Tab 2	**SB 684** by **Brandes (CO-INTRODUCERS) Book, Perry, Montford, Taddeo, Stewart**; (Identical to H 00649) Dental Therapy

842698	A	S	CF, Brandes	Delete L.979 - 1010.	03/15 04:04 PM
972568	A	S L	CF, Rader	Delete L.621 - 852:	03/18 03:30 PM

Tab 3	**SB 686** by **Brandes**; (Identical to H 00471) Fees/Dental Therapists

Tab 4	**SB 818** by **Book**; Mental Health

Tab 5	**SB 1218** by **Book**; (Similar to H 01353) Homelessness

371296	A	S	CF, Book	Delete L.219 - 220:	03/15 04:04 PM

Tab 6	**SB 1300** by **Benacquisto**; (Identical to H 06047) Florida ABLE Program

Tab 7	**SB 1346** by **Gruters**; (Similar to H 01071) Public Records/Homelessness Counts and Databases

The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

CHILDREN, FAMILIES, AND ELDER AFFAIRS
Senator Book, Chair
Senator Mayfield, Vice Chair

MEETING DATE: Monday, March 18, 2019
TIME: 4:00—6:00 p.m.
PLACE: 301 Senate Building

MEMBERS: Senator Book, Chair; Senator Mayfield, Vice Chair; Senators Bean, Harrell, Rader, Torres, and Wright

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Presentation on Behavioral Health		
2	**SB 684** Brandes (Identical H 649, Compare H 471, Linked S 686)	Dental Therapy; Authorizing Medicaid to reimburse for dental services provided in a mobile dental unit that is owned by, operated by, or contracted with a health access setting or another similar setting or program; requiring the chair of the Board of Dentistry to appoint a Council on Dental Therapy effective after a specified timeframe; authorizing the board to require any person who applies to take the examination to practice dental therapy in this state to maintain medical malpractice insurance in a certain amount, etc. CF 03/18/2019 AHS AP	
3	**SB 686** Brandes (Identical H 471, Compare H 649, Linked S 684)	Fees/Dental Therapists; Revising the licensure requirements for dental therapists to include application and examination fees, etc. CF 03/18/2019 AHS AP	
4	**SB 818** Book	Mental Health; Authorizing public defenders and regional counsel to have access to persons held in a facility licensed under chapter 394 or chapter 397; requiring that respondents with a serious mental illness be afforded essential elements of care and placed in a continuum of care regimen; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case in chief; revising the requirements for when a person may be taken to a receiving facility for involuntary examination, etc. CF 03/18/2019 JU AP	

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
5	**SB 1218** Book (Similar H 1353)	Homelessness; Requiring that certain taxes of a specified amount be transferred annually to the Grants and Donations Trust Fund within the Department of Children and Families for the purpose of funding challenge grants; increasing the number of members on the Council on Homelessness to include a representative of the Florida Housing Coalition and the Secretary of the Department of Elder Affairs or his or her designee; revising the duties of the State Office on Homelessness, etc. CF 03/18/2019 AHS AP	
6	**SB 1300** Benacquisto (Identical H 6047)	Florida ABLE Program; Repealing provisions relating to the scheduled reversion of provisions related to the distribution of funds in an ABLE account upon the death of a designated beneficiary, etc. CF 03/18/2019 AHS AP	
7	**SB 1346** Gruters (Similar H 1071)	Public Records/Homelessness Counts and Databases; Creating an exemption from public records requirements for individual identifying information contained in certain homelessness counts and databases; providing for retroactive application of the exemption; providing for future legislative review and repeal of the exemption; providing a statement of public necessity, etc. CF 03/18/2019 GO RC	
	Other Related Meeting Documents		

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 684
INTRODUCER:	Senator Brandes and others
SUBJECT:	Dental Therapy
DATE:	March 15, 2019
REVISED:	

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

I. Summary:

SB 684 authorizes the Department of Health ("DOH") to issue a dental therapist license to an applicant who possesses a degree or certificate in dental therapy from an accredited program. The bill authorizes a licensed dental therapist to perform remediable tasks under the general supervision of a dentist. The bill provides a scope of practice for dental therapists and requires the Board of Dentistry to appoint and establish members of the Council of Dental Therapy.

The bill also authorizes Medicaid to reimburse for dental services provided in a mobile dental unit owned by a health access setting.

The bill will likely have an indeterminate fiscal impact and provides an effective date of July 1, 2019.

II. Present Situation:

Regulation of Dental Practice in Florida

The Board of Dentistry ("the board") regulates dental practice in Florida, including dentists, dental hygienists, and dental assistants under the Dental Practice Act.[1] A dentist is licensed to examine, diagnose, treat, and care for conditions within the human oral cavity and its adjacent tissues and structures.[2] A dental hygienist provides education, preventive and delegated therapeutic dental services.[3]

Any person wishing to practice dentistry in this state must apply to DOH and meet specified requirements. Section 466.006, F.S., requires dentistry licensure applicants to sit for a national

[1] Section 466.004, F.S.
[2] Section 466.003(3), F.S.
[3] Section 466.003(4)-(5), F.S.

exam, a state exam, and a practicum exam.[4] To qualify to take the Florida dental licensure examination, an applicant must be 18 years of age or older, be a graduate of a dental school accredited by the American Dental Association or be a student in the final year of a program at an accredited institution, and have successfully completed the National Board of Dental Examiners (NBDE) dental examination.

Dentists must maintain professional liability insurance or provide proof of professional responsibility. If the dentist obtains professional liability insurance, the coverage must be at least $100,000 per claim, with a minimum annual aggregate of at least $300,000.[5] Alternatively, a dentist may maintain an unexpired, irrevocable letter of credit in the amount of $100,000 per claim, with a minimum aggregate availability of credit of at least $300,000.[6] The professional liability insurance must provide coverage for the actions of any dental hygienist supervised by the dentist.[7]

Health Professional Shortage Areas

The U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) designates Health Professional Shortage Areas (HPSAs) according to criteria developed in accordance with section 332 of the Public Health Services Act. HPSA designations are used to identify areas and population groups within the United States that are experiencing a shortage of health care provider shortages in primary care, dental health, or mental health.[8] The threshold for a dental HPSA is a population-to-provider ratio of at least 5,000:1.[9]

Medically Underserved Area

HRSA also designates Medically Underserved Areas (MUAs) and Medically Underserved Populations (MUPs). MUAs and MUPs identify geographic areas and populations with a lack of access to primary care services.[10] MUAs have a shortage of primary care health services for residents within a geographic area such as a county, a group of neighboring counties, a group of urban census tracts, or a group of county or civil divisions.[11] MUPs are specific sub-groups of people living in a defined geographic area with a shortage of primary care health services who may face economic, cultural, or linguistic barriers to health care.[12] MUPs include, but are not limited to, those who are homeless, low-income, Medicaid-eligible, Native American, or migrant farmworkers.[13]

[4] A passing score is valid for 365 days after the date the official examination results are published. A passing score on an examination obtained in another jurisdiction must be completed on or after October 1, 2011.
[5] Rule 64B5-17.011(1), F.A.C.
[6] Rule 64B5-17.011(2), F.A.C.
[7] Rule 64B5-17.011(4), F.A.C.
[8] Health Resources and Services Administration, *Health Professional Shortage Areas (HPSAs)*, available at https://bhw.hrsa.gov/shortage-designation/hpsas (last visited March 12, 2019).
[9] Id.
[10] Health Resources and Services Administration, *Medically Underserved Areas and Populations (MUA/Ps)*, https://bhw.hrsa.gov/shortage-designation/muap (last visited January 18, 2018).
[11] Id.
[12] Id.
[13] Id.

Access to Dental Care and Dental Workforce in Florida

Nationally, there are 5,866 dental HSPAs, 224 of which are in Florida.[14] Additionally, there are 4,235 MAUs and MAPs in the U.S., 129 of which are in Florida.[15] Currently, there are approximately 57 licensed dentists per 100,000 people in Florida; however, this ratio varies greatly across the state.[16] Most dentists are disproportionately concentrated in the more populous areas of the state. Three counties, Dixie, Glades, and Lafayette, do not have any licensed dentists, while other counties have over 150 dentists per 100,000 residents.[17]

Lack of access to dental care can lead to poor oral health and poor overall health. [18] Research has shown a link between poor oral health and diabetes, heart and lung disease, stroke, respiratory illnesses, and adverse birth outcomes including the delivery of pre-term and low birth weight infants.[19]

Dental Licensure Programs for Underserved Populations in Florida

DOH may issue a permit to a nonprofit corporation chartered to provide dental care for indigent persons. A nonprofit corporation may apply for a permit to employ a non-Florida licensed dentist who is a graduate of an accredited dental school.[20] DOH also issues limited licenses to dentists whose practice is limited to providing services to the indigent or critical need populations within the state.[21] DOH will waive the application and all licensure if the limited licensee applicant submits a notarized statement from the employer that he or she will not be receiving monetary compensation for services provided.

Health Access Licenses

A health access license allows out-of-state dentists who meet certain criteria to practice in a health access setting without the supervision of a Florida licensed dentist.[22] A health access setting is a program or institution of the Department of Children and Families, DOH, Department of Juvenile Justice, a nonprofit health center, a Head Start center, a federally-qualified health center (FQHC) or FQHC look-alike, a school-based prevention program, or a clinic operated by an accredited dental school or accredited dental hygiene program.[23]

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[14] Health Resources and Services Administration, *HPSA Find Results*, https://datawarehouse.hrsa.gov/tools/analyzers/HpsaFindResults.aspx (last visited March 13, 2019).
[15] Health Resources and Services Administration, *MAU Find Results*, https://datawarehouse.hrsa.gov/tools/analyzers/MuaSearchResults.aspx (last visited March 13, 2019).
[16] Florida Department of Health, Florida CHARTS, *Total Licensed Florida Dentists*, http://www.flhealthcharts.com/charts/OtherIndicators/NonVitalIndNoGrpDataViewer.aspx?cid=0326 (last visited March 13, 2019).
[17] Id.
[18] Florida Department of Health, *Florida's Burden of Oral Disease Surveillance Report*, (Aug, 2016), p. 5, *available at*, http://www.floridahealth.gov/programs-and-services/community-health/dental-health/reports/_documents/floridas-burden-oral-disease-surveillance-report.pdf (last visited March 13, 2019).
[19] Id.
[20] Rule 64B5-7.006, F.A.C.
[21] *See* Section 456.015, F.S., and Rule 64B5-7.007, F.A.C.
[22] Section 466.0067, F.S. The dental health access license is scheduled for repeal on January 1, 2020, unless saved from repeal by reenactment by the Legislature (s. 466.00673, F.S.)
[23] Section 466.003(14), F.S. Such institutions or programs must report violations of the Dental Practice Act or standards of care to the Board of Dentistry.

A holder of a health access dental license must apply for renewal of the license each biennium and provide a signed statement that she or he has complied will all continuing education requirements of an active dentist. The health access dental license will be renewed if the applicant:

- Submits documentation from the employer in the health access setting that the licensee has at all times pertinent remained an employee;
- Has not been convicted or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession;
- Has paid the appropriate renewal fee;
- Has not failed the Florida examination requirements since initially receiving the health access dental license or since the last renewal; and
- Has not been reported to the National Practitioner Data Bank, unless the applicant successfully appealed to have his or her name removed from the data bank.

A health access dental license will be revoked upon the termination of the licensee's employment from a qualifying health access setting, final agency action determining that a licensee has violated disciplinary grounds as provided in s. 466.028, F.S., or failure of the Florida dental licensure examination.

It is considered the unlicensed practice of dentistry if a licensee fails to limit his or her practice to a health access setting.[24]

Dental Therapy

Dental therapists are midlevel dental providers, similar to physician assistants in medicine.[25] Dental therapists provide preventive and routine restorative care, such as filling cavities, placing temporary crowns, and extracting badly diseased or loose teeth.[26] Minnesota, Maine, and Vermont have authorized the practice of dental therapy, and dental therapists are authorized to practice in tribal areas of Alaska, Oregon, and Washington.[27]

In 2015, the Commission on Dental Accreditation (CODA) established accreditation standards for dental therapy education programs.[28] There are no CODA-accredited dental therapy education programs. There are currently 3 dental therapy education programs in the United States, which are located in Minnesota and Alaska, and a fourth dental therapy education program is being developed in Vermont. The dental therapy education programs that currently exist are accredited by regional accreditation agencies or approved by state dental boards.

[24] Section 466.00672(2), F.S.
[25] Pew Charitable Trusts, *5 Dental Therapy FAQs*, (April 21, 2016), available at http://www.pewtrusts.org/en/research-and-analysis/q-and-a/2016/04/5-dental-therapy-faqs (last visited March 12, 2019).
[26] Id.
[27] Pew Charitable Trusts, *National Momentum Building for Midlevel Dental Providers*, http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/09/28/states-expand-the-use-of-dental-therapy (last visited March 12, 2019).
[28] Commission on Dental Accreditation, *Accreditation Standards for Dental Therapy Education Programs*, (eff. Feb. 6, 2015), available at http://www.ada.org/~/media/CODA/Files/dt.ashx (last visited March 12, 2019).

III. Effect of Proposed Changes:

Section 1 amends s. 409.906, F.S., to allow Medicaid to provide reimbursement for dental services provided by a mobile dental unit owned by, operated by, or having a contractual relationship with a health access setting or a similar setting or program that serves underserved populations that face serious barriers to accessing dental services. Examples include Early Head Start programs, homeless shelters, schools, and the Special Supplemental Nutrition Program for Women, Infants and Children.

Section 2 amends s. 466.001, F.S., to express legislative intent to ensure every dental therapist practicing in the state meets minimum requirements for safe practice, and that those dental therapists who fall below minimum competency or otherwise present a danger to the public shall be prohibited from practicing.

Section 3 amends s. 466.002, F.S., to provide that nothing in the Dental Practice Act (ch. 466, F.S.) shall apply to dental therapy students while performing regularly assigned work under the curriculum of schools, nor to instructors of dental therapy while performing regularly assigned instructional duties.

Section 4 amends s. 466.003, F.S., to add definitions for dental therapy and dental therapists, and expands the definition of 'health access settings' to include dental therapy programs.

Section 5 amends s. 466.004, F.S., to provide for the creation of the Council on Dental Therapy. Members of the council will be appointed by the chair of the board and consist of one board member to chair the council and three dental therapists actively engaged in the practice of dental therapy in Florida. The council must meet at least three times per year, and at the request of the board chair, a majority of the members, or the council chair. The council is tasked with rule and policy recommendations, which must be reviewed by the board. The board has authority to take final action on adopting recommendations made by the council.

Section 6 amends s. 466.006, F.S., to make dentists who are full-time faculty members of dental therapy schools eligible for what is considered "full-time practice" of dentists for purposes of state licensure.

Section 7 amends s. 466.0075, F.S., to provide that the board may require any person applying to take the dental therapy licensure exam to maintain medical liability insurance sufficient to cover any incident of harm to a patient during a clinical exam.

Section 8 amends s. 466.009, F.S., to allow applicants for a dental therapy license who fail one part of the practical or clinical exam for licensure to retake only that part in order to pass the exam, however if the applicant fails more than one part they must retake the entire exam.

Section 9 amends s. 466.011, F.S., to provide that anyone who satisfies all parts of the newly created s. 466.0225, F.S., pertaining to dental therapy, shall be certified for licensure by DOH.

Section 10 creates s. 466.0136, F.S., requiring all licensed dental therapists to complete at least 24 hours of continuing education (CE) in dental subjects approved by the board biennially. The

bill specifies that CE programs must be programs that, in the opinion of the board, contribute directly to the dental education of the licensee. The bill allows individuals licensed as both a dental therapist and a dental hygienist to count one hour of CE toward the total annual CE requirements for both professions. The bill gives the board rulemaking authority to enforce the provisions of this section, and also allows the board to excuse the requirement for those facing unusual circumstances, emergencies, or hardships.

Section 11 amends s. 466.0016, F.S., requiring licensed dental therapists to display a copy of their license in plain sight of patients at each office where they practice.

Section 12 amends s. 466.017, F.S., requiring the board to adopt rules which establish additional requirements relating to the use of general anesthesia or sedation for dental therapists who work with either. The bill also requires the board to adopt a mechanism to verify compliance with training and certification requirements. The bill requires any dental therapist who uses any form of anesthesia to obtain certification in either basic CPR or advanced cardiac life support as approved by the American Heart Association or American Red Cross, with recertification every two years. The bill provides that dental therapists working under the general supervision of a dentist may administer local anesthesia, including intraoral block anesthesia, soft tissue infiltration anesthesia, or both if they are properly certified. The bill also permits dental therapists to utilize x-ray machines if authorized by their supervising dentist to do so.

Section 13 amends s. 466.018, F.S., provides that a dentist of record shall be primarily responsible for treatment rendered by a dental therapist. The bill requires anyone other than the dentist of record, a dental hygienist, a dental therapist, or a dental assistant to note their initials in the patient record if they perform treatment on a patient.

Section 14 creates s. 466.0225, F.S., requiring any applicant for licensure as a dental therapist to take the appropriate licensure exams, verify an application for licensure by oath, and include two personal photographs with the application. The bill provides that in order to take the dental therapy exams and obtain licensure, an applicant must:

- The applicant must be at least 18 years old;
- Graduate from a CODA-accredited dental therapy school or program, or a program accredited by another entity recognized by the U.S. Department of Education;
- Successfully complete a dental therapy practical or clinical exam produced by the American Board of Dental Examiners (ADEX) within three attempts;
- Not have been disciplined by the Board with the exception of minor violations or citations;
- Not have been convicted, or pled nolo contendere to, a misdemeanor or felony related to the practice of dental therapy; and
- Successfully complete a written laws and rules exam on dental therapy.
-

The bill provides that an applicant who meets these requirements and successfully completes either the ADEX practical/clinical exams or exams in another state deemed comparable by the board shall be licensed to practice dental therapy in Florida.

Section 15 creates s. 466.0227, F.S., providing legislative findings that licensing dental therapists would improve access to high-quality affordable oral health services, and would

rapidly improve such access for low-income, uninsured, and underserved patients. To further this intent, the bill limits dental therapists to practicing in the following settings:

- A health access setting;
- A community health center;
- A military or veterans' hospital or clinic;
- A governmental or public health clinic;
- A school, Head Start program, or school-based prevention program;
- An oral health education institution;
- A hospital;
- A geographical area designated as a dental health professional shortage area by the federal government; or
- Any other clinic or practice setting if at least 50% of the patients are enrolled in Medicaid or lack dental insurance and report an annual income of less than 200% of the federal poverty level.

The bill provides that a dental therapist may provide the following services under the general supervision of a dentist:

- All services specified by CODA;
- Evaluating radiographs;
- Placement of space maintainers;
- Pulpotomies on primary teeth;
- Dispensing and administering nonopioid analgesics, and;
- Oral evaluation of dental disease and forming of treatment plans if authorized by a supervising dentist and subject to any conditions in a collaborative agreement between the dentist and dental therapist.

The bill requires a dental therapist and supervising dentist to enter into a written collaborative agreement prior to performing any of the aforementioned services, and the agreement must include permissible practice settings, practice limitations and protocols, record maintenance procedures, emergency protocols, medication protocols, and supervision criteria. The bill requires supervising dentists to determine the number of hours a dental therapist must perform under direct or indirect supervision before practicing under general supervision. The bill provides that a supervising dentist must be licensed to practice in Florida and is responsible for all services authorized and performed by the dental therapist pursuant to a collaborative agreement. Finally, the bill allows a dental therapist to perform services prior to being seen by the supervising dentist if provided for in the collaborative agreement and if the patient is subsequently referred to a dentist for any additional services needed that exceed to the dental therapist's scope of practice.

Section 16 amends s. 466.026, F.S., to provide that the unlicensed practice of dental therapy, and offering to sell a dental therapy school or college degree to someone who was not granted such a degree, both constitute third-degree felonies. The bill also provides that using the name "dental therapist" or the initials, "D.T." or otherwise holding one's self out as an actively licensed dental therapist without proper licensure is a first-degree misdemeanor.

Section 17 amends s. 466.028, F.S., to provide that the following acts constitute grounds for denial of a dental therapy license or discipline of an existing dental therapy license:

- Having a license to practice dental therapy disciplined by another state or practice jurisdiction;
- Being convicted or found guilty of, or pleading nolo contendere to, a crime related to the practice of dental therapy;
- Aiding or abetting the unlicensed practice of dental therapy;
- Being unable to practice dental therapy with reasonable skill and safety by reason of illness, chemical impairment, or any mental or physical condition, and;
- Fraud, deceit, or misconduct in the practice of dental therapy.

Section 18 amends s. 466.028, F.S., to prohibit anyone other than a licensed dentist from employing dental therapists in the operation of a dental office.

Section 19 amends s. 466.051, F.S., classifying personal identifying information held in a record provided by a dental therapist in response to a dental workforce survey as confidential and exempt under s. 119.07(1), F.S., and s. 24(a), Art. I of the Florida Constitution.

Section 20 requires that by July 1, 2022, a progress report be submitted to the President of the Senate and the Speaker of the House of Representatives which shall include the progress that has been made in Florida to implement dental therapy training programs, licensing, and Medicaid reimbursement. Additionally, data must be submitted demonstrating the effects of dental therapy in Florida. A final report must be submitted to the same parties three years after the first dental therapy license is issued.

Section 21 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Section 19 of the bill requires personal identifying information contained in records provided by dental therapists in response to a dental workforce survey be held confidential and exempt from s. 119.07(1), F.S. and s. 24(a), Art. 1 of the State Constitution. Article I, s. 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a bill creating or expanding an exemption to the public records requirements and must be contained in a separate bill that contains no other subject. This bill expands an existing public records exemption, thus, a separate bill is likely needed to address this issue.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

A corresponding bill, SB 686, addresses the issue of licensure fees for dental therapists.

DOH anticipates an estimated revenue for the first biennium of licensure of approximately $2,277,069, and an estimated revenue for the second biennium of $1,912,892. [29]

B. Private Sector Impact:

There will be an indeterminate fiscal impact on individuals who apply for licensure as dental therapists as they will need to pay application and licensure fees.

C. Government Sector Impact:

Estimated costs to the state for the first biennium of licensure are $584,408, as shown below:[30]

	RECURRING	**NON-RECURRING**
SALARY	$180,484	
OPS	$800	$25,260
EXPENSE	$54,646	$22,145
CONTRACTED SERVICES	$62,404 (Reccuring Biannually)	
HUMAN RESOURCES	$1,316	$107
TOTAL	**$299,650**	**$47,512**

VI. Technical Deficiencies:

None.

[29] Florida Department of Health, 2019 Agency Legislative Bill Analysis, HB 649. February 5, 2019. On file with the Senate Committee on Children, Families and Elder Affairs.
[30] *Id*.

VII. Related Issues:

According to DOH, the proposed language in the newly created s. 466.0225(1), F.S., is outdated as applicants for licensure with DOH are no longer required to submit two photographs as part of the application process.[31]

The bill fails to define "minor violations" as cited in the newly created s. 466.0225, F.S.[32]

The bill provides that a dental therapist may provide services to a patient prior to the patient being seen by a dentist if the collaborative agreement between dentist and dental therapist so allows. DOH has expressed uncertainty over whether this may present a conflict with s. 466.003(10), F.S., which requires a licensed dentist to examine and diagnose a patient before another licensed professional provides services.[33]

VIII. Statutes Affected:

This bill substantially amends sections 409.906, 466.001, 466.002, 466.003, 466.004, 466.006, 466.0075, 466.009, 466.011, 466.016, 466.017, 466.018, 466.026, 466.028, 466.0285, and 466.051 of the Florida Statutes.
This bill creates sections 466.0136, 466.0225, and 466.0227 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[31] *Id*.
[32] *Id*.
[33] *Id*.

842698

LEGISLATIVE ACTION

Senate . House

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

Senate Amendment (with title amendment)

Delete lines 979 - 1010.

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

And the title is amended as follows:

Delete lines 95 - 99

and insert:

circumstances; requiring

LEGISLATIVE ACTION

Senate . House

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. .

. .

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

Senate Amendment (with title amendment)

Delete lines 621 - 852

and insert:

(7) A dental therapist under the direct or indirect supervision of a dentist may administer local anesthesia, including intraoral block anesthesia or soft tissue infiltration anesthesia, or both, if she or he has completed the course described in subsection (5) and presents evidence of current certification in basic or advanced cardiac life support.

(8)~~(7)~~ A licensed dentist, or a dental therapist who is authorized by her or his supervising dentist, may utilize an X-ray machine, expose dental X-ray films, and interpret or read such films. Notwithstanding ~~The provisions of~~ part IV of chapter 468 ~~to the contrary notwithstanding~~, a licensed dentist, or a dental therapist who is authorized by her or his supervising dentist, may authorize or direct a dental assistant to operate such equipment and expose such films under her or his direction and supervision, pursuant to rules adopted by the board in accordance with s. 466.024 which ensure that said assistant is competent by reason of training and experience to operate said equipment in a safe and efficient manner. The board may charge a fee not to exceed $35 to defray the cost of verifying compliance with requirements adopted pursuant to this section.

(9)~~(8)~~ Notwithstanding ~~The provisions of~~ s. 465.0276 ~~notwithstanding~~, a dentist need not register with the board or comply with the continuing education requirements of that section if the dentist confines her or his dispensing activity to the dispensing of fluorides and chlorhexidine ~~chlorohexidine~~ rinse solutions; provided that the dentist complies with and is subject to all laws and rules applicable to pharmacists and pharmacies, including, but not limited to, chapters 465, 499, and 893, and all applicable federal laws and regulations, when dispensing such products.

Section 13. Subsection (1) of section 466.018, Florida Statutes, is amended to read:

466.018 Dentist of record; patient records.—

(1) Each patient shall have a dentist of record. The dentist of record shall remain primarily responsible for all

dental treatment on such patient regardless of whether the treatment is rendered by the dentist or by another dentist, dental therapist, dental hygienist, or dental assistant rendering such treatment in conjunction with, at the direction or request of, or under the supervision of such dentist of record. The dentist of record shall be identified in the record of the patient. If treatment is rendered by a dentist other than the dentist of record or by a dental hygienist, dental therapist, or dental assistant, the name or initials of such person shall be placed in the record of the patient. In any disciplinary proceeding brought pursuant to this chapter or chapter 456, it shall be presumed as a matter of law that treatment was rendered by the dentist of record unless otherwise noted on the patient record pursuant to this section. The dentist of record and any other treating dentist are subject to discipline pursuant to this chapter or chapter 456 for treatment rendered to the patient and performed in violation of such chapter. One of the purposes of this section is to ensure that the responsibility for each patient is assigned to one dentist in a multidentist practice of any nature and to assign primary responsibility to the dentist for treatment rendered by a dental hygienist, dental therapist, or dental assistant under her or his supervision. This section shall not be construed to assign any responsibility to a dentist of record for treatment rendered pursuant to a proper referral to another dentist who does not ~~in~~ practice with the dentist of record or to prohibit a patient from voluntarily selecting a new dentist without permission of the dentist of record.

Section 14. Section 466.0225, Florida Statutes, is created

to read:

466.0225 Examination of dental therapists; licensing.—

(1) Any person desiring to be licensed as a dental therapist shall apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application must include two recent photographs of the applicant.

(2) An applicant is entitled to take the examinations required in this section and receive licensure to practice dental therapy in this state if the applicant:

(a) Is 18 years of age or older;

(b) Is a graduate of a dental therapy college or school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental therapy accrediting entity recognized by the United States Department of Education. For applicants applying for a dental therapy license before January 1, 2024, the board shall approve the applicant's dental therapy education program if the program was administered by a college or school that operates an accredited dental or dental hygiene program and the college or school certifies to the board that the applicant's education substantially conformed to the education standards established by the American Dental Association Commission on Dental Accreditation;

(c) Has successfully completed a dental therapy practical or clinical examination produced by the American Board of Dental Examiners, Inc., (ADEX) or its successor entity, if any, if the board finds that the successor entity's examination meets or exceeds the provisions of this section. If an applicant fails to

pass the ADEX Dental Therapy Examination after three attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board. If a dental therapy examination has not been established by the ADEX, the board shall administer or approve an alternative examination;

(d) Has not been disciplined by a board, except for citation offenses or minor violations;

(e) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession; and

(f) Has successfully completed a written examination on the laws and rules of this state regulating the practice of dental therapy.

(3) An applicant who meets the requirements of this section, and who has successfully completed the examinations identified in paragraph (2)(c) in a jurisdiction other than this state, or who has successfully completed comparable examinations administered or approved by the licensing authority in a jurisdiction other than this state shall be licensed to practice dental therapy in this state if the board determines that the other jurisdiction's examinations and scope of practice are substantially similar to those identified in paragraph (2)(c).

Section 15. Section 466.0227, Florida Statutes, is created to read:

466.0227 Dental therapists; scope and area of practice.—

(1) The Legislature finds that authorizing licensed dental therapists to perform the services specified in subsection (3) would improve access to high-quality affordable oral health

services for all residents in this state. The Legislature intends to rapidly improve such access for low-income, uninsured, and underserved patients and communities. To further this intent, a dental therapist licensed under this chapter is limited to practicing dental therapy in the following settings:

(a) A health access setting, as defined in s. 466.003(16).

(b) A community health center, including an off-site care setting.

(c) A nursing facility.

(d) A military or veterans' hospital or clinic, including an off-site care setting.

(e) A governmental or public health clinic, including an off-site care setting.

(f) A school, Head Start program, or school-based prevention program, as defined in s. 466.003(17).

(g) An oral health education institution, including an off-site care setting.

(h) A hospital.

(i) A geographic area designated as a dental health professional shortage area by the state or the Federal Government which is not located within a federally designated metropolitan statistical area.

(2) Except as otherwise provided in this chapter, a dental therapist may perform the dental therapy services as specified in subsection (3) under the direct or indirect supervision of a dentist to the extent authorized by the supervising dentist and provided within the terms of a written collaborative management agreement signed by the dental therapist and the supervising dentist which meets the requirements of subsection (4). For

purposes of this section, the term:

(a) "Direct supervision" means supervision whereby a dentist diagnoses the condition to be treated, a dentist authorizes the procedure to be performed, a dentist remains on the premises while the procedures are performed, and a dentist approves the work performed before dismissal of the patient.

(b) "Indirect supervision" means supervision whereby a dentist authorizes the procedure and a dentist is on the premises while the procedure is performed.

(3) Dental therapy services include all of the following:

(a) All services, treatments, and competencies identified by the American Dental Association Commission on Dental Accreditation in its Dental Therapy Education Accreditation Standards.

(b) The following state-specific services, if the dental therapist's education included curriculum content satisfying the American Dental Association Commission on Dental Accreditation criteria for state-specific dental therapy services:

1. Evaluating radiographs.

2. Placement of space maintainers.

3. Pulpotomies on primary teeth.

4. Dispensing and administering nonopioid analgesics including nitrous oxide, anti-inflammatories, and antibiotics as authorized by the supervising dentist and within the parameters of the collaborative management agreement.

5. Oral evaluation and assessment of dental disease and formulation of an individualized treatment plan if authorized by a supervising dentist and subject to any conditions, limitations, and protocols specified by the supervising dentist

in the collaborative management agreement.

(4) Before performing any of the services authorized in subsection (3), a dental therapist must enter into a written collaborative management agreement with a supervising dentist. The agreement must be signed by the dental therapist and the supervising dentist and must include:

(a) Practice settings where services may be provided by the dental therapist and the populations to be served by the dental therapist.

(b) Any limitations on the services that may be provided by the dental therapist, including the level of supervision required by the supervising dentist.

(c) Age- and procedure-specific practice protocols for the dental therapist, including case selection criteria, assessment guidelines, and imaging frequency.

(d) A procedure for creating and maintaining dental records for the patients who are treated by the dental therapist.

(e) A plan to manage medical emergencies in each practice setting where the dental therapist provides care.

(f) A quality assurance plan for monitoring care provided by the dental therapist, including patient care review, referral followup, and a quality assurance chart review.

(g) Protocols for the dental therapist to administer and dispense medications, including the specific conditions and circumstances under which the medications are to be dispensed and administered.

(h) Criteria relating to the provision of care by the dental therapist to patients with specific medical conditions or complex medication histories, including requirements for

consultation before the initiation of care.

(i) Supervision criteria of dental therapists.

(j) A plan for the provision of clinical resources and referrals in situations that are beyond the capabilities of the dental therapist.

(5) A supervising dentist may restrict or limit the dental therapist's practice in a collaborative management agreement to be less than the full scope of practice for dental therapists which is authorized in subsection (3).

(6) A supervising dentist may authorize a dental therapist to provide dental therapy services to a patient before the dentist examines or diagnoses the patient if the authority, conditions, and protocols are established in a written collaborative management agreement and if the patient is subsequently referred to a dentist for any needed additional services that exceed the dental therapist's scope of practice or authorization under the collaborative management agreement.

(7) A supervising dentist must be licensed and practicing

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

And the title is amended as follows:

Delete lines 48 - 72

and insert:

direct or indirect supervision of a dentist to administer local anesthesia and utilize an X-ray machine, expose dental X-ray films, and interpret or read such films if specified requirements are met; correcting a term; amending s. 466.018, F.S.; providing that a dentist remains primarily responsible

for the dental treatment of a patient regardless of whether the treatment is provided by a dental therapist; requiring the initials of a dental therapist who renders treatment to a patient to be placed in the record of the patient; creating s. 466.0225, F.S.; providing application requirements and examination and licensure qualifications for dental therapists; creating s. 466.0227, F.S.; providing legislative findings and intent; limiting the practice of dental therapy to specified settings; authorizing a dental therapist to perform specified services under the direct or indirect supervision of a dentist under certain conditions; defining the terms “direct supervision” and “indirect supervision”; specifying state-specific dental therapy services; requiring a collaborative management agreement to be signed by a supervising dentist and a dental therapist and to include certain information;

By Senator Brandes

24-00394-19 2019684__

A bill to be entitled

An act relating to dental therapy; amending s. 409.906, F.S.; authorizing Medicaid to reimburse for dental services provided in a mobile dental unit that is owned by, operated by, or contracted with a health access setting or another similar setting or program; amending s. 466.001, F.S.; revising legislative purpose and intent; amending s. 466.002, F.S.; providing applicability; amending s. 466.003, F.S.; defining the terms "dental therapist" and "dental therapy"; revising the definition of the term "health access setting" to include certain dental therapy programs; amending s. 466.004, F.S.; requiring the chair of the Board of Dentistry to appoint a Council on Dental Therapy effective after a specified timeframe; providing for membership, meetings, and the purpose of the council; amending s. 466.006, F.S.; revising the definition of the terms "full-time practice" and "full-time practice of dentistry within the geographic boundaries of this state within 1 year" to include full-time faculty members of certain dental therapy schools; amending s. 466.0075, F.S.; authorizing the board to require any person who applies to take the examination to practice dental therapy in this state to maintain medical malpractice insurance in a certain amount; amending s. 466.009, F.S.; requiring the Department of Health to allow any person who fails the dental therapy examination to retake the examination; providing that a person who

24-00394-19 2019684__

fails a practical or clinical examination to practice dental therapy and who has failed one part or procedure of the examination may be required to retake only that part or procedure to pass the examination; amending s. 466.011, F.S.; requiring the board to certify applicants for licensure as a dental therapist; creating s. 466.0136, F.S.; requiring the board to require each licensed dental therapist to complete a specified number of hours of continuing professional education; requiring the board to adopt rules and guidelines; authorizing the board to excuse licensees from continuing education requirements in certain circumstances; amending s. 466.016, F.S.; requiring a practitioner of dental therapy to post and display her or his license in each office where she or he practices; amending s. 466.017, F.S.; requiring the board to adopt certain rules relating to dental therapists; authorizing a dental therapist under the general supervision of a dentist to administer local anesthesia and utilize an X-ray machine, expose dental X-ray films, and interpret or read such films if specified requirements are met; correcting a term; amending s. 466.018, F.S.; providing that a dentist remains primarily responsible for the dental treatment of a patient regardless of whether the treatment is provided by a dental therapist; requiring the initials of a dental therapist who renders treatment to a patient to be placed in the record of the patient; creating s. 466.0225, F.S.; providing application

requirements and examination and licensure qualifications for dental therapists; creating s. 466.0227, F.S.; providing legislative findings and intent; limiting the practice of dental therapy to specified settings; authorizing a dental therapist to perform specified services under the general supervision of a dentist under certain conditions; specifying state-specific dental therapy services; requiring a collaborative management agreement to be signed by a supervising dentist and a dental therapist and to include certain information; requiring the supervising dentist to determine the number of hours of practice that a dental therapist must complete before performing certain authorized services; authorizing a supervising dentist to restrict or limit the dental therapist's practice in a collaborative management agreement; providing that a supervising dentist may authorize a dental therapist to provide dental therapy services to a patient before the dentist examines or diagnoses the patient under certain conditions; requiring a supervising dentist to be licensed and practicing in this state; specifying that the supervising dentist is responsible for certain services; amending s. 466.026, F.S.; providing criminal penalties for practicing dental therapy without an active license, selling or offering to sell a diploma from a dental therapy school or college, falsely using a specified name or initials or holding herself or himself out as an actively licensed dental

therapist; amending s. 466.028, F.S.; revising grounds for denial of a license or disciplinary action to include the practice of dental therapy; amending s. 466.0285, F.S.; prohibiting persons other than licensed dentists from employing a dental therapist in the operation of a dental office and from controlling the use of any dental equipment or material in certain circumstances; amending s. 466.051, F.S.; revising a public records exemption to include personal identifying information contained in a record provided by a dental therapist in response to a dental workforce survey and held by the department; requiring the department, in consultation with the board and the Agency for Health Care Administration, to provide reports to the Legislature by specified dates; requiring that certain information and recommendations be included in the reports; providing an effective date.

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

Section 1. Paragraph (c) of subsection (1) of section 409.906, Florida Statutes, is amended, and paragraph (e) is added to subsection (6) of that section, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services

were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(1) ADULT DENTAL SERVICES.—

(c) However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

1. Owned by, operated by, or having a contractual agreement with the Department of Health and complying with Medicaid's county health department clinic services program specifications as a county health department clinic services provider.

2. Owned by, operated by, or having a contractual arrangement with a federally qualified health center and complying with Medicaid's federally qualified health center specifications as a federally qualified health center provider.

3. Rendering dental services to Medicaid recipients, 21 years of age and older, at nursing facilities.

4. Owned by, operated by, or having a contractual agreement with a state-approved dental educational institution.

5. Owned by, operated by, or having a contractual relationship with a health access setting, as defined in s. 466.003(16), or a similar setting or program that serves underserved or vulnerable populations that face serious barriers to accessing dental services, which may include, but is not limited to, Early Head Start programs, homeless shelters, schools, and the Special Supplemental Nutrition Program for Women, Infants, and Children.

