**The Florida Senate**

# COMMITTEE MEETING EXPANDED AGENDA

**HEALTH POLICY**
**Senator Bean, Chair**
**Senator Sobel, Vice Chair**

**MEETING DATE:** Thursday, February 21, 2013
**TIME:** 8:00 —10:30 a.m.
**PLACE:** *Pat Thomas Committee Room,* 412 Knott Building

**MEMBERS:** Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Brandes, Braynon, Flores, Galvano, Garcia, Grimsley, and Joyner

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 1 | **SB 60**<br>Hays<br>(Similar CS/H 529) | Public Records/Identifying Information of Department of Health Personnel; Providing an exemption from public records requirements for certain identifying information of specific current and former personnel of the Department of Health and the spouses and children of such personnel, under specified circumstances; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity, etc.<br><br>HP 02/21/2013 Fav/CS<br>GO<br>RC | Fav/CS<br>Yeas 9 Nays 0 |
| 2 | **SB 520**<br>Bradley<br>(Identical H 195) | Emergency Medical Services; Deleting a requirement that emergency medical technicians, paramedics, and 911 public safety telecommunicators complete an educational course on HIV and AIDS; revising requirements for the certification and recertification of emergency medical technicians and paramedics; revising requirements for institutions that conduct approved programs for the education of emergency medical technicians and paramedics, etc.<br><br>HP 02/21/2013 Favorable<br>CA<br>AP | Favorable<br>Yeas 9 Nays 0 |
| 3 | **SB 398**<br>Bean<br>(Identical H 625) | Physician Assistants; Authorizing a physician assistant to execute all practice-related activities delegated by a supervisory physician unless expressly prohibited, etc.<br><br>HP 02/21/2013 Fav/CS<br>BI<br>JU | Fav/CS<br>Yeas 9 Nays 0 |
| | Consideration of proposed committee bill: | | |
| 4 | **SPB 7014** | Health Flex Plans; Revising the expiration date to extend the availability of health flex plans to low-income uninsured state residents, etc. | Submitted as Committee Bill |

| TAB | BILL NO. and INTRODUCER | BILL DESCRIPTION and SENATE COMMITTEE ACTIONS | COMMITTEE ACTION |
|---|---|---|---|
| 5 | **SB 278**<br>Richter<br>(Compare CS/H 239) | Optometry; Revising references to ocular pharmaceutical agents; requiring certified optometrists to complete a course and examination on general and ocular pharmaceutical agents; requiring clinical laboratories to accept human specimens submitted by practitioners licensed to practice under provisions relating to optometry; prohibiting a certified optometrist from administering and prescribing certain controlled substances, etc.<br><br>HP 02/21/2013 Fav/CS<br>AHS<br>AP | Fav/CS<br>Yeas 6 Nays 3 |

Other Related Meeting Documents

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Health Policy Committee

| | |
|---|---|
| BILL: | CS/SB 60 |
| INTRODUCER: | Health Policy Committee and Senator Hays |
| SUBJECT: | Public Records |
| DATE: | February 21, 2013 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | McElheney | Stovall | HP | **Fav/CS** |
| 2. | | | GO | |
| 3. | | | RC | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## Please see Section VIII. for Additional Information:

| | | |
|---|---|---|
| A. COMMITTEE SUBSTITUTE..... | X | Statement of Substantial Changes |
| B. AMENDMENTS..... | | Technical amendments were recommended |
| | | Amendments were recommended |
| | | Significant amendments were recommended |

## I. Summary:

CS/SB 60 creates a public-records exemption for certain personal indentifying information of current or former personnel of the Department of Health (DOH) whose duties include the investigation or prosecution of complaints against health care practitioners or the inspection of practitioners or facilities licensed by the DOH. The CS also exempts certain personal identifying information related to spouses and children of those persons.

This bill substantially amends section 119.071 of the Florida Statutes.

## II. Present Situation:

### Florida's Public-Records Laws

Florida has a long history of providing public access to the records of governmental and other public entities. The Legislature enacted its first law affording access to public records in 1892.[1] In 1992, Florida voters approved an amendment to the State Constitution which raised the

[1] Section 1390, 1391 F.S. (Rev. 1892)

statutory right of access to public records to a constitutional level.[2] Section 24(a), Art. I, of the State Constitution, provides that:

> Every person has the right to inspect or copy any public records made or received in connection with the official business of any public body, officer, or employee of the state, or persons acting on their behalf, except with respect to records exempted pursuant to this section or specifically made confidential by this Constitution. This section specifically includes the legislative, executive, and judicial branches of government and each agency or department created thereunder; counties, municipalities, and districts; and each constitutional officer, board, and commission, or entity created pursuant to law or this Constitution.

The Public Records Law is contained in ch. 119, F.S., and specifies conditions under which the public must be given access to governmental records. Section 119.07(1)(a), F.S., provides that every person who has custody of a public record must permit the record to be inspected and examined by any person, at any reasonable time, under reasonable conditions, and under supervision by the custodian of the public record. Unless specifically exempted, all agency records are to be available for public inspection.

Section 119.011(12), F.S., defines the term "public record" to include all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of the physical form, characteristics or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency. The Florida Supreme Court has interpreted this definition to encompass all materials made or received by an agency in connection with official business which are "intended to perpetuate, communicate, or formalize knowledge."[3] All such materials, regardless of whether they are in final form, are open for public inspection unless made exempt.[4]

Only the Legislature is authorized to create exemptions to open government requirements.[5] Exemptions must be created by general law and such law must specifically state the public necessity justifying the exemption. Further, the exemption must be no broader than necessary to accomplish the stated purpose of the law.[6] A bill enacting an exemption[7] may not contain other substantive provisions although it may contain multiple exemptions relating to one subject.[8]

There is a difference between records that the Legislature has made exempt from public inspection and those that are *confidential* and exempt. If the Legislature makes a record confidential and exempt, such information may not be released by an agency to anyone other than to the persons or entitles designated in the statute.[9] If a record is simply made exempt from

[2] Article I, s. 24 of the State Constitution
[3] *Shevin v. Byron, Harless, Schaffer, Reid & Associates, Inc*, 379 So. 2d 633, 640 (Fla. 1980)
[4] Wait v. Florida Power & Light Company, 372 *So.2d 420 (Fla. 1979).*
[5] Article I, s. 24 (c), Fla. Constitution.
[6] Memorial Hospital-West Volusia v. News-Journal Corporation, *729 So. 2d 373, 380 (Fla. 1999)*; Halifax Hospital Medical Center v. News Journal Corporation *724 So.2d 567 (Fla. 1979)*
[7] Under s. 119.15, F.S. an existing exemption may be considered a new exemption if the exemption is expanded to cover additional records.
[8] Art. I, s.24 (c), Fla. Constitution.
[9] Attorney General Opinion 85-62

disclosure requirements then an agency is not prohibited from disclosing the record in all circumstances.[10]

**Open Government Sunset Review Act**

The Open Government Sunset Review Act (Act) [11] provides for the systematic review of an exemption from the Public Records Law in the fifth year after its enactment. The act states that an exemption may be created, revised, or maintained only if it serves an identifiable public purpose and if the exemption is no broader than necessary to meet the public purpose it serves. An identifiable public purpose is served if the exemption meets one of three specified criteria and if the Legislature finds that the purpose is sufficiently compelling to override the strong public policy of open government and cannot be accomplished without the exemption. An exemption meets the statutory criteria if it:

- Allows the state or its political subdivisions to effectively and efficiently administer a governmental program, which administration would be significantly impaired without the exemption;

- Protects information of a sensitive personal nature concerning individuals, the release of which would be defamatory or cause unwarranted damage to the good name or reputation of such individuals or would jeopardize the safety of such individuals; or

- Protects information of a confidential nature concerning entities, including, but not limited to, a formula, pattern, device, combination of devices, or compilation of information which is used to protect or further a business advantage over those who do not know or use it, the disclosure of which would injure the affected entity in the marketplace.[12]

The act also requires the Legislature to consider six questions that go to the scope, public purpose, and necessity of the exemption.

**Current Exemptions in Section 119.071(4)(d)(2), F.S, Pertaining to Agency Personnel**

Section 119.071(4)(d), F.S., currently provides public-records exemptions for specified personal identifying and locating information of the following current and former agency personnel, as well as for specified personal identifying and locating information of their spouses and children: law enforcement personnel; personnel within the Department of Children and Family Services who investigate criminal activities; the Department of Health personnel who support those investigations; the Department of Revenue or local government whose responsibilities include revenue collection and enforcement or child support enforcement; certified firefighters; justices and judges; local and statewide prosecuting attorneys; magistrates, administrative law judges, and child support hearing officers; local government agency and water management district human resources administrators; code enforcement officers; guardians ad litem; specified Department of Juvenile Justice personnel; public defenders; criminal conflict and civil regional

[10] *Williams v. City of Minneola*, 575 So.2d 683, 687 (Fla. 5th DCA), review denied, 589 So.2d289 (Fla. 1991).
[11] Section 119.15, F.S.
[12] Section 1119.15(4)(b), F.S.

counsel; investigators or inspectors of the Department of Business and Professional Regulation; and tax collectors.

**Department of Health Regulated Professions**

The DOH is established under s. 20.43, F.S. Section 20.43, F.S., creates several divisions under the DOH, including the Division of Medical Quality Assurance (MQA), which is responsible for the following boards and professions established within the division:

- The Board of Acupuncture, created under ch. 457, F.S.
- The Board of Medicine, created under ch. 458, F.S.
- The Board of Osteopathic Medicine, created under ch. 459, F.S.
- The Board of Chiropractic Medicine, created under ch. 460, F.S.
- The Board of Podiatric Medicine, created under ch. 461, F.S.
- The Board of Optometry, created under ch. 463, F.S.
- The Board of Nursing, created under part I of ch. 464, F.S.
- The Board of Pharmacy, created under ch. 465, F.S.
- The Board of Dentistry, created under ch. 466, F.S.
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.
- The Board of Massage Therapy, created under ch. 480, F.S.
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.
- The Board of Opticianry, created under part I of ch. 484, F.S.
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.
- The Board of Physical Therapy Practice, created under ch. 486, F.S.
- The Board of Psychology, created under ch. 490, F.S.
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.

In addition to the professions regulated by the various aforementioned boards, the MQA also regulates the following professions: emergency medical technicians and paramedics, as provided under ch. 401, F.S.; naturopathy, as provided under ch. 462, F.S.; nursing assistants, as provided under part II of ch. 464, F.S.; midwifery, as provided under ch. 467, F.S.; respiratory therapy, as provided under part V of ch. 468, F.S.; dietetics and nutrition practice, as provided under part X of ch. 468, F.S.; electrolysis, as provided under ch. 478, F.S.; medical physicists, as provided under part IV of ch. 483, F.S.; and school psychologists, as provided under ch. 490, F.S. All professions regulated by the MQA are subject to the general licensing provisions in s. 456.013, F.S.

The DOH also regulates and certifies radiological personnel under part IV of ch. 468, F.S. Certification provisions for radiological personnel are found in s. 468.304, F.S.

**Agency Personnel Information**

Department inspectors and investigators are required to investigate any complaint that is received in writing to determine if it is legally sufficient, to review whether it is signed by the complainant or, if not signed, to determine if it is believed to be true after an initial inquiry by the department. In addition, department inspectors and investigators are required to complete other routine inspections by the department. Department inspectors are also required to hand serve department orders, emergency actions, subpoenas and other legal documents.

Presently, DOH investigative staff and their spouse's and children's personal information are not exempt from public disclosure.

In recent years, DOH investigators have forged strong relationships with law enforcement. With the proliferation of pill mills and the controlled substance abuse epidemic in Florida, DOH investigators have had to be involved in more investigations that involve criminal elements. DOH investigators who inspect massage establishments are identifying and reporting to law enforcement potential criminal activities associated with unlicensed practice of health care professions and other practice violations that are set forth in law as criminal violations. As DOH investigators are exposed to more and more potentially dangerous criminal situations, the investigators and their supervisors have become concerned about the release of personal information that may be used by criminals, or individuals under investigation by DOH, to target investigative staff and their families. Under this bill, personal identifying information of approximately 240 DOH employees would be exempt.[13]

## III. Effect of Proposed Changes:

**Section 1** amends s. 119.071, F.S., to create a public records exemption for the home address, telephone numbers,[14] and photographs of current or former DOH personnel who investigate or prosecute complaints filed against health care practitioners or inspect practitioners or facilities licensed by the DOH. The same information plus place of employment of spouses and children of such personnel, and names and locations of schools and day care facilities attended by children of such personnel are also made exempt.

The bill requires legislative review under the Open Government Sunset Review Act. The exemptions will sunset on October 2, 2018, unless reenacted by the Legislature.

**Section 2** provides a statement of public necessity for the exemptions. The Legislature finds that release of the personal identifying and location information might place these persons in danger of physical and emotional harm from disgruntled individuals who have contentious reactions to actions carried out by personnel of the DOH, or whose business or professional practices have come under the scrutiny of investigators and inspectors of the DOH. The Legislature further finds that the harm in a release of the information outweighs any public benefit that may derive from the disclosure of the information.

[13] *See* Department of Health Bill Analysis for SB 60 (dated November 26, 2012)– on file with the Senate Health Policy Committee.

[14] Under s. 119.071(4)d.1., F.S., the term "telephone numbers" includes home telephone numbers, personal pager telephone numbers, and telephone numbers associated with personal communication devices.

This act shall take effect upon becoming a law.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

**Vote Requirement:**
Section 24(c), art. I of the State Constitution requires a two-thirds vote of each house of the Legislature for passage of a newly-created or expanded public-records or public-meetings exemption. Because this bill creates a new public-records exemption, it requires a two-thirds vote for passage.

**Subject Requirement:**
Section 24(c), art. I of the State Constitution requires the Legislature to create or expand public-records or public-meetings exemptions in legislation separate from substantive law changes. This bill complies with that requirement.

**Public Necessity Statement:**
Section 24(c), art. I of the State Constitution requires a public necessity statement for a newly-created or expanded public-records or public-meetings exemption. This bill complies with that requirement.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Additional Information:

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

**CS by Health Policy on February 21, 2013:**
The CS removes the reference for personnel whose duties *support* the healthcare professionals and facilities regulated by the DOH.

B. Amendments:

None.

135634

LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/25/2013 | . | |
| | . | |
| | . | |
| | . | |

The Committee on Health Policy (Brandes) recommended the following:

**Senate Amendment**

Delete line 183
and insert:
duties include the investigation or prosecution of
Delete line 217
and insert:
Health whose duties include the investigation or
Delete line 228
and insert:
include the investigation or prosecution of

**By** Senator Hays

11-00094-13 201360__

A bill to be entitled

An act relating to public records; amending s. 119.071, F.S.; providing an exemption from public records requirements for certain identifying information of specific current and former personnel of the Department of Health and the spouses and children of such personnel, under specified circumstances; providing for future legislative review and repeal of the exemption under the Open Government Sunset Review Act; providing a statement of public necessity; providing an effective date.

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

Section 1. Paragraph (d) of subsection (4) of section 119.071, Florida Statutes, is amended to read:

119.071 General exemptions from inspection or copying of public records.—

(4) AGENCY PERSONNEL INFORMATION.—

(d)1. For purposes of this paragraph, the term "telephone numbers" includes home telephone numbers, personal cellular telephone numbers, personal pager telephone numbers, and telephone numbers associated with personal communications devices.

2.a. The home addresses, telephone numbers, social security numbers, dates of birth, and photographs of active or former sworn or civilian law enforcement personnel, including correctional and correctional probation officers, personnel of the Department of Children and Families ~~Family Services~~ whose

duties include the investigation of abuse, neglect, exploitation, fraud, theft, or other criminal activities, personnel of the Department of Health whose duties are to support the investigation of child abuse or neglect, and personnel of the Department of Revenue or local governments whose responsibilities include revenue collection and enforcement or child support enforcement; the home addresses, telephone numbers, social security numbers, photographs, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1).

b. The home addresses, telephone numbers, dates of birth, and photographs of firefighters certified in compliance with s. 633.35; the home addresses, telephone numbers, photographs, dates of birth, and places of employment of the spouses and children of such firefighters; and the names and locations of schools and day care facilities attended by the children of such firefighters are exempt from s. 119.07(1).

c. The home addresses, dates of birth, and telephone numbers of current or former justices of the Supreme Court, district court of appeal judges, circuit court judges, and county court judges; the home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of current or former justices and judges; and the names and locations of schools and day care facilities attended by the children of current or former justices and judges are exempt from s. 119.07(1).

d. The home addresses, telephone numbers, social security

numbers, dates of birth, and photographs of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors; the home addresses, telephone numbers, social security numbers, photographs, dates of birth, and places of employment of the spouses and children of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors; and the names and locations of schools and day care facilities attended by the children of current or former state attorneys, assistant state attorneys, statewide prosecutors, or assistant statewide prosecutors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

e. The home addresses, dates of birth, and telephone numbers of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division of Administrative Hearings, and child support enforcement hearing officers; the home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division of Administrative Hearings, and child support enforcement hearing officers; and the names and locations of schools and day care facilities attended by the children of general magistrates, special magistrates, judges of compensation claims, administrative law judges of the Division of Administrative Hearings, and child support enforcement hearing officers are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if the general magistrate, special magistrate, judge of compensation claims, administrative law judge of the

Division of Administrative Hearings, or child support hearing officer provides a written statement that the general magistrate, special magistrate, judge of compensation claims, administrative law judge of the Division of Administrative Hearings, or child support hearing officer has made reasonable efforts to protect such information from being accessible through other means available to the public.

f. The home addresses, telephone numbers, dates of birth, and photographs of current or former human resource, labor relations, or employee relations directors, assistant directors, managers, or assistant managers of any local government agency or water management district whose duties include hiring and firing employees, labor contract negotiation, administration, or other personnel-related duties; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

g. The home addresses, telephone numbers, dates of birth, and photographs of current or former code enforcement officers; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

h. The home addresses, telephone numbers, places of employment, dates of birth, and photographs of current or former

guardians ad litem, as defined in s. 39.820; the names, home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such persons; and the names and locations of schools and day care facilities attended by the children of such persons are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution, if the guardian ad litem provides a written statement that the guardian ad litem has made reasonable efforts to protect such information from being accessible through other means available to the public.

i. The home addresses, telephone numbers, dates of birth, and photographs of current or former juvenile probation officers, juvenile probation supervisors, detention superintendents, assistant detention superintendents, juvenile justice detention officers I and II, juvenile justice detention officer supervisors, juvenile justice residential officers, juvenile justice residential officer supervisors I and II, juvenile justice counselors, juvenile justice counselor supervisors, human services counselor administrators, senior human services counselor administrators, rehabilitation therapists, and social services counselors of the Department of Juvenile Justice; the names, home addresses, telephone numbers, dates of birth, and places of employment of spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

j. The home addresses, telephone numbers, dates of birth, and photographs of current or former public defenders, assistant public defenders, criminal conflict and civil regional counsel,

and assistant criminal conflict and civil regional counsel; the home addresses, telephone numbers, dates of birth, and places of employment of the spouses and children of such defenders or counsel; and the names and locations of schools and day care facilities attended by the children of such defenders or counsel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

k. The home addresses, telephone numbers, and photographs of current or former investigators or inspectors of the Department of Business and Professional Regulation; the names, home addresses, telephone numbers, and places of employment of the spouses and children of such current or former investigators and inspectors; and the names and locations of schools and day care facilities attended by the children of such current or former investigators and inspectors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if the investigator or inspector has made reasonable efforts to protect such information from being accessible through other means available to the public. This sub-subparagraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2017, unless reviewed and saved from repeal through reenactment by the Legislature.

l. The home addresses and telephone numbers of county tax collectors; the names, home addresses, telephone numbers, and places of employment of the spouses and children of such tax collectors; and the names and locations of schools and day care facilities attended by the children of such tax collectors are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if the county tax collector has made reasonable

efforts to protect such information from being accessible through other means available to the public. This sub-subparagraph is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2017, unless reviewed and saved from repeal through reenactment by the Legislature.

m. The home addresses, telephone numbers, and photographs of current or former personnel of the Department of Health whose duties include or support the investigation and prosecution of complaints filed against health care practitioners or the inspection of practitioners or facilities licensed by the Department of Health; the names, home addresses, telephone numbers, and places of employment of the spouses and children of such personnel; and the names and locations of schools and day care facilities attended by the children of such personnel are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution if the personnel have made reasonable efforts to protect such information from being accessible through other means available to the public.

3. An agency that is the custodian of the information specified in subparagraph 2. and that is not the employer of the officer, employee, justice, judge, or other person specified in subparagraph 2. shall maintain the exempt status of that information only if the officer, employee, justice, judge, other person, or employing agency of the designated employee submits a written request for maintenance of the exemption to the custodial agency.

4. The exemptions in this paragraph apply to information held by an agency before, on, or after the effective date of the

exemption.

5.a. Sub-subparagraphs 2.a.-l. are ~~This paragraph is~~ subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2017, unless reviewed and saved from repeal through reenactment by the Legislature.

b. Sub-subparagraph 2.m. is subject to the Open Government Sunset Review Act in accordance with s. 119.15, and shall stand repealed on October 2, 2018, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. The Legislature finds that it is a public necessity that the home addresses, telephone numbers, and photographs of current or former personnel of the Department of Health whose duties include or support the investigation and prosecution of complaints filed against health care practitioners or the inspection of practitioners or facilities licensed by the Department of Health; that the names, home addresses, telephone numbers, and places of employment of the spouses and children of such personnel; and that the names and locations of schools and day care facilities attended by the children of such personnel be made exempt from public record requirements. The Legislature finds that the release of such identifying and location information might place current or former personnel of the Department of Health whose duties include or support the investigation and prosecution of complaints filed against health care practitioners or the inspection of practitioners or facilities licensed by the Department of Health and their family members in danger of physical and emotional harm from disgruntled individuals who

have contentious reactions to actions carried out by personnel of the Department of Health, or whose business or professional practices have come under the scrutiny of investigators and inspectors of the Department of Health. The Legislature further finds that the harm that may result from the release of such personal identifying and location information outweighs any public benefit that may be derived from the disclosure of the information.

Section 3. This act shall take effect upon becoming a law.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Committee on Health Policy

CC: Sandra Stovall, Staff Director
Elizabeth Wells, Administrative Assistant

**Subject:** Committee Agenda Request

**Date:** December 6, 2012

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I respectfully request that **Senate Bill #60**, relating to Public Records/Identifying Information of Department of Health Personnel, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Alan Hays
Florida Senate, District 11
320 Senate Office Building
(850) 487-5011

ENTERED

File signed original with committee office

S-020 (03/2004)

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

| | |
|---|---|
| BILL: | SB 520 |
| INTRODUCER: | Senator Bradley |
| SUBJECT: | Emergency Medical Services |
| DATE: | February 18, 2013 |
| REVISED: | |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Looke | Stovall | HP | **Favorable** |
| 2. | | | CA | |
| 3. | | | AP | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:


SB 520 amends various sections of law regarding the provision of emergency medical services (EMS) to:

- Remove emergency personnel certified under ch. 401, F.S., from the instruction requirements on human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS) contained in s 381.0034, F.S.
- Strike the requirement that any curricula for training emergency medical technicians (EMT) and paramedics include 4 hours of HIV/AIDS instruction.
- Tie the definitions of advanced life support and basic life support to the EMT – Paramedic National Standard and the EMT – Basic National Standard, respectively, as well as the National EMS Education Standards of the United States Department of Transportation (USDOT).
- Add those National EMS Education Standards approved by the Department of Health (DOH) to the allowed standards on which EMS trainers may base their curricula.
- Increase, from 1 year to 2 years, the period of time within which an EMT or a paramedic must pass their required certification exam after completing their training program.
- Increase, from 2 years to 5 years, the period of time within which the DOH must revise its comprehensive state plan for basic and advanced life support systems.

This bill substantially amends sections 381.0034, 401.23, 401.24, 401.27, and 401.2701, F.S.

## II. Present Situation:

### EMT and Paramedic Training and Examination

The EMT – Basic[1] and the EMT – Paramedic[2] National Standard Curricula, as well as the EMS Education Standards,[3] lay out national standards for training emergency personnel. These curricula were developed by the USDOT and are the educational standards that must be met before an EMT or paramedic can be nationally certified by the National Registry of Emergency Medical Technicians (NREMT).[4] By rule, the DOH requires all EMTs and paramedics to meet the training requirements of the 1994 EMT – Basic National Standard Curricula[5] and the 1998 EMT – Paramedic National Standard Curricula,[6] respectively. The USDOT updated those curricula most recently in 2010.[7]

The EMS Education Standards were completed in 2009 and define minimum entry level competencies for each level of EMS personnel. The Standards are meant to phase out the older National Standard Curricula and are less rigid in format than the National Standard Curricula. This less rigid format supports diverse implementation methods and more frequent content updates.[8]

Currently, Florida has reciprocity with the NREMT for the administration of the EMT certification exam and the DOH develops and administers the certification exam for paramedics.[9,10] Florida requires that EMTs and paramedics sit for their examination within 1 year of completing their training requirements. Nationally, EMTs and paramedics are allowed to sit for their exam within 2 years of completing their training.[11]

### HIV/AIDS Training

Persons listed in s. 381.0034(1), F.S., including those certified under ch. 401, F.S., (EMTs, paramedics, and 911 public safety telecommunicators) are required to complete training on the transmission, infection control procedures, clinical management, and prevention of HIV and AIDS. To comply with s. 381.0034, F.S. and s. 401.2701, F.S., requires that any public or private institution in Florida that conducts an approved program for the education of EMTs and paramedics must include in its curricula 4 hours of instruction on HIV/AIDS. According to the DOH, the these HIV/AIDS training requirements for EMTs and paramedics are duplicative

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[1] *Found at*: http://www.nhtsa.gov/people/injury/ems/pub/emtbnsc.pdf, last visited on Feb. 14, 2013.
[2] *Found at*: http://www.health.ny.gov/professionals/ems/original/intro/intro.pdf, last visited on Feb. 14, 2013.
[3] *Found at*: http://www.ems.gov/pdf/811077a.pdf, last visited on Feb. 14, 2013.
[4] Entry requirements for EMT – Basic found at: https://www.nremt.org/nremt/about/reg_basic_history.asp, last visited on Feb. 15, 2013.
[5] Rule 64J-1.008(1)(a)
[6] Rule 64J-1.009(1)(a)
[7] Department of Health Bill Analysis of SB 520, Jan. 31, 2013, *on file with the Senate Committee on Health Policy*.
[8] *Education*, National Highway Safety and Transportation Administration – Emergency Medical Services, *found at* http://www.ems.gov/EducationStandards.htm, last visited on Feb. 18, 2013.
[9] http://doh.state.fl.us/mqa/EMT-Paramedic/emt-lic-requirements.html#, last visited on Feb. 15, 2013.
[10] http://doh.state.fl.us/mqa/Exam/schedule-pmd.htm, last visited on Feb. 15, 2013.
[11] *Supra* 7.

because EMTs and paramedics are also required to complete separate training on blood borne pathogens which includes HIV/AIDS.[12]

**Florida's EMS Strategic Plan**

Section 401.24, F.S., requires that the DOH develop a comprehensive state plan[13] for basic and advanced life support services. This plan must be updated every 2 years and must include, at a minimum:

- Emergency medical systems planning, including the prehospital and hospital phases of patient care, injury control efforts, and the unification of such services into a total delivery system to include air, water, and land transport.
- Requirements for the operation, coordination and ongoing development of emergency medical services which include: basic life support or advanced life support vehicles, equipment, and supplies; communications; personnel; training; public education; state trauma system; injury control; and other medical care components; and
- The definition of areas of responsibility for regulating and planning the ongoing and developing delivery service requirements.

## III. Effect of Proposed Changes:

**Section 1** amends s. 381.0034, F.S., to remove persons certified under ch. 401, F.S., from those people who are required to complete a course on the modes of transmission, infection control procedures, clinical management, and prevention of HIV and AIDS.

**Section 2** amends s. 401.23, F.S., to modify the definitions of "advanced life support" and "basic life support" to:

- Include assessment by qualified persons as part of the definitions in order to update the law to current practice standards.
- Tie the techniques used for advanced life support to those listed in the EMT – Paramedic National Standard Curriculum and the National EMS Education Standards, pursuant to the DOH rules.
- Tie the techniques used for basic life support to the techniques listed in the EMT – Basic National Standard Curriculum and the National EMS Education Standards which are approved by the DOH.

**Section 3** amends s. 401.24, F.S., to increase the period of time within which the DOH must revise their EMS state plan from every 2 years to every 5 years.

**Section 4** amends s. 401.27, F.S., to require training programs for EMTs and paramedics (including those programs taken by EMTs and paramedics trained outside of the state who wish to become certified in Florida) be programs approved by the DOH which are equivalent to the

[12] Id.
[13] The state plan for 2012-2014 can be found at http://www.doh.state.fl.us/demo/ems/Stratplan/2012-2014EMS_StratPlanFinalCopy.pdf, last visited on Feb. 15, 2013

most recent EMT – Basic National Standard Curriculum (for EMTs), the most recent EMT – Paramedic National Standard Curriculum (for paramedics), or to the National EMS Education Standards (for both EMTs and paramedics). This section also increases, from 1 year to 2 years, the amount of time that EMTs and paramedics are allowed to pass their certification exam after completing their training.

**Section 5** amends s. 401.2701, F.S., to allow EMS training programs to use those EMS Education Standards approved by the DOH in developing their curricula and course examinations. This section also strikes the requirement for EMS training programs to include 4 hours of HIV/AIDS training in their courses.

**Section 6** provides an effective date of July 1, 2013.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 520 will likely have an indeterminate positive fiscal effect on EMTs, paramedics, and trainers by removing duplicative HIV/AIDS training provisions.

C. Government Sector Impact:

The DOH places the total government sector costs for implementation of this bill at $3,790, which will be used for the promulgation of new rules.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Additional Information:

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

None.

B. Amendments:

None.

**By** Senator Bradley

7-00941-13 2013520__

A bill to be entitled

An act relating to emergency medical services; amending s. 381.0034, F.S.; deleting a requirement that emergency medical technicians, paramedics, and 911 public safety telecommunicators complete an educational course on HIV and AIDS; amending s. 401.23, F.S.; redefining the terms "basic life support" and "advanced life support" for purposes of the Raymond H. Alexander, M.D., Emergency Medical Transportation Services Act; amending s. 401.24, F.S.; revising the period for review of the comprehensive state plan for emergency medical services and programs; amending s. 401.27, F.S.; revising requirements for the certification and recertification of emergency medical technicians and paramedics; revising requirements for the certification of emergency medical technicians and paramedics trained outside the state; revising the time limit by which applicants trained outside the state must complete the certification examination without having to submit a new application and meet all eligibility and fee requirements; amending s. 401.2701, F.S.; revising requirements for institutions that conduct approved programs for the education of emergency medical technicians and paramedics; revising requirements that students must meet in order to receive a certificate of completion from an approved program; providing an effective date.

