SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

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

BILL: CS/SB 2750

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Peaden

SUBJECT: Health Care

DATE: April 15, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill revises a number of health care practitioner regulatory provisions. The bill:

- Revises the medical licensure requirements for persons to practice as a physician in Florida;
- Authorizes the Department of Health (DOH) to obtain patient records without a written medical release under specified circumstances;
- Transfers authority over the Raymond C. Philips Research and Education Unit from the Department of Children and Family Services to DOH;
- Authorizes DOH to electronically post examination scores on the Internet;
- Revises the definition of "clinic" to exempt certain entities from registration requirements;
- Increases the financial threshold for paid professional liability claims that DOH must post on practitioner profiles;
- Allows the boards or DOH to determine the amount of costs to be assessed in disciplinary actions;
- Establishes grounds for discipline of licensed health care practitioners by a greater weight of evidence;
- Requires licensed health care practitioners to elect a formal administrative hearing within 45 days of service and requires DOH to notify the Division of Administrative Hearings within 45 days after receipt of a petition or request for a formal hearing;
- Revises the time from 20 to 30 days in which a subject of a disciplinary complaint may respond to DOH;
- Provides a formula for the Division of Administrative Hearings to charge DOH for formal hearings relating to discipline;

- Requires the boards to adopt rules for mediation of certain disciplinary violations;
- Provides that the issuance of a citation to a licensed health care practitioner does not constitute discipline for a first offense;
- Authorizes DOH and boards to adopt rules to implement requirements for reporting allegations of sexual misconduct;
- Revises grounds for which a health care practitioner may be disciplined for performing health care services on the wrong patient and establishes an exception to discipline for leaving a foreign body in a patient;
- Provides requirements for what constitutes a valid professional relationship for purposes of Internet prescribing;
- Eliminates requirements for protocols between physicians and specified practitioners;
- Revises criminal background checks for nursing assistants and provides a procedure and fee for license renewal;
- Revises licensure fees for a midwife's license and renewal requirements;
- Revises respiratory care practice requirements and exemptions;
- Revises licensing requirements for clinical social work;
- Limits issuance of the designation "certified master social worker" to current licensees;
- Redefines "medical review committee" to add a committee established by a university board of trustees, and a committee comprised of faculty, residents, students and administrators of an accredited college of medicine, nursing, or other health care discipline;
- Eliminates the continuing education requirements for domestic violence and HIV/AIDS;
- Requires all payments by DOH to the Division of Administrative Hearings after July based on a previous payment formula to revert back to DOH based on the newly established charges in the bill; and
- Requires the Office of Program Policy Analysis and Government Accountability and the Auditor General to jointly conduct an audit of all hearings and billings conducted by DOAH for DOH and submit a report to Legislature.

The bill creates the "Clara Ramsey Care of the Elderly Act", which establishes a category of geriatric specialty nursing called certified geriatric specialist. The bill establishes: (1) a scope of practice for certified geriatric specialists; (2) certification requirements, including education requirements; and (3) penalties for using the title of certified geriatric specialist or for practicing geriatric specialty nursing without a certificate. The bill requires the Agency for Workforce Innovation to create a pilot program for delivery of geriatric nursing education to certified nursing assistants who are employed in a nursing home and to submit evaluation and status reports to the Governor and Legislature. The bill appropriates $157,017 to the Agency for Workforce Innovation to support implementation of the pilot program.

The bill requires home health agencies, hospices and adult day care centers to provide written information to employees, upon their beginning employment, about interacting with patients or participants who have Alzheimer's disease or dementia-related disorders. Employees of these services must subsequently receive training in the care of individuals with Alzheimer's disease or related disorders.

This bill amends sections 393.064, 394.4615, 395.3025, 400.141, 400.145, 456.017, 456.0375, 456.041, 456.049, 456.055, 456.057, 456.063, 456.072, 456.073, 456.077, 456.078, 458.311, 458.315, 458.331, 459.015, 460.413, 461.013, 381.00315, 400.021, 400.211, 400.23, 409.908, 458.303, 1009.65, 1009.66, 464.201, 464.202, 464.203, 464.204, 467.013, 467.0135, 467.017, 468.352, 468.355, 468.368, 491.005, 491.0145, 627.912, 766.101, 400.4785, 400.5571, and 400.6045, Florida Statutes.

This bill creates ss. 464.0125, 400.455 and 491.0146, F.S., and eight undesignated sections of law.

This bill repeals 458.348(3), 468.356, 468.357, 456.031, 456.033, 456.034, 458.313, 458.316, 458.3165, and 458.317, F.S.

II. Present Situation:

General Regulatory Provisions

Chapter 456, F.S., provides the general regulatory provisions for health care professions within the Division of Medical Quality Assurance in the Department of Health. Section 456.001, F.S., defines "health care practitioner" to mean any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); part I, II, III, IV, V, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology, nursing home administration, occupational therapy, radiologic technology, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); part III or IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S., (psychotherapy).

Medical Quality Assurance Trust Fund

Section 20.435(1)(d), F.S., establishes the Medical Quality Assurance Trust Fund to be credited with revenue related to the licensing of health care practitioners. Section 456.025(5), F.S., requires that all licensure fees, fines, or costs awarded to the agency by a court be paid into the trust fund. Section 456.065(3), F.S., requires that the trust fund also be credited with revenues received from the department's unlicensed activity efforts. Funds in the trust fund are to be used for the purpose of providing administrative support for the regulation of health care practitioners and for such other purposes as may be appropriate in accordance with legislative appropriation. Any balance in the trust fund at the end of any fiscal year remains in the trust fund and is available for carrying out the purposes of the trust fund.

Continuing Education

Section 456.031, F.S., requires the boards of specified health care practitioners to require practitioners under their jurisdiction to complete a 1-hour continuing education course on domestic violence as a condition of initial licensure and licensure renewal every two years.

Sections 456.033 and 456.034, F.S., require the boards of specified health care practitioners to complete a continuing education course on HIV/AIDS as a condition of initial licensure and licensure renewal.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had ten meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into thirteen volumes that accompany the main report. Some of the Task Force recommendations that are addressed in this bill include:

Recommendation 17. The Legislature should provide for an audit of the Department of Health's (DOH) disciplinary process and closed claims files.

Recommendation 19. The Legislature should expand the DOH's subpoena authority to include the retrieval of patient records when the patient refuses to cooperate, is unavailable, or fails to execute a patient release. Records obtained under these circumstances would be confidential.

Recommendation 22. The Legislature should require all healthcare provider regulatory boards to designate those violations that may be handled in a one-time, non-reportable, and confidential mediation proceeding. Appropriate standard of care cases should be included.

Recommendation 23. The Legislature should modify upward the dollar amount threshold for closed claims cases to be reported and investigated by the Department.

Recommendation 24. The Legislature should grant exclusive authority to the healthcare provider regulatory boards to determine the amount of administrative costs to be recovered when final action occurs and a respondent is disciplined.

Recommendation 25. The Legislature should change the burden of proof in disciplinary actions from the "clear and convincing evidence" standard, to the "greater weight of the evidence" standard, which is the same burden of proof for a medical malpractice case.

Confidentiality of Patient Records

Section 456.057, F.S., provides that medical records are confidential and, absent certain exceptions, they cannot be shared with or provided to anyone without the consent of the patient. Subsection (5) identifies the circumstances when medical records may be released without written authorization from the patient. The circumstances are as follows:

- To any person, firm, or corporation that has procured or furnished such examination or treatment with the patient's consent;
- When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff;
- In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records; or
- For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.

The Florida Supreme Court has addressed the issue of whether a health care provider, absent any of the above-referenced circumstances, can disclose confidential information contained in a patient's medical records as part of a medical malpractice action.[1] The court ruled that, pursuant to s. 455.241, F.S., (the predecessor to current s. 456.057(6), F.S.), only a health care provider who is a defendant, or reasonably expects to become a defendant, in a medical malpractice action can discuss a patient's medical condition. The court also held that the health care provider can only discuss the patient's medical condition with his or her attorney in conjunction with the defense of the action. The court determined that a defendant's attorney cannot have ex parte discussions about the patient's medical condition with any other treating health care provider.

Under s. 456.057(7), F.S., the Department of Health may obtain patient records pursuant to a subpoena without written authorization from the patient, if the department and the probable cause panel of the appropriate board find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance violating ch. 893, F.S, relating to controlled substances or any professional practice act or that a health care practitioner has practiced his or her profession below that level of care, skill, and treatment required by law and also find that reasonable attempts were made to obtain a patient release.

The department may obtain patient records and insurance information pursuant to a subpoena without written authorization from a patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on the termination of insurance and also find that reasonable attempts were made to obtain a patient release.

The department may obtain patient records, billing records, insurance information, and provider contracts pursuant to a subpoena without written authorization from the patient if the department

[1] *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996).

and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using the appropriate billing code; used information derived from an automobile accident report to solicit or obtain patients personally or through an agent; solicited patients fraudulently; received a kickback; violated patient brokering provisions; presented a false or fraudulent insurance claim; or patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme; and if the subpoena is issued for specific and relevant records.

Health Insurance Portability and Accountability Act of 1996

On December 20, 2000, President Clinton issued landmark rules to protect the privacy of people's medical records. The 1996 Health Insurance Portability and Accountability Act (HIPAA)[2] required the Administration to issue regulations protecting the privacy of health information. The United States Department of Health and Human Services issued Standards for Privacy of Individually Identifiable Health Information on December 28, 2000, which were originally scheduled to go into effect on February 26, 2001. The effective date for the regulations was delayed and will take effect on April 14, 2003. The regulations only apply to health plans, health care clearinghouses and certain health care providers. The regulations permit states to afford greater privacy protections to health information.[3] Exceptions for state law are provided for public health (authority, power, or procedures established under any law providing for the reporting of disease or injury, child abuse, birth, or death, public health surveillance, or public health investigation or intervention) and state regulatory reporting (the ability of a state to require a health plan to report, or to provided access to, information for management audits, financial audits, program monitoring and evaluation, facility licensure or certification, or individual licensure or certification).[4]

Medical Malpractice, Financial Responsibility and Closed Claims

Sections 458.320 and 459.0085, F.S., require Florida-licensed allopathic and osteopathic physicians to maintain professional liability insurance or other specified financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Physicians who have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim. Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to

[2] Section 262 of the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, enacted on August 21, 1996, directed the United States Department of Health and Human Services to develop standards to protect the security, including the confidentiality and integrity, of health information.

