipment, procedures, and medication; mandatory requirements and guidelines for communication between the athletic trainer and a physician, including the reporting to the physician of new or recurring injuries or conditions; ~~, requirements for a written protocol between the athletic trainer and a supervising physician,~~ licensure requirements; ~~,~~ licensure examination; ~~,~~ continuing education requirements; ~~,~~ fees; ~~,~~ records ~~,~~ and reports to be filed by licensees; ~~,~~ protocols; ~~,~~ and any other requirements necessary to regulate the practice of athletic training.

Section 5. Section 468.707, Florida Statutes, is amended to read:

468.707 Licensure ~~by examination;~~ requirements.—Any person desiring to be licensed as an athletic trainer shall apply to the department on a form approved by the department. An

applicant shall also provide records or other evidence, as determined by the board, to prove he or she has met the requirements of this section. The department shall license each applicant who:

(1) Has completed the application form and remitted the required fees.

(2) For a person who applies on or after July 1, 2016, has submitted to background screening pursuant to s. 456.0135. The board may require a background screening for an applicant whose license has expired or who is undergoing disciplinary action ~~Is at least 21 years of age~~.

(3) Has obtained a baccalaureate degree or higher from a college or university professional athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education or its successor ~~an accrediting agency~~ recognized and approved by the United States Department of Education or the Commission on Recognition of Postsecondary Accreditation, approved by the board, or recognized by the Board of Certification, and has passed the national examination to be certified by the Board of Certification.

(4) If graduated before ~~after~~ 2004, has a current certification from ~~has completed an approved athletic training curriculum from a college or university accredited by a program recognized by~~ the Board of Certification.

(5) Has current certification in both cardiopulmonary ~~cardiovascular pulmonary~~ resuscitation and the use of an automated external defibrillator set forth in the continuing education requirements ~~with an automated external defibrillator from the American Red Cross or the American Heart Association,~~

~~or an equivalent certification~~ as determined by the board pursuant to s. 468.711.

(6) Has completed any other requirements as determined by the department and approved by the board ~~passed the examination and is certified by the Board of Certification~~.

Section 6. Paragraph (b) of subsection (1) of section 468.709, Florida Statutes, is amended to read:

468.709 Fees.—

(1) The board shall, by rule, establish fees for the following purposes:

~~(b) An examination fee, not to exceed $200.~~

Section 7. Subsection (2) of section 468.711, Florida Statutes, is amended to read:

468.711 Renewal of license; continuing education.—

(2) The board may, by rule, prescribe continuing education requirements, not to exceed 24 hours biennially. The criteria for continuing education shall be approved by the board and must include a current certification ~~certificate~~ in both cardiopulmonary ~~cardiovascular pulmonary~~ resuscitation and the use of ~~with~~ an automated external defibrillator as set forth in the continuing education requirements ~~from the American Red Cross or the American Heart Association or an equivalent training~~ as determined by the board.

Section 8. Section 468.713, Florida Statutes, is amended to read:

468.713 Responsibilities of athletic trainers.—An athletic trainer shall practice under the direction of ~~within a written protocol established between the athletic trainer and~~ a ~~supervising~~ physician licensed under chapter 458, chapter 459,

chapter 460, or otherwise authorized by Florida law to practice medicine. The physician shall communicate his or her direction through oral or written prescription or protocols as deemed appropriate by the physician for the provision of services and care by the athletic trainer. An athletic trainer shall provide service or care in the manner dictated by the physician ~~or, at an athletic event, pursuant to direction from a physician licensed under chapter 458, chapter 459, chapter 460, or otherwise authorized by Florida law to practice medicine. A written protocol shall require that the athletic trainer notify the supervising physician of new injuries as soon as practicable~~.

Section 9. Section 468.715, Florida Statutes, is amended to read:

468.715 Sexual misconduct.—The athletic trainer-patient ~~trainer-athlete~~ relationship is founded on mutual trust. ~~Sexual misconduct in the practice of athletic training means violation of the athletic trainer-athlete relationship through which the athletic trainer uses such relationship to induce or attempt to induce the athlete to engage, or to engage or attempt to engage the athlete, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the athlete.~~ Sexual misconduct in the practice of athletic training is prohibited under s. 456.063.