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

Section 1. Subsection (1) of section 381.0034, Florida Statutes, is amended to read:

381.0034 Requirement for instruction on HIV and AIDS.—

(1) The Department of Health shall require each person licensed or certified under ~~chapter 401,~~ chapter 467, part IV of chapter 468, or chapter 483, as a condition of biennial relicensure, to complete an educational course approved by the department on the modes of transmission, infection control procedures, clinical management, and prevention of human immunodeficiency virus and acquired immune deficiency syndrome. Such course shall include information on current state ~~Florida~~ law on acquired immune deficiency syndrome and its impact on testing, confidentiality of test results, and treatment of patients. Each such licensee or certificateholder shall submit confirmation of having completed the ~~said~~ course, on a form provided by the department, when submitting fees or application for each biennial renewal.

Section 2. Subsections (1) and (7) of section 401.23, Florida Statutes, are amended to read:

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

(1) "Advanced life support" means assessment or treatment by a person qualified under this part ~~of life-threatening medical emergencies~~ through the use of techniques such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, ~~and~~ cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS

Education Standards ~~by a qualified person~~, pursuant to rules of the department.

(7) "Basic life support" means the assessment or treatment by a person qualified under this part ~~of medical emergencies by a qualified person~~ through the use of techniques ~~such as patient assessment, cardiopulmonary resuscitation (CPR), splinting, obstetrical assistance, bandaging, administration of oxygen, application of medical antishock trousers, administration of a subcutaneous injection using a premeasured autoinjector of epinephrine to a person suffering an anaphylactic reaction, and other techniques~~ described in the EMT-Basic National Standard ~~Emergency Medical Technician Basic Training Course~~ Curriculum or the National EMS Education Standards of the United States Department of Transportation and approved by the department. The term ~~"basic life support" also~~ includes the administration of oxygen and other techniques that ~~which~~ have been approved and are performed under conditions specified by rules of the department.

Section 3. Section 401.24, Florida Statutes, is amended to read:

401.24 Emergency medical services state plan.—The department is responsible, at a minimum, for the improvement and regulation of basic and advanced life support programs. The department shall develop, and ~~biennially~~ revise every 5 years, a comprehensive state plan for basic and advanced life support services, the emergency medical services grants program, trauma centers, the injury control program, and medical disaster preparedness. The state plan shall include, but need not be limited to:

(1) Emergency medical systems planning, including the prehospital and hospital phases of patient care, and injury control effort and unification of such services into a total delivery system to include air, water, and land services.

(2) Requirements for the operation, coordination, and ongoing development of emergency medical services, which includes: basic life support or advanced life support vehicles, equipment, and supplies; communications; personnel; training; public education; state trauma system; injury control; and other medical care components.

(3) The definition of areas of responsibility for regulating and planning the ongoing and developing delivery service requirements.

Section 4. Subsections (4) and (12) of section 401.27, Florida Statutes, are amended to read:

401.27 Personnel; standards and certification.—

(4) An applicant for certification or recertification as an emergency medical technician or paramedic must:

(a) Have completed an appropriate training program ~~course~~ as follows:

1. For an emergency medical technician, an emergency medical technician training program approved by the department as ~~course~~ equivalent to the most recent EMT-Basic National Standard Curriculum or the National EMS Education Standards ~~emergency medical technician basic training course~~ of the United States Department of Transportation ~~as approved by the department~~;

2. For a paramedic, a paramedic training program approved by the department as equivalent to the most recent EMT-Paramedic

National Standard Curriculum or the National EMS Education Standards ~~paramedic course~~ of the United States Department of Transportation ~~as approved by the department~~;

(b) Certify under oath that he or she is not addicted to alcohol or any controlled substance;

(c) Certify under oath that he or she is free from any physical or mental defect or disease that might impair the applicant's ability to perform his or her duties;

(d) Within 2 years ~~1 year~~ after program ~~course~~ completion have passed an examination developed or required by the department;

(e)1. For an emergency medical technician, hold ~~either~~ a current American Heart Association cardiopulmonary resuscitation course card or an American Red Cross cardiopulmonary resuscitation course card or its equivalent as defined by department rule;

2. For a paramedic, hold a certificate of successful course completion in advanced cardiac life support from the American Heart Association or its equivalent as defined by department rule;

(f) Submit the certification fee and the nonrefundable examination fee prescribed in s. 401.34, which examination fee will be required for each examination administered to an applicant; and

(g) Submit a completed application to the department, which application documents compliance with paragraphs (a), (b), (c), (e), (f), (g), and, if applicable, (d). The application must be submitted so as to be received by the department at least 30 calendar days before the next regularly scheduled examination

for which the applicant desires to be scheduled.

(12) An applicant for certification as ~~who is~~ an ~~out-of-state trained~~ emergency medical technician or paramedic who is trained outside the state must provide proof of current emergency medical technician or paramedic certification or registration based upon successful completion of a training program approved by the department as equivalent to the most recent EMT-Basic or EMT-Paramedic National Standard Curriculum or the National EMS Education Standards of the United States Department of Transportation ~~emergency medical technician or paramedic training curriculum~~ and hold a current certificate of successful course completion in cardiopulmonary resuscitation (CPR) or advanced cardiac life support for emergency medical technicians or paramedics, respectively, to be eligible for the certification examination. The applicant must successfully complete the certification examination within 2 years ~~1 year~~ after the date of the receipt of his or her application by the department. After 2 years ~~1 year~~, the applicant must submit a new application, meet all eligibility requirements, and submit all fees to reestablish eligibility to take the certification examination.

Section 5. Paragraph (a) of subsection (1) and subsection (5) of section 401.2701, Florida Statutes, are amended to read:

401.2701 Emergency medical services training programs.—

(1) Any private or public institution in Florida desiring to conduct an approved program for the education of emergency medical technicians and paramedics shall:

(a) Submit a completed application on a form provided by the department, which must include:

1. Evidence that the institution is in compliance with all applicable requirements of the Department of Education.

2. Evidence of an affiliation agreement with a hospital that has an emergency department staffed by at least one physician and one registered nurse.

3. Evidence of an affiliation agreement with a current ~~Florida-licensed~~ emergency medical services provider that is licensed in this state. Such agreement shall include, at a minimum, a commitment by the provider to conduct the field experience portion of the education program.

4. Documentation verifying faculty, including:

a. A medical director who is a licensed physician meeting the applicable requirements for emergency medical services medical directors as outlined in this chapter and rules of the department. The medical director shall have the duty and responsibility of certifying that graduates have successfully completed all phases of the education program and are proficient in basic or advanced life support techniques, as applicable.

b. A program director responsible for the operation, organization, periodic review, administration, development, and approval of the program.

5. Documentation verifying that the curriculum:

a. Meets the ~~course guides and instructor's lesson plans in the~~ most recent Emergency Medical Technician-Basic National Standard Curriculum or the National EMS Education Standards approved by the department ~~Curricula~~ for emergency medical technician programs and Emergency Medical Technician-Paramedic National Standard Curriculum or the National EMS Education Standards approved by the department ~~Curricula~~ for paramedic

programs.

b. Includes 2 hours of instruction on the trauma scorecard methodologies for assessment of adult trauma patients and pediatric trauma patients as specified by the department by rule.

~~c. Includes 4 hours of instruction on HIV/AIDS training consistent with the requirements of chapter 381.~~

6. Evidence of sufficient medical and educational equipment to meet emergency medical services training program needs.

(5) Each approved program must notify the department within 30 days after ~~of~~ any change in the professional or employment status of faculty. Each approved program must require its students to pass a comprehensive final written and practical examination evaluating the skills described in the current United States Department of Transportation EMT-Basic or EMT-Paramedic~~,~~ National Standard Curriculum or the National EMS Education Standards and approved by the department. Each approved program must issue a certificate of completion to program graduates within 14 days after ~~of~~ completion.

Section 6. This act shall take effect July 1, 2013.

The Florida Senate

# Committee Agenda Request

**To:** Senator Aaron Bean, Chair
Committee on Health Policy

**Subject:** Committee Agenda Request

**Date:** February 6, 2013

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I respectfully request that **Senate Bill # 520**, relating to Emergency Medical Services, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Rob Bradley
Florida Senate, District 7



File signed original with committee office

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 398

INTRODUCER: Health Policy Committee and Senator Bean

SUBJECT: Physician Assistants

DATE: February 22, 2013 REVISED:

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | McElheney | Stovall | HP | **Fav/CS** |
| 2. | | | BI | |
| 3. | | | JU | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## Please see Section VIII. for Additional Information:

| | | |
|---|---|---|
| A. COMMITTEE SUBSTITUTE..... | X | Statement of Substantial Changes |
| B. AMENDMENTS..... | | Technical amendments were recommended |
| | | Amendments were recommended |
| | | Significant amendments were recommended |

## I. Summary:

CS/SB 398 clarifies that a supervising physician may delegate to a physician assistant authority to order medications, including controlled substances, for patients in hospitals, ambulatory surgical centers and mobile surgical facilities.

This CS substantially amends sections: 458.347 and 459.022 of the Florida Statutes:

## II. Present Situation:

### Background

A physician assistant (PA) is a medical professional who works as part of a team with a doctor. A PA may perform physical examinations, diagnose and treat illnesses, order and interpret lab tests, perform procedures, assist in surgery, provide patient education and counseling and make rounds in hospitals and nursing homes. A PA is a graduate of an accredited PA educational program who is nationally certified and state-licensed to practice medicine with the supervision

of a physician.[1] In Florida, PAs are licensed and regulated under the Medical Practice Act at s. 458.347, F.S., and the Osteopathic Medical Practice Act at s. 459.022, F.S.

A supervising physician may delegate only tasks and procedures to the physician assistant which are within the supervising physician's scope of practice. The physician assistant may work in any setting that is within the scope of practice of the supervising physician's practice. The Board of Medicine and the Board of Osteopathic Medicine (the boards) are required to adopt rules pertaining to the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision.[2] The supervising physician's scope of practice includes "those tasks and procedures which the supervising physician is qualified by training or experience to perform."[3]

Under current law, a supervisory physician may delegate to a fully licensed PA the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the a formulary of drugs that a physician assistant may not prescribe (generally referred to as the negative formulary).[4] The Legislature specified that the negative formulary must include controlled substances, general anesthetics, and radiographic contrast materials. [5] This same section of law that dictates at least part of the contents of the negative formulary, also provides:

> This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.

The boards adopted the following negative formulary: [6]

> (1) PHYSICIAN ASSISTANTS APPROVED TO PRESCRIBE MEDICINAL DRUGS UNDER THE PROVISIONS OF SECTION 458.347(4)(e) OR 459.022 (4)(e), F.S., ARE NOT AUTHORIZED TO PRESCRIBE THE FOLLOWING MEDICINAL DRUGS, IN PURE FORM OR COMBINATION:
>
> (a) Controlled substances, as defined in Chapter 893, F.S.;
>
> (b) General, spinal or epidural anesthetics;
>
> (c) Radiographic contrast materials.
>
> (2) A supervising physician may delegate to a prescribing physician assistant only such authorized medicinal drugs as are used in the supervising physician's practice, not listed in subsection (1).
>
> (3) Subject to the requirements of this subsection, Sections 458.347 and 459.022, F.S., and the rules enacted thereunder, drugs not appearing on this formulary may be delegated by a supervising physician to a prescribing physician assistant to prescribe.
>
> *(4) Nothing herein prohibits a supervising physician from delegating to a physician assistant the authority to order medicinal drugs for a hospitalized*

[1] *See* American Academy of Physician Assistants available at: http://www.aapa.org/the_pa_profession/what_is_a_pa.aspx (last visited on Feb. 19, 2013).
[2] Sections 458.347(4) and 459.022(4), F.S.
[3] Rules 64B8-30.012 and 64B15-6.010, F.A.C.
[4] Sections 458.347(4)(e) and 459.022(4)(e), F.S.
[5] Section 458.347(4)(f), F.S.
[6] Rules 64B8-30.008 and 64B15-6.0038, F.A.C.

> *patient of the supervising physician, nor does anything herein prohibit a supervising physician from delegating to a physician assistant the administration of a medicinal drug under the direction and supervision of the physician* (emphasis added).

The Florida Academy of Physician Assistants indicates that certain hospitals have questioned the authority of PAs to order medications, specifically controlled substances, in the hospital setting given the uncertainty in the differing terminology between "prescribing" authority and "ordering" authority contained in the law and rules.

The terms "prescribe" and "order" are not defined in the Medical Practice Act or the Osteopathic Medical Practice Act.

An "order" is a term of art generally used in a hospital or institutional setting where an authorized practitioner orders a medication for an inpatient rather than prescribes a medication.[7] The order is recorded in the medical record and the medication is administered to the patient by licensed nurses or other appropriately licensed health care personnel.

Under the Florida Pharmacy Act, a "prescription" includes any order for drugs or medicinal supplies written or transmitted by any means of communication by a duly licensed practitioner authorized by the laws of the state to prescribe such drugs or medicinal supplies and intended to be dispensed by a pharmacist.[8] The Florida Comprehensive Drug Abuse Prevention and Control Act, ch. 893, F.S., provides a similar definition for that term.[9]

**DEA Registration**

An individual practitioner who is an agent or employee of another practitioner (other than a mid-level practitioner[10]) registered to dispense controlled substances, may, when acting in the normal course of business or employment, administer or dispense (other than by issuance of a prescription) controlled substances if and to the extent authorized by state law, under the registration of the employer or principal practitioner in lieu of being registered himself or herself.

Practitioners (e.g., interns, residents, staff physicians, mid-level practitioners) who are agents or employees of a hospital or other institution, may, when acting in the usual course of business or employment, administer, dispense, or prescribe controlled substances under the registration of the hospital or other institution in which he or she is employed, in lieu of individual registration, provided that:

- The dispensing, administering, or prescribing is in the usual course of professional practice; The practitioner is authorized to do so by the state in which he or she practices;

[7] *See for example:* 42 C.F.R. 482.23(c) relating to Conditions of Participation for Hospitals under Medicare, Standard: Preparation and administration of drugs and Rule 64B16-28.602, F.A.C., relating to rules of the Board of Pharmacy for Institutional Class II Dispensing.
[8] Section 465.003(14), F.S.
[9] Section 893.02(22), F.S.
[10] Examples of mid-level practitioners include, but are not limited to: nurse practitioners, nurse midwives, nurse anesthetists, clinical nurse specialists, physician assistants.

- The hospital or other institution has verified that the practitioner is permitted to administer, dispense, or prescribe controlled substances within the state;
- The practitioner acts only within the scope of employment in the hospital or other institution;
- The hospital or other institution authorizes the practitioner to administer, dispense, or prescribe under its registration and assigns a specific internal code number for each practitioner; and
- The hospital or other institution maintains a current list of internal codes and the corresponding practitioner.

## III. Effect of Proposed Changes:

**Sections 1 and 2** amend s. 458.347, F.S., relating to PAs under the medical practice act and s. 459.022, F.S., relating to PAs under the osteopathic medical practice act, respectively, to authorize a supervisory physician to delegate to his or her PA the authority to order medications for the supervisory physician's patient in any hospital, ambulatory surgical center, or mobile surgical facility notwithstanding any provision under the Pharmacy Practice Act or the Florida Comprehensive Drug Abuse Prevention and Control Act. Likewise, the PA is authorized to order any medication under these conditions. Accordingly, a PA could order a controlled substance for his or her supervising physician's patient in a hospital, ambulatory surgical center, or mobile surgical facility if the supervising physician delegated that authority to the PA. Since no specific authorization for prescribing controlled substances is included within ch. 893, F.S., the PA would need to operate under the supervising physician's DEA registration.

The effective date of the bill is July 1, 2013.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

None.

## VIII. Additional Information:

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

**CS by Health Policy on February 21, 2013:**
The CS provides that an order is not a prescription and authorizes the PA to order medications under the direction of the supervisory physician. The CS does not include new authority that may have expanded the scope of practice of a PA.

B. Amendments:

None.

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LEGISLATIVE ACTION

| Senate | . | House |
|---|---|---|
| Comm: RCS | . | |
| 02/21/2013 | . | |
| | . | |
| | . | |
| | . | |

The Committee on Health Policy (Bean) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause
and insert:

Section 1. Paragraph (e) of subsection (4) of section 458.347, Florida Statutes, is amended, and paragraph (g) is added to that subsection, to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary

created pursuant to paragraph (f). A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department a signed affidavit that he or she has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant shall not be required to independently register pursuant to s. 465.0276.

5. The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician’s name, address, and telephone number, the physician assistant’s prescriber number. Unless it is a drug or

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drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

~~7. This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.~~

~~This paragraph does not apply to facilities licensed pursuant to chapter 395.~~

(g) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient in a facility licensed under chapter 395, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 may order any medication under the direction of the supervisory physician.

Section 2. Paragraph (e) of subsection (4) of section 459.022, Florida Statutes, is amended, and paragraph (f) is added to that subsection, to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(e) A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervisory physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department a signed affidavit that she or he has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant shall not

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be required to independently register pursuant to s. 465.0276.

5. The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician's name, address, and telephone number, the physician assistant's prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

~~7. This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.~~

~~This paragraph does not apply to facilities licensed pursuant to chapter 395.~~

(f) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient in a facility licensed under chapter 395, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation. For the purpose of this paragraph, an order is not considered a prescription. A licensed physician assistant working in a facility that is licensed under chapter 395 may order any medication under the

841286

direction of the supervisory physician.

Section 3. This act shall take effect July 1, 2013.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to physician assistants; amending ss. 458.347 and 459.022, F.S.; authorizing a supervisory physician to delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient in a facility licensed under ch. 395, F.S.; deleting provisions to conform to changes made by the act; providing that an order is not a prescription; authorizing a licensed physician assistant to order medication under the direction of the supervisory physician; providing an effective date.

**By** Senator Bean

4-00248A-13 2013398__

A bill to be entitled

An act relating to physician assistants; amending ss. 458.347 and 459.022, F.S.; authorizing a physician assistant to execute all practice-related activities delegated by a supervisory physician unless expressly prohibited; deleting provisions to conform to changes made by the act; amending ss. 458.3475, 458.348, 459.023, and 459.025, F.S.; conforming cross-references; providing an effective date.

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

Section 1. Subsection (4) of section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) A physician assistant may execute all practice-related activities delegated by the supervisory physician unless expressly prohibited in chapter 458 or chapter 459 or rules adopted thereunder.

(b) ~~(a)~~ The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(c) ~~(b)~~ This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(d) ~~(c)~~ A licensed physician assistant ~~assistants~~ may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(e) ~~(d)~~ A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(f) ~~(e)~~ A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to paragraph (g) ~~(f)~~. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that he or she is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervising physician who is registered as a dispensing

practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department a signed affidavit that he or she has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant <u>may</u> ~~shall~~ not be required to independently register pursuant to s. 465.0276.

5. The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician's name, address, and telephone number, the physician assistant's prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under chapter 465 and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

~~7. This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.~~

~~This paragraph does not apply to facilities licensed pursuant to chapter 395.~~

(g) ~~(f)~~1. The council shall establish a formulary of medicinal drugs that a fully licensed physician assistant having prescribing authority under this section or s. 459.022 may not prescribe. The formulary must include controlled substances as defined in chapter 893, general anesthetics, and radiographic contrast materials.

2. In establishing the formulary, the council shall consult with a pharmacist licensed under chapter 465, but not licensed under this chapter or chapter 459, who shall be selected by the State Surgeon General.

3. Only the council shall add to, delete from, or modify the formulary. Any person who requests an addition, deletion, or modification of a medicinal drug listed on such formulary has the burden of proof to show cause why such addition, deletion, or modification should be made.

4. The boards shall adopt the formulary required by this paragraph, and each addition, deletion, or modification to the formulary, by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall be effective 60 days after the date it is filed with the Secretary of State. Upon adoption of the formulary, the department shall mail a copy of such formulary to each fully licensed physician assistant having prescribing authority under this section or s. 459.022, and to each pharmacy licensed by the state. The boards shall establish, by rule, a fee not to exceed $200 to fund the provisions of this paragraph and paragraph (f) ~~(e)~~.

(h) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient in a facility licensed under chapter 395, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

Section 2. Paragraph (b) of subsection (7) of section 458.3475, Florida Statutes, is amended to read:

458.3475 Anesthesiologist assistants.—

(7) ANESTHESIOLOGIST AND ANESTHESIOLOGIST ASSISTANT TO ADVISE THE BOARD.—

(b) In addition to its other duties and responsibilities as prescribed by law, the board shall:

1. Recommend to the department the licensure of anesthesiologist assistants.

2. Develop all rules regulating the use of anesthesiologist assistants by qualified anesthesiologists under this chapter and chapter 459, except for rules relating to the formulary developed under s. 458.347 ~~s. 458.347(4)(f)~~. The board shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule at the regularly scheduled meeting immediately following the submission of the proposed rule. A proposed rule may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules.

3. Address concerns and problems of practicing

anesthesiologist assistants to improve safety in the clinical practices of licensed anesthesiologist assistants.

Section 3. Paragraph (c) of subsection (4) of section 458.348, Florida Statutes, is amended to read:

458.348 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(4) SUPERVISORY RELATIONSHIPS IN MEDICAL OFFICE SETTINGS.—A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician, must comply with the standards set forth in this subsection. For the purpose of this subsection, a physician's "primary practice location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(c) A physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising physician and the services offered at the office are primarily dermatologic or skin care services, which include aesthetic skin care services other than plastic surgery, must comply with the standards listed in subparagraphs 1.-4. Notwithstanding s. 458.347 ~~s. 458.347(4)(e)6.~~, a physician supervising a physician assistant pursuant to this paragraph may not be required to review and cosign charts or medical records prepared by such physician assistant.

1. The physician shall submit to the board the addresses of all offices where he or she is supervising an advanced registered nurse practitioner or a physician ~~physician's~~ assistant which are not the physician's primary practice location.

2. The physician must be board certified or board eligible in dermatology or plastic surgery as recognized by the board pursuant to s. 458.3312.

3. All such offices that are not the physician's primary place of practice must be within 25 miles of the physician's primary place of practice or in a county that is contiguous to the county of the physician's primary place of practice. However, the distance between any of the offices may not exceed 75 miles.

4. The physician may supervise only one office other than the physician's primary place of practice except that until July 1, 2011, the physician may supervise up to two medical offices other than the physician's primary place of practice if the addresses of the offices are submitted to the board before July 1, 2006. ~~Effective July 1, 2011,~~ The physician may supervise only one office other than the physician's primary place of practice, regardless of when the addresses of the offices were submitted to the board.

Section 4. Subsection (4) of section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(a) A physician assistant may execute all practice-related activities delegated by the supervisory physician unless

expressly prohibited in chapter 458 or chapter 459 or rules adopted thereunder.

(b) ~~(a)~~ The boards shall adopt, by rule, the general principles that supervising physicians must use in developing the scope of practice of a physician assistant under direct supervision and under indirect supervision. These principles shall recognize the diversity of both specialty and practice settings in which physician assistants are used.

(c) ~~(b)~~ This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered services rendered by licensed physician assistants.

(d) ~~(c)~~ Licensed physician assistants may not be denied clinical hospital privileges, except for cause, so long as the supervising physician is a staff member in good standing.

(e) ~~(d)~~ A supervisory physician may delegate to a licensed physician assistant, pursuant to a written protocol, the authority to act according to s. 154.04(1)(c). Such delegated authority is limited to the supervising physician's practice in connection with a county health department as defined and established pursuant to chapter 154. The boards shall adopt rules governing the supervision of physician assistants by physicians in county health departments.

(f) ~~(e)~~ A supervisory physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervisory physician's practice unless such medication is listed on the formulary created pursuant to s. 458.347. A fully licensed physician assistant may only prescribe or dispense such medication under the following circumstances:

1. A physician assistant must clearly identify to the patient that she or he is a physician assistant. Furthermore, the physician assistant must inform the patient that the patient has the right to see the physician prior to any prescription being prescribed or dispensed by the physician assistant.

2. The supervisory physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and notify the department of any change in prescriptive privileges of the physician assistant. Authority to dispense may be delegated only by a supervisory physician who is registered as a dispensing practitioner in compliance with s. 465.0276.

3. The physician assistant must file with the department a signed affidavit that she or he has completed a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal application.

4. The department may issue a prescriber number to the physician assistant granting authority for the prescribing of medicinal drugs authorized within this paragraph upon completion of the foregoing requirements. The physician assistant <u>may</u> ~~shall~~ not be required to independently register pursuant to s. 465.0276.

5. The prescription must be written in a form that complies with chapter 499 and must contain, in addition to the supervisory physician’s name, address, and telephone number, the physician assistant’s prescriber number. Unless it is a drug or drug sample dispensed by the physician assistant, the prescription must be filled in a pharmacy permitted under

chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. The appearance of the prescriber number creates a presumption that the physician assistant is authorized to prescribe the medicinal drug and the prescription is valid.

6. The physician assistant must note the prescription or dispensing of medication in the appropriate medical record.

~~7. This paragraph does not prohibit a supervisory physician from delegating to a physician assistant the authority to order medication for a hospitalized patient of the supervisory physician.~~

~~This paragraph does not apply to facilities licensed pursuant to chapter 395.~~

(g) A supervisory physician may delegate to a licensed physician assistant the authority to order medications for the supervisory physician's patient in a facility licensed under chapter 395, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

Section 5. Paragraph (b) of subsection (7) of section 459.023, Florida Statutes, is amended to read:

459.023 Anesthesiologist assistants.—

(7) ANESTHESIOLOGIST AND ANESTHESIOLOGIST ASSISTANT TO ADVISE THE BOARD.—

(b) In addition to its other duties and responsibilities as prescribed by law, the board shall:

1. Recommend to the department the licensure of anesthesiologist assistants.

2. Develop all rules regulating the use of anesthesiologist

assistants by qualified anesthesiologists under this chapter and chapter 458, except for rules relating to the formulary developed under s. 458.347 ~~s. 458.347(4)(f)~~. The board shall also develop rules to ensure that the continuity of supervision is maintained in each practice setting. The boards shall consider adopting a proposed rule at the regularly scheduled meeting immediately following the submission of the proposed rule. A proposed rule may not be adopted by either board unless both boards have accepted and approved the identical language contained in the proposed rule. The language of all proposed rules must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules.

3. Address concerns and problems of practicing anesthesiologist assistants to improve safety in the clinical practices of licensed anesthesiologist assistants.

Section 6. Paragraph (c) of subsection (3) of section 459.025, Florida Statutes, is amended to read:

459.025 Formal supervisory relationships, standing orders, and established protocols; notice; standards.—

(3) SUPERVISORY RELATIONSHIPS IN MEDICAL OFFICE SETTINGS.— An osteopathic physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the osteopathic physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising osteopathic physician, must comply with the standards set forth in this subsection. For the purpose of this subsection, an osteopathic physician's "primary practice

location" means the address reflected on the physician's profile published pursuant to s. 456.041.

(c) An osteopathic physician who supervises an advanced registered nurse practitioner or physician assistant at a medical office other than the osteopathic physician's primary practice location, where the advanced registered nurse practitioner or physician assistant is not under the onsite supervision of a supervising osteopathic physician and the services offered at the office are primarily dermatologic or skin care services, which include aesthetic skin care services other than plastic surgery, must comply with the standards listed in subparagraphs 1.-4. Notwithstanding s. 459.022 ~~s. 459.022(4)(c)6.~~, an osteopathic physician supervising a physician assistant pursuant to this paragraph may not be required to review and cosign charts or medical records prepared by such physician assistant.

1. The osteopathic physician shall submit to the Board of Osteopathic Medicine the addresses of all offices where he or she is supervising or has a protocol with an advanced registered nurse practitioner or a physician ~~physician's~~ assistant which are not the osteopathic physician's primary practice location.

2. The osteopathic physician must be board certified or board eligible in dermatology or plastic surgery as recognized by the Board of Osteopathic Medicine pursuant to s. 459.0152.

3. All such offices that are not the osteopathic physician's primary place of practice must be within 25 miles of the osteopathic physician's primary place of practice or in a county that is contiguous to the county of the osteopathic physician's primary place of practice. However, the distance

between any of the offices may not exceed 75 miles.

4. The osteopathic physician may supervise only one office other than the osteopathic physician's primary place of practice except that until July 1, 2011, the osteopathic physician may supervise up to two medical offices other than the osteopathic physician's primary place of practice if the addresses of the offices are submitted to the Board of Osteopathic Medicine before July 1, 2006. ~~Effective July 1, 2011,~~ The osteopathic physician may supervise only one office other than the osteopathic physician's primary place of practice, regardless of when the addresses of the offices were submitted to the Board of Osteopathic Medicine.

Section 7. This act shall take effect July 1, 2013.

## GEORGIADES.CELIA

**From:** ALEXANDER.DEE
**Sent:** Monday, January 28, 2013 11:23 PM
**To:** STOVALL.SANDRA
**Cc:** GEORGIADES.CELIA
**Subject:** Request for Agenda

Hello Sandra—
Chairman Beans' bill, SB 398 relating to Physician Assistants, has been referenced to the Health Policy Committee. Please consider this email a 'request for agenda'.