(6) CHILDREN'S DENTAL SERVICES.—The agency may pay for diagnostic, preventive, or corrective procedures, including orthodontia in severe cases, provided to a recipient under age 21, by or under the supervision of a licensed dentist. The agency may also reimburse a health access setting as defined in s. 466.003(16) ~~s. 466.003~~ for the remediable tasks that a licensed dental hygienist is authorized to perform under s. 466.024(2). Services provided under this program include treatment of the teeth and associated structures of the oral cavity, as well as treatment of disease, injury, or impairment that may affect the oral or general health of the individual. However, Medicaid will not provide reimbursement for dental services provided in a mobile dental unit, except for a mobile dental unit:

(e) Owned by, operated by, or having a contractual relationship with a health access setting, as defined in s. 466.003(16), or a similar setting or program that serves

underserved or vulnerable populations that face serious barriers to accessing dental services, which may include, but is not limited to, Early Head Start programs, homeless shelters, schools, and the Special Supplemental Nutrition Program for Women, Infants, and Children.

Section 2. Section 466.001, Florida Statutes, is amended to read:

466.001 Legislative purpose and intent.—The legislative purpose for enacting this chapter is to ensure that every dentist, dental therapist, or dental hygienist practicing in this state meets minimum requirements for safe practice without undue clinical interference by persons not licensed under this chapter. It is the legislative intent that dental services be provided only in accordance with ~~the provisions of~~ this chapter and not be delegated to unauthorized individuals. It is the further legislative intent that dentists, dental therapists, and dental hygienists who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in this state. All provisions of this chapter relating to the practice of dentistry, dental therapy, and dental hygiene shall be liberally construed to carry out such purpose and intent.

Section 3. Subsections (5) and (6) of section 466.002, Florida Statutes, are amended to read:

466.002 Persons exempt from operation of chapter.—Nothing in this chapter shall apply to the following practices, acts, and operations:

(5) Students in Florida schools of dentistry, dental therapy, and dental hygiene or dental assistant educational

programs, while performing regularly assigned work under the curriculum of such schools.

(6) Instructors in Florida schools of dentistry, instructors in dental programs that prepare persons holding D.D.S. or D.M.D. degrees for certification by a specialty board and that are accredited in the United States by January 1, 2005, in the same manner as the board recognizes accreditation for Florida schools of dentistry that are not otherwise affiliated with a Florida school of dentistry, or instructors in Florida schools of dental hygiene or dental therapy or dental assistant educational programs, while performing regularly assigned instructional duties under the curriculum of such schools or programs. A full-time dental instructor at a dental school or dental program approved by the board may be allowed to practice dentistry at the teaching facilities of such school or program, upon receiving a teaching permit issued by the board, in strict compliance with such rules as are adopted by the board pertaining to the teaching permit and with the established rules and procedures of the dental school or program as recognized in this section.

Section 4. Subsections (7) through (15) of section 466.003, Florida Statutes, are renumbered as subsections (9) through (17), respectively, present subsections (14) and (15) are amended, and new subsections (7) and (8) are added to that section, to read:

466.003 Definitions.—As used in this chapter:

(7) "Dental therapist" means a person licensed to practice dental therapy pursuant to s. 466.0225.

(8) "Dental therapy" means the rendering of services

pursuant to s. 466.0227 and any related extraoral services or procedures required in the performance of such services.

(16)~~(14)~~ "Health access setting" means a program or an institution of the Department of Children and Families, the Department of Health, the Department of Juvenile Justice, a nonprofit community health center, a Head Start center, a federally qualified health center or look-alike as defined by federal law, a school-based prevention program, a clinic operated by an accredited college of dentistry, or an accredited dental hygiene or dental therapy program in this state if such community service program or institution immediately reports to the Board of Dentistry all violations of s. 466.027, s. 466.028, or other practice act or standard of care violations related to the actions or inactions of a dentist, dental hygienist, dental therapist, or dental assistant engaged in the delivery of dental care in such setting.

(17)~~(15)~~ "School-based prevention program" means preventive oral health services offered at a school by one of the entities defined in subsection (16) ~~(14)~~ or by a nonprofit organization that is exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c)(3) of the Internal Revenue Code.

Section 5. Subsection (2) of section 466.004, Florida Statutes, is amended to read:

466.004 Board of Dentistry.—

(2) To advise the board, it is the intent of the Legislature that councils be appointed as specified in paragraphs (a)-(d) ~~(a), (b), and (c)~~. The department shall provide administrative support to the councils and shall provide

public notice of meetings and agenda of the councils. Councils shall include at least one board member who shall chair the council and shall include nonboard members. All council members shall be appointed by the board chair. Council members shall be appointed for 4-year terms, and all members shall be eligible for reimbursement of expenses in the manner of board members.

(a) A Council on Dental Hygiene shall be appointed by the board chair and shall include one dental hygienist member of the board, who shall chair the council, one dental member of the board, and three dental hygienists who are actively engaged in the practice of dental hygiene in this state. In making the appointments, the chair shall consider recommendations from the Florida Dental Hygiene Association. The council shall meet at the request of the board chair, a majority of the members of the board, or the council chair; however, the council must meet at least three times a year. The council is charged with the responsibility of and shall meet for the purpose of developing rules and policies for recommendation to the board, which the board shall consider, on matters pertaining to that part of dentistry consisting of educational, preventive, or therapeutic dental hygiene services; dental hygiene licensure, discipline, or regulation; and dental hygiene education. Rule and policy recommendations of the council shall be considered by the board at its next regularly scheduled meeting in the same manner in which it considers rule and policy recommendations from designated subcommittees of the board. Any rule or policy proposed by the board pertaining to the specified part of dentistry defined by this subsection shall be referred to the council for a recommendation before final action by the board.

The board may take final action on rules pertaining to the specified part of dentistry defined by this subsection without a council recommendation if the council fails to submit a recommendation in a timely fashion as prescribed by the board.

(b) A Council on Dental Assisting shall be appointed by the board chair and shall include one board member who shall chair the council and three dental assistants who are actively engaged in dental assisting in this state. The council shall meet at the request of the board chair or a majority of the members of the board. The council shall meet for the purpose of developing recommendations to the board on matters pertaining to that part of dentistry related to dental assisting.

(c) Effective 28 months after the first dental therapy license is granted by the board, a Council on Dental Therapy shall be appointed by the board chair and shall include one board member who shall chair the council and three dental therapists who are actively engaged in the practice of dental therapy in this state. The council shall meet at the request of the board chair, a majority of the members of the board, or the council chair; however, the council must meet at least three times per year. The council is charged with the responsibility of, and shall meet for the purpose of, developing rules and policies for recommendation to the board on matters pertaining to that part of dentistry consisting of educational, preventative, or therapeutic dental therapy services; dental therapy licensure, discipline, or regulation; and dental therapy education. Rule and policy recommendations of the council must be considered by the board at its next regularly scheduled meeting in the same manner in which it considers rule and policy

recommendations from designated subcommittees of the board. Any rule or policy proposed by the board pertaining to the specified part of dentistry defined by this subsection must be referred to the council for a recommendation before final action by the board. The board may take final action on rules pertaining to the specified part of dentistry defined by this subsection without a council recommendation if the council fails to submit a recommendation in a timely fashion as prescribed by the board.

(d) ~~(c)~~ With the concurrence of the State Surgeon General, the board chair may create and abolish other advisory councils relating to dental subjects, including, but not limited to: examinations, access to dental care, indigent care, nursing home and institutional care, public health, disciplinary guidelines, and other subjects as appropriate. Such councils shall be appointed by the board chair and shall include at least one board member who shall serve as chair.

Section 6. Subsection (4) and paragraph (b) of subsection (6) of section 466.006, Florida Statutes, are amended to read:

466.006 Examination of dentists.—

(4) Notwithstanding any other provision of law in chapter 456 pertaining to the clinical dental licensure examination or national examinations, to be licensed as a dentist in this state, an applicant must successfully complete the following:

(a) A written examination on the laws and rules of the state regulating the practice of dentistry;

(b)1. A practical or clinical examination, which shall be the American Dental Licensing Examination produced by the American Board of Dental Examiners, Inc., or its successor entity, if any, that is administered in this state and graded by

dentists licensed in this state and employed by the department for just such purpose, provided that the board has attained, and continues to maintain thereafter, representation on the board of directors of the American Board of Dental Examiners, the examination development committee of the American Board of Dental Examiners, and such other committees of the American Board of Dental Examiners as the board deems appropriate by rule to assure that the standards established herein are maintained organizationally. A passing score on the American Dental Licensing Examination administered in this state and graded by dentists who are licensed in this state is valid for 365 days after the date the official examination results are published.

2.a. As an alternative to the requirements of subparagraph 1., an applicant may submit scores from an American Dental Licensing Examination previously administered in a jurisdiction other than this state after October 1, 2011, and such examination results shall be recognized as valid for the purpose of licensure in this state. A passing score on the American Dental Licensing Examination administered out-of-state shall be the same as the passing score for the American Dental Licensing Examination administered in this state and graded by dentists who are licensed in this state. The examination results are valid for 365 days after the date the official examination results are published. The applicant must have completed the examination after October 1, 2011.

b. This subparagraph may not be given retroactive application.

3. If the date of an applicant's passing American Dental Licensing Examination scores from an examination previously

administered in a jurisdiction other than this state under subparagraph 2. is older than 365 days, then such scores shall nevertheless be recognized as valid for the purpose of licensure in this state, but only if the applicant demonstrates that all of the following additional standards have been met:

a.(I) The applicant completed the American Dental Licensing Examination after October 1, 2011.

(II) This sub-subparagraph may not be given retroactive application;

b. The applicant graduated from a dental school accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental accrediting organization recognized by the United States Department of Education. Provided, however, if the applicant did not graduate from such a dental school, the applicant may submit proof of having successfully completed a full-time supplemental general dentistry program accredited by the American Dental Association Commission on Dental Accreditation of at least 2 consecutive academic years at such accredited sponsoring institution. Such program must provide didactic and clinical education at the level of a D.D.S. or D.M.D. program accredited by the American Dental Association Commission on Dental Accreditation;

c. The applicant currently possesses a valid and active dental license in good standing, with no restriction, which has never been revoked, suspended, restricted, or otherwise disciplined, from another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico;

d. The applicant submits proof that he or she has never been reported to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, or the American Association of Dental Boards Clearinghouse. This sub-subparagraph does not apply if the applicant successfully appealed to have his or her name removed from the data banks of these agencies;

e.(I) In the 5 years immediately preceding the date of application for licensure in this state, the applicant must submit proof of having been consecutively engaged in the full-time practice of dentistry in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico, or, if the applicant has been licensed in another state or territory of the United States, the District of Columbia, or the Commonwealth of Puerto Rico for less than 5 years, the applicant must submit proof of having been engaged in the full-time practice of dentistry since the date of his or her initial licensure.

(II) As used in this section, "full-time practice" is defined as a minimum of 1,200 hours per year for each and every year in the consecutive 5-year period or, where applicable, the period since initial licensure, and must include any combination of the following:

(A) Active clinical practice of dentistry providing direct patient care.

(B) Full-time practice as a faculty member employed by a dental<u>, dental therapy,</u> or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(C) Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation.

(III) The board shall develop rules to determine what type of proof of full-time practice is required and to recoup the cost to the board of verifying full-time practice under this section. Such proof must, at a minimum, be:

(A) Admissible as evidence in an administrative proceeding;

(B) Submitted in writing;

(C) Submitted by the applicant under oath with penalties of perjury attached;

(D) Further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice; and

(E) Specifically found by the board to be both credible and admissible.

(IV) An affidavit of only the applicant is not acceptable proof of full-time practice unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath;

f. The applicant must submit documentation that he or she has completed, or will complete, prior to licensure in this state, continuing education equivalent to this state's requirements for the last full reporting biennium;

g. The applicant must prove that he or she has never been convicted of, or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession in any jurisdiction;

h. The applicant must successfully pass a written examination on the laws and rules of this state regulating the practice of dentistry and must successfully pass the computer-based diagnostic skills examination; and

i. The applicant must submit documentation that he or she has successfully completed the National Board of Dental Examiners dental examination.

(6)

(b)1. As used in this section, "full-time practice of dentistry within the geographic boundaries of this state within 1 year" is defined as a minimum of 1,200 hours in the initial year of licensure, which must include any combination of the following:

a. Active clinical practice of dentistry providing direct patient care within the geographic boundaries of this state.

b. Full-time practice as a faculty member employed by a dental<u>, dental therapy,</u> or dental hygiene school approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

c. Full-time practice as a student at a postgraduate dental education program approved by the board or accredited by the American Dental Association Commission on Dental Accreditation and located within the geographic boundaries of this state.

2. The board shall develop rules to determine what type of

proof of full-time practice of dentistry within the geographic boundaries of this state for 1 year is required in order to maintain active licensure and shall develop rules to recoup the cost to the board of verifying maintenance of such full-time practice under this section. Such proof must, at a minimum:

a. Be admissible as evidence in an administrative proceeding;

b. Be submitted in writing;

c. Be submitted by the applicant under oath with penalties of perjury attached;

d. Be further documented by an affidavit of someone unrelated to the applicant who is familiar with the applicant's practice and testifies with particularity that the applicant has been engaged in full-time practice of dentistry within the geographic boundaries of this state within the last 365 days; and

e. Include such additional proof as specifically found by the board to be both credible and admissible.

3. An affidavit of only the applicant is not acceptable proof of full-time practice of dentistry within the geographic boundaries of this state within 1 year, unless it is further attested to by someone unrelated to the applicant who has personal knowledge of the applicant's practice within the last 365 days. If the board deems it necessary to assess credibility or accuracy, the board may require the applicant or the applicant's witnesses to appear before the board and give oral testimony under oath.

Section 7. Section 466.0075, Florida Statutes, is amended to read:

466.0075 Applicants for examination; medical malpractice insurance.—The board may require any person applying to take the examination to practice dentistry in this state, the examination to practice dental therapy in this state, or the examination to practice dental hygiene in this state to maintain medical malpractice insurance in amounts sufficient to cover any incident of harm to a patient during the clinical examination.

Section 8. Subsection (1) of section 466.009, Florida Statutes, is amended, and subsection (4) is added to that section, to read:

466.009 Reexamination.—

(1) The department shall allow ~~permit~~ any person who fails an examination that ~~which~~ is required under s. 466.006, ~~or~~ s. 466.007, or s. 466.0225 to retake the examination. If the examination to be retaken is a practical or clinical examination, the applicant shall pay a reexamination fee set by rule of the board in an amount not to exceed the original examination fee.

(4) If an applicant for a license to practice dental therapy fails the practical or clinical examination and has failed one part or procedure of such examination, she or he may be required to retake only that part or procedure to pass such examination. However, if any such applicant fails more than one part or procedure of any such examination, she or he shall be required to retake the entire examination.

Section 9. Section 466.011, Florida Statutes, is amended to read:

466.011 Licensure.—The board shall certify for licensure by the department any applicant who satisfies the requirements of

s. 466.006, s. 466.0067, ~~or~~ s. 466.007, or s. 466.0225. The board may refuse to certify an applicant who has violated ~~any of the provisions of~~ s. 466.026 or s. 466.028.

Section 10. Section 466.0136, Florida Statutes, is created to read:

466.0136 Continuing education; dental therapists.—In addition to any other requirements for relicensure for dental therapists specified in this chapter, the board shall require each licensed dental therapist to complete at least 24 hours, but not more than 36 hours, biennially of continuing professional education in dental subjects in programs approved by the board or in equivalent programs of continuing education. Programs of continuing education approved by the board must be programs of learning that, in the opinion of the board, contribute directly to the dental education of the dental therapist. An individual who is licensed as both a dental therapist and a dental hygienist may use 1 hour of continuing professional education that is approved for both dental therapy and dental hygiene education to satisfy both dental therapy and dental hygiene continuing education requirements. The board shall adopt rules and guidelines to administer and enforce this section. The dental therapist shall retain in her or his records any receipts, vouchers, or certificates necessary to document completion of the continuing education. Compliance with the continuing education requirements is mandatory for issuance of the renewal certificate. The board may excuse licensees, as a group or as individuals, from all or part of the continuing education requirements if an unusual circumstance, emergency, or hardship prevented compliance with this section.

Section 11. Section 466.016, Florida Statutes, is amended to read:

466.016 License to be displayed.—Every practitioner of dentistry, dental therapy, or dental hygiene within the meaning of this chapter shall post and keep conspicuously displayed her or his license in the office where ~~wherein~~ she or he practices, in plain sight of the practitioner's patients. Any dentist, dental therapist, or dental hygienist who practices at more than one location shall be required to display a copy of her or his license in each office where she or he practices.

Section 12. Present subsections (7) and (8) of section 466.017, Florida Statutes, are renumbered as subsections (8) and (9), respectively, paragraphs (d) and (e) of subsection (3), subsection (4), and present subsections (7) and (8) are amended, and a new subsection (7) is added to that section, to read:

466.017 Prescription of drugs; anesthesia.—

(3) The board shall adopt rules which:

(d) Establish further requirements relating to the use of general anesthesia or sedation, including, but not limited to, office equipment and the training of dental assistants, dental therapists, or dental hygienists who work with dentists using general anesthesia or sedation.

(e) Establish an administrative mechanism enabling the board to verify compliance with training, education, experience, equipment, or certification requirements of dentists, dental therapists, dental hygienists, and dental assistants adopted pursuant to this subsection. The board may charge a fee to defray the cost of verifying compliance with requirements adopted pursuant to this paragraph.

(4) A dentist, dental therapist, or dental hygienist who administers or employs the use of any form of anesthesia must possess a certification in either basic cardiopulmonary resuscitation for health professionals or advanced cardiac life support approved by the American Heart Association or the American Red Cross or an equivalent agency-sponsored course with recertification every 2 years. Each dental office which uses any form of anesthesia must have immediately available and in good working order such resuscitative equipment, oxygen, and other resuscitative drugs as are specified by rule of the board in order to manage possible adverse reactions.

(7) A dental therapist under the general supervision of a dentist may administer local anesthesia, including intraoral block anesthesia or soft tissue infiltration anesthesia, or both, if she or he has completed the course described in subsection (5) and presents evidence of current certification in basic or advanced cardiac life support.

(8) ~~(7)~~ A licensed dentist, or a dental therapist who is authorized by her or his supervising dentist, may utilize an X-ray machine, expose dental X-ray films, and interpret or read such films. Notwithstanding ~~The provisions of~~ part IV of chapter 468 ~~to the contrary notwithstanding~~, a licensed dentist, or a dental therapist who is authorized by her or his supervising dentist, may authorize or direct a dental assistant to operate such equipment and expose such films under her or his direction and supervision, pursuant to rules adopted by the board in accordance with s. 466.024 which ensure that said assistant is competent by reason of training and experience to operate said equipment in a safe and efficient manner. The board may charge a

fee not to exceed $35 to defray the cost of verifying compliance with requirements adopted pursuant to this section.

(9)~~(8)~~ Notwithstanding ~~The provisions of~~ s. 465.0276 ~~notwithstanding~~, a dentist need not register with the board or comply with the continuing education requirements of that section if the dentist confines her or his dispensing activity to the dispensing of fluorides and chlorhexidine ~~chlorohexidine~~ rinse solutions; provided that the dentist complies with and is subject to all laws and rules applicable to pharmacists and pharmacies, including, but not limited to, chapters 465, 499, and 893, and all applicable federal laws and regulations, when dispensing such products.

Section 13. Subsection (1) of section 466.018, Florida Statutes, is amended to read:

466.018 Dentist of record; patient records.—

(1) Each patient shall have a dentist of record. The dentist of record shall remain primarily responsible for all dental treatment on such patient regardless of whether the treatment is rendered by the dentist or by another dentist, dental therapist, dental hygienist, or dental assistant rendering such treatment in conjunction with, at the direction or request of, or under the supervision of such dentist of record. The dentist of record shall be identified in the record of the patient. If treatment is rendered by a dentist other than the dentist of record or by a dental hygienist, dental therapist, or dental assistant, the name or initials of such person shall be placed in the record of the patient. In any disciplinary proceeding brought pursuant to this chapter or chapter 456, it shall be presumed as a matter of law that

treatment was rendered by the dentist of record unless otherwise noted on the patient record pursuant to this section. The dentist of record and any other treating dentist are subject to discipline pursuant to this chapter or chapter 456 for treatment rendered to the patient and performed in violation of such chapter. One of the purposes of this section is to ensure that the responsibility for each patient is assigned to one dentist in a multidentist practice of any nature and to assign primary responsibility to the dentist for treatment rendered by a dental hygienist, dental therapist, or dental assistant under her or his supervision. This section shall not be construed to assign any responsibility to a dentist of record for treatment rendered pursuant to a proper referral to another dentist who does not ~~in~~ practice with the dentist of record or to prohibit a patient from voluntarily selecting a new dentist without permission of the dentist of record.

Section 14. Section 466.0225, Florida Statutes, is created to read:

466.0225 Examination of dental therapists; licensing.—

(1) Any person desiring to be licensed as a dental therapist shall apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application must include two recent photographs of the applicant.

(2) An applicant is entitled to take the examinations required in this section and receive licensure to practice dental therapy in this state if the applicant:

(a) Is 18 years of age or older;

(b) Is a graduate of a dental therapy college or school

accredited by the American Dental Association Commission on Dental Accreditation or its successor entity, if any, or any other dental therapy accrediting entity recognized by the United States Department of Education. For applicants applying for a dental therapy license before January 1, 2024, the board shall approve the applicant's dental therapy education program if the program was administered by a college or school that operates an accredited dental or dental hygiene program and the college or school certifies to the board that the applicant's education substantially conformed to the education standards established by the American Dental Association Commission on Dental Accreditation;

(c) Has successfully completed a dental therapy practical or clinical examination produced by the American Board of Dental Examiners, Inc., (ADEX) or its successor entity, if any, if the board finds that the successor entity's examination meets or exceeds the provisions of this section. If an applicant fails to pass the ADEX Dental Therapy Examination after three attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board. If a dental therapy examination has not been established by the ADEX, the board shall administer or approve an alternative examination;

(d) Has not been disciplined by a board, except for citation offenses or minor violations;

(e) Has not been convicted of or pled nolo contendere to, regardless of adjudication, any felony or misdemeanor related to the practice of a health care profession; and

(f) Has successfully completed a written examination on the

laws and rules of this state regulating the practice of dental therapy.

(3) An applicant who meets the requirements of this section, and who has successfully completed the examinations identified in paragraph (2)(c) in a jurisdiction other than this state, or who has successfully completed comparable examinations administered or approved by the licensing authority in a jurisdiction other than this state shall be licensed to practice dental therapy in this state if the board determines that the other jurisdiction's examinations and scope of practice are substantially similar to those identified in paragraph (2)(c).

Section 15. Section 466.0227, Florida Statutes, is created to read:

466.0227 Dental therapists; scope and area of practice.—

(1) The Legislature finds that authorizing licensed dental therapists to perform the services specified in subsection (3) would improve access to high-quality affordable oral health services for all residents in this state. The Legislature intends to rapidly improve such access for low-income, uninsured, and underserved patients and communities. To further this intent, a dental therapist licensed under this chapter is limited to practicing dental therapy in the following settings:

(a) A health access setting, as defined in s. 466.003(16).

(b) A community health center, including an off-site care setting.

(c) A nursing facility.

(d) A military or veterans' hospital or clinic, including an off-site care setting.

(e) A governmental or public health clinic, including an

off-site care setting.

(f) A school, Head Start program, or school-based prevention program, as defined in s. 466.003(17).

(g) An oral health education institution, including an off-site care setting.

(h) A hospital.

(i) A geographic area designated as a dental health professional shortage area by the state or the Federal Government which is not located within a federally designated metropolitan statistical area.

(j) Any other clinic or practice setting if at least 50 percent of the patients served by the dental therapist in such clinic or practice setting:

1. Are enrolled in Medicaid or another state or local governmental health care program for low-income or uninsured patients; or

2. Do not have dental insurance and report a gross annual income that is less than 200 percent of the applicable federal poverty guidelines.

(2) Except as otherwise provided in this chapter, a dental therapist may perform the dental therapy services specified in subsection (3) under the general supervision of a dentist to the extent authorized by the supervising dentist and provided within the terms of a written collaborative management agreement signed by the dental therapist and the supervising dentist which meets the requirements of subsection (4).

(3) Dental therapy services include all of the following:

(a) All services, treatments, and competencies identified by the American Dental Association Commission on Dental

Accreditation in its Dental Therapy Education Accreditation Standards.

(b) The following state-specific services, if the dental therapist's education included curriculum content satisfying the American Dental Association Commission on Dental Accreditation criteria for state-specific dental therapy services:

1. Evaluating radiographs.

2. Placement of space maintainers.

3. Pulpotomies on primary teeth.

4. Dispensing and administering nonopioid analgesics including nitrous oxide, anti-inflammatories, and antibiotics as authorized by the supervising dentist and within the parameters of the collaborative management agreement.

5. Oral evaluation and assessment of dental disease and formulation of an individualized treatment plan if authorized by a supervising dentist and subject to any conditions, limitations, and protocols specified by the supervising dentist in the collaborative management agreement.

(4) Before performing any of the services authorized in subsection (3), a dental therapist must enter into a written collaborative management agreement with a supervising dentist. The agreement must be signed by the dental therapist and the supervising dentist and must include:

(a) Practice settings where services may be provided by the dental therapist and the populations to be served by the dental therapist.

(b) Any limitations on the services that may be provided by the dental therapist, including the level of supervision required by the supervising dentist.

(c) Age- and procedure-specific practice protocols for the dental therapist, including case selection criteria, assessment guidelines, and imaging frequency.

(d) A procedure for creating and maintaining dental records for the patients who are treated by the dental therapist.

(e) A plan to manage medical emergencies in each practice setting where the dental therapist provides care.

(f) A quality assurance plan for monitoring care provided by the dental therapist, including patient care review, referral followup, and a quality assurance chart review.

(g) Protocols for the dental therapist to administer and dispense medications, including the specific conditions and circumstances under which the medications are to be dispensed and administered.

(h) Criteria relating to the provision of care by the dental therapist to patients with specific medical conditions or complex medication histories, including requirements for consultation before the initiation of care.

(i) Supervision criteria of dental therapists.

(j) A plan for the provision of clinical resources and referrals in situations that are beyond the capabilities of the dental therapist.

(5) A supervising dentist shall determine the number of hours of practice that a dental therapist must complete under direct or indirect supervision of the supervising dentist before the dental therapist may perform any of the services authorized in subsection (3) under general supervision.

(6) A supervising dentist may restrict or limit the dental therapist's practice in a collaborative management agreement to

be less than the full scope of practice for dental therapists which is authorized in subsection (3).

(7) A supervising dentist may authorize a dental therapist to provide dental therapy services to a patient before the dentist examines or diagnoses the patient if the authority, conditions, and protocols are established in a written collaborative management agreement and if the patient is subsequently referred to a dentist for any needed additional services that exceed the dental therapist's scope of practice or authorization under the collaborative management agreement.

(8) A supervising dentist must be licensed and practicing in this state. The supervising dentist is responsible for all services authorized and performed by the dental therapist pursuant to the collaborative management agreement and for providing or arranging followup services to be provided by a dentist for those services that are beyond the dental therapist's scope of practice and authorization under the collaborative management agreement.

Section 16. Section 466.026, Florida Statutes, is amended to read:

466.026 Prohibitions; penalties.—

(1) Each of the following acts constitutes a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084:

(a) Practicing dentistry, dental therapy, or dental hygiene unless the person has an appropriate, active license issued by the department pursuant to this chapter.

(b) Using or attempting to use a license issued pursuant to this chapter which license has been suspended or revoked.

(c) Knowingly employing any person to perform duties outside the scope allowed such person under this chapter or the rules of the board.

(d) Giving false or forged evidence to the department or board for the purpose of obtaining a license.

(e) Selling or offering to sell a diploma conferring a degree from a dental college, ~~or~~ dental hygiene school or college, or dental therapy school or college, or a license issued pursuant to this chapter, or procuring such diploma or license with intent that it shall be used as evidence of that which the document stands for, by a person other than the one upon whom it was conferred or to whom it was granted.

(2) Each of the following acts constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083:

(a) Using the name or title "dentist," the letters "D.D.S." or "D.M.D.", or any other words, letters, title, or descriptive matter which in any way represents a person as being able to diagnose, treat, prescribe, or operate for any disease, pain, deformity, deficiency, injury, or physical condition of the teeth or jaws or oral-maxillofacial region unless the person has an active dentist's license issued by the department pursuant to this chapter.

(b) Using the name "dental hygienist" or the initials "R.D.H." or otherwise holding herself or himself out as an actively licensed dental hygienist or implying to any patient or consumer that she or he is an actively licensed dental hygienist unless that person has an active dental hygienist's license issued by the department pursuant to this chapter.

(c) Using the name "dental therapist" or the initials "D.T." or otherwise holding herself or himself out as an actively licensed dental therapist or implying to any patient or consumer that she or he is an actively licensed dental therapist unless that person has an active dental therapist's license issued by the department pursuant to this chapter.

(d) ~~(c)~~ Presenting as her or his own the license of another.

(e) ~~(d)~~ Knowingly concealing information relative to violations of this chapter.

(f) ~~(e)~~ Performing any services as a dental assistant as defined herein, except in the office of a licensed dentist, unless authorized by this chapter or by rule of the board.

Section 17. Paragraphs (b), (c), (g), (s), and (t) of subsection (1) of section 466.028, Florida Statutes, are amended to read:

466.028 Grounds for disciplinary action; action by the board.—

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

(b) Having a license to practice dentistry, dental therapy, or dental hygiene revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country.

(c) Being convicted or found guilty of or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which relates to the practice of dentistry, dental therapy, or dental hygiene. A plea of nolo contendere shall create a rebuttable presumption of guilt to the underlying criminal charges.

(g) Aiding, assisting, procuring, or advising any unlicensed person to practice dentistry, dental therapy, or dental hygiene contrary to this chapter or to a rule of the department or the board.

(s) Being unable to practice her or his profession with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or her or his designee that probable cause exists to believe that the licensee is unable to practice dentistry, dental therapy, or dental hygiene because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the licensee refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the licensee resides or does business. The licensee against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public. The department shall be entitled to the summary procedure provided in s. 51.011. A licensee affected under this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of her or his profession with reasonable skill and safety to patients.

(t) Fraud, deceit, or misconduct in the practice of dentistry, dental therapy, or dental hygiene.

Section 18. Paragraphs (a) and (b) of subsection (1) of section 466.0285, Florida Statutes, are amended to read:

466.0285 Proprietorship by nondentists.—

(1) No person other than a dentist licensed pursuant to this chapter, nor any entity other than a professional corporation or limited liability company composed of dentists, may:

(a) Employ a dentist, a dental therapist, or a dental hygienist in the operation of a dental office.

(b) Control the use of any dental equipment or material while such equipment or material is being used for the provision of dental services, whether those services are provided by a dentist, a dental therapist, a dental hygienist, or a dental assistant.

Any lease agreement, rental agreement, or other arrangement between a nondentist and a dentist whereby the nondentist provides the dentist with dental equipment or dental materials shall contain a provision whereby the dentist expressly maintains complete care, custody, and control of the equipment or practice.

Section 19. Subsection (1) of section 466.051, Florida Statutes, is amended to read:

466.051 Confidentiality of certain information contained in dental workforce surveys.—

(1) Personal identifying information that is contained in a record provided by a dentist, dental therapist, or dental hygienist licensed under this chapter in response to a dental workforce survey and held by the Department of Health is

confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. Personal identifying information in such a record:

(a) Shall be disclosed with the express written consent of the individual to whom the information pertains or the individual's legally authorized representative.

(b) Shall be disclosed by court order upon a showing of good cause.

(c) May be disclosed to a research entity, if the entity seeks the records or data pursuant to a research protocol approved by the Department of Health, maintains the records or data in accordance with the approved protocol, and enters into a purchase and data-use agreement with the department, the fee provisions of which are consistent with s. 119.07(4). The department may deny a request for records or data if the protocol provides for intrusive follow-back contacts, does not plan for the destruction of the confidential records after the research is concluded, is administratively burdensome, or does not have scientific merit. The agreement must prohibit the release of information by the research entity which would identify individuals, limit the use of records or data to the approved research protocol, and prohibit any other use of the records or data. Copies of records or data issued pursuant to this paragraph remain the property of the department.

Section 20. The Department of Health, in consultation with the Board of Dentistry and the Agency for Health Care Administration, shall submit a progress report to the President of the Senate and the Speaker of the House of Representatives by July 1, 2022, and a final report 3 years after the first dental

therapy license is issued. The reports must include all of the following components:

(1) The progress that has been made in this state to implement dental therapy training programs, licensing, and Medicaid reimbursement.

(2) Data demonstrating the effects of dental therapy in this state on:

(a) Access to dental services;

(b) The use of primary and preventive dental services in underserved regions and populations, including the Medicaid population;

(c) Costs to dental providers, patients, dental insurance carriers, and the state; and

(d) The quality and safety of dental services.

(3) Specific recommendations for any necessary legislative, administrative, or regulatory reform relating to the practice of dental therapy.

(4) Any other information deemed appropriate by the department.

Section 21. This act shall take effect July 1, 2019.

2019 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Florida Department of Health

BILL INFORMATION	
BILL NUMBER:	HB 649
BILL TITLE:	Dental Therapy
BILL SPONSOR:	Rep.Plasencia
EFFECTIVE DATE:	7-1-2019

COMMITTEES OF REFERENCE
1) Health Quality Subcommittee
2) Health Care Appropriations Subcommittee
3) Health & Human Services Committee
4) Click or tap here to enter text.
5) Click or tap here to enter text.

CURRENT COMMITTEE
Health Quality Subcommittee

SIMILAR BILLS	
BILL NUMBER:	Click or tap here to enter text.
SPONSOR:	Click or tap here to enter text.

PREVIOUS LEGISLATION	
BILL NUMBER:	Click or tap here to enter text.
SPONSOR:	Click or tap here to enter text.
YEAR:	Click or tap here to enter text.
LAST ACTION:	Click or tap here to enter text.

IDENTICAL BILLS	
BILL NUMBER:	SB 684
SPONSOR:	Sen. Brandes

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	2-5-2019
LEAD AGENCY ANALYST:	Jessica Sapp
ADDITIONAL ANALYST(S):	Click or tap here to enter text.
LEGAL ANALYST:	Adrienne Rodgers
FISCAL ANALYST:	Darius Pelham

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

HB 649 amends 409.906, F.S. and adds language which authorizes Medicaid to reimburse for dental services provided in a mobile dental unit owned by a health access setting. The bill establish a new dental provider, known as a dental therapist, in Florida Statutes. The bill addresses the examination, licensure, continuing professional education, limits and scope of practice for the dental therapist. The bill requires the Board of Dentistry, chair to appoint and establish members of the Council of Dental Therapy. The department is required to submit a progress report and final report to the Legislature at specified times.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Although the definition of a dental therapist can vary according to state laws, most often a dental therapist is a member of the dental team who provides preventative and restorative dental care, usually for children and adolescents.

The profession of licensed dental therapist does not presently exist under Florida law. Five states currently license dental therapists: Arizona, Michigan, Maine, Minnesota and Vermont. Dental therapists are operating under pilot authority in Oregon and Alaska native tribes have authorized the use of dental therapists. Twelve states are actively exploring authorizing dental therapy. Minnesota, the first state to fully license dental therapists, created a two-tiered licensing model: Dental Therapist (DT) –provides evaluative, preventive, restorative and minor surgical dental care under the direction of a dentist; and Advanced Dental Therapist (ADT) –provides more advanced services under the supervision of a dentist, such as oral evaluation and assessment, treatment plan formulation, and non-surgical extraction of certain diseased teeth. After completing 2,000 hours of the practice of dental therapy under the direct or indirect (on-site) supervision of a dentist, a DT may be eligible for certification as an ADT. The dentist need not be on site or see the patients to be treated by the ADT before they receive care. A DT is limited to practicing in settings that serve primarily low-income, uninsured or underserved patients or communities with a shortage of dental professionals.

Currently, the American Board of Dental Examiners (ADEX) only administers dental and dental hygiene examinations. The only known dental therapy examinations in existence are the Central Regional Dental Testing Services, Inc. (CRDTS) examination and the recently developed Commission on Dental Competency Assessments (CDCA) examination. Section 456.017, F.S., directs the Department to utilize a national examination if one exists. The CRDTS examination fee is $1,700.00.

Note: The dental therapy exam mimics parts of the American Board of Dental Examiners (ADEX) dental exam. As more states reach a consensus on dental therapy as a profession, the exam will likely be transitioned to ADEX. A Periodontal exercise is not given because Minnesota requires dental therapists to possess their dental hygiene license. CDCA could add this Periodontal portion as needed/required by a state. CDCA administers this examination using the same framework of exam administration expected in ADEX dental exam administration. This includes three licensed dentist examiners per evaluation with administrative procedures ensuring anonymity.

Currently, dentists must apply for registration of radiation machines on the Radiation Machine Facility Registration form and submit to the Department of Health, Bureau of Radiation Control, Radiation Machine Section, DOH Form 1107, for approval.

2. EFFECT OF THE BILL:

The bill amends s. 409.906, F.S., expanding the definition of a health access setting to reimburse for dental services. However, the definition of a health access setting was not amended in s. 466.003(14), F.S, the Dental Practice Act.

The bill amends s. 466.003, F.S., creating a definition of a “Dental Therapist.” A Dental Therapist is a person licensed to practice dental therapy pursuant to the newly created s. 466.0225, F.S. It creates a definition for “Dental Therapy” as the rendering of services pursuant to the newly created s. 466.0227, F.S., and any related extraoral service or procedure required in the performance of such services.

This bill amends s. 466.004, F.S., creating the Council on Dental Therapy. Members are appointed by the Chair of the Board of Dentistry and must include one board member, who shall Chair the Council, and three dental therapists who are actively engaged in dental therapy. It specifies criteria the council must adhere to.

The bill amends s. 466.0075, F.S., requiring dental therapy examination applicants maintain medical malpractice insurance in amounts sufficient to cover any incident of harm to a patient during the clinical examination.

The bill creates s. 466.009(4), F.S., which specifies the reexamination requirements of dental therapy applicants. This language is obsolete since the required examination is a national examination. National examination organizations establish criteria for reexamination.

The bill creates s. 466.0136, F.S., establishing continuing education (CE) requirements for license renewal of dental therapists. The bill provides the Board of Dentistry with rule making authority to approve CE providers and courses. The bill allows an individual who is licensed as both a dental therapist and a dental hygienist to use one (1) hour of CE that is approved for both professions. While this bill requires compliance with CE requirements as a condition of renewal, it also provides exceptions, granted by the Board, for licensees, as a group or individual, from all or part of the continuing education requirements if an unusual circumstance, emergency, or hardship has prevented compliance. This exception is consistent with the exceptions set forth for dentists and dental hygienists in ss. 466.0135(4) and 466.014, F.S.

