HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/HB 7053 PCB HMR 20-03 Direct Care Workers
SPONSOR(S): Health & Human Services Committee, Health Care Appropriations Subcommittee and Health Market Reform Subcommittee, Tomkow
TIED BILLS: **IDEN./SIM. BILLS:**

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
Orig. Comm.: Health & Human Services Committee	16 Y, 0 N, As CS	Siples	Calamas

SUMMARY ANALYSIS

Access to health care is an ongoing issue in this state. Florida, which has experienced a significant growth in its general population and its aging population, faces shortages of health care providers and direct care staff.

Direct care workers, such as certified nursing assistants (CNAs), home health aides (HHAs), and personal care assistants (PCAs), provide hands-on assistance to older adults and disabled individuals. They assist with bathing, eating, dressing, and housekeeping. Employers find it difficult to retain individuals in these positions due to a lack of full-time employment and upward mobility.

CS/CS/HB 7053 increases opportunity for advancement for direct care workers by expanding the authority of registered nurses to delegate certain tasks to a certified nursing assistant or a home health aide, including medication administration. The bill also expands the scope of practice for CNAs and HHAs in home health agencies by authorizing CNAs and HHAs to assist with preventative skin care, applying and reapplying bandages for minor cuts and abrasions, and nebulizer treatments.

The bill requires the Agency for Health Care Administration (AHCA) to create and maintain a direct care worker registry. Direct care workers, as well as licensed entities providing such services, may list themselves in the registry, along with their contact information, qualifications, background screening information, and photograph.

Currently, there is no reliable state-based data on the Florida direct care workforce. The bill requires all licensed nursing home facilities, home health agencies, hospices, nurse registries, and homemaker and companion services providers to complete a workforce survey at each biennial licensure renewal.

The bill creates an Excellence in Home Health Program that awards a designation to home health agencies and nurse registries that meet certain criteria. The home health agency or nurse registry may use the designation in marketing materials until such time it no longer holds the designation or no longer qualifies for the designation.

To increase access to health care for the general population, the bill authorizes advanced practice registered nurses (APRNs) who meet certain criteria to practice advanced or specialized nursing without physician supervision or a protocol and authorizes physician assistants (PAs) to practice primary care without physician supervision. Under current law, APRNs must practice under a supervising protocol with a physician and only to the extent that a written protocol allows. Similarly, physician assistants (PAs) must practice under a supervising physician and may only perform those tasks delegated by the physician.

The bill revises the composition of the Council on PAs (Council) so that it has a PA majority. The bill requires the Boards of Medicine and Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council. The bill also expands the scope of practice for all PAs by authorizing them to certify involuntary examination under the Baker Act, file death certificates, certify causes of death, and participate in guardianship plans.

The bill authorizes 4.0 full-time equivalent positions, with associated salary rate of 166,992, and appropriates the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund to AHCA and authorizes 3.5 FTE, with associated salary rate of 183,195, and appropriates $219,089 in recurring and $17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to Department of Health (DOH) to implement the requirements of the bill. The bill has no fiscal impact on local governments.

The bill provides an effective date of July 1, 2020.

I. SUBSTANTIVE ANALYSIS

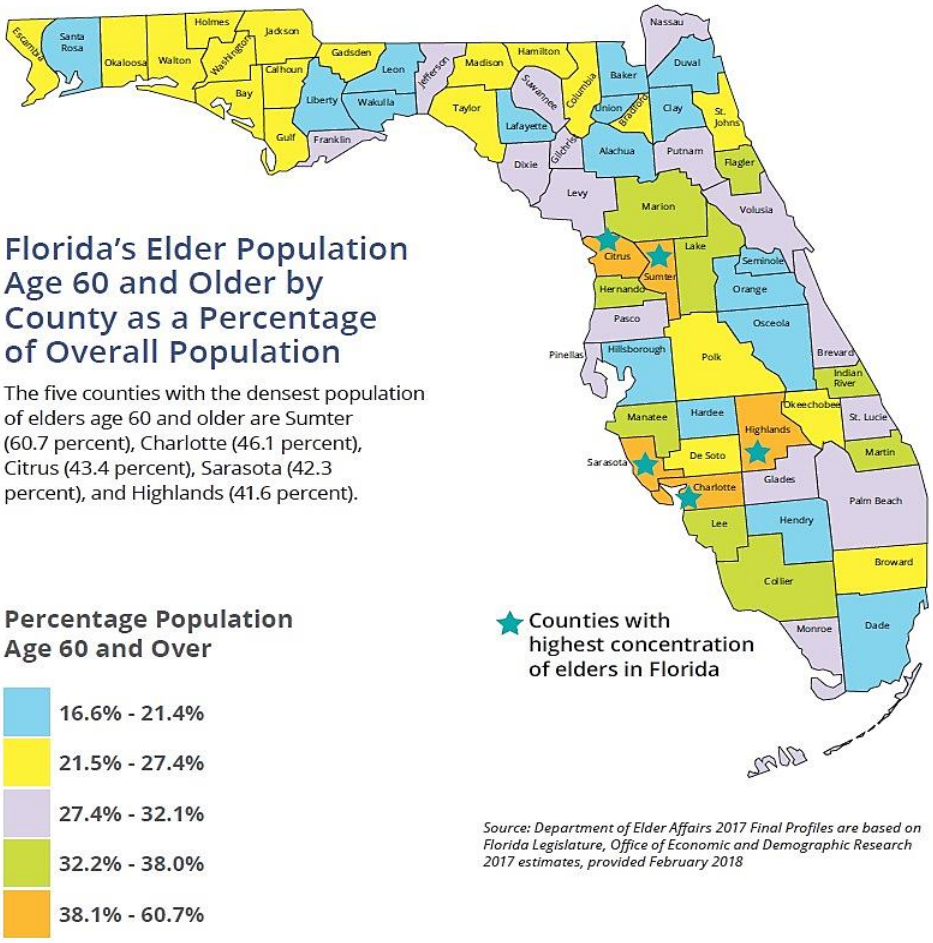
A. EFFECT OF PROPOSED CHANGES:

Current Situation

Florida's Aging Population

In the U.S. in 2015, nearly 19 million people under the age of 65 and nearly 14 million people over the age of 65 reported that they had difficulty taking care of themselves or living independently.[1]

Florida ranks first in the nation in the percentage of residents who are age 65 or older.[2] It is estimated that 20.5 percent of the state's population is over the age of 65.[3] Florida ranks fourth in the nation in the percentage of residents who are 60 and older,[4] and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.[5]



Someone turning 65 today has almost a 70 percent chance of needing some type of long term care services and supports in their remaining years.[6] As Florida grays, individuals with disabilities who need

[1] Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).
[2] Department of Elder Affairs, *2019 Summary of Programs and Services*, (Jan. 2019), available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited January 10, 2020).
[3] U.S. Census Bureau, *Quick Facts: Florida*, (July 1, 2019), available at https://www.census.gov/quickfacts/FL (last visited January 10, 2020). Florida's population is estimated to be 21,477,737.
[4] *Supra* note 1 at p. 8.
[5] Id.
[6] U.S. Department of Health and Human Services, *How Much Care Will You Need?*, (last rev. Oct. 2017), available at https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html (last visited January 20, 2020).

assistance with activities of daily living, such as eating, grooming, and making meals, may also lose their caretakers. Direct care workers may provide such care and enable these individuals to remain in the community.

Direct Care Workers

Direct care workers assist older individuals and those with disabilities with daily tasks, such as dressing, bathing, and eating.[7] They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.[8] Direct care workers account for 70 to 80 percent of all paid hands-on long-term care and personal assistance for the elderly or disabled.[9]

Florida Direct Care Workers

Nursing Assistants or Nursing Aides

Nursing assistants or nursing aides generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals.[10] The Florida Board of Nursing, within the Department of Health, certifies nursing assistants (CNAs) who must, among other things, hold a high school diploma or equivalent, complete a 120-hour board-approved training program, and pass a nursing assistant competency exam, which includes written and practical portions.[11] A CNA must biennially complete 24 hours of inservice training to maintain certification.[12]

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision[13] of a registered nurse or licensed practical nurse.[14] A CNA may perform the following services:[15]

- Personal care services, such as bathing, dressing grooming, and light housekeeping;
- Tasks associated with maintaining mobility, such as ambulating, transferring, positioning, lifting, and performing range of motion exercises;
- Nutrition and hydration tasks, such a feeding or assisting with eating and drinking;
- Tasks associated with elimination, such as toileting, providing catheter care, and emptying or changing ostomy bags;
- Tasks associated with using assistive devices;
- Maintaining the environment and resident safety;
- Taking measurements and gathering data, i.e. pulse, blood, pressure, height, and weight;
- Reporting abnormal resident findings, signs, and symptoms;
- Post mortem care;
- Tasks associated with end of life care;
- Tasks associated with resident socialization, leisure activities, reality orientation, and validation techniques;
- Performing basic first aid, CPR, and emergency care; and

[7] Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at https://phinational.org/policy-research/key-facts-faq/ (last visited November 8, 2019).
[8] Paraprofessional Healthcare Institute, *Direct Care Workforce 2018 Year in Review*, https://phinational.org/resource/the-direct-care-workforce-year-in-review-2018/ (last visited November 12, 2019) and Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?* https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[9] Id.
[10] Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?*, (Feb. 2011), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf (last visited January 14, 2020).
[11] Section 464.203, F.S., and r. 64B9-15.006, F.A.C. Eighty hours must be classroom instruction and 40 hours must be clinical instruction, 20 of which must be in long term care clinical instruction in a licensed nursing home. 42 C.F.R. § 483.95 requires 75 hours of training; Florida training requirements exceed the federal minimum training requirements.
[12] Section 464.203(7), F.S.
[13] Under general supervision, the registered nurse or licensed practical nurse does not need to be present but must be available for consultation and advice, either in person or by a communication device. Rule 64B9-15.001(5), F.A.C
[14] Rule 64B9-15.002, F.A.C.
[15] *Supra* note 14.

- Documentation of CNA services provided to the resident.

A CNA may not work independently and may not may not perform any tasks that requires specialized nursing knowledge, judgement, or skills.[16]

Home Health Aides

Home health aides (HHA) provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or a physical, speech, occupational, or respiratory therapist.[17] In Florida, HHAs are not licensed or certified. However, the Agency for Health Care Administration (AHCA) licenses home health agencies and establishes training requirements for HHAs employed by home health agencies. A HHA must complete at least 75 hours of training and/or successfully pass a competency evaluation by the home health agency.[18] HHAs who work for a home health agency that is not certified by Medicare or Medicaid or who work for a nurse registry must complete 40 hours of training or pass an AHCA-developed competency examination.[19]

AHCA establishes the scope of practice for HHAs performing services under a licensed home health agency. A HHA performs services delegated by and under the supervision of a registered nurse, which include:[20]

- Assisting the patient or client with personal hygiene, ambulation, eating, dressing, shaving, physical transfer, and other personal care activities;
- Maintaining a clean, safe, and healthy environment, including light housekeeping;
- Activities taught by a licensed health professional for a specific patient or client and restricted to:
    - Toileting;
    - Assisting with tasks related to elimination;
    - Assisting with the use of devices for aid to daily living, such as a wheelchair;
    - Assisting with prescribed range of motion exercises;
    - Assisting with prescribed ice cap or collar;
    - Doing simple urine tests for sugar, acetone, or albumin;
    - Measuring and preparing special diets; and
- Assisting with self-administration of medication.