Section 10. Subsections (1) and (5) of section 468.717, Florida Statutes, are amended to read:

468.717 Violations and penalties.—Each of the following acts constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083:

(1) Practicing athletic training, representing oneself as an athletic trainer, or providing athletic trainer services to a patient without being licensed under this part ~~Practicing athletic training for compensation without holding an active license under this part~~.

(5) Using the title "athletic trainer" or "licensed athletic trainer," the abbreviation "AT" or "LAT," or a similar title or abbreviation that suggests licensure as an athletic trainer without being licensed under this part.

Section 11. Subsection (1) of section 468.719, Florida Statutes, is amended to read:

468.719 Disciplinary actions.—

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

~~(a) Failing to include the athletic trainer's name and license number in any advertising, including, but not limited to, business cards and letterhead, related to the practice of athletic training. Advertising shall not include clothing or other novelty items.~~

(a) ~~(b)~~ Committing incompetency or misconduct in the practice of athletic training.

(b) ~~(c)~~ Committing fraud or deceit in the practice of athletic training.

(c) ~~(d)~~ Committing negligence, gross negligence, or repeated negligence in the practice of athletic training.

(d) ~~(c) While practicing athletic training,~~ Being unable to practice athletic training with reasonable skill and safety because of a mental or physical condition or ~~to athletes by reason of~~ illness, or the use of alcohol, controlled substances,

or any other substance that impairs one's ability to practice ~~or drugs or as a result of any mental or physical condition~~.

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

Section 12. Section 468.723, Florida Statutes, is amended to read:

468.723 Exemptions.—This part does not prevent or restrict:

(1) A person licensed in this state under another chapter from engaging in the practice for which he or she is licensed and ~~The professional practice of a licensee of the department who is~~ acting within the scope of such practice.

(2) An athletic training student acting under the direct supervision of a licensed athletic trainer. For purposes of this subsection, "direct supervision" means the physical presence of an athletic trainer so that the athletic trainer is immediately available to the athletic training student and able to intervene on behalf of the athletic training student in accordance with the standards set forth by the Commission on Accreditation of Athletic Training Education or its successor.

(3) A person from administering standard first aid treatment to another person ~~an athlete~~.

(4) A person authorized to practice athletic training in another state when such person is employed by or a volunteer for an out-of-state secondary or postsecondary educational institution, or a recreational, competitive, or professional organization that is temporarily present in this state ~~A person licensed under chapter 548, provided such person is acting within the scope of such license~~.

(5) A person providing personal training instruction for

exercise, aerobics, or weightlifting, if the person does not represent himself or herself as an athletic trainer or as able to provide "athletic trainer" services and if any recognition or treatment of injuries is limited to the provision of first aid.

(6) Third-party payors from reimbursing employers of athletic trainers for covered services rendered by a licensed athletic trainer.

Section 13. Subsection (1) of section 456.0135, Florida Statutes, is amended to read:

456.0135 General background screening provisions.—

(1) An application for initial licensure received on or after January 1, 2013, under chapter 458, chapter 459, chapter 460, chapter 461, chapter 464, s. 465.022, part XIII of chapter 468, or chapter 480 shall include fingerprints pursuant to procedures established by the department through a vendor approved by the Department of Law Enforcement and fees imposed for the initial screening and retention of fingerprints. Fingerprints must be submitted electronically to the Department of Law Enforcement for state processing, and the Department of Law Enforcement shall forward the fingerprints to the Federal Bureau of Investigation for national processing. Each board, or the department if there is no board, shall screen the results to determine if an applicant meets licensure requirements. For any subsequent renewal of the applicant's license that requires a national criminal history check, the department shall request the Department of Law Enforcement to forward the retained fingerprints of the applicant to the Federal Bureau of Investigation unless the fingerprints are enrolled in the national retained print arrest notification program.

Section 14. This act shall take effect January 1, 2016.