[3] Sections 160.201, 160.203, 160.204, and 160.205, C.F.R.

[4] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) generally preempts state health information privacy laws, unless they provide a higher level of protection than the act. (Pub. L. No.104-191, §262, 110 Stat. 1936, 2029.) However, these state privacy provisions may not be preempted if the Secretary of Health and Human Services determines that the state law has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances (as defined in 21 U.S.C. §802), or that is deemed a controlled substance by state law. (45 C.F.R. §160.203 (a)(2)). See also, 42 U.S.C.A. § 1320d-7.

be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Such sign or statement must state:

> "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

With specified exceptions, the Department of Health must suspend on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.

Section 627.912, F.S., requires insurers to report "closed claims" that involve any action for damage for personal injuries in the performance of professional services by a Florida-licensed medical physician, osteopathic physician, podiatric physician, dentist, hospital, crisis stabilization unit, health maintenance organization, ambulatory surgical center, or attorney to the Department of Insurance. DOH must review each closed claim involving a Florida-licensed medical physician, osteopathic physician, podiatric physician, or dentist and determine whether any of the incidents that resulted in the claim involved conduct by the licensed health care practitioner that is subject to disciplinary action.

Section 456.049, F.S., requires medical physicians, osteopathic physicians, physician assistants, podiatric physicians, and dentists to report "closed claims" for damages for personal injury that are alleged to have been caused by the negligence of the practitioner that are not covered by an insurer and reported as a closed claim under s. 627.912, F.S., to DOH. Section 456.051, F.S., specifies that "closed claims" reported under s. 456.049 and s. 627.912, F.S., to DOH are public information except for the name of the claimant or injured person. Any information that DOH possesses that relates to a bankruptcy proceeding by a medical physician, osteopathic physician, physician assistant, podiatric physician, or dentist is public information.

Sections 458.331 and 459.015, F.S., provide grounds for which an allopathic or osteopathic physician may be subject to discipline by his or her board. Allopathic and osteopathic physicians may be subject to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. "Repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000. If it is reported that a physician has had three or more claims with indemnities exceeding $25,000 each within the previous 5-year period, DOH must investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

Similarly, s. 461.013, F.S., provides that a podiatric physician may be subject to discipline for gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar circumstances and conditions. "Repeated malpractice" includes but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000. A dentist is subject to discipline for "dental malpractice" which includes but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of $5,000 in a judgment or settlement, as a result of negligent conduct on behalf of the dentist.

Chapter 766, F.S., deals with medical malpractice and related matters. Section 766.101, F.S., provides for medical review committees to engage in quality assurance activities and the investigations, proceedings and records of a committee are not subject to discovery or introduction into evidence in any civil or administrative action against a health care provider whose services are the subject of the committee's review.

Disciplinary Procedures

Section 456.073, F.S., sets forth procedures DOH must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The department, for the boards under its jurisdiction, must investigate all written complaints filed with it that are legally sufficient. Complaints are legally sufficient if they contain facts, which, if true, show that a licensee has violated any applicable regulations governing the licensee's profession or occupation. Even if the original complainant withdraws or otherwise indicates a desire that the complaint not be investigated or prosecuted to its completion, the department at its discretion may continue its investigation of the complaint. The department may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the department has reason to believe after a preliminary inquiry that the alleged violations are true. If the department has reasonable cause to believe that a licensee has violated any applicable regulations governing the licensee's profession, it may initiate an investigation on its own.

When investigations of licensees within the department's jurisdiction are determined to be complete and legally sufficient, the department is required to prepare, and submit to a probable cause panel of the appropriate board, if there is a board, an investigative report along with a recommendation of the department regarding the existence of probable cause. A board has discretion over whether to delegate the responsibility of determining probable cause to the department or to retain the responsibility to do so by appointing a probable cause panel for the board. The determination as to whether probable cause exists must be made by majority vote of a probable cause panel of the appropriate board, or by the department if there is no board or if the board has delegated the probable cause determination to the department.

The subject of the complaint must be notified regarding the department's investigation of alleged violations that may subject the licensee to disciplinary action. When the department investigates a complaint, it must provide the subject of the complaint or her or his attorney a copy of the complaint or document that resulted in the initiation of the investigation. Except for cases involving physicians, within 20 days after the service of the complaint, the subject of the

complaint may submit a written response to the information contained in the complaint. The department may conduct an investigation without notification to the subject if the act under investigation is a criminal offense. If the department's secretary or her or his designee and the chair of its probable cause panel agree, in writing, that notification to the subject of the investigation would be detrimental to the investigation, then the department may withhold notification of the subject.

If the subject of the complaint makes a written request and agrees to maintain the confidentiality of the information, the subject may review the department's complete investigative file. The licensee may respond within 20 days of the licensee's review of the investigative file to information in the file before it is considered by the probable cause panel. Complaints and information obtained by the department during its investigations are exempt from the public records law until 10 days after probable cause has been found to exist by the probable cause panel or the department, or until the subject of the investigation waives confidentiality. If no probable cause is found to exist, the complaints and information remain confidential in perpetuity.

When the department presents its recommendations regarding the existence of probable cause to the probable cause panel of the appropriate board, the panel may find that probable cause exists or does not exist, or it may find that additional investigative information is necessary in order to make its findings regarding probable cause. Probable cause proceedings are exempt from the noticing requirements of ch. 120, F.S. After the panel convenes and receives the department's final investigative report, the panel may make additional requests for investigative information. Section 456.073(4), F.S., specifies time limits within which the probable cause panel may request additional investigative information from the department and within which the probable cause panel must make a determination regarding the existence of probable cause. Within 30 days of receiving the final investigative report, the department or the appropriate probable cause panel must make a determination regarding the existence of probable cause. The secretary of the department may grant an extension of the 15-day and 30-day time limits outlined in s. 456.073(4), F.S. If the panel does not issue a letter of guidance or find probable cause within the 30-day time limit as extended, the department must make a determination regarding the existence of probable cause within 10 days after the time limit has elapsed.

Instead of making a finding of probable cause, the probable cause panel may issue a letter of guidance to the subject of a disciplinary complaint. Letters of guidance do not constitute discipline. If the panel finds that probable cause exists, it must direct the department to file a formal administrative complaint against the licensee under the provisions of ch. 120, F.S. The department has the option of not prosecuting the complaint if it finds that probable cause has been improvidently found by the probable cause panel. In the event the department does not prosecute the complaint on the grounds that probable cause was improvidently found, it must refer the complaint back to the board that then may independently prosecute the complaint. The department must report to the appropriate board any investigation or disciplinary proceeding not before the Division of Administrative Hearings under ch. 120, F.S., or otherwise not completed within 1 year of the filing of the complaint. The appropriate probable cause panel then has the option to retain independent legal counsel, employ investigators, and continue the investigation, as it deems necessary.

When an administrative complaint is filed against a subject based on an alleged disciplinary violation, the subject of the complaint is informed of her or his right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint. The subject may waive her or his rights to object to the allegations of the complaint, which allows the department to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the department. If the subject of the complaint and the department do not agree in writing that there are no disputed issues of material fact, s. 456.073(5), F.S., requires a formal hearing before a hearing officer of the Division of Administrative Hearings under ch. 120, F.S. The hearing provides a forum for the licensee to dispute the allegations of the administrative complaint. At any point before an administrative hearing is held, the licensee and the department may reach a settlement. The settlement is prepared by the prosecuting attorney and sent to the appropriate board. The board may accept, reject, or modify the settlement offer. If accepted, the board may issue a final order to dispose of the complaint. If rejected or modified by the board, the licensee and department may renegotiate a settlement or the licensee may request a formal hearing. If a hearing is held, the hearing officer makes findings of fact and conclusions of law that are placed in a recommended order. The licensee and the department's prosecuting attorney may file exceptions to the hearing officer's findings of facts. The boards resolve the exceptions to the hearing officer's findings of facts when they issue a final order for the disciplinary action.

The boards within DOH have the status of an agency for certain administrative actions, including licensee discipline. A board may issue an order imposing discipline on any licensee under its jurisdiction as authorized by the profession's practice act and the provisions of ch. 456, F.S. Typically, boards are authorized to impose the following disciplinary penalties against licensees: refusal to certify, or to certify with restrictions, an application for a license; suspension or permanent revocation of a license; restriction of practice or license; imposition of an administrative fine for each count or separate offense; issuance of a reprimand or letter of concern; placement of the licensee on probation for a specified period of time and subject to specified conditions; or corrective action.

Alternatives to Disciplinary Actions

Notwithstanding s. 456.073, the board or department if there is no board, must adopt rules to permit the issuance of citations. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the standard procedures for a disciplinary action under s. 456.073, F.S. If the subject does not dispute the matter in the citation within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. The penalty for a citation must be a fine or other conditions as established by rule.

Notwithstanding s. 456.073, F.S., the board or department if there is no board, must adopt rules to designate which violations of the applicable practice act are appropriate for mediation. They may designate as mediation offenses those complaints where harm caused by the licensee is economic in nature or can be remedied by the licensed health care practitioner.