Sincerely,

***Dee Alexander***
***Chief Legislative Assistant***
Office of Senator Aaron Bean
District 4

TALLAHASSEE OFFICE:
202 Senate Office Building
(850) 487-5004

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

_____
*Meeting Date*

Topic Relating to Physician Assistants

Bill Number 398 *(if applicable)*

Name Dayne Alonso

Amendment Barcode _____ *(if applicable)*

Job Title Physician Assistant

Address 7265 SW 89th Street #311
*Street*

Miami, FL 331
*City* *State* *Zip*

Phone _____

E-mail daynepa@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing Florida Academy of Physician Assistant

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

THE FLORIDA SENATE

# APPEARANCE RECORD

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

2/21/2013
*Meeting Date*

Topic _____ Bill Number 398 *(if applicable)*

Name BRIAN PITTS Amendment Barcode _____ *(if applicable)*

Job Title TRUSTEE

Address 1119 NEWTON AVNUE SOUTH Phone 727-897-9291
*Street*

SAINT PETERSBURG FLORIDA 33705 E-mail JUSTICE2JESUS@YAHOO.COM
*City* *State* *Zip*

Speaking: ☐ For ☐ Against ☑ Information

Representing JUSTICE-2-JESUS

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-21-2013
*Meeting Date*

Topic PHYSICIAN ASSISTANTS

Bill Number SB 398 *(if applicable)*

Name STEPHEN R. WINN

Amendment Barcode *(if applicable)*

Job Title EXECUTIVE DIRECTOR

Address 2007 APALACHEE PARKWAY *Street*

Phone 878-7463

TALLAHASSEE FL 32301 *City State Zip*

E-mail

Speaking: ☒ For ☐ Against ☐ Information WAIVE TIME IN SUPPORT

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2.21.13
*Meeting Date*

Topic Physician Assistants

Bill Number 398 *(if applicable)*

Name Rebecca O'Hara

Amendment Barcode 841286 *(if applicable)*

Job Title VP & Governmental Affairs

Address PO Box 10269
*Street*
Tallahassee, FL 32302
*City* *State* *Zip*

Phone 224-6491

E-mail rohara@flmedical.org

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

Representing FL Medical Association

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

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

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2.21.13
*Meeting Date*

- Bill as Amended -

Topic Physician Assistants

Bill Number 398 *(if applicable)*

Name Rebecca O'hara

Amendment Barcode *(if applicable)*

Job Title VP & Gout. Affairs

Address PO Box 10269 *Street*

Phone 224-6496

Tallahassee, FL 32302
*City* *State* *Zip*

E-mail rohara@flmedical.org

Speaking: ☒ For ☐ Against ☐ Information

Representing FL Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-21-13
*Meeting Date*

Topic PAs

Bill Number 398 Bean
*(if applicable)*

Name MARTHA DECASTRO

Amendment Barcode
*(if applicable)*

Job Title VP for Nursing

Address 300 E College
*Street*

Phone 222 9800

E-mail martha@fha.org

*City* *State* *Zip*

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Hospital Assn

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: SPB 7014

INTRODUCER: For Consideration by Health Policy Committee

SUBJECT: Health Flex Plans

DATE: February 11, 2013 REVISED:

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Lloyd | Stovall | | **Submitted as Committee Bill** |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## I. Summary:

SPB 7014 extends the termination date of the Health Flex program to January 1, 2014 or upon the availability of qualified health plans through an exchange, whichever occurs later. Without legislative action, the Health Flex program will sunset on July 1, 2013.

This proposed bill substantially amends section 408.909, Florida Statutes.

## II. Present Situation:

The Health Flex program was created by the 2002 Legislature to address the health insurance needs of Florida's lower income uninsured adult population.[1] At the time, Florida's uninsured rate was reported as 16.8%, or 2.1 million while for those under 150% of the federal poverty level (FPL) the rate was reported at 34%.[2] Initially launched as a pilot program limited to three areas of the state with the highest incidences of uninsured adults and Indian River County, the program had an original expiration date of July 2004.[3]

Subsequent legislative acts removed the limited geographic reach of the project extending the scope statewide as well as modified the expiration date multiple times until it reached its current

[1] SB 46-E (2003-E Session).
[2] Analysis for SB 46-E by the Senate Committee on Health, Aging and Long Term Care (April. 30, 2002), *available at http://archive.flsenate.gov/data/session/2002E/Senate/bills/analysis/pdf/2002s0046E.hc.pdf (*last visited Feb. 11, 2013).
[3] Id.

expiration date of June 30, 2013.[4] Plans are currently available in six counties: Broward, Hillsborough, Miami-Dade, Palm Beach, Polk, and St. Lucie.[5]

The enacting legislation's intent emphasized alternative approaches for affordable health care options over traditional insurance coverage for the uninsured. Products offered as health flex plans were to include basic and preventive health care services and to coordinate with local service programs.[6]

Health Flex plans can be offered through a variety of means, including by licensed insurers, health maintenance organizations (HMOs), health care providers, local governments, health care districts or other public or private organizations.[7] Products sold under the program are not subject to the Florida Insurance Code.[8] As of September 30, 2012, three plans cover 12,127 members.[9]

| Plan Name | Enrollment – September 30, 2012 |
|---|---|
| American Care, Inc. | 347 |
| Preferred Medical Plan, Inc. | 1,630 |
| Vita Health Plan, Inc. | 10,150 |
| **Total Enrollment:** | **12,127** |

Eligibility for the program has also been modified multiple times since inception. Today, an individual must meet the following requirements:[10]

- Be a resident of the state;
- Have a family income equal to or less than 300% FPL ($69,150 for a family of four based on 2012 federal guidelines);
- Not be covered by a private insurance policy and not be eligible for public coverage such as Medicare, Medicaid, or KidCare, or have not been covered at anytime in the last six months;
- If a person did have coverage in the past six months under an individual health maintenance organization (HMO) contract licensed in the Florida which was also a licensed Health Flex plan on October 1, 2008, the individual may apply for coverage under that same Health Flex plan without a lapse in coverage if all other eligibility requirements are met;
- If a person was covered under Medicaid or KidCare and lost eligibility for Medicaid or KidCare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved Health Flex plan, the individual may apply for coverage in a Health Flex plan without a lapse in coverage if all other eligibility requirements are met;
- Have applied for health care coverage through an approved Health Flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or,

[4] *See Chapter Law 2003-405, Chapter Law 2004-270, Chapter Law 2005-231,Chapter Law 2008-32, Chapter Law 2011-195.*
[5] Florida Agency for Health Care Administration and Florida Office of Insurance Regulation, *Health Flex Plan Program, Annual Report,* 3-5, (January 2013).
[6] SB 46-E (2003-E Session).
[7] s. 408.909(1), F.S.
[8] s. 408.909(4), F.S., *supra at n. 2.*
[9] *Supra,* note 5 at 5-6.
[10] *Supra,* note 5, at p. 2-3.

- Be part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past six months. If the Health Flex plan entity is a health insurer, health plan or HMO, only 50 percent of the employees must meet the income requirement.

Responsibility for the Health Flex program resides with both the Agency for Health Care Administration (Agency) and the Office of Insurance Regulation (Office). The Agency and Office jointly review applications for health flex plans, develop necessary rules, evaluate the program and produce an annual report. The Agency has primary responsibility for reviewing health flex applications and determining whether plans meet quality of care standards and follow standard grievance procedures. The Office is responsible for monitoring the financial viability of each plan.

In March 2010, Congress passed and the President signed the Patient Protection and Affordable Care Act (PPACA).[11] Beginning January 1, 2014, the federal government and some states plan to launch one of the largest components of the PPACA legislation, health benefits exchanges.[12] The exchange implementation coincides with the requirement that, with few exceptions, all individuals must maintain a minimum level of health insurance coverage for themselves and their dependants.[13] New subsidies, advanced premium tax credits, and out of pocket cost sharing maximums become effective at the same time to assist lower income enrollees with the cost of that coverage.[14] These premium assistance measures assist individuals at varying levels from 100% FPL up to 400% FPL ($45,960 for an individual in 2013).[15]

Health care coverage will be available through Medicaid or the Children's Health Insurance Program (CHIP) for the lowest income individuals. Children are covered under Medicaid or CHIP in Florida currently up to 200% FPL.[16] The state may also elect to extend Medicaid eligibility to adults up to 133% FPL.[17, 18]

Under PPACA, a state could opt to run its own exchange, partner with the federal government or default to a federal exchange.[19] Regardless of the option selected by a state, individuals will have a choice of qualified health plans that meet established standards and offer the minimum set of

[11]Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[12]*Id.*
[13]Hinda Chaikind, *Individual Mandate and Related Information Requirements under PPACA*¸ Congressional Research Service, 1, (September 21, 2010), *http://www.ncsl.org/documents/health/Individual_Mandate_Under_PPACA_pdf.*, *(*last visited Feb. 11, 2013).
[14]Kaiser Family Foundation, *Explaining Health Care Reform: Questions About Health Insurance Subsidies* (July 2012), http://www.kff.org/healthreform/upload/7962-02.pdf (last visited Feb. 13, 2013).
[15]78 FR 5182 (5182-5183), January 24, 2013.
[16]State of Florida, Florida KidCare Program, Title XXI State Plan, *Amendment #22, (5),* http://www.fdhc.state.fl.us/medicaid/medikids/PDF/KidCare_Program_Amendment_21_to_Titlle_XXI_2012-07-01.pdf , (last visited Feb. 11, 2013).
[17]*Supra, Note 10.*
[18]*National Federal of Independent Business (NFIB) et al v. Sebelius,* 567 U.S., ___(2012).
[19]Center for Consumer Information and Insurance Oversight, Centers for Medicare and Medicaid Services, *General Guidance on Federally-facilitated Exchanges*, (May 16, 2012), http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf (last visited Feb. 11, 2013).

essential health benefits. In order to be offered on the exchanges, a health plan has to offer the benefits in ten categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.[20]

The essential health benefits requirement does not apply to all plans, including certain current self-insured group plans, health insurance coverage offered in the large group market, and grandfathered health plans. However, non-grandfathered plans that will be offered in 2014 and later both in the new exchanges and outside the exchanges must cover these essential health benefits.[21]

A grandfathered health plan is a plan that existed on March 23, 2010, the date that PPACA was enacted, and that at least one person had been continuously covered for one year.[22] Some consumer protection elements do not apply to grandfathered plans that were part of PPACA but others are applicable, regardless of the type of plan.[23] Providing the essential health benefits are also not required of grandfathered health plans.[24] Additionally, a grandfathered plan can lose its status if significant changes to benefits or cost sharing changes are made to the plan since attaining its grandfathered status.[25] Grandfathered plans are required to disclose their status to their enrollees every time plan materials are distributed and to identify the consumer protections that are not available as a grandfathered plan.[26]

Individuals that do not maintain coverage that meets the PPACA minimum requirements and cannot show a hardship will be subject to a penalty.[27] To qualify for the hardship exemption, an individual who is not eligible for Medicaid and who is above the filing threshold for income taxes must show that the cost of his or her contribution towards self-only coverage for a calendar year will exceed 8 percent of household income.[28]

Under the federal definitions of health insurance coverage and health insurance issuer, coverage includes medical and hospital benefits that are offered by an issuer that is licensed in the state and whose coverage is regulated by that state.[29] Some health coverage may also meet the definition of excepted benefits which would not qualify as minimum essential coverage for the

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[20] Healthcare.gov., http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Feb. 11, 2013).
[21] Center for Consumer Information and Insurance Oversight, *Essential Health Benefits Bulletin (December 16, 2011)*, *http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf*, (last visited Feb. 11, 2013).
[22] Healthcare.gov, *Grandfathered Health Plans*, *http://www.healthcare.gov/law/features/rights/grandfathered-plans/index.html* (Last visited Feb.11, 2013).
[23] Healthcare.gov., http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html, (last visited Feb. 11, 2013).
[24] Sarah Barr, *FAQ: Grandfathered Health Plans* (Dec. 2012), http://www.kaiserhealthnews.org/stories/2012/december/17/grandfathered-plans-faq.aspx (last visited Feb. 12, 2013).
[25] Healthcare.gov, *Keeping the Health Plan You Have: The Affordable Care Act and "Grandfathered Health Plans* (June 14, 2010), http://www.healthcare.gov/news/factsheets/2010/06/keeping-the-health-plan-you-have-grandfathered.html (last visited Feb. 12, 2013).
[26] *Id.*
[27] Pub. Law No. 111-148, H.R. 3590, 111th Cong. (March 23, 2010).
[28] Chaikind, *supra* Note 13 at 3.
[29] 42 U.S.C. s.300gg-91(b).

individual mandate.[30] Examples of excepted benefits would include coverage limited to dental or on-site medical clinics.[31]

Under s. 409.909(4), F.S., the Health Flex plans are not currently subject to the Florida Insurance Code and are not considered an insured product. The plans are not required to cover Florida's mandated benefits or meet solvency requirements. Neither do the current benefits schedules of the Health Flex plans comply with the essential health coverage as the packages do not incorporate all ten essential health benefit categories based on a review of the web based marketing materials for the three plans.[32]

## III. Effect of Proposed Changes:

The bill modifies subsection (10) of s. 409.909, F.S. in order to extend the expiration date for Health Flex plans from June 30, 2013, to January 1, 2014, or upon availability of qualified health plans through an exchange, whichever occurs later. This date extension corresponds to the implementation date of the major components of the Patient Protection and Affordable Care Act (PPACA) relating to exchanges and the individual mandate for insurance coverage.

Given that varying levels of subsidies, advance payment of premium tax credits and other cost sharing limitations are available for individuals up to 400% FPL and those served by the Health Flex program are under 300% FPL, coverage options should be available for most individuals currently under the Health Flex program in the Exchange.

**Other Potential Implications:**

Open enrollment for the exchanges begins October 1, 2013, for January 1, 2014, enrollment. Participants in the Health Flex program should be given ample notice by their respective plan of the impending termination of their coverage to allow sufficient application and transition time to other coverage.

Should Florida elect not to expand Medicaid for adults to 133% FPL, there would be a gap in subsidized coverage options for individuals under 100% FPL.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

[30]Chaikind, *supra* note 13, at 1-2.
[31]42 U.S.C. s. 300gg-91(c)
[32]Websites for three Health Flex plans reviewed on February 12, 2013: American Care Plans, *Health Flex Plans,* *http://www.healthflex.org/files/HealthFlexBrochure.pdf*, Preferred Medical Plan, Medi-Flex Plan, https://www.pmphmo.com/plans.php, and Vita Health Plan, http://www.vitahealth.org/index.aspx?page=453, (last visited Feb. 11, 2013).

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector employers may participate in the Health Flex program and can contribute towards the cost of their employees' health coverage. Other options for contributing towards the cost of employees' health coverage will be available in the Exchange.

With the termination of the Health Flex program, enrollees would likely transition into the exchanges to access premium subsidies or Medicaid, if Florida extends eligibility to the adult population, as appropriate to their income level.

C. Government Sector Impact:

One plan, Vita offered by the Health Care District of Palm Beach County, offsets the cost of coverage. The Health Care District currently subsidizes approximately two thirds of the total premium with the enrollee paying the remaining one third of the total premium.[33] Upon termination of this program, the District would be able to redirect these funds.

With the termination of the Health Flex program, enrollees would likely transition into the exchanges to access premium subsidies or Medicaid, if Florida extends eligibility to the adult population, as appropriate to their income level.

## VI. Technical Deficiencies:

None.

## VII. Related Issues:

The exchanges under PPACA are scheduled to hold their first open enrollment period starting October 1, 2013, for effective dates as early as January 1, 2014. The Agency, Office and the Health Care District of Palm Beach County which is the plan with the largest Health Flex plan enrollment, have expressed concern as to whether or not existing Health Flex plan members will successfully transition during the inaugural open enrollment period. These entities have suggested an additional extension beyond January 1, 2014, may be necessary to ensure enrollees have sufficient time to find other coverage.

[33] *Supra*, Note 5, at 6.

## VIII. Additional Information:

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

None.

B. Amendments:

None.

**FOR CONSIDERATION By** the Committee on Health Policy

588-01579A-13 20137014__

A bill to be entitled

An act relating to health flex plans; amending s. 408.909, F.S.; revising the expiration date to extend the availability of health flex plans to low-income uninsured state residents; providing an effective date.

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

Section 1. Subsection (10) of section 408.909, Florida Statutes, is amended to read:

408.909 Health flex plans.—

(1) INTENT.—The Legislature finds that a significant proportion of the residents of this state are unable to obtain affordable health insurance coverage. Therefore, it is the intent of the Legislature to expand the availability of health care options for low-income uninsured state residents by encouraging health insurers, health maintenance organizations, health-care-provider-sponsored organizations, local governments, health care districts, or other public or private community-based organizations to develop alternative approaches to traditional health insurance which emphasize coverage for basic and preventive health care services. To the maximum extent possible, these options should be coordinated with existing governmental or community-based health services programs in a manner that is consistent with the objectives and requirements of such programs.

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

(a) "Agency" means the Agency for Health Care

Administration.

(b) "Office" means the Office of Insurance Regulation of the Financial Services Commission.

(c) "Enrollee" means an individual who has been determined to be eligible for and is receiving health care coverage under a health flex plan approved under this section.

(d) "Health care coverage" or "health flex plan coverage" means health care services that are covered as benefits under an approved health flex plan or that are otherwise provided, either directly or through arrangements with other persons, via a health flex plan on a prepaid per capita basis or on a prepaid aggregate fixed-sum basis.

(e) "Health flex plan" means a health plan approved under subsection (3) which guarantees payment for specified health care coverage provided to the enrollee who purchases coverage directly from the plan or through a small business purchasing arrangement sponsored by a local government.

(f) "Health flex plan entity" means a health insurer, health maintenance organization, health-care-provider-sponsored organization, local government, health care district, other public or private community-based organization, or public-private partnership that develops and implements an approved health flex plan and is responsible for administering the health flex plan and paying all claims for health flex plan coverage by enrollees of the health flex plan.

(3) PROGRAM.—The agency and the office shall each approve or disapprove health flex plans that provide health care coverage for eligible participants. A health flex plan may limit or exclude benefits otherwise required by law for insurers

offering coverage in this state, may cap the total amount of claims paid per year per enrollee, may limit the number of enrollees, or may take any combination of those actions. A health flex plan offering may include the option of a catastrophic plan supplementing the health flex plan.

(a) The agency shall develop guidelines for the review of applications for health flex plans and shall disapprove or withdraw approval of plans that do not meet or no longer meet minimum standards for quality of care and access to care. The agency shall ensure that the health flex plans follow standardized grievance procedures similar to those required of health maintenance organizations.

(b) The office shall develop guidelines for the review of health flex plan applications and provide regulatory oversight of health flex plan advertisement and marketing procedures. The office shall disapprove or shall withdraw approval of plans that:

1. Contain any ambiguous, inconsistent, or misleading provisions or any exceptions or conditions that deceptively affect or limit the benefits purported to be assumed in the general coverage provided by the health flex plan;

2. Provide benefits that are unreasonable in relation to the premium charged or contain provisions that are unfair or inequitable or contrary to the public policy of this state, that encourage misrepresentation, or that result in unfair discrimination in sales practices;

3. Cannot demonstrate that the health flex plan is financially sound and that the applicant is able to underwrite or finance the health care coverage provided; or

4. Cannot demonstrate that the applicant and its management are in compliance with the standards required under s. 624.404(3).

(c) The agency and the Financial Services Commission may adopt rules as needed to administer this section.

(4) LICENSE NOT REQUIRED.—Neither the licensing requirements of the Florida Insurance Code nor chapter 641, relating to health maintenance organizations, is applicable to a health flex plan approved under this section, unless expressly made applicable. However, for the purpose of prohibiting unfair trade practices, health flex plans are considered to be insurance subject to the applicable provisions of part IX of chapter 626, except as otherwise provided in this section.

(5) ELIGIBILITY.—Eligibility to enroll in an approved health flex plan is limited to residents of this state who:

(a)1. Have a family income equal to or less than 300 percent of the federal poverty level;

2. Are not covered by a private insurance policy and are not eligible for coverage through a public health insurance program, such as Medicare or Medicaid, or another public health care program, such as Kidcare, and have not been covered at any time during the past 6 months, except that:

a. A person who was covered under an individual health maintenance contract issued by a health maintenance organization licensed under part I of chapter 641 which was also an approved health flex plan on October 1, 2008, may apply for coverage in the same health maintenance organization's health flex plan without a lapse in coverage if all other eligibility requirements are met; or

b. A person who was covered under Medicaid or Kidcare and lost eligibility for the Medicaid or Kidcare subsidy due to income restrictions within 90 days prior to applying for health care coverage through an approved health flex plan may apply for coverage in a health flex plan without a lapse in coverage if all other eligibility requirements are met; and

3. Have applied for health care coverage as an individual through an approved health flex plan and have agreed to make any payments required for participation, including periodic payments or payments due at the time health care services are provided; or

(b) Are part of an employer group of which at least 75 percent of the employees have a family income equal to or less than 300 percent of the federal poverty level and the employer group is not covered by a private health insurance policy and has not been covered at any time during the past 6 months. If the health flex plan entity is a health insurer, health plan, or health maintenance organization licensed under Florida law, only 50 percent of the employees must meet the income requirements for the purpose of this paragraph.

(6) RECORDS.—Each health flex plan shall maintain enrollment data and reasonable records of its losses, expenses, and claims experience and shall make those records reasonably available to enable the office to monitor and determine the financial viability of the health flex plan, as necessary. Provider networks and total enrollment by area shall be reported to the agency biannually to enable the agency to monitor access to care.

(7) NOTICE.—The denial of coverage by a health flex plan,

or the nonrenewal or cancellation of coverage, must be accompanied by the specific reasons for denial, nonrenewal, or cancellation. Notice of nonrenewal or cancellation must be provided at least 45 days in advance of the nonrenewal or cancellation, except that 10 days' written notice must be given for cancellation due to nonpayment of premiums. If the health flex plan fails to give the required notice, the health flex plan coverage must remain in effect until notice is appropriately given.

(8) NONENTITLEMENT.—Coverage under an approved health flex plan is not an entitlement, and a cause of action does not arise against the state, a local government entity, or any other political subdivision of this state, or against the agency, for failure to make coverage available to eligible persons under this section.

(9) PROGRAM EVALUATION.—The agency and the office shall evaluate the pilot program and its effect on the entities that seek approval as health flex plans, on the number of enrollees, and on the scope of the health care coverage offered under a health flex plan; shall provide an assessment of the health flex plans and their potential applicability in other settings; shall use health flex plans to gather more information to evaluate low-income consumer driven benefit packages; and shall, by January 1, 2005, and annually thereafter, jointly submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

(10) EXPIRATION.—This section expires <u>January 1, 2014, or upon the availability of qualified health plans through an exchange, whichever occurs later</u> ~~July 1, 2013~~.

Section 2. This act shall take effect June 30, 2013.

**The Florida Senate**

# BILL ANALYSIS AND FISCAL IMPACT STATEMENT

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

Prepared By: The Professional Staff of the Committee on Health Policy

| | |
|---|---|
| BILL: | CS/SB 278 |
| INTRODUCER: | Health Policy Committee and Senator Richter |
| SUBJECT: | Optometry |
| DATE: | February 25, 2013 REVISED: |

| | ANALYST | STAFF DIRECTOR | REFERENCE | ACTION |
|---|---|---|---|---|
| 1. | Stovall | Stovall | HP | **Fav/CS** |
| 2. | | | AHS | |
| 3. | | | AP | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |

## Please see Section VIII. for Additional Information:

| | | |
|---|---|---|
| A. COMMITTEE SUBSTITUTE..... | X | Statement of Substantial Changes |
| B. AMENDMENTS..... | | Technical amendments were recommended |
| | | Amendments were recommended |
| | | Significant amendments were recommended |

## I. Summary:

CS/SB 278 authorizes licensed certified optometrists to administer or prescribe oral ocular pharmaceutical agents, including controlled substances in Schedule III, Schedule IV, or Schedule V for the relief of pain due to ocular conditions of the eye and its appendages. The oral ocular pharmaceutical agents that may be administered or prescribed must be included in a formulary adopted by the Board of Optometry (board) in rule. Before administering or prescribing oral ocular pharmaceutical agents, the certified optometrist must complete a course and examination on general and ocular pharmaceutical agents, which are jointly developed and administered by the Florida Medical Association and the Florida Optometric Association. The first course and examination must be presented by July 1, 2013.

The bill defines the term "ocular pharmaceutical agent" to mean a pharmaceutical agent that is administered topically or orally for the diagnosis or treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques The formulary committee is required to submit specific findings of fact and grounds for recommendations for additions and modifications to, or deletions from the formulary of ocular pharmaceutical agents that certain optometrists may use in their practice. The board is bound by the formulary committee's recommendations on oral ocular pharmaceutical agents that certified optometrists

may administer and prescribe unless competent substantial evidence is presented to the board sufficient to rebut the committee's recommendation.

The bill prohibits an optometrist from prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug for the purpose of treating a systemic disease.

A certified optometrist is authorized to perform eye examinations, including a dilated examination, related to pugilistic exhibitions (boxing, kickboxing, or mixed martial arts matches). The bill authorizes an optometrist to operate a clinical laboratory to treat his or her own patients and requires other clinical laboratories to accept specimens submitted for examination by an optometrist.

This bill substantially amends the following sections of the Florida Statutes: 463.002, 463.005, 463.0055, 463.0057, 463.006, 463.0135, 463.014, 483.035, 483.041, 483.181, 893.02, 893.05.

## II. Present Situation:

Optometry is the diagnosis of conditions of the human eye and its appendages (eyelids, eyebrows, the conjunctiva, and the lacrimal apparatus).[1] An optometrist is a primary health care provider licensed to engage in the practice of optometry.[2]

In Florida, certified optometrists may administer topical ocular pharmaceutical agents to assist in determining refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages. Certified optometrists may prescribe vision therapy, corrective lenses, and topical pharmaceutical agents for the eyes and appendages, but may not perform surgical procedures in Florida.[3] A certified optometrist may remove superficial foreign bodes (foreign matter that is embedded in the conjunctiva or cornea but which has not penetrated the globe).[4]

To be licensed as a certified optometrist[5] in Florida, the applicant must:[6]

- Be at least 18 years of age.
- Submit satisfactory proof that the applicant is of good moral character.
- Have graduated from a 4-year program at an accredited school or college of optometry.
- Have completed at least 110 hours of transcript-quality coursework and clinical training in general and ocular pharmacology at an institution that:
  - has facilities for both didactic and clinical instructions in pharmacology; and

[1] Section 463.002(5), F.S.
[2] As of January 30, 2013, there were 3,137 active licenses in Florida. 3,019 were certified optometrists and 118 were optometrists according to the Department of Health, *2013 Bill Analysis, Economic Statement, and Fiscal Note for SB 278*, dated February 1, 2013. A copy is on file with the Senate Health Policy Committee
[3] Section 463.014(4), F.S.
[4] *Ibid.*
[5] All practitioners initially licensed after July 1, 1993. must be certified optometrists. *See* s. 463.002(3)(c), F.S.
[6] *See* Rule 64B13-4.004, F.A.C.

  - is accredited by a regional or professional accrediting organization that is recognized and approved by the Commission of Postsecondary Accreditation of the US Department of Education.
- Have completed at least 1 year of supervised experience in differential diagnosis of eye disease or disorders as part of the optometric training or in a clinical setting as part of the optometric experience.
- Pass the Florida Examination which consists of
  - Part I – a written examination on applicable Florida laws and rules governing the practice of optometry
  - Part II – a practical examination containing a clinical portion and a pharmacology/ocular disease portion
  - Part III – the Applied Basic Science portion of the examination developed by the National Board of Examiners in Optometry (NBEO); and
  - Part IV – the Clinical Science portion of the examination developed by the NBEO.
- Complete a 2-hour course relating to prevention of medical errors.

Ophthalmologists are medical physicians[7] who specialize in diseases of the eye. Ophthalmologists provide a full spectrum of eye care, from prescribing corrective lenses and medications to performing eye surgery. Ophthalmologists also care for patients with more advanced and complicated diseases than do optometrists. Ophthalmologist training involves an undergraduate degree, 4 years of medical school, completion of 1 year of an internship, and at least 3 years of residency training in ophthalmology.[8]

Florida law requires optometrists who diagnose patients with certain diseases to refer such patients to ophthalmologists for further treatment.[9] Optometrists are also required to maintain the names of at least three physicians, clinics, or hospitals to which they may refer patients who experience adverse drug reactions.[10]

**Administration of Medications by Optometrists**

Licensed certified optometrists may administer and prescribe topical ocular pharmaceutical agents that are included in a formulary adopted by rule[11] by the Board of Optometry (the board). Such pharmaceuticals must be related to the diagnosis and treatment of ocular conditions and must not require surgery or other invasive techniques for administration.

To be certified for prescribing privileges, an optometrist must:[12]

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[7] Ophthalmologists are licensed under ch. 458, F.S., relating to Medical Practice or ch. 459, F.S., relating to Osteopathic Medicine.
[8] American Academy of Ophthalmology, *About Ophthalmology and Eye M.D.s., available at:* http://www.aao.org/about/eyemds.cfm (last visited Feb. 17, 2013).
[9] Diagnoses which mandate a referral to an ophthalmologist include acute angle glaucoma, congenital or infantile glaucoma, infectious corneal diseases refractory to standard treatment, and retinal detachment. *See* s. 463.0135(2), F.S.
[10] *See* s. 463.0135, F.S.
[11] The formulary is listed in Rule 64B13-18.002, F.A.C., and includes agents to dilate and constrict pupils, local anesthetics, antibiotics, anti-inflammatory agents, antihistamines, antivirals, and anti-glaucoma medications. All medications are for topical ocular use only.
[12] Rule 64B13-10.001, F.A.C.

- Complete at least 110 hours of board-approved coursework and clinical training in general and ocular pharmacology at an accredited institution. Such training may have been part of an optometry training program;
- Complete at least 1 year of supervised experience in differential diagnosis of eye disorders, which may occur during training or clinical practice;
- Pass part II of the National Board of Examiners in Optometry examination;[13] and
- Pay a $500 fee.[14]

Certification for prescribing privileges is a required component of the general licensure process for optometrists and has been so for over 25 years.[15] Optometrists who are not certified may use topical anesthetics solely for glaucoma examinations.[16]

**Formulary Committee and Formulary**

A committee of five members reviews requests for additions to, deletions from, or modifications to a formulary of topical ocular pharmaceutical agents (TOPA) for administration and prescription by certified optometrists. The formulary committee provides to the board advisory opinions and recommendations on such requests. The formulary committee is comprised of two optometrists, appointed by the Board of Optometry; two ophthalmologists, appointed by the Board of Medicine; and one person with a doctorate degree in pharmacology, appointed by the State Surgeon General.[17] Currently, the two optometrists on the formulary committee are certified optometrists.[18]

The board adopts the TOPA by rule. The State Surgeon General may challenge any rule or proposed rule for the TOPA formulary on the grounds that it:[19]

- Is an invalid exercise of delegated legislative authority.
- Does not protect the public from any significant and discernible harm or damage.
- Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state.
- Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

**Prescribing Controlled Substances**

The Drug Enforcement Administration (DEA) within the U.S. Department of Justice is tasked with monitoring controlled substances and preventing their abuse. Controlled substances fall into five categories, or schedules, depending on their addictive potential. Drug schedules are

[13] This examination consists of 60 simulated patient cases to assess the examinee's performance in clinical practice situations *available at: http://www.optometry.org/part_2_pam.cfm* (last visited Feb. 17, 2013).
[14] Rule 64B13-6.001(9), F.A.C.
[15] *See* s. 463.006, F.S.; and Department of Health, *2013 Bill Analysis, Economic Statement, and Fiscal Note for SB 278,* dated February 1, 2013. A copy is on file with the Senate Health Policy Committee.
[16] *See* s. 463.0055(1), F.S.
[17] s. 463.0055, F.S.
[18] *Supra* 14.
[19] s. 463.0055(4)(c), F.S.

specified by the United States Department of Justice Drug Enforcement Administration in 21 C.F.R. §§ 1308.11-15 and in s. 893.03, F.S.

