FLORIDA HOUSE OF REPRESENTATIVES
BILL ANALYSIS

This bill analysis was prepared by nonpartisan committee staff and does not constitute an official statement of legislative intent.

BILL #: CS/HB 353	**COMPANION BILL:** SB 844 (Jones)
TITLE: Sickle Cell Care Management and Treatment Continuing Education	**LINKED BILLS:** None
SPONSOR(S): Robinson, F.	**RELATED BILLS:** None

Committee References

Health Professions & Programs
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Health & Human Services

SUMMARY

Effect of the Bill:
CS/HB 353 requires information related to the treatment of pain for patients with sickle cell disease to be included in the continuing education course on controlled substance prescribing required for licensure renewal of certain health care practitioners registered to prescribe controlled substances.

Fiscal or Economic Impact:
The bill has no fiscal impact on state or local government and a nominal fiscal impact on the private sector.

See Fiscal or Economic Impact

JUMP TO SUMMARY ANALYSIS RELEVANT INFORMATION BILL HISTORY

ANALYSIS

EFFECT OF THE BILL:

CS/HB 353 requires information related to the treatment of pain for patients with sickle cell disease (SCD) to be included in the continuing education (CE) course on controlled substance prescribing required for the biennial licensure renewal of allopathic physicians[1] and osteopathic physicians[2] registered with the United States Drug Enforcement Agency (DEA) to prescribe controlled substances.[3] (Section 1).

The addition of this material ensures that these prescribers have some familiarity with the unique features of SCD pain crises and may prevent undertreatment.

The bill provides an effective date of July 1, 2026. (Section 2).

FISCAL OR ECONOMIC IMPACT:

PRIVATE SECTOR:

CE providers that offer the controlled substances CE required under s. 456.44, F.S., will need to update the course content to incorporate the content required by the bill, in order for the course to continue satisfying the requirement, which may result in an increased workload.

[1] Allopathic (medical) physicians are licensed under ch. 458, F.S.
[2] Osteopathic physicians are licensed under ch. 459, F.S.
[3] While this requirement applies to all prescribers registered with the DEA, a practitioner is exempt from the CE requirement in s. 456.0301, F.S., if they are otherwise required under the applicable practice act to complete a minimum of two hours of CE coursework on the safe and effective prescribing of controlled substances. Dentists and podiatric physicians are required in the respective practice acts to complete a minimum of two hours on the subject, while APRNs and PAs must complete a minimum of three hours pursuant to their own practice acts.

RELEVANT INFORMATION

SUBJECT OVERVIEW:

Sickle Cell Disease

Sickle cell disease (SCD) is an inherited blood disorder affecting approximately 100,000 people in the United States.[4] SCD is both a rare disease, in that it affects fewer than 200,000 people nationally,[5] as well as the most common inherited blood disorder in the United States.[6] More than 90 percent of people affected by SCD in the United States are of Black or African American heritage.[7] SCD is a lifelong condition that is present and detectable at birth; children born in the United States are screened for SCD at birth in every state.[8] Florida began screening newborns for SCD in 1988.[9]

There are many forms of SCD of varying levels of severity, all of which are inherited and affect the body's red blood cells. Sickle cell anemia (SCA) is the most common and severe form of the disease; in SCA, abnormal hemoglobin causes red blood cells to become rigid and buckle into the iconic sickle shape. The deformed red blood cells damage blood vessels and over time contribute to a cascade of negative health effects beginning in infancy, such as intense vasocclusive pain episodes, strokes, organ failure, and recurrent infections.[10]

The severity of complications from SCD generally worsen as people age, but treatment and prevention strategies can mitigate complications and lengthen the lives of people with SCD.[11] SCD was historically perceived as a childhood disease due to high rates of childhood mortality, however, more than 90 percent of those living with the disease today are expected to survive into adulthood.[12] Roughly 60 percent of individuals with SCD in the US today are adults, but the life expectancy of individuals with SCD remains approximately 22 years shorter than the general population.[13]

Management of Sickle Cell Disease

SCD management primarily focuses on treating and preventing complications caused by the disease such as infection, stroke, vision loss, severe anemia, and acute pain episodes. The most well-researched treatments for SCD relate to mitigating the risk of infection and stroke in children. While there have been developments in recent years, there remains a lack of research-driven data specific to adult populations with SCD and a knowledge gap among providers regarding the best practice in managing and treating complications of SCD.[14]