A HHA may not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, or any other services that has not been included in the patient's plan of care.[21]

Personal Care Assistants

Personal care assistants (PCAs) work in either private or group homes.[22] They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.[23] (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living, they also help individuals go to work and remain

[16] *Supra* note 14.
[17] *Supra* note 10. If the only service the home health agency provides, is physical, speech, or occupational therapy, in additional to the home health aide or CNA services, the licensed therapist may provide supervision.
[18] Agency for Health Care Administration, *Home Health Aides,* available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml (last visited January 20, 2020).
[19] Rules 59A-8.0095(5)
[20] Id., and 64B9-15.002, F.A.C.
[21] Rule 59A-8.0095(5)(p), F.A.C.
[22] *Supra* note 10.
[23] Id.

engaged in their communities.[24] A growing number of these workers are employed and supervised directly by consumers.

There are no minimum training requirements for PCAs, and there is no agency that directly regulates them. PCAs may be employed by or provide services through a home health agency or homemaker/companion agency, although some PCAs work independently and are directly supervised by the employing family or individual.

A PCA does not have a clearly defined scope of practice because it is not a regulated profession. However, the Florida Medicaid program defines personal care services as medically necessary assistance with activities of daily living to enable an individual to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.[25] Florida Medicaid authorizes the following personal care services:[26]

- Bathing or assistance with bathing;
- Assistance with dressing, including application of prosthetic devices or therapeutic stockings;
- Grooming and skin care;
- Positioning;
- Transfers;
- Toileting and maintaining continence;
- Assistance with eating; and
- Non-skilled medical task delegated by a registered nurse, and may include assisting with pre-measured medications, monitoring vital signs, and measuring intake and output.

Medication Administration and Assistance with Self-Administration

Medication Administration

Medication administration means to obtain and provide a single dose of a medication to a patient for his or her consumption.[27] Currently, neither CNAs nor HHAs may administer medication to a patient. However, Florida law authorizes unlicensed direct care personnel who complete a 6-hour training course to administer medication under the developmental disabilities program.[28] Many other states authorize HHAs or CNAs who complete additional training to administer medication.[29] For example, Texas authorizes home health medication aides.[30] Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.[31] Connecticut has a stand-alone medication administration technician profession.[32]

Assistance with Self-Administration

Some patients are capable of administering their own medication, but need assistance to ensure that they are taking the correct medication, at the proper dosage, and at the correct time. Under current law, HHAs may assist with self-administration after completion of prescribed training.

HHAs must complete two hours of training to assist with self-administration of medication.[33] The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common

[24] Id.
[25] Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.
[26] Id.
[27] Section 465.003, F.S.
[28] Section 393.506, F.S.
[29] Some states specifically certify or license medication aides.
[30] *See* TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.
[31] *See* ARIZ. REV. STAT. §32-1650, GA. CODE. ANN. 31-7-12.2, 225 ILL. COMP. STAT. 65 (pilot program), MINN. R. 4658.1360, N.C. GEN. STAT. § 131E-114.2, respectively.
[32] *See* CONN. GEN. STAT. §17a-210-1, et. seq.
[33] *Supra* note 19.

medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.[34] This 2-hour training may be included in the initial 75-hour or 40-hour HHA training.

Assistance with self-administration of medication includes:[35]

- Taking the medication, in its properly labeled container, from where it is stored to the patient;
- In the presence of the patient, reading the label, opening the container, removing a prescribed amount of medication from the container, and closing the container;
- Placing an oral dose in the patient's hand or placing the dosage in another container and helping the patient by lifting the container to his or her mouth;
- Applying topical medications;
- Returning the medication container to proper storage; and
- Keeping a record of when a patient receives assistance.

A HHA with the authority to assist with self-administration of medication may not:[36]

- Mix, compound, convert, or calculate medication doses;
- Prepare syringes for injection or the administration of medications by any injectable route;
- Administer medications through intermittent positive pressure breathing machines or a nebulizer;
- Administer medications by way of a tube inserted in a cavity of the body;
- Administer parenteral preparations;
- Irrigate or use debriding agents to treat a skin condition;
- Prepare rectal, urethral, or vaginal medications.
- Administer medications ordered by the physician or health care professional with prescriptive authority to be given "as needed," unless the order is written with specific parameters that preclude independent judgment on the part of the HHA, and at the request of a competent patient;
- Administer medications for which the time of administration, the amount, the strength of dosage, the method of administration, or the reason for administration requires judgment or discretion on the part of the unlicensed person.

CNAs who are not working for a home health agency may not assist with medication administration.

Direct Care Workforce Challenges

The federal Bureau of Labor Statistics estimate that home health aides and personal care assistants are in the top five occupations with the fastest job growth in the U.S. economy.[37] The demand for home health aides and nursing assistants is expected to increase by 34 percent by 2025.[38] However, the turnover rate in long term care is estimated to be between 45 to 66 percent.[39]

[34] Id.
[35] Section 400.488(3), F.S.
[36] Section 400.488(4), F.S.
[37] U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*, (March 2018), available at https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltts-direct-care-worker-report.pdf (last visited January 14, 2020).
[38] Id.
[39] Kezia Scales, PhD, *Staffing in Long-Term Care is a National Crisis*, (June 8, 2018), available at https://phinational.org/recruitment-retention-long-term-care-national-perspective/ (last visited January 14, 2020).

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.[40] Direct care workers also often have substantial family caregiving obligations, which adds to the stress of the job and contribute to the days missed from work.[41]

High turnover rates have a negative impact on both employers and patients. Turnover may have a negative impact on patient care and employers must incur costs for continuous recruitment and training of new employees.[42] Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.[43] Employers must pay costs related to filling vacancies and training new employees. It is estimated that turnover costs direct care employers approximately $4.1 billion per year.[44] Turnover can cause a break in continuity of care and a reduction in the quality of care, which may ultimately affect the patient's quality of life.[45]

Approximately two-thirds of HHAs and PCAs work part time.[46] This may be due to personal needs; however, many home care workers receive several assignments to work in a day the total of which does not amount to a full work day. For example, a HHA may be scheduled to see two separate clients for three hours each, but due to the time to travel between patients, the HHA is unable to achieve a full 8-hour work day. Many direct workers also face other obstacles to remaining in their jobs, including challenges with transportation, family commitments, or health care.[47] Some states or regions have launched matching service registries to make it easier for workers to find clients and build schedules to suit individual needs and commitments.[48]

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.[49] Many direct care workers chose the career because they wanted to help people, and this motivation also plays a role in retaining workers in direct care.[50] However, many direct care workers leave the career field for other entry-level jobs in the food and hospitality industry that pay similarly, are less mentally and physically strenuous, and provide opportunities for advancement.[51] In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.[52]

Direct care workers are also at an increased risk of work-related injuries.[53] Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.[54] By contrast, the injury rate across all occupations is 100 per 10,000 workers.[55]

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[40] *Supra* note 1, at pp. 27-37.
[41] U.S. Department of Health and Human Services, *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs – Certified Nursing Assistants and Home Health Aides*, (March 2011), available at https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf (last visited January 20, 2020).
[42] Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, *Retooling for an Aging America: Building the Health Care Workforce*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf (last visited January 14, 2020).
[43] Dorie Seavey, Better Jobs Better Care, *The Cost of Frontline Turnover in Long-Term Care*, (Oct. 2004), available at https://phinational.org/wp-content/uploads/legacy/clearinghouse/TOCostReport.pdf (last visited January 25, 2020).
[44] *Supra* note 42.
[45] Id.
[46] Paraprofessional Healthcare Institute, *U.S. Home Care Workers: Key Facts*, available at https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf (last visited January 14, 2020).
[47] Paraprofessional Healthcare Institute, *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, available at https://phinational.org/wp-content/uploads/2018/05/RRGuide-PHI-2018.pdf (last visited January 20, 2020).
[48] Allison Cook, Paraprofessional Healthcare Institute, *Issue Brief: Localized Strategies For Addressing the Workforce Crisis in Home Care*, (Oct. 2019), available at https://phinational.org/wp-content/uploads/2019/11/Localized-Strategies-2019-PHI.pdf (last visited January 20, 2020).
[49] *Supra* note 41.
[50] *Supra* note 41, at p. 48.
[51] *Supra* note 42.
[52] Id.
[53] *Supra* note 41.
[54] Stephen Campbell, Paraprofessional Healthcare Institute, *Issue Brief: Workplace Injuries and the Direct Care Workforce*, (April 2018), available at https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf (last visited January 20, 2020).
[55] Id.

In order to meet the future demand for direct care worker, employers will need to consider options such as offering better compensation, full-time hours, better training and advancement opportunities, and improved working conditions.[56]

Direct Care Workforce Data

In 2009, the federal Centers for Medicare and Medicaid Services (CMS) issued a report acknowledging that there was a lack of ongoing, reliable state-based information about the direct care workforce.[57] This lack of information has hampered the ability to develop policy to ensure that a stable and quality direct care workforce is available to meet the increasing demand for long term care services.[58]

CMS proposed that states collect a minimum data set of information on direct care workers, including the:

- Number umber of direct care workers (full time and part time);
- Stability of the direct care workforce (turnover and vacancies); and
- Average compensation of workers (wages and benefits).

Collecting this minimum data on the direct care workforce enables states to, among other things:[59]

- Create a baseline against which the progress of workforce initiatives can be measured;
- Inform policy formulation regarding workforce initiatives;
- Help identify and set long-term priorities for long-term care reform and system changes; and
- Promote integrated planning and coordinated approaches for long-term care and comparability of data across programs to assist in the assessment and evaluation of adopted policy initiatives.

This information will also enable states to determine the most useful deployment of state resources, anticipate increased demand for services, and assess trends in workforce turnover and related costs.[60]

In addition to direct care workers who are employed by entities, like home health agencies and nursing home facilities, there is a growing "gray market" comprised of independent providers. These independent providers are directly employed by the individuals to whom they provide care[61] and some may be employed by individuals through government-funded programs, such as Medicaid.[62] However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

Regulation of Long Term Care Providers

The Division of Health Quality Assurance (HQA) within AHCA licenses, certifies, and regulates 40 different types of health care providers. Regulated providers include, among others, these providers of long-term care services:

- Nursing home facilities under part II of ch. 400, F.S.
- Assisted living facilities under part I of ch. 429, F.S.
- Home health agencies under part III of ch. 400, F.S.
- Companion or homemaker services providers under part III of ch. 400, F.S.
- Nurse registries under part III of ch. 400, F.S.
- Hospices under part IV of ch. 400, F.S.

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[56] *Supra* note 46, at p. 8.
[57] Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, *The Need for Monitoring Long-Term Direct Service Workforce and Recommendations for Data Collection*, (Feb. 2009), available at https://www.medicaid.gov/sites/default/files/2019-12/monitoring-dsw.pdf (last visited January 8, 2020).
[58] Id.
[59] Id at p. 8.
[60] Id.
[61] *Supra* note 1 at 18.
[62] For example, see *supra* note 25.