The bill amends s. 466.017, F.S., allowing dental therapists to administer local anesthesia, under the general supervision of dentist, including intraoral block anesthesia or soft tissue infiltration anesthesia, or both, if he or she has completed the required course and presents evidence of current certification in basic or advanced cardiac life support. Unlike dental hygienists, who currently must be certified by the board to administer local anesthesia and their license status reflects this designation, this bill allows dental therapists to administer anesthesia without submitting the required training documentation to the Department for certification, therefore, no designation authorizing the administration of anesthesia would be made on their license status. This bill also authorizes a dental therapist to utilize an x-ray machine, expose dental x-ray films, and interpret or read such films. It is unclear if dental therapists would be subject to the radiation machine registration requirements set forth in Rule 64E-5.511, F.A.C.

The bill creates s. 466.0225, F.S., which sets forth the examination and licensing requirements for dental therapists.

For applicants applying before January 1, 2024, the board shall approve the applicant's dental therapy education program if the program was administered by a college or school that operates an accredited dental or dental hygiene program and the college certifies to the board that the applicant's education substantially conforms to the education standards established by CODA. If the board is required to review each application to make this determination, this may require the board to form a credentials committee that will add to regulatory costs.

If the applicant fails to pass the ADEX dental therapy examination in 3 attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board. If a dental therapy examination has not been established by the ADEX, the board shall administer or approve an alternative examination.

The effect of the requirement for a written laws and rules examination is that one would have to be developed as it currently does not exist. This section also creates endorsement language for those applicants coming from another jurisdiction. It requires the board to determine the other jurisdiction's examinations and scope of practice are substantially similar to those identified in s. 466.0225(2)(c), F.S. The effect is that additional board meetings will be required for the board to review endorsement applications and determine substantial similarity which could delay licensure for those applicants.

The bill creates s. 466.0227, F.S., which establishes the scope and area of practice for a dental therapist.

The proposed language specifies the requirements of a written collaborative management agreement and requires the supervising dentist to determine the number of hours a dental therapist must complete under direct or indirect supervision before the dental therapist may perform authorized services. The language allows a dental therapist to provide services to a patient before the dentist examines or diagnoses the patient. The current definition of general supervision, is specified in s. 466.003(10), F.S., and Rule 64B5-16.001(6), F.A.C., which requires that a licensed dentist examine the patient, diagnose a condition to be treated, and authorize the procedure performed. The supervising dentist is responsible for all services authorized and performed by the dental therapist and for providing follow-up services that are beyond the dental therapist's scope of practice.

Included in the scope of practice authorized under the proposed language for a dental therapist is “dispensing and administering nonopioid analgesics including nitrous oxide, anti-inflammatories, and antibiotics as authorized by the supervising dentist and within the parameters of the collaborative management agreement.”

The bill amends s. 466.026, F.S., prohibiting the practice of dental therapy without a license and title protection for “dental therapist” or the initials “D.T.”

It provides an effective date of July 1, 2019. The effect of this effective date is that key activities associated with creating a new profession will not be completed. Some key activities are the development of paper and online applications as well as designing, testing, and implementing multiple electronic systems. In addition, numerous rules will have to be promulgated to implement this legislation and the board would have to certify the national examination. A January 2020 effective date would allow sufficient time to establish the infrastructure needed to support this legislation.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☒ N☐

If yes, explain:	The Board of Dentistry would be required to engage in rulemaking to incorporate a dental therapy application into Chapter 64B5-2, F.A.C. The Board would be required to amend Chapter 64B5-12, F.A.C to incorporate continuing education requirements for dental therapists.
Is the change consistent with the agency’s core mission?	Y☐ N☒
Rule(s) impacted (provide references to F.A.C., etc.):	Chapter 64B5-2, F.A.C., and Chapter 64B5-12, F.A.C.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	A progress report shall be submitted to the President of the Senate and the Speaker of the House which shall include the progress that has been made in Florida to implement dental therapy training programs, licensing, and Medicaid reimbursement. Additionally, data must be submitted demonstrating the effects of dental therapy in Florida.
Date Due:	7-1-2022
Bill Section Number(s):	Section 20

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☒ N☐

Board:	Board of Dentistry
Board Purpose:	To develop rules and policies regarding dental therapy licensure, discipline, regulation, and education.

Who Appoints:	The Board of Dentistry Chair
Changes:	The proposed language would create a newly formed Council on Dental Therapy
Bill Section Number(s):	Section 5

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y☐ N☒

Revenues:	N/A
Expenditures:	
Does the legislation increase local taxes or fees? If yes, explain.	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	Click or tap here to enter text.

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☒ N☐

Revenues:	Currently the initial licensure fee, as provided in section 456.013, F.S., at $300 for the first biennium. Thereafter, the renewal licensure fees are calculated, as provided in section 466.013, at $300. The Unlicensed Activity (ULA) fee of $5 will also be assessed upon initial licensure, and renewal in accordance with Section 456.035(3), F.S. Based on MQA FY1718 data and using Minnesota as a model, it is estimated that 8,115 applicants will apply for DT licensure, and that 4,657 DH will not reapply for renewal in the next biennium. First biennium revenues are calculated based on 8,115 estimated applicants for licensure. The estimated revenue for initial licensure fees is $2,434,500 (8,115x $300). The unlicensed activity revenues are calculated based on 8,115 initial licensees for a total of $40,575 (8,115 x $5). The fees collected are subject to the 8% general revenue surcharge and $198,006 ($2,434,500+ $40,575 * .08) is deducted from the estimated amounts to be collected. Second biennium revenues are calculated based on 8,115 estimated DT licensure renewals and a reduction of 4,657 DH renewals. The estimated revenue for DT renewal fees is $2,434,500 (8,115 x $300). The unlicensed activity revenues are calculated based on 8,115 initial licensees for a total of $40,575 (8,115 x$5). The estimated reduction in revenue for DH renewal fees is based on 4,657 non-renewals for a total of $372,560 (4,657 x $80) The reduction in unlicensed activity revenues are calculated based on 4,657 non-renewals for a total of $23,285 (4/657 x $5).The estimated net revenue is $2,079,230 ($2,434,500 + $40,575 - $372,560 -$23,285).The fees collected

	are subject to the 8% general revenue surcharge and $166,338 ($2,079,230 *.08) is deducted from the estimated amounts to be collected. The total estimated revenue for the first biennium is $2,277,069. The total estimated revenue for the second biennium is $1,912,892.
Expenditures:	3.5 full-time equivalent (FTE) positions and 1 OPS will be required to implement the provisions of this bill. OPS position is computed at base of the position plus 1.15% for Medicare. Salary is computed at base of the position plus 43% for benefits. As of June 30, 2018, 1 FTE can manage an active/inactive licensure pool size of 6,805 for Dental Hygienist. The projected licensee pool size for Dental Therapy is 8,115 and the expected DH reduction is 4,657; therefore, 1 FTE is justified. Further, it is also anticipated that 1 OPS will be required to handle the initial influx of applicants. 1 FTE Regulatory Specialist II, no travel and 1 OPS Regulatory Specialist II, no travel, is requested. Based on the LBR standards, the total FTE cost is $50,760 ($39,934/Salary + $10,497/Expense + $329/HR) and the total OPS cost is $35,864 ($25,260/OPS + $10,497/Expense + $107/HR) for a total cost of $86,625. Based on FY17-18 enforcement data, it is estimated that there will be 170 complaints filed against Dental Therapist and 35 of those complaints will be deemed legally sufficient for investigation and prosecution. MQA can manage a workload of 36 cases per FTE for investigation and 36 cases per FTE for prosecution; therefore, 2 FTEs are justified. 1 FTE Investigation Specialist II, medium travel, and 1 FTE Senior Attorney, no travel, is requested. Based on the LBR standards, the total FTE cost is $151,841 ($120,583/Salary + $30,600/Expense +$658/HR). Based on FY17-18 data, MQA can manage a workload of 9,748 calls per FTE. MQA anticipates 3,819 additional telephone calls in the Communication Center. .5 Regulatory Specialist II, no travel, is requested. Based on the LBR standards, the total FTE cost is $30,793 ($19,967/Salary+ $10,497/Expense + $329/HR). MQA anticipates holding 4, 1 day meetings per year with 4 council members and 2 DOH staff. The average travel cost for professions licensed under chapter 491,F.S. is $450 per day for a total cost of $ $7,200. The average cost for meeting rooms and equipment is $1,875 per day for a total cost of $7,500. The cost for member compensation at $50 per day for each council member totals $800. Total estimated meeting cost is $15,500($14,700/Expense + $800/OPS). DOH currently contracts services for processing of initial and renewal applications and related fees. The cost of the contracted service is based on a $7.69 per application rate. It is projected 8,115 new applications will be processed for a cost of $62,404 (8,115x$7.69). DOH will incur non-recurring costs for rulemaking, which current budget authority is adequate to absorb. Consistent with adding any new profession, DOH will update the Licensing and Enforcement Information Database System (LEIDS) licensure system to

	accommodate the new Dental Therapy license, which current resources are adequate to absorb. DOH will incur an increase in workload associated the development and maintenance of a new website, online renewals, online applications, etc., which current resources are adequate to absorb. The total estimated cost for the first biennium is $584,408 in the following categories: Annual Estimated Cost Salary - $180,484/Recurring OPS – $800/Recurring + $25,260/Non-Recurring Expense - $54,646/Recurring + $22,145/Non-Recurring ContractedServices - $62,404/Recurring Biannual Human Resources - $1,316/Recurring + $107/Non-Recurring
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☒ N☐

Revenues:	Unknown
Expenditures:	Individuals seeding Dental Therapy licensure will be required to pay the initial licensure and renewal fees.
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	Click or tap here to enter text.
Bill Section Number:	Click or tap here to enter text.

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	The License and Enforcement Database System (LEIDS), document repository and the licensure/registration renewal system must be updated to reflect the addition of this profession. The VERSA Online system (system that supports all online infrastructure support for online applications, license renewal) will need to be programmed to reflect the addition of this profession. The Division of Medical Quality Assurance will incur an increase inworkload to update the existing infrastructure, LEIDS, create a web presence and develop an online application.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☒ N☐

If yes, describe the anticipated impact including any fiscal impact.	Click or tap here to enter text.

ADDITIONAL COMMENTS

The proposed language in s. 466.0225(1), F.S., contains outdated language requiring the applicant to submit two recent photographs to the Department. Historically, photographs were required when the Department developed and administered examinations and photographs were used for identification purposes.

The bill creates s. 466.0225, F.S., which sets forth the examination and licensing requirements for dental therapists. One of those requirements states that the applicant "Has not been disciplined by a board, except for citation offenses or minor violations". This language is not clear as to who defines minor violations.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	It is unclear whether this language would allow a dental therapist to provide services to a patient before a dentist examines or diagnoses the patient. This could present a conflict with a section 466.003(10), F.S., and Florida Administrative Code Rule 64B5-16.001(6), which requires a licensed dentist to examine a patient, diagnose the condition to be treated and authorize the procedure to be performed before another licensed professional can provide services.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 686
INTRODUCER:	Senator Brandes
SUBJECT:	Fees/Dental Therapists
DATE:	March 15, 2019
REVISED:	

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

I. Summary:

SB 686 requires the Board of Dentistry to impose application and examination fees on individuals seeking to obtain licensure as dental therapists.

The Florida Constitution requires that legislation imposing or authorizing new state taxes or fees[1] and legislation that raises existing state taxes or fees[2] to be passed by a two-thirds vote of the membership of each house of the Legislature, and the tax or fee provisions must be passed in a separate bill.[3] SB 686 imposes licensure fees on a new type of licensee created by SB 684. As such, the Florida Constitution may require that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

The provisions of the bill take effect on the same date that SB 684, or other similar legislation, takes effect if such legislation is passed in the same legislative session or extension thereof.

II. Present Situation:

Dental Therapists

Currently, dental therapy is not defined under statute as a licensed profession in Florida. Five states currently license dental therapists: Arizona, Michigan, Maine, Minnesota and Vermont, and an additional twelve states are actively exploring authorizing dental therapy.[4] A dental

[1] FLA. CONST. art. VII, s. 19(a).
[2] FLA. CONST. art. VII, s. 19(b).
[3] FLA. CONST. art. VII, s. 19(e).
[4] Florida Department of Health, 2019 Agency Legislative Bill Analysis, HB 649. February 5, 2019. On file with the Senate Committee on Children, Families and Elder Affairs.

therapist is limited to practicing in settings that serve primarily low-income, uninsured or underserved patients or communities with a shortage of dental professionals.[5]

For more information on dental therapists and on the specifics of SB 684, see the analysis of SB 684.

Licensure Fees

Article VII, s. 19, of the Florida Constitution requires that a new state tax or fee, as well as an increased state tax or fee, must be approved by two-thirds of the membership of each house of the Legislature and must be contained in a separate bill that contains no other subject. Article VII, s. 19(d)(1), of the Florida Constitution defines "fee" to mean "any charge or payment required by law, including any fee for service, fee or cost for licenses, and charge for service."

III. Effect of Proposed Changes:

Section 1 amends s. 466.0225, F.S., as created in SB 684, requiring that any individual applying for licensure as a dental therapist must pay a nonrefundable application fee set by the Board of Dentistry not to exceed $100 and an examination fee set by the Board of Dentistry not to exceed $225. The bill provides that the examination fee may be refunded if the applicant is found to be ineligible to take the examinations.

Section 2 provides that the provisions of the bill take effect on the same date that SB 684, or other similar legislation, takes effect if such legislation is passed in the same legislative session or extension thereof.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

SB 686 applies creates new statutory application and examination fees for a new type of licensee created by SB 684. As such, the Florida Constitution requires that the fees be passed in a separate bill by a two-thirds vote of the membership of each house of the Legislature.

[5] *Id*.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill is expected to generate approximately $2.3 million during the first biennium of licensure, and approximately $1.9 million during the second biennium of licensure, to support the regulation of dental therapists by the Department of Health.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 466.0225 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Brandes

24-01156-19 2019686__

A bill to be entitled

An act relating to fees; amending s. 466.0225, F.S.; revising the licensure requirements for dental therapists to include application and examination fees; providing a contingent effective date.

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

Section 1. Subsection (1) of section 466.0225, Florida Statutes, as created by SB ____, is amended to read:

466.0225 Examination of dental therapists; licensing.—

(1) Any person desiring to be licensed as a dental therapist must apply to the department to take the licensure examinations and shall verify the information required on the application by oath. The application must include two recent photographs of the applicant. There shall be a nonrefundable application fee set by the board not to exceed $100 and an examination fee set by the board not to exceed $225. The examination fee may be refunded if the applicant is found ineligible to take the examinations.

Section 2. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes a law.

2019 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Florida Department of Health

BILL INFORMATION	
BILL NUMBER:	HB 649
BILL TITLE:	Dental Therapy
BILL SPONSOR:	Rep.Plasencia
EFFECTIVE DATE:	7-1-2019

COMMITTEES OF REFERENCE
1) Health Quality Subcommittee
2) Health Care Appropriations Subcommittee
3) Health & Human Services Committee
4) Click or tap here to enter text.
5) Click or tap here to enter text.

CURRENT COMMITTEE
Health Quality Subcommittee

SIMILAR BILLS	
BILL NUMBER:	Click or tap here to enter text.
SPONSOR:	Click or tap here to enter text.

PREVIOUS LEGISLATION	
BILL NUMBER:	Click or tap here to enter text.
SPONSOR:	Click or tap here to enter text.
YEAR:	Click or tap here to enter text.
LAST ACTION:	Click or tap here to enter text.

IDENTICAL BILLS	
BILL NUMBER:	SB 684
SPONSOR:	Sen. Brandes

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	2-5-2019
LEAD AGENCY ANALYST:	Jessica Sapp
ADDITIONAL ANALYST(S):	Click or tap here to enter text.
LEGAL ANALYST:	Adrienne Rodgers
FISCAL ANALYST:	Darius Pelham

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

HB 649 amends 409.906, F.S. and adds language which authorizes Medicaid to reimburse for dental services provided in a mobile dental unit owned by a health access setting. The bill establish a new dental provider, known as a dental therapist, in Florida Statutes. The bill addresses the examination, licensure, continuing professional education, limits and scope of practice for the dental therapist. The bill requires the Board of Dentistry, chair to appoint and establish members of the Council of Dental Therapy. The department is required to submit a progress report and final report to the Legislature at specified times.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Although the definition of a dental therapist can vary according to state laws, most often a dental therapist is a member of the dental team who provides preventative and restorative dental care, usually for children and adolescents.

The profession of licensed dental therapist does not presently exist under Florida law. Five states currently license dental therapists: Arizona, Michigan, Maine, Minnesota and Vermont. Dental therapists are operating under pilot authority in Oregon and Alaska native tribes have authorized the use of dental therapists. Twelve states are actively exploring authorizing dental therapy. Minnesota, the first state to fully license dental therapists, created a two-tiered licensing model: Dental Therapist (DT) –provides evaluative, preventive, restorative and minor surgical dental care under the direction of a dentist; and Advanced Dental Therapist (ADT) –provides more advanced services under the supervision of a dentist, such as oral evaluation and assessment, treatment plan formulation, and non-surgical extraction of certain diseased teeth. After completing 2,000 hours of the practice of dental therapy under the direct or indirect (on-site) supervision of a dentist, a DT may be eligible for certification as an ADT. The dentist need not be on site or see the patients to be treated by the ADT before they receive care. A DT is limited to practicing in settings that serve primarily low-income, uninsured or underserved patients or communities with a shortage of dental professionals.

Currently, the American Board of Dental Examiners (ADEX) only administers dental and dental hygiene examinations. The only known dental therapy examinations in existence are the Central Regional Dental Testing Services, Inc. (CRDTS) examination and the recently developed Commission on Dental Competency Assessments (CDCA) examination. Section 456.017, F.S., directs the Department to utilize a national examination if one exists. The CRDTS examination fee is $1,700.00.

Note: The dental therapy exam mimics parts of the American Board of Dental Examiners (ADEX) dental exam. As more states reach a consensus on dental therapy as a profession, the exam will likely be transitioned to ADEX. A Periodontal exercise is not given because Minnesota requires dental therapists to possess their dental hygiene license. CDCA could add this Periodontal portion as needed/required by a state. CDCA administers this examination using the same framework of exam administration expected in ADEX dental exam administration. This includes three licensed dentist examiners per evaluation with administrative procedures ensuring anonymity.

Currently, dentists must apply for registration of radiation machines on the Radiation Machine Facility Registration form and submit to the Department of Health, Bureau of Radiation Control, Radiation Machine Section, DOH Form 1107, for approval.

2. EFFECT OF THE BILL:

The bill amends s. 409.906, F.S., expanding the definition of a health access setting to reimburse for dental services. However, the definition of a health access setting was not amended in s. 466.003(14), F.S, the Dental Practice Act.

The bill amends s. 466.003, F.S., creating a definition of a “Dental Therapist.” A Dental Therapist is a person licensed to practice dental therapy pursuant to the newly created s. 466.0225, F.S. It creates a definition for “Dental Therapy” as the rendering of services pursuant to the newly created s. 466.0227, F.S., and any related extraoral service or procedure required in the performance of such services.

This bill amends s. 466.004, F.S., creating the Council on Dental Therapy. Members are appointed by the Chair of the Board of Dentistry and must include one board member, who shall Chair the Council, and three dental therapists who are actively engaged in dental therapy. It specifies criteria the council must adhere to.

The bill amends s. 466.0075, F.S., requiring dental therapy examination applicants maintain medical malpractice insurance in amounts sufficient to cover any incident of harm to a patient during the clinical examination.

The bill creates s. 466.009(4), F.S., which specifies the reexamination requirements of dental therapy applicants. This language is obsolete since the required examination is a national examination. National examination organizations establish criteria for reexamination.

The bill creates s. 466.0136, F.S., establishing continuing education (CE) requirements for license renewal of dental therapists. The bill provides the Board of Dentistry with rule making authority to approve CE providers and courses. The bill allows an individual who is licensed as both a dental therapist and a dental hygienist to use one (1) hour of CE that is approved for both professions. While this bill requires compliance with CE requirements as a condition of renewal, it also provides exceptions, granted by the Board, for licensees, as a group or individual, from all or part of the continuing education requirements if an unusual circumstance, emergency, or hardship has prevented compliance. This exception is consistent with the exceptions set forth for dentists and dental hygienists in ss. 466.0135(4) and 466.014, F.S.

The bill amends s. 466.017, F.S., allowing dental therapists to administer local anesthesia, under the general supervision of dentist, including intraoral block anesthesia or soft tissue infiltration anesthesia, or both, if he or she has completed the required course and presents evidence of current certification in basic or advanced cardiac life support. Unlike dental hygienists, who currently must be certified by the board to administer local anesthesia and their license status reflects this designation, this bill allows dental therapists to administer anesthesia without submitting the required training documentation to the Department for certification, therefore, no designation authorizing the administration of anesthesia would be made on their license status. This bill also authorizes a dental therapist to utilize an x-ray machine, expose dental x-ray films, and interpret or read such films. It is unclear if dental therapists would be subject to the radiation machine registration requirements set forth in Rule 64E-5.511, F.A.C.

The bill creates s. 466.0225, F.S., which sets forth the examination and licensing requirements for dental therapists.

For applicants applying before January 1, 2024, the board shall approve the applicant's dental therapy education program if the program was administered by a college or school that operates an accredited dental or dental hygiene program and the college certifies to the board that the applicant's education substantially conforms to the education standards established by CODA. If the board is required to review each application to make this determination, this may require the board to form a credentials committee that will add to regulatory costs.

If the applicant fails to pass the ADEX dental therapy examination in 3 attempts, the applicant is not eligible to retake the examination unless the applicant completes additional education requirements as specified by the board. If a dental therapy examination has not been established by the ADEX, the board shall administer or approve an alternative examination.

The effect of the requirement for a written laws and rules examination is that one would have to be developed as it currently does not exist. This section also creates endorsement language for those applicants coming from another jurisdiction. It requires the board to determine the other jurisdiction's examinations and scope of practice are substantially similar to those identified in s. 466.0225(2)(c), F.S. The effect is that additional board meetings will be required for the board to review endorsement applications and determine substantial similarity which could delay licensure for those applicants.

The bill creates s. 466.0227, F.S., which establishes the scope and area of practice for a dental therapist.

The proposed language specifies the requirements of a written collaborative management agreement and requires the supervising dentist to determine the number of hours a dental therapist must complete under direct or indirect supervision before the dental therapist may perform authorized services. The language allows a dental therapist to provide services to a patient before the dentist examines or diagnoses the patient. The current definition of general supervision, is specified in s. 466.003(10), F.S., and Rule 64B5-16.001(6), F.A.C., which requires that a licensed dentist examine the patient, diagnose a condition to be treated, and authorize the procedure performed. The supervising dentist is responsible for all services authorized and performed by the dental therapist and for providing follow-up services that are beyond the dental therapist's scope of practice.

Included in the scope of practice authorized under the proposed language for a dental therapist is “dispensing and administering nonopioid analgesics including nitrous oxide, anti-inflammatories, and antibiotics as authorized by the supervising dentist and within the parameters of the collaborative management agreement.”

The bill amends s. 466.026, F.S., prohibiting the practice of dental therapy without a license and title protection for “dental therapist” or the initials “D.T.”

It provides an effective date of July 1, 2019. The effect of this effective date is that key activities associated with creating a new profession will not be completed. Some key activities are the development of paper and online applications as well as designing, testing, and implementing multiple electronic systems. In addition, numerous rules will have to be promulgated to implement this legislation and the board would have to certify the national examination. A January 2020 effective date would allow sufficient time to establish the infrastructure needed to support this legislation.

3. DOES THE BILL DIRECT OR ALLOW THE AGENCY/BOARD/COMMISSION/DEPARTMENT TO DEVELOP, ADOPT, OR ELIMINATE RULES, REGULATIONS, POLICIES, OR PROCEDURES? Y☒ N☐

If yes, explain:	The Board of Dentistry would be required to engage in rulemaking to incorporate a dental therapy application into Chapter 64B5-2, F.A.C. The Board would be required to amend Chapter 64B5-12, F.A.C to incorporate continuing education requirements for dental therapists.
Is the change consistent with the agency’s core mission?	Y☐ N☒
Rule(s) impacted (provide references to F.A.C., etc.):	Chapter 64B5-2, F.A.C., and Chapter 64B5-12, F.A.C.

4. WHAT IS THE POSITION OF AFFECTED CITIZENS OR STAKEHOLDER GROUPS?

Proponents and summary of position:	Unknown
Opponents and summary of position:	Unknown

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y☐ N☒

If yes, provide a description:	A progress report shall be submitted to the President of the Senate and the Speaker of the House which shall include the progress that has been made in Florida to implement dental therapy training programs, licensing, and Medicaid reimbursement. Additionally, data must be submitted demonstrating the effects of dental therapy in Florida.
Date Due:	7-1-2022
Bill Section Number(s):	Section 20

6. ARE THERE ANY NEW GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSIONS, ETC. REQUIRED BY THIS BILL? Y☒ N☐

Board:	Board of Dentistry
Board Purpose:	To develop rules and policies regarding dental therapy licensure, discipline, regulation, and education.

Who Appoints:	The Board of Dentistry Chair
Changes:	The proposed language would create a newly formed Council on Dental Therapy
Bill Section Number(s):	Section 5

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y☐ N☒

Revenues:	N/A
Expenditures:	
Does the legislation increase local taxes or fees? If yes, explain.	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	Click or tap here to enter text.

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y☒ N☐

Revenues:	Currently the initial licensure fee, as provided in section 456.013, F.S., at $300 for the first biennium. Thereafter, the renewal licensure fees are calculated, as provided in section 466.013, at $300. The Unlicensed Activity (ULA) fee of $5 will also be assessed upon initial licensure, and renewal in accordance with Section 456.035(3), F.S. Based on MQA FY1718 data and using Minnesota as a model, it is estimated that 8,115 applicants will apply for DT licensure, and that 4,657 DH will not reapply for renewal in the next biennium. First biennium revenues are calculated based on 8,115 estimated applicants for licensure. The estimated revenue for initial licensure fees is $2,434,500 (8,115x $300). The unlicensed activity revenues are calculated based on 8,115 initial licensees for a total of $40,575 (8,115 x $5). The fees collected are subject to the 8% general revenue surcharge and $198,006 ($2,434,500+ $40,575 * .08) is deducted from the estimated amounts to be collected. Second biennium revenues are calculated based on 8,115 estimated DT licensure renewals and a reduction of 4,657 DH renewals. The estimated revenue for DT renewal fees is $2,434,500 (8,115 x $300). The unlicensed activity revenues are calculated based on 8,115 initial licensees for a total of $40,575 (8,115 x$5). The estimated reduction in revenue for DH renewal fees is based on 4,657 non-renewals for a total of $372,560 (4,657 x $80) The reduction in unlicensed activity revenues are calculated based on 4,657 non-renewals for a total of $23,285 (4/657 x $5).The estimated net revenue is $2,079,230 ($2,434,500 + $40,575 - $372,560 -$23,285).The fees collected

	are subject to the 8% general revenue surcharge and $166,338 ($2,079,230 *.08) is deducted from the estimated amounts to be collected. The total estimated revenue for the first biennium is $2,277,069. The total estimated revenue for the second biennium is $1,912,892.
Expenditures:	3.5 full-time equivalent (FTE) positions and 1 OPS will be required to implement the provisions of this bill. OPS position is computed at base of the position plus 1.15% for Medicare. Salary is computed at base of the position plus 43% for benefits. As of June 30, 2018, 1 FTE can manage an active/inactive licensure pool size of 6,805 for Dental Hygienist. The projected licensee pool size for Dental Therapy is 8,115 and the expected DH reduction is 4,657; therefore, 1 FTE is justified. Further, it is also anticipated that 1 OPS will be required to handle the initial influx of applicants. 1 FTE Regulatory Specialist II, no travel and 1 OPS Regulatory Specialist II, no travel, is requested. Based on the LBR standards, the total FTE cost is $50,760 ($39,934/Salary + $10,497/Expense + $329/HR) and the total OPS cost is $35,864 ($25,260/OPS + $10,497/Expense + $107/HR) for a total cost of $86,625. Based on FY17-18 enforcement data, it is estimated that there will be 170 complaints filed against Dental Therapist and 35 of those complaints will be deemed legally sufficient for investigation and prosecution. MQA can manage a workload of 36 cases per FTE for investigation and 36 cases per FTE for prosecution; therefore, 2 FTEs are justified. 1 FTE Investigation Specialist II, medium travel, and 1 FTE Senior Attorney, no travel, is requested. Based on the LBR standards, the total FTE cost is $151,841 ($120,583/Salary + $30,600/Expense +$658/HR). Based on FY17-18 data, MQA can manage a workload of 9,748 calls per FTE. MQA anticipates 3,819 additional telephone calls in the Communication Center. .5 Regulatory Specialist II, no travel, is requested. Based on the LBR standards, the total FTE cost is $30,793 ($19,967/Salary+ $10,497/Expense + $329/HR). MQA anticipates holding 4, 1 day meetings per year with 4 council members and 2 DOH staff. The average travel cost for professions licensed under chapter 491,F.S. is $450 per day for a total cost of $ $7,200. The average cost for meeting rooms and equipment is $1,875 per day for a total cost of $7,500. The cost for member compensation at $50 per day for each council member totals $800. Total estimated meeting cost is $15,500($14,700/Expense + $800/OPS). DOH currently contracts services for processing of initial and renewal applications and related fees. The cost of the contracted service is based on a $7.69 per application rate. It is projected 8,115 new applications will be processed for a cost of $62,404 (8,115x$7.69). DOH will incur non-recurring costs for rulemaking, which current budget authority is adequate to absorb. Consistent with adding any new profession, DOH will update the Licensing and Enforcement Information Database System (LEIDS) licensure system to

	accommodate the new Dental Therapy license, which current resources are adequate to absorb. DOH will incur an increase in workload associated the development and maintenance of a new website, online renewals, online applications, etc., which current resources are adequate to absorb. The total estimated cost for the first biennium is $584,408 in the following categories: Annual Estimated Cost Salary - $180,484/Recurring OPS – $800/Recurring + $25,260/Non-Recurring Expense - $54,646/Recurring + $22,145/Non-Recurring ContractedServices - $62,404/Recurring Biannual Human Resources - $1,316/Recurring + $107/Non-Recurring
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A FISCAL IMPACT TO THE PRIVATE SECTOR? Y☒ N☐

Revenues:	Unknown
Expenditures:	Individuals seeding Dental Therapy licensure will be required to pay the initial licensure and renewal fees.
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y☐ N☒

If yes, explain impact.	Click or tap here to enter text.
Bill Section Number:	Click or tap here to enter text.

TECHNOLOGY IMPACT

1. DOES THE BILL IMPACT THE AGENCY'S TECHNOLOGY SYSTEMS (I.E. IT SUPPORT, LICENSING SOFTWARE, DATA STORAGE, ETC.)? Y☐ N☒

If yes, describe the anticipated impact to the agency including any fiscal impact.	The License and Enforcement Database System (LEIDS), document repository and the licensure/registration renewal system must be updated to reflect the addition of this profession. The VERSA Online system (system that supports all online infrastructure support for online applications, license renewal) will need to be programmed to reflect the addition of this profession. The Division of Medical Quality Assurance will incur an increase inworkload to update the existing infrastructure, LEIDS, create a web presence and develop an online application.

FEDERAL IMPACT

1. DOES THE BILL HAVE A FEDERAL IMPACT (I.E. FEDERAL COMPLIANCE, FEDERAL FUNDING, FEDERAL AGENCY INVOLVEMENT, ETC.)? Y☒ N☐

If yes, describe the anticipated impact including any fiscal impact.	Click or tap here to enter text.

ADDITIONAL COMMENTS

The proposed language in s. 466.0225(1), F.S., contains outdated language requiring the applicant to submit two recent photographs to the Department. Historically, photographs were required when the Department developed and administered examinations and photographs were used for identification purposes.

The bill creates s. 466.0225, F.S., which sets forth the examination and licensing requirements for dental therapists. One of those requirements states that the applicant "Has not been disciplined by a board, except for citation offenses or minor violations". This language is not clear as to who defines minor violations.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	It is unclear whether this language would allow a dental therapist to provide services to a patient before a dentist examines or diagnoses the patient. This could present a conflict with a section 466.003(10), F.S., and Florida Administrative Code Rule 64B5-16.001(6), which requires a licensed dentist to examine a patient, diagnose the condition to be treated and authorize the procedure to be performed before another licensed professional can provide services.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 818
INTRODUCER:	Senator Book
SUBJECT:	Mental Health
DATE:	March 15, 2019
REVISED:	

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

I. Summary:

SB 818 makes several changes to both the Baker Act and the Marchman Act. The bill broadens the criteria to serve additional individuals under both the Baker Act and Marchman Act and requires additional services to be provided under both provisions.

The bill allows both Baker Act and Marchman Act respondents to be held for up to 10 days (increased from 5) before a hearing on an involuntary assessment petition, and allows individuals treated on an involuntary basis under the Marchman Act to be held in a treatment facility for a longer period of time following a hearing on an involuntary assessment petition.

The bill also broadens the contempt authority of the court for minors involuntarily admitted under the Marchman Act and makes significant changes to court procedures, filing deadlines, and responsibilities for Marchman Act petitioners.

The bill will likely have a significant state and local fiscal impact, particularly on the Department of Children and Families (DCF), courts, state attorneys, and public defenders throughout the state, and has an effective date of July 1, 2019.

II. Present Situation:

Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, known as the Baker Act.[1] The Act authorized treatment programs for mental, emotional, and behavioral disorders. The Baker Act required programs to include comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to facilitate recovery.

[1] Chapter 71-131, Laws of Fla.; The Baker Act is contained in ch. 394, F.S.

Additionally, the Baker Act provides protections and rights to individuals examined or treated for mental illness. Legal procedures are addressed for mental health examination and treatment, including voluntary admission, involuntary admission, involuntary inpatient treatment, and involuntary outpatient treatment.

Mental illness creates enormous social and economic costs.[2] Unemployment rates for persons having mental disorders are high relative to the overall population.[3] Rates of unemployment for people having a severe mental illness range between 60 percent and 100 percent.[4] Mental illness increases a person's risk of homelessness in America threefold.[5] Approximately 33 percent of the nation's homeless live with a serious mental disorder, such as schizophrenia, for which they are untreated.[6] Often the combination of homelessness and mental illness leads to incarceration, which further decreases a person's chance of receiving proper treatment and leads to future recidivism.[7]

Marchman Act

In 1993, the Legislature adopted the Hal S. Marchman Alcohol and Other Drug Services Act. The Marchman Act provides a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery support services. Services must be provided in the least restrictive environment to promote long-term recovery. The Marchman Act includes various protections and rights of patients served.

Individual Bill of Rights

Both the Marchman Act and the Baker Act provide an individual bill of rights.[8] Rights in common include the right to dignity, right to quality of treatment, right to not be refused treatment at a state-funded facility due to an inability to pay, right to communicate with others, right to care and custody of personal effects, and the right to petition the court on a writ of habeus corpus. The individual bill of rights also imposes liability for damages on persons who violate individual rights.[9] The Marchman Act bill of rights includes the right to confidentiality of clinical records. The individual is the only person who may consent to disclosure.[10] The Baker Act addresses confidentiality in a separate section of law and permits limited disclosure by the individual, a guardian, or a guardian advocate.[11] The Marchman Act ensures the right to habeus corpus, which means that a petition for release may be filed with the court by an individual

[2] MentalMenace.com, *Mental Illness: The Invisible Menace; Economic Impact,* http://www.mentalmenace.com/economicimpact.php (last visited March 14, 2019).
[3] MentalMenace.com, *Mental Illness: The Invisible Menace: More impacts and facts,* http://www.mentalmenace.com/impactsfacts.php (last visited March 14, 2019).
[4] *Id.*
[5] Family Guidance Center for Behavioral Health Care, *How does Mental Illness Impact Rates of Homelessness?,* (last visited March 14, 2019), http://www.familyguidance.org/how-does-mental-illness-impact-rates-of-homelessness/.
[6] *Id.*
[7] *Id.*
[8] Section 397.501, F.S., provides "Rights of Individuals" for individuals served through the Marchman Act; s. 394.459, F.S., provides "Rights of Individuals" for individuals served through the Baker Act.
[9] Sections 397.501(10)(a) and 394.459(10), F.S.
[10] Section 397.501(7), F.S.
[11] Section 394.4615(1) and (2), F.S.

involuntarily retained or his or her parent or representative.[12] In addition to the petitioners authorized in the Marchman Act, the Baker Act permits the DCF to file a writ for habeus corpus on behalf of the individual.[13]

Transportation to a Facility

The Marchman Act authorizes an applicant seeking to have a person admitted to a facility, the person's spouse or guardian, a law enforcement officer, or a health officer to transport the individual for an emergency assessment and stabilization.[14]

The Baker Act requires each county to designate a single law enforcement agency to transfer the person in need of services. If the person is in custody based on noncriminal or minor criminal behavior, the law enforcement officer will transport the person to the nearest receiving facility. If, however, the person is arrested for a felony the person must first be processed in the same manner as any other criminal suspect. The law enforcement officer must then transport the person to the nearest facility, unless the facility is unable to provide adequate security.[15]

The Marchman Act allows law enforcement officers, however, to temporarily detain substance-impaired persons in a jail setting. An adult not charged with a crime may be detained for his or her own protection in a municipal or county jail or other appropriate detention facility. Detention in jail is not considered to be an arrest, is temporary, and requires the detention facility to provide if necessary the transfer of the detainee to an appropriate licensed service provider with an available bed.[16] However, the Baker Act prohibits the detention in jail of a mentally ill person if he or she has not been charged with a crime.[17]

Voluntary Admission to a Facility

The Marchman Act authorizes persons who wish to enter treatment for substance abuse to apply to a service provider for voluntary admission. A minor is authorized to consent to treatment for substance abuse.[18] Under the Baker Act, a guardian of a minor must give consent for mental health treatment under a voluntary admission.[19]

When a person is voluntarily admitted to a facility, the emergency contact for the person must be recorded in the individual record.[20] When a person is involuntarily admitted, contact information for the individual's guardian, guardian advocate, or representative, and the individual's attorney must be entered into the individual record.[21] The Marchman Act does not address emergency contacts.

[12] Section 397.501(9), F.S.
[13] Section 394.459(8)(a), F.S.
[14] Section 397.6795, F.S.
[15] Section 394.462(1)(f) and (g), F.S.
[16] Section 397.6772(1), F.S.
[17] Section 394.459(1), F.S.
[18] Section 397.601(1) and (4)(a), F.S.
[19] Section 394.4625(1)(a), F.S.
[20] Section 394.4597(1), F.S.
[21] Section 394.4597(2), F.S.