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[4] Centers for Disease Control and Prevention, *Data & Statistics on Sickle Cell Disease*. Available at https://www.cdc.gov/sickle-cell/data/?CDC_AAref_Val=https://www.cdc.gov/ncbddd/sicklecell/data.html (last visited February 5, 2026).
[5] National Organization for Rare Disorders, *NORD Rare Disease Database*. Available at https://rarediseases.org/rare-diseases/ (last visited February 5, 2026).
[6] American Society of Hematology, *Sickle Cell Disease*. Available at https://www.hematology.org/education/patients/anemia/sickle-cell-disease (last visited February 5, 2026).
[7] *Supra*, note 4.
[8] National Organization for Rare Disorders, *Sickle Cell Disease* (2024). Available at https://rarediseases.org/rare-diseases/sickle-cell-disease/ (last visited February 5, 2026).
[9] *See*, Rule 64C-7.002, F.A.C.
[10] *Supra*, note 8.
[11] *Supra*, note 4.
[12] DiMartino, L. D., Baumann, A. A., Hsu, L. L., Kanter, J., Gordeuk, V. R., Glassberg, J., Treadwell, M. J., Melvin, C. L., Telfair, J., Klesges, L. M., King, A., Wun, T., Shah, N., Gibson, R. W., Hankins, J. S., & Sickle Cell Disease Implementation Consortium (2018). *The sickle cell disease implementation consortium: Translating evidence-based guidelines into practice for sickle cell disease.* American journal of hematology, 93(12), E391–E395. https://doi.org/10.1002/ajh.25282.
[13] Lubeck D, Agodoa I, Bhakta N, et al. (2019) *Estimated Life Expectancy and Income of Patients With Sickle Cell Disease Compared With Those Without Sickle Cell Disease*. JAMA Netw Open. 2019;2(11):e1915374. doi:10.1001/jamanetworkopen.2019.15374. Available at https://jamanetwork.com/journals/jamanetworkopen/article-abstract/2755485 (last visited February 8, 2026).
[14] Adams-Graves, P. & Bronte-James, L. *Recent Treatment Guidelines for Managing Adult Patients with Sickle Cell Disease: Challenges in Access to Care, Social Issues, and Adherence*. (2016). Expert Review of Hematology, 9:6, 511-614. http://dx.doi.org/10.1080/17474086.2016.1180242 *See also*, Smeltzer, M.P., Howell, K.E., Treadwell, M. (2021). *Identifying barriers to evidence-based care for sickle cell disease: results from the Sickle Cell Disease Implementation Consortium cross-sectional survey of healthcare providers in the USA*. BMJ Open 2021. DOI: 10.1136/bmjopen-2021-050880

The nature of SCD inherently leads to a greater use of health care services compared to the general population, but gaps in access to appropriate care are common and lead to unmitigated health crises and a greater consumption of costly emergency medical services.[15] Health care practitioners who have not specialized in the treatment of SCD express discomfort in prescribing essential treatments for SCD,[16] and a lack of knowledge regarding recent treatment developments.[17]

Access to adequate care is especially challenging for young adults transitioning from pediatric to adult care settings.[18] While SCD has historically been associated with childhood mortality, more than 90 percent of those living with the disease are expected to survive into adulthood today.[19] The system of care for SCD has developed with a focus on pediatric patients; as a result, patients with SCD are more likely to receive well-managed preventative care as children through specialized pediatric programs. Patients aging out of pediatric care and transitioning into adult care are less likely to have access to consistent and appropriate SCD care, which leads to higher rates of emergency department reliance than other age groups.[20]

Use of Opioids in Treating SCD Pain Crises

Opioids are commonly necessary for treating the severe pain that results from acute vasocclusive pain crises, which are the most common cause of hospital admissions for individuals with SCD.[21] SCD patients with three or more admissions to the hospital for sickle cell pain are at an increased risk of death.[22] While opioids are not generally recommended for treatment of chronic pain associated with SCD due to the significant risks of overdose and addiction associated with frequent opioid use, they are, however, very effective for treating instances acute severe pain. [23]

Patients with SCD who present to emergency care settings in the midst of pain crises may be perceived as drug seekers or abusers and have their pain severity doubted and undertreated.[24] Educational gaps and biases among