In addition to provider-specific requirements listed in the authorizing statutes for each provider type listed above, the Health Care Licensing Procedures Act (Act), in part II of ch. 408, F.S., establishes uniform licensing procedures and statutes for 29 provider types regulated by HQA. The Act authorizes HQA to inspect facilities, verify compliance with licensure requirements, identify deficiencies or violations, and impose fines and penalties for noncompliance.

Nursing Home Staffing

Section 400.23(3), F.S., establishes minimum staffing requirements for nursing home facilities:

- A minimum weekly[63] average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants and licensed nursing staff.
- A minimum of 2.5 hours of direct care per resident per day provided by certified nursing assistant staff. A facility may not staff at a ratio of less than one certified nursing assistant per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.

When computing the staffing ratio for certified nursing assistants, nursing home facilities are allowed to use uncertified nursing assistants under certain conditions to satisfy the staffing ratio requirements so long as their job duties only include nursing assistant-related duties.[64] If approved by AHCA, licensed nurses may also be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.[65] Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.[66]

Paid Feeding Assistants

Under federal regulations, nursing home facilities may employ trained feeding assistants to help residents who have no complicated feeding problems but need some assistance in eating or drinking.[67] Such feeding assistants must complete a state-approved training course, which must, at minimum, be eight hours and provide training on:[68]

- Feeding techniques;
- Assistance with feeding and hydration;
- Communication and interpersonal skills;
- Appropriate responses to resident behavior;
- Safety and emergency procedures, including the Heimlich maneuver;
- Infection control;
- Residents rights; and
- Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

Paid feeding assistants must work under the supervision of a registered nurse or licensed practical nurse. Facilities must maintain a record of all individuals that have successfully complete the training course and it uses as paid feeding assistants. Currently, paid feeding assistants are not allowed in Florida as there are no state-approved training courses. AHCA

[63] A week is defined as Sunday through Saturday.
[64] Sections 400.23(3)(a)2. and 400.211(2), F.S. Nursing facilities may employ uncertified nursing assistants for up to 4 months if they are enrolled in, or have completed, a state-approving nursing assistant program, have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state, or have preliminarily passed the state's certification exam.
[65] Section 400.23(3)(a)4., F.S., and r. 59A-4.108(7), F.A.C. The hours of a licensed nurse with dual job responsibilities may not be counted twice.
[66] Sections 400.23(3)(b), F.S.
[67] 42 C.F.R. s. 483.60(h). Complicated feeding problems include, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.
[68] 42 C.F.R. s. 483.160.

Background Screening

Certain licensees, including CNAs, and certain individuals who provide services to vulnerable populations[69] must pass a background screening to be approved for certification or employment. Chapter 435, F.S., outlines the screening requirements.

Every person required by law to be screened pursuant to ch. 435, F.S., must submit a complete set of information necessary to conduct a screening to his or her employer.[70] A level 1 screening includes, at a minimum, employment history checks and statewide criminal correspondence checks through the Florida Department of Law Enforcement (FDLE) and a check of the Dru Sjodin National Sex Offender Public Website,[71] and may include criminal records checks through local law enforcement agencies. A level 2 background screening includes, but, is not limited to, fingerprinting for statewide criminal history records checks through FDLE and national criminal history checks through the Federal Bureau of Investigation (FBI), and may include local criminal records checks through local law enforcement agencies.[72]

For both level 1 and 2 screenings, the employer must submit the information necessary for screening to FDLE within five working days after receiving it.[73] The FDLE notifies the employer or agency whether a screening has revealed any disqualifying information.[74]

The Care Provider Background Screening Clearinghouse (Clearinghouse), housed within AHCA, warehouses criminal history checks of individuals who have direct contact with vulnerable persons and are required to be screened by AHCA, Department of Health, Department of Children and Families, Agency for Persons with Disabilities, Division of Vocational Rehabilitation, Department of Elder Affairs, Department of Juvenile Justice, and local child care licensing agencies.[75] The Clearinghouse allows the background screening results to be shared among these agencies, so that the employee or licensee does not have to undergo multiple background screenings when changing employers.[76] Employers register with the Clearinghouse and maintain the employment status of its employees listed in the Clearinghouse by timely reporting changes in employment.[77]

Health Care Workforce

Health Care Professional Shortage

The U.S. has a current health care provider shortage.[78] As of December 31, 2019, the U.S. Department of Health and Human Services has designated 7,655 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,392 additional primary care physicians to eliminate the shortage), 6,520 Dental HPSAs (requiring 10,258 additional dentists to eliminate the shortage), and 6,117 Mental Health HPSAs (requiring 6,335 additional psychiatrists to eliminate the shortage).[79]

[69] "Vulnerable person" means a minor or a person over the age of 18 whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, developmental disability or dysfunction, or brain damage, or the infirmities of aging.
[70] Section 435.05(1)(a), F.S.
[71] The Dru Sjodin National Sex Offender Public Website is a U.S. government website that links public state, territorial, and tribal sex offender registries in one national search site. The website is available at https://www.nsopw.gov/ (last visited January 20, 2020).
[72] Section 435.04, F.S.
[73] Section 435.05(1)(b)-(c), F.S.
[74] Section 435.05(1)(c), F.S.
[75] Section 435.12, F.S.
[76] Section 435.12(1), F.S.
[77] Section 435.12(20, F.S.
[78] U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), available at https://data.hrsa.gov/topics/health-workforce/shortage-areas (last visited February 20, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.
[79] Id.

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population[80] and ongoing efforts to expand access.[81] Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.[82] Additionally, as more individuals qualify for health care benefits, there will necessarily be greater demand for more health care professionals to provide these services.

Florida is not immune to this national problem and also has a health care provider shortage itself. Florida has 735 HPSAs just for primary care, dental care, and mental health.[83] It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.[84]

Health Care Workforce Data

Physician Workforce

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 46,900 and 121,900 across all specialties by 2032.[85] In 2018, there were 277.8 physicians[86] actively practicing per 100,000 population in the U.S., ranging from a high of 449.5 in Massachusetts to a low of 191.3 in Mississippi.[87] The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states. Regarding primary care physicians, there were 92.5 per 100,000 population.[88]

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.[89] Although Florida is the third most populous state in the nation,[90] it ranks as having the 23rd highest physician to population ratio.[91] In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population, ranking Florida 31st compared to other states.[92]

In its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.[93] Additionally, 35 percent of practicing physicians are age 60 and older.[94]

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[80] There will be an increase in the U.S. population, estimated to grow from just over 323 million in 2016 to approximately 355 million in 2030, eventually reaching just under 405 million in 2060. *See* U.S. Census Bureau, *2017 National Populations Projections Tables* available at https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html (last visited February 20, 2020). Click on "Table 1. Projected population size and births, deaths, and migration."

[81] Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, (April 2019), available at https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf (last visited February 20, 2020).

[82] Id.

[83] *Supra* note 78.

[84] Id.

[85] *Supra* note 81.

[86] These totals include allopathic and osteopathic physicians.

[87] Association of American Medical Colleges, *2019 State Physician Workforce Data Book,* November 2019, pg. 5, available at https://store.aamc.org/2019-state-physician-workforce-data-report.html (last visited on February 21, 2020). The book must be downloaded to view its contents.

[88] Id.

[89] *Supra* note 87, at pp. 7-8

[90] As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020).

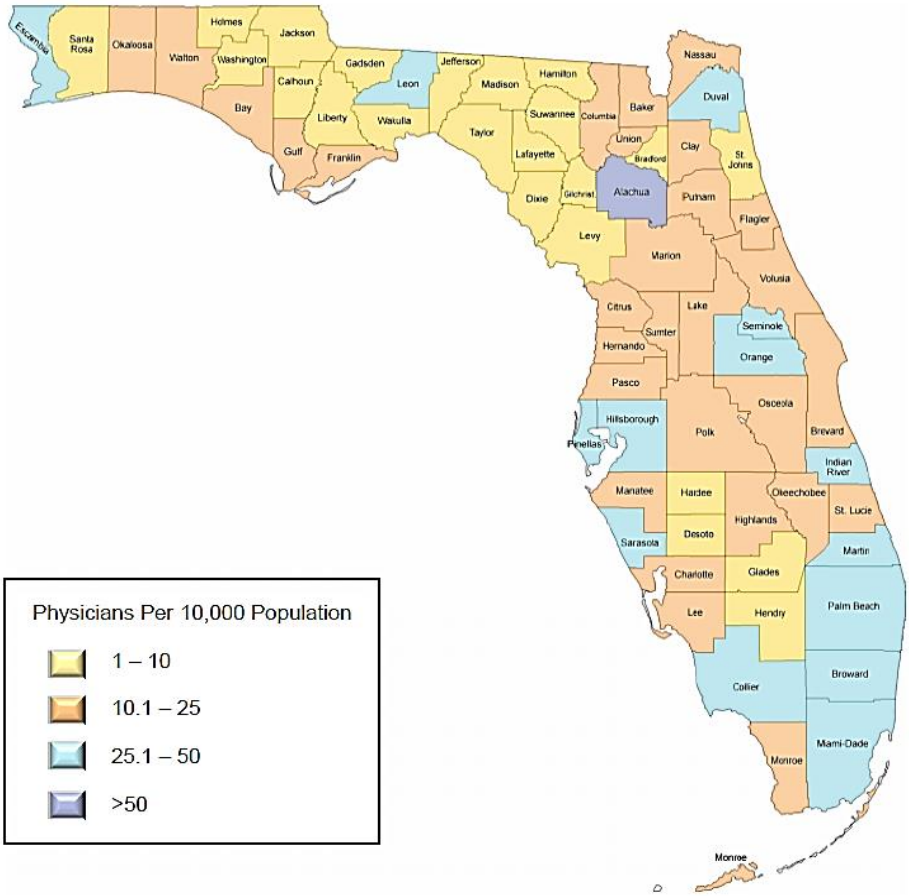
[91] *Supra* note 87, at pp. 7-8.

[92] *Supra* note 87, at pp. 12-13.

[93] Florida Department of Health, "2019 Physician Workforce Annual Report," (Nov. 2019), available at: http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2019DOHPhysicianWorkforceReport-10-30-19.pdf (last visited on February 21, 2020).

[94] Id. at p. 9.