Medical Licensing

Chapter 458, F.S., provides for the licensure of allopathic physicians by the Board of Medicine. The chapter sets forth licensure by examination requirements in s. 458.311, F.S., and licensure by endorsement requirements in s. 458.315, F.S., for physicians already licensed in another jurisdiction who wish to seek licensure to practice medicine in Florida. In addition to full licensure to practice medicine the chapter provides for the issuance of licensure for limited practice in: s. 458.316, F.S., which provides for a temporary certificate for practice in areas of critical need; s. 458.316, F.S, which provides for a public health certificate; s. 458.3165, F.S., which provides for a public psychiatry certificate; and the s. 458.317, F.S., which provides for limited licensure. Each category of licensure for limited practice establishes requirements that applicants must meet in order to practice safely in Florida. Several provisions have been adopted by the Legislature as a means of providing alternative licensure pathways for certain foreign-trained physicians.

Professional Regulation

Nursing Assistants are regulated by the Board of Nursing under pt. II, ch. 464, F.S. The part provides requirements for a criminal history check under ch. 435, F.S., of applicants and procedures for discipline of a nursing assistant who intentionally violate applicable regulations. Nursing assistants are not subject to licensure renewal. Certification as a nursing assistant continues in effect until a nursing assistant allows a period of 24 consecutive months to elapse during which the nursing assistant fails to perform any nursing-related services. If so, the nursing assistant must complete a new training and competency evaluation program.

Part V, ch. 468, F.S., governs the practice of respiratory therapy. The part provides definitions and licensure requirements for respiratory care practitioners. Section 468.355, F.S., specifies licensure requirements for a person to become a certified respiratory therapist. A Florida-licensed respiratory therapist may voluntarily be certified as a Certified Respiratory Therapist or registered as a Registered Respiratory Therapist pursuant to the requirements of the National Board for Respiratory Care. The National Board for Respiratory Care is a national organization recognized by the Council that provides voluntary certification for respiratory care practitioners, which is recognized under Florida licensure laws. The National Board for Respiratory Care currently offers five credentialing programs. These examinations include the: certification examination for entry level respiratory therapists for the designation of (CRT); and the registry examination for advanced respiratory therapy practitioners (RRT).

Midwifery is regulated by the Department of Health under ch. 467, F.S. The chapter provides licensing and continuing education requirements, and requires midwives to maintain and submit an emergency care plan at licensure renewal.

Chapter 491, F.S., provides for the regulation of clinical social work, marriage and family therapy, and mental health counseling. The chapter provides licensing requirements for the practice of psychotherapy. Under s. 491.0145, F.S., the Department of Health may certify a person for a designation as a certified master social worker who meets specified requirements.

Nursing

Nursing home staffing standards are established in s. 400.23 (3), F.S., and in rule 59A-4.108, F.A.C. A nursing home must provide a minimum certified nursing assistant (CNA) staffing of 2.6 hours of direct care per resident per day, and the staffing requirement will increase to 2.9 hours of direct care per resident per day on January 1, 2004. The statute also establishes a minimum of one CNA per 20 residents. Each nursing home must provide one hour of direct care per resident per day by a licensed nurse, and a nursing home may never staff below one licensed nurse per 40 residents. These staffing requirements were enacted by the 2001 Legislature in CS/CS/CS/SB 1202, which required staffing increases to be phased in over a 3-year period. That legislation also required training for staff and implementation of a risk management program in nursing homes.

The national shortage of nurses affects nursing homes as well as hospitals. The shortage is caused in part by a shortage of nursing faculty to oversee clinical experience by nurses in training. At the organizational session of the Legislature in November 2002, Senate President Jim King proposed a special program to train CNAs working in nursing homes in the skills of geriatric nursing. The proposal to create educational opportunities in the long-term care setting would permit programs with clinical experience in geriatric nursing only, thus avoiding the problem of finding faculty to oversee the other clinical experiences of the practical nursing curriculum.

Scope of Practice in Nursing

Part I, ch. 464, F.S., provides for the regulation of nursing. The "practice of professional nursing" is defined to mean the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychological, biological, physical, and social sciences which shall include, but not be limited to, specified modalities; the administration of medications and treatments as prescribed or authorized by a duly licensed practitioner; and the supervision and teaching of other personnel in the theory and performance of any of the above acts. The "practice of practical nursing" is defined to mean the performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm and the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist. The definition of practice of professional nursing and the practice of practical nursing provide that the professional nurse and the practical nurse must be responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

Florida Board of Nursing Approval of Nursing Programs

Professional (RN) or practical nursing (LPN) licensure applicants must graduate from an approved nursing program as a prerequisite to being allowed to sit for the nursing licensure examination. Under part I, ch. 464, F. S., the Florida Board of Nursing must adopt rules regarding educational objectives, faculty qualifications, curriculum guidelines, administrative procedures, and clinical training as are necessary to ensure that approved nursing programs graduate nurses capable of competent practice. The part requires any institution wishing to

conduct an approved nursing program in Florida to apply to the Department of Health and to show compliance with the requirements of the part and any applicable administrative rules adopted by the board.

Chapter 2002-230, L.O.F., modified the provisions governing approval of nursing programs by the Florida Board of Nursing. The law exempts from certain board administrative rules, any nursing program that maintains accreditation through a nursing accrediting body recognized by the United States Department of Education, if the program maintains a student pass rate on the National Clinical Licensure Exam (NCLEX®) of not less than ten percentage points below the national average pass rate as reported annually by the National Council of State Boards of Nursing (NCSBN). The Florida Board of Nursing must review an institution whose passing rate on the NCLEX® falls below the standard established in the law and may assist an institution in complying with the standard.

There are a limited number of clinical slots for nursing programs in Florida. The shortage of nursing faculty to supervise students' clinical experience also contributes to the shortage of clinical slots.

Requirements for Certification as a "Certified Nursing Assistant" in Florida

Part II, ch. 464, F.S., provides for the regulation of certified nursing assistants by the Florida Board of Nursing. The Board of Nursing has authority to adopt by rule testing procedures for use in certifying nursing assistants and must adopt rules regulating the practice of nursing assistants to enforce this part.[5] The Florida Department of Education was responsible for approving nursing assistant training programs until the Florida Board of Nursing assumed that responsibility on October 1, 2000. The Florida Board of Nursing must issue a certificate to any person who demonstrates minimum competency to read and write and successfully passes the required Level I or Level II criminal background screening required under s. 400.215, F.S., and meets one of the following criteria:

1. Successful completion of an approved training program and achievement of a minimum score on the nursing assistant competency examination;
2. Achievement of a minimum score on the nursing assistant competency examination by an applicant who has a high school diploma or its equivalent or who is at least 18 years old;
3. Current certification in another state; or
4. Completion of the curriculum under the Enterprise Florida Jobs and Education Partnership Grant and achievement of a minimum score on the nursing assistant competency examination.

The nursing assistant competency examination has two parts: (1) a two-hour written test with fifty multiple-choice questions written in English; and (2) a manual skills evaluation that requires the applicant to perform five randomly-selected nursing assistant skills. An oral examination

[5] On March 24, 2003, the Joint Administrative Procedures Committee objected to the Board of Nursing's Proposed Rule 64B9-15.002, F.A.C., setting forth certified nursing assistant authorized duties and requirements for supervision. JAPC found it objectionable because there was no statutory authority for the rule.

must be administered as a substitute for the written portion of the examination upon an applicant's request.

Completion of a state-approved training program is not required before an applicant may sit for the nursing assistant competency examination if the applicant is 18 years of age or older, or has a high school diploma or its equivalent. If a nursing assistant applicant was certified, and remained active and in good standing on another state's certified nursing assistant registry, the applicant can obtain certification from Florida, as long as the applicant successfully passes the required Level I or Level II criminal background screening. An applicant is eligible to take the nursing assistant competency examination three times. After the third attempt the applicant is not eligible for reexamination unless the applicant completes an approved training program.

Certification as a nursing assistant is valid until a nursing assistant allows a period of 24 consecutive months to pass during which the nursing assistant fails to perform any nursing-related services for compensation. When a nursing assistant fails to perform any nursing-related services for monetary compensation for a period of 24 consecutive months, the nursing assistant must complete a new training and competency evaluation program. Nursing assistants must maintain a current address with the Florida Board of Nursing and must complete 18 hours of in-service training during each calendar year.

Licensure Requirements for Licensed Practical Nurses in Florida

To become licensed as a practical nurse in Florida, an applicant must pass a national licensing examination developed by the National Council of State Boards of Nursing (NCSBN) or a similar national organization. To sit for the examination in Florida, an applicant must complete an application and pay the Florida Department of Health fees totaling $180, which includes the following fees: $75 initial licensure fee; $75 examination fee; $5 unlicensed activity fee; $5 Nursing Student Loan Forgiveness Fund fee; and $20 fingerprint/criminal background fee (includes $5 for administrative costs). The applicant must provide sufficient information for a statewide criminal records correspondence check through the Florida Department of Law Enforcement; be in good mental and physical health; have a high school diploma or the equivalent; have completed the requirements of a Florida Board of Nursing approved nursing program for licensed practical nurses or the practical nursing education equivalency; and have the ability to communicate in English. The practical nursing education equivalency is defined by Board of Nursing rule to mean professional nursing courses of study, completed with a grade of "C-" or better, which meet the standards of practical nursing education required in approved practical nursing programs in Florida.

Prior to the application for examination, any convicted felon must obtain a restoration of his or her civil rights in order to become eligible to sit for the examination. If an applicant has been convicted or found guilty of, or has entered a plea of nolo contendere to, regardless of adjudication, any offense other than a minor traffic violation, the applicant must submit arrest and certified court records stating the nature of the offense and final disposition of the case so that a determination can be made by the Florida Board of Nursing whether the offense relates to the practice of nursing.