The Baker Act requires an individualized treatment plan to be provided to the individual within five days after admission to a facility.[22] The Marchman Act does not address individualized treatment plans.

Involuntary Admission to a Facility

Criteria for Involuntary Admission

The Marchman Act provides that a person meets the criteria for involuntary admission if a good faith reason exists to believe that the person is substance abuse impaired and because of the impairment:

- Has lost the power of self-control with respect to substance abuse; and either
- Has inflicted, threatened to or attempted to inflict self-harm; or
- Is in need of services and due to the impairment, judgment is so impaired that the person is incapable of appreciating the need for services.[23]

Protective Custody

A person who meets the criteria for involuntary admission under the Marchman Act may be taken into protective custody by a law enforcement officer.[24] The person may consent to have the law enforcement officer transport the person to his or her home, a hospital, or a licensed detoxification or addictions receiving facility.[25] If the person does not consent, the law enforcement officer may transport the person without using unreasonable force.[26]

Time Limits

A critical 72-hour period applies under both the Marchman and the Baker Act. Under the Marchman Act, a person may only be held in protective custody for a 72-hour period, unless a petition for involuntary assessment or treatment has been timely filed with the court within that timeframe to extend protective custody.[27] The Baker Act provides that a person cannot be held in a receiving facility for involuntary examination for more than 72 hours.[28] Within that 72-hour examination period, or, if the 72 hours ends on a weekend or holiday, no later than the next working day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will resume custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment.[29]

[22] Section 394.459(2)(e), F.S.
[23] Section 397.675, F.S.
[24] Section 397.677, F.S.
[25] Section 397.6771, F.S.
[26] Section 397.6772(1), F.S.
[27] Section 397.6773(1) and (2), F.S.
[28] Section 394.463(2)(f), F.S.
[29] Section 394.463(2)(i)4., F.S.

Under the Marchman Act, if the court grants the petition for involuntary admission, the person may be admitted for a period of five days to a facility for involuntary assessment and stabilization.[30] If the facility needs more time, the facility may request a seven-day extension from the court.[31] Based on the involuntary assessment, the facility may retain the person pending a court decision on a petition for involuntary treatment.[32]

Under the Baker Act, the court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.[33] The petitioner must show, by clear and convincing evidence all available less restrictive treatment alternatives are inappropriate and that the individual:

- Is mentally ill and because of the illness has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Is manifestly incapable of surviving alone or with the help of willing and responsible family and friends, and without treatment is likely suffer neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.[34]

Notice Requirements

The Marchman Act requires the nearest relative of a minor to be notified if the minor is taken into protective custody.[35] No time requirement is provided in law. Under the Baker Act, receiving facilities are required to promptly notify a patient's guardian, guardian advocate, attorney, and representative within 24 hours after the patient arrives at the facility on an involuntary basis, unless the patient requests otherwise.[36] In requiring notice on behalf of a patient, current law does not distinguish between adult and minor patients. The facility must provide notice to the Florida local advocacy council no later than the next working day after the patient is admitted.

Mental Illness and Substance Abuse

According to the National Alliance on Mental Illness (NAMI), about 50 percent of persons with severe mental health disorders are affected by substance abuse.[37] NAMI also estimates that 29 percent of people diagnosed as mentally ill abuse alcohol or other drugs.[38] When mental health disorders are left untreated, substance abuse likely increases. When substance abuse increases, mental health symptoms often escalate as well or new symptoms are triggered. This could also be due to discontinuation of taking prescribed medications or the contraindications for substance

[30] Section 397.6811, F.S.
[31] Section 397.6821, F.S.
[32] Section 397.6822, F.S.
[33] Sections 394.4655(6) and 394.467(6), F.S.
[34] Section 394.467(1), F.S.
[35] Section 397.6772(2), F.S.
[36] Section 394.4599(2)(a) and (b), F.S.
[37] Donna M. White, OPCI, CACP, *Living with Co-Occurring Mental & Substance Abuse Disorders, available at* http://psychcentral.com/blog/archives/2013/10/02/living-with-co-occuring-mental-substance (last visited on March 14, 2019).
[38] *Id.*

abuse and mental health medications. When taken with other medications, mental health medications can become less effective.[39]

Advance Directive for Mental Health or Substance Abuse Treatment

Florida law currently allows an individual to create an advance directive which designates a surrogate to make health care decisions for the individual and provides a process for the execution of the directive.[40] Current law also allows an individual to designate a separate surrogate to consent to mental health treatment for the individual if the individual is determined by a court to be incompetent to consent to treatment.[41] A mental health or substance abuse treatment advance directive is much like a living will for health care; acute episodes of mental illness temporarily destroy the capacity required to give informed consent and often prevent people from realizing they are sick, causing them to refuse intervention.[42] Even in the midst of acute episodes, many people do not meet commitment criteria because they are not likely to injure themselves or others and are still able to care for their basic needs.[43] If left untreated, acute episodes may spiral out of control before the person meets commitment criteria.[44]

Mental Health Courts

Mental health courts are a type of problem-solving court that combines judicial supervision with community mental health treatment and other support services in order to reduce criminal activity and improve the quality of life of participants. Mental health court programs are not established or defined in Florida Statutes. A key objective of mental health courts is to prevent the jailing of offenders with mental illness by diverting them to appropriate community services or to significantly reduce time spent incarcerated.

Crisis Stabilization Units

Individuals experiencing severe emotional or behavioral problems often require emergency treatment to stabilize their situations before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to individuals on a voluntary or involuntary basis. Individuals receiving services on an involuntary basis must be taken to a facility that has been designated by DCF as a "receiving facility" as defined in Part I of ch. 394, F.S.[45]

Receiving facilities, often referred to as Baker Act Receiving Facilities, are public or private facilities designated by DCF for the purposes of receiving and examining individuals on an involuntary basis under emergency conditions and to provide short-term treatment. Receiving facilities that receive public funds from one of the managing entities to provide mental health

[39] *Id.*
[40] Section 765.202, F.S.
[41] Section 765.202(5), F.S.
[42] Judy A. Clausen, *Making the Case for a Model Mental Health Advance Directive Statute,* 14 YALE J. HEALTH POL'Y, L. & ETHICS 1, (Winter 2014).
[43] *Id* at 17.
[44] *Id.*
[45] Section 394.455(26), F.S.

services to all persons regardless of their ability to pay are considered public receiving facilities.[46]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals brought to the unit under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services.[47] CSUs provide services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs. Individuals often enter the public mental health system through CSUs. Managing entities must follow current statutes and rules that require CSUs to be paid for bed availability rather than utilization.

III. Effect of Proposed Changes:

Section 1 amends s. 27.59, F.S., to grant public defenders and regional conflict counsel permission to inquire of all persons held in a receiving facility pursuant to the Baker and/or Marchman Act.

Section 2 amends s. 394.455, F.S., defining "neglect or refuse to care for himself or herself" to include evidence that a person is unable to provide adequate food or shelter for themselves, is substantially unable to make an informed treatment choice, or needs care or treatment to prevent deterioration. The bill also adds criteria for a "real and present threat of substantial harm" to include evidence that an untreated person will lack, refuse, or not receive health services or will suffer severe harm leading to an inability to function cognitively or in their community generally.

Section 3 amends s. 394.459, F.S., relating to rights of patients, to require that a patient with a serious mental illness who has been released after being Baker Acted must be provided with a post-discharge continuum of care regimen. DCF is provided with rulemaking authority to determine what services will be available in such regimens and which serious mental illnesses will entitle an individual to services. Current law only requires the state to provide involuntary treatment at a state hospital.

Section 4 amends s. 394.461, F.S., to allow civil patients to be admitted to designated receiving facilities under the Baker Act without undergoing a transfer evaluation. The bill also provides that before the close of the State's case in a Baker Act hearing for involuntary placement, the state may establish that a transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation. The bill also prohibits the court from considering the substantive information in the transfer evaluation unless the evaluator (typically a health care practitioner) testifies at the hearing.

[46] Section 394.455(25), F.S.
[47] Section 394.875, F.S.

Section 5 amends s. 394.463, F.S., providing that a person may be subject to an involuntary examination if the person is subject to severe harm and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends. The bill also provides that if there is a substantial likelihood that without care or treatment the person will cause serious harm to themselves or others in the near future, as evidenced by his or her recent behavior, actions, or omissions, to include property damage.

The bill requires a petition for involuntary services be filed in circuit court in all cases involving involuntary examination.

Section 6 amends s. 394.4655, F.S., relating to involuntary outpatient services, to provide that in lieu of inpatient treatment, a court may order a respondent in a Baker Act case into outpatient treatment for up to six months if it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis, can follow a treatment plan, and is not likely to become more dangerous or deteriorate if such a plan is followed.

The bill also requires that for the duration of their treatment, the respondent must have a willing, able, and responsible supervisor who will inform the court of any failure to comply with the treatment plan. The bill requires the court to retain jurisdiction over the parties for entry of further orders after a hearing. The bill eliminates all other existing procedures in this section pertaining to criteria and procedures for involuntary examination.

Section 7 amends s. 394.467, F.S., to add a likelihood of committing property damage to the criteria for involuntary inpatient placement. The bill provides that with respect to a hearing on involuntary inpatient placement, both the patient and the state are independently entitled to at least one continuance of the hearing. The patient's continuance may be for a period of up to 4 weeks and requires concurrence of the patient's counsel. The state's continuance may be for a period of up to 7 court working days and requires a showing of good cause and due diligence by the state before it can be requested. The state's failure to timely review and readily available document or failure to attempt to contact a known witness does not merit a continuance. The bill requires the court to increase the number of court working days in which the hearing may be held from 5 to 7. The bill allows for all witnesses to a hearing to appear telephonically or by other remote means. The bill also allows the state attorney to access the patient, any witnesses, and any records needed to prepare its case.

The bill increases the period of time during which a patient being treated on an involuntary basis may be retained at a treatment facility or otherwise continue to receive inpatient services from 90 days to 6 months. The bill also permits a court to order an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be placed in a state treatment facility only if evaluations show that such individuals may benefit from behavioral health treatment; such individuals may be referred to the Agency for Persons with Disabilities or the Department of Elder Affairs for placement in a medical rehabilitation facility or supportive residential placement addressing their needs.

Section 8 amends s. 397.305, F.S., revising legislative intent related to the Marchman Act to include that patients be placed in the most appropriate and least restrictive environment conducive to long-term recovery while protecting individual rights.

Section 9 amends s. 397.311, F.S., to make the same changes to definitions in statute to the Marchman Act as the bill makes to the Baker Act in section 2.

Section 10 amends s. 397.334, F.S., requires that the coordinated strategy utilized in treatment-based drug court programs must be provided in writing to the program participant before the participant agrees to enter the program.

The bill also provides that in cases involving minors who violate an involuntary treatment order, the court may hold the minor in contempt for the same amount of time as their court-ordered treatment, so long as the court informs the minor that the contempt can be immediately ended by compliance with the treatment plan. If a contempt order results in incarceration, status conference hearings must be held every 2 to 4 weeks to assess the minor's well-being and inquire whether the minor will enter treatment. If the minor agrees to enter treatment service providers are requires to prioritize their entry into treatment.

Section 11 creates s. 397.412, F.S., allowing service providers to retain individuals involuntarily held under the Marchman Act until their court-ordered treatment plan is complete so long as the individual still meets the involuntary treatment criteria and no less restrictive means of care are available.

The bill also requires all service providers licensed to provide residential treatment to Marchman Act patients to install the necessary security features to prevent the premature departure of involuntary patients, and enact policies to differentiate between voluntary and involuntary patients. The bill specifies that this does not classify such facilities as secure facilities under statute.

Section 12 amends s. 397.501, F.S., to require that a patient with a serious substance abuse addiction who has been released after being Marchman Acted must be provided with a post-discharge continuum of care regimen. DCF is provided with rulemaking authority to determine what services will be available in such regimens and which serious substance abuse addictions will entitle an individual to services.

Section 13 amends s. 396.675, F.S., to make the same changes to involuntary treatment criteria to the Marchman Act as the bill makes to the Baker Act in section 5.

Section 14 amends s. 397.6751, F.S., requiring that all patients admitted under the Marchman Act be placed in the most appropriate and least restrictive environment conducive to the patient's treatment needs.

Section 15 amends s. 397.681, F.S., makes the state attorney the real party of interest in all Marchman Act proceedings.

Section 16 repeals s. 397. 6811, F.S., relating to involuntary assessment and stabilization.

Section 17 repeals s. 397. 6814, F.S., relating to contents of a petition in an involuntary assessment and stabilization matter.

Section 18 repeals s. 397. 6815, F.S., relating to procedure in an involuntary assessment and stabilization matter.

Section 19 repeals s. 397. 6818, F.S., relating to court determination.

Section 20 repeals s. 397. 6819, F.S., relating to responsibility of a licensed service in an involuntary assessment and stabilization matter.

Section 21 repeals s. 397. 6821, F.S., relating to an extension of time for completion of an involuntary assessment and stabilization.

Section 22 repeals s. 397. 6822, F.S., relating to disposition of an individual after an involuntary assessment.

Section 23 amends s. 397.6943, F.S., changing the criteria for a person to be subject to an involuntary treatment petition from 'meets the criteria' for involuntary treatment to, 'reasonably appears to meet the criteria.'

Section 24 amends s. 397.695, F.S., changing instances of the word 'services' to 'treatment' and allowing the court to waive or prohibit service of process fees for indigent respondents.

Section 25 amends 397.6951, F.S., changing instances of the word 'services' to 'treatment' and removing the requirement that a petition for involuntary treatment contain findings and recommendations of an assessment by a qualified professional.

The bill requires a petition for involuntary treatment to demonstrate that the petitioner believes that without treatment the respondent is likely to either:

- suffer from neglect or refuse to care for themselves which poses a real and substantial threat of harm and is unavoidable without the help of others or provisions of services; or
- inflict serious harm to themselves or others, including property damage.

The bill provides that a petition may be accompanied by a certificate or report of a qualified professional or licensed physician who has examined the respondent within the past 30 days. The certificate must contain the professional's findings and if the respondent refuses to submit to an examination must document the refusal.

The bill provides that in the event of an emergency requiring an expedited hearing, the petition must contain documented reasons for expediting the hearing.

Section 26 amends s. 397.6955, F.S., revising the duties of the court upon the filing of a Marchman Act petition for involuntary treatment. The bill requires the clerk of court to notify the state attorney upon the filing of such a petition, notify the respondent's counsel if any has been

retained, and schedule a hearing on the petition within 10 court working days unless a continuance is granted.

In the case of an emergency, the bill allows the court rely solely on the contents of a petition to enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The bill allows the court to order a law enforcement officer to take the respondent into custody and deliver them to the nearest service provider while the full hearing is conducted.

Section 27 amends s. 397.6957, F.S., requires a respondent to be present during a hearing on an involuntary treatment petition unless the respondent has knowingly and willingly waived their right to appear. Testimony from family members familiar with the respondent's history and how it relates to their current condition is permissible. The bill allows for all witnesses to a hearing to appear telephonically or by other remote means.

The bill provides that if the respondent has not previously been assessed by a qualified professional, the court must allow 10 days for the respondent to undergo such evaluation, unless the court suspects that the respondent will not appear at a rescheduled hearing or refuses to submit to an evaluation, the court may enter a preliminary order committing the respondent to an appropriate treatment facility until the rescheduled hearing date. The respondent's evaluation must occur within 72 hours of arrival at the treatment facility. If the facility cannot have the evaluation completed in this time period, they must petition the court for an extension of time not to extend beyond a period of 3 days before the reschedule hearing. Copies of the evaluation report must be provided to all parties and their counsel, and the respondent may be held and treatment initiated until the rescheduled hearing. The court may order law enforcement to transport the respondent as needed to and from a treatment facility to the court for the rescheduled hearing.

The bill requires the petitioner to prove, through clear and convincing evidence that the respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, and has a history of lack of compliance with treatment. The bill requires the petitioner to also prove that it is likely that the respondent poses a threat of substantial harm to their own well-being and it is apparent that such harm may not be avoided through the help of willing, able, and responsible family member or friends or the provision of services, or that there is a substantial likelihood that, unless admitted, the respondent will cause harm to themselves or others, which may include property damage.

The bill allows the court to initiate involuntary proceedings at any point during the hearing if it reasonably believes that the respondent is likely to injure themselves if allowed to remain free. Any treatment order entered by the court at the conclusion of the hearing must contain findings regarding the respondent's need for treatment and the appropriateness of other less restrictive alternatives. The bill also allows such orders to designate specific service providers.

Section 28 amends s. 397.697, F.S., providing that in order to qualify for involuntary outpatient treatment an individual must be accompanied by a willing, able, and responsible advocate who will inform the court if the individual fails to comply with their outpatient program. The bill also requires that if outpatient treatment is offered in lieu of inpatient treatment, it may be offered for up to six months if it is established that the respondent meets involuntary placement criteria and

has been involuntarily ordered into inpatient treatment at least twice during the past 36 months, the outpatient provider is in the same county as the respondent, and the respondent's treating physician certifies that the respondent can be more appropriately treated on an outpatient basis, can follow a treatment plan, and is not likely to become more dangerous or deteriorate if such a plan is followed.

The bill requires the court to retain jurisdiction in all cases resulting in involuntary inpatient treatment so that it may monitor compliance with treatment, change treatment modalities, or initiate contempt of court proceedings as needed.

The bill also provides that in cases involving minors who violate an involuntary treatment order, the court may hold the minor in contempt for the same amount of time as their court-ordered treatment, so long as the court informs the minor that the contempt can be immediately ended by compliance with the treatment plan. If a contempt order results in incarceration, status conference hearings must be held every 2 to 4 weeks to assess the minor's well-being and inquire whether the minor will enter treatment. If the minor agrees to enter treatment service providers are requires to prioritize their entry into treatment.

Finally the bill clarifies that while subject to the court's oversight, a service provider's authority is separate and distinct from the court's continuing jurisdiction.

Section 29 amends s. 397.6975, F.S., allows a service provider to petition the court for an extension of an involuntary treatment period if an individual in treatment is nearing the end of their court-ordered time period in treatment and it appears that they will require additional care. The bill provides that such a petition will preferably be filed at least 10 days before the expiration of the current scheduled treatment period. The bill requires the court to immediately schedule a hearing to be held not more than 10 court working days after the filing of the petition. The bill allows the court to order additional treatment if the original time period will expire before the hearing is concluded and it appears likely to the court that additional treatment will be required.

Section 30 creates s. 397.6976, F.S., providing that a person who meets the involuntary treatment criteria under the Marchman Act and is determined to be a habitual abuser may be committed by the court, after notice and hearing, to inpatient or outpatient treatment without an assessment, not to exceed 90 days unless extended as permitted under statute. The bill defines a habitual abuser as any person who has been involuntarily treated under the Marchman Act 3 or more times during the 24 months before the date of the hearing if each prior treatment was initially for a 90 day period.

Section 31 repeals s. 397.6978, F.S., relating to guardian advocates; patients incompetent consent; and substance abuse disorder.

Section 32 amends s. 397.706, F.S., applying the changes made to ss. 397.334 and 397.697, F.S., to the court's contempt authority regarding minors to cases involving juvenile offenders.

Section 33 amends s. 394.4599, F.S., removing the requirement that notice for involuntary outpatient services be filed with the criminal county court or the circuit court for the county in

which the individual is hospitalized in cases of involuntary inpatient treatment under the Baker Act.

Section 34 amends s. 394.4615, F.S., to eliminate provisions of s. 394.4655, relating to involuntary outpatient services, rendered inapplicable by the bill.

Section 35 amends s. 397.6971, F.S., relating to early from involuntary treatment, to change all instances of the word 'services' to the word 'treatment.'

Section 36 amends s. 397.6977, F.S., relating to disposition of an individual upon completion of involuntary treatment, to change all instances of the word 'services' to the word 'treatment.'

Section 37 amends s. 212.055, F.S., relating to the county public hospital surtax to correct a cross reference to a definition in chapter 397, F.S. relating to substance abuse.

Section 38 amends s. 394.4598, F.S., relating to guardian advocates to correct a cross reference.

Section 39 amends s. 394.462, F.S., to eliminate two cross references to s. 397.6822, F.S., which is repealed by the bill.

Section 40 amends s. 394.495, F.S., requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, psychiatrist, or a person working under the direct supervision of one of these professionals may perform an assessment.

Section 41 amends s. 394.496, F.S., requiring that for assessments of children and adolescents under the Baker Act, a clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist must be among the persons included in developing a services plan for the child or adolescent.

Section 42 amends s. 394.9085, F.S., adds a cross reference to s. 394.455(41), F.S.

Section 43 amends s. 397.416, F.S., to change a cross reference.

Section 44 amends s. 409.972, F.S., to change a cross reference.

Section 45 amends s. 440.102, F.S., to correct two cross references.

Section 46 amends s. 464.012, F.S., relating to the scope of practice for advanced registered nurse practitioners to correct a cross reference.

Section 47 amends s. 744.2007, relating to public guardians to change a cross reference.

Section 48 amends s. 790.065, relating sale and delivery of firearms to eliminate cross references.

Section 49 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

There will likely be an impact on service providers providing residential treatment who must make accommodations to ensure their facilities can prevent Marchman Act respondents from leaving prematurely and to separate voluntary from involuntary populations. There is also likely to be an impact on Marchman Act treatment facilities as a result of the longer period of time for which Marchman Act respondents can be held, and by the new individuals held under the 'habitual abusers' provision of the bill.

C. Government Sector Impact:

State Government

DCF will likely be impacted by serving an increased number of individuals under both the Baker Act and Marchman Act.

There will be an impact on the courts throughout the state in order to meet the changes in filing deadlines, hearing timeframes, and other changes to the Baker and Marchman Acts made by the bill. There will also be an impact resulting from holding hearings on an extension of time for individuals to be held for treatment under the Marchman Act, and for holding hearings on habitual abuse matters.

There will likely be an impact on state attorney's offices throughout the state as they are made the real part of interest in all Marchman Act cases.

There will also be a likely impact to public defenders throughout the state as there are likely to be more individuals served under both the Baker Act and Marchman Act, and because public defenders may need to hire additional staff to serve Baker Act respondents who can be accessed at an increased level by public defenders representing them.

Local Government

There will be additional costs borne by law enforcement for transporting more individuals under both the Baker Act and Marchman Act, resulting in a likely fiscal impact for sheriffs' offices throughout the state. Additionally, sheriffs will likely be impacted by the waiver of service of process fees in Marchman Act cases.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 27.59, 394.455, 394.459, 394.461, 394.463, 394.4655, 394.467, 397.305, 397.311, 397.334, , 397.501, 397.675, 397.6751, 397.681, , 397.693, 397.695, 397.6951, 397.6955, 397.6957, 397.697, 397.6975, 397.706, 394.4599, 394.4615, 397.6971, 397.6977, 212.055, 394.4598, 394.462, 394.495, 394.496, 394.9085, 397.416, 409.972, 440.102, 464.012, 744.2007, and 790.065 of the Florida Statutes.

This bill creates sections 397.412 and 397.6976 of the Florida Statutes.

This bill repeals sections 397.6811, 397.6814, 397.6815, 397.6818, 397.6819, 397.6821, 397.6822, and 397.6978 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Book

32-00225D-19 2019818__

A bill to be entitled

An act relating to mental health; amending s. 27.59, F.S.; authorizing public defenders and regional counsel to have access to persons held in a facility licensed under chapter 394 or chapter 397; amending s. 394.455, F.S.; conforming a cross-reference; defining the terms "neglect or refuse to care for himself or herself" and "real and present threat of substantial harm"; amending s. 394.459, F.S.; requiring that respondents with a serious mental illness be afforded essential elements of care and placed in a continuum of care regimen; requiring the Department of Children and Families to adopt certain rules; amending s. 394.461, F.S.; authorizing the state to establish that a transfer evaluation was performed by providing the court with a copy of the evaluation before the close of the state's case in chief; prohibiting the court from considering substantive information in the transfer evaluation unless the evaluator testifies at the hearing; amending s. 394.463, F.S.; revising the requirements for when a person may be taken to a receiving facility for involuntary examination; conforming provisions to changes made by the act; amending s. 394.4655, F.S.; revising the requirements for involuntary outpatient treatment; amending s. 394.467, F.S.; revising the requirements for when a person may be ordered for involuntary inpatient placement; revising requirements for continuances of hearings; revising the time period in which a court is

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required to hold a hearing on involuntary inpatient placement; revising the conditions under which a court may waive the requirement for a patient to be present at an involuntary inpatient placement hearing; authorizing the court to permit all witnesses to remotely attend and testify at the hearing though certain means; authorizing the state attorney to access certain persons and records; revising the period of time a court may require a patient to receive services; providing an exception to the prohibition on a court ordering certain individuals to be involuntarily placed in a state treatment facility; conforming a cross-reference; amending s. 397.305, F.S.; revising the purposes of ch. 397, F.S.; amending s. 397.311, F.S.; defining the terms "involuntary treatment," "neglect or refuse to care for himself or herself," and "real and present threat of substantial harm"; amending s. 397.334, F.S.; providing requirements for holding a minor in contempt of court in cases that involve a minor violating an involuntary treatment order; requiring service providers to prioritize a minor's placement into treatment under certain circumstances; creating s. 397.412, F.S.; authorizing licensed service providers to refuse an individual's request to prematurely leave a court-ordered involuntary treatment program under certain circumstances; requiring certain licensed service providers to install certain security features and enact certain policies; specifying the installation of

such security features does not make the treatment center a secure facility; amending s. 397.501, F.S.; requiring that respondents with serious substance abuse addictions be afforded essential elements of care and placed in a continuum of care regimen; requiring the department to adopt certain rules; amending s. 397.675, F.S.; revising the criteria for involuntary admissions; amending s. 397.6751, F.S.; revising the responsibilities of a service provider; amending s. 397.681, F.S.; requiring that the state attorney represent the state as the real party of interest in an involuntary proceeding; authorizing the state attorney to access certain persons and records; specifying that certain changes are contingent on legislative funding; conforming provisions to changes made by the act; repealing s. 397.6811, F.S., relating to involuntary assessment and stabilization; repealing s. 397.6814, F.S., relating to petitions for involuntary assessment and stabilization; repealing s. 397.6815, F.S., relating to involuntary assessment and stabilization procedures; repealing s. 397.6818, F.S., relating to court determinations for petitions for involuntary assessment and stabilization; repealing s. 397.6819, F.S., relating to the responsibilities of licensed service providers with regard to involuntary assessment and stabilization; repealing s. 397.6821, F.S., relating to extensions of time for completion of involuntary assessment and stabilization; repealing s. 397.6822, F.S., relating to the disposition of

individuals after involuntary assessments; amending s. 397.693, F.S.; revising the circumstances under which a person is eligible for court-ordered involuntary treatment; amending s. 397.695, F.S.; authorizing the court or clerk of the court to waive or prohibit any service of process fees for an indigent petitioner; amending s. 397.6951, F.S.; revising the requirements for the contents of a petition for involuntary treatment; providing that a petitioner may include a certificate or report of a qualified professional with the petition; requiring the certificate or report to contain certain information; requiring that certain additional information must be included if an emergency exists; amending s. 397.6955, F.S.; requiring the clerk of the court to notify the state attorney's office upon the receipt of a petition filed for involuntary treatment; revising when a hearing must be held on the petition; providing requirements for when a petitioner asserts that emergency circumstances are present or the court determines that an emergency exists; amending s. 397.6957, F.S.; expanding the exemption from the requirement that a respondent be present at a hearing on a petition for involuntary treatment; authorizing the court to permit all witnesses to remotely attend and testify at the hearing through certain means; deleting a provision requiring the court to appoint a guardian advocate under certain circumstances; requiring the court to give a respondent who was not assessed or had

previously refused to be assessed the opportunity to consent to a certain examination; requiring that the court reschedule and continue the hearing to allow for such examination, if the respondent consents; requiring that the assessment of a respondent occur within a specified timeframe; authorizing a service provider to petition the court for an extension of time under certain circumstances; authorizing the court to grant additional time to complete an evaluation; requiring a qualified professional to provide copies of his or her report to the court and all relevant parties and counsel; authorizing certain entities to take specified actions based upon the involuntary assessment; authorizing a court or magistrate to order certain persons to take a respondent into custody and transport him or her to or from certain service providers or the court; revising the petitioner's burden of proof in the hearing; authorizing the court to initiate involuntary proceedings under certain circumstances; requiring that, if a treatment order is issued, it must include certain findings; providing that a treatment order may designate a specific service provider; amending s. 397.697, F.S.; requiring that an individual meet certain requirements to qualify for involuntary outpatient treatment; specifying that certain hearings may be set by the motion of a party or under the court's own authority; providing requirements for holding a minor in contempt of court in cases that

involve a minor violating an involuntary treatment order; requiring service providers to prioritize a minor's placement into treatment under certain circumstances; specifying that a service provider's authority is separate and distinct from the court's jurisdiction; amending s. 397.6975, F.S.; requiring that a petition for renewal of involuntary treatment be filed before the expiration of the court-ordered treatment period; authorizing certain entities to file such a petition; revising the timeframe within which the court is required to schedule a hearing; authorizing the court to order additional treatment under certain circumstances; providing that such treatment period must be deducted from time granted in a subsequent extension petition; creating s. 397.6976, F.S.; authorizing the court to commit certain persons to inpatient or outpatient treatment, or a combination thereof, without an assessment, under certain circumstances; limiting the treatment period to a specified number of days unless the period is extended; defining the term "habitual abuser"; repealing s. 397.6978, F.S., relating to the appointment of guardian advocates; amending s. 397.706, F.S.; providing requirements for holding a minor in contempt of court in cases that involve a minor violating an involuntary treatment order; requiring service providers to prioritize a minor's placement into treatment under certain circumstances; amending ss. 394.4599, 394.4615, 397.6971, and

397.6977, F.S.; conforming provisions to changes made by the act; amending ss. 212.055, 394.4598, 394.462, 394.495, 394.496, 394.9085, 397.416, 409.972, 440.102, 464.012, 744.2007, and 790.065, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Section 27.59, Florida Statutes, is amended to read:

27.59 Access to prisoners and patients in mental health or treatment facilities.—The public defenders, assistant public defenders, criminal conflict and civil regional counsel, and assistant regional counsel shall be empowered to inquire of all persons who are incarcerated in lieu of bond or are held in a facility licensed under chapter 394 or chapter 397 and to tender them advice and counsel at any time.~~, but the provisions of~~ This section does ~~shall~~ not apply ~~with respect~~ to persons who have engaged private counsel.

Section 2. Present subsections (31) through (38) and (39) through (48) of section 394.455, Florida Statutes, are redesignated as subsections (32) through (39) and (41) through (50), respectively, subsection (22) of that section is amended, and new subsections (31) and (40) are added to that section, to read:

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

(22) "Involuntary examination" means an examination performed under s. 394.463, s. 397.6772, s. 397.679, or s. 397.6798~~, or s. 397.6811~~ to determine whether a person qualifies

for involuntary services.

(31) "Neglect or refuse to care for himself or herself" includes, but is not limited to, evidence that a person:

(a) Is unable to satisfy basic needs for nourishment, medical care, shelter, or safety in a manner that creates a substantial probability of imminent death, serious physical debilitation, or disease;

(b) Is substantially unable to make an informed treatment choice; or

(c) Needs care or treatment to prevent deterioration.

(40) "Real and present threat of substantial harm" includes, but is not limited to, evidence of a substantial probability that the untreated person will:

(a) Lack, refuse, or not receive services for health or safety; or

(b) Suffer severe mental, emotional, or physical harm that will result in the loss of ability to function in the community or the loss of cognitive or volitional control over thoughts or actions.

Section 3. Subsection (13) is added to section 394.459, Florida Statutes, to read:

394.459 Rights of patients.—

(13) POST-DISCHARGE RIGHT TO CONTINUUM OF CARE.—Upon discharge, a respondent with a serious mental illness must be afforded the essential elements of recovery and placed in a continuum of care regimen. The department shall adopt rules specifying the services that must be provided to such respondents and identifying which serious mental illnesses entitle a respondent to such services.

Section 4. Subsection (2) of section 394.461, Florida Statutes, is amended to read:

394.461 Designation of receiving and treatment facilities and receiving systems.—The department is authorized to designate and monitor receiving facilities, treatment facilities, and receiving systems and may suspend or withdraw such designation for failure to comply with this part and rules adopted under this part. Unless designated by the department, facilities are not permitted to hold or treat involuntary patients under this part.

(2) TREATMENT FACILITY.— The department may designate any state-owned, state-operated, or state-supported facility as a state treatment facility. A civil patient may ~~shall~~ not be admitted to a state treatment facility without previously undergoing a transfer evaluation. Before the close of the state's case in chief in a ~~court~~ hearing for involuntary placement ~~in a state treatment facility~~, the state may establish that the transfer evaluation was performed and the document properly executed by providing the court with a copy of the transfer evaluation. The court may not ~~shall receive and~~ consider the substantive information ~~documented~~ in the transfer evaluation unless the evaluator testifies at the hearing. Any other facility, including a private facility or a federal facility, may be designated as a treatment facility by the department, provided that such designation is agreed to by the appropriate governing body or authority of the facility.

Section 5. Subsection (1) and paragraphs (g) and (h) of subsection (2) of section 394.463, Florida Statutes, are amended to read:

394.463 Involuntary examination.—

(1) CRITERIA.—A person may be taken to a receiving facility for involuntary examination if there is reason to believe that the person has a mental illness and because of his or her mental illness:

(a)1. The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination; or

2. The person is unable to determine for himself or herself whether examination is necessary; and

(b)1. Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

2. There is a substantial likelihood that without care or treatment the person will cause serious ~~bodily~~ harm to himself or herself or others in the near future, as evidenced by his or her ~~recent~~ behavior, actions, or omissions. Such harm includes, but is not limited to, property damage.

(2) INVOLUNTARY EXAMINATION.—

(g) The examination period must be for up to 72 hours. For a minor, the examination shall be initiated within 12 hours after the patient's arrival at the facility. Within the examination period or, if the examination period ends on a weekend or holiday, no later than the next working day thereafter, one of the following actions must be taken, based on

the individual needs of the patient:

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

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

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

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

(h) A person for whom an involuntary examination has been initiated who is being evaluated or treated at a hospital for an emergency medical condition specified in s. 395.002 must be examined by a facility within the examination period specified in paragraph (g). The examination period begins when the patient arrives at the hospital and ceases when the attending physician documents that the patient has an emergency medical condition. If the patient is examined at a hospital providing emergency

medical services by a professional qualified to perform an involuntary examination and is found as a result of that examination not to meet the criteria for involuntary outpatient services pursuant to s. 394.4655 ~~s. 394.4655(2)~~ or involuntary inpatient placement pursuant to s. 394.467(1), the patient may be offered voluntary services or placement, if appropriate, or released directly from the hospital providing emergency medical services. The finding by the professional that the patient has been examined and does not meet the criteria for involuntary inpatient services or involuntary outpatient placement must be entered into the patient's clinical record. This paragraph is not intended to prevent a hospital providing emergency medical services from appropriately transferring a patient to another hospital before stabilization if the requirements of s. 395.1041(3)(c) have been met.

Section 6. Section 394.4655, Florida Statutes, is amended to read:

394.4655 Involuntary outpatient services.—

(1)(a) In lieu of inpatient treatment, the court may order a respondent into outpatient treatment for up to 6 months if, during a hearing under s. 394.467, it is established that the respondent meets involuntary placement criteria and has been involuntarily ordered into inpatient treatment under this chapter at least twice during the last 36 months, the outpatient treatment is provided in the county in which the respondent resides, and the respondent's treating physician certifies, within a reasonable degree of medical probability, that the respondent:

1. Can be more appropriately treated on an outpatient

basis;

2. Can follow a prescribed treatment plan; and

3. Is not likely become dangerous, suffer more serious harm or illness, or further deteriorate if such plan is followed.

(b) For the duration of his or her treatment, the respondent must be supervised by a willing, able, and responsible friend, family member, social worker, case manager of a licensed service provider, guardian, or guardian advocate. Such supervisor must inform the court, state attorney, and public defender of any failure by the respondent to comply with his or her outpatient program.

(2) As the circumstances may require, the court shall retain jurisdiction over the case and parties for the entry of such further orders after a hearing.

(3) A criminal county court exercising its original jurisdiction in a misdemeanor case under s. 34.01 may also order a person into involuntary outpatient services.