- Schedule I controlled substances currently have no accepted medical use in treatment in the United States and therefore may not be prescribed, administered, or dispensed for medical use. These substances have a high potential for abuse and include heroin, lysergic acid diethylamide (LSD), and marijuana.
- Schedule II controlled substances have a high potential for abuse which may lead to severe psychological or physical dependence, including morphine and its derivatives, amphetamines, cocaine, and pentobarbital.
- Schedule III controlled substances have lower abuse potential than Schedule II substances but may still cause psychological or physical dependence. Schedule III substances include products containing less than 15 milligrams (mg) of hydrocodone (such as Vicodin) or less than 90 mg of codeine per dose (such as Tylenol #3), ketamine, and anabolic steroids.
- Schedule IV substances have a low potential for abuse and include propoxyphene (Darvocet), alprazolam (Xanax), and lorazepam (Ativan).
- Schedule V controlled substances have an extremely low potential for abuse and primarily consist of preparations containing limited quantities of certain narcotics, such as cough syrup.[20]

Any health care professional wishing to prescribe controlled substances must apply for a prescribing number from the DEA. Prescribing numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee. The DEA will grant prescribing numbers to a wide range of health care professionals, including physicians, nurse practitioners, physician assistants, optometrists, dentists, and veterinarians, but such professionals may only prescribe controlled substances that have been authorized to them under state law. The DEA prescribing numbers must be renewed every 3 years.[21]

In Florida, only licensed physicians, dentists, veterinarians, naturopaths, and podiatrists are currently permitted to prescribe controlled substances, and they may only prescribe medications within the scope of their own practices.[22]

**Clinical Laboratories**

A clinical laboratory is a location in which body fluids or tissues are analyzed for purposes of the diagnosis, assessment, or prevention of a medical condition. Clinical laboratories may be free-standing facilities, may be part of a hospital, or may be part of a private practitioner's office.[23] Practitioners authorized to operate their own clinical laboratories exclusively to diagnose and treat their own patients are physicians, chiropractors, podiatrists, naturopaths, and dentists. Laboratories must be biennially licensed and inspected by the Agency for Health Care

[20] DEA, Office of Diversion Control, *Controlled Substance Schedules, available at*: http://www.deadiversion.usdoj.gov/schedules/index.html (last visited Feb. 17, 2013).
[21] DEA, *Questions and Answers available at*: http://www.deadiversion.usdoj.gov/drugreg/faq.htm#3 (last visited Feb. 17, 2013).
[22] *See* ss. 893.02(21) and 893.05, F.S.
[23] *See* s. 483.041, F.S.

Administration to ensure quality standards in examination of specimens, equipment, sanitation, staffing, and other measures.[24]

A clinical laboratory may examine human specimens at the request of the following licensed practitioners:[25]

- Physicians
- Physician assistants
- Medical assistants
- Chiropractors
- Chiropractic assistants
- Chiropractic physician's assistants
- Podiatrists
- Naturopaths
- Dentists
- Nurse practitioners

Results of laboratory tests must be reported directly to the requesting practitioner. The same price must be charged regardless of what type of practitioner requests the testing.

## III. Effect of Proposed Changes:

The bill authorizes licensed certified optometrists to administer or prescribe oral ocular pharmaceutical agents in addition to topical ocular pharmaceutical agents which is currently authorized in law.

**Section 1** amends s. 463.002, F.S., to remove the limiting reference to *topical* ocular pharmaceutical agents in the definition of optometry and defines the term "ocular pharmaceutical agent". This term means a pharmaceutical agent that is administered topically or orally for the diagnosis or treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques.

A licensed practitioner who is not a certified optometrist is required to display at his or her practice a sign that states, "I am a licensed practitioner, not a certified optometrist, and I am not able to prescribe pharmaceutical agents." This disclosure is currently required, however, it refers to not being able to prescribe topical ocular pharmaceutical agents.

**Section 2** amends s. 463.005, F.S., to remove the limiting reference to *topical* with respect to authority for the board to adopt rules relating to the administration and prescription of ocular pharmaceutical agents.

**Section 3** amends s. 463.0055, F.S., to authorize certified optometrists to administer and prescribe oral pharmaceutical agents in addition to topical ocular pharmaceutical agents. A licensed practitioner who is not a certified optometrist is authorized under existing law to use

[24] *See* s. 483.051, F.S.
[25] *See* s. 483.181, F.S.

topically applied anesthetics solely for glaucoma examination and prohibited from administering or prescribing topical ocular pharmaceutical agents. The CS continues to authorize the use of topically applied anesthetics for glaucoma examinations but prohibits the licensed optometrist who is not also certified from administering or prescribing pharmaceutical agents.

The bill requires a certified optometrist to complete a course and subsequent examination on general and ocular pharmaceutical agents and the side effects of those agents prior to administering or prescribing these agents. The Florida Medical Association and the Florida Optometric Association are required to jointly develop and administer the course and examination at a site or sites selected by these associations. The first course and examination must be presented by July 1, 2013, and subsequent courses and examinations must occur at least annually thereafter.

The required number of hours for the training depends upon when the certified optometrist was licensed. For certified optometrists licensed before January 1, 1990, the course must consist of 50 contact hours with 25 of these hours Internet-based. For certified optometrists licensed on or after January 1, 1990, the course must consist of 20 contact hours, with 10 of these hours Internet-based.

The composition of the formulary committee is modified to require that the two optometrist members must be certified optometrists. The bill adds that the formulary must consist of pharmaceutical agents which are appropriate to treat and diagnose ocular diseases and disorders, in addition to the existing requirement that it include those agents which a certified optometrist is qualified to use in the practice of optometry.

The formulary committee is required to submit to the board as a part of its opinions and recommendations concerning additions to, deletions from, of modifications for the formulary, specific findings of fact and grounds for its recommendation. The CS provides that these findings, opinions, and recommendations are not considered decisions which affect substantial interests subject to administrative review under ss. 120.569 and 120.57, F.S. The board is bound by the committee's recommendations on oral ocular pharmaceutical agents unless competent substantial evidence is presented to the board sufficient to rebut the committee's recommendation.

The bill conforms the requirement for a certified optometrist to have a prescriber number and include that number on a prescription to include all authorized pharmaceutical agents.

**Section 4** amends s. 463.0057, F.S., to require the holder of a faculty certificate to satisfy the additional coursework and examination requirements in addition to the existing requirements for administering and prescribing topical ocular pharmaceutical agents prior to administering or prescribing *any* pharmaceutical agents.

**Section 5** amends s. 463.006, F.S., to require the examination for licensure and certification as a certified optometrist in Florida to include the use and side effects of [all] pharmaceutical agents. This is a change from current law which requires the examination to emphasize the side effects of ocular pharmaceutical agents.

**Section 6** amends s. 463.0135, F.S., to add that a certified optometrist is authorized to perform any eye examination, including a dilated examination required or authorized for pugilistic exhibitions (boxing, kickboxing, or mixed martial arts matches).

**Section 7** amends s. 463.014, F.S., to prohibit a licensed practitioner from prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug to treat a systemic disease. Current law prohibits a licensed practitioner for performing any of these activities with a systemic drug.

**Sections 8 and 10** amend ss. 483.035 and 483.181, F.S., respectively, to authorize an optometrist to operate a clinical laboratory to treat his or her own patients and require other clinical laboratories to accept specimens submitted for examination by an optometrist.

**Section 9** amends s. 483.041, F.S., to modify the definition of "licensed practitioner" with respect to clinical laboratories. It refers to a person licensed under ch. 463, F.S., related to the practice of optometry as a physician. However, ch. 463, F.S., does not refer to licensed practitioners and certified optometrists as physicians.

**Section 11** amends s. 893.02, F.S., to add certified optometrists to the list of practitioners who may prescribe or administer controlled substances if licensed by the federal DEA.

**Section 12** amends s. 893.05, F.S., to prohibit a certified optometrist from administering or prescribing a Schedule I or Schedule II controlled substance. The CS authorizes a certified optometrist who has complied with the additional coursework and examination requirements in this bill to administer oral analgesics listed in Schedule III, Schedule IV, or Schedule V for the relief of pain due to ocular conditions of the eye and its appendages.

**Section 13** provides that the act is effective July 1, 2013.

## IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

## V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Certified optometrists who complete the additional coursework and successfully pass the examination will be able to provide a broader range of services for their patients by administering and prescribing oral pharmaceutical agents. Although a fee for the coursework and examination is not specified in the bill, it is reasonable to assume that optometrists would incur a fee.

C. Government Sector Impact:

The Department of Health (DOH) indicates additional workload and costs will be incurred for rulemaking, modifications to the licensure system, tracking of certified optometrists who have completed the coursework and examination, and potential complaints related to the bill. However, the DOH indicates that current resources are adequate to absorb the workload and costs.

## VI. Technical Deficiencies:

See lines 237 – 239. The CS amends the definition of a licensed practitioner for purposes of clinical laboratories. As amended, a "licensed practitioner" means a physician licensed under … chapter 463. However, ch. 463, F.S., does not refer to an optometrist, whether licensed or certified and licensed, as a physician. This could be corrected by deleting lines 238 and 239 and inserting: under chapter 458, chapter 459, chapter 460, or chapter 461; a certified optometrist licensed under chapter 463; a dentist licensed under chapter 466, a person.

Line 291 refers to Schedule III, IV, or V. It should state, Schedule III, Schedule IV, or Schedule V.

## VII. Related Issues:

Section 456.44, F.S., provides standards of practice and registration requirements for practitioners who prescribe certain controlled substances for the treatment of chronic nonmalignant pain. This section of law lists the specific practice acts under which the practitioners to whom this requirement applies are regulated. Chapter 463, F.S., relating to the practice of optometry is not included in this list and these provisions are not included in this bill. As a result, certified optometrists would not be required to register and follow these standards of practice if treating chronic nonmalignant pain with controlled substances.

## VIII. Additional Information:

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

**CS by Health Policy on February 21, 2013:**
Defines ocular pharmaceutical agent; requires the first course and examination to be available on or before July 1, 2013; requires the formulary committee to submit specific findings of fact and grounds for recommendations which the board must follow when the board adopts the formulary by rule unless it has competent substantial evidence to rebut

the recommendation; expands the subject matter of the examination for licensure as a certified optometrist to emphasize the use and side effects of [all] pharmaceutical agents, not just ocular pharmaceutical agents; and authorizes certified optometrists who have completed the coursework and examination to administer (Schedule III, IV, or V) oral analgesics for relief of pain due to ocular conditions..

B. Amendments:

None.

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LEGISLATIVE ACTION

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The Committee on Health Policy (Garcia) recommended the following:

**Senate Amendment (with title amendment)**

Delete everything after the enacting clause and insert:

Section 1. Paragraph (b) of subsection (3) and subsections (4) and (5) of section 463.002, Florida Statutes, are amended, and subsection (11) is added to that section, to read:

463.002 Definitions.—As used in this chapter, the term:

(3)

(b) A licensed practitioner who is not a certified optometrist is ~~shall be~~ required to display at her or his place of practice a sign that ~~which~~ states, "I am a licensed

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practitioner, not a certified optometrist, and I am not able to prescribe ~~topical ocular~~ pharmaceutical agents."

(4) "Certified optometrist" means a licensed practitioner authorized by the board to administer and prescribe ~~topical~~ ocular pharmaceutical agents.

(5) "Optometry" means the diagnosis of conditions of the human eye and its appendages; the employment of ~~any~~ objective or subjective means or methods, including the administration of ~~topical~~ ocular pharmaceutical agents, for the purpose of determining the refractive powers of the human eyes, or ~~any~~ visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and ~~any~~ other means or methods, including ~~topical~~ ocular pharmaceutical agents, for the correction, remedy, or relief of ~~any~~ insufficiencies or abnormal conditions of the human eyes and their appendages.

(11) "Ocular pharmaceutical agent" means a pharmaceutical agent that is administered topically or orally for the diagnosis or treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques.

Section 2. Paragraph (g) of subsection (1) of section 463.005, Florida Statutes, is amended to read:

463.005 Authority of the board.—

(1) The Board of Optometry may ~~has authority to~~ adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it. Such rules ~~shall~~ include, but are not ~~be~~ limited to, rules relating to:

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(g) Administration and prescription of ~~topical~~ ocular pharmaceutical agents.

Section 3. Section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ~~topical~~ ocular pharmaceutical agents; committee.—

(1)(a) Certified optometrists may administer and prescribe ~~topical~~ ocular pharmaceutical agents as provided in this section for the diagnosis and treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques. However, a licensed practitioner who is not certified may use topically applied anesthetics solely for the purpose of glaucoma examinations, but is otherwise prohibited from administering or prescribing ~~topical ocular~~ pharmaceutical agents.

(b) Before a certified optometrist may administer or prescribe oral ocular pharmaceutical agents, the certified optometrist must complete a course and subsequent examination on general and ocular pharmaceutical agents and the side effects of those agents. For certified optometrists licensed before January 1, 1990, the course consists of 50 contact hours, with 25 of those hours web-based. For certified optometrists licensed on or after January 1, 1990, the course consists of 20 contact hours, with 10 of those hours web-based. The first course and examination shall be presented by July 1, 2013, and shall be administered at least annually thereafter. The Florida Medical Association and the Florida Optometric Association shall jointly develop and administer a course and examination for such purpose and jointly determine the site or sites for the course and

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examination.

(2)(a) There is ~~hereby~~ created a committee composed of two certified optometrists licensed pursuant to this chapter, appointed by the Board of Optometry, two board-certified ophthalmologists licensed pursuant to chapter 458 or chapter 459, appointed by the Board of Medicine, and one additional person with a doctorate degree in pharmacology who is not licensed pursuant to chapter 458, chapter 459, or this chapter, appointed by the State Surgeon General. The committee shall review requests for additions to, deletions from, or modifications of a formulary of ~~topical~~ ocular pharmaceutical agents for administration and prescription by certified optometrists and shall provide to the board advisory opinions and recommendations on such requests. The committee's opinions and recommendations must state specific findings of fact and grounds for its recommendation. The committee's findings, opinions, and recommendations are not subject to review pursuant to ss. 120.569 and 120.57. The formulary shall consist of those ~~topical~~ ocular pharmaceutical agents that ~~which~~ are appropriate to treat and diagnose ocular diseases and disorders and which the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the formulary by rule. The board is bound by the committee's recommendations on oral ocular pharmaceutical agents unless competent substantial evidence is presented to the board sufficient to rebut the committee's recommendation. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule becomes ~~shall become~~ effective 60 days from the date it is filed with the Secretary of State.

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(b) The formulary may be added to, deleted from, or modified according to the procedure described in paragraph (a). A ~~Any~~ person who requests an addition, deletion, or modification of an authorized ~~topical~~ ocular pharmaceutical agent has ~~shall have~~ the burden of proof to show cause why such addition, deletion, or modification should be made.

(c) The State Surgeon General has ~~shall have~~ standing to challenge a ~~any~~ rule or proposed rule of the board pursuant to s. 120.56. In addition to challenges to an ~~for any~~ invalid exercise of delegated legislative authority, the administrative law judge, upon such a challenge by the State Surgeon General, may declare all or part of a rule or proposed rule invalid if it:

1. Does not protect the public from ~~any~~ significant and discernible harm or damages;

2. Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or

3. Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

However, ~~there shall not be created~~ a presumption of the existence of ~~any of~~ the conditions cited in this subsection is not created in the event that the rule or proposed rule is challenged.

(d) Upon adoption of the formulary required by this section, and upon each addition, deletion, or modification to the formulary, the board shall mail a copy of the amended formulary to each certified optometrist and to each pharmacy

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licensed by the state.

(3) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for an ~~a topical~~ ocular pharmaceutical agent pursuant to this section must include ~~shall have~~ the prescriber number ~~printed thereon~~.

Section 4. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section~~,~~ but may not administer or prescribe ~~topical~~ ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of ss. 463.0055(1)(b) and ~~s.~~ 463.006(1)(b)4. and 5.

Section 5. Subsections (2) and (3) of section 463.006, Florida Statutes, are amended to read:

463.006 Licensure and certification by examination.—

(2) The examination consists ~~shall consist~~ of the appropriate subjects, including applicable state laws and rules and general and ocular pharmacology with emphasis on the use ~~topical application~~ and side effects of ~~ocular~~ pharmaceutical agents. The board may by rule substitute a national examination as part or all of the examination and may by rule offer a practical examination in addition to the written examination.

(3) Each applicant who successfully passes the examination and otherwise meets the requirements of this chapter is entitled to be licensed as a practitioner and to be certified to administer and prescribe ~~topical ocular~~ pharmaceutical agents in the diagnosis and treatment of ocular conditions.

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Section 6. Subsection (10) is added to section 463.0135, Florida Statutes, to read:

463.0135 Standards of practice.—

(10) A certified optometrist may perform any eye examination, including a dilated examination, required or authorized by chapter 548 or by rules adopted to implement that chapter.

Section 7. Subsection (3) of section 463.014, Florida Statutes, is amended to read:

463.014 Certain acts prohibited.—

(3) Prescribing, ordering, dispensing, administering, supplying, selling, or giving any drug for the purpose of treating a systemic disease ~~systemic drugs~~ by a licensed practitioner is prohibited.

Section 8. Subsection (1) of section 483.035, Florida Statutes, is amended to read:

483.035 Clinical laboratories operated by practitioners for exclusive use; licensure and regulation.—

(1) A clinical laboratory operated by one or more practitioners licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, or chapter 466, exclusively in connection with the diagnosis and treatment of their own patients, must be licensed under this part and must comply with the provisions of this part, except that the agency shall adopt rules for staffing, for personnel, including education and training of personnel, for proficiency testing, and for construction standards relating to the licensure and operation of the laboratory based upon and not exceeding the same standards contained in the federal Clinical Laboratory

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Improvement Amendments of 1988 and the federal regulations adopted thereunder.

Section 9. Subsection (7) of section 483.041, Florida Statutes, is amended to read:

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

(7) "Licensed practitioner" means a physician licensed under chapter 458, chapter 459, chapter 460, ~~or~~ chapter 461, or chapter 463; a dentist licensed under chapter 466; a person licensed under chapter 462; or an advanced registered nurse practitioner licensed under part I of chapter 464; or a duly licensed practitioner from another state licensed under similar statutes who orders examinations on materials or specimens for nonresidents of the State of Florida, but who reside in the same state as the requesting licensed practitioner.

Section 10. Subsection (5) of section 483.181, Florida Statutes, is amended to read:

483.181 Acceptance, collection, identification, and examination of specimens.—

(5) A clinical laboratory licensed under this part must accept a human specimen submitted for examination by a practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, s. 464.012, or chapter 466, if the specimen and test are the type performed by the clinical laboratory. A clinical laboratory may only refuse a specimen based upon a history of nonpayment for services by the practitioner. A clinical laboratory may ~~shall~~ not charge different prices for tests based upon the chapter under which a practitioner submitting a specimen for testing is licensed.

Section 11. Subsection (21) of section 893.02, Florida

606544

Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(21) "Practitioner" means a physician licensed pursuant to chapter 458, a dentist licensed pursuant to chapter 466, a veterinarian licensed pursuant to chapter 474, an osteopathic physician licensed pursuant to chapter 459, a naturopath licensed pursuant to chapter 462, a certified optometrist licensed pursuant to chapter 463, or a podiatric physician licensed pursuant to chapter 461, provided such practitioner holds a valid federal controlled substance registry number.

Section 12. Subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the same to be administered by a licensed nurse or an intern practitioner under his or her direction and supervision only. A veterinarian may so prescribe, administer, dispense, mix, or prepare a controlled substance for use on animals only, and may cause it to be administered by an assistant or orderly under the veterinarian's direction and supervision only. A certified optometrist licensed under chapter 463 may not administer or prescribe pharmaceutical agents listed in Schedule I or Schedule II of s. 893.03. A certified optometrist who has complied with the provisions of section

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463.0055(1)(b) may administer oral analgesics listed in Schedule III, IV, or V for the relief of pain due to ocular conditions of the eye and its appendages.

Section 13. This act shall take effect July 1, 2013.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to the practice of optometry; amending s. 463.002, F.S.; requiring a licensed practitioner who is not a certified optometrist to display a specifically worded sign; revising definitions; defining the term "ocular pharmaceutical agent"; amending s. 463.005, F.S.; authorizing the Board of Optometry to adopt rules relating to the administration and prescription of ocular pharmaceutical agents; amending s. 463.0055, F.S.; requiring a certified optometrist to complete a course and examination on general and ocular pharmaceutical agents before administering or prescribing oral ocular pharmaceutical agents; specifying the number of required course hours based on the date of licensure; requiring the Florida Medical Association and the Florida Optometric Association to jointly develop and administer the course and examination; revising provisions relating to the development of a formulary of pharmaceutical agents; amending s. 463.0057, F.S.;

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prohibiting the holder of an optometric faculty certificate from administering or prescribing pharmaceutical agents; amending s. 463.006, F.S.; revising provisions relating to licensure and certification of optometrists; amending s. 463.0135, F.S.; authorizing a certified optometrist to perform certain eye examinations; amending s. 463.014, F.S.; prohibiting a licensed practitioner of optometry from providing any drug for the purpose of treating a systemic disease; amending s. 483.035, F.S.; requiring a clinical laboratory operated by a licensed practitioner of optometry to be licensed under ch. 463, F.S.; amending s. 483.041, F.S.; revising the definition of the term "licensed practitioner" to include certified optometrists; amending s. 483.181, F.S.; providing for an optometrist to accept a human specimen for examination, under certain conditions; amending s. 893.02, F.S.; redefining the term "practitioner" to include certified optometrists; amending s. 893.05, F.S.; prohibiting a certified optometrist from administering or prescribing pharmaceutical agents listed in Schedule I or Schedule II of the Florida Comprehensive Drug Abuse Prevention and Control Act; authorizing certain certified optometrists to administer certain oral analgesics; providing an effective date.

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LEGISLATIVE ACTION

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The Committee on Health Policy (Sobel) recommended the following:

**Senate Amendment to Amendment (606544) (with title amendment)**

Delete line 76
and insert:
459, appointed by the Board of Medicine, one physician board-certified in obstetrics and gynecology licensed pursuant to chapter 458 or chapter 459, appointed by the Board of Medicine, and one additional

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

490950

Delete line 271

and insert:

administer the course and examination; revising the membership of a certain committee by adding a physician board-certified in obstetrics and gynecology; specifying requirements for committee recommendations and binding the board to committee recommendations on certain agents; revising

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LEGISLATIVE ACTION

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The Committee on Health Policy (Sobel) recommended the following:

**Senate Amendment to Amendment (606544) (with title amendment)**

Delete lines 83 - 96

and insert:

optometrists ~~and shall provide to the board advisory opinions and recommendations on such requests~~. The committee shall establish a formulary of ocular pharmaceutical agents which a certified optometrist having prescribing authority under this section may prescribe. The formulary must consist only of those ocular pharmaceutical agents that are appropriate to treat and diagnose ocular diseases and disorders in which the certified

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optometrist is qualified to use in the practice of optometry. Only the committee ~~The formulary shall consist of those topical ocular pharmaceutical agents which the certified optometrist is qualified to use in the practice of optometry. The board~~ shall ~~establish,~~ add to, delete from, or modify the formulary ~~by rule~~. Thereafter the board shall adopt the formulary required by this paragraph by rule.

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

And the title is amended as follows:

Delete line 271

and insert:

administer the course and examination; revising the duties of a certain committee; requiring the board to adopt the committee's formulary; revising

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LEGISLATIVE ACTION

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| 02/21/2013 | . | |
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The Committee on Health Policy (Galvano) recommended the following:

**Senate Amendment to Amendment (606544) (with title amendment)**

Between lines 164 and 165
insert:

Section 7. Section 463.0137, Florida Statutes, is created to read:

463.0137 Reports of adverse incidents in the practice of optometry.—

(1) Any adverse incident that occurs in the practice of optometry must be reported to the department in accordance with this section.

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(2) The required notification to the department must be submitted in writing by certified mail and postmarked within 15 days after the occurrence of the adverse incident.

(3) The term "adverse incident," as used in this section, means an event that is associated in whole or in part with the prescribing of an oral ocular pharmaceutical agent and that results in one of the following:

(a) Any condition that requires the transfer of a patient to a hospital licensed under chapter 395;

(b) Any condition that requires the patient to obtain care from a physician licensed under chapter 458 or chapter 459, other than a referral or a consultation required under this chapter;

(c) Permanent physical injury to the patient;

(d) Partial or complete permanent loss of sight by the patient; or

(e) Death of the patient.

(4) The department shall review each incident and determine whether it potentially involved conduct by the licensed practitioner which may be subject to disciplinary action, in which case s. 456.073 applies. Disciplinary action, if any, shall be taken by the board.

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

And the title is amended as follows:

Delete line 280

and insert:

certain eye examinations; creating s. 463.0137, F.S., requiring certified optometrists to report to the

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Department of Health any adverse incident associated with an oral ocular pharmaceutical agent prescribed by that certified optometrist to the patient; defining adverse incident; requiring the department to review adverse incident reports, determine whether conduct of the prescribing optometrist is the subject of disciplinary action, and take disciplinary action if it was; amending s. 463.014, F.S.;

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LEGISLATIVE ACTION

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The Committee on Health Policy (Galvano) recommended the following:

**Senate Amendment to Amendment (606544) (with directory and title amendments)**

Between lines 164 and 165
insert:

(11) Comanagement of postoperative care shall be conducted pursuant to an established protocol that governs the relationship between the operating surgeon and the optometrist. The patient shall be informed that he or she has the right to be seen by the operating ophthalmologist during the entire postoperative period and that either the operating ophthalmologist or the optometrist will be available for

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emergency care throughout the postoperative period. The patient must be informed of the fees, if any, to be charged by the optometrist who has been delegated certain postoperative-care responsibilities and must be provided with an accurate and comprehensive itemized statement of the specific postoperative-care services that the operating surgeon and the optometrist each have rendered, along with the charge for each service. The patient must consent in writing to the comanagement relationship for her or his care.

====== D I R E C T O R Y  C L A U S E  A M E N D M E N T ======
And the directory clause is amended as follows:

Delete lines 158 - 159

and insert:

Section 6. Subsections (10) and (11) are added to section 463.0135, Florida Statutes, to read:

================ T I T L E  A M E N D M E N T ================
And the title is amended as follows:

Delete line 280

and insert:

certain eye examinations; requiring a postoperative comanagement care arrangement between an ophthalmologist and an optometrist to be governed by a written comanagement agreement; requiring certain notifications, fees, and itemized statement of postoperative care services to be provided to the

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patient; requiring a patient to consent in writing to the comanagement relationship for her or his care; amending s. 463.014, F.S.;

**By** Senator Richter

23-00197A-13 2013278__

A bill to be entitled

An act relating to optometry; amending s. 463.002, F.S.; revising definitions; amending s. 463.005, F.S.; revising a reference to ocular pharmaceutical agents; amending and reordering s. 463.0055, F.S.; revising references to ocular pharmaceutical agents; requiring certified optometrists to complete a course and examination on general and ocular pharmaceutical agents; requiring the Florida Medical Association and the Florida Optometric Association to jointly administer, develop, and determine the course site for the course and examination; requiring the associations to present the first course and examination by a specified date and to administer the course and examination at least annually; requiring two optometrists appointed to the formulary committee to be licensed and certified; requiring that the formulary consist of pharmaceutical agents that are appropriate to treat and diagnose ocular diseases and disorders; amending s. 463.0057, F.S.; revising reference to ocular pharmaceutical agents; adding a cross-reference to changes made by the act; amending s. 463.006, F.S.; revising reference to ocular pharmaceutical agents; incorporating mandating language that was removed from the definitions; amending s. 463.0135, F.S.; providing that a certified optometrist is authorized to perform any eye examination required or authorized by chapter 548; amending s. 463.014, F.S.; making technical and

grammatical changes; amending s. 483.035, F.S., relating to licensure and regulation of clinical laboratories operated by practitioners for exclusive use; providing applicability to clinical laboratories operated by practitioners licensed to practice optometry; amending s. 483.041, F.S.; revising the definition of the term "licensed practitioner" to include a practitioner licensed under ch. 463, F.S.; amending s. 483.181, F.S.; requiring clinical laboratories to accept human specimens submitted by practitioners licensed to practice under ch. 463, F.S.; amending s. 893.02, F.S.; revising the definition of the term "practitioner" to include certified optometrists for purposes of the Florida Comprehensive Drug Abuse Prevention and Control Act; amending s. 893.05, F.S.; prohibiting a certified optometrist from administering and prescribing certain controlled substances; providing an effective date.

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

Section 1. Subsections (3), (4), and (5) of section 463.002, Florida Statutes, are amended to read:

463.002 Definitions.—As used in this chapter, the term:

(3)~~(a)~~ "Licensed practitioner" means a person who is a primary health care provider licensed to engage in the practice of optometry under the authority of this chapter.

~~(b) A licensed practitioner who is not a certified optometrist shall be required to display at her or his place of~~

~~practice a sign which states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe topical ocular pharmaceutical agents."~~

~~(c) All practitioners initially licensed after July 1, 1993, must be certified optometrists.~~

(4) "Certified optometrist" means a licensed practitioner authorized by the board to administer and prescribe ~~topical~~ ocular pharmaceutical agents.

(5) "Optometry" means the diagnosis of conditions of the human eye and its appendages; the employment of any objective or subjective means or methods, including the administration of ~~topical ocular~~ pharmaceutical agents, for the purpose of determining the refractive powers of the human eyes, or any visual, muscular, neurological, or anatomic anomalies of the human eyes and their appendages; and the prescribing and employment of lenses, prisms, frames, mountings, contact lenses, orthoptic exercises, light frequencies, and any other means or methods, including ~~topical ocular~~ pharmaceutical agents, for the correction, remedy, or relief of any insufficiencies or abnormal conditions of the human eyes and their appendages.