Once the Florida Board of Nursing has certified an applicant to take the examination, the applicant must submit a letter of authorization from the board and pay $200 to the NCSBN examination vendor to sit for the computerized national nursing examination (NCLEX-PN®). An applicant is eligible to sit for the license examination up to three consecutive times. After the third failed examination, the applicant must complete a Florida Board of Nursing remedial course before he or she may be approved for reexamination up to three additional times before the applicant is required to retake remediation. The applicant must apply for reexamination within 6 months after completion of remediation. The Florida Board of Nursing has established, by rule, requirements for the curriculum of the remedial course for reexamination which include a minimum of 80 hours of didactic education and 96 hours of clinical experience in a medical-surgical setting. The content of the practical nurse remedial course must include medical, surgical, obstetric, pediatric and geriatric nursing.

Articulation of Nursing Education Programs

Florida has an articulation agreement for health education programs that permits a student to learn in modules from the basic health sciences course in high school to bachelor's degree programs. The CNA standards are the basis for the LPN standards. The high school core also articulates into LPN and associate degree in nursing (A.D.N.) programs. Most community colleges have a "bridge" program for LPN to RN. Universities are required to accept and speed the progress of registered nurses who hold an AS degree and want to get their BS in nursing (known as AS to BS articulation). Under AS to BS articulation, a university must accept the AS degree as a block of designated nursing courses and may not, for instance, decide not to give credit for a course or to accept some courses as electives rather than as credits toward the nursing degree.

The articulation among health education programs in Florida is designed to ensure that a student's (and in many cases, the state's) investment of time and money at one level of education can provide a building block to the next education program when the health care worker is ready to move up to the next level of skill and knowledge.

Workforce Perspective—Nurses Now

Nurses Now is a partnership between the Agency for Workforce Innovation (AWI), the Florida Department of Education, Division of Community Colleges and Division of Workforce Education, the Department of Health, and the nurse education and training community to address the critical statewide need for nursing instructors, Registered Nurses, and Licensed Practical Nurses. The U.S. Department of Labor has earmarked a $2 million training grant for Florida's Nurses Now project. AWI will serve as the lead agency, project manager, fiscal agent and liaison with the 24 Regional Workforce Development Boards. AWI will also serve as liaison with private education and training providers. The Department of Education will be the liaison with the state university system, community colleges and public secondary and post secondary school system nursing education and training programs. Activities will include increasing the awareness of careers in nursing, education and training opportunities in nursing, career advancement opportunities, and increasing the capacity of the education and training system to meet the increased need for nurses. Regional Workforce Boards, through their One Stop delivery system, will determine participant eligibility.

To achieve the goals of Nurses Now, the state will develop a targeted statewide recruitment campaign to attract and train 330 eligible adults, older youth (19-21 years of age), dislocated workers, incumbent workers, veterans, and inactive licensed nurses to enroll in education and training programs that will prepare them to enter or reenter the nursing profession in Florida or progress to a higher level of the career ladder. The state, working in partnership with education entities and health care facilities, will identify and facilitate the replication of innovative training options and professional certifications.

In addition to increasing the number of training opportunities, Nurses Now will identify innovative and alternative education and training delivery systems that provide opportunities for students in all areas of the state to access training and receive clinical experiences in health care facilities or with patient care simulators. A Nurses Now website will provide linkages to education and training programs, exemplary practices, scholarship and loan information, and employment and training resources of the One Stop delivery system and regional workforce boards.

Clara Ramsey

Clara Ramsey worked as an aide to Jacksonville lawmakers for 13 years. She was attentive to the concerns of the constituents who called on their senator for assistance. She was beloved by all who encountered her joyful spirit and her calm way of accomplishing objectives. In the months preceding her untimely death in an automobile accident on February 23, 2003, Mrs. Ramsey was working on the geriatric nursing proposal that is created in this bill.

Alzheimer's Disease

Alzheimer's disease is a progressive, irreversible brain disorder with no known cause or cure. Symptoms of the disease include memory loss, confusion, impaired judgment, personality changes, disorientation, and loss of language skills. Always fatal, Alzheimer's disease is the most common form of irreversible dementia. How rapidly it advances varies from person to person, but it eventually causes confusion, personality and behavior changes and impaired judgment. Communication becomes difficult as the affected person struggles to find words, finish thoughts or follow directions. Most people with Alzheimer's disease become unable to care for themselves.

There is no known treatment that will cure Alzheimer's disease. For those who are currently suffering with the disease, medications can only help control symptoms and/or slow the progression of the disease. Approximately 100,000 victims die and 360,000 new cases of Alzheimer's disease are diagnosed each year in the United States. It is estimated that by 2050, 14 million Americans will have this disease. In every nation where life expectancy has increased, so has the incidence of Alzheimer's disease. It is estimated that by 2020, 30 million people will be affected by this disorder worldwide and by 2050 the number could increase to 45 million.

Florida's Alzheimer's Disease Initiative

Section 430.502, F.S., establishes memory disorder clinics at three medical schools in the state, plus ten additional memory disorder clinics in other medical settings. The purpose of these

clinics is to conduct research and training in a diagnostic and therapeutic setting for persons with Alzheimer's disease, conduct research and develop caregiver-training materials. Individuals diagnosed with or suspected of having Alzheimer's disease are eligible for memory disorder clinic services. Memory disorder clinics are located at:

- Mayo Clinic in Jacksonville;
- The University of Florida in Gainesville;
- East Central Florida Memory Disorder Clinic in Melbourne;
- Orlando Regional Healthcare System in Orlando;
- University of South Florida in Tampa;
- North Broward Medical Center in Pompano Beach;
- University of Miami in Miami;
- Mount Sinai Medical Center in Miami Beach;
- West Florida Regional Medical Center in Pensacola;
- St. Mary's Medical Center in West Palm Beach;
- Tallahassee Memorial Health Care in Tallahassee;
- Lee Memorial Memory Disorder Clinic in Ft. Myers; and
- Sarasota Memorial Hospital in Sarasota.

The memory disorder clinics have developed extensive educational programs targeted at doctors, medical students, caregivers, and nursing home staff. Four Model Day Care programs have been established in conjunction with Memory Disorder Clinics to test therapeutic models, provide training, and to deliver day care services to persons with Alzheimer's disease and related disorders. Model day care centers receive a state general revenue appropriation of $125,510 each.

The Department of Elderly Affairs provides respite care services to relieve the families of persons with Alzheimer's disease and related disorders from the burden of care giving. The Alzheimer's respite program receives approximately $7.8 million in General Revenue funding and serves approximately 3,800 clients annually.

Training Requirements for Service Providers

Currently home health agencies, hospices and adult day care centers do not require special training for staff caring for residents, patients, or participants diagnosed with Alzheimer's disease or dementia–related disorders. However, minimum Alzheimer's training is currently required for nursing homes pursuant to s. 400.1755, F.S., and Chapter 58A-4, Florida Administrative Code (F.A.C), and assisted living facilities pursuant to s. 400.4178, F.S., and Chapter 58A-5.0191(9)(a), F.A.C.

There are 1,091 home health agencies licensed in Florida. The 2000 Florida Legislature revised the home health agency statutes to permit home heath aides to pass a competency test in lieu of training. Home health agencies generally provide services of short duration to patients. Home health agency employees go into homes one or more times per week, or per month, for an hour or two; they are typically not the caregivers of the patients. Under s. 400.4785, F.S., a home health agency that claims that it provides special care for persons who have Alzheimer's disease

must disclose in its advertisements or in a separate document those services that distinguish the care as being especially suitable to persons with Alzheimer's disease.

There are 41 hospices licensed in Florida. Hospice patients are seen more frequently in their homes and may reside in hospice facilities. Under s. 400.6045, F.S., a hospice that claims that it provides special care for persons who have Alzheimer's disease must disclose in its advertisements or in a separate document those services that distinguish the care as being especially suitable to persons with Alzheimer's disease.

There are 166 adult day care centers licensed in Florida offering 7,871 slots (slots indicate the total number of participants that may be served at one time). Participants in adult day care programs are generally elderly clients who spend a portion of their day at the centers. Most adult day care centers are open 8-12 hours a day and offer temporary care to an elderly participant. Under s. 400.5571, F.S., an adult day care center that claims that it provides special care for persons who have Alzheimer's disease must disclose in its advertisements or in a separate document those services that distinguish the care as being especially suitable to persons with Alzheimer's disease.

The Agency for Health Care Administration (AHCA) administers and develops rules for the home health agency programs. The Department of Elderly Affairs has rule writing authority for the adult day care centers (ADCCs) and hospices. AHCA licenses and inspects all three of these provider types to determine compliance with licensure requirements.

III. Effect of Proposed Changes:

Section 1. Amends s. 393.064, F.S., to provide that the Department of Health rather than the Department of Children and Family Services shall have the authority to contract for the supervision and management of the Raymond C. Philips Research and Education Unit to conform with changes made when the two departments were separated.

Section 2. Amends s. 394.4615, F.S., relating to confidentiality of clinical records, to provide that a patient has reasonable access to their clinical records, unless such access is determined by the patient's physician to be a danger to the patient's life or safety rather than the current statutory standard. The current standard for release of such records by a patient's physician is whether the access will be "harmful to the patient." Section 394.4615(1), F.S., authorizes a psychiatrist to deny a patient access to his or her records when the psychiatrist determines that access would be "harmful" to the patient. The federal Health Insurance Portability and Accountability Act of 1996 regulations state that access may be denied only if access would pose a danger to the patient's life or safety.

Section 3. Amends s. 395.3025, F.S., relating to the confidentiality of hospital patient records, to restrict disclosures to licensed health care practitioners rather than facility personnel and attending physicians for use in connection with the treatment of a patient. References to the Agency for Health Care Administration are revised to the Department of Health in provisions which currently grant the agency access upon subpoena to patient records for use in the investigation, prosecution, and appeal of disciplinary proceedings. The administrator or records custodian in a licensed hospital or facility is required to certify that a true and complete copy of

the records requested by the department pursuant to subpoena or patient release has been provided to the department or otherwise identify those documents that have not been provided.