The following map illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.[95]

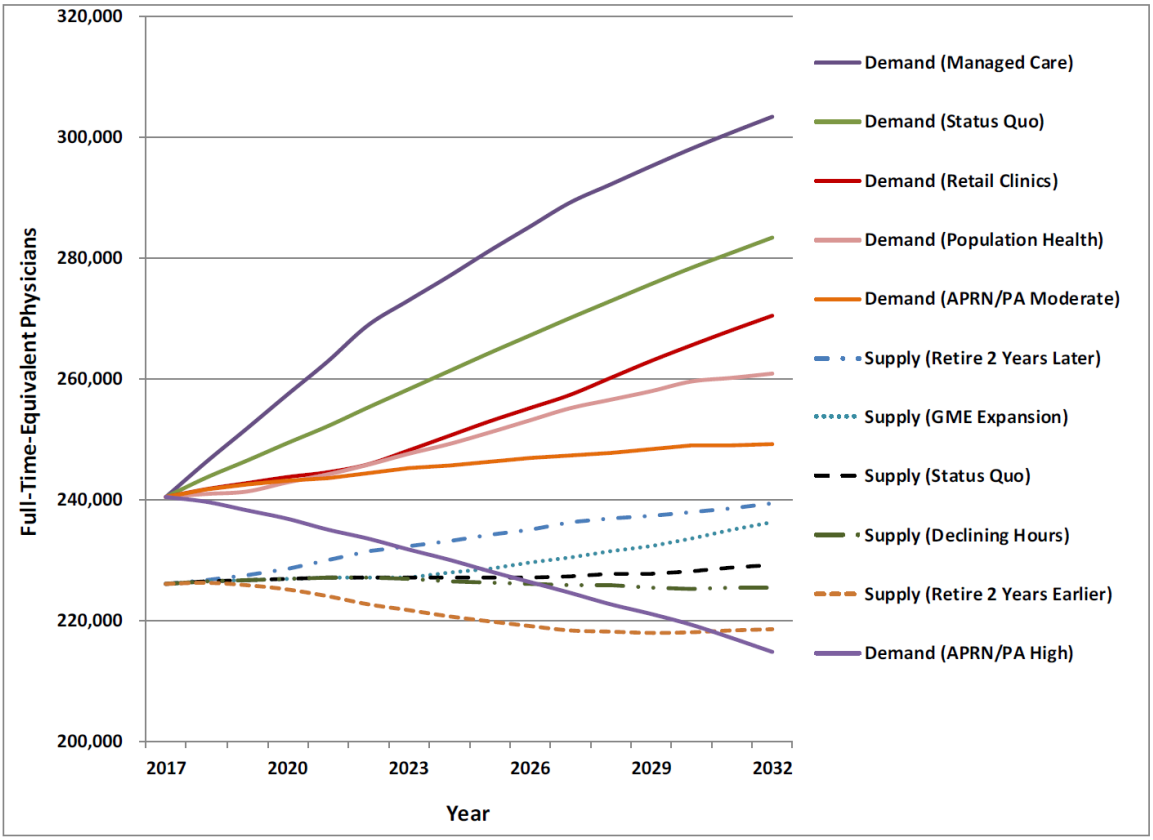


The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.[96] Currently, primary care physicians make up 28 percent of the physician workforce.[97] In 2018, 26 percent of new medical school graduates entered the workforce as primary care providers, and this rate will maintain the status quo of the supply of primary care physicians.[98] However, in almost any scenario, the projected supply and demand for primary care physicians demonstrate that demand will exceed supply except the scenario that reflects the highest use of APRNs and PAs.[99]

The table below compares the effects of a moderate increase in the use of APRNs and PAs, greater use of alternate settings such as retail clinics, delayed physician retirement, expansion in graduate medical education, and changes in payment and delivery system, on the supply and demand for primary care physicians.[100]

[95] Id. at p. 42.
[96] *Supra* note 81. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.
[97] Id. at p. 45.
[98] Id. at p. 46.
[99] Id at p. 18.
[100] Id.

Exhibit 3: Projected Supply and Demand for Primary Care Physicians, 2017-2032



In Florida, more than a third of the practicing physicians are primary care physicians (34.9 percent).[101] Of these, 14.2 percent of family medicine physicians and 11.0 percent of general internal medicine physicians have expressed an intention to retire in the next five years and approximately 4.5 percent and 4.4 percent, respectively, have expressed an intention to relocate out of the state in the next five years.[102]

Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNPs), 45,000 certified registered nurse anesthetists (CRNAs), 6,500 certified nurse midwives (CNMs), and 3,059,800 registered nurses (RNs) employed in the U.S.[103] There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.[104]

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.[105] There are also 309,761 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 156 APRNs and 1,469 RNs.[106] The Florida Center for Nursing Center) estimates that in 2016 and 2017, the number of APRNs

[101] *Supra* note 93 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.
[102] Id at p. 25.
[103] U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," *available at*: http://data.bls.gov/projections/occupationProj (last visited on February 21, 2020).
[104] These ratios were calculated using the U.S. Census Bureau's total population estimate for 2018, which was 327,167,434, which is available at: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.
[105] Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan, Fiscal Year 2018-2019*, available at http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/annual-report-1819.pdf (last visited February 21, 2020).
[106] These ratios were calculated using population estimates as of April 1, 2019 provided by the Florida Office of Economic & Demographic Research, which is 21,091,609, and available at: http://edr.state.fl.us/Content/population-demographics/data/2019_Pop_Estimates.pdf (last visited February 21, 2020).

who are actually working is 22,795,[107] and the number of RNs who are actually working is 208,870.[108] Using these numbers the figures are: 108 APRNs and 990 RNs per 100,000 population.

The Center also reports that approximately 45 percent of Florida's RNs[109] and 39 percent of the state's APRNs[110] are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.[111]

Physician Assistant Workforce

In Florida, there are approximately 9,784 actively licensed physician assistants (PAs),[112] which means there are approximately 46 PAs per 100,000 Florida population. Approximately 21 percent of certified PAs in Florida are practicing in primary care, which includes family medicine, general internal medicine, and general pediatrics.[113] On average, a full-time PA sees 83 patients a week.[114]

Advanced Practice Nurses

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)[115] is licensed in one of four roles: a certified nurse practitioner (CNP), certified nurse midwife (CNM), clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA).[116] As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.[117]

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The Board of Nursing (Board), established under s. 464.004, F.S., provides by rule the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices. Additionally, the Board is responsible for administratively disciplining an APRN who commits an act prohibited under ss. 464.018 or 456.072, F.S.

Section 464.003(2), F.S., defines the term "advanced or specialized nursing practice" to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[118] In addition to

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[107] Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Advanced Registered Nurse Practitioners*, (June 2018), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1611&PortalId=0&TabId=151 (last visited on February 21, 2020).
[108] Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Registered Nurses*, (June 2018), available at https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1608&PortalId=0&TabId=151 (last visited on February 21, 2020).
[109] *Supra* note 108. Of working RNs in this state, 25.4 percent are 51 to 60 years old and 20.1 percent are 61 or older.
[110] *Supra* note 107. Of working APRNs in this state, 22.6 percent are 51 to 60 years old and 16.7 percent are 61 or older.
[111] Florida Center for Nursing, Presentation on Florida's Nurse Workforce, January 23, 2019, available at https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting Packets&FileName=hgs 1-23-19.pdf (last visited on November 20, 2019).
[112] *Supra* note 105.
[113] National Commission on Certification of Physician Assistants, *2018 Statistical Profile of Certified Physician Assistants by State: An Annual Report of the National Commission on Certification of Physician Assistants*, (Jan. 2019), available at https://prodcmsstoragesa.blob.core.windows.net/uploads/files/2018StatisticalProfileofCertifiedPhysicianAssistants.pdf (last visited March 12, 2019). Please note that PAs must pass the initial certification examination to qualify for licensure in Florida; however, certification is not an ongoing requirement for licensure.
[114] Id at p. 47.
[115] Section 464.003(3), F.S.
[116] Section 464.012(4), F.S. In 2018, the Florida Legislature enacted a law which changed the occupational title from "Advanced Registered Nurse Practitioner (APRN)" to "Advanced Practice Registered Nurse (APRN)," and also reclassified a Clinical Nurse Specialist as a type of APRN instead of a stand-alone occupation (*see* ch. 2018-106, Laws of Fla.). DOH is still in the process of effectuating this transition.
[117] Email correspondence from DOH dated November 25, 2019, on file with committee staff.
[118] Section 464.012(3)-(4), F.S.

advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[119]

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master's degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.[120] A nursing specialty board must:[121]

- Attest to the competency of nurses in a clinical specialty area;
- Require a written examination prior to certification;
- Require nurses to complete a formal program prior to eligibility for examination;
- Maintain program accreditation or review mechanism that adheres to criteria which are substantially equivalent to requirements in Florida; and
- Identify standards or scope of practice statements appropriate for each nursing specialty.

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal. The APRN must have professional liability coverage of at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the amount of at least $100,000 per claim with a minimum aggregate availability of at least $300,000 and which is payable to the APRN as beneficiary.[122] By comparison, physicians must establish some method of financial responsibility with the same coverage amounts and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement but must notify patients that they have chosen not to carry malpractice insurance.[123]

Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, HB 423 eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.[124]

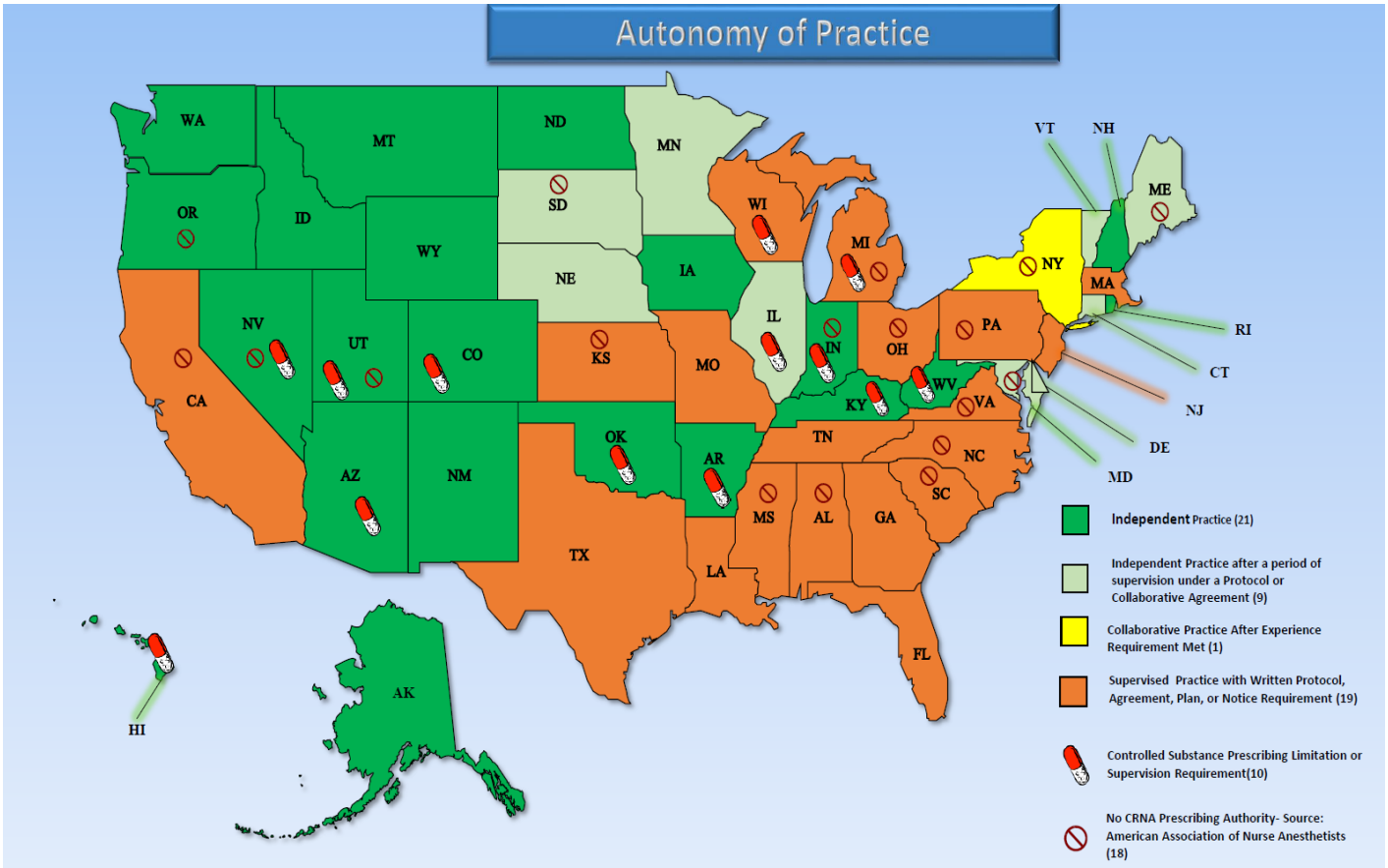
APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:[125]