Senator Rene Garcia, Chair
Appropriations Subcommittee on Health and Human Services
201 The Capitol
404 South Monroe Street
Tallahassee, Florida 32399-1100

The Florida Senate

Committee Agenda Request

To: Senator Rene Garcia, Chair
Appropriations Subcommittee on Health and Human Services

Subject: Committee Agenda Request

Date: March 26, 2015

I respectfully request that **Senate Bill #816**, relating to Home Health Agencies, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Denise Grimsley
Florida Senate, District 21

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

4/8/15 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting) SB 16

Meeting Date *Bill Number (if applicable)*

Topic Home Health *Amendment Barcode (if applicable)*

Name Drew Smith

Job Title Governmental Consult

Address 1907 Brown St Phone 850 222 2595

Street

Tall FL 32308 Email Drew@SmithSmith.Net

City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information Waive Speaking: [X] In Support [ ] Against

(The Chair will read this information into the record.)

Representing Home Care Association of America

Appearing at request of Chair: [ ] Yes [X] No Lobbyist registered with Legislature: [X] 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 the Senator or Senate Professional Staff conducting the meeting)

4/8/15
Meeting Date

SB 816
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name ~~Home Care Association of Florida~~ Leanne Norr

Job Title Government Affairs Dir.

Address 1363 e Lafayette
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-222-8967

Email ~~[illegible]~~

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Home Care Association of FL

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] 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

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 Appropriations Subcommittee on Health and Human Services

BILL:	SB 816
INTRODUCER:	Senator Grimsley
SUBJECT:	Home Health Agencies
DATE:	April 7, 2015
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Favorable**
3.			FP	

I. Summary:

SB 816 eliminates the requirement for a home health agency (HHA) to provide a quarterly report to the Agency for Health Care Administration (AHCA) which details:

- The number of insulin-dependent diabetic patients receiving insulin injection services;
- The number of patients receiving both home health services from the HHA and hospice services;
- The number of patients receiving HHA services; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the HHA in excess of $25,000 during the quarter.

The bill also eliminates the requirement that the AHCA fine HHAs who fail to submit the report $200 per day, up to a maximum of $5,000 per quarter.

The bill requires HHAs when renewing their license biennially to submit to the AHCA the number of patients who received home health services from the HHA on the day that that the licensure renewal application is filed.

The effective date of the bill is July 1, 2015.

II. Present Situation:

A home health agency (HHA) is an organization that provides home health services and staffing services.[1] Home health services provided by an HHA include health and medical services and medical equipment provided to an individual in his or her home, such as nursing care, physical

[1] Section 400.462(12), F.S.

and occupational therapy, and home health aide services.[2] Home health agencies are regulated by the Agency for Health Care Administration (AHCA) pursuant to ch. 400, part III, F.S.

In 2008, the Legislature passed ch. 2008-246, L.O.F., which provided HHA anti-fraud measures, including the requirement for an HHA quarterly report to be submitted to the AHCA within 15 days following the end of each quarter. The Legislature enacted the law to combat an increase in Medicaid fraud in HHAs during the early to mid-2000s. In Fiscal Year 2004-2005, the AHCA's Bureau of Medicaid Program Integrity (MPI) opened 47 investigations of HHAs for Medicaid fraud, 72 in Fiscal Year 2005-2006, and 144 in Fiscal Year 2006-2007.[3] Between 2004 and 2007, 19 HHAs were terminated from the Medicaid program in Miami-Dade County alone.[4] In 2013, the Legislature passed ch. 2013-133, L.O.F., which amended these requirements to reduce the fine assessed against HHAs that violate the reporting requirements to $200 per day up to a maximum of $5,000 per quarter and to exempt HHAs that are not, or do not share a controlling interest with a licensee that is, a Medicaid or Medicare provider.

Section 400.474(7), F.S., enacted in ch. 2008-246, L.O.F., and amended by ch. 2013-133, L.O.F., requires HHAs to report data as it existed on the last day of the quarter for four items that are markers for possible fraudulent activity. These items include:

- The number of insulin-dependent diabetic patients receiving insulin injection services;
- The number of patients receiving both home health services from the HHA and hospice services;
- The number of patients receiving HHA services; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the HHA in excess of $25,000 during the quarter.

