The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Diaz, Chair
Senator Brodeur, Vice Chair

MEETING DATE: Wednesday, March 17, 2021
TIME: 9:00—11:30 a.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Diaz, Chair; Senator Brodeur, Vice Chair; Senators Albritton, Baxley, Bean, Book, Cruz, Farmer, Garcia, and Jones

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
	PUBLIC TESTIMONY WILL BE RECEIVED FROM ROOM A3 AT THE DONALD L. TUCKER CIVIC CENTER, 505 W. PENSACOLA STREET, TALLAHASSEE, FL. 32301		
1	**CS/SB 614** Criminal Justice / Rodriguez (Similar H 1625)	Assault or Battery on Hospital Personnel; Providing enhanced criminal penalties for persons who knowingly commit assault or battery upon hospital personnel, etc. CJ 02/16/2021 Fav/CS HP 03/17/2021 Favorable RC	Favorable Yeas 9 Nays 0
2	**SB 818** Burgess (Similar H 941)	Mental Health Professionals; For purposes of clinical experience requirements for licensure as a mental health counselor, deleting a requirement that a licensed mental health professional be on the premises when a registered intern is providing clinical services in a private practice setting; authorizing courts to appoint mental health professionals licensed under ch. 491, F.S., as experts in criminal cases, etc. HP 03/17/2021 Favorable CJ RC	Favorable Yeas 9 Nays 0
3	**SB 1142** Rodrigues (Identical H 721)	Prohibited Acts by Health Care Practitioners; Subjecting health care practitioners to discipline for making misleading, deceptive, or fraudulent representations related to their specialty designations; subjecting health care practitioners to discipline for failing to provide written or oral notice to patients of their specialty designation; requiring the Department of Health, instead of applicable health care practitioner boards, to enforce the written or oral notice requirement, etc. HP 03/17/2021 Fav/CS AHS AP	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1442** Boyd (Identical H 1091)	Substance Abuse Prevention; Revising provisions relating to the prescribing, ordering, and dispensing of emergency opioid antagonists to certain persons; requiring the Department of Health to develop and implement a statewide awareness campaign to educate the public regarding opioid overdoses and the safe storage and administration of emergency opioid antagonists; requiring the department, in coordination with the Board of Pharmacy, to establish and administer the At-home Drug Deactivation and Disposal System Program for a specified purpose, etc. HP 03/17/2021 Favorable AHS AP	Favorable Yeas 10 Nays 0
5	**CS/SB 532** Education / Burgess (Similar H 135)	Workforce Education; Revising the workforce education programs that school district career centers are authorized to conduct, etc. ED 03/02/2021 Temporarily Postponed ED 03/09/2021 Fav/CS HP 03/17/2021 Favorable RC	Favorable Yeas 9 Nays 0
6	**SB 1934** Book (Compare H 1579)	Health Care Practitioner Discipline; Subjecting health care practitioners to disciplinary action for specified offenses; requiring the Department of Health to issue emergency orders to suspend certain physicians' licenses if they are arrested for committing or attempting, soliciting, or conspiring to commit acts that would constitute violations of specified criminal offenses involving a child; requiring the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze certain laws and rules and their application; requiring all state agencies, upon OPPAGA's request, to assist OPPAGA and provide requested information and data, etc. HP 03/17/2021 Favorable CJ RC	Favorable Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
7	**SB 716** Book (Identical H 361)	Consent for Pelvic Examinations; Revising the definition of the term "pelvic examination"; revising the circumstances under which a pelvic examination may be performed without written consent; authorizing written consent for a pelvic examination to be obtained as a part of a general consent form and to allow multiple health care practitioners or students to perform the examination, etc. HP 03/17/2021 Fav/CS JU RC	Fav/CS Yeas 9 Nays 0
8	**SB 874** Brodeur (Similar H 627)	Alzheimer's Disease Awareness; Requiring the Department of Health, in collaboration with the Department of Elderly Affairs and the Alzheimer's Association, to consolidate and disseminate certain information to certain health care practitioners for a specified purpose, etc. HP 03/17/2021 Favorable AHS AP	Favorable Yeas 10 Nays 0
9	**SB 852** Brodeur	Medicaid Modernization; Authorizing Medicaid to reimburse for certain remote evaluation and patient monitoring services, etc. HP 03/17/2021 Favorable AHS AP	Favorable Yeas 10 Nays 0
10	**SB 864** Brodeur (Identical H 6079, Compare H 247, H 831, S 660)	Telehealth; Revising the definition of the term "telehealth"; revising an exemption from telehealth registration requirements, etc. HP 03/17/2021 Fav/CS AHS AP	Fav/CS Yeas 10 Nays 0
11	**SB 1132** Bean (Identical H 485)	Personal Care Attendants; Authorizing nursing home facilities to employ personal care attendants if they complete a certain training program developed by the Agency for Health Care Administration, in consultation with the Board of Nursing; authorizing certain persons to be employed by a nursing home facility as personal care attendants for a specified period if a certain training requirement is met, etc. HP 03/17/2021 Fav/CS CF AP	Fav/CS Yeas 8 Nays 1