Section 2. Paragraph (g) of subsection (1) of section 463.005, Florida Statutes, is amended to read:

463.005 Authority of the board.—

(1) The Board of Optometry has authority to adopt rules pursuant to ss. 120.536(1) and 120.54 to implement the provisions of this chapter conferring duties upon it. Such rules shall include, but not be limited to, rules relating to:

(g) Administration and prescription of ~~topical~~ ocular pharmaceutical agents.

Section 3. Section 463.0055, Florida Statutes, is reordered and amended to read:

463.0055 Administration and prescription of ~~topical~~ ocular pharmaceutical agents; course and examination on pharmaceutical agents; prescriber number; formulary committee.—

(1) A certified optometrist ~~optometrists~~ may administer and prescribe ~~topical ocular~~ pharmaceutical agents as provided in this section for the diagnosis and treatment of ocular conditions of the human eye and its appendages without the use of surgery or other invasive techniques. ~~However,~~ A licensed practitioner who is not certified may use topically applied anesthetics solely for the purpose of glaucoma examinations, but is otherwise prohibited from administering or prescribing ~~topical ocular~~ pharmaceutical agents.

(2) Before a certified optometrist may administer or prescribe oral ocular pharmaceutical agents, the certified optometrist must complete a course and subsequent examination on general and ocular pharmaceutical agents and the side effects of those agents. For certified optometrists licensed before January 1, 1990, the course must consist of 50 contact hours, and 25 of those hours must be Internet-based. For certified optometrists licensed on or after January 1, 1990, the course must consist of 20 contact hours, and 10 of those hours must be Internet-based. The Florida Medical Association and the Florida Optometric Association shall jointly develop and administer such course and examination and jointly determine the site or sites for the course and examination. The associations shall present the first course and examination by January 1, 2014, and shall thereafter administer the course and examination at least annually.

(4)~~(2)~~(a) There is ~~hereby~~ created a committee composed of two optometrists licensed and certified pursuant to this chapter, appointed by the Board of Optometry;~~,~~ two board-certified ophthalmologists licensed pursuant to chapter 458 or chapter 459, appointed by the Board of Medicine;~~,~~ and one additional person with a doctorate degree in pharmacology who is not licensed pursuant to chapter 458, chapter 459, or this chapter, appointed by the State Surgeon General. The committee shall review requests for additions to, deletions from, or modifications of a formulary of ~~topical~~ ocular pharmaceutical agents for administration and prescription by certified optometrists and shall provide to the board advisory opinions and recommendations on such requests. The formulary must ~~shall~~ consist of those ~~topical ocular~~ pharmaceutical agents which are appropriate to treat and diagnose ocular diseases and disorders and which the certified optometrist is qualified to use in the practice of optometry. The board shall establish, add to, delete from, or modify the formulary by rule. Notwithstanding any provision of chapter 120 to the contrary, the formulary rule shall become effective 60 days from the date it is filed with the Secretary of State.

(b) The formulary may be added to, deleted from, or modified according to the procedure described in paragraph (a). Any person who requests an addition, deletion, or modification of an authorized ~~topical~~ ocular pharmaceutical agent has ~~shall have~~ the burden of proof to show cause why such addition, deletion, or modification should be made.

(c) The State Surgeon General has ~~shall have~~ standing to challenge any rule or proposed rule of the board pursuant to s.

120.56. In addition to challenges for any invalid exercise of delegated legislative authority, the administrative law judge, upon such a challenge by the State Surgeon General, may declare all or part of a rule or proposed rule invalid if it:

1. Does not protect the public from any significant and discernible harm or damages;

2. Unreasonably restricts competition or the availability of professional services in the state or in a significant part of the state; or

3. Unnecessarily increases the cost of professional services without a corresponding or equivalent public benefit.

However, ~~there shall not be created~~ a presumption of the existence of any of the conditions cited in this subsection is not created if ~~in the event that~~ the rule or proposed rule is challenged.

(d) Upon adoption of the formulary required by this section, and upon each addition, deletion, or modification to the formulary, the board shall mail a copy of the amended formulary to each certified optometrist and to each pharmacy licensed by the state.

(3) A certified optometrist shall be issued a prescriber number by the board. Any prescription written by a certified optometrist for a ~~topical ocular~~ pharmaceutical agent pursuant to this section must ~~shall~~ have the prescriber number printed thereon.

Section 4. Subsection (3) of section 463.0057, Florida Statutes, is amended to read:

463.0057 Optometric faculty certificate.—

(3) The holder of a faculty certificate may engage in the practice of optometry as permitted by this section~~,~~ but may not administer or prescribe ~~topical~~ ocular pharmaceutical agents unless the certificateholder has satisfied the requirements of ss. 463.0055(2) and ~~s.~~ 463.006(1)(b)4. and 5.

Section 5. Subsections (2) and (3) of section 463.006, Florida Statutes, are amended, and subsections (4) and (5) are added to that section, to read:

463.006 Licensure and certification by examination.—

(2) The examination must ~~shall~~ consist of the appropriate subjects, including applicable state laws and rules and general and ocular pharmacology with emphasis on the use ~~topical application~~ and side effects of ocular pharmaceutical agents. The board may by rule substitute a national examination as part or all of the examination and may by rule offer a practical examination in addition to the written examination.

(3) An ~~Each~~ applicant who successfully passes the examination and otherwise meets the requirements of this chapter is entitled to be licensed as a practitioner and to be certified to administer and prescribe ~~topical ocular~~ pharmaceutical agents in the diagnosis and treatment of ocular conditions.

(4) A licensed practitioner who is not a certified optometrist shall display at her or his place of practice a sign that states, "I am a Licensed Practitioner, not a Certified Optometrist, and I am not able to prescribe ocular pharmaceutical agents."

(5) A practitioner initially licensed after July 1, 1993, must be a certified optometrist.

Section 6. Subsection (10) is added to section 463.0135,

Florida Statutes, to read:

463.0135 Standards of practice.—

(10) A certified optometrist is authorized to perform any eye examination, including a dilated examination, required or authorized by chapter 548 or by rules adopted to implement the provisions of that chapter.

Section 7. Subsection (3) of section 463.014, Florida Statutes, is amended to read:

463.014 Certain acts prohibited.—

(3) A licensed practitioner may not prescribe, order, dispense, administer, supply, sell, or give any drug for the purpose of treating a systemic disease ~~Prescribing, ordering, dispensing, administering, supplying, selling, or giving any systemic drugs by a licensed practitioner is prohibited~~.

Section 8. Subsection (1) of section 483.035, Florida Statutes, is amended to read:

483.035 Clinical laboratories operated by practitioners for exclusive use; licensure and regulation.—

(1) A clinical laboratory operated by one or more practitioners licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, or chapter 466, exclusively in connection with the diagnosis and treatment of their own patients, must be licensed under this part and must comply with the provisions of this part, except that the agency shall adopt rules for staffing, for personnel, including education and training of personnel, for proficiency testing, and for construction standards relating to the licensure and operation of the laboratory based upon and not exceeding the same standards contained in the federal Clinical Laboratory

Improvement Amendments of 1988 and the federal regulations adopted thereunder.

Section 9. Subsection (7) of section 483.041, Florida Statutes, is amended to read:

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

(7) "Licensed practitioner" means a physician licensed under chapter 458, chapter 459, chapter 460, ~~or~~ chapter 461, or chapter 463; a dentist licensed under chapter 466; a person licensed under chapter 462; or an advanced registered nurse practitioner licensed under part I of chapter 464; or a duly licensed practitioner from another state licensed under similar statutes who orders examinations on materials or specimens for nonresidents of the State of Florida, but who reside in the same state as the requesting licensed practitioner.

Section 10. Subsection (5) of section 483.181, Florida Statutes, is amended to read:

483.181 Acceptance, collection, identification, and examination of specimens.—

(5) A clinical laboratory licensed under this part must accept a human specimen submitted for examination by a practitioner licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, s. 464.012, or chapter 466, if the specimen and test are the type performed by the clinical laboratory. A clinical laboratory may only refuse a specimen based upon a history of nonpayment for services by the practitioner. A clinical laboratory may ~~shall~~ not charge different prices for tests based upon the chapter under which a practitioner submitting a specimen for testing is licensed.

Section 11. Subsection (21) of section 893.02, Florida

Statutes, is amended to read:

893.02 Definitions.—The following words and phrases as used in this chapter shall have the following meanings, unless the context otherwise requires:

(21) "Practitioner" means a physician licensed pursuant to chapter 458, a dentist licensed pursuant to chapter 466, a veterinarian licensed pursuant to chapter 474, an osteopathic physician licensed pursuant to chapter 459, a naturopath licensed pursuant to chapter 462, a certified optometrist licensed pursuant to chapter 463, or a podiatric physician licensed pursuant to chapter 461, if ~~provided~~ such practitioner holds a valid federal controlled substance registry number.

Section 12. Subsection (1) of section 893.05, Florida Statutes, is amended to read:

893.05 Practitioners and persons administering controlled substances in their absence.—

(1) A practitioner, in good faith and in the course of his or her professional practice only, may prescribe, administer, dispense, mix, or otherwise prepare a controlled substance, or the practitioner may cause the same to be administered by a licensed nurse or an intern practitioner under his or her direction and supervision only. A veterinarian may so prescribe, administer, dispense, mix, or prepare a controlled substance for use on animals only, and may cause it to be administered by an assistant or orderly under the veterinarian's direction and supervision only. An optometrist licensed and certified under chapter 463 may not administer or prescribe a controlled substance in Schedule I or Schedule II of the Florida Comprehensive Drug Abuse Prevention and Control Act.

Section 13. This act shall take effect July 1, 2013.

# THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

**COMMITTEES:**
Gaming, *Chair*
Appropriations
Appropriations Subcommittee on Education
Appropriations Subcommittee on Health and Human Services
Banking and Insurance
Commerce and Tourism
Judiciary
Rules
Transportation

**JOINT COMMITTEE:**
Joint Legislative Budget Commission

**SENATOR GARRETT RICHTER**
*President Pro Tempore*
23rd District

January 21, 2013

The Honorable Aaron, Chair
Committee on Health Policy
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean:

Senate Bill 278, related to Optometry, has been referred to the Committee on Health Policy. I would appreciate the placing of this bill on the committee's agenda at your earliest convenience.

Thank you for your consideration.

Sincerely,

Garrett Richter

cc: Sandra Stovall, Staff Director

ENTERED

REPLY TO:
❒ 3299 E. Tamiami Trail, Suite 203, Naples, Florida 34112-4961 (239) 417-6205
❒ 404 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5023
❒ 25 Homestead Road North, Suite 42 B, Lehigh Acres, Florida 33936 (239) 338-2777

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

**DON GAETZ**
**President of the Senate**

**GARRETT RICHTER**
**President Pro Tempore**

FLORIDA SENATE
JAN 22 2013
Health Policy Committee

8:27

THE FLORIDA SENATE

# APPEARANCE RECORD

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

2/21/13
*Meeting Date*

Topic SB 278

Bill Number SB 278 *(if applicable)*

Name Charles Slonim MD

Amendment Barcode _____ *(if applicable)*

Job Title ophthalmologist

Address 2409 S. Dundee St. *Street*

Phone 8139742064

Tampa, FL 33629 *City State Zip*

E-mail charles.slonim@va.gov

Speaking: ☐ For ☒ Against ☐ Information

Representing Florida Society of Ophthalmology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/20/11)

8:34

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

02/21/13
*Meeting Date*

Topic Relating to Optometry

Bill Number SB 278 *(if applicable)*

Name Walter L. "Mickey" Presha (pronounced "Pre-shay")

Amendment Barcode *(if applicable)*

Job Title President and CEO, Manatee County Rural Health Services

Address PO Box 499 *Street*

Phone 941 776 4000

Parrish, FL 34219 *City* *State* *Zip*

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing Manatee County Rural Health Services

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/20/11)

THE FLORIDA SENATE

# COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

2-21-2013
*Date*

WAIVE TIME IN OPPOSITION

SB 278
*Bill Number*

*Barcode*

Name STEPHEN R. WINN

Phone 878-7463

Address 2007 APALACHEE PARKWAY
*Street*
TALLAHASSEE FL 32301
*City* *State* *Zip*

E-mail

Job Title EX. DIR.

Speaking: ☐ For ☒ Against ☐ Information

Appearing at request of Chair ☐

Subject OPTOMETRY

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Lobbyist registered with Legislature: ☒ Yes ☐ No

Pursuant to s. 11.061, *Florida Statutes*, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

**If designated employee:** Time: from_____ ___ .m. to _____ ___ .m.

S-001 (04/14/10)

8:37

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

Feb 21, 2013
*Meeting Date*

Topic Optometry

Bill Number SB 278 *(if applicable)*

Name Dr. Kenneth Woliner, MD

Amendment Barcode *(if applicable)*

Job Title FAMILY MEDICINE (primary care) physician

Address 9325 Glades Road, #104
*Street*
Boca Raton FL 33434
*City* *State* *Zip*

Phone 561-314-0950

E-mail knw6@cornell.edu

Speaking: ☐ For ☑ Against ☐ Information

Representing Myself as a primary care family physician (and a member of the Florida Medical Association)

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

8:40

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

21 FEB 13
*Meeting Date*

Topic OPTOMETRY PRESCRIBING

Bill Number SB 278 *(if applicable)*

Name KURT F. HEITMAN

Amendment Barcode *(if applicable)*

Job Title M.D.

Address 113 DOCTOR'S DR.
*Street*

Phone 864 269-3333

GREENVILLE, SC 29605
*City* *State* *Zip*

E-mail KHEITMAN@SOUTHERN-EYE.COM

Speaking: ☐ For ☒ Against ☐ Information

Representing AMERICAN ACADEMY OF OPHTHALMOLOGY

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

847

THE FLORIDA SENATE

# APPEARANCE RECORD

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

2-21-13
*Meeting Date*

Topic OPTOMETRY

Bill Number SB 278 *(if applicable)*

Name Stacey J. Kruger, MD

Amendment Barcode _____ *(if applicable)*

Job Title Pediatric Ophthalmologist

Address 8585 SW 72 ST. # 201 *Street*

Phone 305-274-4123

MIAMI *City* FL *State* 33143 *Zip*

E-mail SKrugerechildeyecare.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Society of Ophthalmology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

848

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

2/21/13
*Meeting Date*

Topic Surgery only by Surgeons

Bill Number 278 *(if applicable)*

Name Jaime Membreno M.D.

Amendment Barcode *(if applicable)*

Job Title Surgeon

Address 1000 Sla Meranot
*Street*
Winter Park FL 3278
*City* *State* *Zip*

Phone

E-mail

Speaking: ☐ For ☐ Against ☐ Information

Representing Ophthalmology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

# APPEARANCE RECORD

849

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

2/21/13
*Meeting Date*

Topic OPTOMETRIC PRESCRIBING

Bill Number 278 *(if applicable)*

Name Deepak Raja

Amendment Barcode *(if applicable)*

Job Title MD

Address 6068 S. Apopka-Vineland Rd, Ste 60 *Street*

Phone (407) 704-3937

Orlando FL 32819 *City* *State* *Zip*

E-mail DrRaja@eyesandlids.com

Speaking: ☐ For ☒ Against ☐ Information

Representing Ophthalmology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

853

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

FEB 21 2013
*Meeting Date*

Topic SENATE BILL 278 Bill Number 278 *(if applicable)*

Name DR. JIM ROWSEY Amendment Barcode *(if applicable)*

Job Title CHAIRMAN DEPARTMENT OF OPHTHALMOLOGY UNIVERSITY OF SOUTH FLORIDA RETIRED

Address 1214 SAND DOLLAR LANE Phone 727-642-7017
*Street*

SARASOTA FLA 34242 E-mail JROWSEY@VERIZON.NET
*City* *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

Representing FLORIDA SOCIETY OF OPHTHALMOLOGY

Appearing at request of Chair: ☐ Yes ☒ No Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

856

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-21-13
*Meeting Date*

Topic Optometric Prescribing

Bill Number SB 278 *(if applicable)*

Name Robert Palmer

Amendment Barcode *(if applicable)*

Job Title State Affairs Policy Director

Address 20 F Street & Suite 400
*Street*

Washington D.C. 20001
*City* *State* *Zip*

Phone 202-737-6662

E-mail bpalmer@aaodc.org

Speaking: ☐ For ☒ Against ☐ Information

Representing American Academy of Ophthalmology

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

21 Feb 2013
*Meeting Date*

Topic Optometry

Bill Number SM 278 *(if applicable)*

Name WALTER "MICKEY" PRESLAR

Amendment Barcode *(if applicable)*

Job Title President / CEO

Address 880 33-1 St Ct
*Street*

Phone

Pompano, FLA
*City* *State* *Zip*

E-mail

Speaking: ☑ For ☐ Against ☐ Information

Representing MPP Co. Rural Health Svs, Inc.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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S-001 (10/20/11)

9:59

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/21/13
*Meeting Date*

Topic Optometry

Bill Number SB 178 *(if applicable)*

Name Bruce May

Amendment Barcode *(if applicable)*

Job Title Lawyer

Address PO Drawer 810 *Street*

Phone 850-224-7000

Tallahassee *City* FL. *State* 32302 *Zip*

E-mail

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Society of Ophth

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

9:06

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-21-13
*Meeting Date*

Topic optometry

Bill Number 278 *(if applicable)*

Name Dr. Kimberly Reed

Amendment Barcode *(if applicable)*

Job Title optometrist

Address 2780 SW 116th Ave
*Street*

Phone 954-262-4227

Davie FL 33330
*City* *State* *Zip*

E-mail

Speaking: ☒ For ☐ Against ☐ Information

Representing optometry

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

2/21/2013
*Meeting Date*

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

Topic Bill # 278 / OPTOMETRY

Bill Number 278 *(if applicable)*

Name Alberto Aran MD

Amendment Barcode *(if applicable)*

Job Title PHYSICIAN / MEDICAL DIRECTOR

Address 1097 S.W. LeJeune Rd
*Street*

Phone

Miami, Florida 33134
*City* *State* *Zip*

E-mail

Speaking: ☒ For ☐ Against ☐ Information

Representing ARAN EYE ASSOCIATES

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

9:22

# APPEARANCE RECORD

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

*Meeting Date*

Topic Optometry Bill — Bill Number 278 *(if applicable)*

Name Dr. John McClane — Amendment Barcode *(if applicable)*

Job Title optometric physician

Address 6 South 14th Street — Phone 904 206-0605

*Street*

Fernandina Beach FL 32034 — E-mail mcclaneiii@aol.com

*City* *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Representing Optometry

Appearing at request of Chair: ☐ Yes ☐ No — Lobbyist registered with Legislature: ☐ Yes ☑ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

9:27

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

Feb. 21, 2013
*Meeting Date*

Topic Optometry

Bill Number SB 278 *(if applicable)*

Name John E. Griffin

Amendment Barcode *(if applicable)*

Job Title Attorney

Address 2930 Wellington Circle Suite 201
*Street*
Tallahassee FL 32312
*City* *State* *Zip*

Phone (850) 894-1009

E-mail JEGriffin@carson-adkinslaw.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Florida Optometric Association, Inc.

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2-21-13
*Meeting Date*

Topic Optometry

Bill Number 278 *(if applicable)*

Name Rebecca O'hara

Amendment Barcode *(if applicable)*

Job Title VP & Governmental Affairs

Address PO Box 10269 *Street*
Tally, FL 32301 *City* *State* *Zip*

Phone 224.1494

E-mail roharа@flmedical.org

Speaking: ☐ For ☒ Against ☐ Information

Representing FL Medical Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/20/11)

THE FLORIDA SENATE

# APPEARANCE RECORD

9:32

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

2/21/2013
*Meeting Date*

Topic _____ Bill Number 278 *(if applicable)*

Name BRIAN PITTS Amendment Barcode _____ *(if applicable)*

Job Title TRUSTEE

Address 1119 NEWTON AVNUE SOUTH Phone 727-897-9291
*Street*

SAINT PETERSBURG FLORIDA 33705 E-mail JUSTICE2JESUS@YAHOO.COM
*City* *State* *Zip*

Speaking: ☑ For ☐ Against ☑ Information

Representing JUSTICE-2-JESUS

Appearing at request of Chair: ☐ Yes ☑ No Lobbyist registered with Legislature: ☐ Yes ☑ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

9:36

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2-21-13
*Meeting Date*

Topic Citizen

Bill Number SB 278 HB 239 *(if applicable)*

Name Jerrel Holton

Amendment Barcode *(if applicable)*

Job Title City Councilman

Address 1539 Rustling Pines Blvd *Street*

Phone

Midway FL 32343 *City State Zip*

E-mail

Speaking: ☒ For ☐ Against ☐ Information

Representing

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/20/11)

9:38

**THE FLORIDA SENATE**

# APPEARANCE RECORD

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

2/21/13
*Meeting Date*

Topic Optometry & Ophthalmology 278

Bill Number 278 *(if applicable)*

Name Mark Michels MD

Amendment Barcode *(if applicable)*

Job Title Vitreo Retinal Surgeon

Address 3399 PGA Blvd #350 *Street*

Phone 561 624-0099

Palm Beach Gardens *City* FL *State* 33410 *Zip*

E-mail drmichels@retinacare specialists.com

Speaking: ☐ For ☐ Against ☒ Information

Representing FSO

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No N/A

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

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S-001 (10/20/11)

**THE FLORIDA SENATE**

# APPEARANCE RECORD

9:46

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

2/21/13
*Meeting Date*

Topic Convergence of eye surgery Bill

Bill Number 278 *(if applicable)*

Name Brad Ozen

Amendment Barcode *(if applicable)*

Job Title Ophthalmologist

Address 8918 Jog road
*Street*
Boynton Beach FL 33472
*City* *State* *Zip*

Phone 561-455-0098

E-mail rlodad@bellsouth.net

Speaking: ☐ For ☒ Against ☐ Information

Representing FSO

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

*While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.*

***This form is part of the public record for this meeting.***

S-001 (10/20/11)

# The Florida Legislature

OFFICE OF PROGRAM POLICY ANALYSIS AND GOVERNMENT ACCOUNTABILITY

**Kathy McGuire, Interim Director**


RESEARCH MEMORANDUM

# Expanding Scope of Practice for Advanced Registered Nurse Practitioners, Physician Assistants, Optometrists, and Dental Hygienists

December 30, 2010


## *Summary*

As requested, OPPAGA examined the implications of expanding particular aspects of the scope of practice for three groups of health care practitioners: advanced registered nurse practitioners (ARNPs) and physician assistants (PAs); optometrists; and dental hygienists. Scope of practice laws detail the services that health professionals are authorized to offer and the settings in which they can practice. Our research addressed the following issues.

- For ARNPs and PAs, differences between Florida's scope of practice laws and those of other states, arguments for and against expanding the scope of practice, and the potential cost savings from greater use of ARNPs and PAs in primary care.
- For optometrists, differences between Florida's laws and those of other states in authorizing optometrists to prescribe oral medications, arguments for and against revising prescription authority, and the potential cost savings and effect on health care access for Medicaid participants if Florida authorized optometrists to prescribe oral medications.
- For dental hygienists, differences between Florida's laws and those of other states in authorizing hygienists to provide preventive dental care without dentist authorization, arguments for and against authorizing dental hygienists to practice more independently, and the potential effect on access to preventive dental care for Medicaid participants if dental hygienists practiced more independently.


## *Advanced Registered Nurse Practitioners and Physician Assistants*

Unlike most other states, Florida does not allow ARNPs and PAs to prescribe controlled substances. States vary in authorizing ARNPs and PAs to directly bill insurance companies and managed care organizations; Florida law neither prohibits nor requires insurance companies and managed care companies to allow ARNPs and PAs to bill them directly. Opponents of expanding the scope of practice of ARNPs and PAs cite concerns about patient safety. Proponents assert that these practitioners are qualified to prescribe such medications and expanding scope of practice would increase access to health care. OPPAGA's estimates of potential cost-savings from expanding ARNP and PA scope of practice range from $7 million to $44 million annually for Medicaid, $744,000 to $2.2 million for state employee health insurance, and $339 million across Florida's health care system.


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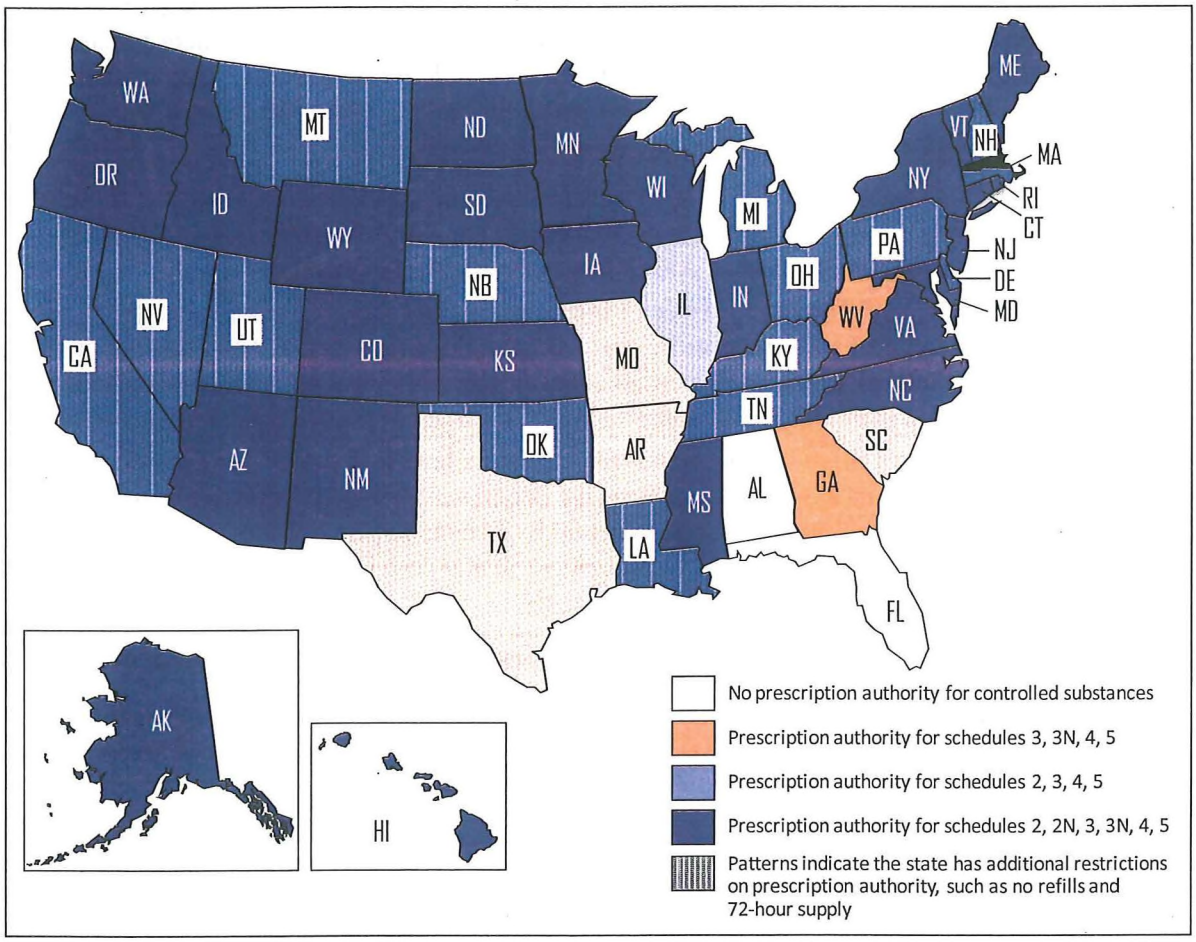
Several factors could affect implementation and the time needed for ARNPs and PAs to assume more responsibility for providing primary care services. These factors include the need for the Department of Health to promulgate rules, the need for the health care industry and providers to change billing practices, and patients' willingness to receive treatment from these practitioners instead of physicians.

## *How do Florida's laws differ from those of other states regarding scope of practice of ARNPs and PAs?*

Florida is one of two states that do not allow ARNPs or PAs to prescribe controlled substances. Alabama and Florida do not allow ARNPs to prescribe controlled substances, and Kentucky and Florida do not allow PAs to prescribe controlled substances. As shown in Exhibits 1 and 2, the remaining states have granted ARNPs and PAs this authority to varying degrees.

**Exhibit 1**
**Florida is One of Two States that Do Not Allow Advanced Registered Nurse Practitioners (ARNPs) to Prescribe Controlled Substances[1, 2]**

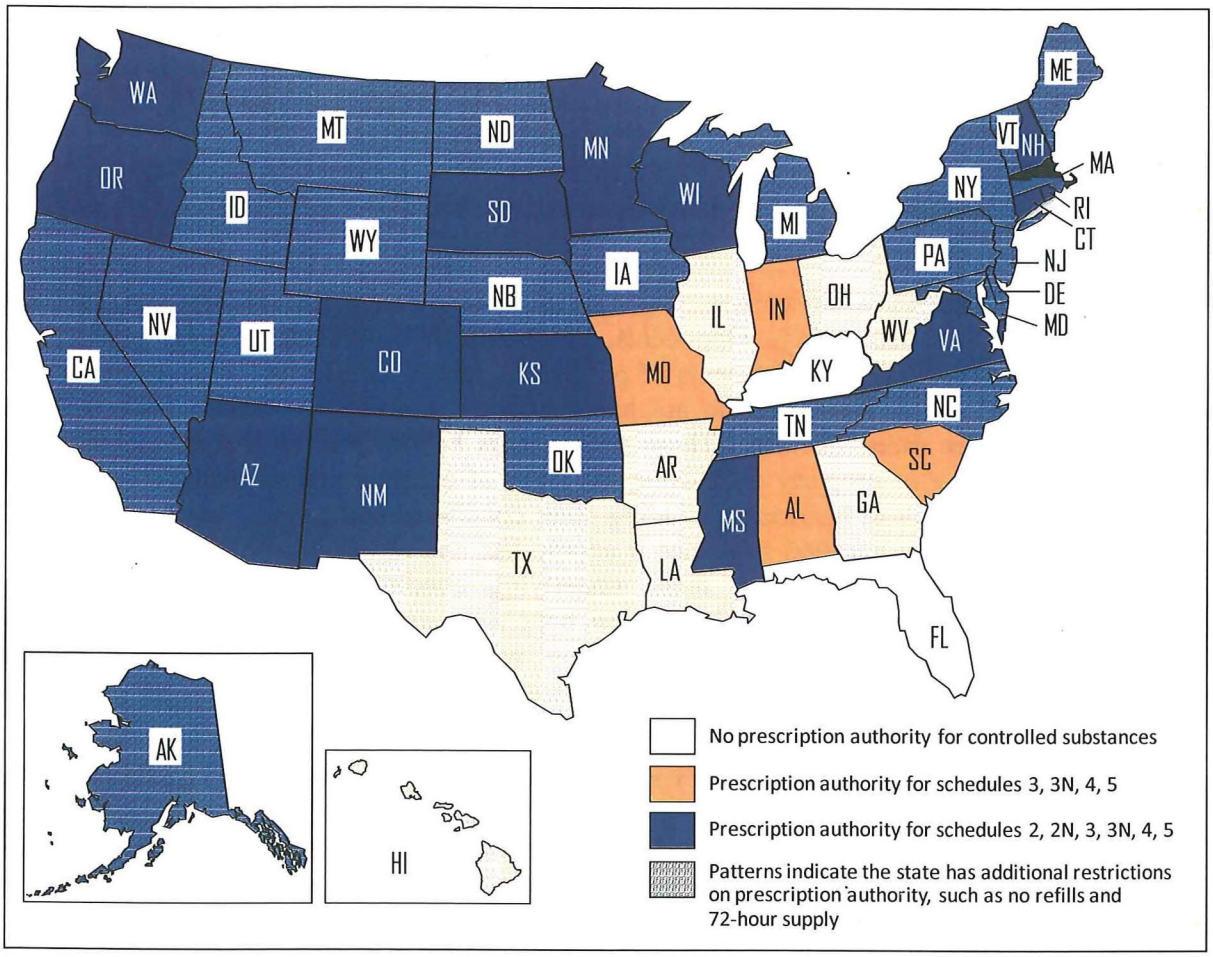



[1] The drugs and drug products considered controlled substances are categorized into five schedules. For more information on the schedules, see: www.deadiversion.usdoj.gov/drugreg/practioners/index.html.