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

~~(a) "Court" means a circuit court or a criminal county court.~~

~~(b) "Criminal county court" means a county court exercising its original jurisdiction in a misdemeanor case under s. 34.01.~~

~~(2) CRITERIA FOR INVOLUNTARY OUTPATIENT SERVICES.—A person may be ordered to involuntary outpatient services upon a finding of the court, by clear and convincing evidence, that the person meets all of the following criteria:~~

~~(a) The person is 18 years of age or older.~~

~~(b) The person has a mental illness.~~

~~(c) The person is unlikely to survive safely in the~~

~~community without supervision, based on a clinical determination.~~

~~(d) The person has a history of lack of compliance with treatment for mental illness.~~

~~(e) The person has:~~

~~1. At least twice within the immediately preceding 36 months been involuntarily admitted to a receiving or treatment facility as defined in s. 394.455, or has received mental health services in a forensic or correctional facility. The 36-month period does not include any period during which the person was admitted or incarcerated; or~~

~~2. Engaged in one or more acts of serious violent behavior toward self or others, or attempts at serious bodily harm to himself or herself or others, within the preceding 36 months.~~

~~(f) The person is, as a result of his or her mental illness, unlikely to voluntarily participate in the recommended treatment plan and has refused voluntary services for treatment after sufficient and conscientious explanation and disclosure of why the services are necessary or is unable to determine for himself or herself whether services are necessary.~~

~~(g) In view of the person's treatment history and current behavior, the person is in need of involuntary outpatient services in order to prevent a relapse or deterioration that would be likely to result in serious bodily harm to himself or herself or others, or a substantial harm to his or her well-being as set forth in s. 394.463(1).~~

~~(h) It is likely that the person will benefit from involuntary outpatient services.~~

~~(i) All available, less restrictive alternatives that would~~

~~offer an opportunity for improvement of his or her condition have been judged to be inappropriate or unavailable.~~

~~(3) INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. A patient who is being recommended for involuntary outpatient services by the administrator of the facility where the patient has been examined may be retained by the facility after adherence to the notice procedures provided in s. 394.4599. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate that authorizes the facility to retain the patient pending completion of a hearing. The certificate must be made a part of the patient's clinical record.~~

~~2. If the patient has been stabilized and no longer meets the criteria for involuntary examination pursuant to s. 394.463(1), the patient must be released from the facility while~~

~~awaiting the hearing for involuntary outpatient services. Before filing a petition for involuntary outpatient services, the administrator of the facility or a designated department representative must identify the service provider that will have primary responsibility for service provision under an order for involuntary outpatient services, unless the person is otherwise participating in outpatient psychiatric treatment and is not in need of public financing for that treatment, in which case the individual, if eligible, may be ordered to involuntary treatment pursuant to the existing psychiatric treatment relationship.~~

~~3. The service provider shall prepare a written proposed treatment plan in consultation with the patient or the patient's guardian advocate, if appointed, for the court's consideration for inclusion in the involuntary outpatient services order that addresses the nature and extent of the mental illness and any co-occurring substance use disorder that necessitate involuntary outpatient services. The treatment plan must specify the likely level of care, including the use of medication, and anticipated discharge criteria for terminating involuntary outpatient services. Service providers may select and supervise other individuals to implement specific aspects of the treatment plan. The services in the plan must be deemed clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker who consults with, or is employed or contracted by, the service provider. The service provider must certify to the court in the proposed plan whether sufficient services for improvement and stabilization are currently available and whether the service provider agrees to provide those services.~~

~~If the service provider certifies that the services in the proposed treatment plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(b) If a patient in involuntary inpatient placement meets the criteria for involuntary outpatient services, the administrator of the facility may, before the expiration of the period during which the facility is authorized to retain the patient, recommend involuntary outpatient services. The recommendation must be supported by the opinion of a psychiatrist and the second opinion of a clinical psychologist or another psychiatrist, both of whom have personally examined the patient within the preceding 72 hours, that the criteria for involuntary outpatient services are met. However, if the administrator certifies that a psychiatrist or clinical psychologist is not available to provide the second opinion, the second opinion may be provided by a licensed physician who has postgraduate training and experience in diagnosis and treatment of mental illness, a physician assistant who has at least 3 years' experience and is supervised by such licensed physician or a psychiatrist, a clinical social worker, or by a psychiatric nurse. Any second opinion authorized in this subparagraph may be conducted through a face-to-face examination, in person or by electronic means. Such recommendation must be entered on an involuntary outpatient services certificate, and the certificate must be made a part of the patient's clinical record.~~

~~(c)1. The administrator of the treatment facility shall~~

~~provide a copy of the involuntary outpatient services certificate and a copy of the state mental health discharge form to the managing entity in the county where the patient will be residing. For persons who are leaving a state mental health treatment facility, the petition for involuntary outpatient services must be filed in the county where the patient will be residing.~~

~~2. The service provider that will have primary responsibility for service provision shall be identified by the designated department representative before the order for involuntary outpatient services and must, before filing a petition for involuntary outpatient services, certify to the court whether the services recommended in the patient's discharge plan are available and whether the service provider agrees to provide those services. The service provider must develop with the patient, or the patient's guardian advocate, if appointed, a treatment or service plan that addresses the needs identified in the discharge plan. The plan must be deemed to be clinically appropriate by a physician, clinical psychologist, psychiatric nurse, mental health counselor, marriage and family therapist, or clinical social worker, as defined in this chapter, who consults with, or is employed or contracted by, the service provider.~~

~~3. If the service provider certifies that the services in the proposed treatment or service plan are not available, the petitioner may not file the petition. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(4) PETITION FOR INVOLUNTARY OUTPATIENT SERVICES.~~

~~(a) A petition for involuntary outpatient services may be filed by:~~

~~1. The administrator of a receiving facility; or~~

~~2. The administrator of a treatment facility.~~

~~(b) Each required criterion for involuntary outpatient services must be alleged and substantiated in the petition for involuntary outpatient services. A copy of the certificate recommending involuntary outpatient services completed by a qualified professional specified in subsection (3) must be attached to the petition. A copy of the proposed treatment plan must be attached to the petition. Before the petition is filed, the service provider shall certify that the services in the proposed plan are available. If the necessary services are not available, the petition may not be filed. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services.~~

~~(c) The petition for involuntary outpatient services must be filed in the county where the patient is located, unless the patient is being placed from a state treatment facility, in which case the petition must be filed in the county where the patient will reside. When the petition has been filed, the clerk of the court shall provide copies of the petition and the proposed treatment plan to the department, the managing entity, the patient, the patient's guardian or representative, the state attorney, and the public defender or the patient's private counsel. A fee may not be charged for filing a petition under this subsection.~~

~~(5) APPOINTMENT OF COUNSEL. Within 1 court working day after the filing of a petition for involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of the appointment. The public defender shall represent the person until the petition is dismissed, the court order expires, or the patient is discharged from involuntary outpatient services. An attorney who represents the patient must be provided access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(6) CONTINUANCE OF HEARING. The patient is entitled, with the concurrence of the patient's counsel, to at least one continuance of the hearing. The continuance shall be for a period of up to 4 weeks.~~

~~(7) HEARING ON INVOLUNTARY OUTPATIENT SERVICES.~~

~~(a)1. The court shall hold the hearing on involuntary outpatient services within 5 working days after the filing of the petition, unless a continuance is granted. The hearing must be held in the county where the petition is filed, must be as convenient to the patient as is consistent with orderly procedure, and must be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient and if the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. The state~~

~~attorney for the circuit in which the patient is located shall represent the state, rather than the petitioner, as the real party in interest in the proceeding.~~

~~2. The court may appoint a magistrate to preside at the hearing. One of the professionals who executed the involuntary outpatient services certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the person's prior history and how that prior history relates to the person's current condition. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.~~

~~(b)1. If the court concludes that the patient meets the criteria for involuntary outpatient services pursuant to subsection (2), the court shall issue an order for involuntary outpatient services. The court order shall be for a period of up to 90 days. The order must specify the nature and extent of the patient's mental illness. The order of the court and the treatment plan must be made part of the patient's clinical record. The service provider shall discharge a patient from involuntary outpatient services when the order expires or any time the patient no longer meets the criteria for involuntary~~

~~placement. Upon discharge, the service provider shall send a certificate of discharge to the court.~~

~~2. The court may not order the department or the service provider to provide services if the program or service is not available in the patient's local community, if there is no space available in the program or service for the patient, or if funding is not available for the program or service. The service provider must notify the managing entity if the requested services are not available. The managing entity must document such efforts to obtain the requested services. A copy of the order must be sent to the managing entity by the service provider within 1 working day after it is received from the court. The order may be submitted electronically through existing data systems. After the order for involuntary services is issued, the service provider and the patient may modify the treatment plan. For any material modification of the treatment plan to which the patient or, if one is appointed, the patient's guardian advocate agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~3. If, in the clinical judgment of a physician, the patient has failed or has refused to comply with the treatment ordered by the court, and, in the clinical judgment of the physician, efforts were made to solicit compliance and the patient may meet the criteria for involuntary examination, a person may be brought to a receiving facility pursuant to s. 394.463. If, after examination, the patient does not meet the criteria for~~

~~involuntary inpatient placement pursuant to s. 394.467, the patient must be discharged from the facility. The involuntary outpatient services order shall remain in effect unless the service provider determines that the patient no longer meets the criteria for involuntary outpatient services or until the order expires. The service provider must determine whether modifications should be made to the existing treatment plan and must attempt to continue to engage the patient in treatment. For any material modification of the treatment plan to which the patient or the patient's guardian advocate, if applicable, agrees, the service provider shall send notice of the modification to the court. Any material modifications of the treatment plan which are contested by the patient or the patient's guardian advocate, if applicable, must be approved or disapproved by the court consistent with subsection (3).~~

~~(c) If, at any time before the conclusion of the initial hearing on involuntary outpatient services, it appears to the court that the person does not meet the criteria for involuntary outpatient services under this section but, instead, meets the criteria for involuntary inpatient placement, the court may order the person admitted for involuntary inpatient examination under s. 394.463. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, the court may order the person to be admitted for involuntary assessment for a period of 5 days pursuant to s. 397.6811. Thereafter, all proceedings are governed by chapter 397.~~

~~(d) At the hearing on involuntary outpatient services, the court shall consider testimony and evidence regarding the~~

~~patient's competence to consent to services. If the court finds that the patient is incompetent to consent to treatment, it shall appoint a guardian advocate as provided in s. 394.4598. The guardian advocate shall be appointed or discharged in accordance with s. 394.4598.~~

~~(e) The administrator of the receiving facility or the designated department representative shall provide a copy of the court order and adequate documentation of a patient's mental illness to the service provider for involuntary outpatient services. Such documentation must include any advance directives made by the patient, a psychiatric evaluation of the patient, and any evaluations of the patient performed by a psychologist or a clinical social worker.~~

~~(8) PROCEDURE FOR CONTINUED INVOLUNTARY OUTPATIENT SERVICES.—~~

~~(a)1. If the person continues to meet the criteria for involuntary outpatient services, the service provider shall, at least 10 days before the expiration of the period during which the treatment is ordered for the person, file in the court that issued the order for involuntary outpatient services a petition for continued involuntary outpatient services. The court shall immediately schedule a hearing on the petition to be held within 15 days after the petition is filed.~~

~~2. The existing involuntary outpatient services order remains in effect until disposition on the petition for continued involuntary outpatient services.~~

~~3. A certificate shall be attached to the petition which includes a statement from the person's physician or clinical psychologist justifying the request, a brief description of the~~

~~patient's treatment during the time he or she was receiving involuntary services, and an individualized plan of continued treatment.~~

~~4. The service provider shall develop the individualized plan of continued treatment in consultation with the patient or the patient's guardian advocate, if applicable. When the petition has been filed, the clerk of the court shall provide copies of the certificate and the individualized plan of continued services to the department, the patient, the patient's guardian advocate, the state attorney, and the patient's private counsel or the public defender.~~

~~(b) Within 1 court working day after the filing of a petition for continued involuntary outpatient services, the court shall appoint the public defender to represent the person who is the subject of the petition, unless the person is otherwise represented by counsel. The clerk of the court shall immediately notify the public defender of such appointment. The public defender shall represent the person until the petition is dismissed or the court order expires or the patient is discharged from involuntary outpatient services. Any attorney representing the patient shall have access to the patient, witnesses, and records relevant to the presentation of the patient's case and shall represent the interests of the patient, regardless of the source of payment to the attorney.~~

~~(c) Hearings on petitions for continued involuntary outpatient services must be before the court that issued the order for involuntary outpatient services. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this paragraph must meet the~~

~~requirements of subsection (7), except that the time period included in paragraph (2)(c) is not applicable in determining the appropriateness of additional periods of involuntary outpatient placement.~~

~~(d) Notice of the hearing must be provided as set forth in s. 394.4599. The patient and the patient's attorney may agree to a period of continued outpatient services without a court hearing.~~

~~(e) The same procedure must be repeated before the expiration of each additional period the patient is placed in treatment.~~

~~(f) If the patient has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the patient's competence. Section 394.4598 governs the discharge of the guardian advocate if the patient's competency to consent to treatment has been restored.~~

Section 7. Subsections (1) and (5) and paragraphs (a), (b), and (c) of subsection (6) of section 394.467, Florida Statutes, are amended to read:

394.467 Involuntary inpatient placement.—

(1) CRITERIA.—A person may be ordered for involuntary inpatient placement for treatment upon a finding of the court by clear and convincing evidence that:

(a) He or she has a mental illness and because of his or her mental illness:

1.a. He or she has refused voluntary inpatient placement for treatment after sufficient and conscientious explanation and disclosure of the purpose of inpatient placement for treatment; or

b. He or she is unable to determine for himself or herself whether inpatient placement is necessary; and

2.a. He or she is incapable of surviving alone or with the help of willing, able, and responsible family or friends, including available alternative services, and, without treatment, is likely to suffer from neglect or refuse to care for himself or herself, and such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; or

b. There is substantial likelihood that in the near future he or she will inflict serious ~~bodily~~ harm to ~~on~~ self or others, which includes property damage, as evidenced by acts, omissions, or ~~recent~~ behavior causing, attempting, or threatening such harm; and

(b) All available less restrictive treatment alternatives that would offer an opportunity for improvement of his or her condition have been judged to be inappropriate.

(5) CONTINUANCE OF HEARING.—The patient and the state are independently entitled ~~is entitled, with the concurrence of the patient's counsel,~~ to at least one continuance of the hearing. The patient's continuance may be for a period of ~~for~~ up to 4 weeks and requires the concurrence of his or her counsel. The state's continuance may be for a period of up to 7 court working days and requires a showing of good cause and due diligence by the state before requesting the continuance. The state's failure to timely review any readily available document or failure to attempt to contact a known witness does not warrant a continuance.

(6) HEARING ON INVOLUNTARY INPATIENT PLACEMENT.—

(a)1. The court shall hold the hearing on involuntary inpatient placement within 7 ~~5~~ court working days, unless a continuance is granted.

2. Except for good cause documented in the court file, the hearing must be held in the county or the facility, as appropriate, where the patient is located, must be as convenient to the patient as is consistent with orderly procedure, and shall be conducted in physical settings not likely to be injurious to the patient's condition. If the court finds that the patient's attendance at the hearing is not consistent with the best interests of the patient or is likely injurious to the patient, or the patient knowingly, intelligently, and voluntarily waives his or her right to be present, and the patient's counsel does not object, the court may waive the presence of the patient from all or any portion of the hearing. Absent a showing of good cause, the court may permit all witnesses, including, but not limited to, any medical professionals or personnel who are or have been involved with the patient's treatment, to remotely attend and testify at the hearing under oath via the most appropriate and convenient technological method of communication available to the court, including, but not limited to, teleconference. The state attorney for the circuit in which the patient is located shall represent the state, rather than the petitioning facility administrator, as the real party in interest in the proceeding. In preparing its case, the state attorney may access, by subpoena if necessary, the patient, witnesses, and records that are relevant to the state's case. Such records include, but are not limited to, any social media, school records, and reports

documenting contact the patient may have had with law enforcement officers or other state agencies.

3. The court may appoint a magistrate to preside at the hearing. One of the professionals who executed the petition for involuntary inpatient placement certificate shall be a witness. The patient and the patient's guardian or representative shall be informed by the court of the right to an independent expert examination. If the patient cannot afford such an examination, the court shall ensure that one is provided, as otherwise provided for by law. The independent expert's report is confidential and not discoverable, unless the expert is to be called as a witness for the patient at the hearing. The testimony in the hearing must be given under oath, and the proceedings must be recorded. The patient may refuse to testify at the hearing.

(b) If the court concludes that the patient meets the criteria for involuntary inpatient placement, it may order that the patient be transferred to a treatment facility or, if the patient is at a treatment facility, that the patient be retained there or be treated at any other appropriate facility, or that the patient receive services, on an involuntary basis, for up to ~~90 days. However, any order for involuntary mental health services in a treatment facility may be for up to~~ 6 months. The order shall specify the nature and extent of the patient's mental illness. The court may not order an individual with traumatic brain injury or dementia who lacks a co-occurring mental illness to be involuntarily placed in a state treatment facility unless evaluations such as, but not limited to, the Glasgow Outcome Scale or the Rancho Los Amigos Levels of

Cognitive Functioning Scale show that such individuals may benefit from behavioral health treatment. Such individuals must be referred to the Agency for Persons with Disabilities or the Department of Elderly Affairs for further evaluation and placement in a medical rehabilitation facility or supportive residential placement that addresses their individual needs. The facility shall discharge a patient any time the patient no longer meets the criteria for involuntary inpatient placement, unless the patient has transferred to voluntary status.

(c) If at any time before the conclusion of the hearing on involuntary inpatient placement it appears to the court that the person does not meet the criteria for involuntary inpatient placement under this section, but instead meets the criteria for involuntary outpatient services, the court may order the person into ~~evaluated for~~ involuntary outpatient services if the requirements of s. 394.4655 are met ~~pursuant to s. 394.4655. The petition and hearing procedures set forth in s. 394.4655 shall apply~~. If the person instead meets the criteria for involuntary assessment, protective custody, or involuntary admission pursuant to s. 397.675, then the court may order the person to be admitted for involuntary assessment ~~for a period of 5 days~~ pursuant to s. 397.6957 ~~s. 397.6811~~. Thereafter, all proceedings are governed by chapter 397.

Section 8. Subsection (3) of section 397.305, Florida Statutes, is amended to read:

397.305 Legislative findings, intent, and purpose.—

(3) It is the purpose of this chapter to provide for a comprehensive continuum of accessible and quality substance abuse prevention, intervention, clinical treatment, and recovery

support services in the most appropriate and least restrictive environment which promotes long-term recovery while protecting and respecting the rights of individuals, primarily through community-based private not-for-profit providers working with local governmental programs involving a wide range of agencies from both the public and private sectors.

Section 9. Present subsections (29) through (35) and (36) through (49) of section 397.311, Florida Statutes, are redesignated as subsections (30) through (36) and (38) through (51), respectively, subsection (23) of that section is amended, and new subsections (29) and (37) are added to that section, to read:

397.311 Definitions.—As used in this chapter, except part VIII, the term:

(23) "Involuntary treatment ~~services~~" means an array of behavioral health services that may be ordered by the court for persons with substance abuse impairment or co-occurring substance abuse impairment and mental health disorders.

(29) "Neglect or refuse to care for himself or herself" includes, but is not limited to, evidence that a person:

(a) Is unable to satisfy basic needs for nourishment, medical care, shelter, or safety in a manner that creates a substantial probability of imminent death, serious physical debilitation, or disease;

(b) Is substantially unable to make an informed treatment choice; or

(c) Needs care or treatment to prevent deterioration.

(37) "Real and present threat of substantial harm" includes, but is not limited to, evidence of a substantial

probability that the untreated person will:

(a) Lack, refuse, or not receive services for health or safety; or

(b) Suffer severe mental, emotional, or physical harm that will result in the loss of ability to function in the community or the loss of cognitive or volitional control over thoughts or actions.

Section 10. Subsection (5) of section 397.334, Florida Statutes, is amended to read:

397.334 Treatment-based drug court programs.—

(5) Treatment-based drug court programs may include pretrial intervention programs as provided in ss. 948.08, 948.16, and 985.345, treatment-based drug court programs authorized in chapter 39, postadjudicatory programs as provided in ss. 948.01, 948.06, and 948.20, and review of the status of compliance or noncompliance of sentenced offenders through a treatment-based drug court program. While enrolled in a treatment-based drug court program, the participant is subject to a coordinated strategy developed by a drug court team under subsection (4). The coordinated strategy must be provided in writing to the participant before the participant agrees to enter into a treatment-based drug court program. The coordinated strategy may include a protocol of sanctions that may be imposed upon the participant for noncompliance with program rules. The protocol of sanctions may include, but is not limited to, placement in a substance abuse treatment program offered by a licensed service provider as defined in s. 397.311 or in a jail-based treatment program or serving a period of secure detention under chapter 985 if a child or a period of incarceration ~~within~~

~~the time limits established~~ for contempt of court if an adult. In cases involving minors violating an involuntary treatment order, the court's civil contempt powers are exempt from the time limitations of chapters 984 and 985 and the court may instead hold the minor in contempt for the same amount of time as their court-ordered treatment, provided that the court clearly informs the minor that he or she can immediately purge the contempt finding by complying with the treatment order. Should this contempt order result in incarceration, the court must hold a status conference every 2 to 4 weeks to assess the minor's well-being and inquire into whether he or she will go to, and remain in, treatment. If the incarcerated minor agrees to comply with the court's involuntary treatment order, service providers must prioritize his or her placement into treatment ~~The coordinated strategy must be provided in writing to the participant before the participant agrees to enter into a treatment-based drug court program~~.

Section 11. Section 397.412, Florida Statutes, is created to read:

397.412 Ability to hold involuntarily committed persons.—

(1) Unless presented with a court order releasing a person from care, all service providers licensed under this chapter may refuse an individual's request to prematurely leave his or her court-ordered involuntary treatment program provided that all of the following criteria are met:

(a) Said individual still meets the involuntary treatment criteria.

(b) There are no available, lesser restrictive means of care that adequately address the person's needs. Facilities must

notify the court and all relevant parties in writing if an individual is released.

(2) Notwithstanding this chapter or any state administrative rule, all service providers licensed to provide residential treatment under this chapter must install the necessary security features in their facilities to safely prevent the premature departure of their involuntary patients and must enact policies that enable the differentiation of voluntary and involuntary patients at the facility. The installation of such security features does not make the treatment center a secure facility and does not require the treatment center to comply with any other law or regulation governing secured facilities.

Section 12. Subsection (11) is added to section 397.501, Florida Statutes, to read:

397.501 Rights of individuals.—Individuals receiving substance abuse services from any service provider are guaranteed protection of the rights specified in this section, unless otherwise expressly provided, and service providers must ensure the protection of such rights.

(11) POST-DISCHARGE RIGHT TO CONTINUUM OF CARE.—Upon discharge, a respondent with a serious substance abuse addiction must be afforded the essential elements of recovery and placed in a continuum of care regimen. The department shall adopt rules specifying the services that must be provided to such respondents and identifying which substance abuse addictions entitle a respondent to such services.

Section 13. Subsection (2) of section 397.675, Florida Statutes, is amended to read:

397.675 Criteria for involuntary admissions, including protective custody, emergency admission, and other involuntary assessment, involuntary treatment, and alternative involuntary assessment for minors, for purposes of assessment and stabilization, and for involuntary treatment.—A person meets the criteria for involuntary admission if there is good faith reason to believe that the person is substance abuse impaired or has a co-occurring mental health disorder and, because of such impairment or disorder:

(2)(a) Is in need of substance abuse services and, by reason of substance abuse impairment, his or her judgment has been so impaired that he or she is incapable of appreciating his or her need for such services and of making a rational decision in that regard, although mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for such services; ~~or~~

(b) Without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; ~~,~~ or

(c) There is substantial likelihood that the person has inflicted, or threatened to or attempted to inflict, or, unless admitted, in the near future, as evidenced by his or her behavior, actions, or omissions, will likely ~~is likely to~~ inflict serious~~, physical~~ harm to self or others. Such harm includes, but is not limited to, property damage ~~on himself,~~

~~herself, or another~~.

Section 14. Subsection (1) of section 397.6751, Florida Statutes, is amended to read:

397.6751 Service provider responsibilities regarding involuntary admissions.—

(1) It is the responsibility of the service provider to:

(a) Ensure that a person who is admitted to a licensed service component meets the admission criteria specified in s. 397.675;

(b) Ascertain whether the medical and behavioral conditions of the person, as presented, are beyond the safe management capabilities of the service provider;

(c) Provide for the admission of the person to the service component that represents the most appropriate and least restrictive available setting that is responsive to the person's treatment needs;

(d) Verify that the admission of the person to the service component does not result in a census in excess of its licensed service capacity;

(e) Determine whether the cost of services is within the financial means of the person or those who are financially responsible for the person's care; and

(f) Take all necessary measures to ensure that each individual in treatment is provided with a safe environment, and to ensure that each individual whose medical condition or behavioral problem becomes such that he or she cannot be safely managed by the service component is discharged and referred to a more appropriate setting for care.

Section 15. Section 397.681, Florida Statutes, is amended

to read:

397.681 Involuntary petitions; general provisions; court jurisdiction and right to counsel.—

(1) JURISDICTION.—The courts have jurisdiction of ~~involuntary assessment and stabilization petitions and~~ involuntary treatment petitions for substance abuse impaired persons, and such petitions must be filed with the clerk of the court in the county where the person is located. The clerk of the court may not charge a fee for the filing of a petition under this section. The chief judge may appoint a general or special magistrate to preside over all or part of the proceedings. The alleged impaired person is named as the respondent.

(2) RIGHT TO COUNSEL.—A respondent has the right to counsel at every stage of a proceeding relating to a petition for his or her ~~involuntary assessment and a petition for his or her~~ involuntary treatment for substance abuse impairment. A respondent who desires counsel and is unable to afford private counsel has the right to court-appointed counsel and to the benefits of s. 57.081. If the court believes that the respondent needs the assistance of counsel, the court shall appoint such counsel for the respondent without regard to the respondent's wishes. If the respondent is a minor not otherwise represented in the proceeding, the court shall immediately appoint a guardian ad litem to act on the minor's behalf.

(3) STATE REPRESENTATIVE.—For all court-involved involuntary proceedings under this chapter, the state attorney for the circuit in which the respondent is located shall represent the state rather than the petitioner as the real party

of interest in the proceeding, but the state attorney must be respectful of the petitioner's interests and concerns. The state attorney may access, by subpoena if necessary, the respondent, witnesses, and records that are relevant to the state's case. Such records include, but are not limited to, any social media, school records, and reports documenting contact the respondent may have had with law enforcement officers or other state agencies. The petitioner may not access any records obtained by the state attorney unless such records are entered into the court file. This subsection shall take effect only when the Legislature provides the requisite funding to the state attorney for its additional staffing needs.

Section 16. Section 397.6811, Florida Statutes, is repealed.

Section 17. Section 397.6814, Florida Statutes, is repealed.

Section 18. Section 397.6815, Florida Statutes, is repealed.

Section 19. Section 397.6818, Florida Statutes, is repealed.

Section 20. Section 397.6819, Florida Statutes, is repealed.

Section 21. Section 397.6821, Florida Statutes, is repealed.

Section 22. Section 397.6822, Florida Statutes, is repealed.

Section 23. Section 397.693, Florida Statutes, is amended to read:

397.693 Involuntary treatment.—A person may be the subject

of a petition for court-ordered involuntary treatment pursuant to this part, if that person:

(1) Reasonably appears to meet ~~meets~~ the criteria for involuntary admission provided in s. 397.675; ~~and:~~

(2)~~(1)~~ Has been placed under protective custody pursuant to s. 397.677 within the previous 10 days;

(3)~~(2)~~ Has been subject to an emergency admission pursuant to s. 397.679 within the previous 10 days;

(4)~~(3)~~ Has been assessed by a qualified professional within 30 ~~5~~ days;

~~(4) Has been subject to involuntary assessment and stabilization pursuant to s. 397.6818 within the previous 12 days;~~ or

(5) Has been subject to alternative involuntary treatment ~~admission~~ pursuant to s. 397.6957(1)(c) ~~s. 397.6822~~ within the previous 30 ~~12~~ days.

Section 24. Section 397.695, Florida Statutes, is amended to read:

397.695 Involuntary treatment ~~services~~; persons who may petition.—

(1) If the respondent is an adult, a petition for involuntary treatment ~~services~~ may be filed by the respondent's spouse or legal guardian, any relative, a service provider, or an adult who has direct personal knowledge of the respondent's substance abuse impairment and his or her prior course of assessment and treatment.

(2) If the respondent is a minor, a petition for involuntary treatment may be filed by a parent, legal guardian, or service provider.

(3) The court or the clerk of the court may waive or prohibit any service of process fees if a petitioner is determined to be indigent under s. 57.082.

Section 25. Section 397.6951, Florida Statutes, is amended to read:

397.6951 Contents of petition for involuntary treatment ~~services~~.—

(1) A petition for involuntary treatment ~~services~~ must contain the name of the respondent; the name of the petitioner or petitioners; the relationship between the respondent and the petitioner; the name of the respondent's attorney, if known; ~~the findings and recommendations of the assessment performed by the qualified professional;~~ and the factual allegations presented by the petitioner establishing the need for involuntary ~~outpatient~~ services. The factual allegations must demonstrate:

(a)~~(1)~~ The reason for the petitioner's belief that the respondent is substance abuse impaired;

(b)~~(2)~~ The reason for the petitioner's belief that because of such impairment the respondent has lost the power of self-control with respect to substance abuse; and

(c)1.~~(3)(a)~~ The reason the petitioner believes that either:

a. The respondent, without care or treatment, is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the provision of other services; or

b.(I) There is substantial likelihood that the person has

inflicted, or threatened to or attempted to inflict, serious harm to self or others, which includes property damage; or

(II) Unless admitted, in the near future, as evidenced by his or her behavior, actions, or omissions, the person will likely inflict serious harm to self or others, which includes property damage ~~has inflicted or is likely to inflict physical harm on himself or herself or others unless the court orders the involuntary services~~; or

2.~~(b)~~ The reason the petitioner believes that the respondent is in need of substance abuse services but refuses ~~respondent's refusal~~ to voluntarily receive care is due to ~~based on~~ judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care.

(2) The petition may be accompanied by a certificate or report of a qualified professional or a licensed physician who has examined the respondent within 30 days before the petition's submission. Such certificate or report must include the qualified professional or physician's findings relating to his or her assessment of the patient and his or her treatment recommendations. In the event that the respondent refuses to submit to an evaluation, such refusal must be documented in the petition.

(3) In the event of an emergency, the petition must also describe the respondent's exigent circumstances and include a request for an expedited hearing or the issuance of an ex parte assessment and stabilization order that is to be executed while the hearing is pending.

Section 26. Section 397.6955, Florida Statutes, is amended

to read:

397.6955 Duties of court upon filing of petition for involuntary treatment ~~services~~.—

(1) Upon the filing of a petition for involuntary treatment ~~services~~ for a substance abuse impaired person with the clerk of the court, the clerk must notify the state attorney's office. In addition, the court shall immediately determine whether the respondent is represented by an attorney or whether the appointment of counsel for the respondent is appropriate. If, based on the contents of the petition, the court appoints counsel for the person, the clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel, created pursuant to s. 27.511, of the appointment. The office of criminal conflict and civil regional counsel shall represent the person until the petition is dismissed, the court order expires, or the person is discharged from involuntary treatment ~~services~~. An attorney that represents the person named in the petition shall have access to the person, witnesses, and records relevant to the presentation of the person's case and shall represent the interests of the person, regardless of the source of payment to the attorney.

(2) The court shall schedule a hearing to be held on the petition within 10 court working ~~5~~ days unless a continuance is granted. The court may appoint a magistrate to preside at the hearing.

(3) A copy of the petition and notice of the hearing must be provided to the respondent; the respondent's parent, guardian, or legal custodian, in the case of a minor; the respondent's attorney, if known; the petitioner; the

respondent's spouse or guardian, if applicable; and such other persons as the court may direct. If the respondent is a minor, a copy of the petition and notice of the hearing must be personally delivered to the respondent. The court shall also issue a summons to the person whose admission is sought.

(4) When the petitioner asserts that emergency circumstances are present, or when upon review of the petition the court determines that an emergency exists, the court may rely solely on the contents of the petition and, without the appointment of an attorney, enter an ex parte order authorizing the involuntary assessment and stabilization of the respondent. The court may also order a law enforcement officer or other designated agent of the court to take the respondent into custody and deliver him or her to the nearest appropriate licensed service provider to be evaluated while the full hearing is pending. The service provider may hold the respondent until his or her hearing, which may be held on an expedited basis if, upon compliance with subsections (1) and (3), proof of service on all relevant parties is provided.

Section 27. Section 397.6957, Florida Statutes, is amended to read:

397.6957 Hearing on petition for involuntary treatment ~~services~~.—

(1)(a) The respondent must be present at a hearing on a petition for involuntary treatment unless he or she knowingly, intelligently, and voluntarily waived his or her right to be present, or the court finds that his or her presence is not consistent with his or her best interests or is likely to be injurious to himself or herself or others. ~~services,~~ The court

shall hear and review all relevant evidence, including testimony from individuals such as family members familiar with the respondent's prior history and how it relates to his or her current condition; and the ~~review of~~ results of the assessment completed by the qualified professional in connection with this chapter. Absent a showing of good cause, the court may permit all witnesses, such as any medical professionals or personnel who are or have been involved with the respondent's treatment, to remotely attend and testify at the hearing under oath via the most appropriate and convenient technological method of communication available to the court, including, but not limited to, teleconference ~~the respondent's protective custody, emergency admission, involuntary assessment, or alternative involuntary admission. The respondent must be present unless the court finds that his or her presence is likely to be injurious to himself or herself or others, in which event the court must appoint a guardian advocate to act in behalf of the respondent throughout the proceedings~~.

(b) If the respondent was not, or had previously refused to be, assessed by a qualified professional or a licensed physician and the court reasonably believes, based on the petition and evidence presented, that the respondent qualifies for involuntary placement, the court must give the respondent an opportunity to consent to an examination by a court-appointed or otherwise agreed upon physician. If the respondent consents, the court shall reschedule the hearing within 10 court working days and, after notifying the parties of the rescheduled hearing date, continue the case. The assessment must occur before the rescheduled hearing date unless the court orders otherwise.

However, if the respondent refuses to be assessed, or if the respondent agrees to be assessed but the court suspects that the respondent will not voluntarily appear at a rescheduled hearing, the court may enter a preliminary order committing the respondent to an appropriate treatment facility for further evaluation until the date of the rescheduled hearing.

(c)1. The respondent's assessment by a qualified professional must occur within 72 hours of his or her arrival at the licensed service provider. If the person conducting the assessment is not a licensed physician, the assessment must be reviewed by a licensed physician within the 72-hour period. However, the service provider may petition the court in writing for an extension of time to complete an evaluation if a qualified professional is unable to complete the assessment and stabilize the respondent within 72 hours after the respondent's arrival. The service provider must furnish copies of its request to all parties in accordance with applicable confidentiality requirements. With or without a hearing, the court may grant additional time, not to exceed 3 days before the rescheduled treatment hearing.

2. Upon the completion of his or her report, the qualified professional, in accordance with applicable confidentiality requirements, shall provide copies to the court and all relevant parties and counsel. Based upon the involuntary assessment, a service provider; a qualified professional of the hospital, detoxification facility, or addictions receiving facility; or, when a less restrictive component has been used, a qualified professional may hold the respondent until the rescheduled hearing and may initiate treatment. If the court subsequently

finds that treatment is necessary, any days of treatment provided before such hearing may be deducted from the court's final treatment order. Alternatively, the qualified professional or service provider may either release the individual and, if appropriate, refer him or her to another treatment facility or service provider or to community services; or allow the individual, with his or her consent, to remain voluntarily at the licensed service provider.

(d) The court or magistrate may order a law enforcement officer or other designated agent of the court to take the respondent into custody and transport him or her to or from the treating or assessing service provider and the court for his or her hearing.

(2) The petitioner has the burden of proving by clear and convincing evidence that:

(a) The respondent is substance abuse impaired, has lost the power of self-control with respect to substance abuse, and has a history of lack of compliance with treatment for substance abuse; and

(b) Because of such impairment the respondent is unlikely to voluntarily participate in the recommended services or is unable to determine for himself or herself whether services are necessary and:

1.a. Without services, the respondent is likely to suffer from neglect or refuse to care for himself or herself; that such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and that it is not apparent that such harm may be avoided through the help of willing, able, and responsible family members or friends or the

provisions of other services; or

b. There is a substantial likelihood that, unless admitted, ~~without services~~ the respondent has inflicted, or threatened to or attempted to inflict, or in the near future, as evidenced by his or her behavior, acts, or omissions, will likely cause serious harm to self or others, which includes property damage ~~will cause serious bodily harm to himself, herself, or another in the near future, as evidenced by recent behavior~~; or

2. The respondent is in need of substance abuse services but refuses ~~respondent's refusal~~ to voluntarily receive care due to ~~is based on~~ judgment so impaired by reason of substance abuse that the respondent is incapable of appreciating his or her need for care and of making a rational decision regarding that need for care. Mere refusal to receive such services does not constitute evidence of lack of judgment with respect to his or her need for services.

~~(3) One of the qualified professionals who executed the involuntary services certificate must be a witness. The court shall allow testimony from individuals, including family members, deemed by the court to be relevant under state law, regarding the respondent's prior history and how that prior history relates to the person's current condition. The~~ Testimony in the hearing must be taken under oath, and the proceedings must be recorded. The respondent ~~patient~~ may refuse to testify at the hearing.

(4) If at any point during the hearing the court has reason to believe that the respondent, due to mental illness other than or in addition to substance abuse impairment, is likely to injure himself or herself or another if allowed to remain at

liberty, or otherwise meets the involuntary commitment provisions of part I of chapter 394, the court may initiate involuntary proceedings under such provisions.

(5)~~(4)~~ At the conclusion of the hearing, the court shall either dismiss the petition or order the respondent to receive involuntary treatment ~~services~~ from his or her chosen licensed service provider if possible and appropriate. Any treatment order must include findings regarding the respondent's need for treatment and the appropriateness of other least restrictive alternatives. Such order may designate a specific service provider.

Section 28. Section 397.697, Florida Statutes, is amended to read:

397.697 Court determination; effect of court order for involuntary treatment ~~services~~.—

(1)(a) When the court finds that the conditions for involuntary treatment ~~services~~ have been proved by clear and convincing evidence, it may order the respondent to receive involuntary treatment ~~services~~ from a publicly funded licensed service provider for a period not to exceed 90 days. The court may also order a respondent to undergo treatment through a privately funded licensed service provider if the respondent has the ability to pay for the treatment, or if any person on the respondent's behalf voluntarily demonstrates a willingness and an ability to pay for the treatment. If the court finds it necessary, it may direct the sheriff to take the respondent into custody and deliver him or her to the licensed service provider specified in the court order, or to the nearest appropriate licensed service provider, for involuntary treatment ~~services~~.

When the conditions justifying involuntary treatment ~~services~~ no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment ~~services~~ are expected to exist after 90 days of treatment ~~services~~, a renewal of the involuntary treatment ~~services~~ order may be requested pursuant to s. 397.6975 before the end of the 90-day period.

(b) To qualify for involuntary outpatient treatment, an individual must be supervised by a willing, able, and responsible friend, family member, social worker, guardian, guardian advocate, or case manager of a licensed service provider; and this supervisor shall inform the court if the respondent fails to comply with his or her outpatient program. In addition, unless the respondent has been involuntarily ordered into inpatient treatment under this chapter at least twice during the last 36 months, he or she must receive an assessment from a qualified professional or licensed physician expressly recommending outpatient services, and the respondent must agree to follow a prescribed outpatient treatment plan. It must also appear that the respondent is unlikely to become dangerous, suffer more serious harm or illness, or further deteriorate if such plan is followed.

(2) In all cases resulting in an order for involuntary treatment ~~services~~, the court shall retain jurisdiction over the case and the parties for the entry of such further orders as the circumstances may require, including, but not limited to, monitoring compliance with treatment, changing the treatment modality, or initiating contempt of court proceedings for violating any valid order issued pursuant to chapter 397.

Hearings under this section may be set by motion of the parties or under the court's own authority. In cases involving minors violating an involuntary treatment order, the court's civil contempt powers are exempt from the time limitations of chapters 984 and 985 and the court may instead hold the minor in contempt for the same amount of time as their court-ordered treatment, provided that the court clearly informs the minor that he or she can immediately purge the contempt finding by complying with the treatment order. Should this contempt order result in incarceration, the court must hold a status conference every 2 to 4 weeks to assess the minor's well-being and inquire into whether he or she will go to, and remain in, treatment. If the incarcerated minor agrees to comply with the court's involuntary treatment order, service providers must prioritize his or her placement into treatment. The court's requirements for notification of proposed release must be included in the original order.