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[15] DiMartino, L. D., Baumann, A. A., Hsu, L. L., Kanter, J., Gordeuk, V. R., Glassberg, J., Treadwell, M. J., Melvin, C. L., Telfair, J., Klesges, L. M., King, A., Wun, T., Shah, N., Gibson, R. W., Hankins, J. S., & Sickle Cell Disease Implementation Consortium (2018). *The sickle cell disease implementation consortium: Translating evidence-based guidelines into practice for sickle cell disease.* American journal of hematology, 93(12), E391–E395. https://doi.org/10.1002/ajh.25282. *See also*, Brousseau, D.C., Owens, P.L., Mosso, A.L., Panepinto, J.A., Steiner, C.A. (2010). *Acute Care Utilization and Rehospitalizations for Sickle Cell Disease*. JAMA. 2010;303(13):1288–1294. doi:10.1001/jama.2010.378

[16] Lanzkron S, Haywood C Jr, Hassell KL, Rand C. *Provider barriers to hydroxyurea use in adults with sickle cell disease: a survey of the sickle cell disease adult provider network*. (2008) Journal of the National Medical Association. 100(8): 968-973. https://doi.org/10.1016/S0027-9684(15)31419-X

[17] Robinson, K., Esgro, R., Cooper, S., LoPresti, M., & Carson, B. *Identifying and Addressing Knowledge and Confidence Gaps Regarding the Management of Patients with Sickle Cell Disease Via Engaging Continuing Medical Education*. (2023). *Blood* 142 (Supplement 1): 7228. doi: https://doi.org/10.1182/blood-2023-177576

[18] Hemker, B., Brouseau, D., Yan, K., Hoffmann, R., & Panepinto. *When Children with Sickle Cell Disease Become Adults: Lack of Outpatient Care Leads to Increased Use of the Emergency Department* (2011). American Journal of Hematology. 86:10, 863-865. https://doi.org/10.1002/ajh.22106

[19] *Id*.

[20] Blinder, M. A., Duh, M. S., Sasane, M., Trahey, A., Paley, C., & Vekeman, F. (2015). *Age-Related Emergency Department Reliance in Patients with Sickle Cell Disease*. The Journal of emergency medicine, 49(4), 513–522.e1. https://doi.org/10.1016/j.jemermed.2014.12.080

[21] Ballas, S., Opioids and Sickle Cell Disease: From Opium to the Opioid Epidemic (2021). Cardeza Foundation for Hematologic Research. Paper 67. Available at https://jdc.jefferson.edu/cgi/viewcontent.cgi?article=1065&context=cardeza_foundation (last visited February 7, 2026).

[22] American College of Emergency Physicians, *Sickle Cell: Guidance on evaluation and management of patients with Sickle Cell Disease in the ED* (2023). Available at https://poctools.acep.org/POCTool/SickleCell/df0c5789-695b-4ceb-8fde-9f3db269a26d (last visited February 8, 2026).

[23] Brandow, A.M., et al., *American Society of Hematology 2020 guidelines for sickle cell disease: management of acute and chronic pain*. (2020). *Blood Adv* 2020; 4 (12): 2656–2701. doi: https://doi.org/10.1182/bloodadvances.2020001851

[24] DiMartino, L. D., Baumann, A. A., Hsu, L. L., Kanter, J., Gordeuk, V. R., Glassberg, J., Treadwell, M. J., Melvin, C. L., Telfair, J., Klesges, L. M., King, A., Wun, T., Shah, N., Gibson, R. W., Hankins, J. S., & Sickle Cell Disease Implementation Consortium (2018). *The sickle cell disease implementation consortium: Translating evidence-based guidelines into practice for sickle cell disease.* American journal of hematology, 93(12), E391–E395. https://doi.org/10.1002/ajh.25282

providers, staff, and patients create barriers to communication and trust, and erode the provider–patient relationship, which can result in inadequate or inappropriate treatment of patients.[25]

According to both the American Society of Hematology SCD Guidelines[26] and the American College of Emergency Physicians (ACEP), the severity of sickle cell pain necessitates pain medication be administered within 60 minutes of arrival at the emergency department.[27] ACEP further recommends not to wait for lab results before initiating pain medications, as there are no lab values that can confirm or rule-out a sickle cell pain crisis.[28]

Health Care Professional Licensure

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.[29] The MQA works in conjunction with 22 professional boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions. Every profession is regulated by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA, as well as a profession- or field-specific practice act which outlines requirements and standards that vary by profession and establishes the individual professional boards. Professional boards are responsible for approving or denying applications for initial licensure,[30] establishing continuing medical education requirements,[31] and are involved in disciplinary hearings.[32]