The AHCA is required to impose a fine of $200 per day up to a maximum of $5,000 per quarter if the report is not submitted within the first 15 days following the close of the quarter. From July 1, 2008, to date, $8,317,650 in fines have been assessed and $5,635,108 in fines have been collected.[5] Also, the number of HHAs that fail to submit the reports each quarter has decreased since the passage of ch. 2008-286, L.O.F. For the quarter ending December 31, 2012, 42 of the 2,250 licensed HHAs failed to submit their reports.[6]

The AHCA uses the data on the number of patients on the last day of the quarter as an indicator of the number of patients when a home health agency is closing. In addition, the data on numbers of patients is used as an indicator that the home health agency may not be operational, along with other information. Failing to provide at least one service for a period of 60 days is grounds to deny or revoke a license under s. 400.474(1)(2)(e), F.S. The AHCA already collects the number of patients admitted over a 12-month period, from each home health agency on the biennial license renewal application as required by s. 400.471(2)(c), F.S.[7]

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[2] Section 400.462(14)(a)-(c), F.S.
[3] Information contained in this portion of this bill analysis is from the analysis for CS/SB 1374 by the Senate Committee on Health Regulation (Mar. 7, 2008) (on file with the Senate Committee on Health Policy).
[4] Id.
[5] AHCA, *Senate Bill 816 Analysis* (Jan. 23, 2015) (on file with the Senate Committee on Health Policy).
[6] AHCA, *House Bill 4031 Analysis* (SB 1094) (Mar. 14, 2013) (on file with the Senate Committee on Health Policy).
[7] Id.

III. Effect of Proposed Changes:

The bill eliminates the requirement for an HHA to provide a quarterly report to the AHCA which details:

- The number of insulin-dependent diabetic patients receiving insulin injection services;
- The number of patients receiving both home health services from the HHA and hospice services;
- The number of patients receiving HHA services; and
- The names and license numbers of nurses whose primary job responsibility is to provide home health services to patients and who received remuneration from the HHA in excess of $25,000 during the quarter.

The bill also eliminates the requirement that the AHCA fine HHAs who fail to submit the report $200 per day up to a maximum of $5,000 per quarter.

The bill requires HHAs when renewing their license to submit to the AHCA the number of patients who received home health services from the HHA on the day that that the licensure renewal application is filed.

The bill provides an effective date of July 1, 2015.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Under SB 816, HHAs may see an indeterminate positive fiscal impact by not having to prepare and file the quarterly report. Additionally, HHAs who would have failed to provide the quarterly report to the AHCA will see an indeterminate positive fiscal impact due to the elimination of the fine currently assessed.

C. Government Sector Impact:

The AHCA will see an indeterminate negative fiscal impact due to the loss of revenue from the elimination of the fine assessed on HHAs who fail to submit their quarterly report.[8]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 400.474 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.

[8] *Supra* note 5.

By Senator Grimsley

21-00820-15 2015816__

A bill to be entitled

An act relating to home health agencies; amending s. 400.474, F.S.; revising the information that a home health agency is required to submit to the Agency for Health Care Administration for license renewal; removing the requirement that a home health agency submit quarterly reports; providing an effective date.

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

Section 1. Subsection (7) of section 400.474, Florida Statutes, is amended to read:

400.474 Administrative penalties.—

(7) A home health agency shall submit to the agency, with each license renewal application, the number of patients who receive home health services from the home health agency on the day that the license renewal application is filed~~, within 15 days after the end of each calendar quarter, a written report that includes the following data as they existed on the last day of the quarter:~~

~~(a) The number of insulin-dependent diabetic patients who receive insulin-injection services from the home health agency~~.

~~(b) The number of patients who receive both home health services from the home health agency and hospice services.~~

~~(c) The number of patients who receive home health services from the home health agency.~~

~~(d) The name and license number of each nurse whose primary job responsibility is to provide home health services to patients and who received remuneration from the home health~~

21-00820-15 2015816__

~~agency in excess of $25,000 during the calendar quarter.~~

~~If the home health agency fails to submit the written quarterly report within 15 days after the end of each calendar quarter, the Agency for Health Care Administration shall impose a fine against the home health agency in the amount of $200 per day until the Agency for Health Care Administration receives the report, except that the total fine imposed pursuant to this subsection may not exceed $5,000 per quarter. A home health agency is exempt from submission of the report and the imposition of the fine if it is not a Medicaid or Medicare provider or if it does not share a controlling interest with a licensee, as defined in s. 408.803, which bills the Florida Medicaid program or the Medicare program.~~

Section 2. This act shall take effect July 1, 2015.