Researchers or facility personnel for research purposes are granted access to hospital patient records if the facility or researchers demonstrate compliance with specified federal confidentiality requirements. The bill also provides for release of patient information for "marketing" purposes as established in federal HIPAA regulations regarding patient confidentiality and protection of records.

Section 4. Amends s. 400.141, F.S., relating to nursing home records, to require the release of a certified copy to the Department of Health when subpoenaed for health care practitioner disciplinary cases. The provisions of ch. 456, F.S., apply to records obtained pursuant to this section.

Section 5. Amends s. 400.145, F.S., relating to treatment records of nursing home residents, providing for release of a certified copy to the Department of Health when subpoenaed for health care practitioner disciplinary cases.

Section 6. Creates s. 400.455, F.S., to require assisted living facilities to provide certified copies of requested records to the Department of Health for health care practitioner discipline cases.

Section 7. Amends s. 456.017, F.S., relating to examinations, to authorize the Department of Health to post examination scores electronically on the Internet in lieu of mailing the scores to each applicant. The requirements of ch. 120, F.S., relating to administrative procedures is satisfied if the electronic posting of the examination scores by the department is accompanied with a notification of rights. The date of receipt of the examination scores shall be the date the examination scores are posted electronically. The department must notify the examinee when scores are posted electronically of the availability of a post-examination review.

Section 8. Amends s. 456.0375, F.S., relating to the registration of certain health clinics, to revise the definition of "clinic" to provide that clinic registration requirements do not apply to: community college and university clinics or clinical facilities affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows.

Section 9. Amends s. 456.041, F.S., relating to practitioner profiles, to increase the financial threshold for paid professional liability claims that the Department of Health must post on practitioner profiles for medical physicians, osteopathic physicians, or podiatric physicians from $5,000 to $50,000 or more.

Section 10. Amends s. 456.049, F.S., relating to self-reported professional liability claims not reported by insurers, to place a minimum financial threshold rather than any amount for the claims that a licensed medical physician, osteopathic physician, podiatric physician or dentist must report to the Department of Health. The physicians must report final judgments or settlements of $50,000 or more and the dentists must report final judgments or settlements of $25,000 or more.

Section 11. Amends s. 456.055, F.S., relating to limitations on the denial of claims to chiropractic and podiatric health care, to expand it to all health care providers. Notwithstanding any other law, a claim for payment for a services by a Florida-licensed health care provider which is identified on the claim by a current procedural terminology code and submitted for payment to specified health insurers or managed care entities must be paid in the same amount to all health care providers submitting a claim for payment of a service identified by the same procedural terminology code, regardless of the licensure of the health care provider.

Section 12. Amends s. 456.057, F.S., relating to confidentiality of patient records, to not require the Department of Health to obtain a patient release for patient records if the matter investigated was reported to the department as a professional liability closed claim from an insurer under s. 627.912, F.S., or self-reported by a licensed health care practitioner under s. 456.049, F.S.

The Department of Health is authorized to obtain patient records pursuant to a subpoena for specified disciplinary violations applicable to licensed health care practitioners without written authorization from the patient if the patient refuses to cooperate or in the department's discretion, an attempt to obtain a patient release would be detrimental to the investigation.

The health care practitioner or records owner is required to certify that a true and complete copy of the records requested by the department pursuant to subpoena or patient release has been provided to the department or otherwise identify those documents that have not been provided.

Section 13. Amends s. 456.063, F.S., relating to sexual misconduct, to authorize each board, or the Department of Health, if there is no board, to adopt rules to administer the requirements for reporting allegations of sexual misconduct, including rules to determine the sufficiency of the allegations.

Section 14. Amends s. 456.072, F.S., relating to grounds for which a licensed health care practitioner may be subject to discipline, to limit a ground under which a licensed health care practitioner is liable for leaving a foreign body in a patient. An exception to the prohibition on leaving a foreign body in a patient is established if the foreign body is medically indicated and documented in the patient record. For purposes of the prohibition, it is legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the patient unless medically indicated and documented in the patient record.

A health care practitioner is liable for prescribing, administering, dispensing, or distributing a legend drug, including a controlled substance, if the practitioner knows or reasonably should know that the receiving patient has not established a valid professional relationship with the prescribing practitioner. A medical questionnaire completed via Internet, telephone, electronic transfer, or mail does not establish a valid professional relationship.

Health care practitioner regulatory boards or the Department of Health are authorized to determine the amount of costs, including attorney's fees, to be assessed in disciplinary cases of health care practitioners. A procedure for assessment of the costs by the department or appropriate board is specified.

The department must establish grounds for revocation or suspension of a license by clear and convincing evidence. Any other form of discipline must be established by the greater weight of the evidence.

Section 15. Amends s. 456.073, F.S., relating to disciplinary proceedings, to delete an exception to disciplinary complaint procedures involving physicians and granting them a specified period to review complaint information. The time in which a subject may provide a written response to a disciplinary complaint is expanded from 20 days to 30 days. The right of a licensed health care practitioner to elect a formal hearing is revised from any circumstance during a proceeding in which a party raises an issue of disputed fact during an informal hearing to affirmatively require the licensee to dispute an issue of material fact and request a formal hearing within 45 days after service of the administrative complaint. Notwithstanding s. 120.569(2), F.S., the department must notify the division within 45 days after receipt of a petition or request for hearing which the department has determined requires a formal hearing before an administrative judge.

Additional requirements are imposed on the Division of Administrative Hearings for formal hearings. The division must maintain time records for each case it receives and must charge its expenses to the Medical Quality Assurance Trust Fund based on an hourly rate as specified in this section. The costs charged must include actual travel and copying expenses, plus a $100 hourly fee for the actual time spent on the case by the administrative law judge or hearing officer. There shall be a one-time filing fee per case of $50. No charge is incurred for hearings cancelled more than 21 days in advance; if the hearing is cancelled between 3 and 21 days in advance, the charge shall be for actual expenses incurred. If a formal hearing is cancelled less than 72 hours before the start of the hearing the charge shall be for the actual expenses incurred and a cancellation fee of $250.

Section 16. Amends s. 456.077, F.S., to specify that each citation issued to a licensed health care practitioner by the Department of Health for a first offense does not constitute discipline. Requirements for a citation to be issued within 6 months after the filing of the complaint that is the basis for the citation are eliminated.

Section 17. Amends s. 456.078, F.S., relating to mediation, to require rather than authorize the Department of Health and regulatory boards to designate as mediation offenses specified complaints. Such complaints must be those where harm caused by the licensee (health care practitioner or establishment) is economic in nature, except complaints involving fraud, can be remedied by the licensee or does not result in an adverse incident. “Adverse incident” is defined to mean events specified in the section such as death, brain or spinal damage to the patient, the performance of a wrong-site surgical procedure and other surgical errors. A successful mediation must include a statement of whether or not the resolution constitutes discipline. Any licensee who completes a successful mediation must pay the department’s administrative cost for the mediation. A licensee may not go through the mediation process more than once if the allegation relates to the breach of the standard of care for that health care professional. Each board must adopt rules designating violations appropriate for mediation by January 1, 2004. Failure to do so, gives the department exclusive authority to adopt rules as required for administering mediation.

Section 18. Amends s. 458.311, F.S., relating to medical licensure requirements, to overhaul the licensure by examination provision and the licensure by endorsement provisions to create one

uniform set of licensure requirements for the practice of medicine. The bill allows an applicant for physician licensure to practice medicine in Florida if the applicant: is at least 21 years of age; of good moral character; has not committed any act or offense in Florida or another jurisdiction which would constitute the basis for disciplining a Florida-licensed physician; has submitted a set of fingerprints and payment in amount equal to costs incurred by the Department of Health for the criminal background check of the applicant; has caused to be submitted verification of core credentials by the Federation Credentials Verification Services of the Federation of State Medical Boards; if the applicant holds a valid license in another state, has submitted evidence of the active licensed practice of medicine in another jurisdiction for at least 2 years of the immediately preceding 4 years, or evidence of successful completion of board-approved postgraduate training program within 2 years preceding filing of an application for licensure. "Active licensed practice of medicine" is defined in the section.

The applicant must demonstrate that he or she has meet one of the following medical education requirements:

- Is a graduate of an allopathic medical school recognized and approved by the United States Department of Education or an allopathic medical school within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction; or
- Is a graduate of an allopathic international medical school registered with the World Health Organization and has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG), holds an active, valid certificate issued by ECFMG, and has passed the examination used by that commission.

If the language of instruction of the medical school is other than English, the applicant must show competency in English as specified in the section. The applicant must have completed an approved residency or fellowship of at least 2 years, in one specialty area which is counted as a regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties, with specified exceptions for those who have completed their training prior to October 1, 2003, or October 1, 1992, as applicable. Applicants must have obtained a passing score of a national medical licensure examination as specified in the section. The Department of Health and the Board of Medicine must assure that applicants meet the criteria for licensure through an investigative process.

Section 19. Amends s. 458.315, F.S., to revise the requirements for issuance of a limited license to practice relating to limited physician licensure to consolidate provisions in four existing sections of statute. The bill replaces current ss. 458.315, 458.316, 458.3165 and 458.317, F.S., relating to temporary certificates in areas of critical need, public health certificates, public psychiatry certificates, and limited licenses, respectively. The bill establishes limited licensure with one uniform set of licensure requirements to streamline and simplify the limited licensure process.