1. Independent nursing practice;
2. Transitory period in which an APRN is supervised by a physician or independent APRN prior to authority to engage in independent nursing practice;
3. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or

[119] Section 464.003, F.S., and s. 464.012, F.S.
[120] Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.
[121] Rule 64B9-4.002(3), F.A.C.
[122] Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09, "Financial Responsibility," is incorporated into the rule by reference. Certain licensees, such as those who practice exclusively for federal or state governments, only practice in conjunction with a teaching position, or can demonstrate no malpractice exposure in this state are exempt from the financial responsibility requirements.
[123] If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.
[124] Chapter 2016-224, Laws of Fla.
[125] Findings based on research conducted by professional staff of the Health and Human Services Committee.

4. Supervised nursing practice or prescribing that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.



APRN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which permits APRN full practice authority.[126] Under the rule, an APRN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APRN is subject to state law with regard to the prescribing or administration of controlled substances. The rule is limited to CNPs, CNMs, and CNSs, and does not apply to CRNAs. In Florida, 59 VA medical centers and health care clinics are affected by this policy change.[127]

APRN Autonomy in Florida

Florida is a supervisory state. Under s. 464.012(3), F.S., APRNs may perform only those nursing and medical practices delineated in a written physician protocol. A physician providing primary health care services may supervise APRNs in up to four medical offices,[128] in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices

[126] U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Grants Full Practice Authority to Advanced Practice Registered Nurses," (December 14, 2016), available at https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847 (last visited February 21, 2020). The final rule can be found at https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf (last visited on February 21, 2020).
[127] U.S. Department of Veterans Affairs, Veterans Health Administration, "Locations: Florida," available at: http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1 (last visited February 21, 2020).
[128] The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.

in addition to the physician's primary practice location may be supervised.[129] Furthermore, a special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.[130]

APRN Scope of Practice

State laws vary as to the scope within which an APRN may practice, which is often determined by whether the APRN is a CNP, CNM, CNS, or CRNA, and often relates to the authority to prescribe drugs and sign documents.

Twenty of the 30 independent practice states authorize an APRN to prescribe controlled substances to a patient without physician supervision. Several independent practice states, such as Arkansas, Kentucky, Michigan, Oklahoma, and Wisconsin, require APRNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.[131] In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017. [132] The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,[133] as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.[134] The map on p. 7 illustrates the varying controlled substance prescribing requirements throughout the U.S.

Thirty-nine states, including Florida, recognize APRNs as "primary care providers" in policy.[135] Recognizing APRNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.[136] Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

APRN Scope of Practice in Florida

Within the framework of the written protocol, an APRN may:

- Prescribe, dispense, administer, or order any drug;[137];
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and
- Perform certain acts within his or her specialty.[138]

[129] Sections 458.348, and 459.025, F.S.
[130] *Id*.
[131] *Supra* note 125. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.
[132] Chapter 2016-224, Laws of Fla.
[133] Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.
[134] *Supra* note 125.
[135] Scope of Practice Policy, *Nurse Practitioners: Nurse Practitioner as Primary Care Provider*, available at http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/ (last visited February 21, 2020). APRNs may practice as a primary care provider in states that do not specifically recognize them as such.
[136] Tine Hansen-Turton, BA, MGA, et. al., "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," POLICY, POLITICS & NURSING PRACTICE, *7*:3 (Aug. 2006), pp. 216-226.
[137] Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.
[138] Sections 464.012(3),(4), and 464.003, F.S.

APRNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APRNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.[139]

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APRNs provide a different quality of care than physicians,[140] a multitude of reports and studies suggest treatment by an APRN is just as safe as treatment by a physician. In 2018, the Cochrane Collaboration updated a review of the findings of 25 articles comparing physician and APRN patient outcomes, which was first published in 2009. The review found that, in general, compared to primary care physicians, APRNS:[141]

- Probably provide equal or possibly even better quality of care compared to primary care physicians;
- Probably achieve equal or better health outcomes for patients;
- Probably achieve higher levels of patient satisfaction;
- Had longer consultation lengths and higher return visits; and
- Had comparable resource utilization outcomes.

The study was unable to ascertain the effects of nurse-led care on the costs of care.

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.[142]

A recently published study of medically complex patients within the VA health care system found that patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.[143] This same study found that patients of APRNs and PAs also sought care at in an emergency department of a hospital less frequently than patients of physicians. A 2013 study, found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.[144]

[139] Sections 394.463(2) and 382.008, F.S.
[140] When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D.,"Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. ENGL. J. MED. 2013, 368:1898-1906, available at http://www.nejm.org/doi/full/10.1056/NEJMsa1212938 (last visited on February 21, 2020).
[141] Laurant, M., et al., The Cochrane Collaboration, "Nurses as Substitute for Doctors in Primary Care," July 16, 2018, available at https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001271.pub3/full (last visited on February 21, 2020).
[142] National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available *at* http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf (last visited on February 21, 2020).
[143] Perri A. Morgan, et. al. "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," HEALTH AFFAIRS, 38:6 (2019), available at https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00014 (last visited February 21, 2020).
[144] Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, available at http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf (last visited on February 21, 2020).

Cost Savings

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.[145]

A 2012 Texas analysis of APRN practice concluded that more efficient use of APRNs in the provision of patient care, especially primary care, would improve patient outcomes, reduce overall health care costs, and increase access to health care.[146] The report estimated savings of $16.1 billion in total expenditures and $8 billion in output (gross product) each year.[147] Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to $483.9 million to the state and $233.2 million to local government entities each year.[148]

Another study found that states that allow APRNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use.[149] The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).[150]

Finally, a study found that individuals treated by primary care APRNs who were dually-eligible for Medicaid and Medicare had a lower risk of preventable hospitalizations and emergency department use than those cared for by primary care physicians.[151] The study also found that primary care APRNs treating those with chronic illnesses received the same health care services consistent with established guidelines as those treated by primary care physicians.[152]

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.[153] The FTC finds scope of practice restrictions anti-competitive, reduce competitive market pressures, increase out-of-pocket prices, limit service hours, and reduce the distribution of services.[154] The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.[155]

Physician Assistants

PAs are regulated by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine for PAs licensed under ch. 459, F.S.

Council on Physician Assistants

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[145] The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at https://cdn.ymaws.com/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Ultilization%20Economic%20Impact%20Report%20May%202012.pdf (last visited on February 21, 2020).
[146] Id.
[147] Id.
[148] Id.
[149] *Supra* note 144.
[150] Id.
[151] Peter Buerhaus, American Enterprise Institute, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, (Sept. 2018), available at https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/ (last visited February 21, 2020).
[152] Id.
[153] Federal Trade Commission, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, (Mar. 2014), available at https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf (last visited February).
[154] Id.
[155] Id.

The Council consists of five members including three physicians who are members of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and one licensed PA appointed by the Surgeon General.[156] Two of the physicians must be physicians who supervise physician assistants in their practice. The Council is responsible for:[157]

- Making recommendations to DOH regarding the licensure of PAs;
- Developing rules for the regulation of PAs for consideration for adoption by the boards;
- Making recommendations to the boards regarding all matters relating to PAs;
- Addressing concerns and problems of practicing PAs to ensure patient safety; and
- Denying, restricting, or placing conditions on the license of PA who fails to meet the licensing requirements.

Licensure and Regulation of PAs

An applicant for a PA license must apply to DOH, and DOH must issue a license to a person certified by the Council as having met all of the following requirements:[158]

- Completed an approved PA training program;
- Obtained a passing score on the National Commission on Certification of Physician Assistants exam;
- Acknowledged any prior felony convictions;
- Submitted to a background screening and have no disqualifying offenses;[159]
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course description from a PA training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the National Commission on Certification of Physician Assistants.[160] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially and must take a re-certification examination every 10 years.[161]

PA Education

PA education programs are typically three years and award master's degrees.[162] Many programs require students to have health care experience as a condition for admission.[163] PA students receive classroom training in:[164]

- Anatomy;
- Physiology;
- Biochemistry;
- Pharmacology;
- Physical diagnosis;
- Pathophysiology;

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[156] Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307 and 459.004, F.S., respectively.
[157] Id,
[158] Sections 458.347(7) and 459.022(7), F.S.
[159] Section 456.0135, F.S.
[160] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[161] National Commission on Certification of Physician Assistants, *Maintaining Certification*, available at https://www.nccpa.net/CertificationProcess (last visited February 21, 2020).
[162] American Academy of PAs, *Become a PA*, available at https://www.aapa.org/career-central/become-a-pa/ (last visited February 21, 2020).
[163] Id.
[164] Id.

- Microbiology;
- Clinical laboratory science;
- Behavioral science; and
- Medical Ethics.