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
12	**SB 894** Diaz (Compare H 431, H 1299)	Physician Assistants; Deleting a limitation on the number of physician assistants a physician may supervise at one time; revising physician assistant continuing education requirements related to prescribing controlled substance medications; requiring the Board of Medicine and the Board of Osteopathic Medicine to register physician assistants as autonomous physician assistants if they meet specified criteria; authorizing physician assistants to directly bill and receive payment from public and private insurance companies, etc. HP 03/17/2021 Fav/CS AHS AP	Fav/CS Yeas 7 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 Committee on Health Policy

BILL:	CS/SB 614
INTRODUCER:	Criminal Justice Committee and Senator Rodriguez
SUBJECT:	Assault or Battery on Hospital Personnel
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Siples	Jones	CJ	**Fav/CS**
2.	Looke	Brown	HP	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 614 amends s. 784.07, F.S., which reclassifies the misdemeanor or felony degrees of assault and battery offenses if such offenses are knowingly committed against a law enforcement officer, firefighter, or other specified persons. The bill defines the term "hospital personnel" and adds such personnel to the list of specified persons protected under that section of statute. The reclassification of the offense has the effect of increasing the maximum sentence that may be imposed for the offense.

The Legislature's Office of Economic and Demographic Research preliminarily estimates that the bill will have a "positive insignificant" prison bed impact (an increase of 10 or fewer prison beds).

The bill provides an effective date of October 1, 2021.

II. Present Situation:

Hospitals

Hospitals are licensed by the Agency for Healthcare Administration (AHCA) under ch. 395, F.S., and the general licensure provisions of part II of ch. 408, F.S. A hospital is an establishment that:

- Offers services more intensive than those required for room, board, personal services, and general nursing care, and offers facilities and beds for use beyond 24 hours by individuals

who require diagnosis, treatment, or care for illness, injury, deformity, infirmity, abnormality, disease, or pregnancy; and
- Regularly makes available at least clinical laboratory services, diagnostic x-ray services, and treatment facilities for surgery or obstetrical care, or other definitive treatment of similar extent.[1]

Hospitals in Florida employ approximately 287,244 individuals and 59,199 medical staff.[2] Hospitals employ individuals in a number of occupations, including healthcare practitioners, healthcare support, office and administrative staff, janitorial and maintenance, food preparation and service, community and social services, business and financial operations, information technology, and management and executive positions.[3]

Violence against Healthcare Personnel

Workplace violence is defined as any act or threat of physical violence, harassment, intimidation, or other disruptive behavior that occurs at the work site.[4] The impact of workplace violence can range from psychological issues to physical injury, or even death.[5] There are four types of workplace violence:
- The perpetrator has no association with the workplace or employees;
- The perpetrator is a customer or patient of the workplace or employee;
- The perpetrator is a current or former employee of the workplace; and
- The perpetrator has a personal relationship with the employee but not with the workplace.[6]

The second type of violence, usually committed by patients, their families, or their friends, is the most common type of violence against healthcare employees.[7] Hospitals settings create extreme levels of stress for patients, their families and friends, as well as employees of the institution.[8] Fear, illness, and emotional circumstances contribute to agitation and aggression from patients.