The bill allows physicians who have been licensed to practice medicine in any jurisdiction in the United States, U. S. territory or Canada for at least two years and who submit evidence of the active licensed practice for at least two of the immediately preceding four years to receive a

license to provide uncompensated health care services to low-income or uninsured persons. If the applicant has not been in the active licensed practice of medicine within the prior 3 years, a Florida-licensed physician approved by the Board of Medicine must supervise the applicant for 6 months after he or she is granted a limited license to practice or as needed to ensure that the applicant is qualified for licensure The applicant must not have committed any act or offense in Florida or any other jurisdiction which would constitute the basis for disciplining a Florida-licensed physician. The applicant must submit a set of fingerprints for a criminal background check and submit to a search of the Federation of State Medical Boards' databank.

The recipient of a medical physician's limited license used for noncompensated practice may only practice in the employ of specified programs and facilities that provide uncompensated health care services by volunteer licensed health care professionals to low-income persons whose income levels do not exceed 150 percent of the federal poverty level or to uninsured persons. These facilities shall include but not be limited to: community and migrant health centers of the Department of Health funded under s. 330 of the United States Public Health Service Act, and volunteer programs under contract with the department to provide uncompensated care under s. 766.1115, F.S.

The recipient of a medical physician's limited license for compensated practice may practice only in the employ of programs and facilities that provide health care services. These programs and facilities include, but are not limited to: the Departments of Corrections, county or municipal correctional facilities, the Department of Juvenile Justice, the Department of Children and Family Services, the Department of Health and those programs and facilities funded under s. 330 of the United States Public Health Service Act. Programs and facilities must be located within federally designated Primary Care Health Professional Shortage Areas unless otherwise approved by the Secretary of the Department of Health.

The recipient of a limited license must notify the Board of Medicine within 30 days after accepting employment and of all approved institutions in which the licensee practices and those in which the licensee has been denied practice privileges. The licensee must renew the limited license biennially and verify compliance with the restrictions prescribed in this section and other applicable provisions of ch. 458, F.S.

Procedures are specified for any person who holds an active or inactive license to practice medicine in Florida to convert that license to a limited license in order to provide volunteer, uncompensated care for low-income persons. The application and all licensure fees, including neurological injury compensation assessments are waived for the applicant. The limited license provisions do not limit any policy by the board to grant licenses to other physicians who are licensed in other states under conditions less restrictive than the requirements of this section. The board may refuse to authorize a physician otherwise qualified in the employ of any agency or institution if the agency or institution has caused or permitted violations of ch. 458, F.S., which it knew or should have known were occurring.

Section 20. Amends s. 458.331, F.S., to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to medical physicians. To conform, the threshold amount for physician closed claims reported and investigated by the Department of Health is increased from $25,000

to $50,000. The number of days are increased from 30 to 45 for a physician to submit a written response to the Department of Health for information contained in a disciplinary complaint.

Section 21. Repeals s. 458.348(3), F.S., relating to protocols relating to electrolysis or electrology using laser or light-based hair removal or reduction.

Section 22. Amends s. 459.015, F.S., to increase the threshold amount from $25,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to osteopathic physicians. The number of days are increased from 30 to 45 for a physician to submit a written response to the Department of Health for information contained in a disciplinary complaint.

Section 23. Amends s. 460.413, F.S., relating to chiropractic physicians, to increase the number of days are from 30 to 45 for a chiropractic physician to submit a written response to the Department of Health for information contained in a disciplinary complaint.

Section 24. Amends s. 461.013, F.S., relating to podiatric physicians, to increase the threshold amount from $10,000 to $50,000 of indemnities paid within a 5-year period for purposes of the violation of gross or repeated malpractice applicable to podiatric physicians.

Section 25. Cites the bill as the "Clara Ramsey Care of the Elderly Act". The act is named for Clara Ramsey, a long-time Legislative aide who worked on the development of this geriatric nursing initiative.

Section 26. Creates the Certified Geriatric Specialist Preparation Pilot Program for delivery of geriatric nursing education to CNAs who wish to become certified geriatric specialists. The AWI must select two pilot sites in nursing homes that:

- Have received the Gold Seal designation under s. 400.235, F.S.,
- Have been designated a teaching nursing home under s. 430.80, F.S., or
- Have not received a class I or class II deficiency, under s. 400.23(8), F.S., within the 30 months preceding application for the program.

To be able to receive geriatric nursing education under the pilot program, a CNA must have been employed by a participating nursing home for at least one year and have received a high school diploma or its equivalent. The geriatric nursing education must be provided at the worksite and in coordination with the CNA's work schedule. Faculty will provide the instruction under a nursing program approved pursuant to s. 464.019, F.S.

The training must prepare the CNA to meet the requirements for certified geriatric specialist. The didactic and clinical training will include all portions of the practical nursing curriculum approved under s. 464.019, F.S., except for pediatric and obstetric/maternal-child training; it must also include additional training in the maintenance of health, the prevention of injury, and the provision of palliative care for geriatric patients.

Section 27. Creates the Certified Geriatric Specialty Nursing Initiative Steering Committee to guide the implementation of the pilot program. The steering committee is composed of the following members:

1. The Chair of the Board of Nursing or his or her designee,
2. A representative of the AWI, appointed by the Director of Workforce Innovation,
3. A representative of Workforce Florida, Inc., appointed by the Chair of the Board of Directors of Workforce Florida, Inc.,
4. A representative of the Department of Education, appointed by the Secretary of Education,
5. A representative of the Agency for Health Care Administration, appointed by the Secretary of Health Care Administration,
6. The Director of the Florida Center for Nursing, and
7. A representative of a Gold Seal nursing home, appointed by the Secretary of Health Care Administration.

The steering committee must provide consultation and guidance to AWI on matters of policy during the implementation of the pilot program and must provide oversight to the evaluation of the pilot program. Pursuant to s. 112.061, F.S., members of the steering committee will be reimbursed for expenses only. The steering committee must complete its activities by June 30, 2006, and the authorization for the steering committee ends on that date.

Section 28. Requires AWI to conduct or contract for an evaluation of the pilot program. The agency must ensure that an evaluation report is submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2006. The evaluation must address the experience and success of the certified nursing assistants in the pilot program and must contain recommendations regarding the expansion of the delivery of geriatric nursing education in nursing homes.

Section 29. Requires AWI, in consultation with the steering committee, to submit status reports and recommendations regarding the pilot program to the Governor, the President of the Senate, and the Speaker of the House of Representatives on January 1, 2004, January 1, 2005, and January 1, 2006.

Section 30. Creates s. 464.0125, F.S., to provide definitions and responsibilities for certified geriatric specialists. *Certified geriatric specialist* is defined as a person who meets the qualifications specified in the section and who is certified by the board to practice as a certified geriatric specialist. *Geriatric patient* means any patient who is 60 years of age or older. The bill defines *practice of certified geriatric specialty nursing* as the performance of selected acts in facilities licensed under part II or part III of chapter 400, F.S., including the administration of treatments and medications, in the care of ill, injured, or infirm geriatric patients and the promotion of wellness, maintenance of health, and prevention of illness of geriatric patients under the direction of a registered nurse, a licensed physician, a licensed osteopathic physician, a licensed podiatric physician, or a licensed dentist.

The scope of practice of a certified geriatric specialist includes the practice of practical nursing as defined in s. 464.003, F.S., for geriatric patients only, except for any act in which instruction and clinical knowledge of pediatric nursing or obstetric/maternal-child nursing is required. A certified geriatric specialist, while providing nursing services in facilities licensed under part II or part III of chapter 400, F.S., may supervise the activities of certified nursing assistants and other unlicensed personnel providing services in such facilities in accordance with rules adopted

by the Board of Nursing. The certified geriatric specialist must be responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in performing certified geriatric specialty nursing.

Any certified nursing assistant desiring to be certified as a certified geriatric specialist may apply to the department and submit proof that he or she holds a current certificate as a certified nursing assistant and has satisfactorily completed the following requirements:

1. Is in good mental and physical health, is a recipient of a high school diploma or the equivalent, and has completed the requirements for graduation from an approved program for nursing, or its equivalent as determined by the board, for the preparation of licensed practical nurses, except for instruction and clinical knowledge of pediatric nursing or obstetric/maternal-child nursing. Any program that is approved on July 1, 2003, by the board for the preparation of registered nurses or licensed practical nurses may provide training for the preparation of certified geriatric specialists without further board approval.

2. Has the ability to communicate in the English language, which may be determined by an examination given by the department.

3. Has provided sufficient information, which must be submitted by the department for a statewide criminal records correspondence check through the Department of Law Enforcement.

Each applicant who meets the requirements will, unless denied pursuant to s. 464.018, F.S., be entitled to certification as a certified geriatric specialist. The board must certify, and the department must issue a certificate to practice as a certified geriatric specialist to, any CNA meeting the qualifications. The board must establish an application fee not to exceed $100 and a biennial renewal fee not to exceed $50. The board is authorized to adopt rules to implement the provisions of the section.

A person receiving certification as a geriatric specialist must:

1. Work only within the confines of a facility licensed under part II or part III of chapter 400, F.S.

2. Care for geriatric patients only.

3. Comply with the minimum standards of practice for nurses and be subject to disciplinary action for violations of s. 464.018, F.S.

Any certified geriatric specialist who completes the additional instruction and coursework in an approved nursing program pursuant to s. 464.019, F.S., for the preparation of practical nursing in the areas of pediatric nursing and obstetric/maternal-child nursing, unless denied pursuant to s. 464.018, F.S., shall be entitled to licensure as a licensed practical nurse if the applicant otherwise meets the requirements of s. 464.008, F.S.

The bill provides restrictions and penalties.

1. Only persons who hold certificates to practice as certified geriatric specialists in Florida or who are performing services within the practice of certified geriatric specialty nursing under the exception set forth in s. 464.022(8), F.S., will have the right to use the title *Certified Geriatric Specialist* and the abbreviation *C.G.S.*
2. No person shall practice or advertise as, or assume the title of, certified geriatric specialist or use the abbreviation C.G.S., or take any other action that would lead the public to believe that person was certified as such or is performing services within the practice of certified geriatric specialty nursing under the exception set forth in s. 464.022(8), F.S., unless that person is certified to practice as such.
3. A violation of the subsection is a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083, F.S.
4. Practicing certified geriatric specialty nursing without holding an active certificate to do so constitutes a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084, F.S.