A PA student must also complete approximately 2,000 hours of clinical rotations, with an emphasis on primary care in ambulatory clinics, physician offices, and acute or long-term care facilities.[165] A PA student's rotation could also include family medicine, internal medicine, obstetrics and gynecology, pediatrics, general surgery, emergency medicine, or psychiatry.[166]

PA Scope of Practice

PAs may only practice under the direct or indirect supervision of an allopathic or osteopathic physician with whom they have a clinical relationship.[167] A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice.[168] The supervising physician is responsible and liable for any acts or omissions of the PA and may not supervise more than four PAs at any time.[169]

The Boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate, is dependent upon the:

- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;
- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[170]

A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient.[171] A supervising physician may delegate the authority for a PA to:

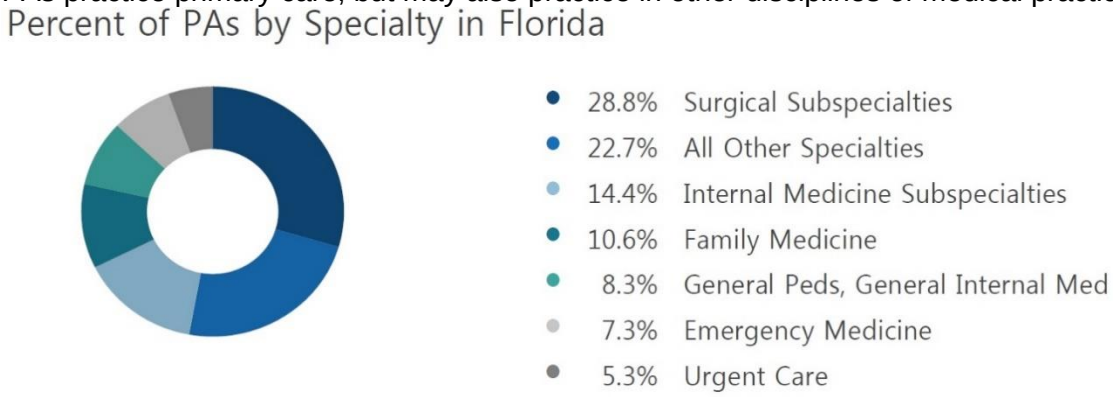
- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the formulary established by the Council;[172]
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under chapter 395, F.S., or a nursing homes licensed under part II of chapter 400, F.S.;[173] and

[165] Id.
[166] Id.
[167] Sections 458.347(2)(f) and 459.022(2)(f), F.S., define supervision as responsible supervision and control which requires the easy availability or physical presence of the licensed physician for consultation and direction of the PA.
[168] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[169] Sections 458.347(15) and 459.022(15), F.S.
[170] Rules 64B8-30.001, F.A.C., and 64B15-6.001, F.A.C.
[171] "Direct supervision" refers to the physical presence of the supervising physician so that the physician is immediately available to the PA when needed. "Indirect supervision" refers to the reasonable physical proximity of the supervising physician to the PA or availability by telecommunication. *Supra* note 170.
[172] Sections 458.347(4)(f), F.S., and 459.022(e), F.S., directs the Council to establish a formulary listing the medical drugs that a PA may not prescribe. The formulary in Rules 64B8-30.008, F.A.C., and 64B15-6.0038, F.A.C., prohibits PAs from prescribing; general, spinal or epidural anesthetics; radiographic contrast materials; and psychiatric mental health controlled substances for children younger than 18 years of age. It also restricts the prescribing of Schedule II controlled substances to a 7-day supply. However, the rules authorize physicians to delegate to PAs the authority to order controlled substances in hospitals and other facilities licensed under ch. 395, F.S.
[173] Chapter 395, F.S., provides for the regulation and the licensure of hospitals and trauma centers, part II of ch. 400, F.S., provides for the regulation and licensure of nursing home facilities.

- Perform any other service that are is not expressly prohibited in ch. 458, F.S., ch. 459, F.S., or the rules adopted thereunder.[174]

PA Practice Characteristics

In the United States, approximately 26 percent of PAs work in primary care, which includes family medicine, general internal medicine, and general pediatrics.[175] Approximately 19 percent of Florida-licensed PAs practice primary care, but may also practice in other disciplines of medical practice:[176]



PA Adverse Incident Reporting

A PA must report to DOH, any adverse incident occurring in an office practice setting within 15 days after the occurrence of the adverse incident.[177] DOH must review each report to determine if discipline against the PA's license is warranted.[178]

An adverse incident in an office setting is defined as an event over which the PA could exercise control and which is associated with a medical intervention and results in one of the following patient injuries:[179]

- The death of a patient;
- Brain or spinal damage to a patient;
- The performance of a surgical procedure on the wrong patient;
- If the procedure results in death; brain or spinal damage; permanent disfigurement; the fracture or dislocation of bones or joints; a limitation of neurological, physical, or sensory functions; or any condition that required the transfer of a patient, the performance of:
    - A wrong-site surgical procedure;
    - A wrong surgical procedure; or
    - A surgical repair of damage to a patient resulting from a planned surgical procedure where the damage is not a recognized specific risk as disclosed to the patient and documented through the informed consent process;
- A procedure to remove unplanned foreign objects remaining from a surgical procedure; or
- Any condition that required the transfer of a patient to a hospital from an ambulatory surgical center or any facility or any office maintained by a physician for the practice of medicine which is not licensed under ch. 395, F.S.

Reports and Studies Related to Physician Assistants

[174] Sections 458.347(4) and 459.022(e), F.S.
[175] *Supra* note 113.
[176] American Academy of PAs, *Florida Practice Profile*, available at https://www.aapa.org/wp-content/uploads/2016/12/PAs_In_Florida.pdf (last visited March 14, 2019).
[177] Sections 458.351 and 459.026, F.S.
[178] Sections 458.351(5) and 459.026(5), F.S.
[179] Sections 458.351(4) and 459.026(4), F.S.

Several studies have shown that PAs provide care that is comparable to physicians. One study examined more than 23,000 patient visits to more than 1,100 practitioners to determine the quality of care provided by APRNs, PAs, and physicians.[180] The study found that there was no statistically significant differences in the care provided by APRNs and PAs and that provided by primary care physicians.[181] Additionally, the study noted that PAs provided more health education services than primary care physicians.[182]

Another study assessed the care PAs, APRNs, and primary care physicians provided to diabetic patients within the VA health care system. This study suggests that there are similar chronic illness outcomes for physicians, APRNs, and PAs.[183]

Finally, a study assessed the care received by medically complex patients within the VA health care system and found that the patients of primary care APRNs and PAs incurred less outpatient, pharmacy, and total expenditures than patients of physicians.[184]

Effect of Proposed Changes

Direct Care Workers

Nurse Delegation in Home Health Agencies

CS/CS/HB 7053 authorizes a registered nurse to delegate any task, including medication administration, to a home health aide (HHA)[185] who do not work in a nursing home facility, as long as the registered nurse determines that the HHA is competent to perform the tasks, the task is delegable under federal law, and the task:

- Is within the nurse's scope of practice;
- Frequently recurs in the routine care of a patient or group of patients;
- Is performed according to an established sequence of steps;
- Involved little or no modification from one patient to another;
- May be performed with a predictable outcome;
- Does not inherently involve ongoing assessment, interpretation, or clinical judgement; and
- Does not endanger a patient's life or well-being.

Medication Administration

Currently, HHAs can only assist a patient with medication but not actually provide it to the patient. The bill authorizes a registered nurse to delegate administration of oral, transdermal, ophthalmic, otic, rectal, inhaled, enteral, or topical prescription medications to a HHA. Once delegated the authority, the HHA can provide a dose of a prescribed or over-the-counter medication to a patient in the manner indicated by the prescribing health care practitioner. A nurse may delegate medication administration to the HHA if the HHA:

- Has completed a 6-hour training course approved by the Board of Nursing or AHCA, respectively; and
- Has been found competent to administer medication to a patient in a safe and sanitary manner.

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[180] Kurtzman, Ellen T. PhD, MPH, RN, FAAN and Barnow, Burt S. PhD., "A Comparison of Nurse Practitioners, Physician Assistants, and Primary Care Physicians' Patterns of Practice and Quality of Care in Health Centers," 55 MEDICAL CARE 6: 615 (June 2017), *abstract* available at https://journals.lww.com/lww-medicalcare/Abstract/2017/06000/A_Comparison_of_Nurse_Practitioners,_Physician.11.aspx (last visited February 21, 2020).
[181] Id.
[182] Id.
[183] Jackson, G., et. al., "Intermediate Diabetes Outcomes in Patients Managed by Physicians, Nurse Practitioners, or Physician Assistants: A Cohort Study," ANNALS OF INTERNAL MEDICINE 169:825–835 (Nov. 2018), *abstract*, available at https://annals.org/aim/article-abstract/2716077/intermediate-diabetes-outcomes-patients-managed-physicians-nurse-practitioners-physician-assistants (last visited February 21, 2020).
[184] *Supra* note 143.
[185] Home health aide includes those CNAs who work in positions that work as home health aides or equivalent positions.

A registered nurse or physician must conduct the training and determine whether the HHA can competently administer medication, and annually validate such competency. A HHA who has qualified to administer medications must annually complete 2 hours of inservice training in medication administration and medication error prevention. This inservice training is in addition to the training that HHAs must currently complete. The bill places an affirmative duty on a nursing facility or home health agency to ensure that HHAs performing medication administration meet these requirements.

The bill requires the Board of Nursing and AHCA to adopt rules, in consultation with each other, on the standards and procedures that a HHA must follow for medication administration. Such rules must address qualifications for trainers, medication label requirements, documentation and recordkeeping, storage and disposal of medication, instructions for safe medication administration, informed consent, training curriculum, and validation procedures.

The bill specifically prohibits a registered nurse from delegating the administration of medications listed as Schedule II, Schedule III, or Schedule IV controlled substances. However, a HHA may administer Schedule V controlled substances.

The bill authorizes the Board of Nursing to adopt rules, in consultation with AHCA, on delegation of duties. The bill also creates a grounds for discipline against a registered nurse's license if the nurse delegates responsibilities to an individual that the nurse knows or has reason to know that such individual is not qualified to perform.

This authority will align Florida with other states that allow CNAs or HHAs to administer medication.

Direct Care Workforce Survey

Beginning January 1, 2021, the bill requires each licensed nursing home facility, assisted living facility, home health agency, nurse registry, or companion or homemaker services provider to complete a survey on the direct care workforce at each license renewal. AHCA must adopt a survey form by rule, which requests the following information of each licensee:

- Number of registered nurses, licensed practical nurses, and direct care workers employed or contracted by the licensee;
- Turnover and vacancy rates of registered nurses, licensed practical nurses, and direct care workers and contributing factors, as applicable;
- Average wage for registered nurses, licensed practical nurses, and each category of direct care worker for employees and contractors of the licensee;
- Employment benefits for registered nurses, licensed practical nurses, and direct care workers and average cost to the employer and employee or contractor; and
- Type and availability of training for registered nurses, licensed practical nurses, and direct care workers.

The bill authorizes AHCA to establish a schedule for the survey in rule but prohibits AHCA from issuing a license renewal until the licensee submits a completed survey. The administrator or designee must complete the survey and attest to the accuracy of the information provided, to the best of his or her knowledge.

AHCA must review and analyze the data received at least monthly and publish the results of the analysis on its website. The analysis should address:

- The number of direct care workers in the state, both full-time and part-time;
- Turnover rate and causes of turnover;
- Vacancy rate;
- Average hourly wage;
- Benefits offered; and
- Availability of post-employment training.

Direct Care Worker Registry

The bill directs AHCA to create and maintain a voluntary registry of home care workers,[186] accessible by the general public. A link to the registry must be available on the home page of its website. The registry must include:

- The full name, date of birth, social security number,[187] and a full face, passport-type color photograph of the home care worker;
- Preferred contact information for the home care worker or contact information for the employing home care services provider;[188]
- Name of the state-approved training program the home care worker completed and the date on which the training was completed;
- The number of years the home care worker has provided home health care services for compensation;
- Any disciplinary action taken or pending against a certification by the Department of Health, if the home care worker is a CNA; and
- Whether the home care worker provides services to special populations.