CourtSmart Tag Report

Room: SB 401 **Case:** **Type:**
Caption: Appropriations Subcommittee on Health and Human Services **Judge:**

Started: 4/8/2015 10:04:57 AM
Ends: 4/8/2015 10:45:21 AM Length: 00:40:25

10:04:58 AM Called to Order
10:05:11 AM Roll Call
10:05:50 AM TAB:5 CS/SB 512
10:06:47 AM Rich Rasmussen, U.P. Florida Hospital Association waives in support
10:06:49 AM Chris Nuland, Florida Public Health Association waives in support
10:06:57 AM Michael Ragner
10:14:17 AM Sen. Smith
10:15:34 AM Sen. Garcia
10:16:31 AM Sen. Sobel
10:19:27 AM Jesse Fry, Policy Analyst, The AIDS Institute
10:20:44 AM Stephen Winn, Lobbyist, Executive Director, Florida Osteopathic Medical Association waives in support
10:23:07 AM Sen. Sobel
10:25:16 AM Roll Call
10:25:38 AM Favorable
10:25:39 AM TAB:7 SB 1040
10:26:50 AM Sen. Smith
10:27:01 AM Holly Miller, Government Affairs Counsel, FMA waives in support
10:27:07 AM Avery Coleman, Lobbyist, Florida Association of Community Health Centers waives in support
10:27:15 AM Jesse Fry, Policy Analyst, The AIDS Institute waives in support
10:27:17 AM Christian Minor, Director of Government Affairs, The Florida Smart Justice Alliance waives in support
10:27:26 AM Hansel Tookes, Resident Physician, Jackson Memorial Hospital
10:29:22 AM Stephen Winn, Executive Director, Florida Osteopathic Medical Association waives in support
10:29:28 AM Michael Rajner
10:30:34 AM Paul Arons, MD waives in support
10:30:48 AM Chris Nuland, Florida Public Health Association waives in support
10:30:56 AM Martha DeCastro, Florida Hospital Association waives in support
10:31:07 AM Roll Call
10:31:25 AM Favorable
10:31:38 AM TAB:1 SB 24
10:31:48 AM Christine Biron, Legislative Assistant
10:32:48 AM Roll Call
10:33:03 AM Favorable
10:33:14 AM TAB:2 CS/SB 40
10:33:23 AM Joel Ramos, Legislative Assistant
10:34:41 AM Roll Call
10:34:55 AM Favorable
10:35:23 AM TAB: 3 CS/SB 58
10:36:03 AM Roll Call
10:36:18 AM Favorable
10:36:27 AM TAB:6 CS/SB 950
10:36:39 AM Elizabeth Fetterhoff, Legislative Assistant
10:37:49 AM Stephen Winn, Executive Director, Florida Osteopathic Medical Association waives in support
10:37:53 AM Chris Nuland, Florida Public Health Association waives in support
10:38:01 AM Roll Call
10:38:04 AM Favorable
10:38:35 AM TAB: 4 CS/SB 80
10:38:46 AM William McRea, Legislative Assistant
10:38:59 AM Sen. Smith
10:40:12 AM Sen. Benacquisto
10:40:39 AM TAB:8 CS/SB 1526
10:40:50 AM Jim Brown, Legislative Assistant
10:41:49 AM Jerry Stevens, Athletic Trainer, Athletic Trainers Association of Florida waives in support

10:41:51 AM Roll Call
10:42:07 AM Favorable
10:42:17 AM TAB:9 SB 816
10:42:56 AM Drew Smith, Government Consult, Home Care Association of America waives in support
10:43:10 AM Leanne Norr, Government Affairs Director, Home Care Association of Florida waives in support
10:43:21 AM Roll Call
10:43:42 AM Favorable
10:44:39 AM William McRea
10:44:44 AM Roll Call
10:45:05 AM Favorable
10:45:15 AM Adjourn