Section 31. Amends s. 381.00315, F.S., to authorize the temporary reactivation of the inactive certification of a certified geriatric specialist in the event of a public health emergency.

Section 32. Amends s. 400.021, F.S., to add certified geriatric specialists to the individuals who may render nursing services in a nursing home.

Section 33. Amends s. 400.211, F.S., to permit the employment in a nursing home of a certified geriatric specialist as a CNA, just as a registered nurse or practical nurse could be employed as a CNA.

Section 34. Amends s. 400.23(3), F.S., to authorize the inclusion of certified geriatric specialists as nursing staff in the computation of nursing staffing minimums in a nursing home.

Section 35. Amends s. 409.908(2), F.S., to include certified geriatric specialists in the direct care subcomponent when patient costs are calculated for nursing home reimbursement by the Medicaid program.

Section 36. Amends s. 458.303(2), F.S., to permit certified geriatric specialists to practice under the direct supervision of a licensed physician.

Section 37. Amends s. 1009.65, F.S., to make certified geriatric specialists eligible for participation in the Medical Education Reimbursement and Loan Repayment Program, up to $4,000 per year.

Section 38. Amends s. 1009.66(2), F.S., to make certified geriatric specialists eligible for participation in the Nursing Student Loan Forgiveness Program.

Section 39. Provides an appropriation of $157,017 from the General Revenue Fund to AWI to support implementation of the pilot program.

Section 40. Amends s. 464.201, F.S., to define the "practice of a certified nursing assistant" to mean providing care and assisting persons with tasks relating to the activities of daily living. Such tasks are those associated with personal care, maintaining mobility, nutrition and hydration, toileting and elimination, assistive devices, safety and cleanliness, data gathering, reporting abnormal signs and symptoms, post mortem care, patient socialization and reality orientation, end-of-life care, CPR and emergency care, residents' or patients' rights, documentation of nursing assistant services, and other tasks that a certified nurse assistant may perform after training beyond that required for initial certification and upon validation of competence in that skill by a registered nurse. This section does not restrict the ability of any person who is otherwise trained and educated from performing such tasks.

Section 41. Amends s. 464.202, F.S., relating to the duties and powers of the Board of Nursing, to require the board to adopt rules regulating the practice of certified nursing assistants which specify the scope of practice authorized and level of supervision required for the practice of certified nursing assistants.

Section 42. Amends s. 464.203, F.S., relating to certified nursing assistants, to make persons applying to become a certified nursing assistant subject to national criminal history checks in lieu of the criminal background screening requirements under ch. 435, F.S. A procedure is specified for the submission of fingerprints and information to the Department of Health along with a payment equal to the costs incurred by the department. The Department of Health must review the results of the criminal history check and issue a license to any applicants who have met all of the other requirements for licensure and have no criminal history, and refer all applicants with criminal histories back to the Board of Nursing for determination as to whether a licensed should be issued and under what conditions.

Procedures for renewal of the certificate of a nursing assistant are specified. The Department of Health must renew a nursing assistant certificate upon receipt of a fee no greater than $50 biennially. The department must adopt rules establishing a procedure for the biennial renewal of certificates.

Section 43. Amends s. 464.204, F.S., to revise the grounds for which nursing assistants are subject to discipline for intentionally violating any provision of chapters 464 or 456, F.S., to no longer require proof that the act was done intentionally.

Section 44. Amends s. 467.013, F.S., relating to midwives to revise the requirements for placement of midwife's license on inactive status pursuant to department rule and to authorize the Department of Health to establish the application procedures. Continuing education requirements for midwives as part of license reactivation are eliminated.

Section 45. Amends s. 467.0135, F.S., relating to fees for midwives, to eliminate examination fees. The fees for licensure of midwives is revised to authorize the Department of Health to charge a renewal fee of $500 for an active license and $500 for an inactive license and to refund the application fee.

Section 46. Amends s. 467.017, F.S., relating to midwives, to revise requirements for emergency care plans to provide that a midwife submit an emergency care plan upon request of the Department of Health rather than at licensure renewal.

Section 47. Substantially rewords s. 468.352, F.S., relating to definitions for the regulation of respiratory care, to revise the definition of the various terms. "Critical care" is redefined to mean care given to a patient in any setting involving a life-threatening emergency. "Direct supervision" is redefined to mean supervision under the direction of a licensed, registered, or certified respiratory therapist who is physically on the premises and readily available, as defined by the board. The definition in current law for "noncritical care" is eliminated. The term, "physician supervision" (currently defined as "direct supervision") is defined to mean supervision and control by a licensed allopathic or osteopathic physician who assumes legal liability for the services rendered by the personnel employed in his or her office.

"Certified respiratory therapist" is redefined to mean any person licensed under part V, ch. 468, F.S., who is certified by the National Board for Respiratory Care or its successor, who is employed to deliver respiratory care services, under the order of a Florida-licensed allopathic or osteopathic physician in accordance with protocols established by a hospital or other health care provider or the Board of Respiratory Care, and who functions in situations of unsupervised patient contact requiring individual judgment. "Registered respiratory therapist" is redefined to mean any person licensed under this part who is registered by the National Board for Respiratory Care or its successor, and who is employed to deliver respiratory care services under the order of a Florida-licensed allopathic or osteopathic physician in accordance with protocols established by a hospital or other health care provider or the Board of Respiratory Care, and who functions in situations of unsupervised patient contact requiring individual judgment.

The "practice of respiratory care" or "respiratory therapy" is defined to mean the allied health specialty associated with the cardiopulmonary system that is practiced under the orders of a Florida-licensed allopathic or osteopathic physician and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the Board of Respiratory Care. "Respiratory care practitioner" is defined to mean any person licensed under part V, ch. 468, F.S., to deliver respiratory care services under direct supervision and pursuant to an order of a Florida-licensed allopathic or osteopathic physician.

The definition of "respiratory care services" is revised to include evaluation and disease management; diagnostic and therapeutic use of respiratory equipment, devices, or medical gas; administration of drugs, as duly ordered or prescribed by a Florida-licensed allopathic or osteopathic physician and in accordance with protocols, policies, and procedures established by a hospital or other health care provider or the Board of Respiratory Care; initiation, management, and maintenance of equipment to assist and support ventilation and respiration; diagnostic procedures, research, and therapeutic treatment and procedures; cardiopulmonary resuscitation; advanced cardiac life support, neonatal resuscitation, and pediatric advanced life support, or equivalent functions; insertion and maintenance of artificial airways and intravascular catheters; performing sleep-disorder studies; education; and the initiation and management of hyperbaric oxygen.

Section 48. Substantially rewords s. 468.355, F.S., relating to eligibility for respiratory care licensure and temporary licensure, to revise licensure requirements for respiratory therapists. To be eligible for licensure as a respiratory therapist an applicant must be certified as a "Certified Respiratory Therapist" or registered as a "Registered Respiratory Therapist" by the National Board for Respiratory Care, or its successor.

Section 49. Substantially rewords s. 468.368, F.S., relating to exemptions to respiratory care regulation for certain persons, to substantially revise the exemptions. Under the revised exemptions to respiratory care regulation, the regulation may not be construed to prevent or restrict the practice, service, or activities of: any person licensed in Florida by any other law from engaging in the profession or occupation for which he or she is licensed; any legally qualified person in Florida or another state or territory who is employed by the United States government while such person is discharging his or her official duties; a friend or family member who is providing respiratory care services to an ill person and who does not represent himself or herself to be a respiratory care practitioner or respiratory therapist; an individual providing respiratory care services in an emergency who does not represent himself or herself as a respiratory care practitioner or respiratory therapist; any individual employed to deliver, assemble, set up, or test equipment for use in a home, upon the order of a Florida-licensed allopathic or osteopathic physician; any individual performing polysomnography under medical direction as related to the diagnosis and evaluation of treatment for sleep disorders; any individual certified or registered as a pulmonary function technologist who is credentialed by the National Board for Respiratory Care for performing cardiopulmonary diagnostic studies; any student who is enrolled in an accredited respiratory care program approved by the Florida Board of Respiratory Care, while performing respiratory care as an integral part of a required course; the delivery of incidental respiratory care to noninstitutionalized persons by surrogate family members who do not represent themselves as registered or certified respiratory care therapists; and any individual credentialed in hyperbaric medicine by the Underseas Hyperbaric Society, or its equivalent as determined by the Florida Board of Respiratory Care, while performing related duties.

Section 50. Effective, January 1, 2004, repeals s. 468.356, F.S., which provides requirements for the approval of respiratory care therapy educational programs and repeals s. 468.357, F.S., which specifies procedures for the licensure by examination of persons wishing to practice as certified respiratory therapists.

Section 51. Amends s. 491.005, F.S., relating to clinical social work licensure by examination, to require applicants to pass a theory and practice examination that has been approved by the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling and to require that it may be taken only following the completion of the clinical experience requirement for clinical social workers. The licensure requirements are revised to allow applicants to satisfy all coursework requirements either by successfully completing the required course as a student or by teaching the required graduate course as an instructor or professor in an accredited institution.

Section 52. Amends s. 491.0145, F.S., relating to certified master social worker, to prohibit the Department of Health from adopting any rules that would allow a person who was not licensed as a certified master social worker in accordance with ch. 491, F.S., on January 1, 1990, to become licensed. In effect, this would prevent any additional applicants from being granted the designation.

Section 53. Creates s. 491.0146, F.S., to provide that all licenses to practice as a certified master social worker issued pursuant to ch. 491, F.S., and valid on October 1, 2002, remain in full force and effect.