Controlled Substance Prescribing

Current law allows for physicians,[33] physician assistants (PAs),[34] advanced practice registered nurses (APRNs),[35] podiatric physicians,[36] and dentists[37] to be authorized to prescribe controlled substances to treat chronic malignant pain, pursuant to the requirements and restrictions in their respective practice acts. In order to be authorized to prescribe controlled substances to treat chronic nonmalignant pain, a practitioner must designate themselves as a controlled substance prescribing practitioner on his or her practitioner profile and comply with all requirements specified in s. 456.44, F.S., and in rules established by the respective professional board.[38] Federal law requires a practitioner to register with the United States Drug Enforcement Administration (DEA) before he or she may lawfully dispense[39] a controlled substance.[40]

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[25] Glassberg, G., *Improving Emergency Department-Based Care of Sickle Cell Pain* (2017). Hematology. American Society of Hematology. Education Program, 2017(1), 412–417. https://doi.org/10.1182/asheducation-2017.1.412

[26] American Society of Hematology, *ASH Clinical Practice Guidelines: ASH SCD Guidelines: Management of Acute and Chronic Pain* (2020). Available at https://www.hematology.org/education/clinicians/guidelines-and-quality-care/clinical-practice-guidelines/scd-guidelines-management-of-acute-and-chronic-pain (last visited February 7, 2026).

[27] American College of Emergency Physicians, Sickle Cell: Guidance on evaluation and management of patients with Sickle Cell Disease in the ED (2023). Available at https://poctools.acep.org/POCTool/SickleCell/df0c5789-695b-4ceb-8fde-9f3db269a26d (last visited February 8, 2026).

[28] *Id*.

[29] Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dieticians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, mental health counselors, and psychotherapists, among others.

[30] S. 456.013, F.S.

[31] *Id*.

[32] S. 456.072, F.S

[33] Allopathic physicians licensed under ch. 458, F.S., and osteopathic physicians licensed under ch. 459, F.S.

[34] *See*, ss. 458.347(4)(f), F.S., and 459.022(8)(c), F.S.

[35] *See*, s. 464.012(6)(a), F.S.

[36] *See*, s. 461.003(5), F.S.

[37] *See*, s. 466.02751, F.S.

[38] S. 456.44(2), F.S., Rule 64B18-23.002(2)(g), F.A.C.

[39] Federal law relating to drug abuse prevention and control states that the term "dispense" means "to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term "dispenser" means a practitioner who so delivers a controlled substance to an ultimate user or research subject. 21 U.S.C. § 802(10).

[40] 21 U.S.C. § 822(a)(2); 21 C.F.R. § 1301.11(a).

As a condition to receiving DEA registration, a practitioner must complete at least 8 hours of training on the treatment and management of patients with opioid or other substance use disorders, the safe pharmacological management of dental pain and screening, brief intervention, and referral for appropriate treatment of patients with or at risk of developing opioid or other substance use disorders.[41]

Federal law makes it unlawful for a registrant to dispense a controlled substance not authorized by his or DEA registration to another registrant or other authorized person.[42] A registrant who engages in such unlawful practice is subject to a civil penalty of not more than $25,000 and to criminal prosecution.[43]

Continuing Education Requirements

Health care practitioners are required to complete continuing education (CE) courses as a condition of biennial licensure renewal. The number of CE hours that a health care practitioner must complete and the prescribed subjects vary by profession. A health care practitioner may be subject to disciplinary action for failure to comply with CE requirements.[44]

Current law requires all health care practitioners who are registered with the United States DEA to prescribe controlled substances to complete a board-approved 2-hour CE course on prescribing controlled substances as a condition of licensure renewal.[45] The course must address:[46]

- The current standards for prescribing controlled substances, particularly opiates;
- Alternatives to controlled substances;
- Nonpharmacological therapies;
- Emergency opioid antagonists; and
- The risks of opioid addiction following all stages of treatment in the management of acute pain.

There is no requirement in current law for this course to contain information related to the treatment of pain associated with SCD.

The controlled substances CE must be offered by a statewide professional association of physicians in this state that is accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 Credit or the American Osteopathic Category 1-A continuing medical education credit.[47] The Florida Medical Association and the Florida Osteopathic Medical Association are the only entities that meet these criteria.

A practitioner is exempt from this specific CE requirement if they are otherwise required under the applicable practice act to complete a minimum of two hours of CE coursework on the safe and effective prescribing of controlled substances.[48] Dentists[49] and podiatric physicians[50] are required in the respective practice acts to complete a minimum of two hours on the subject, while APRNs[51] and PAs[52] must complete a minimum of three hours pursuant to their own practice acts. As such, the required course content as specified by s. 456.0301, F.S., only expressly applies to allopathic and osteopathic physicians registered with the DEA.