The bill authorizes AHCA to automatically populate work history information based on information in its records. The bill also authorizes AHCA to enter into an agreement with the Department of Health to obtain disciplinary history. A home care worker must meet the same background screening requirements to be included in the registry if the home care worker is not a CNA or currently employed by a home health agency.

The bill requires AHCA to post a disclaimer on each page of the home care worker registry website in bold, 14-point font stating that AHCA does not guarantee the accuracy of the information entered by a third party and does not endorse any individual listed in the registry.

Excellence in Home Health Award Program

The bill creates a gold seal program to designate home health agencies and nurse registries that meet certain criteria. The home health agency or nurse registry must have been actively licensed and operating for at least 24 months and have had no licensure denials revocations, or serious deficiencies during the preceding 24 months to be considered for the award

AHCA must adopt rules establishing standards for the award, including those relating to:

- Patient satisfaction;
- Patients requiring emergency care for wound infections;
- Patients admitted or re-admitted to an acute care hospital;
- Patient improvement in the activities of daily living;
- Employee satisfaction, if applicable;
- Quality of employee training, if applicable;
- Employee retention rates, if applicable; and
- High performance under federal Medicaid electronic visit verification requirements, if applicable.

The standards relating to employees will not apply to nurse registries since nurse registries do not directly employ the health care personnel who provide the health care services to patients. Medicaid electronic visit verification applies only to those entities that provide Medicaid-funded personal care

[186] The bill defines "home care worker" as a certified nursing assistant certified under Part II of ch. 464, F.S., or a home health aide as defined in s. 400.462, F.S., which is a person who is trained or qualified, as provided by rule, and who provides hands-on personal care, performs simple procedures as an extension of therapy or nursing services, assists in ambulation exercises, or assists in administering medication as permitted in rule and for which the person has received training established by AHCA.
[187] The bill expressly prohibits AHCA from displaying the social security number on its website.
[188] The bill defines "home care services provider" as a home health agency or nurse registry.

services or home health services.[189] Therefore, the standard will not apply to a home health agency or a nurse registry that does not provide such Medicaid-funded services.

The bill authorizes an award recipient to use the designation in advertising and marketing. However, a home health agency or nurse registry may not use the designation if the entity:

- Has not been awarded the designation;
- Fails to review the award upon expiration of an award designation;
- Has undergone a change in ownership;
- Has been notified that it no longer meets the criteria for the award upon re-application after expiration of the award designation.

The award designation is not transferrable. The award designation or denial is not subject to chapter 120, F.S.

Self-Administration of Medication

The bill authorizes a CNA or HHA to provide assistance with preventative skin care and applying and replacing bandages for minor cuts and abrasions. The bill also authorizes a CNA or HHA to assist with nebulizer treatments to include:

- Assisting with devices set up and cleaning in the presence of the patient;
- Confirming that the medication is intended for the patient;
- Orally advising the patient of the medication name and purpose;
- Removing the prescribed amount for a single treatment from a properly labeled container; and
- Assisting the patient with placing the dose into the medicine receptacle or mouthpiece.

The bill requires a CNA or HHA assisting with self-administration to confirm that the medication is intended for the patient taking the medication. The CNA or HHA must also verbally advise the resident of the name and the purpose of the medication.

Paid Feeding Assistants

The bill authorizes nursing home facilities to use paid feeding assistants who successfully complete a 12-hour training course that meets federal nursing home regulations and is approved by AHCA. The bill prohibits paid feeding assistants from counting towards minimum staffing requirements.

Regulation of APRNs and PAs

General APRN Provisions

The bill requires APRNs to apply to the Board for licensure, rather than DOH, to reflect current practice. Currently, applicants for licensure as APRNs submit documentation that they meet certification and financial responsibility requirements directly to the Board, rather than DOH. The bill also authorizes APRNs to sign, certify, stamp, verify, or endorse any document that requires the signature, certification, stamp, verification, or endorsement of a physician.

General PA Provisions

The bill revises the composition of the Council so that it has a PA majority. Under the bill, the Council is composed of one physician who is a member of the Board of Medicine, one physician who is a member of the Board of Osteopathic Medicine, and three licensed PAs appointed by the Surgeon General. The physician members must supervise PAs in their practices.

[189] Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Section 12006 of the 21st Century Cures Act Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS) and Home Health Care Services*, available at

The bill requires the Board of Medicine or the Board of Osteopathic Medicine to approve PA training programs, without the programs first being recommended by the Council.

The bill removes a requirement that a PA notify a patient that he or she has the right to see a physician prior to prescribing or dispensing a prescription.

The bill expands the scope of practice for PAs to authorize them to:

- Certify a person for involuntary examination under the Baker Act;
- File death certificates and certify a cause of death; and
- Examine and provide a report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

Autonomous Practice for APRNs and PAs

Registration Requirements

The bill authorizes an APRN who meets certain eligibility criteria to register with the Board of Nursing to engage in autonomous practice and perform acts of advanced or specialized nursing practice without a supervisory protocol or supervision by a physician. The bill also authorizes a PA who meets certain eligibility to register with the Board of Medicine or the Board of Osteopathic Medicine to practice primary care as an autonomous PA without supervision by a physician.

To register to engage in autonomous practice, an APRN or PA must hold an active and unencumbered Florida license and must have:

- Completed, in any U.S. jurisdiction, at least 2,000 clinical instructional hours or clinical practice hours supervised by an actively licensed physician within the 5-year period immediately preceding the registration request;
- Not been subject to any disciplinary action during the five years immediately preceding the application;
- Completed a graduate level course in pharmacology; and
- Any other appropriate requirement adopted by rule by the respective boards.

The bill also requires APRNs and PAs (jointly referred to as practitioners) who practice autonomously to obtain and maintain liability coverage at least $100,000 per claim with a minimum annual aggregate of at least $300,000. However, this requirement does not apply to practitioners who:

- Practices exclusively as an officer, employee, or agent of the federal government or of the state or its agencies or subdivisions;
- Is not practicing in this state and whose license is inactive;
- Practices only in conjunction with teaching duties at an accredited school or its main teaching hospitals; and
- Not practicing in this state but holds an active license to practice. Such practitioners must notify DOH if they initiate or resume autonomous practice in this state.

The registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN or PA license. To maintain registration, an APRN must complete at least 10 hours of continuing education approved by the Board in pharmacology for each biennial renewal.[190] An autonomous PA does not have to complete any additional continuing medical education hours above the 100 hours required for PA licensure renewal.

[190] The bill provides an exception to the 10 hours of continuing education in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

The bill directs DOH to create practitioner profiles for autonomous PAs, which conspicuously informs the public of the autonomous PA's registration. The bill also requires that DOH conspicuously distinguishes the practitioner profiles of APRNs registered to engage in autonomous practice.

Scope of Practice

Pursuant to the bill, an APRN registered to engage in autonomous practice is authorized to perform any advanced or specialized nursing act currently authorized for an APRN, without the supervision of a physician or a written protocol. In addition to those acts, the registered APRN may autonomously and without supervision or a written protocol perform the following acts:

- Admit, discharge, or manage the care of a patient requiring the services of a health care facility, as authorized under federal law or rule.
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.
- Certify causes of death and sign, correct, and file death certificates.
- Act as a patient's primary care provider.
- Execute a certificate to subject a person to involuntary examination under the Baker Act.
- Examine, and approve the release of, a person admitted into a receiving facility under the Baker Act, if the APRN holds a national certification as a psychiatric-mental health advanced practice nurse.
- Perform certain physical examinations currently reserved to physicians and physician assistants by Florida law, such as examinations of pilots, law enforcement officers, and suspected child abuse victims.
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court.

The bill reestablishes the advisory committee that was abolished in 2016, to make evidence-based recommendations about medical acts an APRN who is practicing autonomously may perform. The 7-member joint committee is to be composed of four APRNs appointed by the Board of Nursing, two physicians recommended by the Board of Medicine, and the State Surgeon General or his or her designee. The bill requires the Board of Nursing to act on any recommendation of the committee within 90 days of submission. The Board may choose to adopt a recommendation, reject a recommendation, or otherwise act on it as the Board deems appropriate. Under current law, APRNs may only perform medical acts as authorized within the framework of a physician protocol. The advisory committee recommendations may provide autonomous APRNs the authority to perform certain medical acts that they are currently performing under protocols.

The bill authorizes an autonomous PA to:

- Only render primary care services as defined by the applicable board rule;
- Render services consistent with the scope of his or her education and experience and provided in accordance with rules adopted by the applicable board;
- Prescribe, dispense, administer, or order any medicinal drug to the extent authorized under a formulary adopted by the Council;
- Order any medication for administration to a patient in a facility licensed under ch. 395, F.S., or part II of ch. 400, F.S.;[191]
- Examine and report on a ward's medical and mental health conditions in the annual guardianship plan submitted to the court; and
- Provide a signature, certification, stamp, verification, affidavit, or other endorsement that is otherwise required by law to be provided by a physician.

The bill requires the Council to develop rules defining the primary specialties in which an autonomous PA may practice. Such specialties may include internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology.

[191] This includes ambulatory surgical centers, hospitals, and nursing homes.

The bill also authorizes autonomous PAs to participate in the Public School Volunteer Health Care Practitioner Program. This program allows any participating health care practitioner who agrees to provide his or her services, without compensation, in a public school for at least 80 hours a year for each school year during the biennial licensure period to be eligible for waiver of the biennial license renewal fee for an active license and fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9), F.S.

The bill also requires autonomous PAs to comply with the Florida Patient's Bill of Rights and Responsibilities Act.

Accountability

The bill imposes safeguards to ensure APRNs registered to engage in autonomous practice do so safely, similar to those for physicians.[192] The bill defines an adverse incident as an event over which the APRN could exercise control and which is associated with a medical or nursing intervention, including the prescribing of controlled substances, rather than a condition for which such intervention occurred, which results in at least one of the following:

- A condition that requires the transfer to a hospital;
- Permanent physical injury to the patient; or
- Death of the patient.

If such an event occurs, the APRN must report the adverse incident to DOH, in writing, within 15 days of its occurrence or discovery of its occurrence, consistent with the requirements for doctors. DOH must review the adverse incident to determine if the APRN committed any act that would make the APRN subject to disciplinary action.

PAs are subject to the existing adverse incident requirements for physicians.

In addition, the bill requires several other accountability measures for APRNs registered to engage in autonomous practice. The bill authorizes the Board to administratively discipline and APRN for several delineated prohibited acts related to relationships with patients, business practices, and nursing practices:

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a slit-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;
- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Performing professional services that have not been authorized by the patient or his or her representative except as provided by the Medical Consent Law[193] and the Good Samaritan Act;[194]
- Performing any procedure or prescribing any medicinal drug that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;

[192] *See* ss. 458.351 and 459.026, F.S.
[193] Section 766.103, F.S.
[194] Section 768.13, F.S.

- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

PAs are subject to the same discipline as physicians as it relates to relationships with patients, business practices, and medical practices.

The bill provides an effective date of July 1, 2020.