Section 54. Amends s. 627.912, F.S., to increase the threshold amount to $50,000 or more for closed claims reported to the Department of Health for medical physicians, osteopathic physicians, or podiatric physicians. The threshold amount is increased to $25,000 or more for closed claims reported to the Department of Health for dentists.

Section 55. Amends s. 766.101, F.S., relating to medical review committees, to redefine "medical review committee" to add a committee established by a university board of trustees and a committee comprised of faculty, residents, students, and administrators of an accredited college of medicine, college of nursing, or other health care discipline.

Section 56. Repeals s. 456.031, F.S., which provides continuing education requirements on domestic violence; ss. 456.033, and 456.034, F.S., which provide requirements for continuing education relating to domestic violence and HIV and AIDS; s. 458.313,F.S., which provides requirements for medical physician licensure by endorsement; s. 458.316, F.S., which provides requirements for the issuance of a public health certificate to practice medicine; s. 458.3165, F.S., which provides requirements for the issuance of a public psychiatry certificate; and s. 458.317, F.S., which provides requirements for the issuance of limited licenses to practice medicine in Florida.

Section 57. Creates an undesignated section of law, to provide that all payments made after July 1, 2003, by the Department of Health to the Division of Administrative Hearings which are based on a formula in effect prior to that date must revert to the Department of Health. Effective July 1, 2004, the Division of Administrative Hearings must bill the Department of Health in accordance with s. 456.073(5), F.S. as created in this bill.

The Office of Program Policy Analysis and Government Accountability and the Auditor General are required to conduct a joint audit of all hearings and billings conducted by the Division of Administrative Hearings for all state agencies and nonstate agencies. The findings and recommendations regarding the manner in which the Division of Administrative Hearings charges for its services must be presented in a report to the President of the Senate and the Speaker of the House of Representatives on or before January 1, 2003. The report must recommend alternative billing formulas.

Section 58. Creates the "Florida Alzheimer's Training Act" in sections 58 – 61 of the bill.

Sections 59 - 61. Amend ss. 400.4785, 400.5571, and 400.6045, F.S., to require home health agencies, hospices and adult day care centers to provide written information to employees, upon their beginning employment, about interacting with patients or participants who have Alzheimer's disease or dementia-related disorders. Employees of these services must subsequently receive training in the care of individuals with Alzheimer's disease or related disorders.

Under amendments to s. 400.4786, F.S., all newly hired home health agency employees providing direct care to patients must complete four hours of training in Alzheimer's disease and dementia-related disorders within 9 months after beginning employment with the agency. Nearly all of the 1,091 home health agencies in Florida provide services to elderly persons with the exception of a small number (less than 50) that specialize in pediatric patients. As an indication of the number of newly hired staff that may be affected by the bill, the Florida Department of Labor estimated that there were 28,989 home health aides in 1996 and projected that there would be 52,171 aides in 2006. There may also be a large number of nurses, therapists and other employees who would be required to be trained upon employment with a home health agency. Future estimates of new employees and personnel for adult day care centers and hospices are unknown.

Newly hired hospice employees (under s. 400.6045, F.S.) and adult day care center personnel (under s. 400.5571, F.S.) who are expected to, or whose responsibilities require them to, have direct contact with participants who have Alzheimer's disease or dementia-related disorders must complete at least one hour of dementia training within the first three months after beginning employment. Newly hired hospice and adult day care center employees who will be providing direct care to participants who have Alzheimer's or dementia-related disorders must complete an additional three hours of training within nine months after beginning employment. An employee who is hired on or after July 1, 2003, must complete the required training by July 1, 2004, or by the deadline specified in the bill, whichever is later.

Employees who have received the Alzheimer's training would not be required to repeat it if they change employment to another home health agency, hospice, adult day care center, nursing home or assisted living facility. While home health agencies, hospices and adult day care centers will be required to provide Alzheimer's disease information to all their employees, the bill makes it the responsibility of the employee as well as the provider to obtain the training.

The Department of Elderly Affairs (DOEA) or its designee must approve the one-hour, three-hour and four-hour training courses, and DOEA must develop rules to establish standards for employees who are subject to the training and for the trainers and the training. The training requirements currently in place for nursing homes and assisted living facilities provide for a one hour and three-hour program. DOEA must keep a list of current approved training providers.

The bill mandates that the four hours of training must be part of the total hours of training required annually as a condition of certification for certified nursing assistants. Licensed health care practitioners' continuing education hours would be counted toward the four hours required by the bill.

Section 62. This section and sections 25- 41 of the bill take effect upon becoming a law, and except as otherwise expressly provided in this bill, the act takes effect July 1, 2003.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Art. III, ss. 19(f) of the Florida Constitution.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Certified nursing assistants will be subject to a license renewal fee no greater than $50 biennially.

For provisions of the bill relating to geriatric specialists:

	FY 2003-04 Amount	FY 2004-05 Amount	FY 2005-06 Amount
Application fee for registration as a certified geriatric specialist - Total Estimated Revenue		$4,000	

Department of Health estimate for FY 2004-05 assumes 40 certified geriatric specialists would be licensed.

B. Private Sector Impact:

The bill requires medical licensure applicants to use the Federation of State Medical Boards Verification Service (FCVS). This service will cost the applicant $250.

According to AHCA, the actual cost for Alzheimer's training to all the providers in this bill cannot be determined at this time. Since some of the training will be used toward individuals' certification or licensure, some of the costs are likely to be borne by the individuals; however, the home health agencies, adult day care centers and hospices are also expected to bear some of the new training costs. The fee structure for the training of the employees has not been determined; however, the fees and cost to assisted living facility employees are currently defined in rule. In Chapter 58A-5.0191(11), F.A.C., the Alzheimer's training fees range from no charge to $30.

C. Government Sector Impact:

The Division of Administrative Hearings (DOAH) will incur a potential cost reallocation to follow the formula outlined.

DOH reports that the 45-day timeframe for election of a formal hearing may have the effect of reducing the number of cases being referred to the Division of Administrative Hearings and, thereby, reducing the annual costs of formal hearings. This section also changes the methodology for billing the department for costs of formal hearings. The fiscal impact on the Medical Quality Assurance Trust Fund (MQATF) is substantial. In FY 2002-2003, the MQATF was charged $2,159,008 for DOAH services and it is anticipated that reimbursement in FY 03-04 will be $1,429,367. The number of actual hearing hours in FY 00-01 was 824 and in FY 2001-2002 it was 716. By using an average of 770 actual hearing hours, the cost for DOAH services is estimated at $77,000 plus a one-time fee of $50 for an estimated 250 cases per year or a total of $89,500. It is indeterminate as to the amount of expenses that would be incurred by DOAH in cases cancelled 21 days or less from the scheduled date of the hearing. Estimated cost savings to the MQATF are computed by assuming that annual DOAH costs would be $100,000 in lieu of $1,429,367 for a net savings estimated at $1,329,367 in fiscal year 2003-2004 and year 2004-2005.

The Office of Program Policy Analysis and Government Accountability and the Auditor General will have costs to jointly conduct the audit of the Division of Administrative Hearings.

The Department of Health will incur minimal costs to revise existing administrative rules for the Board of Respiratory Care.

According to the Agency for Health Care Administration, there should not be a significant fiscal impact to the Agency. The Department of Elderly Affairs would incur the cost for developing standards for the training through rules, approving trainers, and maintaining lists of approved trainers.

For provisions of the bill creating the Clara Ramsey Act:

FISCAL IMPACT ON AWI:	**FY 2003-04 Amount / FTE**	**FY 2004-05 Amount / FTE**	**FY 2005-06 Amount / FTE**
Program Manager	$6,360	$6,360	$6,360
Data Processing	$1,000	$1,000	$1,000
Fringe Benefits (35%)	$2,576	$2,576	$2,576
Indirect Costs (15.51%)	$1,541	$1,541	$1,541
Staff Travel 2 trips /month x 2 people x 400mi @ $.29 x 12 months	$5,560	$5,560	$5,560
Contracted Services for reporting, coordination, correlation site visits and evaluation:	$72,500/ 1 FTE	$72,500/ 1 FTE	$72,500/ 1 FTE

FISCAL IMPACT ON AWI:	FY 2003-04 Amount / FTE	FY 2004-05 Amount / FTE	FY 2005-06 Amount / FTE
Tuition, Books, Fees, Medicals and Training Supplies: 24 participants per Program Sites @ $2,000 per year	$48,000	$96,000	$48,000
Travel Expenses for Steering Committee Meetings			
4 trips x 6 persons x $350 airfare	$ 8,400		
4 trips x 6 persons x 50 (per diem) x 2 days	$ 2,400		
4 trips x 6 persons x $30 x 2 days (car)	$ 4,440		
4 trips x 2 nights lodging@ $80 x 6 persons	$ 3,840		
Annual total	$19,080	$19,080	$19,080
Duplication/Printing of Annual Reports / Final Evaluation	$ 400	$ 400	$ 400
Total Annual Cost:	$157,017	$205,017	$159,537

FISCAL IMPACT ON THE DEPARTMENT OF HEALTH:	FY 2004-05 Amount / FTE	FY 2005-06 Amount/FTE
Non-Recurring:		
EXPENSE: Standard Expense Package	$2,603	
OCO: Standard OCO Package	$2,000	
Total Non-Recurring	$4,603	
Recurring and Annualized Continuation Effects:		
Salaries/Benefits: Regulatory Specialist I	$42,230	$42,230
EXPENSES: Standard Expense Package	$5,416	$5,416
Total Recurring Costs	$47,646	$47,646
Total of Estimated Non-recurring and Recurring Expenses	$52,249	$47,646

One RSI, pay grade 15, would be required starting in year 2. The annual mid-point for pay band 3 was used to establish recurring salary and benefits. There may be other indeterminate costs associated with implementing this program such as modifying PRAES (the Medical Quality Assurance practitioner data base), printing forms, etc.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Amendments:

None.