(3) An involuntary treatment ~~services~~ order also authorizes the licensed service provider to require the individual to receive treatment ~~services~~ that will benefit him or her, including treatment ~~services~~ at any licensable service component of a licensed service provider. While subject to the court's oversight, the service provider's authority under this section is separate and distinct from the court's continuing jurisdiction under subsection (2).

(4) If the court orders involuntary treatment ~~services~~, a copy of the order must be sent to the managing entity within 1 working day after it is received from the court. Documents may be submitted electronically through ~~though~~ existing data

systems, if applicable.

Section 29. Section 397.6975, Florida Statutes, is amended to read:

397.6975 Extension of involuntary treatment ~~services~~ period.—

(1) Whenever a service provider believes that an individual who is nearing the scheduled date of his or her release from involuntary care ~~services~~ continues to meet the criteria for involuntary treatment ~~services~~ in s. 397.693, a petition for renewal of the involuntary treatment ~~services~~ order must ~~may~~ be filed with the court ~~at least 10 days~~ before the expiration of the court-ordered treatment ~~services~~ period, preferably at least 10 days before the expiration of such period. The petition may be filed by the service provider or by the petitioner of the initial treatment order if the petition is accompanied by supporting documentation from the service provider. The court shall immediately schedule a hearing to be held not more than 10 court working ~~15~~ days after filing of the petition. Should the original treatment period expire while such hearing is pending, the court may order additional treatment if, upon reviewing the extension petition, the court concludes that an extension order will likely be granted. However, any additional treatment time must be deducted from any extension of treatment time granted. The court shall provide the copy of the petition for renewal and the notice of the hearing to all parties to the proceeding. The hearing is conducted pursuant to s. 397.6957.

(2) If the court finds that the petition for renewal of the involuntary treatment ~~services~~ order should be granted, it may order the respondent to receive involuntary treatment ~~services~~

for a period not to exceed an additional 90 days. When the conditions justifying involuntary treatment ~~services~~ no longer exist, the individual must be released as provided in s. 397.6971. When the conditions justifying involuntary treatment ~~services~~ continue to exist after an additional 90 days of treatment ~~service~~, a new petition requesting renewal of the involuntary treatment ~~services~~ order may be filed pursuant to this section.

(3) Within 1 court working day after the filing of a petition for continued involuntary treatment ~~services~~, the court shall appoint the office of criminal conflict and civil regional counsel to represent the respondent, unless the respondent is otherwise represented by counsel. The clerk of the court shall immediately notify the office of criminal conflict and civil regional counsel of such appointment. The office of criminal conflict and civil regional counsel shall represent the respondent until the petition is dismissed or the court order expires or the respondent is discharged from involuntary treatment ~~services~~. Any attorney representing the respondent shall have access to the respondent, witnesses, and records relevant to the presentation of the respondent's case and shall represent the interests of the respondent, regardless of the source of payment to the attorney.

(4) Hearings on petitions for continued involuntary treatment ~~services~~ shall be before the circuit court. The court may appoint a magistrate to preside at the hearing. The procedures for obtaining an order pursuant to this section shall be in accordance with s. 397.697.

(5) Notice of hearing shall be provided to the respondent

or his or her counsel. The respondent and the respondent's counsel may agree to a period of continued involuntary treatment ~~services~~ without a court hearing.

(6) The same procedure shall be repeated before the expiration of each additional period of involuntary treatment ~~services~~.

(7) If the respondent has previously been found incompetent to consent to treatment, the court shall consider testimony and evidence regarding the respondent's competence.

Section 30. Section 397.6976, Florida Statutes, is created to read:

397.6976 Involuntary treatment of habitual abusers.—Upon petition by any person authorized under s. 397.695, a person who meets the involuntary treatment criteria of this chapter who is also determined to be an habitual abuser may be committed by the court, after notice and hearing as provided in this chapter, to inpatient or outpatient treatment, or some combination thereof, without an assessment. Such commitment may not be for longer than 90 days, unless extended pursuant to s. 397.6975. For purposes of this section, "habitual abuser" means any person who has been involuntarily treated for substance abuse under this chapter three or more times during the 24 months before the date of the hearing, if each prior commitment order was initially for a period of 90 days.

Section 31. Section 397.6978, Florida Statutes, is repealed.

Section 32. Subsection (4) of section 397.706, Florida Statutes, is amended to read:

397.706 Screening, assessment, and disposition of juvenile

offenders.—

(4) The court may require juvenile offenders and their families to participate in substance abuse assessment and treatment services in accordance with the provisions of chapter 984 or chapter 985 and may use its contempt powers to enforce its orders. In cases involving minors violating an involuntary treatment order, the court's civil contempt powers are exempt from the time limitations of chapters 984 and 985 and the court may instead hold the minor in contempt for the same amount of time as their court-ordered treatment, provided that the court clearly informs the minor that he or she can immediately purge the contempt finding by complying with the treatment order. Should this contempt order result in incarceration, the court must hold a status conference every 2 to 4 weeks to assess the minor's well-being and inquire into whether he or she will go to, and remain in, treatment. If the incarcerated minor agrees to comply with the court's involuntary treatment order, service providers must prioritize his or her placement into treatment.

Section 33. Paragraph (d) of subsection (2) of section 394.4599, Florida Statutes, is amended to read:

394.4599 Notice.—

(2) INVOLUNTARY ADMISSION.—

(d) The written notice of the filing of the petition for involuntary services for an individual being held must contain the following:

1. Notice that the petition for~~:~~

~~a.~~ involuntary inpatient treatment pursuant to s. 394.467 has been filed with the circuit court in the county in which the individual is hospitalized and the address of such court~~; or~~

~~b. Involuntary outpatient services pursuant to s. 394.4655 has been filed with the criminal county court, as defined in s. 394.4655(1), or the circuit court, as applicable, in the county in which the individual is hospitalized and the address of such court~~.

2. Notice that the office of the public defender has been appointed to represent the individual in the proceeding, if the individual is not otherwise represented by counsel.

3. The date, time, and place of the hearing and the name of each examining expert and every other person expected to testify in support of continued detention.

4. Notice that the individual, the individual's guardian, guardian advocate, health care surrogate or proxy, or representative, or the administrator may apply for a change of venue for the convenience of the parties or witnesses or because of the condition of the individual.

5. Notice that the individual is entitled to an independent expert examination and, if the individual cannot afford such an examination, that the court will provide for one.

Section 34. Subsection (3) of section 394.4615, Florida Statutes, is amended to read:

394.4615 Clinical records; confidentiality.—

(3) Information from the clinical record may be released in the following circumstances:

(a) When a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient.

(b) When the administrator of the facility or secretary of the department deems release to a qualified researcher as defined in administrative rule, an aftercare treatment provider, or an employee or agent of the department is necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, aftercare planning, or evaluation of programs.

For the purpose of determining whether a person meets the criteria for involuntary outpatient placement ~~or for preparing the proposed treatment plan pursuant to s. 394.4655~~, the clinical record may be released to the state attorney, the public defender or the patient's private legal counsel, the court, and to the appropriate mental health professionals~~,~~ ~~including the service provider identified in s. 394.4655(7)(b)2.,~~ in accordance with state and federal law.

Section 35. Section 397.6971, Florida Statutes, is amended to read:

397.6971 Early release from involuntary treatment ~~services~~.—

(1) At any time before the end of the 90-day involuntary treatment ~~services~~ period, or before the end of any extension granted pursuant to s. 397.6975, an individual receiving involuntary treatment ~~services~~ may be determined eligible for discharge to the most appropriate referral or disposition for the individual when any of the following apply:

(a) The individual no longer meets the criteria for involuntary admission and has given his or her informed consent to be transferred to voluntary treatment status.

(b) If the individual was admitted on the grounds of likelihood of infliction of physical harm upon himself or herself or others, such likelihood no longer exists.

(c) If the individual was admitted on the grounds of need for assessment and stabilization or treatment, accompanied by inability to make a determination respecting such need:

1. Such inability no longer exists; or

2. It is evident that further treatment will not bring about further significant improvements in the individual's condition.

(d) The individual is no longer in need of treatment ~~services~~.

(e) The director of the service provider determines that the individual is beyond the safe management capabilities of the provider.

(2) Whenever a qualified professional determines that an individual admitted for involuntary treatment ~~services~~ qualifies for early release under subsection (1), the service provider shall immediately discharge the individual and must notify all persons specified by the court in the original treatment order.

Section 36. Section 397.6977, Florida Statutes, is amended to read:

397.6977 Disposition of individual upon completion of involuntary treatment ~~services~~.—At the conclusion of the 90-day period of court-ordered involuntary treatment ~~services~~, the respondent is automatically discharged unless a motion for renewal of the involuntary treatment ~~services~~ order has been filed with the court pursuant to s. 397.6975.

Section 37. Paragraph (e) of subsection (5) of section

212.055, Florida Statutes, is amended to read:

212.055 Discretionary sales surtaxes; legislative intent; authorization and use of proceeds.—It is the legislative intent that any authorization for imposition of a discretionary sales surtax shall be published in the Florida Statutes as a subsection of this section, irrespective of the duration of the levy. Each enactment shall specify the types of counties authorized to levy; the rate or rates which may be imposed; the maximum length of time the surtax may be imposed, if any; the procedure which must be followed to secure voter approval, if required; the purpose for which the proceeds may be expended; and such other requirements as the Legislature may provide. Taxable transactions and administrative procedures shall be as provided in s. 212.054.

(5) COUNTY PUBLIC HOSPITAL SURTAX.—Any county as defined in s. 125.011(1) may levy the surtax authorized in this subsection pursuant to an ordinance either approved by extraordinary vote of the county commission or conditioned to take effect only upon approval by a majority vote of the electors of the county voting in a referendum. In a county as defined in s. 125.011(1), for the purposes of this subsection, "county public general hospital" means a general hospital as defined in s. 395.002 which is owned, operated, maintained, or governed by the county or its agency, authority, or public health trust.

(e) A governing board, agency, or authority shall be chartered by the county commission upon this act becoming law. The governing board, agency, or authority shall adopt and implement a health care plan for indigent health care services. The governing board, agency, or authority shall consist of no

more than seven and no fewer than five members appointed by the county commission. The members of the governing board, agency, or authority shall be at least 18 years of age and residents of the county. No member may be employed by or affiliated with a health care provider or the public health trust, agency, or authority responsible for the county public general hospital. The following community organizations shall each appoint a representative to a nominating committee: the South Florida Hospital and Healthcare Association, the Miami-Dade County Public Health Trust, the Dade County Medical Association, the Miami-Dade County Homeless Trust, and the Mayor of Miami-Dade County. This committee shall nominate between 10 and 14 county citizens for the governing board, agency, or authority. The slate shall be presented to the county commission and the county commission shall confirm the top five to seven nominees, depending on the size of the governing board. Until such time as the governing board, agency, or authority is created, the funds provided for in subparagraph (d)2. shall be placed in a restricted account set aside from other county funds and not disbursed by the county for any other purpose.

1. The plan shall divide the county into a minimum of four and maximum of six service areas, with no more than one participant hospital per service area. The county public general hospital shall be designated as the provider for one of the service areas. Services shall be provided through participants' primary acute care facilities.

2. The plan and subsequent amendments to it shall fund a defined range of health care services for both indigent persons and the medically poor, including primary care, preventive care,

hospital emergency room care, and hospital care necessary to stabilize the patient. For the purposes of this section, "stabilization" means stabilization as defined in s. 397.311 ~~s. 397.311(45)~~. Where consistent with these objectives, the plan may include services rendered by physicians, clinics, community hospitals, and alternative delivery sites, as well as at least one regional referral hospital per service area. The plan shall provide that agreements negotiated between the governing board, agency, or authority and providers shall recognize hospitals that render a disproportionate share of indigent care, provide other incentives to promote the delivery of charity care to draw down federal funds where appropriate, and require cost containment, including, but not limited to, case management. From the funds specified in subparagraphs (d)1. and 2. for indigent health care services, service providers shall receive reimbursement at a Medicaid rate to be determined by the governing board, agency, or authority created pursuant to this paragraph for the initial emergency room visit, and a per-member per-month fee or capitation for those members enrolled in their service area, as compensation for the services rendered following the initial emergency visit. Except for provisions of emergency services, upon determination of eligibility, enrollment shall be deemed to have occurred at the time services were rendered. The provisions for specific reimbursement of emergency services shall be repealed on July 1, 2001, unless otherwise reenacted by the Legislature. The capitation amount or rate shall be determined before program implementation by an independent actuarial consultant. In no event shall such reimbursement rates exceed the Medicaid rate. The plan must also

provide that any hospitals owned and operated by government entities on or after the effective date of this act must, as a condition of receiving funds under this subsection, afford public access equal to that provided under s. 286.011 as to any meeting of the governing board, agency, or authority the subject of which is budgeting resources for the retention of charity care, as that term is defined in the rules of the Agency for Health Care Administration. The plan shall also include innovative health care programs that provide cost-effective alternatives to traditional methods of service and delivery funding.

3. The plan's benefits shall be made available to all county residents currently eligible to receive health care services as indigents or medically poor as defined in paragraph (4)(d).

4. Eligible residents who participate in the health care plan shall receive coverage for a period of 12 months or the period extending from the time of enrollment to the end of the current fiscal year, per enrollment period, whichever is less.

5. At the end of each fiscal year, the governing board, agency, or authority shall prepare an audit that reviews the budget of the plan, delivery of services, and quality of services, and makes recommendations to increase the plan's efficiency. The audit shall take into account participant hospital satisfaction with the plan and assess the amount of poststabilization patient transfers requested, and accepted or denied, by the county public general hospital.

Section 38. Subsection (1) of section 394.4598, Florida Statutes, is amended to read:

394.4598 Guardian advocate.—

(1) The administrator may petition the court for the appointment of a guardian advocate based upon the opinion of a psychiatrist that the patient is incompetent to consent to treatment. If the court finds that a patient is incompetent to consent to treatment and has not been adjudicated incapacitated and a guardian with the authority to consent to mental health treatment appointed, it shall appoint a guardian advocate. The patient has the right to have an attorney represent him or her at the hearing. If the person is indigent, the court shall appoint the office of the public defender to represent him or her at the hearing. The patient has the right to testify, cross-examine witnesses, and present witnesses. The proceeding shall be recorded either electronically or stenographically, and testimony shall be provided under oath. One of the professionals authorized to give an opinion in support of a petition for involuntary placement, as described in ~~s. 394.4655 or~~ s. 394.467, must testify. A guardian advocate must meet the qualifications of a guardian contained in part IV of chapter 744, except that a professional referred to in this part, an employee of the facility providing direct services to the patient under this part, a departmental employee, a facility administrator, or member of the Florida local advocacy council may ~~shall~~ not be appointed. A person who is appointed as a guardian advocate must agree to the appointment.

Section 39. Section 394.462, Florida Statutes, is amended to read:

394.462 Transportation.—A transportation plan shall be developed and implemented by each county in collaboration with

the managing entity in accordance with this section. A county may enter into a memorandum of understanding with the governing boards of nearby counties to establish a shared transportation plan. When multiple counties enter into a memorandum of understanding for this purpose, the counties shall notify the managing entity and provide it with a copy of the agreement. The transportation plan shall describe methods of transport to a facility within the designated receiving system for individuals subject to involuntary examination under s. 394.463 or involuntary admission under s. 397.6772, s. 397.679, or s. 397.6798, ~~or s. 397.6811,~~ and may identify responsibility for other transportation to a participating facility when necessary and agreed to by the facility. The plan may rely on emergency medical transport services or private transport companies, as appropriate. The plan shall comply with the transportation provisions of this section and ss. 397.6772, 397.6795, ~~397.6822,~~ and 397.697.

(1) TRANSPORTATION TO A RECEIVING FACILITY.—

(a) Each county shall designate a single law enforcement agency within the county, or portions thereof, to take a person into custody upon the entry of an ex parte order or the execution of a certificate for involuntary examination by an authorized professional and to transport that person to the appropriate facility within the designated receiving system pursuant to a transportation plan.

(b)1. The designated law enforcement agency may decline to transport the person to a receiving facility only if:

a. The jurisdiction designated by the county has contracted on an annual basis with an emergency medical transport service

or private transport company for transportation of persons to receiving facilities pursuant to this section at the sole cost of the county; and

b. The law enforcement agency and the emergency medical transport service or private transport company agree that the continued presence of law enforcement personnel is not necessary for the safety of the person or others.

2. The entity providing transportation may seek reimbursement for transportation expenses. The party responsible for payment for such transportation is the person receiving the transportation. The county shall seek reimbursement from the following sources in the following order:

a. From a private or public third-party payor, if the person receiving the transportation has applicable coverage.

b. From the person receiving the transportation.

c. From a financial settlement for medical care, treatment, hospitalization, or transportation payable or accruing to the injured party.

(c) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transport of the patient. Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(d) Any company that contracts with a governing board of a county to transport patients shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(e) When a law enforcement officer takes custody of a person pursuant to this part, the officer may request assistance

from emergency medical personnel if such assistance is needed for the safety of the officer or the person in custody.

(f) When a member of a mental health overlay program or a mobile crisis response service is a professional authorized to initiate an involuntary examination pursuant to s. 394.463 or s. 397.675 and that professional evaluates a person and determines that transportation to a receiving facility is needed, the service, at its discretion, may transport the person to the facility or may call on the law enforcement agency or other transportation arrangement best suited to the needs of the patient.

(g) When any law enforcement officer has custody of a person based on either noncriminal or minor criminal behavior that meets the statutory guidelines for involuntary examination pursuant to s. 394.463, the law enforcement officer shall transport the person to the appropriate facility within the designated receiving system pursuant to a transportation plan. Persons who meet the statutory guidelines for involuntary admission pursuant to s. 397.675 may also be transported by law enforcement officers to the extent resources are available and as otherwise provided by law. Such persons shall be transported to an appropriate facility within the designated receiving system pursuant to a transportation plan.

(h) When any law enforcement officer has arrested a person for a felony and it appears that the person meets the statutory guidelines for involuntary examination or placement under this part, such person must first be processed in the same manner as any other criminal suspect. The law enforcement agency shall thereafter immediately notify the appropriate facility within

the designated receiving system pursuant to a transportation plan. The receiving facility shall be responsible for promptly arranging for the examination and treatment of the person. A receiving facility is not required to admit a person charged with a crime for whom the facility determines and documents that it is unable to provide adequate security, but shall provide examination and treatment to the person where he or she is held.

(i) If the appropriate law enforcement officer believes that a person has an emergency medical condition as defined in s. 395.002, the person may be first transported to a hospital for emergency medical treatment, regardless of whether the hospital is a designated receiving facility.

(j) The costs of transportation, evaluation, hospitalization, and treatment incurred under this subsection by persons who have been arrested for violations of any state law or county or municipal ordinance may be recovered as provided in s. 901.35.

(k) The appropriate facility within the designated receiving system pursuant to a transportation plan must accept persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, for involuntary examination pursuant to s. 394.463.

(l) The appropriate facility within the designated receiving system pursuant to a transportation plan must provide persons brought by law enforcement officers, or an emergency medical transport service or a private transport company authorized by the county, pursuant to s. 397.675, a basic screening or triage sufficient to refer the person to the

appropriate services.

(m) Each law enforcement agency designated pursuant to paragraph (a) shall establish a policy that reflects a single set of protocols for the safe and secure transportation and transfer of custody of the person. Each law enforcement agency shall provide a copy of the protocols to the managing entity.

(n) When a jurisdiction has entered into a contract with an emergency medical transport service or a private transport company for transportation of persons to facilities within the designated receiving system, such service or company shall be given preference for transportation of persons from nursing homes, assisted living facilities, adult day care centers, or adult family-care homes, unless the behavior of the person being transported is such that transportation by a law enforcement officer is necessary.

(o) This section may not be construed to limit emergency examination and treatment of incapacitated persons provided in accordance with s. 401.445.

(2) TRANSPORTATION TO A TREATMENT FACILITY.—

(a) If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting a voluntary or involuntary patient to a treatment facility, the transportation plan established by the governing board of the county or counties must specify how the hospitalized patient will be transported to, from, and between facilities in a safe and dignified manner.

(b) A company that transports a patient pursuant to this subsection is considered an independent contractor and is solely liable for the safe and dignified transportation of the patient.

Such company must be insured and provide no less than $100,000 in liability insurance with respect to the transport of patients.

(c) A company that contracts with one or more counties to transport patients in accordance with this section shall comply with the applicable rules of the department to ensure the safety and dignity of patients.

(d) County or municipal law enforcement and correctional personnel and equipment may not be used to transport patients adjudicated incapacitated or found by the court to meet the criteria for involuntary placement pursuant to s. 394.467, except in small rural counties where there are no cost-efficient alternatives.

(3) TRANSFER OF CUSTODY.—Custody of a person who is transported pursuant to this part, along with related documentation, shall be relinquished to a responsible individual at the appropriate receiving or treatment facility.

Section 40. Subsection (3) of section 394.495, Florida Statutes, is amended to read:

394.495 Child and adolescent mental health system of care; programs and services.—

(3) Assessments must be performed by:

(a) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (32), (35), or (36)~~;

(b) A professional licensed under chapter 491; or

(c) A person who is under the direct supervision of a clinical psychologist, clinical social worker, physician,

psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~qualified professional as defined in s. 394.455(5), (7), (32), (35), or (36)~~ or a professional licensed under chapter 491.

Section 41. Subsection (5) of section 394.496, Florida Statutes, is amended to read:

394.496 Service planning.—

(5) A clinical psychologist, clinical social worker, physician, psychiatric nurse, or psychiatrist as those terms are defined in s. 394.455 ~~professional as defined in s. 394.455(5), (7), (32), (35), or (36)~~ or a professional licensed under chapter 491 must be included among those persons developing the services plan.

Section 42. Subsection (6) of section 394.9085, Florida Statutes, is amended to read:

394.9085 Behavioral provider liability.—

(6) For purposes of this section, the terms "detoxification services," "addictions receiving facility," and "receiving facility" have the same meanings as those provided in ss. 397.311(26)(a)4., 397.311(26)(a)1., and 394.455(41) ~~394.455(39)~~, respectively.

Section 43. Section 397.416, Florida Statutes, is amended to read:

397.416 Substance abuse treatment services; qualified professional.—Notwithstanding any other provision of law, a person who was certified through a certification process recognized by the former Department of Health and Rehabilitative Services before January 1, 1995, may perform the duties of a qualified professional with respect to substance abuse treatment

services as defined in this chapter, and need not meet the certification requirements contained in s. 397.311(35) ~~s. 397.311(34)~~.

Section 44. Paragraph (b) of subsection (1) of section 409.972, Florida Statutes, is amended to read:

409.972 Mandatory and voluntary enrollment.—

(1) The following Medicaid-eligible persons are exempt from mandatory managed care enrollment required by s. 409.965, and may voluntarily choose to participate in the managed medical assistance program:

(b) Medicaid recipients residing in residential commitment facilities operated through the Department of Juvenile Justice or a treatment facility as defined in s. 394.455 ~~s. 394.455(47)~~.

Section 45. Paragraphs (d) and (g) of subsection (1) of section 440.102, Florida Statutes, are amended to read:

440.102 Drug-free workplace program requirements.—The following provisions apply to a drug-free workplace program implemented pursuant to law or to rules adopted by the Agency for Health Care Administration:

(1) DEFINITIONS.—Except where the context otherwise requires, as used in this act:

(d) "Drug rehabilitation program" means a service provider, as defined in s. 397.311 ~~established pursuant to s. 397.311(43)~~, that provides confidential, timely, and expert identification, assessment, and resolution of employee drug abuse.

(g) "Employee assistance program" means an established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug abuse; referrals of

employees for appropriate diagnosis, treatment, and assistance; and followup services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by service providers, as defined in s. 397.311 ~~pursuant to s. 397.311(43)~~.

Section 46. Paragraph (e) of subsection (4) of section 464.012, Florida Statutes, is amended to read:

464.012 Licensure of advanced practice registered nurses; fees; controlled substance prescribing.—

(4) In addition to the general functions specified in subsection (3), an advanced practice registered nurse may perform the following acts within his or her specialty:

(e) A psychiatric nurse, who meets the requirements in s. 394.455(36) ~~s. 394.455(35)~~, within the framework of an established protocol with a psychiatrist, may prescribe psychotropic controlled substances for the treatment of mental disorders.

Section 47. Subsection (7) of section 744.2007, Florida Statutes, is amended to read:

744.2007 Powers and duties.—

(7) A public guardian may not commit a ward to a treatment facility, as defined in s. 394.455 ~~s. 394.455(47)~~, without an involuntary placement proceeding as provided by law.

Section 48. Paragraph (a) of subsection (2) of section 790.065, Florida Statutes, is amended to read:

790.065 Sale and delivery of firearms.—

(2) Upon receipt of a request for a criminal history record

check, the Department of Law Enforcement shall, during the licensee's call or by return call, forthwith:

(a) Review any records available to determine if the potential buyer or transferee:

1. Has been convicted of a felony and is prohibited from receipt or possession of a firearm pursuant to s. 790.23;

2. Has been convicted of a misdemeanor crime of domestic violence, and therefore is prohibited from purchasing a firearm;

3. Has had adjudication of guilt withheld or imposition of sentence suspended on any felony or misdemeanor crime of domestic violence unless 3 years have elapsed since probation or any other conditions set by the court have been fulfilled or expunction has occurred; or

4. Has been adjudicated mentally defective or has been committed to a mental institution by a court or as provided in sub-sub-subparagraph b.(II), and as a result is prohibited by state or federal law from purchasing a firearm.

a. As used in this subparagraph, "adjudicated mentally defective" means a determination by a court that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease, is a danger to himself or herself or to others or lacks the mental capacity to contract or manage his or her own affairs. The phrase includes a judicial finding of incapacity under s. 744.331(6)(a), an acquittal by reason of insanity of a person charged with a criminal offense, and a judicial finding that a criminal defendant is not competent to stand trial.

b. As used in this subparagraph, "committed to a mental institution" means:

(I) Involuntary commitment, commitment for mental defectiveness or mental illness, and commitment for substance abuse. The phrase includes involuntary inpatient placement under s. 394.467 ~~as defined in s. 394.467, involuntary outpatient placement as defined in s. 394.4655, involuntary assessment and stabilization under s. 397.6818,~~ and involuntary substance abuse treatment under s. 397.6957, but does not include a person in a mental institution for observation or discharged from a mental institution based upon the initial review by the physician or a voluntary admission to a mental institution; or

(II) Notwithstanding sub-sub-subparagraph (I), voluntary admission to a mental institution for outpatient or inpatient treatment of a person who had an involuntary examination under s. 394.463, where each of the following conditions have been met:

(A) An examining physician found that the person is an imminent danger to himself or herself or others.

(B) The examining physician certified that if the person did not agree to voluntary treatment, a petition for involuntary outpatient or inpatient treatment would have been filed under s. 394.463(2)(g)4., or the examining physician certified that a petition was filed and the person subsequently agreed to voluntary treatment prior to a court hearing on the petition.

(C) Before agreeing to voluntary treatment, the person received written notice of that finding and certification, and written notice that as a result of such finding, he or she may be prohibited from purchasing a firearm, and may not be eligible to apply for or retain a concealed weapon or firearms license under s. 790.06 and the person acknowledged such notice in

writing, in substantially the following form:

"I understand that the doctor who examined me believes I am a danger to myself or to others. I understand that if I do not agree to voluntary treatment, a petition will be filed in court to require me to receive involuntary treatment. I understand that if that petition is filed, I have the right to contest it. In the event a petition has been filed, I understand that I can subsequently agree to voluntary treatment prior to a court hearing. I understand that by agreeing to voluntary treatment in either of these situations, I may be prohibited from buying firearms and from applying for or retaining a concealed weapons or firearms license until I apply for and receive relief from that restriction under Florida law."

(D) A judge or a magistrate has, pursuant to sub-sub-subparagraph c.(II), reviewed the record of the finding, certification, notice, and written acknowledgment classifying the person as an imminent danger to himself or herself or others, and ordered that such record be submitted to the department.

c. In order to check for these conditions, the department shall compile and maintain an automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.

(I) Except as provided in sub-sub-subparagraph (II), clerks of court shall submit these records to the department within 1 month after the rendition of the adjudication or commitment.

Reports shall be submitted in an automated format. The reports must, at a minimum, include the name, along with any known alias or former name, the sex, and the date of birth of the subject.

(II) For persons committed to a mental institution pursuant to sub-sub-subparagraph b.(II), within 24 hours after the person's agreement to voluntary admission, a record of the finding, certification, notice, and written acknowledgment must be filed by the administrator of the receiving or treatment facility, as defined in s. 394.455, with the clerk of the court for the county in which the involuntary examination under s. 394.463 occurred. No fee shall be charged for the filing under this sub-sub-subparagraph. The clerk must present the records to a judge or magistrate within 24 hours after receipt of the records. A judge or magistrate is required and has the lawful authority to review the records ex parte and, if the judge or magistrate determines that the record supports the classifying of the person as an imminent danger to himself or herself or others, to order that the record be submitted to the department. If a judge or magistrate orders the submittal of the record to the department, the record must be submitted to the department within 24 hours.

d. A person who has been adjudicated mentally defective or committed to a mental institution, as those terms are defined in this paragraph, may petition the court that made the adjudication or commitment, or the court that ordered that the record be submitted to the department pursuant to sub-sub-subparagraph c.(II), for relief from the firearm disabilities imposed by such adjudication or commitment. A copy of the petition shall be served on the state attorney for the county in

which the person was adjudicated or committed. The state attorney may object to and present evidence relevant to the relief sought by the petition. The hearing on the petition may be open or closed as the petitioner may choose. The petitioner may present evidence and subpoena witnesses to appear at the hearing on the petition. The petitioner may confront and cross-examine witnesses called by the state attorney. A record of the hearing shall be made by a certified court reporter or by court-approved electronic means. The court shall make written findings of fact and conclusions of law on the issues before it and issue a final order. The court shall grant the relief requested in the petition if the court finds, based on the evidence presented with respect to the petitioner's reputation, the petitioner's mental health record and, if applicable, criminal history record, the circumstances surrounding the firearm disability, and any other evidence in the record, that the petitioner will not be likely to act in a manner that is dangerous to public safety and that granting the relief would not be contrary to the public interest. If the final order denies relief, the petitioner may not petition again for relief from firearm disabilities until 1 year after the date of the final order. The petitioner may seek judicial review of a final order denying relief in the district court of appeal having jurisdiction over the court that issued the order. The review shall be conducted de novo. Relief from a firearm disability granted under this sub-subparagraph has no effect on the loss of civil rights, including firearm rights, for any reason other than the particular adjudication of mental defectiveness or commitment to a mental institution from which relief is granted.

e. Upon receipt of proper notice of relief from firearm disabilities granted under sub-subparagraph d., the department shall delete any mental health record of the person granted relief from the automated database of persons who are prohibited from purchasing a firearm based on court records of adjudications of mental defectiveness or commitments to mental institutions.

f. The department is authorized to disclose data collected pursuant to this subparagraph to agencies of the Federal Government and other states for use exclusively in determining the lawfulness of a firearm sale or transfer. The department is also authorized to disclose this data to the Department of Agriculture and Consumer Services for purposes of determining eligibility for issuance of a concealed weapons or concealed firearms license and for determining whether a basis exists for revoking or suspending a previously issued license pursuant to s. 790.06(10). When a potential buyer or transferee appeals a nonapproval based on these records, the clerks of court and mental institutions shall, upon request by the department, provide information to help determine whether the potential buyer or transferee is the same person as the subject of the record. Photographs and any other data that could confirm or negate identity must be made available to the department for such purposes, notwithstanding any other provision of state law to the contrary. Any such information that is made confidential or exempt from disclosure by law shall retain such confidential or exempt status when transferred to the department.

Section 49. This act shall take effect July 1, 2019.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1218
INTRODUCER:	Senator Book
SUBJECT:	Homelessness
DATE:	March 15, 2019
REVISED:	

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

I. Summary:

SB 1218 creates a dedicated revenue source for challenge grants provided to the State Office on Homelessness and local homeless continuums of care (CoC), which are dedicated to preventing and ending homelessness throughout the state. The bill also increases the amount of funds each CoC may receive annually through challenge grants.

The bill makes a number of changes to chapter 420, F.S., relating to homelessness, with the aim of bringing state law in line with corresponding federal statutes in order to eliminate outdated provisions and allow sources of federal funding matches to be accessed on an expedited basis.

The bill will likely have a fiscal impact on the state through the increased provision of funding for homelessness challenge grants, and has an effective date of July 1, 2019.

II. Present Situation:

Housing for Individuals with Lower Incomes

In 1986[1] the Legislature found that:

- Decent, safe, and sanitary housing for individuals of very low income, low income, and moderate income is a critical need in the state;
- New and rehabilitated housing must be provided at a cost affordable to such persons in order to alleviate this critical need;
- Special programs are needed to stimulate private enterprise to build and rehabilitate housing in order to help eradicate slum conditions and provide housing for very-low-income persons, low-income persons, and moderate-income persons as a matter of public purpose; and

[1] Chapter 86-192, Laws of Fla.

- Public-private partnerships are an essential means of bringing together resources to provide affordable housing.[2]

As a result of these findings, the Legislature determined that legislation was urgently needed to alleviate crucial problems related to housing shortages for individuals with very low,[3] low[4] and moderate[5] incomes. In 1986, part VI of ch. 420, F.S., was titled as the "Florida Affordable Care Act of 1986"[6] and programs and funding mechanisms were created over the years to help remedy low-income housing issues.

State Office on Homelessness

In 2001, the Legislature created the State Office on Homelessness within the Department of Children and Families (DCF) to serve as a central point of contact within state government on homelessness. The State Office on Homelessness is responsible for coordinating resources and programs across all levels of government, and with private providers that serve the homeless. It also manages targeted state grants to support the implementation of local homeless service continuum of care plans.[7]

Council on Homelessness

The inter-agency Council on Homelessness was also created in 2001. The 17-member council is charged with developing recommendations on how to reduce homelessness statewide and advising the State Office on Homelessness.[8]

Local Coalitions for the Homeless

DCF is required to establish local coalitions to plan, network, coordinate, and monitor the delivery of services to the homeless.[9] Groups and organizations provided the opportunity to participate in such coalitions include:

- Organizations and agencies providing mental health and substance abuse services;
- County health departments and community health centers;

[2] Section 420.6015, F.S.
[3] "Very-low-income persons" means one or more persons or a family, the total annual adjusted gross household income of which does not exceed 50 percent of the median annual adjusted gross income for households within the state, or 50 percent of the median annual adjusted gross income for households within the metropolitan statistical area (MSA) or within the county in which the person or family resides, whichever is greater.
[4] "Low-income persons" means one or more persons or a family, the total annual adjusted gross household income of which does not exceed 80 percent of the median annual adjusted gross income for households within the state, or 80 percent of the median annual adjusted gross income for households within the metropolitan statistical area (MSA) or within the county in which the person or family resides, whichever is greater.
[5] "Moderate-income persons" means one or more persons or a family, the total annual adjusted gross household income of which is less than 120 percent of the median annual adjusted gross income for households within the state, or 120 percent of the median annual adjusted gross income for households within the metropolitan statistical area (MSA) or within the county in which the household is located, whichever is greater.
[6] Chapter 86-192, Laws of Fla., Part VI, was subsequently renamed the "Affordable Housing Planning and Community Assistance Act." Chapter 92-317, Laws of Fla.
[7] Section 420.622(1), F.S.
[8] *Id*.
[9] Section 420.623, F.S.

- Organizations and agencies providing food, shelter, or other services targeted to the homeless;
- Local law enforcement agencies;
- Local workforce development boards;
- County and municipal governments;
- Local public housing authorities;
- Local school districts;
- Local organizations and agencies serving specific subgroups of the homeless population such as veterans, victims of domestic violence, persons with HIV/AIDS, and runaway youth; and
- Local community-based care alliances.[10]

Continuum of Care

A local coalition serves as the lead agency for the local homeless assistance continuum of care.[11] A local CoC is a framework for a comprehensive and seamless array of emergency, transitional, and permanent housing, and services to address the various needs of the homeless and those at risk of homelessness.[12] The purpose of a CoC is to help communities or regions envision, plan, and implement comprehensive and long-term solutions.[13]

DCF interacts with the state's 28 CoCs through the State Office on Homelessness, which serves as the state's central point of contact on homelessness. The State Office on Homelessness has designated local entities to serve as lead agencies for local planning efforts to create homeless assistance CoC systems. The State Office on Homelessness has made these designations in consultation with the local homeless coalitions and the Florida offices of the federal Department of Housing and Urban Development (HUD).

The CoC planning effort is an ongoing process that addresses all subpopulations of the homeless. The development of a local CoC plan is a prerequisite to applying for federal housing grants through HUD. The plan also makes the community eligible to compete for the state's Challenge Grants and Homeless Housing Assistance Grants.[14]

Challenge Grants

The State Office on Homelessness is authorized to accept and administer moneys appropriated to it to provide Challenge Grants annually to designated lead agencies of homeless assistance CoCs.[15] The State Office on Homelessness may award grants in an amount of up to $500,000 per lead agency.[16] A lead agency may spend a maximum of 8 percent of its funding on administrative costs. To qualify for the grant, a lead agency must develop and implement a local

[10] *Id*.
[11] *Id*.
[12] Section 420.624, F.S.
[13] *Id*.
[14] Florida Department of Children and Families, *Lead Agencies*, available at: http://www.myflfamilies.com/service-programs/homelessness/lead-agencies (last visited March 15, 2019).
[15] "Section 420.621(1), F.S., defines "Continuum of Care" to mean the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness."
[16] Section 420.622, F.S.

homeless assistance continuum of care plan for its designated area.[17] There is no dedicated revenue for these grants which in the past have been funded by the Sadowski State and Local Housing Trust Funds, general revenue, and state trust funds.

Pursuant to s. 420.624, F.S., the DCF provides funding for local homeless assistance CoC, which is a framework for providing an array of emergency, transitional, and permanent housing, and services to address the various needs of homeless persons and persons at risk of becoming homeless.