[2] Hawaii and Missouri are in the process of promulgating rules authorizing ARNPs to prescribe controlled substances.

Source: U.S. Department of Justice, Drug Enforcement Administration.

**Exhibit 2**
**Florida is One of Two States that Do Not Allow Physician Assistants (PAs) to Prescribe Controlled Substances[1]**




[1] The drugs and drug products considered controlled substances are categorized into five schedules. For more information on the schedules, see: www.deadiversion.usdoj.gov/drugreg/practioners/index.html.

Source: U.S. Department of Justice, Drug Enforcement Administration.

Florida law neither prohibits nor requires insurance companies to allow direct billing for ARNPs and PAs; other states' laws vary widely on whether and how they address this issue. Information from the American Academy of Physician Assistants on 33 states' statutes and rules shows that 9 other states have statutory language similar to Florida, while 5 states have language allowing direct billing by physician assistants. In three of the states that authorize direct billing, the provisions only apply to the Medicaid program. Another 19 states specifically prohibit PAs from billing for services. Managed care organizations' billing policies generally reflect the scope of practice provisions of their states. Managed care organizations in states that allow ARNPs to practice independently typically allow ARNPs to directly bill.[1]

[1] A 2007 survey of managed care organizations in the United States found that in states requiring no physician involvement for ARNPs to prescribe, 71% of managed care organizations allow ARNPs to directly bill as providers in their networks. In states that require physician collaboration for ARNPs to prescribe, as in Florida, 50% of managed care organizations allow ARNPs to directly bill as providers in their networks.

Prescribing and billing practices can affect the extent to which ARNPs and PAs can practice independently of physician supervision. Although some ARNPs in Florida establish their own primary care practices, statutes require that they do so under an agreement with a physician to provide supervision. Alternatively, ARNPs and PAs often practice within physicians' offices. In either instance, the physician establishes the level of supervision other than prescription of drugs, such as whether the physician will be consulted on decisions involving patient care, will review and approve some or all patient medical charts, or will be involved in approving patient care decisions to varying degrees based on types of illnesses and treatments.

## *What are arguments for and against expanding the scope of practice for ARNPs and PAs?*

**Opponents.** Arguments against expanding the scope of practice for ARNPs and PAs are primarily related to patient safety. Opponents, which include health care provider groups, cite differences in the education requirements of physicians versus ARNPs and PAs, and conclude that these health care professionals do not have sufficient training and medical education to safely practice more independently. These stakeholders believe that physicians are the only professionals capable of properly diagnosing the array of possible patient medical conditions, weighing patients' medical histories (including other conditions and existing medications), and determining whether a controlled substance is appropriate and can be prescribed safely. This is because controlled substances can mask underlying conditions, result in serious drug interactions, and/or lead to addiction. In addition, opponents argue that because ARNPs and PAs lack adequate education and training, practicing without the current level of physician supervision could lead to delays in diagnosing serious conditions, as well as higher utilization and costs due to more frequent referrals for diagnostic and other services.

**Proponents.** Stakeholders who favor expanding the scope of practice for ARNPs and PAs believe that patient safety would not be compromised. Some ARNPs and PAs assert that they have sufficient training and education to safely prescribe controlled substances and practice more independently. They also cite research that shows similar or better patient outcomes for care provided by ARNPs and PAs compared to outcomes for care provided by physicians. For example, an October 2008 study found that after adjusting for a variety of indicators of patient complexity, adults who exclusively visited physician assistants for 30% or more of their health care had an average of 16% fewer visits per year.[2]

Proponents also believe that expanding scope of practice would increase access to health care. About 70% to 80% of nurse practitioners work in primary care, which includes pediatrics, adult health care, gerontology, and nurse midwifery. A 2008 U.S. Government Accountability Office study reported that the per capita supply of nurse practitioners annually increased by an average of 9% over a 10-year period. In contrast, a recent survey of medical school graduates showed that only 2% were choosing to work in primary care, in part due to high educational debt and low salaries relative to more lucrative medical specialties. Proponents also believe that expanding scope of practice would improve choice for patients interested in seeing ARNPs or PAs as primary care providers and facilitate ARNPs' and PAs' inclusion in managed care organization provider directories.

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[2] Morgan, P.A. (2008). Impact of Physician Assistant Care on Office Visit Resource Use in the United States. *Health Services Research*, 43(5), 1906-1922.

## *What are the potential cost savings from greater use of ARNPs and PAs in primary care?*

OPPAGA's estimates of potential cost savings from expanding scope of practice in primary care range from $7 million to $44 million annually for Medicaid, $744,000 to $2.2 million for state employee health insurance, and $339 million across Florida's entire health care system. Several factors could affect the implementation and time needed to achieve these savings.

We used three methods to estimate the potential cost savings from greater use of ARNPs and PAs in primary care based on differences in the reimbursement rates for their services compared to those of physicians. Insurance companies and the Medicaid and Medicare programs often realize cost savings by reimbursing services provided by ARNPs and PAs at a lower rate than services provided by physicians. For example, Florida's Medicaid program pays an average of $40 for primary care office visits with ARNPs or PAs, compared to $49 for office visits with physicians.

**Method 1: Savings of an estimated $7 million in annual appropriations for Medicaid and $747,000 in annual appropriations for state employee health insurance.** Our first method focused on providing a somewhat conservative estimate of state savings (both general revenue and trust funds) for the Medicaid and state employee health insurance programs. This method assumes that ARNPs and PAs would assume responsibility for most of the primary care office visits for conditions similar to those treated in retail clinics. To derive this estimate, we modified a technique used in a 2009 RAND Corporation report that described various ways the Massachusetts could control its health care spending.[3] RAND used survey data to estimate the number of office visits in the state related to cough, earache, fever, nasal congestion, skin rash, and throat symptoms, which RAND analysts chose because these are frequently the types of symptoms for which patients visit retail clinics and receive services from ARNPs and PAs. RAND determined the number of office visits in which physicians treated similar symptoms, and estimated the cost savings if these services had instead been provided by an ARNP or PA.

To apply this method to Florida, we used fee-for-service claims data for participants in Florida's Medicaid program and active employees in the state employees' health insurance program, which resulted in estimated reductions of $7 million in Medicaid and $747,000 in state employee health insurance annual spending.[4] Of this amount, we estimated that the state would save $3.2 million in general revenue funds for the Medicaid program; we could not develop a similar estimate for the state employees' health insurance program.[5] Although similar savings may be achieved in these programs' managed care plans, we could not provide a savings estimate because Medicaid has only recently begun collecting encounter data on managed care office visits, and a similar data system does not exist for state employee health insurance.[6]

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[3] Eibner, C.E., Hussey, P.S., Ridgely, M.S., & McGlynn, E.A. (2009). *Controlling health care spending in Massachusetts: An analysis of options*. (Publication No. 09-219-HCF-01). Boston, MA: RAND Corporation.

[4] We excluded Medicare eligible participants, early retirees, and Consolidated Omnibus Budget Reconciliation Act (COBRA) participants because the state does not cover the full cost of these claims. For Medicare eligible individuals, Medicare is their primary insurance coverage and the state plan only covers remaining costs. Early retirees and COBRA participants pay the full cost of their health insurance premiums.

[5] We estimated the general revenue savings for Medicaid using the Federal Medical Assistance Percentage of 56.04% for Federal Fiscal Year 2011. The state employees' health insurance trust fund is funded primarily by premiums paid by subscribers and employers. Employers use various funding sources to pay for salary and benefits; thus, the amount of general revenue used to pay premiums varies by employer.

[6] Approximately one-third of Medicaid enrollees and 44% of state employees receive health care through a managed care health plan.

**Method 2: Maximum savings of an estimated $44 million in annual appropriations for Medicaid and $2.2 million in annual appropriations for state employee health insurance.** Our second method focused on the maximum, upper range of state savings, assuming that ARNPs and PAs would take responsibility for a substantial portion of office visits in primary care settings. For this estimate, we used the fee-for-service claims data from the Medicaid and state employee health insurance programs. We first identified those primary care office visit procedure codes that were performed by physicians, and by ARNPs and PAs.[7] We then developed an average cost per procedure for ARNPs and PAs. Finally, we calculated the difference between the physicians' cost and the average ARNP and PA cost for each primary care physician claim. The sum of these differences represents estimated savings of approximately $44 million annually in Medicaid costs and $2.2 million annually in state employee health insurance costs.[8, 9] Of these amounts, we estimated that the state would save $19.5 million in general revenue funds for the Medicaid program; we could not develop a similar estimate for the state employees' health insurance program.

Estimates based on the first two methods have some limitations. Savings would accrue gradually over time due to the time required for ARNPs and PAs to be given more responsibility for these office visits. In addition, ARNPs and PAs likely would not assume responsibility for all of these office visits. Currently, they conduct 0.1% of the primary care office visits for state employees and 8.7% of the primary care office visits for Medicaid participants. Further, the estimates from the second method ($44 million for Medicaid and $2.2 million for state employee health insurance) are maximum estimates of the potential for cost savings.

**Method 3: Maximum savings of an estimated $339 million in annual savings across Florida's health care system.** We could not verify a stakeholder estimate that the potential savings for all payers of primary care in Florida would be $1 billion because the estimate was not based on statewide claims data, and other aspects of the estimate were based on assumptions and professional judgment. We therefore used the data from our second analysis of state employee health insurance claims to attempt to validate the upper range of savings across Florida's health care system. We applied the estimated savings percentage from Method 2 to information provided by the federal Agency for Healthcare Research and Quality, which used survey data to estimate the cost of all primary care office visits in Florida.[10] After adjusting for differences in age groups, we estimated that Floridians and entities, such as employers, that pay for health care could save a maximum of $339 million annually if ARNPs and PAs conducted all primary care office visits.[11]

As with the Medicaid program and state employee health insurance program savings estimates, this estimate is a maximum estimate of the potential for cost savings, and has limitations.

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[7] For this analysis, we considered physicians as primary care providers if their specialty was adult primary care, family practice, general practice, geriatrics, gynecology, internal medicine, obstetrics, obstetrics-gynecology, and pediatrics,

[8] As with the first method, this analysis only included participants in Medicaid fee-for-service programs, and excludes Medicare eligible individuals, early retirees, and COBRA participants from the state employee insurance population.

[9] Our analysis of state employee health insurance claims fee-for-service data base showed that costs of visits to ARNPs and PAs were 8.5% less than physicians.

[10] The federal Agency for Healthcare Research and Quality compiles an annual survey, the Medical Expenditures Panel Survey, from different sources to analyze national health care costs and other factors. The Agency for Healthcare Research and Quality provided data on the frequency and cost of primary care office visits in Florida.

[11] We weighted the estimate for age groups to account for the higher concentration of elders statewide than was included in state employee health insurance fee-for-service claims data.

Savings would accrue gradually over a long period due to the time required for ARNPs and PAs to take responsibility for these office visits. Also, ARNPs and PAs likely would not assume responsibility for all of these office visits.

**Several factors could affect the implementation and the time needed for ARNPs and PAs to assume primary care services.** Changing the scope of practice for ARNPs and PAs would require the Department of Health to promulgate administrative rules to implement these changes, which could take over a year.[12] Florida administrative laws require agencies to obtain input from stakeholders and hold public rule workshops, which can delay promulgation of rules that may be controversial or contentious. Although some states have promulgated rules to implement changes in ARNP or PA scope of practice quickly, others have experienced delays. Exhibit 3 lists states that have granted ARNPs and PAs controlled substance prescription authority since 2005, the effective date of the statutory authority, and the date rules were promulgated. In half of these instances, it took over a year to promulgate the necessary rules.

**Exhibit 3**
**The Time to Promulgate Rules to Implement Changes in ARNP and PA Controlled Substance Prescription Authority Varies Across States**

| | State | Effective Date of Statutory Authority | Date Rule Promulgated |
|---|---|---|---|
| Advanced Registered Nurse Practitioners (ARNPs) | Hawaii | July 2, 2009 | Not yet promulgated |
| | Kentucky | July 12, 2006 | August 2006 |
| | Missouri | June 10, 2008 | Not yet promulgated |
| Physician Assistants (PAs) | Alabama | October 1, 2009 | March 24, 2010 |
| | Indiana | July 1, 2007 | May 5, 2010 |
| | Missouri | August 28, 2009 | Accomplished without rule |
| | New Jersey | September 17, 2005 | June 2, 2008 |
| | Ohio | May 17, 2006 | October 31, 2007 |

Source: OPPAGA analysis of state laws and rules.

Expanding ARNP and PA scope of practice would also require changes in both industry and provider billing practices. Under Medicare, Medicaid, and private insurance, patient visits to ARNPs and PAs can be billed at 100% of the physician reimbursement rate if directly supervised by the physician and billed under the physician's provider number with the physician as the treating provider; this is referred to as "incident-to" billing in Medicare. To maximize cost savings, ARNPs and PAs would need to stop billing for services under their supervising physician's billing number and instead bill under their own provider numbers. This change would be difficult to mandate within a physician's practice because physicians decide the protocol for their degree of involvement in office visits that occur within their practices and for other supervisory agreements. These protocols are determined by the physician's professional judgment.

Another factor that could affect potential cost savings is that some patients may be reluctant to see an ARNP or PA instead of a physician for primary care. A 2004 study found that on average, ARNPs and PAs attended 33% of adult visits and 20% of pediatric visits.[13]

[12] The time frame required for rule adoptions referenced in this memo may also be affected by CS/CS/HB 1565, enacted during the 2010 Regular Session of the Legislature, and made effective November 17, 2010 by HJR 9A, the veto of the Governor notwithstanding.
[13] Roblin, D. (2004). Use of midlevel practitioners to achieve labor cost savings in the primary care practice of an MCO. *Health Care Economics*, 39(3), 607-625.

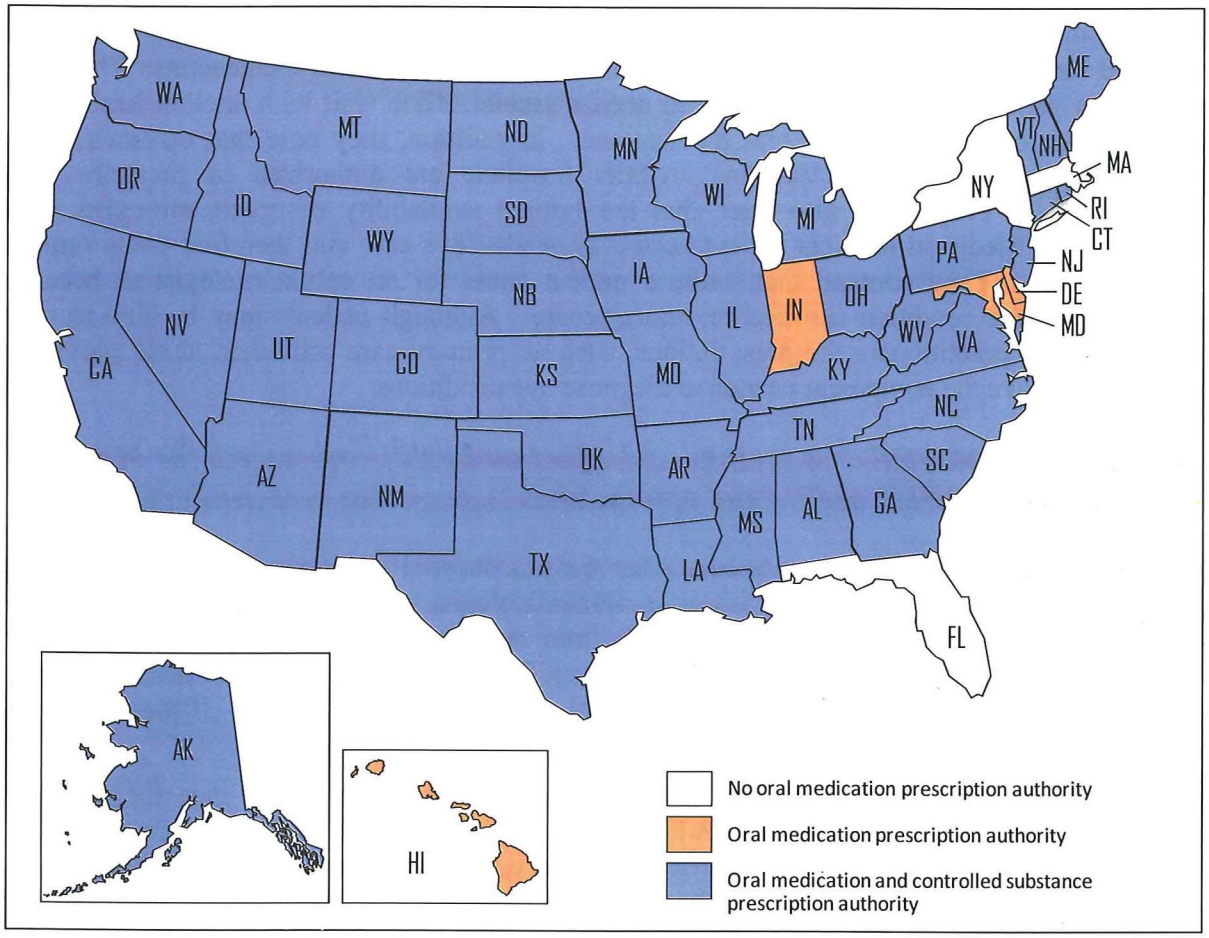
## Optometrists

While most other states authorize optometrists to prescribe oral medications and controlled substances, Florida does not. Opponents' arguments against giving optometrists this authority primarily relate to patient safety. Proponents' arguments include cost savings due to less frequent referrals to ophthalmologists and increased patient access to eye care. Our analysis found minimal cost savings to the state as a result of expanding optometrists' prescription authority. However, making this change may enhance Medicaid participants' access to eye care. Florida's administrative rule promulgation process would affect the length of time needed to implement changes to optometrists' prescription drug authority.

### *How do Florida's laws differ from those of other states in authorizing optometrists to prescribe oral medications?*

Florida is one of three states that do not authorize optometrists to prescribe oral medications for their patients. In addition, 43 of the 47 states that grant optometrists this authority also allow them to prescribe controlled substances, as shown in Exhibit 4. In Florida, certified optometrists may only prescribe topical eye medications. If an optometrist diagnoses a condition that would be best addressed with an oral medication, the patient must see another practitioner, such as an ophthalmologist, for treatment.

**Exhibit 4**
**Florida is One of Three States that Do Not Authorize Optometrists to Prescribe Oral Medications[1]**




[1] Oral medications that are prescribed to patients for eye care include antibiotics, steroids, antivirals, and pain medication.
Source: Florida Optometric Association.

## *What are arguments for and against revising optometrists' prescription authority?*

**Opponents.** Stakeholders opposed to giving optometrists more prescription authority, which include health care provider groups, argue that optometrists do not have sufficient training and medical education to safely prescribe oral medications, including controlled substances, and that only physicians are sufficiently trained to make safe medication decisions. These opponents contend that Florida's large elder population makes comparisons to other states' prescription authority policies problematic. Opponents also maintain that giving optometrists more prescription authority would increase the risk of misdiagnosis or delayed diagnosis of serious problems. Further, in many situations, opponents argue that an additional visit to an ophthalmologist or other licensed physician is inevitable. For example, when a patient is diagnosed with glaucoma, the optometrist is required by law to refer the patient to a physician.

**Proponents.** Stakeholders in favor of granting optometrists more prescription authority cite cost savings from fewer referrals to ophthalmologists and increased access to eye care for underserved populations, such as Medicaid participants in rural areas. These stakeholders argue that optometrists receive sufficient training, including coursework in systemic pharmacology required for licensure and continuing education, to safely prescribe oral medications. They also assert that patients would be less likely to need a second office visit with another health care professional for treatment with oral medications. In addition, they note that optometrists in Florida's federally-operated Veterans' Affairs hospitals are authorized to prescribe oral medications.[14] Proponents also state that the limited availability of ophthalmologists who participate in Medicaid restricts patient access to needed eye care and therefore compromises patient safety. They contend that while a patient waits for an ophthalmologist to become available, an eye condition can become more severe. Although patients may be able to visit other types of practitioners for prescriptions, such as primary care providers, these providers often do not have the equipment needed to diagnose eye conditions.

## *What are the potential cost savings and effect on health care access for Medicaid participants if Florida authorized optometrists to prescribe oral medications?*

**Potential cost savings may be minimal.** Our analysis showed minimal potential cost savings from avoiding a subsequent office visit to an ophthalmologist because there were relatively few ophthalmologist office visits that resulted from an optometrist referral in which the ophthalmologist prescribed medications. We identified 499 Medicaid beneficiaries and state employees who may have received such a referral over the course of a year. If these referrals had not occurred, the state would have saved approximately $10,000 in claims.

To assess potential state cost savings, we analyzed fee-for-service claims data for the state Medicaid program and active employees in the state employees' health insurance program. Our methodology identified all Medicaid participants who visited an ophthalmologist within 60 days of visiting an optometrist and state employees who visited an ophthalmologist within 30 days of visiting an optometrist. (We used different periods for the two programs after asking program administrators for conservative estimates of the time patients may need to wait for an appointment with an ophthalmologist.) From these individuals, we then identified those that received a prescription for an oral medication within one week after visiting an ophthalmologist. Based on the total cost of the ophthalmologist claims, we estimated that authorizing optometrists to prescribe oral medication would result in $10,000 in potential cost savings.

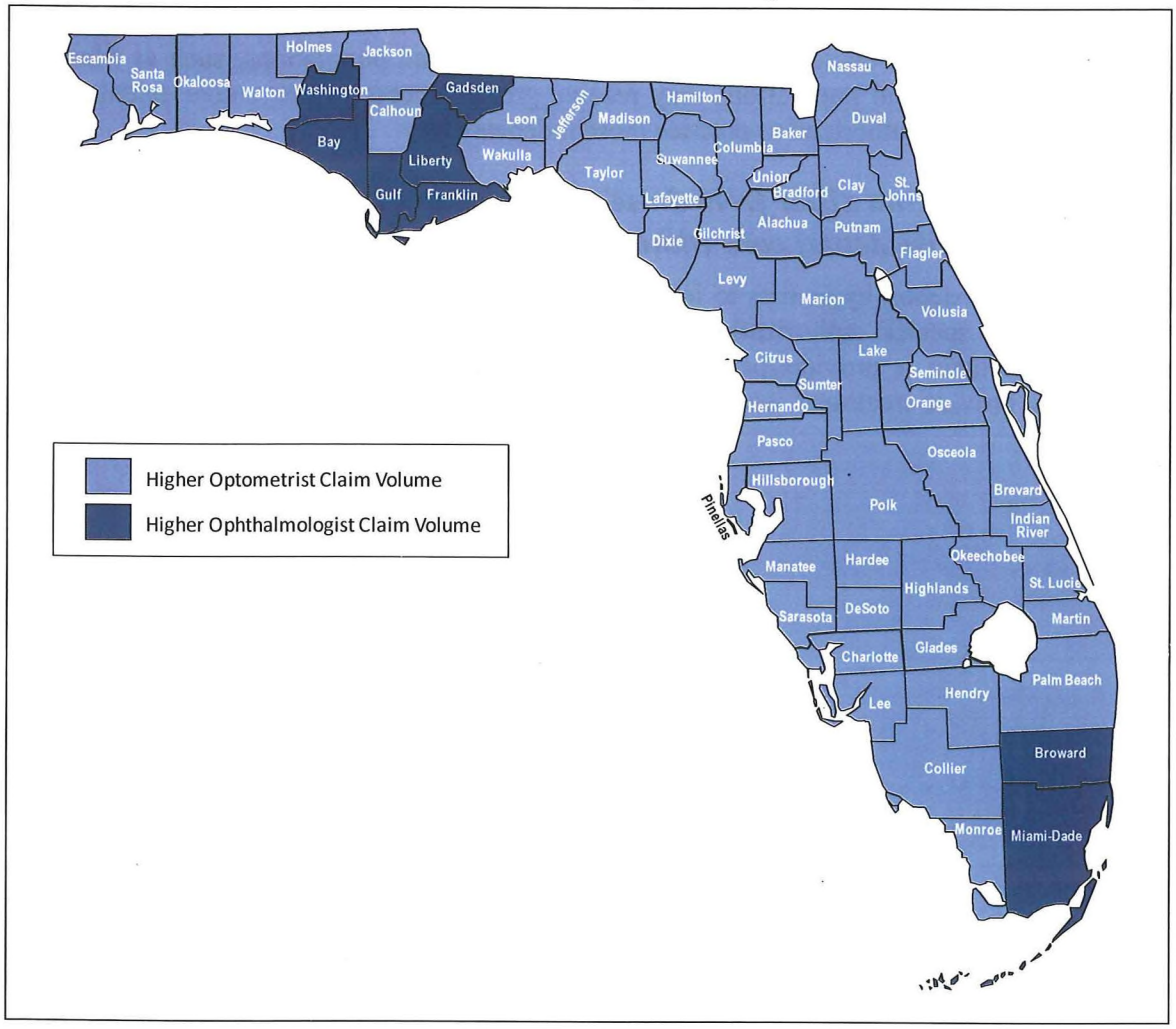
Our analysis had some methodological and data limitations. Patients may have been able to see a practitioner other than an ophthalmologist. We could not assume there was a link between an optometrist office visit and an office visit to any other practitioner within 30 to 60 days; therefore, we did not include all possible types of practitioner office visits in our analysis. In addition, employees in the fee-for-service portion of the state employees' health insurance program have other options for eye care, including supplemental vision coverage and an additional network of vision services providers who will provide a 20% discount on materials and services paid out-of-pocket by subscribers. According to program administrators, if

[14] According to the U.S. Department of Veterans Affairs (VA), 42 optometrists in Florida's VA hospitals are allowed to prescribe oral medications. The department's policy is that if optometrists are licensed in another state that gives them oral medication prescription authority, then VA hospitals can approve optometrists for writing prescriptions for oral medications.

employees see an optometrist under one of these options, they often pay the cost of the office visit themselves and do not generate a claim. Further, our analysis of claims data did not include participants in managed care plans.

**Medicaid participants could have greater access to eye care.** Authorizing optometrists to prescribe oral medications could provide Florida Medicaid participants additional options for eye care. As shown in Exhibit 5, in 59 of 67 (88%) of Florida's counties, optometrists submitted more Medicaid claims than ophthalmologists during Fiscal Year 2008-09.[15]

**Exhibit 5**
**Optometrists Submitted More Medicaid Claims than Ophthalmologists in 59 Counties**




Source: OPPAGA analysis of Medicaid data.

[15] We could not make county comparisons of the number of optometrists and ophthalmologists who provide services to Medicaid participants because not all Medicaid providers have unique provider identifiers.

**Rule promulgation would affect how quickly changes in optometrist prescription authority could be implemented.** It may take over a year to complete rule promulgation to address a change in optometrists' prescription authority. Florida administrative laws require agencies to obtain input from stakeholders and hold public rule workshops, which can delay promulgation of rules that may be controversial.