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[41] 21 U.S.C. § 823(m)(1).
[42] 21 U.S.C. § 842(a)(2).
[43] 21 U.S.C. § 842(c).
[44] S. 456.072, F.S.
[45] S. 456.0301(1), F.S.
[46] *Id.*
[47] *Id.*
[48] S. 456.0301(1)(a), F.S.
[49] *See*, s. 466.0135, F.S.
[50] *See*, s. 461.007(3), F.S.
[51] *See*, s. 464.013(3)(b), F.S.
[52] *See*, ss. 458.347(4)(e), F.S., and 459.022(4)(e), F.S.

Controlled Substances

Florida Law

Chapter 893, F.S., the Florida Comprehensive Drug Abuse Prevention and Control Act, classifies controlled substances into five categories, called schedules. These schedules regulate the manufacture, distribution, preparation, and dispensing of the substances listed therein. The distinguishing factors between the different drug schedules are the "potential for abuse"[53] of the substance and whether there is a currently accepted medical use for the substance.[54]

The controlled substance schedules are as follows.

- Schedule I substances have a high potential for abuse and currently have no accepted medical use in the United States, including substances such as cannabis, heroin, LSD, MDMA, and psilocybin and psilocin.[55]
- Schedule II substances have a high potential for abuse and have a currently accepted but severely restricted medical use in the United States, including substances such as amphetamine, codeine, fentanyl, methamphetamine, morphine, raw opium, and oxycodone.[56]
- Schedule III substances have a potential for abuse less than the substances contained in Schedules I and II and have a currently accepted medical use in the United States, including substances such as anabolic steroids and ketamine.[57]
- Schedule IV substances have a low potential for abuse relative to substances in Schedule III and have a currently accepted medical use in the United States, including substances such as benzodiazepines and barbiturates.[58]
- Schedule V substances have a low potential for abuse relative to the substances in Schedule IV and have a currently accepted medical use in the United States, including substances such as mixtures that contain small quantities of opiates, narcotics, or stimulants.[59]

Federal Law

The Federal Controlled Substances Act[60] also classifies controlled substances into schedules based on the potential for abuse and whether there is a currently accepted medical use for the substance. The Drug Enforcement Administration (DEA) is required to consider the following when determining where to schedule a substance:[61]

- The substance's actual or relative potential for abuse;
- Scientific evidence of the substance's pharmacological effect, if known;
- The state of current scientific knowledge regarding the substance;
- The substance's history and current pattern of abuse;
- The scope, duration, and significance of abuse;
- What, if any, risk there is to public health;

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[53] S. 893.02(22), F.S., defines "potential for abuse" to mean that a substance has properties as a central nervous system stimulant or depressant or a hallucinogen that create a substantial likelihood of its being: 1) used in amounts that create a hazard to the user's health or safety of the community; 2) diverted from legal channels and distributed through illegal channels; or 3) taken on the user's own initiative rather than on the basis of professional medical advice.
[54] *See* s. 893.03, F.S.
[55] S. 893.03(1), F.S.
[56] S. 893.03(2), F.S.
[57] S. 893.03(3), F.S.
[58] S. 893.03(4), F.S.
[59] S. 893.03(5), F.S.
[60] 21 U.S.C. § 812.
[61] 21 U.S.C. § 811(c).

- The substance's psychic or physiological dependence liability; and
- Whether the substance is an immediate precursor of a substance already controlled.

RECENT LEGISLATION:

YEAR	BILL #/SUBJECT	HOUSE/*SENATE* SPONSOR(S)	OTHER INFORMATION
2025	HB 333 - Sickle Cell Care Management and Treatment Education	Robinson, F./ *Rouson*	Died in the Health Care Professions & Programs Subcommittee
2024	CS/HB 349 - Sickle Cell Care Management and Treatment Education	Robinson, F./ *Rouson*	Died in the Health & Human Services Committee

BILL HISTORY

COMMITTEE REFERENCE	ACTION	DATE	STAFF DIRECTOR/ POLICY CHIEF	ANALYSIS PREPARED BY
Health Professions & Programs Subcommittee	15 Y, 0 N, As CS	2/11/2026	McElroy	Osborne
THE CHANGES ADOPTED BY THE COMMITTEE:	Removed a new continuing education requirement for physicians and nurses related to sickle cell disease.			
Health & Human Services Committee				

THIS BILL ANALYSIS HAS BEEN UPDATED TO INCORPORATE ALL OF THE CHANGES DESCRIBED ABOVE.