In 2017, the Collier homeless coalition used the challenge grant to help the Shelter for Abused Women & Children with staffing of two case managers who work in outreach and transitional housing, and the remainder of the funds provided emergency rental or utility assistance to nearly 89 adults and 129 children.[18] The Volusia/Flagler coalition have utilized challenge grant funding to help lower-income residents pay rent following job losses, car accidents, and other costly expenses.[19] The Tampa-Hillsborough Homeless Initiative has used challenge grant money to establish a financial incentive program for developers, landlords, and property owners which has been successful at reducing levels of homelessness throughout Hillsborough County.[20]

Rapid ReHousing

Rapid ReHousing is a model for providing housing for individuals and families who are homeless. The model places a priority on moving a family or individual experiencing homelessness into permanent housing as quickly as possible, hopefully within 30 days of a client becoming homeless and entering a program. While originally focused primarily on people experiencing homelessness due to short-term financial crises, programs across the country have begun to assist individuals and families who are traditionally perceived as more difficult to serve. This includes people with limited or no income, survivors of domestic violence, and those with substance abuse issues. Although the duration of financial assistance may vary, many programs find that, on average, 4 to 6 months of financial assistance is sufficient to stably re-house a household.[21]

Since federal funding for rapid re-housing first became available in 2008, a number of communities, including Palm Beach County, Florida, that prioritized rapid re-housing as a response to homelessness have seen decreases in the amount of time that households spend homeless, less recidivism, and improved permanent housing outcomes relative to other available interventions.[22]

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[17] *Id*.
[18] https://www.news-press.com/story/news/2018/07/04/gov-rick-scott-acts-resolve-homeless-grant-funding-southwest-florida-agencies/757846002/ (last visited March 15, 2019).
[19] https://www.gainesville.com/news/20180703/state-moves-to-fund-homeless-programs (last visited March 15, 2019).
[20] The University of Tampa, *Cypress Landing Cost-Benefit Analysis Report*, (2015). On filed with the Senate Children, Families, and Elder Affairs Committee.
[21] National Alliance to End Homelessness, *Rapid Re-Housing: A History and Core Components*, (2014), available at: http://www.endhomelessness.org/library/entry/rapid-re-housing-a-history-and-core-components (last visited March 15, 2019).
[22] *Id*.

There are three core components of rapid re-housing: housing identification, rent and move-in assistance (financial), and rapid re-housing case management and services. While all three components are present and available in effective rapid re-housing programs, there are instances where the components are provided by different entities or agencies, or where a household does not utilize all three.[23] A key element of rapid re-housing is the "Housing First" philosophy, which offers housing without preconditions such as employment, income, lack of a criminal background, or sobriety. If issues such as these need to be addressed, the household can address them most effectively once they are in housing.[24]

III. Effect of Proposed Changes:

Section 1 amends s. 201.15, F.S., requiring that $10 million of all document stamp tax money collected annually by the state be dedicated to funding the Grants and Donations Trust Fund for the challenge grant program within DCF.

Section 2 amends s. 420.621, F.S., modifying the definition of 'continuum of care' to mean a group organized to carry out responsibilities imposed under ch. 420, F.S., to coordinate, plan, and pursue ending homelessness in a designated catchment area. The bill provides that a CoC should be comprised of local community organizations to the extent that they are represented within the catchment area and available to participate.

The bill defines 'continuum of care lead agency' or 'continuum of care collaborative applicant' as the organization designated by a CoC pursuant to s. 420.6225, F.S.

The bill also redefines 'homeless' to mean either:
- an individual or family who lacks a fixed, regular, and adequate nighttime residence as defined under 'homeless' in federal statute;
- an individual or family who will immediately lose their primary nighttime residence as defined under 'homeless' in federal statute; or
- additional populations as may be defined by the Florida Housing Finance Corporation (FHFC).

Section 3 amends s. 420.622, F.S., adding one member of the FHFC and the Secretary of the Department of Elder Affairs, or his or her designee, to the Council on Homelessness. The bill provides that members of the council are encouraged to have experience in the administration or provision of resources, services, or housing that addresses the needs of persons experiencing homelessness.

The bill replaces the term 'regionally developed plans' with the term 'local continuum of care plans' to bring state statute in line with federal law. The bill also requires the State Office on Homelessness to collect, maintain, and make available information concerning persons who are homeless, including summary demographics information drawn from the local continuum of care

[23] *Id*.
[24] The Florida Legislature expressed the intent to encourage homeless continuums of care to adopt the Housing First approach to ending homelessness for individuals and families in 2009. See s. 420.6275, F.S.

Housing Inventory Chart required by HUD. The bill replaces all instances of the term 'local homeless continuum of care' and 'local homeless assistance coalition' with 'continuum of care.'

The bill also revises the goals of the State Office on Homelessness to promote a federal policy agenda that is responsive to the needs of those who are homeless or at risk of homelessness, rather than only the current homeless population. The bill modifies policy objectives to reflect an emphasis on ending homelessness in the state, as opposed to meeting the needs of the homeless.

The bill increases the amount of funds available to each CoC for challenge grants from $500,000 to $750,000 per continuum of care lead agency, and requires each CoC lead agency to document the commitment of local government or private organizations to provide matching funds or in-kind support in an amount equal to 25 percent of the grant requested.

Section 4 creates s. 420.6225, to provide that the purpose of a CoC is to coordinate community efforts to prevent and end homelessness in its catchment area. The bill requires each CoC to designate a collaborative applicant that is responsible for submitting a CoC funding application for the designated catchment area to HUD. The bill provides that the collaborative applicant shall serve as the point of contact to the State Office on Homelessness. The bill also requires CoC catchment areas to be designated and revised as necessary by the State Office on Homelessness, and the catchment areas must be consistent with the CoC catchment areas recognized by HUD. The bill provides that the State Office on Homelessness shall recognize only one CoC lead agency for each catchment area.

The bill requires each CoC to create a 'continuum of care plan,' which must include outreach to unsheltered individuals and families, a coordinated entry system for services, identification of emergency shelters, identification of permanent supportive housing, rapid rehousing, and an ongoing planning mechanism to homelessness for all subpopulations of persons experiencing homelessness.

The bill also requires CoCs to promote participation by all interested individuals and organizations and may not exclude anyone on the basis of race, color, national origin, sex, handicap, familial status, or religion. The bill also provides for coordination of these individuals and organizations, to the extent possible, with other mainstream health and social services.

Section 5 creates s. 420.6227, F.S., to create a new version of the grant-in-aid program already existing under current law in s. 420.625, F.S. The bill replaces references to 'local agencies' with references to 'continuums of care' in order to bring the state grant-in-aid program language and requirements in line with federal statutes and ultimately allow federal matching dollars to be drawn down more efficiently.

Section 6 repeals s. 420.623, F.S., relating to local coalitions for the homeless.

Section 7 repeals s. 420.624, F.S., relating to local homeless assistance continuums of care.

Section 8 repeals s. 420.625, F.S., relating to the grant-in-aid program.

Section 9 amends s. 420.626, F.S., making technical revisions to discharge guidelines for homelessness facilities and institutions.

Section 10 amends s. 420.6265, F.S., to revise legislative intent with respect to rapid rehousing. The bill provides that findings that rapid rehousing should employ temporary financial assistance for the purposes of both quickly moving families and individuals into permanent housing and using housing stabilization support services to help them remain stably housed. The bill also expands legislative intent to provide that rapid rehousing has proven to be a cost-effective approach to ending homelessness, and is demonstrably proven to be more cost-effective than alternative approaches.

Section 11 amends s. 420.6275, F.S., to revise legislative intent with respect to the housing first methodology. The bill provides findings that housing first is a cost-effective approach to ending homelessness and reducing the length of time of homelessness for many individuals and families. The bill also provides legislative intent to emphasize maintaining stable housing under the housing first approach.

Section 12 amends s. 420.507, F.S., to correct two cross references.

Section 13 provides an effective date of July 1, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

The bill will direct $10 million annually from the Sadowski State and Local Housing Trust Funds to the challenge grants.

B. Private Sector Impact:

None.

C. Government Sector Impact:

There will be a fiscal impact to the state from increasing the amount of eligible challenge grant funding for each CoC lead agency from $500,000 to $750,000. Challenge grants totaled $4.1 million statewide for fiscal year 2018-2019.[25]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends sections 201.15, 420.621, 420.622, 420.626, 420.6265, 420.6275, and 420.507 of the Florida Statutes.

This bill creates sections 420.6225 and 420.6227 of the Florida Statutes.

This bill repeals sections 420.623, 420.624, and 420.625 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[25] Specific Appropriation 345, General Appropriations Act, Chapter 2018-9, Laws of Florida.

371296

LEGISLATIVE ACTION

Senate . House

. . . . .

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

Senate Amendment

Delete lines 219 - 220

and insert:

~~applied to~~

By Senator Book

32-00548A-19 20191218__

A bill to be entitled

An act relating to homelessness; amending s. 201.15, F.S.; requiring that certain taxes of a specified amount be transferred annually to the Grants and Donations Trust Fund within the Department of Children and Families for the purpose of funding challenge grants; amending s. 420.621, F.S.; revising, adding, and deleting defined terms; amending s. 420.622, F.S.; increasing the number of members on the Council on Homelessness to include a representative of the Florida Housing Coalition and the Secretary of the Department of Elder Affairs or his or her designee; providing that appointed council members are encouraged to have certain experience; revising the duties of the State Office on Homelessness; revising requirements for the state's system of homeless programs; requiring entities that receive state funding to provide summary aggregated data to assist the council in providing certain information; removing the requirement that the office have the concurrence of the council to accept and administer moneys appropriated to it to provide certain annual challenge grants to continuums of care lead agencies; clarifying the source of such appropriation; increasing the maximum amount of grant awards per continuum of care lead agency; conforming provisions to changes made by the act; revising requirements for use of grant funds by continuum of care lead agencies; revising preference criteria for certain grants; increasing the

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maximum percentage of its funding which a continuum of care lead agency may spend on administrative costs; requiring such agencies to submit a final report to the Department of Children and Families documenting certain outcomes achieved by grant-funded programs; removing the requirement that the office have the concurrence of the council to administer moneys given to it to provide homeless housing assistance grants annually to certain continuum of care lead agencies to acquire, construct, or rehabilitate permanent housing units for homeless persons; conforming a provision to changes made by the act; requiring grant applicants to be ranked competitively based on criteria determined by the office; deleting preference requirements; increasing the minimum number of years for which projects must reserve certain units acquired, constructed, or rehabilitated; increasing the maximum percentage of funds the office and each applicant may spend on administrative costs; revising certain performance measure requirements; authorizing, instead of requiring, the Department of Children and Families, with input from the council, to adopt rules relating to certain grants and related issues; revising requirements for an annual report the council must submit to the Governor, Legislature, and Secretary of Children and Families; authorizing the office to administer moneys appropriated to it for distribution among certain designated continuum of care lead agencies and entities; creating s. 420.6225, F.S.;

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

specifying the purpose of a continuum of care; requiring each continuum of care, pursuant to federal law, to designate a collaborative applicant that is responsible for submitting the continuum of care funding application for the designated catchment area to the United States Department of Housing and Urban Development; providing requirements for such designated collaborative applicants; authorizing the applicant to be referred to as the continuum of care lead agency; providing requirements for continuum of care catchment areas and lead agencies; requiring that each continuum of care create a continuum of care plan for specified purposes; specifying requirements for such plans; requiring continuums of care to promote participation by all interested individuals and organizations, subject to certain requirements; creating s. 420.6227, F.S.; providing legislative findings and program purpose; establishing a grant-in-aid program to help continuums of care prevent and end homelessness, which may include any aspect of the local continuum of care plan; requiring continuums of care to submit an application for grant-in-aid funds to the office for review; requiring the office to develop guidelines for the development, evaluation, and approval of spending plans; requiring grant-in-aid funds for continuums of care to be administered by the office and awarded on a competitive basis; requiring the office to distribute such funds to local agencies to fund programs that are required by the local

continuum of care plan, based on certain recommendations; limiting the percentage of the total state funds awarded under a spending plan which may be used by the continuum of care lead agency for staffing and administrative expenditures; requiring entities contracting with local agencies to provide services through certain financial assistance programs to provide a specified minimum percentage of the funding necessary for the support of project operations; authorizing in-kind contributions to be evaluated and counted as part or all of the required local funding, at the discretion of the office; repealing s. 420.623, F.S., relating to local coalitions for the homeless; repealing s. 420.624, F.S., relating to local homeless assistance continuums of care; repealing s. 420.625, F.S., relating to a grant-in-aid program; amending s. 420.626, F.S.; revising procedures that certain facilities and institutions are encouraged to develop and implement to reduce the discharge of persons into homelessness when such persons are admitted or housed for a specified period at such facilities or institutions; amending s. 420.6265, F.S.; revising legislative findings and intent for Rapid ReHousing; revising the Rapid ReHousing methodology; amending s. 420.6275, F.S.; revising legislative findings relating to Housing First; revising the Housing First methodology to reflect current practice; amending s. 420.507, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Paragraph (c) of subsection (4) of section 201.15, Florida Statutes, is amended, and subsection (5) of that section is republished, to read:

201.15 Distribution of taxes collected.—All taxes collected under this chapter are hereby pledged and shall be first made available to make payments when due on bonds issued pursuant to s. 215.618 or s. 215.619, or any other bonds authorized to be issued on a parity basis with such bonds. Such pledge and availability for the payment of these bonds shall have priority over any requirement for the payment of service charges or costs of collection and enforcement under this section. All taxes collected under this chapter, except taxes distributed to the Land Acquisition Trust Fund pursuant to subsections (1) and (2), are subject to the service charge imposed in s. 215.20(1). Before distribution pursuant to this section, the Department of Revenue shall deduct amounts necessary to pay the costs of the collection and enforcement of the tax levied by this chapter. The costs and service charge may not be levied against any portion of taxes pledged to debt service on bonds to the extent that the costs and service charge are required to pay any amounts relating to the bonds. All of the costs of the collection and enforcement of the tax levied by this chapter and the service charge shall be available and transferred to the extent necessary to pay debt service and any other amounts payable with respect to bonds authorized before January 1, 2017, secured by revenues distributed pursuant to this section. All

taxes remaining after deduction of costs shall be distributed as follows:

(4) After the required distributions to the Land Acquisition Trust Fund pursuant to subsections (1) and (2) and deduction of the service charge imposed pursuant to s. 215.20(1), the remainder shall be distributed as follows:

(c) Eleven and twenty-four hundredths percent of the remainder in each fiscal year shall be paid into the State Treasury to the credit of the State Housing Trust Fund. Of such funds, the first $35 million shall be transferred annually, subject to any distribution required under subsection (5), to the State Economic Enhancement and Development Trust Fund within the Department of Economic Opportunity. The next $10 million shall be transferred annually, subject to any distribution required under subsection (5), to the Grants and Donations Trust Fund within the Department of Children and Families for the purpose of funding the challenge grants established in s. 420.622(4). The remainder shall be used as follows:

1. Half of that amount shall be used for the purposes for which the State Housing Trust Fund was created and exists by law.

2. Half of that amount shall be paid into the State Treasury to the credit of the Local Government Housing Trust Fund and used for the purposes for which the Local Government Housing Trust Fund was created and exists by law.

(5) Distributions to the State Housing Trust Fund pursuant to paragraphs (4)(c) and (d) must be sufficient to cover amounts required to be transferred to the Florida Affordable Housing Guarantee Program’s annual debt service reserve and guarantee

fund pursuant to s. 420.5092(6)(a) and (b) up to the amount required to be transferred to such reserve and fund based on the percentage distribution of documentary stamp tax revenues to the State Housing Trust Fund which is in effect in the 2004-2005 fiscal year.

Section 2. Section 420.621, Florida Statutes, is amended to read:

420.621 Definitions.—As used in ss. 420.621-420.628, the term:

(1) "Continuum of care" means the group organized to carry out the responsibilities imposed under ss. 420.621-420.628 to coordinate, plan, and pursue ending homelessness in a designated catchment area. The group is composed of representatives from certain organizations, including, but not limited to, nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and organizations that serve homeless and formerly homeless persons, to the extent that these organizations are represented within the designated catchment area and are available to participate ~~the community components needed to organize and deliver housing and services to meet the specific needs of people who are homeless as they move to stable housing and maximum self-sufficiency. It includes action steps to end homelessness and prevent a return to homelessness~~.

(2) "Continuum of care lead agency" or "continuum of care

collaborative applicant" means the organization designated by a continuum of care pursuant to s. 420.6225.

(3) ~~(2)~~ "Council on Homelessness" means the council created in s. 420.622.

(4) ~~(3)~~ "Department" means the Department of Children and Families.

~~(4) "District" means a service district of the department, as set forth in s. 20.19.~~

(5) "Homeless~~,~~" means any of the following:

(a) An individual or family who lacks a fixed, regular, and adequate nighttime residence as defined under "homeless" in 24 C.F.R. 578.3.

(b) An individual or family who will imminently lose their primary nighttime residence as defined under "homeless" in 24 C.F.R. 578.3.

(c) Additional populations as may be defined in rules developed by the Florida Housing Finance Corporation ~~applied to an individual, or "individual experiencing homelessness" means an individual who lacks a fixed, regular, and adequate nighttime residence and includes an individual who:~~

~~(a) Is sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;~~

~~(b) Is living in a motel, hotel, travel trailer park, or camping ground due to a lack of alternative adequate accommodations;~~

~~(c) Is living in an emergency or transitional shelter;~~

~~(d) Has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings;~~

~~(c) Is living in a car, park, public space, abandoned building, bus or train station, or similar setting; or~~

~~(f) Is a migratory individual who qualifies as homeless because he or she is living in circumstances described in paragraphs (a)-(e).~~

~~The terms do not refer to an individual imprisoned pursuant to state or federal law or to individuals or families who are sharing housing due to cultural preferences, voluntary arrangements, or traditional networks of support. The terms include an individual who has been released from jail, prison, the juvenile justice system, the child welfare system, a mental health and developmental disability facility, a residential addiction treatment program, or a hospital, for whom no subsequent residence has been identified, and who lacks the resources and support network to obtain housing~~.

~~(6) "Local coalition for the homeless" means a coalition established pursuant to s. 420.623.~~

~~(7) "New and temporary homeless" means individuals or families who are homeless due to societal factors.~~

(6)~~(8)~~ "State Office on Homelessness" means the state office created in s. 420.622.

Section 3. Section 420.622, Florida Statutes, is amended to read:

420.622 State Office on Homelessness; Council on Homelessness.—

(1) The State Office on Homelessness is created within the Department of Children and Families to provide interagency, council, and other related coordination on issues relating to

homelessness.

(2) The Council on Homelessness is created to consist of 19 ~~17~~ representatives of public and private agencies who shall develop policy and advise the State Office on Homelessness. The council members shall be: the Secretary of Children and Families, or his or her designee; the executive director of the Department of Economic Opportunity, or his or her designee, who shall advise the council on issues related to rural development; the State Surgeon General, or his or her designee; the Executive Director of Veterans' Affairs, or his or her designee; the Secretary of Corrections, or his or her designee; the Secretary of Health Care Administration, or his or her designee; the Commissioner of Education, or his or her designee; the Director of CareerSource Florida, Inc., or his or her designee; one representative of the Florida Association of Counties; one representative of the Florida League of Cities; one representative of the Florida Supportive Housing Coalition; one representative of the Florida Housing Coalition; the Executive Director of the Florida Housing Finance Corporation, or his or her designee; one representative of the Florida Coalition for the Homeless; the Secretary of the Department of Elder Affairs, or his or her designee; and four members appointed by the Governor. The council members shall be nonpaid volunteers and shall be reimbursed only for travel expenses. The appointed members of the council shall be appointed to staggered 2-year terms~~,~~ and are encouraged to have experience in the administration or provision of resources, services, or housing that addresses the needs of persons experiencing homelessness. The council shall meet at least four times per year. The

importance of minority, gender, and geographic representation shall be considered in appointing members to the council.

(3) The State Office on Homelessness, pursuant to the policies set by the council and subject to the availability of funding, shall:

(a) Coordinate among state, local, and private agencies and providers to produce a statewide consolidated inventory for the state's entire system of homeless programs which incorporates local continuum of care plans ~~regionally developed plans~~. Such programs include, but are not limited to:

1. Programs authorized under the McKinney-Vento Homeless Assistance ~~Stewart B. McKinney Homeless Assistance~~ Act of 1987, as amended by the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009, 42 U.S.C. ss. 11302 ~~ss. 11371~~ et seq., and carried out under funds awarded to this state; and

2. Programs, components thereof, or activities that assist persons who are homeless or at risk for homelessness.

(b) Collect, maintain, and make available information concerning persons who are homeless ~~or at risk for homelessness~~, including summary demographics information drawn from the local continuum of care Homeless Management Information System or the annual Point-in-Time Count, ~~current services and resources available~~ and the local continuum of care Housing Inventory Chart required by the Department of Housing and Urban Development~~, the cost and availability of services and programs, and the met and unmet needs of this population~~. All entities that receive state funding must provide summary aggregated ~~access to all~~ data ~~they maintain in summary form~~, with no

individual identifying information, to assist the council in providing this information. The State Office on Homelessness, in consultation with the designated lead agencies for a ~~local homeless~~ continuum of care and with the Council on Homelessness, shall develop a process by which summary data is collected ~~the system and process of data collection~~ from all lead agencies for the purpose of analyzing trends and assessing impacts in the ~~statewide homeless delivery~~ system for delivering services to the homeless. ~~Any statewide homelessness survey and database system must comply with all state and federal statutory and regulatory confidentiality requirements.~~

(c) Annually evaluate state and continuum of care system programs ~~local services and resources~~ and develop a consolidated plan for addressing the needs of the homeless or those at risk for homelessness.

(d) Explore, compile, and disseminate information regarding public and private funding sources for state and local programs serving the homeless and provide technical assistance in applying for such funding.

(e) Monitor and provide recommendations for coordinating the activities and programs of ~~local~~ continuums of care ~~coalitions for the homeless~~ and promote the effectiveness of programs to prevent and end homelessness in the state ~~addressing the needs of the homeless~~.

(f) Provide technical assistance to facilitate efforts to support and strengthen ~~establish, maintain, and expand local homeless assistance~~ continuums of care.

(g) Develop and assist in the coordination of policies and procedures relating to the discharge or transfer from the care

or custody of state-supported or state-regulated entities persons who are homeless or at risk for homelessness.

(h) Spearhead outreach efforts for maximizing access by people who are homeless or at risk for homelessness to state and federal programs and resources.

(i) Promote a federal policy agenda that is responsive to the needs of those who are homeless or at risk of homelessness ~~the homeless population~~ in this state.

(j) Review reports on continuum of care system performance measures and ~~Develop outcome and accountability measures and promote and~~ use such measures to evaluate program effectiveness and make recommendations for improving current practices to work toward ending homelessness in this state ~~in order to best meet the needs of the homeless~~.

(k) Formulate policies and legislative proposals aimed at preventing and ending homelessness in this state ~~to address more effectively the needs of the homeless~~ and coordinate the implementation of state and federal legislative policies.

(l) Convene meetings and workshops of state and local agencies, continuums of care ~~local coalitions and programs~~, and other stakeholders for the purpose of developing and reviewing policies, services, activities, coordination, and funding of efforts to end homelessness ~~meet the needs of the homeless~~.

(m) With the input of the continuums of care, conduct or promote research on the effectiveness of current programs and propose pilot projects aimed at ending homelessness ~~improving services~~.

(n) Serve as an advocate for issues relating to homelessness.

(o) Investigate ways to improve access to participation in state funding and other programs for prevention and reduction ~~alleviation~~ of homelessness to faith-based organizations and collaborate and coordinate with faith-based organizations.

(4) The State Office on Homelessness~~, with the concurrence of the Council on Homelessness,~~ shall accept and administer moneys appropriated to it pursuant to s. 201.15(4)(c) to provide annual "challenge grants" to lead agencies of ~~homeless assistance~~ continuums of care designated by the State Office on Homelessness pursuant to s. 420.6225 ~~s. 420.624~~. The department shall establish varying levels of grant awards up to $750,000 ~~$500,000~~ per continuum of care lead agency. The department, in consultation with the Council on Homelessness, shall specify a grant award level in the notice of the solicitation of grant applications.

(a) To qualify for the grant, a continuum of care lead agency must develop and implement a local ~~homeless assistance~~ continuum of care plan for its designated catchment area. The services and housing funded through the grant must be implemented through the continuum of care's ~~continuum of care plan must implement a~~ coordinated ~~assessment or central intake~~ entry system as provided in s. 420.6225(5)(b) and must be designed to ~~screen,~~ assess~~,~~ and refer persons seeking assistance to the appropriate housing intervention and service provider. The continuum of care lead agency shall also document the commitment of local government or private organizations to provide matching funds or in-kind support in an amount equal to 25 percent of the grant requested. Expenditures of leveraged funds or resources, including third-party cash or in-kind

contributions, are authorized only for eligible activities carried out in connection with a ~~committed on one~~ project in which such funds or resources have not been used as leverage or match for any other project or program. ~~and~~ The expenditures must be certified through a written commitment.

(b) Preference must be given to those continuum of care lead agencies that have demonstrated the ability of their continuum of care to help households move out of homelessness ~~provide quality services to homeless persons and the ability to leverage federal homeless assistance funding under the Stewart B. McKinney Act with local government funding or private funding for the provision of services to homeless persons~~.

~~(c) Preference must be given to lead agencies in catchment areas with the greatest need for the provision of housing and services to the homeless, relative to the population of the catchment area.~~

(c) ~~(d)~~ The grant may be used to fund any of the housing, program, or service needs included in the local ~~homeless assistance~~ continuum of care plan. The continuum of care lead agency may allocate the grant to programs, services, or housing providers that implement the local ~~homeless assistance~~ continuum of care plan. The lead agency may provide subgrants to a local agency to implement programs or services or provide housing identified for funding in the lead agency's application to the department. A lead agency may spend a maximum of 10 ~~8~~ percent of its funding on administrative costs.

(d) ~~(e)~~ The continuum of care lead agency shall submit a final report to the department documenting the outcomes achieved by the grant-funded programs ~~grant~~ in enabling persons who are

homeless to return to permanent housing, thereby ending such person's episode of homelessness.

(5) The State Office on Homelessness~~, with the concurrence of the Council on Homelessness,~~ may administer moneys given ~~appropriated~~ to it to provide homeless housing assistance grants annually to continuum of care lead agencies ~~for local homeless assistance continuum of care, as~~ recognized by the State Office on Homelessness~~,~~ to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons. These moneys shall consist of any sums that the state may appropriate, as well as money received from donations, gifts, bequests, or otherwise from any public or private source, which are intended to acquire, construct, or rehabilitate ~~transitional or~~ permanent housing units for homeless persons.

(a) Grant applicants shall be ranked competitively based on criteria determined by the State Office on Homelessness. ~~Preference must be given to applicants who leverage additional private funds and public funds, particularly federal funds designated for the acquisition, construction, or rehabilitation of transitional or permanent housing for homeless persons; who acquire, build, or rehabilitate the greatest number of units; or who acquire, build, or rehabilitate in catchment areas having the greatest need for housing for the homeless relative to the population of the catchment area.~~

(b) Funding for any particular project may not exceed $750,000.

(c) Projects must reserve, for a minimum of 20 ~~10~~ years, the number of units acquired, constructed, or rehabilitated through homeless housing assistance grant funding to serve

persons who are homeless at the time they assume tenancy.

(d) No more than two grants may be awarded annually in any given ~~local homeless assistance~~ continuum of care catchment area.

(e) A project may not be funded which is not included in the local ~~homeless assistance~~ continuum of care plan, as recognized by the State Office on Homelessness, for the catchment area in which the project is located.

(f) The maximum percentage of funds that the State Office on Homelessness and each applicant may spend on administrative costs is 10 ~~5~~ percent.

(6) The State Office on Homelessness, in conjunction with the Council on Homelessness, shall establish performance measures related to state funding provided through the State Office on Homelessness and utilize those grant-related measures to ~~and specific objectives by which it may~~ evaluate the performance and outcomes of continuum of care lead agencies that receive state grant funds. ~~Challenge Grants made through the State Office on Homelessness shall be distributed to lead agencies based on their overall performance and their achievement of specified objectives. Each lead agency for which grants are made under this section shall provide the State Office on Homelessness a thorough evaluation of the effectiveness of the program in achieving its stated purpose. In evaluating the performance of the lead agencies, the State Office on Homelessness shall base its criteria upon the program objectives, goals, and priorities that were set forth by the lead agencies in their proposals for funding. Such criteria may include, but are not limited to, the number of persons or~~

~~households that are no longer homeless, the rate of recidivism to homelessness, and the number of persons who obtain gainful employment.~~

(7) The State Office on Homelessness must monitor the challenge grants and homeless housing assistance grants to ensure proper expenditure of funds and compliance with the conditions of the applicant's contract.

(8) The Department of Children and Families, with input from the Council on Homelessness, may ~~must~~ adopt rules relating to the challenge grants and the homeless housing assistance grants and related issues consistent with the purposes of this section.

(9) The council shall, by June 30 of each year, provide to the Governor, the Legislature, and the Secretary of Children and Families a report summarizing the extent of homelessness in the state and the council's recommendations for ending ~~reducing~~ homelessness in this state.

(10) The State Office on Homelessness may administer moneys appropriated to it for distribution among the ~~28 local homeless continuums of care~~ continuum of care lead agencies and entities funded in the 2017-2018 state fiscal year which are designated by the office as local coalitions for the homeless ~~designated by the Department of Children and Families~~.

Section 4. Section 420.6225, Florida Statutes, is created to read:

420.6225 Continuum of care.—

(1) The purpose of a continuum of care, as defined in s. 420.621, is to coordinate community efforts to prevent and end homelessness in its catchment area designated as provided in

subsection (3) and to fulfill the responsibilities set forth in this chapter.

(2) Pursuant to the federal HEARTH Act of 2009, each continuum of care is required to designate a collaborative applicant that is responsible for submitting the continuum of care funding application for the designated catchment area to the United States Department of Housing and Urban Development. The continuum of care designated collaborative applicant shall serve as the point of contact to the State Office on Homelessness, is accountable for representations made in the application, and, in carrying out responsibilities under this chapter, may be referred to as the continuum of care lead agency.

(3) Continuum of care catchment areas must be designated and revised as necessary by the State Office on Homelessness and must be consistent with the continuum of care catchment areas recognized by the United States Department of Housing and Urban Development for the purposes of awarding federal homeless assistance funding for continuum of care programs.

(4) The State Office on Homelessness shall recognize only one continuum of care lead agency for each designated catchment area. Such continuum of care lead agency must be consistent with the continuum of care collaborative applicant designation recognized by the United States Department of Housing and Urban Development in the awarding of federal funds to continuums of care.

(5) Each continuum of care shall create a continuum of care plan, the purpose of which is to implement an effective and efficient housing crisis response system to prevent and end

homelessness in the continuum of care catchment area. A continuum of care plan must include all of the following components:

(a) Outreach to unsheltered individuals and families to link them with appropriate housing interventions.

(b) A coordinated entry system, compliant with the requirements of the federal HEARTH Act of 2009, which is designed to coordinate intake, utilize common assessment tools, prioritize households for housing interventions, and refer households to the appropriate housing intervention.

(c) Emergency shelter, designed to provide safe temporary shelter while the household is in the process of obtaining permanent housing.

(d) Supportive services, designed to maximize housing stability once the household is in permanent housing.

(e) Permanent supportive housing, designed to provide long-term affordable housing and support services to persons with disabilities who are moving out of homelessness.

(f) Rapid ReHousing, as specified in s. 420.6265.

(g) Permanent housing, including linkages to affordable housing, subsidized housing, long-term rent assistance, housing vouchers, and mainstream private sector housing.

(h) An ongoing planning mechanism to end homelessness for all subpopulations of persons experiencing homelessness.

(6) Continuums of care must promote participation by all interested individuals and organizations and may not exclude individuals and organizations on the basis of race, color, national origin, sex, handicap, familial status, or religion. Faith-based organizations, local governments, and persons who

have experienced homelessness are encouraged to participate. To the extent possible, these individuals and organizations must be coordinated and integrated with other mainstream health, social services, and employment programs for which homeless populations may be eligible, including, but not limited to, Medicaid, the State Children's Health Insurance Program, the Temporary Assistance for Needy Families Program, the Food Assistance Program, and services funded through the Mental Health and Substance Abuse Block Grant, the Workforce Innovation and Opportunity Act, and the welfare-to-work grant program.

Section 5. Section 420.6227, Florida Statutes, is created to read:

420.6227 Grant-in-aid program.—

(1) LEGISLATIVE FINDINGS.—The Legislature hereby finds and declares that many services for households experiencing homelessness have been provided by local communities through voluntary private agencies and religious organizations and that those resources have not been sufficient to prevent and end homelessness in Florida. The Legislature recognizes that the level of need and types of problems associated with homelessness may vary from community to community, due to the diversity and geographic distribution of the homeless population and the resulting differing needs of particular communities.

(2) PURPOSE.—The principal purpose of the grant-in-aid program is to provide needed assistance to continuums of care to enable them to do all of the following:

(a) Assist persons in their communities who have become, or may likely become, homeless.

(b) Help homeless households move to permanent housing as

quickly as possible.

(3) ESTABLISHMENT.—There is hereby established a state grant-in-aid program to help continuums of care prevent and end homelessness, which may include any aspect of the local continuum of care plan, as described in s. 420.6225.

(4) APPLICATION PROCEDURE.—Continuums of care that intend to apply for the grant-in-aid program must submit an application for grant-in-aid funds to the State Office on Homelessness for review.

(5) SPENDING PLANS.—The State Office on Homelessness shall develop guidelines for the development, evaluation, and approval of spending plans that are created by local continuum of care lead agencies.

(6) ALLOCATION OF GRANT FUNDS.—The State Office on Homelessness shall administer state grant-in-aid funds for continuums of care, which must be awarded on a competitive basis.

(7) DISTRIBUTION TO LOCAL AGENCIES.—The State Office on Homelessness shall distribute funds awarded under subsection (6) to local agencies to fund programs that are required by the local continuum of care plan, as described in s. 420.6225 and provided in subsection (3), based upon the recommendations of the local continuum of care lead agencies, in accordance with spending plans that are developed by the lead agencies and approved by the office. Not more than 10 percent of the total state funds awarded under a spending plan may be used by the continuum of care lead agency for staffing and administrative expenditures.

(8) LOCAL MATCHING FUNDS.—If an entity contracts with local

agencies to provide services and receives financial assistance obtained under this section, the entity must provide a minimum of 25 percent of the funding necessary for the support of project operations. In-kind contributions, including, but not limited to, materials, commodities, transportation, office space, other types of facilities, or personal services may be evaluated and counted as part or all of the required local funding, at the discretion of the State Office on Homelessness.

Section 6. Section 420.623, Florida Statutes, is repealed.

Section 7. Section 420.624, Florida Statutes, is repealed.

Section 8. Section 420.625, Florida Statutes, is repealed.

Section 9. Subsection (3) of section 420.626, Florida Statutes, is amended, and subsection (2) of that section is republished, to read:

420.626 Homelessness; discharge guidelines.—

(2) The following facilities and institutions are encouraged to develop and implement procedures designed to reduce the discharge of persons into homelessness when such persons are admitted or housed for more than 24 hours at such facilities or institutions: hospitals and inpatient medical facilities; crisis stabilization units; residential treatment facilities; assisted living facilities; and detoxification centers.

(3) The procedures should include all of the following:

(a) Development and implementation of a screening process or other mechanism for identifying persons to be discharged from the facility or institution who are at considerable risk for homelessness or face some imminent threat to health and safety upon discharge.~~;~~

(b) Development and implementation of a discharge plan addressing how identified persons will secure housing and other needed care and support upon discharge.~~;~~

(c) Communication with ~~Assessment of the capabilities of~~ the entities to whom identified persons may potentially be discharged to determine their capability to serve such persons and their acceptance of such discharge into their programs, and selection of the entity determined to be best equipped to provide or facilitate the provision of suitable care and support.~~;~~

(d) Coordination of effort and sharing of information with entities that are expected to bear the responsibility for providing care or support to identified persons upon discharge.~~;~~ ~~and~~

(e) Provision of sufficient medication, medical equipment and supplies, clothing, transportation, and other basic resources necessary to assure that the health and well-being of identified persons are not jeopardized upon their discharge.

Section 10. Section 420.6265, Florida Statutes, is amended to read:

420.6265 Rapid ReHousing.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that Rapid ReHousing is a strategy of using temporary financial assistance ~~and case management~~ to quickly move an individual or family out of homelessness and into permanent housing, and using housing stabilization support services to help them remain stably housed.

(b) The Legislature also finds that public and private

solutions to homelessness in the past have focused on providing individuals and families who are experiencing homelessness with emergency shelter, transitional housing, or a combination of both. While emergency shelter and transitional housing programs may provide critical access to services for individuals and families in crisis, the programs often fail to address permanent housing ~~their long-term~~ needs and may unnecessarily extend their episodes of homelessness.

(c) The Legislature further finds that most households become homeless as a result of a financial crisis that prevents individuals and families from paying rent or a domestic conflict that results in one member being ejected or leaving without resources or a plan for housing.

(d) The Legislature further finds that Rapid ReHousing has proven to be a cost-effective ~~is an alternative~~ approach to ending homelessness which reduces ~~to the current system of emergency shelter or transitional housing which tends to reduce~~ the length of time that a person is homeless and is demonstrably ~~has proven to be~~ more cost effective than alternative approaches.

(e) It is therefore the intent of the Legislature to encourage ~~homeless~~ continuums of care to adopt the Rapid ReHousing approach to ending ~~preventing~~ homelessness for individuals and families who do not require the intensive ~~intense~~ level of supports provided in the permanent supportive housing model.

(2) RAPID REHOUSING METHODOLOGY.—

(a) The Rapid ReHousing response to homelessness differs from traditional approaches to addressing homelessness by

focusing on each individual's or family's barriers to housing. By using this approach, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness.

(b) In Rapid ReHousing, when an individual or a family is identified as being homeless, the individual or family is assessed and prioritized for housing through the continuum of care's coordinated entry system, temporary assistance is provided to allow the individual or family to obtain permanent housing as quickly as possible, and necessary~~, if needed,~~ assistance is provided to allow the individual or family to retain housing.

(c) The objective of Rapid ReHousing is to provide assistance for as short a term as possible so that the individual or family receiving assistance attains stability and integration into the community as quickly as possible ~~does not develop a dependency on the assistance~~.

Section 11. Section 420.6275, Florida Statutes, is amended to read:

420.6275 Housing First.—

(1) LEGISLATIVE FINDINGS AND INTENT.—

(a) The Legislature finds that many communities plan to manage homelessness rather than ~~plan~~ to end it.

(b) The Legislature also finds that for nearly ~~most of the past~~ two decades, public and private solutions to homelessness ~~have~~ focused on providing individuals and families who were ~~are~~ experiencing homelessness with emergency shelter, transitional housing, or a combination of both. This strategy failed to recognize that, while emergency shelter programs may provide

critical access to services for individuals and families in crisis, they often fail to address their long-term needs.

(c) The Legislature further finds that Housing First is a cost-effective ~~an alternative~~ approach ~~to the current system of emergency shelter or transitional housing which tends~~ to ending homelessness and reducing ~~reduce~~ the length of time of homelessness for many individuals and families ~~and has proven to be cost-effective~~.

(d) It is therefore the intent of the Legislature to encourage ~~homeless~~ continuums of care to adopt the Housing First approach to ending homelessness for individuals and families.