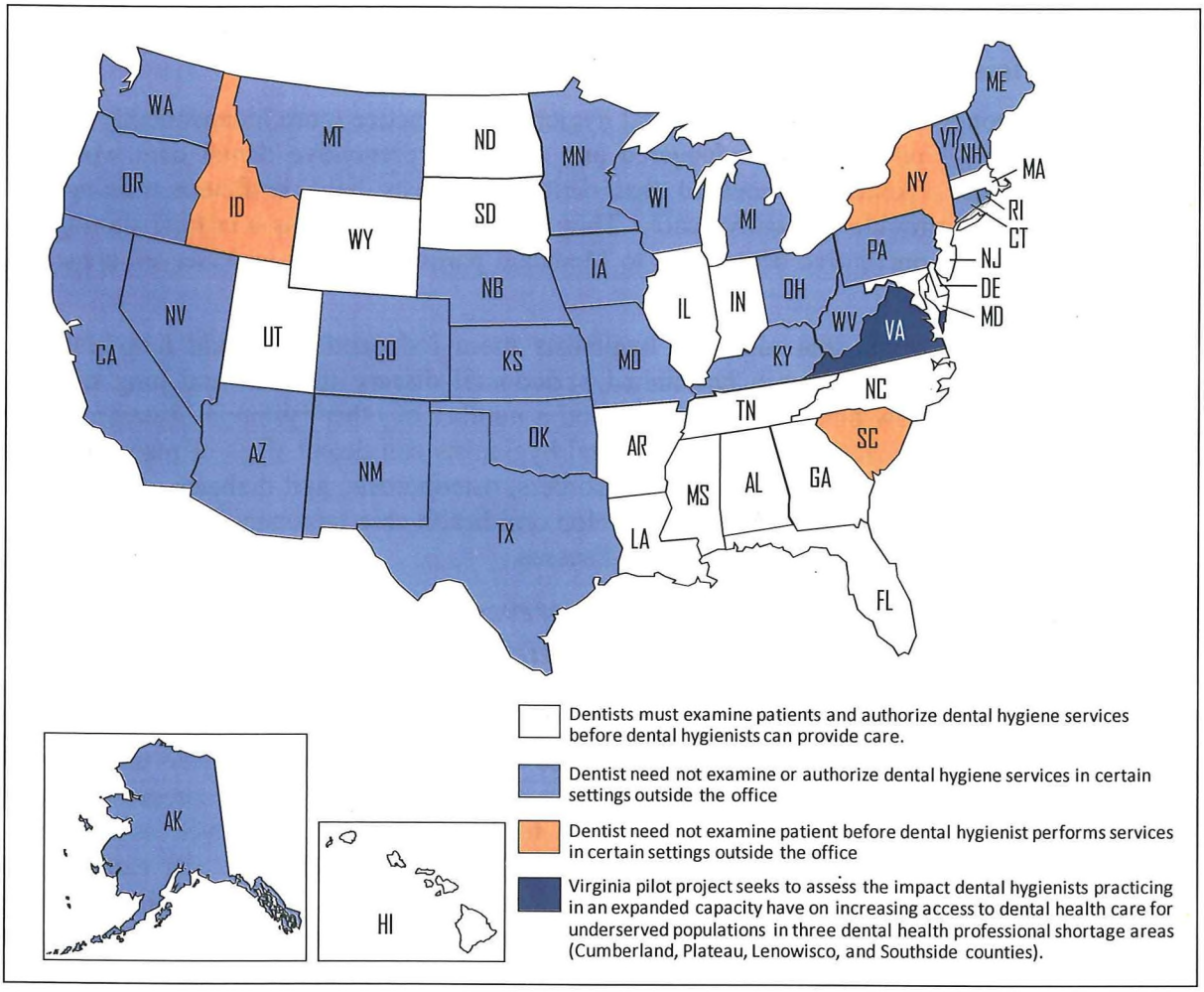
## *Dental Hygienists*

Thirty states allow dental hygienists to initiate patient treatment, such as cleanings, without the specific authorization of a dentist, but Florida does not allow dental hygienists this level of independence. Opponents of allowing dental hygienists more independently cite concerns with patient safety and question whether it would significantly improve access to preventive dental care. Proponents argue that dental hygienists are trained to provide these services, and giving them more independence could improve access for underserved populations, such as Medicaid participants. Underserved populations may receive greater access to preventive dental care if dental hygienists were authorized to practice more independently.

### *How do Florida's laws differ from those of other states in authorizing hygienists to provide preventive dental care without dentist authorization?*

Thirty states allow dental hygienists to initiate treatment based on their assessment of patients' needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider/patient relationship (see Exhibit 6). In Florida, a dental hygienist may provide treatment without a dentist's presence, but a dentist must first authorize the treatment.

**Exhibit 6**
**Thirty States Allow Dental Hygienists to Provide Preventive Dental Care Without Prior Dentist Authorization[1]**




[1] Rules allowing dental hygienists to provide preventive care without prior dentist approval are pending in Kentucky.
Source: American Dental Hygienists Association.

## *What are arguments for and against authorizing dental hygienists to practice more independently?*

**Opponents.** Opponents' argue that dental hygienists are not trained to diagnose, and that practitioners need to know about patients' underlying medical conditions to safely provide preventive dental care. For example, some patients may need to take antibiotics before receiving routine dental care. In addition, dental hygienists are not required to carry malpractice insurance; thus, it is unclear who would be liable if a dental hygienist providing care in a health access setting became involved in a lawsuit. Dentists are currently liable for the care provided by their dental hygienists.

Opponents also argue that expanding the scope of practice for dental hygienists may not necessarily provide greater access to care in underserved areas. They cited a 2005 report sponsored by the American Dental Association that found there were only 17 independent dental hygienist practices in Colorado, which allows unsupervised dental hygiene practices. The report also concluded that the dental hygienists in independent practice do not tend to locate in rural areas or have fees significantly different from those of dental practices.

**Proponents.** Proponents of authorizing dental hygienists to practice more independently believe that patient safety would not be endangered and access to preventive dental care would be enhanced. These stakeholders contend that dental hygienists have sufficient training and education to safely provide preventive care. They assert that Florida has a critical shortage of dentists that provide preventive dental care to Medicaid participants and underserved areas and populations.

Further, proponents argue that allowing hygienists more independence could help improve patients' overall health. Research has linked periodontal disease to heart and lung disease; diabetes; pre-mature, low-birth weight babies; and a number of other systemic diseases. They assert that during oral health examinations, dental hygienists can detect signs of many diseases and conditions like HIV, oral cancer, eating disorders, osteoporosis, and diabetes. In addition, dental hygienists can work with patients to develop oral health care treatment plans that manage oral infection so it does not exacerbate serious diseases.

### *What are the potential effects on access to preventive dental care for Medicaid participants if Florida authorized dental hygienists to practice more independently?*

Giving dental hygienists more authority to practice independently could provide underserved populations greater access to preventive dental care. Florida's Medicaid program covers preventive dental services for children from birth to 20 years old.[16] However, as shown in Exhibit 7, some rural counties lack dentists to serve Medicaid participants. For example, in Franklin, Glades, Levy, Suwannee, and Union counties, no dentists filed a claim with the Medicaid program during Fiscal Year 2008-09, although there were 10,797 children residing in these counties who were eligible for Medicaid dental services.[17] In addition, in 15 counties, 92 practices filed a dental claim with Medicaid, although 244,951 children were eligible for Medicaid dental services.

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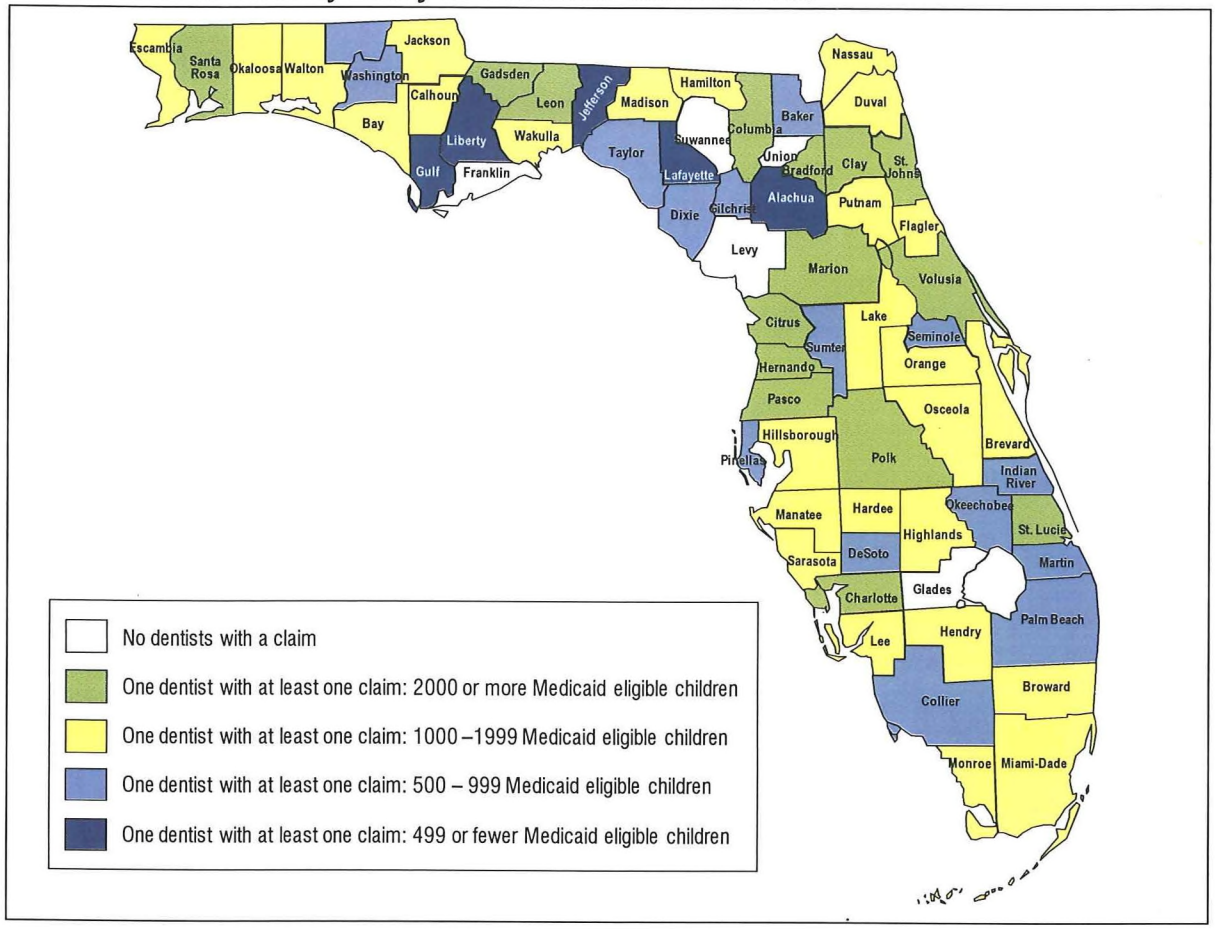
[16] During Fiscal Year 2008-09, Medicaid paid approximately $123 million for dental services, of which 6.5% ($8 million) was for preventive services such as cleanings, fluoride applications, sealants, and oral hygiene instructions. These claims included $22,116 paid to two Alabama dentists who treated Florida Medicaid patients.

[17] Due to variations in population density and other characteristics, the American Dental Association has not established a standard for the number of dentists per capita.

**Exhibit 7**
**Access to Dentists Varies by County for Children Enrolled in Medicaid**




Source: OPPAGA analysis of Medicaid data.

Statutory changes to supervision requirements for dental hygienists may also provide hygienists the ability to serve patients in settings that focus on underserved areas. These settings include programs and institutions of the Department of Children and Family Services, the Department of Health, and the Department of Juvenile Justice; nonprofit community health centers; Head Start centers; federally qualified health centers (FQHCs); FQHC look-alikes as defined by federal law; school-based prevention programs; clinics operated by accredited colleges of dentistry; and accredited dental hygiene programs.

**DEPARTMENT OF**
**VETERANS AFFAIRS**

# Memorandum

Date: FEB 0 5 2009

From: Director (00)

Subj: Administrative Investigation Board (AIB)

To: Deana Lum, OD (Fresno)
Linda Margulies, MD (Northern CA)
Stacy Moeder (151Y)
Kintina Edouard (11)

Thru: Associate Director (001)
Chief of Staff (11)
Deputy Chief of Staff (11)

1. In accordance with VA Directive and Handbook 0700 (Administrative Investigations), you are hereby appointed to an Administrative Investigation Board (AIB). Stacy Moeder shall serve as chair of the AIB. The AIB shall conduct a thorough investigation into the facts and circumstances regarding the credentialing/privileging of Optometrists as it relates to caring for glaucoma patients, the relationship between Optometry and Ophthalmology Services and whether or not a culture exists that would prevent Optometrists from engaging Ophthalmology support in the management of glaucoma patients. Attached is the latest Issue Brief on the background information on the allegations.

2. This memorandum authorizes you to inquire into all aspects of this matter; to require VA employees to cooperate with you; to require all employees having any knowledge of the complaint to furnish testimony under oath or affirmation without a pledge of confidentiality; to obtain voluntary sworn testimony from other individuals; to administer oaths and affirmations; and to gather other evidence that you determine is necessary and relevant. These authorities are delegated for the purposes and duration of this investigation only. Your investigation shall be conducted and reported in accordance with VA Directive 0700 and VA Handbook 0700 (Administrative Investigations), which are included in your packet for your review.

3. Preparations for the investigation should begin immediately. You shall submit your completed report and investigative file to me by April 10, 2009 unless an extension is granted.

4. Your report shall be submitted in standard format, as described in Chapter 6 of VA Handbook 0700 with the following headings:

- Subject Line
- Preliminary Statement
- Findings of Fact
- Conclusions
- Signature
- Exhibits

5. You are not required to make any recommendations.

6. Terri Monisteri, Risk Manager, at extension 67751, will act as your technical advisor throughout the investigation.

7. Thank you for your participation in the important matter.

Elizabeth Joyce Freeman

Attachments: [VA Handbook and Directive 0700]

CC: AFGE Local 2110

Department of
Veterans Affairs

# Memorandum

Date: April 1, 2009

From: Administrative Investigation Board (AIB)

Subj: Investigation Report

To: Director (00)
Thru: Chief of Staff (11)

1. Authority: The Director's Memorandum of Appointment dated February 5, 2009, and VA Policy M-2, Chapter 35.

2. Purpose: The AIB's purpose is to conduct an investigation into the facts and circumstances regarding the credentialing/privileging of optometrists as it relates to glaucoma patients, the relationship between Optometry and Ophthalmology Services and whether or not a culture exists that would prevent optometrists from engaging Ophthalmology support in the management of glaucoma patients.

3. Scope: The investigation was limited to privileging and adherence to assigned privileges for optometrists, standard of care for glaucoma patients, and how and when the Optometry section referred patients with glaucoma to Ophthalmology and the cultural and physical environment in which Optometrists worked.

4. Exhibit Listing:

a. Exhibit 1: VHA Issue Brief Dated January 27, 2009 titled "Potentially Avoidable Vision Loss in a VA Palo Alto Health Care System Glaucoma Patient"

b. Exhibit 2: VHA Issue Brief Dated January 30, 2009 titled "Potentially Avoidable Vision Loss in a VA Palo Alto Health Care System Glaucoma Patient"

c. Exhibit 3: VHA Issue Brief Dated February 5, 2009 titled "Potentially Avoidable Vision Loss in a VA Palo Alto Health Care System Glaucoma Patient"

d. Exhibit 4: Ophthalmology and Optometry Staff Listing, dated February 23, 2009

e. Exhibit 5: Optometry Privileges

i) Curtis Keswick, OD
ii) Jennine Kirby, OD
iii) Shanida Ingalla, OD
iv) Michelle Suwabe, OD
v) Anna Margarita Geronimo, OD
vi) Jon Wada, OD

vii) David Yang, OD
viii) Robert Theaker, OD
ix) Debbie Fan, OD
x) Zibya Karolia, OD
xi) Katherine Portugal, OD
xii) Joanna Leong, OD
xiii) Betty Chun, OD
xiv) Elaine Chung, OD
xv) Shirley Hong, OD
xvi) Grace Jeng, OD
xvii) Heather Jonasson, OD
xviii) Vanessa Pineda, OD
xix) Susan Tran, OD

f. Exhibit 6: CA State Board of Optometry, Excerpts from Business and Professions Code, Dated 2006

g. Exhibit 7: Department of Consumer Affairs, CA State Board of Optometry, Fact Sheet

h. Exhibit 8: Service Agreement between Primary Care and Ophthalmology/Optometry Dated December 2008

i. Exhibit 9: Surgical Service, Reappraisal Profile for Clinical Privileges, (b) (6) Dated November 2005 and October 2007

j. Exhibit 10: Surgical Service, Reappraisal Profile for Clinical Privileges, (b) (6), Dated May 2006 and April 2008

k. Exhibit 11: Results Glaucoma Chart Review January 26, 2008 to January 26, 2009, Conducted by Ophthalmology Service. Includes Comprehensive Summary Report, Suggested as High Risk and Suggested for Peer Review

l. Exhibit 12: Sworn Testimony - (b) (6)

m. Exhibit 13: Sworn Testimony - (b) (6)

n. Exhibit 14: Sworn Testimony - (b) (6)

o. Exhibit 15: Sworn Testimony - (b) (6)

p. Exhibit 16: Sworn Testimony – (b) (6)

q. Exhibit 17: Sworn Testimony - (b) (6)

r. Exhibit 18: Sworn Testimony - (b) (6)

s. Exhibit 19: Sworn Testimony - (b) (6)

t. Exhibit 20: Sworn Testimony - (b) (6)

u. Exhibit 21: Sworn Testimony - (b) (6)

v. Exhibit 22: Sworn Testimony - (b) (6)

w. Exhibit 23: Sworn Testimony – (b) (6)

5. Findings:

a. An Optometry patient at the Veterans Affairs Palo Alto Health Care System (VAPAHCS) was identified as having significant visual loss as a consequence of poorly controlled glaucoma. An internal and external peer review was done on this case that rated the care at a level 3. Due to concerns about quality of care in other glaucoma patients at the VAPAHCS, a look back process was initiated to identify patients with glaucoma that had been managed by Optometry alone from Jan 1, 2008 to Dec 31, 2008. A total of 381 patients were identified through this process with review of the charts. After the 381 charts were reviewed, 21 additional patients were identified as having progressive visual loss while under the care of Optometry. An additional 89 patients have been identified at being at risk for visual loss. The 21 patients identified with progressive visual loss are being brought in for evaluation by Ophthalmology and each case will be peer reviewed. The 89 patients identified at high risk for visual loss will also be brought in for evaluation by Ophthalmology.

b. Glaucoma patients have been severely harmed by Optometry not referring patients to Ophthalmology. Several patients have experienced loss of vision and visual field.

c. Damage to the patients may have been prevented or slowed if Optometry had referred patients to Ophthalmology, for more aggressive glaucoma management with medications, laser surgery or incisional surgery.

d. VAPAHCS privilege Level 2, number 7 available to Optometry allows the "diagnosis and management of uncomplicated glaucoma" by an optometrist, but requires consultation with Ophthalmology and with the primary care provider. All VAPAHCS optometrists, except one, Dr. (b) (6) have Level 2, number 7 privileges. One optometrist, Dr. (b) (6) did not treat glaucoma but was privileged to do so.

e. Interviewed optometrists, Drs. (b) (6) (b) (6) were practicing beyond their approved optometric privileges by treating glaucoma without consultation from Ophthalmology and Primary Care. Additionally, based on testimony from Dr. (b) (6) all VAPAHCS staff optometrists, were practicing beyond their approved optometric privileges by treating glaucoma without consulting Ophthalmology or Primary Care.

f. All optometrists completed and signed their privileging application. Those optometrists interviewed did not know what their privileges were as defined on their privileging form. Upon review of patient chart (C9804), Dr. (b) (6) was also treating glaucoma even though he was not privileged to do so.

g. Optometrists who hold a California Optometry license, can treat glaucoma only after receiving a Therapeutic Pharmaceutical Glaucoma (TPG) certification. All VAPAHCS optometrists hold California licenses.

h. Testimony from Dr. (b) (6) states that there are no VAPAHCS optometrists currently on staff who have received the TPG certification. Interviewed optometrists, Drs. (b) (6), have not obtained TPG certification in the State of California to treat glaucoma.

i. Optometry staff state that barriers to referring patients to Ophthalmology do not exist. An additional signature process is in place to allow easy and efficient transfer of care of patients from Optometry to Ophthalmology. Optometry staff stated that they have not had adverse experiences with the referral process and that patients are seen in a timely manner by Ophthalmology.

j. Neither Dr. (b) (6) nor staff optometrists, interviewed, could give a reason to explain the lack of referrals for glaucoma patients to Ophthalmology.

k. Patients were not informed, by Optometry, that they may see Ophthalmology for their glaucoma management or evaluation.

l. Dr (b) (6) and Dr. (b) (6) obtained Washington state licenses in addition to their California licenses with the purpose to practice beyond their California license, especially in the area of glaucoma. Dr. (b) (6) stated he was advised to obtain this second state license by Dr. (b) (6), the current (b) (6) for the Department of Veterans Affairs.

m. Dr. (b) (6) was added as an additional signer for glaucoma patients of other optometrists at all VAPAHCS sites where optometric services were offered. He stated that he knew his staff was not certified (TPG) in the state of California to treat glaucoma and that under his Washington state license he could treat glaucoma. He co-signed the notes to cover the lack of certification of other staff optometrists. The patients were not physically seen or examined by Dr. (b) (6) in the majority of circumstances preventing adequate evaluation and management of patients. He was not approved to practice in this manner.

n. Dr. (b) (6) did not have optometrists follow the privileges as delineated for Optometry for glaucoma. He made this a uniform policy in Optometry for many years, such that the optometrists interviewed stated they believed that they were allowed to disregard their delineated privileges for consultation with Ophthalmology. The Board perceived that the majority of optometrists did not understand the depth and seriousness of the care/referral mismanagement. This was systemic in Optometry.

o. There is an established service agreement between primary care and the eye care providers that specifies which patients should be referred to Optometry or Ophthalmology. This service agreement has been in effect for many years and the most recent agreement was resigned in December 2008. It was signed by both eye Section Chiefs of Optometry and Ophthalmology. The agreement was not being followed for referrals. The service agreement states patients currently on medications for glaucoma or patients with diagnosis of glaucoma suspect should be referred to Ophthalmology. Most of the staff, optometrists and ophthalmologists, was not aware of this service agreement.

p. All optometrists are employed part time, except one who is full time. The Optometry staff currently numbers 19 individuals equaling 7.725 FTEE. Most optometrists worked in different clinics, on a rotating basis, throughout the health care system. Scheduling was very complicated. This created a lack of optometry provider continuity. Patients are identified as seeing 3-4 different optometrists for their care.

q. Dr. (b) (6) and the other staff optometrists were not fully knowledgeable of the risk factors used in assessing glaucoma and applying those factors to moderate or high risk patients.

r. Dr. (b) (6) and the other staff optometrists did not act appropriately upon the correct assessment of glaucoma patients to refer them to a higher level of care.

s. Organizationally, Optometry and Ophthalmology are separate services each reporting independently to the Chief of Surgery. The sections are also located in separate buildings. Optometry is in building 5 and Ophthalmology is in building 100. This physical separation contributes to poor communication and redundancies between the two sections and is a detriment to working together as an Eye Care Team.

t. There is no significant, regular communication between the Chiefs of Optometry and Ophthalmology.

u. There are not regular meetings between Chief of Optometry and Chief of Ophthalmology with the Chief of Surgical Services.

v. There is a lack of internal communication within the Optometry section due to infrequent Optometry staff meetings.

w. Ophthalmology is not involved in providing input into the credentialing and privileging process for Optometry.

x. The optometrists stated there was not animosity between Optometry and Ophthalmology. Several described a couple of incidents that occurred five to six years ago involving one staff ophthalmologist. No incidents were mentioned after Dr. (b) (6) assumed the Chief of Ophthalmology position. Both optometrists and

ophthalmologists described their relationship as professional to non-existent. However, there were no recent acts of disrespect or harassment reported.

y. Optometrists sited that relationships are particularly strong and cordial at the Livermore VA, where Optometry and Ophthalmology work together and cooperatively in the same space as an Eye Care Team.

z. Other Optometry privileges (outside of glaucoma) at VAPAHCS do not specify the safeguards for referral to Ophthalmology as defined for California State Law. This could present ambiguity as to what the privileges are for Optometry. For example they do not specify how long the medications can be used and when referral to Ophthalmology is required.

aa. There was sometimes incomplete information on the CPRS glaucoma flow charts and notes that summarized the care of the patients. This occurred in both Optometry and Ophthalmology.

6. Conclusions:

a. All VAPAHCS Staff optometrists worked outside and beyond their approved VA Optometry privileges in treating glaucoma. There was one exception Dr. (b) (6) at the (b) (6) for whom the Board could not find evidence that she treated Glaucoma.

b. No VAPAHCS optometrists are licensed to treat glaucoma in California under current state regulations and none have the required California Therapeutic Pharmaceutical Glaucoma Certification (TPG).

c. Optometry did not meet the standard of care for the treatment of glaucoma.

d. Despite all optometrists signing their privileging documents, they were either unaware of what their privileges were or thought they could treat glaucoma without the required consultation with Ophthalmology.

e. Dr. (b) (6), knowingly allowed and directed the staff optometrists to work outside their approved privileges. He co-signed glaucoma patients' notes with the intent to legitimize the practice.

f. Dr. (b) (6) created an environment of isolation from VA Palo Alto Health Care System, and Ophthalmology specifically by rotating staff between Divisions and CBOCs. Optometrists did not question instructions (or lack of instruction), clinical practice guidelines, license restrictions and privileges.

g. Dr. (b) (6) attempts to manage all glaucoma cases within Optometry and not refer the patients to a higher level of care to Ophthalmology, resulted in progressive or severe visual loss in some patients. Visual loss may have been

prevented or delayed with earlier referral and more aggressive treatment with medications, laser, or surgery.

h. The Board could not document any recent incidents of harassment, disrespect or non-professional behavior by Ophthalmology staff towards Optometry staff. The rare incidents that were reported were 5-6 years old.

i. There was a lack of supervisory or clinical oversight of Dr. (b) (6) and the Optometry Section.

j. There was a lack of Optometry continuity of care due to multiple Optometry providers seeing the same patient at different visits.

k. There were not standardized CPRS flow charts that summarize the care of the glaucoma patients in both Optometry and Ophthalmology.

l. Administratively, Optometry and Ophthalmology are separate services independently reporting to the Chief of Surgery, as well as being physically located in different buildings. This arrangement is detrimental to working together as an Eye Care Team as well as creating inefficiencies and redundancies in patient care, equipment, and space.

m. There was little communication, both formal and informal, between Optometry, Ophthalmology and Chief, Surgical Service.

7. Recommendations:

a. Integrate the two independent sections of Optometry and Ophthalmology to establish one Eye Care Team. Recommendation includes consolidating the two sections into one shared, unified space and having a qualified individual lead the team both administratively and clinically. The Board's assessment is this arrangement will provide the best quality, efficient, and cost effective care and help build a sense of collegiality between Optometry and Ophthalmology.

b. Integrate the Morbidity and Mortality reports for Optometry and Ophthalmology and/or devise a method to regularly review Optometry clinical outcomes.

c. Improve the reappraisal process for Optometry clinical privileges to better assess clinical performance in the specified privileges. Develop proctoring requirements and minimum case load standards to better assess competency and maintenance of competency. Incorporate these requirements into the privileging application.

d. Consolidate FTEE levels for Optometry. Move towards employment of full-time staff and significantly reduce the number of fractional optometry appointments. Reduce the rotation of multiple staff optometrists between Divisions and CBOCs.

e. Improve communication between management and providers and between providers by having regular staff meeting for all staff in Optometry and Ophthalmology. Ensure that all staff understands what he/she is privileged to do at VAPAHCS.

f. Require the Chief of Ophthalmology's concurrence in the development and assignment of Optometry privileges. Review the current privileging and re-privileging process to ensure VAPAHCS Optometry privileges are within the California standard of care for optometrists. For example, if glaucoma or other eye diseases are to be treated by Optometry, privileges should not exceed the community standard as defined by California State Law for Optometrists. This would include the requirement of optometrists having the TPG certification.

g. Establish and communicate service agreements between Optometry and Ophthalmology.

h. Review with Optometry staff the seriousness and adverse consequences to patients of their clinical practice.

i. Provide adequate staffing in the CBOCs and Clinics so that both Ophthalmology and Optometry coverage is available. This may require new or additional FTE particularly in Ophthalmology.

j. Create and implement standardized flow charts to summarize the pertinent clinical information on the glaucoma patients that may be used by Optometry and Ophthalmology.

Stacy Moeder, Chair,
Administrative Board of Investigation

Kintina Edouard
Member

Deana Lum, OD
Member

Linda Margulies, MD
Member

d. Consolidate FTEE levels for Optometry. Move towards employment of full-time staff and significantly reduce the number of fractional optometry appointments. Reduce the rotation of multiple staff optometrists between Divisions and CBOCs.

e. Improve communication between management and providers and between providers by having regular staff meeting for all staff in Optometry and Ophthalmology. Ensure that all staff understands what he/she is privileged to do at VAPAHCS.

f. Require the Chief of Ophthalmology's concurrence in the development and assignment of Optometry privileges. Review the current privileging and re-privileging process to ensure VAPAHCS Optometry privileges are within the California standard of care for optometrists. For example, if glaucoma or other eye diseases are to be treated by Optometry, privileges should not exceed the community standard as defined by California State Law for Optometrists. This would include the requirement of optometrists having the TPG certification.

g. Establish and communicate service agreements between Optometry and Ophthalmology.

h. Review with Optometry staff the seriousness and adverse consequences to patients of their clinical practice.

i. Provide adequate staffing in the CBOCs and Clinics so that both Ophthalmology and Optometry coverage is available. This may require new or additional FTE particularly in Ophthalmology.

j. Create and implement standardized flow charts to summarize the pertinent clinical information on the glaucoma patients that may be used by Optometry and Ophthalmology.

Stacy Molder, Chair,
Administrative Board of Investigation

Kristina Edoulard
Member

Deane Lum, OD
Member

Accept / Reject

Linda Margulies, MD
Member

Elizabeth Joyce Freeman
Director

DEPARTMENT OF
VETERANS AFFAIRS

# Memorandum

Date: APR 0 9 2009

From: Director (00)

Subj: Administrative Investigation – Action Plan

To: Chief of Surgical Service (112)
Chief of Human Resources Management Service (05)

Thru: Chief of Staff (11)
Associate Director (001)

1. Scope: An investigation into the facts and circumstances regarding the credentialing/privileging of optometrists as it relates to glaucoma patients, the relationship between Optometry and Ophthalmology services and whether or not a culture exists that would prevent Optometrists from engaging Ophthalmology support in the management of glaucoma patients.

2. Findings: A copy of the investigative report is kept in the Quality Management Office.

3. Conclusions: All VAPAHCS staff optometrists worked outside and beyond their approved VA Optometry privileges in treating glaucoma. There was one exception Dr. (b) (6) at the (b) (6) for whom the Board could not find evidence that she treated Glaucoma.

No VAPAHCS optometrists are licensed to treat glaucoma in California under current state regulations and none have the required California Therapeutic Pharmaceutical Glaucoma Certification (TPG).

Optometry did not meet the standard of care for the treatment of glaucoma.

Despite all optometrists signing their privileging documents they were either unaware of what their privileges were or thought they could treat glaucoma without the required consultation with Ophthalmology.

Dr. (b) (6) knowingly allowed and directed the staff optometrists to work outside their approved privileges. He co-signed glaucoma patients' notes with the intent to legitimize the practice. He created an environment of isolation from Palo Alto Health Care System, and Ophthalmology specifically by rotating staff between Divisions and CBOCs. Optometrists did not question instructions (or lack of instruction), clinical practice guidelines, license restrictions and privileges.
There was a lack of supervisory or clinical oversight of Dr. (b) (6) and the Optometry section.

Administratively, Optometry and Ophthalmology are separate services independently reporting to the Chief of Surgery, as well as being physically located in different buildings. This arrangement is detrimental to working together as an Eye Care Team as well as creating inefficiencies and redundancies in patient care, equipment, and space.

There was little communication, either formal or informal, between Optometry, Ophthalmology and Chief of Surgical Service.