B. SECTION DIRECTORY:

Section 1: Amends s. 400.141, F.S., relating to administration and management of nursing home facilities.
Section 2: Amends s. 400.23, F.S., relating to rules; evaluation and deficiencies; licensure status.
Section 3: Amends s. 400.462, F.S., relating to definitions.
Section 4: Amends s. 400.464, F.S., relating to home health agencies to be licensed; expiration of license; unlawful acts; penalties.
Section 5: Amends s. 400.488, F.S., relating to assistance with self-administration of medication.
Section 6: Creates s. 400.489, F.S., relating to administration of medication by a home health aide; staff training requirements.
Section 7: Creates s. 400.490, F.S., relating to nurse delegated tasks.
Section 8: Creates s. 400.52, F.S., relating to Excellence in Home Health program.
Section 9: Creates s. 408.064, F.S., relating to Home Care Services Registry.
Section 10: Creates s. 408.822, F.S., relating to direct care workforce survey.
Section 11: Creates s. 464.0156, F.S., relating to delegation of duties.
Section 12: Amends s. 464.018, F.S., relating to disciplinary actions.
Section 13: Creates s. 464.2035, F.S., relating to administration of medication.
Section 14: Amends s. 456.0391, F.S., relating to advanced practice registered nurses and autonomous physician assistants; information required for licensure or registration.
Section 15: Amends s. 456.041, F.S., relating to practitioner profile; creation.
Section 16: Amends s. 458.347, F.S., relating to physician assistants.
Section 17: Amends s. 459.022, F.S., relating to physician assistants.
Section 18: Amends s. 464.012, F.S., relating to licensure of advanced practice registered nurses; fees; controlled substance prescribing.
Section 19: Creates s. 464.0123, F.S., autonomous practice by an advanced practice registered nurse.
Section 20: Creates s. 464.0155, F.S., relating to reports of adverse incidents by advanced practice registered nurses.
Section 21: Amends s. 39.01, F.S., relating to definitions.
Section 22: Amends s. 39.303, F.S., relating to child protection teams and sexual abuse treatment programs; services; eligible cases.
Section 23: Amends s. 39.304, F.S., relating to photographs, medical examinations, X rays, and medical treatment of abused, abandoned, or neglected child.
Section 24: Amends s. 110.12315, F.S., relating to the prescription drug program.
Section 25: Amends s. 252.515, F.S., relating to the Postdisaster Relief Assistance Act; immunity from civil liability.
Section 26: Amends s. 310.071, F.S., relating to deputy pilot certification.
Section 27: Amends s. 310.073, F.S., relating to state pilot licensing.
Section 28: Amends s. 310.081, F.S., relating to department to examine and license state pilots and certificate deputy pilots; vacancies.
Section 29: Amends s. 320.0848, F.S., relating to persons who have disabilities; issuance of disabled parking permits; temporary permits; permits for certain providers of transportation services to persons who have disabilities.
Section 30: Amends s. 381.00315, F.S., relating to public health advisories; public health emergencies; isolation and quarantines.

Section 31: Amends s. 381.00593, F.S., relating to public school volunteer health care practitioner program.
Section 32: Amends s. 381.026, F.S., relating to Florida Patient's Bill of Rights and Responsibilities.
Section 33: Amends s. 382.008, F.S., relating to death, fetal death, and nonviable birth registration.
Section 34: Amends s. 382.011, F.S., relating to medical examiner determination of cause of death.
Section 35: Amends s. 383.14, F.S., relating to screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
Section 36: Amends s. 390.0111, F.S., relating to termination of pregnancies.
Section 37: Amends s. 390.012, F.S., relating to powers of agency; rules; and disposal of fetal remains.
Section 38: Amends s. 394.463, F.S., relating to involuntary examination.
Section 39: Amends s. 395.0191, F.S., relating to staff membership and clinical privileges.
Section 40: Amends s. 395.602, F.S., relating to rural hospitals.
Section 41: Amends s. 397.501, F.S., relating to rights of individuals.
Section 42: Amends s. 397.679, F.S., relating to emergency admission; circumstances justifying.
Section 43: Amends s. 397.6793, F.S., relating to professional's certificate for emergency admission.
Section 44: Amends s. 400.021, F.S., relating to definitions.
Section 45: Amends s. 400.172, F.S., relating to respite care provided in nursing home facilities.
Section 46: Amends s. 400.487, F.S., relating to Home health service agreements; physician's, physician assistant's, autonomous physician assistant's, and advanced practice registered nurse's treatment orders; patient assessment; establishment and review of plan of care; provision of services; orders not to resuscitate.
Section 47: Amends s. 400.506, F.S., relating to licensure of nurse registries; requirements; and penalties.
Section 48: Amends s. 400.9973, F.S., relating to client admission, transfer, and discharge.
Section 49: Amends s. 400.9974, F.S., relating to client comprehensive treatment plans; client services.
Section 50: Amends s. 400.9976, F.S., relating to administration of medication.
Section 51: Amends s. 400.9979, F.S., relating to restraint and seclusion; client safety.
Section 52: Amends s. 401.445, F.S., relating to emergency examination and treatment of incapacitated persons.
Section 53: Amends s. 409.906, F.S., relating to optional Medicaid services.
Section 54: Amends s. 409.908, F.S., relating to reimbursement of Medicaid providers.
Section 55: Amends s. 409.973, F.S., relating to benefits.
Section 56: Amends s. 429.26, F.S., relating to appropriateness of placements; and examinations of residents.
Section 57: Amends s. 429.918, F.S., relating to licensure designation as a specialized Alzheimer's services adult day care center.
Section 58: Amends s. 440.102, F.S., relating to drug-free workplace program requirements.
Section 59: Amends s. 456.053, F.S., relating to financial arrangements between referring health care providers and providers of health care services.
Section 60: Amends s. 456.072, F.S., relating to grounds for discipline; penalties; and enforcement.
Section 61: Amends s. 456.44, F.S., relating to controlled substance prescribing.
Section 62: Amends s. 458.3265, F.S., relating to pain-management clinics.
Section 63: Amends s. 458.331, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 64: Amends s. 459.0137, F.S., relating to pain-management clinics.
Section 65: Amends s. 459.015, F.S., relating to grounds for disciplinary action; action by the board and department.
Section 66: Amends s. 464.003, F.S., relating to definitions.
Section 67: Amends s. 464.0205, relating to retired volunteer nurse certificate.
Section 68: Amends s. 480.0475, F.S., relating to massage establishments and prohibited practices.
Section 69: Amends s. 493.6108, F.S., relating to investigation of applicants by Department of Agriculture and Consumer Services.
Section 70: Amends s. 626.9707, F.S., relating to disability insurance; discrimination on basis of sickle-cell trait prohibited.
Section 71: Amends s. 627.357, F.S., relating to medical malpractice self-insurance.

Section 72: Amends s. 627.736, F.S., relating to required personal injury protection benefits; exclusions; priority; and claims.
Section 73: Amends s. 633.412, F.S., relating to firefighters and qualifications for certification.
Section 74: Amends s. 641.495, F.S., relating to requirements for issuance and maintenance of certificate.
Section 75: Amends s. 744.2006, F.S., relating to Office of Public and Professional Guardians; appointment, notification.
Section 76: Amends s. 744.331, F.S., relating to procedures to determine incapacity.
Section 77: Amends s. 744.3675, F.S., relating to the annual guardianship plan.
Section 78: Amends s. 766.103, F.S., relating to Florida Medical Consent Law.
Section 79: Amends s. 766.105, F.S., relating to Florida Patient's Compensation Fund.
Section 80: Amends s. 766.1115, F.S., relating to health care providers; creation of agency relationship with governmental contractors.
Section 81: Amends s. 766.1116, F.S., relating to health care practitioner; waiver of license renewal fees and continuing education requirements.
Section 82: Amends s. 766.118, F.S., relating to determination of noneconomic damages.
Section 83: Amends s. 768.135, F.S., relating to volunteer team physicians; immunity.
Section 84: Amends s. 794.08, F.S., relating to female genital mutilation.
Section 85: Amends s. 893.02, F.S., relating to definitions.
Section 86: Amends s. 943.13, F.S., relating to officers' minimum qualifications for employment or appointment.
Section 87: Amends s. 945.603, F.S., relating to powers and duties of authority.
Section 88: Amends s. 948.03, F.S., relating to terms and conditions of probation.
Section 89: Amends s. 984.03, F.S., relating to definitions.
Section 90: Amends s. 985.03, F.S., relating to definitions.
Section 91: Amends s. 1002.20, F.S., relating to K-12 student and parent rights.
Section 92: Amends s. 1002.42, F.S., relating to private schools.
Section 93: Amends s. 1006.062, F.S., relating to administration of medication and provision of medical services by district school board personnel.
Section 94: Amends s. 1006.20, F.S., relating to athletics in public K-12 schools.
Section 95: Amends s. 1009.65, F.S., relating to Medical Education Reimbursement and Loan Repayment Program.
Section 96: Provides an appropriation.
Section 97: Provides an appropriation.
Section 98: Provides an effective date of July 1, 2020.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   HB 7017 authorizes an initial registration fee of $100 for APRNs who choose to practice autonomously, and a biennial renewal fee of $50 to maintain such registration. The total revenue DOH will receive from such fees is indeterminate because the number of APRNs who will choose to register to engage in autonomous practice is not predictable.

2. Expenditures:

   CS/CS/HB 7053 authorizes 4.0 full-time equivalent positions, with associated salary rate of 166,992, and appropriates the sums of $643,659 in recurring and $555,200 in nonrecurring funds from the Health Care Trust Fund to the Agency for Health Care Administration for the purpose of implementing the direct care worker registry, direct care workforce survey, and the Excellence in Home Health award program.

   The bill also authorizes 3.5 full-time equivalent positions, with association salary rate of183,895, and appropriates $219,089 in recurring funds, and $17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to DOH for the regulation of autonomous APRNs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Home health agencies and nursing facilities may incur costs associated with providing medication administration training to CNAs and HHAs.

Consumers will have access to a centralized database of home care workers and may reduce costs associated with researching and hiring such individuals. Home care workers may acquire work, or more consistent work, using the registry.

APRNs who register to practice independently must pay a registration fee, as well as a fee to renew their registration. HB 7017 authorizes the Board of Nursing to set the application and biennial renewal fees, up to $100 and $50, respectively. Such APRNs will also have to pay for the additional continuing education hours required by the bill.

APRNs and PAs who have paid physicians for supervision will achieve cost-savings if they register to practice autonomously since supervision will no longer be needed.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to affect county or municipal governments.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

AHCA has sufficient rule-making authority to implement the bill.

The Boards of Medicine, Osteopathic Medicine, and Nursing have sufficient rule-making authority implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On February 26, 2020, the Health and Human Services Committee adopted two amendments and reported the bill favorably as a committee substitute. The amendments:

- Authorized nurse registries to participate in the Excellence in Home Health award program.
- Revised the timeframe in which a physician assistant must acquire the supervised clinical hours to practice autonomously from 3 years to 5 years preceding the date of application.
- Clarified that the supervising physician may hold a license in any state, including Florida, rather than another state.

This analysis is drafted to the committee substitute as passed by the Health and Human Services Committee.