(2) HOUSING FIRST METHODOLOGY.—

(a) The Housing First approach to homelessness provides permanent ~~differs from traditional approaches by providing~~ housing assistance, followed by ~~case management, and~~ support services responsive to individual or family needs once ~~after~~ housing is obtained. By using this approach ~~when appropriate~~, communities can significantly reduce the amount of time that individuals and families are homeless and prevent further episodes of homelessness. Housing First emphasizes that social services provided to enhance individual and family well-being can be more effective when people are in their own home, and:

1. The housing is not time-limited.

2. The housing is not contingent on compliance with services. Instead, participants must comply with a standard lease agreement.

3. Individuals and families ~~and~~ are provided with individualized ~~the~~ services and support ~~that are~~ necessary to help them maintain stable housing ~~do so successfully~~.

~~3. A background check and any rehabilitation necessary to combat an addiction related to alcoholism or substance abuse has been completed by the individual for whom assistance or support services are provided.~~

(b) The Housing First approach addresses the societal causes of homelessness and advocates for the immediate return of individuals and families into housing and communities. Housing First links affordable housing with community-based social service and health care organizations ~~Housing First provides a critical link between the emergency and transitional housing system and community-based social service, educational, and health care organizations~~ and consists of four components:

1. Crisis intervention and short-term stabilization.

2. Screening, intake, and needs assessment.

3. Provision of housing resources.

4. Provision of case management.

Section 12. Paragraph (d) of subsection (22) of section 420.507, Florida Statutes, is amended to read:

420.507 Powers of the corporation.—The corporation shall have all the powers necessary or convenient to carry out and effectuate the purposes and provisions of this part, including the following powers which are in addition to all other powers granted by other provisions of this part:

(22) To develop and administer the State Apartment Incentive Loan Program. In developing and administering that program, the corporation may:

(d) In counties or rural areas of counties that do not have existing units set aside for homeless persons, forgive indebtedness for loans provided to create permanent rental

housing units for persons who are homeless, as defined in s. 420.621 ~~s. 420.621(5)~~, or for persons residing in time-limited transitional housing or institutions as a result of a lack of permanent, affordable housing. Such developments must be supported by a ~~local homeless assistance~~ continuum of care developed under s. 420.6225 ~~s. 420.624~~, be developed by nonprofit applicants, be small properties as defined by corporation rule, and be a project in the local housing assistance continuum of care plan recognized by the State Office on Homelessness.

Section 13. This act shall take effect July 1, 2019.

THE UNIVERSITY OF TAMPA

CYPRESS LANDING COST-BENEFIT ANALYSIS REPORT

Prepared for

Housing First, Steps Forward

Prepared by

J.E. Sumerau, Norma A. Winston, and Jack M. Geller

College of Social Science, Mathematics & Education,

The University of Tampa

2015

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CYPRESS LANDING COST BENEFIT ANALYSIS REPORT

J. E. Sumerau, Norma A. Winston and Jack M. Geller
University of Tampa

EXECUTIVE SUMMARY

The Steps Forward Initiative (SF) established Cypress Landing as a Housing First site for combatting chronic homelessness in the Tampa Bay region in 2012 with funding provided by federal agencies and support from Hillsborough County and Gracepoint Wellness.

The SF is designed to provide comprehensive housing and support services to chronically homeless individuals. Initial federal funding created the capacity to renovate an existing apartment complex (Cypress Landing) and provide health and social services to residents through Gracepoint Wellness. The program uses a housing first strategy providing safe homes for people formerly living on the street, and integrated health, mental health, and substance treatment services.

The housing first approach has been incorporated as a priority strategy based on evidence from other cities – Portland, Seattle, and Denver for example – suggesting this approach is more beneficial for both communities and homeless populations. The goals of the SF are to increase residential stability among chronically homeless people and increase the overall health status of these people while reducing the utilization and costs of emergency services provided to these people with taxpayer funds.

The Cost Benefit Analysis in this study focused on examining the actual health and emergency service costs of the sample of residents prior to and after moving in to Cypress Landing. Cypress Landing residents and Gracepoint representatives provided raw data on these costs including medical, psychiatric, legal, and substance abuse treatments and associated costs for the entire period. Cost data come from official records managed by Gracepoint Wellness in relation to actual cases.

Table 1: SERVICES UTILIZED BY NUMBER OF NIGHTS BEFORE AND AFTER RESIDING IN CYPRESS LANDING

N=17	Pre-Entry	Post-Entry	Decrease	Percent Decrease
Emergency Room	62	12	50	81%
Detox Services	146	0	146	100%
Incarceration*	1,140	196	944	83%
Emergency Shelter	2,125	0	2,125	100%
Total Nights Used	**3,473**	**208**	**3,265**	**94%**

*Data on number of nights in jail was gathered from the Hillsborough Sheriff's website.

Table 2: COSTS OF SERVICE UTILIZATION BEFORE AND AFTER RESIDING IN CYPRESS LANDING				
N=17	**Pre-Entry**	**Post-Entry**	**Cost Savings**	**Percent Decrease**
Outpatient Services	$85,878.00	$12,737.28	$73,140.72	85%
Inpatient Services	$204,203.00	$46,283.00	$157,920.00	77%
Emergency Room	$196,788.00	$38,088.00	$158,700.00	81%
Detox Services	$27,156.00	$0.00	$27,156.00	100%
Incarceration	$82,080.00	$14,112.00	$67,968.00	83%
Emergency Shelters	Cost estimate unavailable	$0.00	.....	.....
Total Savings			**$484,884.72**	

Table 1 shows how the utilization of services decreased once the homeless were in permanent housing while Table 2 shows the costs associated with these changes. In every case, the costs declined markedly after establishing residency at Cypress Landing.

The study further examined the responses of the participants to ascertain the experiences of these participants with the program in a qualitative fashion. Qualitative data came from participant observation and interviews conducted at the Cypress Landing location with residents in the fall of 2013.

The findings document an overall reduction in cost of **$484,884.72** associated with the housing of homeless persons at Cypress Landing as well as an overall increase in quality of life reported by these residents. After two years of operation, the data suggest that the SF approach utilized in the Cypress Landing project appears to offer qualitative and quantitative benefit, and the promise of concrete progress in managing chronically homeless populations in the Tampa Bay Region.

BACKGROUND

The Steps Forward (http://stepsforwardtampa.com) initiative is a collaborative between community leaders in Tampa, Florida, Gracepoint Wellness (http://www.gracepointwellness.org) and Hillsborough County (http://www.hillsboroughcounty.org). Together, the collaborative combines a Housing First approach with treatment and support options provided by teams of multi-disciplinary and multi-agency providers to assist chronically homeless individuals to obtain permanent housing, support services, and eligible benefits to help them gain the stability needed to end their homelessness.

The collaborative was initially funding via federal grants to provide integrated housing and services for chronically homeless individuals. In 2012, the collaborative renovated and opened Cypress Landings as the first property in this program and in early 2013 residents began moving into and living in the apartments. Cypress Landing is an apartment building located in North Tampa wherein each unit offers a one-bedroom, one-bathroom domicile.

PROGRAM ELEMENTS

The Housing First approach is designed to respond to the most acute need of chronically homeless individuals – housing – and through the provision of housing, to respond to other services participants may need to maintain housing and improve health and functioning. For those who do not require immediate treatment, the Housing First approach allows access to housing immediately. Likewise, for those who need treatment but have had negative experiences or are unable to acquire it, providing housing builds trust and lessens the negative impact of homelessness on overall health while offering positive treatment experience and outcomes. For those who are ready for treatment, the approach assists them in obtaining treatment and holding their housing for them during treatment processes. For those who engage in treatment prior to gaining permanent housing, a housing unit is made available to them following treatment.
Housing is provided through a combination of rental assistance techniques. In the case of Cypress Landings, residents are required to provide a percentage of the cost of housing based upon a sliding scale tied to how much income they have or can acquire through services. The remaining fees and costs of housing units are covered through the program.

The collaborative uses intensive case management strategies that have the capacity to bring integrated support services, such as health care, mental health care, substance treatment, evaluation (mental and physical), case management, benefits acquisition, and employment/education opportunities, to the residents. Part of this process is to bring these resources to the community itself and / or help with transportation so that lesser resources do not forestall participants from gaining benefits. This readiness of care builds trust and collaboration between residents and support services while helping to decrease fear among residents who have had negative experiences with other systems of care.

PARTICIPATION STATUS

The program began accepting referrals in 2012 as the property was being readied for use. By the end of the year, the property was ready for people to move in and the program had an ongoing list of referral and applicants from which to draw residents. We explore the baseline experiences of these participants in relation to current outcomes below.

The program prioritized individuals who had long-term chronic homelessness experiences and who were primarily living via the streets. In so doing, they sought to capture the potential residents most in need of care.

COST BENEFITS METHODOLOGY

All Cypress Landing residents who lived in the community at any time since the initial move in period early in 2013 were eligible for inclusion in the study. A total of 27 people met the criteria at the times (fall 2013 for qualitative responses, summer 2014 for quantitative records) of the study. Seventeen (17) of these people participated in in-depth interviews about their experiences and reflections prior to and during their stay at Cypress Landing. This report is based on these 17 cases as well as aggregate data from every resident involved in the project collected as part of ongoing evaluation and monitoring by Gracepoint Wellness.

The project utilized two methods of data collection. First, 17 respondents were interviewed about their experiences, utilization of services, and opinions about the property prior to and after moving in to Cypress Landing. From these qualitative reports, we were able to capture the residents' perceptions of the program itself. The second data collection method involved working with Gracepoint Wellness to gather aggregated data on service utilization prior to and following move in to the property. In so doing, we were able to capture a snapshot of the effects of the program on service costs in the area. These data were blinded so that no respondents' identities were obtained in relation to their private records.

Once all the data was analyzed an average cost /saving observation was noted for each type of service outcome, we turned to the qualitative responses to ascertain shared or differential perceptions between providers and residents. No discrepancies emerged, and thus we calculated differentials between service cost before and after initiation into the program for residents as a whole. In this report, we provide samples from both data sources to reveal the benefits – in terms of cost and quality – of the program to date.

QUANTITATIVE COST BENEFITS RESULTS

The following findings come from the second data source noted above – aggregated records kept by Gracepoint Wellness for evaluation and monitoring of programs and services offered. In comparison to qualitative reports from residents, these findings affirm the perspectives and memories of the residents themselves, and point to concrete cost benefits achieved to date by taking a Housing First approach in the Tampa Bay Region.

Outpatient and Inpatient Services: Prior to move in at Cypress Landing, Gracepoint's recorded cost for outpatient services totaled $85,878 in 2012. After 18 months of operation, however, outpatient service costs for the population recorded by Gracepoint Wellness totaled $12,737.28 after Housing First Team services. Outpatient service costs thus decreased by $73,141 or 85 percent. We see a similar pattern with Inpatient services where prior to move-in these costs totaled $204,203, but after residing in Cypress Landing the population's cost totaled only $46,283 for a difference of $157,920 (or a 77 percent decrease). The initiation of this program has thus generated dramatic cost reductions in both inpatient and outpatient services.

Emergency Room Services: As measured by nights in the emergency room, records reveal that the population accounted for 62 nights utilizing emergency services prior to moving into Cypress Landing. The number of nights in the emergency room following move in at Cypress Landing, however, fell to 12: an 81 percent decrease within the

population. As noted in interviews, residents had less need for emergency services or nights spent in the emergency room when they were able to "go home" when not feeling well.

Detox Services: As measured by nights spent in detox facilities, records reveal the population accounted for 146 nights prior to moving into Cypress Landings. However, since moving into Cypress Landings, the population spent **zero** nights in detox facilities.

Incarceration: Echoing detox and emergency services, Hillsborough County Sheriff's records revealed that this population spent many nights in jail in the 18 months prior to moving into Cypress Landing: 1,140 nights in total. After moving into Cypress Landing, however, this number dropped dramatically to 196 nights. A conservative estimate would suggest a decline of 83 percent in the number of nights incarcerated.

Emergency Shelters: While the above examples already reveal dramatic declines in service use (and thus cost to taxpayers) generated by providing residents with housing, it is also noteworthy that respondents noted **zero** use of shelters after acquiring housing. This is not surprising, but it is relevant for costs since the same population utilized emergency shelters for 2,125 nights in the proceeding 18 months. Their absence both cut down on costs and freed up space for others in need of a space for the night.

To help clarify and monetize the cost savings resulting from housing chronically homeless persons at Cypress Landing we were able, in most cases, to draw upon reliable public sources of information with which to estimate costs. In 2013, for instance, the average charge for an emergency room visit to Medicaid (the lowest payer in FL) was $3,174.00 www.floridahealthfinder.gov. Based on this figure, we estimate the cost of emergency room visits for residents prior to living at Cypress Landing (62 nights) to be $196,788.00. Concomitant with the reduction in number of emergency room visits after taking up residency at Cypress Landing (12), the cost decreased to $38,088.00. This represents a savings in emergency room costs of $158,700.00 (81%).

Similarly, according to the 2012 Denver Housing First study (2006), the average cost of one night's incarceration was $72 while the average cost of detox treatment was $186 per day. Using these figures, the 1,140 nights spent in incarceration prior to living in Cypress Landing is valued at $82,080.00. After residing in Cypress Landing, the incarceration rate dropped to 196 nights with a cost of $14,112.00: hence, a saving of $67,968.00. Likewise, Cypress Landing residents reported spending a total of 146 nights in detox centers. The estimated cost of $27,156.00 was reduced to zero (or by 100%) after the homeless individuals moved into Cypress Landing. Thus, conservative estimates suggest a cost savings of $253,824.00 on three of the five services discussed above, when the homeless are provided with stable housing. When the savings in costs of in/out patient services (see above) reported by Gracepoint Wellness ($231,060.72) are included, the total saving is estimated at **$484,884.72.**

QUALITATIVE COST BENEFIT RESULTS

The following findings build upon the qualitative observations utilizing the first data source noted above – in-depth interviews with 17 residents of Cypress Landing. Rather than an exhaustive catalogue, we note the two main themes in the interviews and provide examples from the conversations. Similar to the quantitative findings, these results point to concrete quality of life benefits achieved to date by taking a Housing First approach in the Tampa Bay Region.

Hope: One of the primary patterns in residents' responses involved the ways housing allowed them to come back from hard times. They noted that people often looked down on homeless people, but that everyone needs help sometimes and we would be better off trying to help people who fall on hard times like they do at Cypress Landing. The following illustrations offer typical examples:

> "Homeless people (sic) a lot of us just had a bad thing in life...something went wrong...so, stop looking down on homeless people...do things to help the homeless instead...everybody wants and needs some help."
>
> "It was hard out there so it's much better right in here. You got a roof over your head, you can buy whatever, then you can move on with your life now. There is no comparison. This is something so big, here you feel like you have hope."
>
> "When you're on the street you start to feel desperate, you get anxious, and here you start to feel calm. It makes a person feel really good, on the street you feel like a piece of trash, an animal that's just left out there."

Opportunity: The other primary pattern that emerged in the interviews involved the ways housing itself generated opportunities for the residents by removing some of the major obstacles – not being able to plan anything, not having a place to regroup, always on the move – to creating better lives for themselves. Residents regularly noted that life on the street was a constant barrage of obstacles and hardships, but that once they had a place to live and sleep much of the difficulty in their lives was already gone. As a result, within homes, they could begin to focus on more long-term changes and goals for their lives. The following examples offer illustrative cases:

> "If you're packing a bag and you're out in the rain, you better hope you have a poncho, you better hope you have enough supplies. If you're going to stash it, it's like a child ---there goes your responsibility, people would just pick it up. Being inside here, I don't have an abundance of clothes, but I have what I need. I'm not doing anything so I'm not going through my clothes. You find yourself prepared with some organizational skills."
>
> "It's the environment here. I've been in an environment where there are other recovering alcoholics and other recovering addicts and we talked to one another and were a sounding board for each other. It's been helpful. We had weekly visits and we talk about the issues. They also teach you techniques that when the urges strike certain things that you can do to alleviate the urges and desires."
>
> "Every shelter I've been to was nothing more than a pain in the butt. You couldn't even ask a question, just take your bag and go there. But here, I think the way things have been approached to me always been a very smooth way of let's fact find. It's not the light hanging over the head and we're being interrogated or anything like that, it's a fact finding situation that is growing and evolving with us".

Throughout the interviews, residents' repeatedly mentioned the "life changing," "hope," and "opportunities" Cypress Landing provided them that were nowhere to be found on the streets. In fact, many of them took the time to show the interviewer around their apartments, and talk about the pride they and others took in keeping up the

property, their homes, and their community in the complex. They regularly spoke of their entrance into this property and program as an opportunity that changed their whole lives, and offered examples of ways they were attempting to become more independent through job training, benefits acquisition, and programs offered within the complex by Gracepoint Wellness. While the program saved the city money, it also gave the participants a sense of meaning and purpose in their own lives.

CONCLUSION

The initial establishment and operation of Cypress Landing has demonstrated significant progress in reducing the public cost of chronic homelessness and facilitating a better quality of life for chronically homeless people. By providing housing to chronically homeless persons at Cypress Landing which both anchored their lives in a space of their own and allowed us to better reach them with services, the costs of providing for this population were markedly reduced and the personal benefits to the homeless increased. The reduction of taxpayer costs associated with incarceration, medical services, emergency services, and detox centers also represents a significant way to better serve the larger community and more efficiently use taxpayer dollars.

The data strongly suggest that such an approach has the potential for improving the status – health wise and socially – of chronically homeless populations while reducing taxpayer burdens at the same time. Furthermore, such efforts may significantly improve the quality of life for these populations and the wider community as the negative impacts of people living and sleeping on the streets is eliminated over time.

It is critical to create an ongoing source of funding to continue programs like Cypress Landing in the Tampa Bay Region and to replicate these programs throughout our community.

REFERENCES

Perlman, Jennifer and John Parvensky. 2006. "Denver Housing First Collaborative: Cost Benefit Analysis and Program Outcomes Report." Colorado Coalition for the Homeless.

*This research was requested by Housing First, Steps Forward, a nonprofit corporation organized by Tampa and Hillsborough County business leaders to provide housing for the chronic homeless in our community. "Housing First" has been shown nationwide to not only to be the path to ending chronic homelessness, but also to provide significant tax payer cost savings over attempting to deal with this population in the streets.

** Our sincere thanks go to the residents of Cypress Landing who participated in this study. We are grateful as well, to Joseph Pondolfino, Ymeisa Melendez and Joanne Joseph, all of Gracepoint Wellness, for providing quantitative data for this report.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1300
INTRODUCER:	Senator Benacquisto
SUBJECT:	Florida ABLE Program
DATE:	March 15, 2019
REVISED:	

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

I. Summary:

SB 1300 bill repeals section 11 of the 2018-2019 budget implementing bill. Section 10 of the implementing bill prohibits the Medicaid program from filing a claim upon the death of a Medicaid recipient who has assets in an ABLE account. Contributions to ABLE accounts are tax exempt and pay for a variety of expenses related to maintaining the health, independence and quality of life for people with disabilities. By repealing section 11, the changes in the implementing bill that prohibit a claim by Medicaid will remain in effect.

The bill is expected to have an insignificant fiscal impact to the state and has an effective date of June 30, 2019.

II. Present Situation:

ABLE Act

Signed into law in December 2014, the Stephen Beck, Jr. Achieving a Better Life Experience (ABLE) Act authorized states to establish tax-advantaged savings programs for individuals with a disabilities.[1] In 2015, Virginia became the first state to approve and pass ABLE legislation after passage of the federal ABLE Act. The act created Section 529A of the Internal Revenue Code. This is the federal legal framework that establishes the specific rules and requirements of an ABLE account. Such accounts are tax-advantaged savings accounts for eligible individuals with disabilities. Millions of individuals with disabilities and their families depend on a wide variety of public benefits for income, health care, food and housing assistance. Many of these benefits require meeting a means or resource test that limits the eligibility of individuals who report more than $2,000 in cash savings, retirement funds and other items of significant value.

[1] ABLEnow website, see https://www.able-now.com/, last visited March 14, 2019.

For the first time in public policy, the ABLE Act recognizes the extra and significant costs of living with a disability. ABLE accounts allow eligible individuals the opportunity to save and fund a variety of qualified disability expenses without endangering eligibility for certain benefits such as Medicaid and Supplemental Security Income (SSI).

Florida's ABLE Program

Section 1009.986, F.S., established the ABLE program to encourage and assist the saving of private funds in tax-exempt accounts in order to pay for the qualified disability expenses of eligible individuals with disabilities. The Legislature intended that the qualified ABLE program be implemented in a manner that is consistent with federal law authorizing the program and that maximizes program efficiency and effectiveness.

Medicaid

The Florida Medicaid program is a partnership between the federal and state governments. Each state operates its own Medicaid program under a state plan approved by the federal Centers for Medicare and Medicaid Services (CMS). The state plan outlines Medicaid eligibility standards, policies, and reimbursement methodologies. Florida Medicaid is administered by the AHCA and financed with federal and state funds. Approximately 3.9 million Floridians are currently enrolled in Medicaid, and the program is expected to cost $28.2 billion in 2019-2020.[2]

Eligibility for Medicaid is based on a number of factors, including age, household, or individual income, and assets. State eligibility payment guidelines are provided in s. 409.903, F.S., for mandatory payments for eligible persons and s. 409.904, F.S., for optional payments for eligible persons. Minimum coverage thresholds are established in federal law for certain population groups, such as children. Many of the persons with developmental disabilities that are assisted by the ABLE program are also served by the Medicaid program. State and federal law require states to file a lien or claim on the estate of persons served by Medicaid after their death to recover the costs of their medical care.[3] In addition, s. 1009.986, F.S., allows recoveries for Medicaid recipients from their ALBE account.

2018-2019 General Appropriations Act and Implementing Bill

Specific appropriation 70 of the 2018-2019 General Appropriations Act (Chapter 2018-9, Laws of Florida) provided $2.2 million in general revenue to the ABLE program for student financial aid. Each year, the Legislature passes an implementing bill to make temporary changes in the Florida Statutes to implement the provisions of the General Appropriations Act. The implementing bill (Chapter 2018-10, Laws of Florida) makes needed changes in statute and provides for these changes to revert back to prior text on July 1, 2019. Section 10 of the implementing bill prohibits the Medicaid program from filing a claim on a recipient who receives assistance from an ABLE account. Section 11 restores the text so that this prohibition is in effect only during fiscal year 2018-2019.

[2] Social Services Estimating Conference, Medicaid Caseloads and Expenditures, November 18, 2018 and December 10, 2018—Executive Summary http://edr.state.fl.us/Content/conferences/medicaid/execsummary.pdf (last visited March 13, 2019).
[3] Section 409.9101, F.S.

III. Effect of Proposed Changes:

Section 1 of the bill repeals section 11 of the 2018-2019 implementing bill (Chapter 2018-10, Laws of Florida). Section 10 of the implementing bill prohibits the Medicaid program from filing a claim on a Medicaid client who receives assistance from the ABLE program. By repealing section 11, the changes in section 10 of the implementing bill will remain in effect.

Section 2 provides an effective date of June 30, 2019.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The state's Medicaid program will not be able to make a claim on the ABLE account of any Medicaid recipient who also receives assistance from the ABLE program. The fiscal impact to the state is unknown, but is not expected to be significant.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill repeals section 11 of chapter 2018-10, Laws of Florida.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Benacquisto

27-01627-19 20191300__

A bill to be entitled

An act relating to the Florida ABLE program; repealing s. 11 of chapter 2018-10, Laws of Florida, relating to the scheduled reversion of provisions related to the distribution of funds in an ABLE account upon the death of a designated beneficiary; providing an effective date.

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

Section 1. Section 11 of chapter 2018-10, Laws of Florida, is repealed.

Section 2. This act shall take effect June 30, 2019.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

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

BILL:	SB 1346
INTRODUCER:	Senator Gruters
SUBJECT:	Public Records/Homelessness Counts and Databases
DATE:	March 15, 2019
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Preston	Hendon	CF	**Pre-meeting**
2.			GO	
3.			RC	

I. Summary:

SB 1346 creates an exemption from the public records requirements for individual identifying information on homeless persons. Such data is collected pursuant to federal and state law and if made public, could lead to discrimination, injury, and pose a barrier to homeless persons receiving services. The bill provides the exemption is subject to the Open Government Sunset Review Act and unless reviewed and saved from repeal through reenactment by the Legislature shall be repealed on October 2, 2024.

This bill requires a two-thirds vote from each chamber for passage because the bill creates a public records exemption.

This bill has no fiscal impact on the state and will become effective upon becoming law.

II. Present Situation:

Homelessness

Although recent progress has been made in reducing the number of homeless individuals and families, ending homelessness remains a priority in communities across the country. According to a Point-in-Time Count from January 2017, 564,708 people were homeless on a given night in the United States.[1]This number includes both homeless individuals and homeless families. An estimated 12.2% of the homeless population are chronically homeless, defined as someone who experiences homelessness repeatedly and/or for long periods of time, and they have a disability such as serious mental illness, chronic substance use disorders, or chronic medical issues.[2] Other

[1] National Alliance to End Homelessness. *Available at*: https://endhomelessness.org/homelessness-in-america/homelessness-statistics/state-of-homelessness-report/ (Last visited March 12, 2019).
[2] National Alliance to End Homelessness. *Available at*: https://endhomelessness.org/the-state-of-homelessness-in-america-2015-trends-in-chronic-homelessness/ (Last visited March 12, 2019).

sub-populations that are a key focus include veterans, youth aging out of foster care, and LGBTQ youth. At the federal level, the Department of Housing and Urban Development (HUD) oversees efforts to reduce and eliminate homelessness.

In Florida, responsibility for addressing homelessness is shared between the Department of Children and Families (DCF or the department) and the Department of Economic Opportunity (DEO). The State Office on Homelessness is housed within DCF to coordinate efforts relating to homelessness.[3] DCF supports the Council on Homelessness (council) that oversees services and funding the homeless.[4] The council develops policy and advises the State Office on Homelessness. The council members include:

- The secretary of DCF;
- The executive director of DEO;
- The State Surgeon General;
- The executive director of Veterans' Affairs;
- The secretary of the Department of Corrections;
- The secretary of the Agency for Health Care Administration;
- The commissioner of Education;
- The director of CareerSource Florida, Inc;.
- One representative of the Florida Association of Counties;
- One representative of the Florida League of Cities,
- One representative of the Florida Supportive Housing Coalition;
- The executive director of the Florida Housing Finance Corporation;
- One representative of the Florida Coalition for the Homeless; and
- Four members appointed by the Governor.[5]

The council coordinates among state, local, and private agencies and providers to produce a statewide inventory for the state's system of homeless programs which incorporates regionally developed plans.

DEO establishes local coalitions to plan, network, coordinate, and monitor the delivery of services to the homeless.[6] The local coalitions develop the local homeless continuum of care plan[7], for the area of the county or region served by the local homeless coalition. Unless otherwise specified in the plan, the local coalition serves as the lead agency for the local homeless assistance continuum of care. The local coalitions receive funding from a grant program to provide services to the homeless.[8] The amount of these grants, referred to as "challenge" grants, totaled $4.1 million statewide for fiscal year 2018-2019.[9] In addition, the

[3] Section 420.622, F.S.
[4] *Id.*
[5] *Id*.
[6] Section 420.623, F.S.
[7] Section 420.624, F.S., provides that a local homeless assistance continuum of care is a framework for a comprehensive and seamless array of emergency, transitional, and permanent housing, and services to address the various needs of homeless persons and persons at risk for homelessness.
[8] Section 420.625, F.S.
[9] Specific Appropriation 345, General Appropriations Act, Chapter 2018-9, Laws of Florida.

budget contains $7.7 million for emergency shelter grants and $3.6 million for homeless housing grants.[10]

Local communities must establish a homeless assistance continuum of care.[11] This continuum is a framework for a comprehensive and seamless array of emergency, transitional, and permanent housing, and services to address the various needs of homeless persons and persons at risk for homelessness. Each local continuum of care plan must designate a lead agency that will serve as the point of contact and accountability to the State Office on Homelessness. The lead agency may be a local homeless coalition, municipal or county government, or other public agency or private, not-for-profit corporation.

Data on Homelessness

In Florida, the council collects, maintains, and makes available information concerning persons who are homeless or at risk for homelessness, including demographics information, current services and resources available, the cost and availability of services and programs, and the met and unmet needs of this population. All entities that receive state funding must provide access to all data they maintain to the council. This data is provided to the council in summary form, with no individual identifying information. The State Office on Homelessness, in consultation with the council and lead agencies for a local homeless continuum of care, specifies the system and process of data collection. All lead agencies provide data for the purpose of analyzing trends and assessing impacts in the statewide homeless delivery system. Any statewide homelessness survey and database system must comply with all state and federal statutory and regulatory confidentiality requirements.

The U.S. Department of Housing and Urban Development (HUD) maintains Homeless Management Information Systems (HMIS) to better inform homeless policy and decision making at the federal, state, and local levels.[12] HUD collects national-level data on the extent and nature of homelessness over time. Specifically, a HMIS can be used to produce an unduplicated count of homeless persons, understand patterns of service use, and measure the effectiveness of homeless programs. Data on homeless persons is collected and maintained at the local level. HMIS implementations can encompass geographic areas ranging from a single county to an entire state.

The HEARTH Act, enacted into law on May 20, 2009, requires that all communities have an HMIS with the capacity to collect unduplicated counts of individuals and families experiencing homelessness.[13] These data systems must collect the following data elements for the homeless:

- Name
- Social Security Number
- Date of Birth
- Race
- Ethnicity

[10] Specific Appropriations 346 and 347, General Appropriations Act, Chapter 2018-9, Laws of Florida.
[11] Section 420.624, F.S.
[12] Department of Housing and Urban Development. *Available at*: https://www.hudexchange.info/programs/hmis/. (Last visited March 12, 2019).
[13] *Id*.

- Gender
- Veteran Status
- Disabling Condition
- Residence Prior to Project Entry
- Project Entry Date
- Project Exit Date
- Destination
- Personal ID
- Household ID
- Relationship to Head of Household
- Client Location Code
- Length of Time on Street, in an Emergency Shelter or Safe Haven

HUD is currently developing rules for basic privacy and security requirements for client-level data.[14]

Public Records Law

The Florida Constitution provides that the public has the right to inspect or copy records made or received in connection with official governmental business.[15] This applies to the official business of any public body, officer or employee of the state, including all three branches of state government, local governmental entities, and any person acting on behalf of the government.[16]

In addition to the Florida Constitution, the Florida Statutes provide that the public may access legislative and executive branch records.[17] Chapter 119, F.S., constitutes the main body of public records laws, and is known as the Public Records Act.[18] The Public Records Act states that:

> it is the policy of this state that all state, county and municipal records are open for personal inspection and copying by any person. Providing access to public records is a duty of each agency.[19]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[20] The Florida Supreme

[14] *Id*.
[15] FLA. CONST., art. I, s. 24(a).
[16] *Id*.
[17] The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). Also see *Times Pub. Co. v. Ake*, 660 So. 2d 255 (Fla. 1995). The Legislature's records are public pursuant to s. 11.0431, F.S. Public records exemptions for the Legislatures are primarily located in s. 11.0431(2)-(3), F.S.
[18] Public records laws are found throughout the Florida Statutes.
[19] Section 119.01(1), F.S.
[20] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purposes of this chapter, the Commission on Ethics, the Public Service Commission,

Court has interpreted public records as being "any material prepared in connection with official agency business which is intended to perpetuate, communicate or formalize knowledge of some type."[21] A violation of the Public Records Act may result in civil or criminal liability.[22]

The Legislature may create an exemption to public records requirements.[23] An exemption must pass by a two-thirds vote of the House and the Senate.[24] In addition, an exemption must explicitly lay out the public necessity justifying the exemption, and the exemption must be no broader than necessary to accomplish the stated purpose of the exemption.[25] A statutory exemption which does not meet these criteria may be unconstitutional and may not be judicially saved.[26]

When creating a public records exemption, the Legislature may provide that a record is "confidential and exempt" or "exempt."[27] Records designated as "confidential and exempt" may be released by the records custodian only under the circumstances defined by the Legislature. Records designated as "exempt" are not required to be made available for public inspection, but may be released at the discretion of the records custodian under certain circumstances.[28]

Open Government Sunset Review Act

The Open Government Sunset Review Act (referred to hereafter as the "OGSR") prescribes a legislative review process for newly created or substantially amended public records or open meetings exemptions.[29] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[30]

The OGSR provides that a public records or open meetings exemption may be created or maintained only if it serves an identifiable public purpose and is no broader than is necessary.[31] An exemption serves an identifiable purpose if it meets one of the following purposes and the Legislature finds that the purpose of the exemption outweighs open government policy and cannot be accomplished without the exemption:

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and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency."

[21] *Shevin v. Byron, Harless, Schaffer, Reid and Assoc. Inc*., 379 So. 2d 633, 640 (Fla. 1980).

[22] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are the penalties for violating those laws.

[23] FLA. CONST., art. I, s. 24(c).

[24] *Id.*

[25] *Id*.

[26] *Halifax Hosp. Medical Center v. New-Journal Corp*., 724 So. 2d 567 (Fla. 1999). See also *Baker County Press, Inc. v. Baker County Medical Services, Inc*., 870 So. 2d 189 (Fla. 1st DCA 2004).

[27] If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So. 2d 48 (Fla. 5th DCA 2004).

[28] *Williams v. City of Minneola*, 575 So. 2d 687 (Fla. 5th DCA 1991).

[29] Section 119.15, F.S. Section 119.15(4)(b), F.S., provides that an exemption is considered to be substantially amended if it is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to section 119.15(2), F.S.

[30] Section 119.15(3), F.S.

[31] Section 119.15(6)(b), F.S.

- It allows the state or its political subdivision to effectively and efficiently administer a program, and administration would be significantly impaired without the exemption;[32]
- Releasing sensitive personal information would be defamatory or would jeopardize an individual's safety. If this public purpose is cited as the basis of an exemption, however, only personal identifying information is exempt;[33] or
- It protects trade or business secrets.[34]

The OGSR also requires specified questions to be considered during the review process.[35] In examining an exemption, the OGSR asks the Legislature to carefully question the purpose and necessity of reenacting the exemption.

If, in reenacting an exemption, the exemption is expanded, then a public necessity statement and a two-thirds vote for passage are required.[36] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are not required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless provided for by law.[37]

III. Effect of Proposed Changes:

The bill creates s. 420.6231, F.S., to provide an exemption to the public records requirements for individual identifying information in homelessness surveys and databases. The bill defines "individual identifying information" as any information that directly or indirectly identifies a person. The bill would exempt information held before and after the effective date of the bill. The bill allows the release of aggregate information on homelessness. The bill states that the exemption is subject to the Open Government Sunset Review Act and unless reenacted by the Legislature, expires October 2, 2024.

The bill finds that it is a public necessity to exempt this information from the public records requirements because the release of such information could lead to discrimination, injury, and pose a barrier to homeless persons receiving services.

The bill shall take effect upon becoming a law.

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[32] Section 119.15(6)(b)1., F.S.
[33] Section 119.15(6)(b)2., F.S.
[34] Section 119.15(6)(b)3., F.S.
[35] Section 119.15(6)(a), F.S. The specified questions are:
1. What specific records or meetings are affected by the exemption?
2. Whom does the exemption uniquely affect, as opposed to the general public?
3. What is the identifiable public purpose or goal of the exemption?
4. Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
5. Is the record or meeting protected by another exemption?
6. Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?
[36] FLA. CONST. art. I, s. 24(c).
[37] Section 119.15(7), F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Voting Requirement
Article I, Section 24(c) of the Florida Constitution requires a two-thirds vote of each chamber for public records exemptions to pass.

Breadth of Exemption
Article I, Section 24(c) of the Florida Constitution requires a newly created public records exemption to be no broader than necessary to accomplish the state purpose of the law. The bill exempts certain identifying information of homeless persons. This bill appears to be no broader than necessary to accomplish the public necessity for this public records exemption.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private agencies and organizations will have to ensure that identifying information on homeless persons is held in confidence.

C. Government Sector Impact:

Governmental agencies and organizations will have to ensure that identifying information on homeless persons is held in confidence.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 420.6231 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Gruters

23-01080-19 20191346__

A bill to be entitled

An act relating to public records; creating s. 420.6231, F.S.; defining terms; creating an exemption from public records requirements for individual identifying information contained in certain homelessness counts and databases; providing for retroactive application of the exemption; providing for future legislative review and repeal of the exemption; providing construction; providing a statement of public necessity; providing a directive to the Division of Law Revision; providing an effective date.

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

Section 1. Section 420.6231, Florida Statutes, is created to read:

420.6231 Individual identifying information in homelessness counts and databases; public records exemption.—

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

(a) "Individual identifying information" means information that directly or indirectly identifies a specific person, can be manipulated to identify a specific person, or can be linked with other available information to identify a specific person.

(b) "Point-in-Time Count" means an unduplicated count of both the sheltered and unsheltered people in a community who are experiencing homelessness. For purposes of this section, the term includes all survey information received from such persons.

(2) Individual identifying information of a person

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contained in a Point-in-Time Count or a homeless management information system which is collected pursuant to 42 U.S.C. 119, subchapter IV and 24 C.F.R. part 91 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution. This exemption applies to individual identifying information collected before, on, or after the effective date of this act. This subsection is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2024, unless reviewed and saved from repeal through reenactment by the Legislature.

(3) This section does not preclude the release of aggregate information in a Point-in-Time Count or data in a homeless management information system which does not disclose the individual identifying information of a person.

Section 2. (1) The Legislature finds that it is a public necessity that the individual identifying information of a person contained in a Point-in-Time Count or in a homeless management information system collected pursuant to 42 U.S.C. 119, subchapter IV and 24 C.F.R. part 91 be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution.

(2) Public knowledge of such information could lead to discrimination against or ridicule of an individual, which could make such individual reluctant to seek assistance. Public knowledge of such information may also create a greater risk of injury to affected individuals who are survivors of domestic violence or suffer from mental illness or substance abuse. Additionally, public knowledge of such information may create a heightened risk for fraud and identity theft to affected

individuals.

(3) The harm from disclosing the individual identifying information of a person contained in a Point-in-Time Count or in a homeless management information system outweighs any public benefit that can be derived from widespread and unfettered access to such information. The exemption is narrowly written so that certain aggregate information may still be disclosed.

(4) Further, pursuant to 42 U.S.C. s. 11363, victim service providers must protect the personally identifying information about a client and may not disclose any personally identifying information about a client for purposes of a homeless management information system.

(5) For the foregoing reasons, the Legislature finds that such information must be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution.

Section 3. The Division of Law Revision is directed to replace the phrase "the effective date of this act" wherever it occurs in this act with the date this act becomes a law.

Section 4. This act shall take effect upon becoming a law.