4. Recommendations:

a. The Chief of Surgical Service to consult with the Chief of Human Resources Management Service to discuss the appropriate disciplinary action to be taken on Dr. (b) (6) and other optometry staff.

b. The Chief of Surgical Service to integrate the two independent sections of Optometry and Ophthalmology to establish one Eye Care Team. Consolidating the two sections into one shared, unified space and having a qualified individual lead the team both administratively and clinically.

c. The Chief of Surgical Service to integrate the Morbidity and Mortality reports for Optometry and Ophthalmology and/ or devise a method to regularly review Optometry clinical outcomes.

d. The Chief of Surgical Service to improve the reappraisal process for Optometry's clinical privileges to better assess clinical performance in the specified privileges. To ensure that all optometrists who hold a California license receive the Therapeutic Pharmaceutical Glaucoma (TPG) certification. Develop proctoring requirements and minimum case load standards to better assess competency and maintenance of competency.

e. The Chief of Surgical Service to ensure that all optometry staff understands what he/she is privileged to do at VAPAHCS.

f. The Chief of Surgical Service to consult with the Chief of Human Resources Management Service to consolidate FTEE levels for Optometry. Move towards employment of full-time staff and significantly reduce the number of fractional optometry appointments. Reduce the rotation of multiple staff optometrists between Divisions and CBOCs and to provide adequate staffing so that both Ophthalmology and Optometry coverage is available.

g. The Chief of Surgical Service to require the Chief of Ophthalmology's concurrence in the development and assignment of Optometry privileges. Review the current privileging and reprivileging process to ensure VAPAHCS Optometry privileges are within the California standard of care for optometrists.

h. The Chief of Surgical Service to ensure that optometrists and ophthalmologists are made aware of the service agreement between Optometry and Ophthalmology.

i. The Chief of Surgical Service to improve communication between management and providers by having regular staff meetings for all staff in Optometry and Ophthalmology.

j. The Chief of Surgical Service to review with Optometry staff the seriousness and adverse consequences to patients of their clinical practice.

5. Please send a report to Terri Monisteri, Risk Manager (QM/RM), indicating that action items have been addressed and include the supporting documentation(s). Your report is due May 8, 2009.

6. If you have further questions, please contact Ms. Monisteri at (650) 493-5000, extension 67751.

Elizabeth Joyce Freeman
Director

A1

# SERVICE AGREEMENT BETWEEN PRIMARY CARE AND OPHTHALMOLOGY/OPTOMETRY

**Purpose:**

1. To define the list of conditions that should be managed in Primary Care and the process for making a referral to Ophthalmology/Optometry.
2. To describe the time frame or conditions when a patient will be discharged from Ophthalmology/Optometry back to Primary Care.
3. To identify tests or procedures that should be completed prior to or concurrent with making the referral.
4. To maximize use of Ophthalmology/Optometry expertise, knowledge, time and resources.
5. To facilitate quality patient care by reducing the waiting time to obtain an Ophthalmology/Optometry consultation/evaluation.
6. To assure patients are seen at the most appropriate level of care.

**Primary Care Will:**

1. Use the Electronic Consult package to order a consult
2. Comply with testing requirements defined in the Electronic Consult package or Service Directives. No pre-work testing is currently required for referral to eye care.
3. Evaluate the results of any pre- consultation tests that they order to determine if the scheduled appointment date is appropriate or if immediate intervention is required.
4. **For any patient felt to need an appointment on an urgent/emergent basis contact the Ophthalmology/Optometry provider on call to determine the optimal way to address the patient's needs.**

**Ophthalmology/Optometry Will:**

1. Accept consultations for any condition related to the eye. The following referral guidelines should be used in determining if a condition should be sent to ophthalmology or optometry:

   **Ophthalmology Referral**

   - Acute eye problems: decreased vision within the last month, pain, redness felt to be secondary to a medical condition, either systemic or confined to the eye
   - Previously diagnosed diabetic retinopathy, or those patients in which proliferative retinopathy is suspect e.g. Diabetic on insulin, diabetic with HTN, diabetic for 10 years, diabetic with microalbumiurea, hyperlipidemia, HgA1c over 8.0 and those with previous laser treatment.
   - Lid lesions possibly needing biopsy or excision
   - Medical conditions with high risk for eye disease, particularly with acute complaints, e.g.: Grave's disease, collagen vascular disease, certain

rheumatologic disorders, connective tissue diseases, including rheumatoid arthritis and lupus, and other HLA B27 associated conditions, neurologic complaints including headache associated with visual symptoms and acute diplopia
- Acute trauma (possibly involving the globe or lid lacerations)
- Patients with flashes and/or floaters
- Glaucoma Management- patients currently on medication for glaucoma or patients with diagnosis of glaucoma suspect
- Previously diagnosed or treated medical eye diseases such as cataract, retinal disease
- Ocular symptoms in an eye with a corneal transplant

**Optometry Referral**
- Refraction for new or replacement glasses, routine eye examinations every two years, and exams for low vision
- Diabetic and hypertensive patient's eye examinations
- Red, itchy, burning eye patients
- Glaucoma evaluation with referral to Ophthalmology as needed.
- Patients on eye altering medications such as ethambutol, plaquenil

If the baseline eye exam is normal for the well controlled (i.e. HBA1C <8 in past 12 months), non-insulin requiring, older-onset diabetic patient a follow up exam in 2 years is indicated (this is instead of one year). All others will be seen annually or as recommended by the Eye Clinic Team.

2. Be available for phone consultation by calling the on call ophthalmologist or onsite ophthalmology or optometry attending.
3. Define any pre-consultation test requirements and make this available in the electronic consult package.
4. Electronic consults will be reviewed daily and acted upon within 7 days. The patient will be scheduled in a time frame as defined in this agreement. The services will work collaboratively to ensure that the appropriate eye care professional sees the patient. The services will notify the Primary Care provider and the patient, as appropriate, of the appointment date.
5. Attempt to see all routine consults within 30 days. **Any patient felt to need an appointment on an urgent/emergent basis should be discussed with Ophthalmology/Optometry service to determine the optimal way to address the patient's needs.**
6. Consult reports will be entered into CPRS within 7 days of completing the consult.
7. Assume that most specialty care is time limited. The care will continue until resolution of the problem or until the problem is sufficiently stable that the patient may be returned to the primary care provider with treatment recommendations and guidelines for referral back to specialty care. Those patients with ongoing eye issues which require the expertise of an eye care professional will continue to

be followed either ophthalmology or optometry. The need for such ongoing care will be documented in the progress notes.

8. Recommended follow-up for patients will be documented in the CPRS Consult note. A discussion with the Primary Care provider may be necessary prior to the discharge from the Ophthalmology/Optometry clinic.
9. Inform the patient on the last visit date that he/she no longer needs to be seen in Ophthalmology/Optometry Clinic and is being discharged back to his/her Primary Care provider for continuing care. (CPRS documentation will reflect the discussion and any specific treatment-plan requirements).
10. Participate in educational sessions for primary care.

**Eye Care and Primary Care Will:**

1. Meet to discuss and develop treatment plans for any patient in which there is a disagreement on if the patient needs ongoing specialty care versus management in primary care alone.
2. Monitor and evaluate new patient appointment availability, at least quarterly, using the KLF data and the Ambulatory Care Monthly Clinic Statistic report.
3. Review and re-evaluate this agreement at least annually.

_____
ACOS/Ambulatory Care

Date_____

Chief, Ophthalmology

Date 12-03-2008

_____
Chief of Staff

Date_____

Chief, Optometry

Date 12-11-08

**REVIEW DATE 11/14/2008**

**RENEWAL DATE 11/14/2009**

**Department of Veterans Affairs**

# Memorandum

**Date:** May 8, 2009

**From:** Chief, Surgical Service (112)

**Subj:** Administrative Investigation – Action Plan

**To:** Director (00)

**Thru:** Chief of Staff (11)
Associate Director (001)

1. The Administrative Investigation – Action Plan for VAPAHCS Optometry is being submitted in response to the memorandum dated April 9, 2009.

A. Section 3 – Conclusions: *There was a lack of supervisory or clinical oversight of Dr.* (b) (6) *and the Optometry section.*
   a. The Chief of Surgical Service provided oversight on the development of a service agreement in 2004 between Optometry, Ophthalmology, and Primary Care. This outlined (1) primary care referrals to Optometry and Ophthalmology, (2) evaluation and management of various eye conditions and diseases by Optometry and Ophthalmology, (3) referrals from Optometry to Ophthalmology, and (4) discharge back to primary care.
   b. The service agreement is reviewed and renewed annually. [see attachments A1 – A3]

B. Section 4 – Recommendations:
   a. *The Chief of Surgical Service to consult with the Chief of Human Resources Management Service to discuss the appropriate disciplinary action to be taken on Dr.* (b) (6) *and other optometry staff.*
      i. The Chief of Surgical Service discussed with the Chief of Human Resources Management Service (HRMS) and Chief of Staff on the appropriate course of action for (b) (6) (b) (6) and the other optometrists involved with the mismanagement of glaucoma patients.
      ii. Dr. (b) (6) was placed on administrative leave per the Director on February 5, 2009, and (b) (6) part-time staff optometrist, was placed on administrative duties on February 2, 2009.
      iii. To date, HRMS is reviewing records for appropriate action to be taken in regards to Drs. (b) (6).

   b. *The Chief of Surgical Service to integrate the two independent sections of Optometry and Ophthalmology to establish one Eye Care Team.*

*Consolidating the two sections into one shared, unified space and having a qualified individual lead the team both administratively and clinically.*

i. In concurrence with the Chief of Staff and Chief of HRMS, the Chief of Surgical Service announced via a memorandum that effective February 19, 2009, the Chief of Ophthalmology will begin serving as the Chief of Eye Care over both Ophthalmology and Optometry. Optometry was also organizationally placed under the Ophthalmology section, reassigning the Assistant Chief of Optometry to Manager of Optometry. [see attachment B]

ii. The Chief of Surgical Service met with the Chief of Staff on April 10, 2009, and with the Deputy Chief of Staff on April 15, 2009, to request the consolidation of Optometry and Ophthalmology into one unified space. Optometry's proposal (attachment C) was submitted along with staffing and equipment needs for Palo Alto, Livermore, Monterey, and San Jose. A similar request for a unified space was requested by the Chief of Surgical Service in 2007, recognizing the critical need for joining the two sections for improved collaboration and efficiency. [see attachment C]

c. *The Chief of Surgical Service to integrate the Morbidity and Mortality reports for Optometry and Ophthalmology and/or devise a method to regularly review Optometry clinical outcomes.*

i. Although Dr. (b) (6) had few Morbidity and Mortality (M&M) entries for what he deemed as deviating from the standard of care within VAPAHCS Optometry, they were not M&Ms. Optometry is not expected to have any reported M&Ms.

ii. A thorough On-going Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) for Optometry are currently being developed to evaluate and monitor clinical evaluation, management, and outcomes. Triggers will be implemented for an FPPE action plan when needed. Regular review will provide timely assessment of clinical outcomes.

d. *The Chief of Surgical Service to improve the reappraisal process for Optometry's clinical privileges to better assess clinical performance in the specified privileges. To ensure that all optometrists, who hold a California license, receive the Therapeutic Pharmaceutical Glaucoma (TPG) certification. Develop proctoring requirements and minimum case load standards to better assess competency and maintenance of competency.*

i. A thorough On-going Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) for Optometry are currently being developed to evaluate and monitor clinical evaluation, management, and outcomes. This will offer a more robust and timely Q&A process to minimize and prevent deviations from the standard of care.

ii. VAPAHCS Optometry will not be required to obtain the Therapeutic Pharmaceutical Glaucoma certification; all suspect and confirmed glaucoma cases must be referred to Ophthalmology for evaluation and treatment as of February 10, 2009. This direct order was signed and returned by all staff and fee basis optometrists to Surgical Service. [see attachment D]

e. *The Chief of Surgical Service to ensure that all optometry staff understands what he/she is privileged to do at VAPAHCS.*
   i. All staff and fee basis Optometrists received the revised Delineation of Clinical Privileges for Optometry (see Section 1(B)(d)(i)(1)) effective April 21, 2009 from the Medical Staff Office.
   ii. **At the next scheduled Optometry meeting, May 21, 2009, the Chief of Surgical Service will address the issue of privileging to ensure a thorough understanding by the optometrists.**

f. *The Chief of Surgical Service to consult with the Chief of Human Resources Management Service to consolidate FTEE levels for Optometry. Move towards employment of full-time staff and significantly reduce the number of fractional optometry appointments. Reduce the rotation of multiple staff optometrists between Divisions and CBOCs and to provide adequate staffing so that both Ophthalmology and Optometry coverage is available.*
   i. Redistributing current FTEE levels to increase more full-time staff would not allow for enough personnel to cover the Palo Alto, Livermore, Monterey, and San Jose Optometry clinics.
   ii. Given the current modified hiring freeze, the Chief of Surgical Service met with the Chief of Staff on April 10, 2009, and with the Deputy Chief of Staff on April 15, 2009, per requested procedure to review needs for Optometry and Ophthalmology. At this time, the request was made for two additional FTEEs in Optometry to raise two part-time Optometrists to full-time status, raise the other part-time staff to levels sufficient to give them regular work schedules at designated CBOCS, and greatly reduce the need for fee basis. Status is still pending.
   iii. Once appropriate action has been determined for Drs. Keswick and Suwabe, their combined 0.7 FTEE will be immediately utilized to reduce use of fee basis.
   iv. Staffing will be regularly reviewed to further employ more full-time, regularly-assigned staff.

g. *The Chief of Surgical Service to require the Chief of Ophthalmology's concurrence in the development and assignment of Optometry privileges. Review the current privileging and re-privileging process to ensure*

*VAPAHCS Optometry privileges are within the California standard of care for optometrists.*

i. After reviewing a number of other VA-facility Optometry privileges, the Chief of Surgical Service, Chief of Eye Care (Ophthlamology and Optometry), Manager of Optometry, and another senior staff Ophthalmologist collaborated to develop revised clinical privileges with extensive changes for VAPAHCS Optometrists.

1. The revised Optometry privileges include specifics on resident supervision, prescribing of medications, treatment of eye diseases and when to refer to Ophthalmology, and proctoring requirements. Approved by the Medical Executive Board (MEB) on April 21, 2009, all optometrists are being updated on their Delineation of Clinical Privileges and will be forwarded for approval to the Professional Standards Board and MEB. [see attachments E1 – E5]

h. *The Chief of Surgical Service to ensure that optometrists and ophthalmologists are made aware of the service agreement between Optometry and Ophthalmology.*

i. Surgical Service policy for the referral of VAPAHCS glaucoma suspect and confirmed cases in Optometry to Ophthalmology was developed effective February 19, 2009. This guideline was developed in collaboration between the Chief of Surgical Service, the former Chief of Ophthalmology, who is now the Chief of Eye Care, and concurrence by the Chief of Staff as an immediate response to the mismanagement of glaucoma patients in Optometry. This is still in effect today and will be revised as needed. [see attachment F]

ii. Effective March 25, 2009, a Surgical Service policy for the management of glaucoma medication prescriptions obtained outside of the VA was established in collaboration between the Chief of Surgical Service, Chief of Eye Care, and Manager of Optometry with concurrence by the Chief of Staff. [see attachment G]

iii. A service agreement between Ophthalmology, Optometry, and Primary Care is renewed annually and were previously signed by the ACOS of Ambulatory Care, Chief of Staff, and Chiefs of Ophthalmology and Optometry (see Section 1(A)(a) and 1(A)(b)). [see attachments A1 – A3]

i. *The Chief of Surgical Service to improve communication between management and providers by having regular staff meetings for all staff in Optometry and Ophthalmology.*

i. Surgical Service Staff meetings are held for providers of all sections, including Optometry and Ophthalmology, but added effort

was made to encourage Optometrists, who were regularly represented by Dr. (b) (6) to attend the meetings. All optometrists and ophthalmologists will continually be encouraged to attend.

ii. Recognizing that all Optometry and Ophthalmology staff cannot attend the staff meetings at the same time due to clinics, OR, or their tours of duty, key notes or minutes from the meetings are e-mailed for everyone's review.

iii. The Chief of Eye Care, Ophthalmology staff, and the Manager of Optometry have regularly met or been in correspondence with each other over eye care issues ranging from equipment needs to glaucoma medications and management, referrals, privileges, and patient care.

1. Eye Care meetings for Ophthalmology and Optometry will be initiated to encourage continued collaboration and communication for improved patient care.

iv. Close collaboration is required between Ophthalmology and Optometry, and the Chief of Surgical Service will ensure compliance through regular follow-up.

j. *The Chief of Surgical Service to review with Optometry staff the seriousness and adverse consequences to patients of their clinical practice.*

i. The Chief of Surgical Service discussed the seriousness and adverse consequences of Optometry's management of glaucoma care with the staff optometrists on February 5, 2009. Furthermore, Surgical Service's new glaucoma care guidelines and the requirement to refer all suspect and confirmed glaucoma cases to Ophthalmology were reviewed. This was solidified by the implementation of policies outlined in attachments D – G.

ii. The Chief of Surgical Service will again meet with all Optometry staff to discuss the seriousness and consequences of what has transpired as soon as HRMS has determined their course of action with Drs. Keswick and Suwabe.

2. If you have any questions regarding this Action Plan, please contact Thomas Burdon, MD, Chief of Surgical Service, at x 65357.

cc: Risk Manager (QM/RM)

B

**Department of Veterans Affairs**

# Memorandum

Date: February 19, 2009

From: Chief, Surgical Service (112)

Subj: VA Palo Alto Health Care System (VAPAHCS) Eye Care

To: VAPAHCS Ophthalmology and Optometry

1. To improve collaboration and coordination of patient eye care at VAPAHCS, effective immediately, Optometry will function under the direct supervision of Ophthalmology. Both specialties will now serve under the new section name, Eye Care, within Surgical Service.

2. Glenn Cockerham, MD, Chief of Ophthalmology, will now serve as Chief of Eye Care.

3. Jennine Kirby, OD will now serve as Manager of Optometry, directly reporting to the Chief of Eye Care.

4. For any questions regarding this matter, please contact Lisa Mizumoto in Surgical Service at extension 60596.

Thomas A. Burdon, MD

C

Optometry Space Needs in Bldg 100

5 exam rooms
- One long enough for low vision
- WC Accessibility?

1 testing room
- Camera
- HVF
- Topographer
- Autorefractor
- Pachymeter

1 shared office/consultation room
- 2 desks
- Space for consultation
- Book cases

1 private office
1 PSA office
Space for Omnicell
Space for Storage
- Accessible
- BV/ LV/CL supplies
- Extra small equipment
  - Hand held SL, tonopen, etc...

Conference Room – shared with ophthalmology?

***This does not allow for any growth between now and 2013 when the new Ambulatory Care Center is proposed to be done. If adequate planning is desired to meet growing eye care demand, I would propose at least one more exam lane and one more shared office/consultation room.

D

**Department of Veterans Affairs**

# Memorandum

Date: February 10, 2009

From: Chief, Surgical Service (112)

Subj: Direct Order – Glaucoma Care

To: VAPAHCS Optometrists (FT, PT, Fee Basis)

1. The VA Palo Alto Health Care System (VAPAHCS) is committed to providing the highest standard of care for our veterans. To ensure optimal eye care, an integrated approach to glaucoma diagnosis, treatment, and management is being developed through a collaboration of the departments of Ophthalmology and Optometry at VAPAHCS.

2. Effective immediately, all VAPAHCS Optometry patients with suspect or confirmed glaucoma will be referred to Ophthalmology at a VA facility for evaluation. Said patients will not be independently cared for by VAPAHCS Optometry but will be co-managed by Optometry and Ophthalmology.

3. This direct order will remain in place until further notice. Failure to comply with this order may result in disciplinary action.

4. If you have any questions, please contact Cathy Glynn-Milley, RN, in Ophthalmology, at extension 67133.

Thomas A. Burdon, M.D.

Acknowledged Receipt:

Print Name: _____

Sign: _____ Date: _____

E1

Department of Veterans Affairs

# Memorandum

Date: April 24, 2009

From: Chief of Staff/Medical Staff Office (11MSO)

Subj: OPTOMETRY PRIVILEGES REVISION

To: XXXX, OD

1. On April 21, 2009 the Medical Executive Board (MEB) approved the revision of Optometry privileges. Due to extensive changes to the Delineation of Clinical Privileges in Optometry form and to be in compliance with Service policy, it is necessary for you to complete the attached Application for Change of Clinical Privileges packet.

2. Please complete the attached packet in it's entirety to update your clinical privileges. Please return the completed packet in the pre-paid postage envelope provided **NO LATER THAN MAY 15, 2009**

3. Your immediate response will be greatly appreciated. If you have questions regarding this memo, please contact the undersigned at 650-852-3274

Angela Boese
Medical Staff Coordinator

VA FORM 2105
JAN 2005

F

**Department of Veterans Affairs**

# Memorandum

**Date:** February 19, 2009

**From:** Chief, Surgical Service (112)

**Subj:** Guidelines for Referral of VA Palo Alto Health Care System (VAPAHCS) Glaucoma Suspects and Glaucoma Patients to Ophthalmology

**To:** VAPAHCS Optometry & Ophthalmology

1. To clarify the previous directive dated February 10, 2009, regarding glaucoma care at VAPAHCS, the following considerations apply:

    a. For immediate referral of patients presenting with high intraocular pressures (>30 mm), please call the VAPAHCS Eye Clinic Hotline at (650) 496-2565.

    b. For glaucoma suspects and known glaucoma patients, please add the Ophthalmology Clinical Coordinator, Cathy Glynn-Milley, RN, and Program Support Assistant, Victoria Griswold, as additional signers to your notes. Ophthalmology will then determine the timing of the visit. For patient referrals to Livermore Ophthalmology, please add Leonard Goldschmidt, MD and Donna Wing, LVN as signers.

    c. The Optometry section will perform vision, intraocular pressures, stereo disc examinations, and pachymetry on all patients. In the disposition, please indicate whether patient condition is stable or unstable and any other information to help guide scheduling. Please do not schedule Optometry follow-up at this time.

    d. Automated visual fields with Humphrey 30-2 SITA standard format, HRT III, OCT, and fundus photography will be performed at VA Palo Alto Ophthalmology during the initial visit. Stable patients will be referred back to Optometry for follow-up. The mechanism for efficient referral to Optometry is being developed.

2. All Optometry fellows, residents, and students are required to follow these guidelines.

3. For any questions regarding the referral guidelines, please contact Cathy Glynn-Milley, RN at extension 67133.

Thomas A. Burdon, MD

**Department of Veterans Affairs**

# Memorandum

**Date:** March 25, 2009

**From:** Chief, Surgical Service (112)

**Subj:** Guideline – Management of Glaucoma Medication Prescriptions Obtained Outside of the VA

**To:** VA Palo Alto Health Care System (VAPAHCS) Ophthalmology and Optometry Sections

1. Some glaucoma patients obtain eye medications from VAPAHCS Pharmacy Service, while receiving care from Ophthalmologists outside of the VA. In such a situation, the VA effectively assumes liability for glaucoma management and failures associated with medication complications.

2. Effective immediately, to ensure quality of care and proper documentation, VAPAHCS policy requires that all glaucoma patients be seen at least yearly by Ophthalmology at the Palo Alto or Livermore divisions in order to receive glaucoma medications through the VA.

3. Glaucoma patients will be advised of this policy and the recommendation for referral to VA Ophthalmology at their next optometry visit. Glaucoma patients that refuse referral will be advised that they will no longer be able to obtain glaucoma medication refills through the VA, and this will be annotated in the patient record.

4. VA Optometrists will use provider discretion regarding interim glaucoma medication refills while the patient transfers care to VA Ophthalmology or for up to 6 months when the patient has refused VA care.

5. The Point of Contact for this issue is Catherine Glynn-Milley, RN, Ophthalmology Clinical Coordinator, at 650-858-3908 or catherine.glynn-milley@va.gov

Thomas A. Burdon, MD

# CourtSmart Tag Report

**Room:** KN 412 **Case:** **Type:**
**Caption:** Senate Health Policy Committee **Judge:**

**Started: 2/21/2013 8:01:50 AM**
**Ends: 2/21/2013 10:01:23 AM Length: 01:59:34**

| | |
|---|---|
| **8:01:59 AM** | Meeting called to order |
| **8:02:23 AM** | Roll call |
| **8:03:09 AM** | SB 60 Introduced |
| **8:03:59 AM** | Chair |
| **8:04:42 AM** | Vote on SB 60 |
| **8:04:56 AM** | Chair |
| **8:05:11 AM** | SB 520 Introduced |
| **8:05:41 AM** | Vote on SB 520 |
| **8:05:59 AM** | Chair |
| **8:06:05 AM** | SPB 7014 Introduced |
| **8:07:02 AM** | Chair |
| **8:07:10 AM** | Vote on SPB 7014 |
| **8:07:42 AM** | SB 398 Introduced by Chair Bean |
| **8:09:21 AM** | Senator Joyner |
| **8:09:44 AM** | Senator Sobel |
| **8:10:12 AM** | Sen. Garcia |
| **8:10:45 AM** | Dayne Alonso - Florida Academy of Physicians Assistants |
| **8:12:03 AM** | Sen. Bean |
| **8:12:10 AM** | Dayne Alonso |
| **8:13:32 AM** | Sen. Sobel |
| **8:14:13 AM** | Brian Pitts - Justice 2 Jesus |
| **8:15:28 AM** | Sen. Sobel |
| **8:15:38 AM** | Vote on SB 398 |
| **8:16:11 AM** | Chair Bean |
| **8:16:17 AM** | Sen. Galvano |
| **8:16:36 AM** | Chair Bean |
| **8:17:08 AM** | SB 278 Introduced by Sen. Richter |
| **8:21:41 AM** | Chair Bean |
| **8:22:28 AM** | Sen. Sobel Inquires about SB 278 |
| **8:23:04 AM** | Sen. Richter |
| **8:23:17 AM** | Sen. Sobel |
| **8:24:00 AM** | Sen. Richter |
| **8:24:44 AM** | Chair Bean |
| **8:25:36 AM** | Sen. Galvano |
| **8:26:34 AM** | Chair Bean |
| **8:28:07 AM** | Dr. Charles Slonim, Florida Society of Ophthalmology - Public Testimony |
| **8:32:45 AM** | Chair Bean |
| **8:32:50 AM** | Sen. Sobel |
| **8:32:57 AM** | Dr. Slonim |
| **8:33:56 AM** | Sen. Sobel |
| **8:34:00 AM** | Dr. Slonim |
| **8:34:18 AM** | Chair Bean |
| **8:34:27 AM** | Walter Presha - Manatee County Rural Health Services - Public Testimony |
| **8:38:21 AM** | Chair Bean |
| **8:38:27 AM** | Stephen Winn - Florida Osteopathic Medical Assoc - Waives in opposition |
| **8:39:05 AM** | Chair Bean |
| **8:39:10 AM** | Dr. Kenneth Woliner - Public Testimony |
| **8:40:58 AM** | Chair Bean |
| **8:41:36 AM** | Dr. Kurt Heitman - American Academy of Ophthalmologysts - Public Testimony |
| **8:44:20 AM** | Chair Bean |
| **8:44:28 AM** | Dr. Stacey Kruger - Florida Society of Ophthalmology - Public Testimony |
| **8:46:30 AM** | Sen. Sobel |

**8:46:34 AM** Dr. Kruger
**8:48:30 AM** Chair Bean
**8:48:33 AM** Dr. Jaime Membreno - Public Testimony
**8:50:05 AM** Chair Bean
**8:50:10 AM** Dr. Deepak Raja - Public Testimony
**8:53:35 AM** Chair Bean
**8:53:40 AM** Dr. Jim Rowsey - Florida Society of Ophthalmology - Public Testimony
**8:56:28 AM** Chair Bean
**8:56:42 AM** Robert Palmer - American Academy of Ophthalmology - Public Testimony
**8:59:27 AM** Chair Bean
**8:59:52 AM** Bruce May - Florida Society of Ophthalmology - Public Testimony
**9:03:48 AM** Chair Bean
**9:03:52 AM** Sen. Sobel
**9:04:03 AM** Bruce May
**9:06:29 AM** Chair Bean
**9:06:36 AM** Dr. Kimberly Reed - Optometrist - Public Testimony
**9:11:27 AM** Chair Bean
**9:11:30 AM** Sen. Sobel
**9:11:36 AM** Kimberly Reed
**9:11:59 AM** Sen. Sobel
**9:12:04 AM** Kimberly Reed
**9:12:52 AM** Chair Bean
**9:13:10 AM** Sen. Joyner
**9:13:21 AM** Kimberly Reed
**9:14:31 AM** Sen. Joyner
**9:14:35 AM** Kimberly Reed
**9:15:39 AM** Chair Bean
**9:15:48 AM** Dr. Alberto Aran - Aran Eye Associates - Public Testimony
**9:18:49 AM** Chair Bean
**9:18:52 AM** Sen. Sobel
**9:19:00 AM** Dr. Aran
**9:21:43 AM** Chair Bean
**9:21:46 AM** Sen. Braynon
**9:22:01 AM** Dr. Aran
**9:22:25 AM** Chair Bean
**9:22:30 AM** Dr. John MccLane - Public Testimony
**9:25:06 AM** Sen. Sobel
**9:26:03 AM** Dr. MccLane
**9:26:47 AM** Chair Bean
**9:27:04 AM** John Griffin - Florida Optometric Association, Inc. - Public Testimony
**9:32:10 AM** Chair Bean
**9:32:19 AM** Rebecca O'hara - Florida Medical Association - Public Testimony
**9:33:11 AM** Chair Bean
**9:33:14 AM** Brian Pitts - Justice 2 Jesus - Public Testimony
**9:36:33 AM** Chair Bean
**9:36:40 AM** Jerrod Holton - Midway City Council - Public Testimony
**9:38:27 AM** Chair Bean
**9:38:42 AM** Dr. Mark Michels - FSO - Public Testimony
**9:46:26 AM** Chair Bean
**9:46:38 AM** Dr. Brad Oren - FSO - Public Testimony
**9:49:30 AM** Chair Bean
**9:50:02 AM** Amendment by Sen. Garcia adopted
**9:50:16 AM** Sen. Sobel
**9:51:05 AM** John Griffin
**9:52:16 AM** Chair Bean opens debate on SB 278
**9:52:27 AM** Sen. Sobel
**9:55:26 AM** Chair Bean
**9:55:33 AM** Sen. Grimsley
**9:58:28 AM** Chair Bean
**9:58:34 AM** Sen. Richter closes on his bill
**10:00:15 AM** Chair Bean
**10:00:33 AM** Vote on SB 278

**10:01:03 AM** Chair Bean
**10:01:06 AM** Sen. Joyner moves we rise