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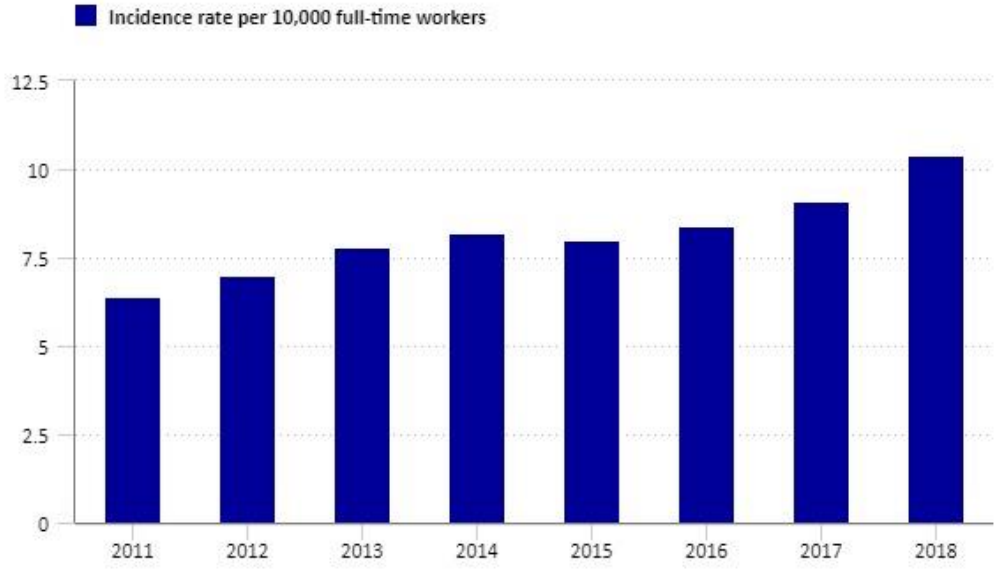
[1] Section 395.002(12), F.S. The term "hospital" does not include an institution conducted by adherents of a well-recognized church or religious denomination that depends exclusively on prayer or spiritual means to heal, care for, or treat any person.
[2] Florida Health Care Association, *2021 Directory of Hospitals*, p. 11, *available at* http://www.fha.org/reports-and-resources/hospital-directory.aspx (select "view the digital edition online") (last visited March 9, 2021).
[3] Becker's Hospital Review, *What Occupations Make up the Hospital Workforce?* (April 2, 2014), *available at* https://www.beckershospitalreview.com/hr/what-occupations-make-up-the-hospital-workforce.html (last visited March 9, 2021).
[4] U.S. Department of Labor, Occupational Safety and Health Administration, *Workplace Violence*, *available at* https://www.osha.gov/workplace-violence#:~:text=Workplace%20violence%20is%20any%20act,%2C%20clients%2C%20customers%20and%20visitors (last visited March 9, 2021).
[5] Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, *Occupational Violence*, (last rev. Sept. 22, 2020), *available at* https://www.cdc.gov/niosh/topics/violence/default.html (last visited March 9, 2021).
[6] James P. Phillips, M.D., *Workplace Violence against Health Care Workers in the United States*, NEW ENGLAND J OF MEDICINE, 374(17) (April 28, 2016), pp. 1662, *available at* https://www.researchgate.net/publication/301686568_Workplace_Violence_against_Health_Care_Workers_in_the_United_States (last visited March 9, 2021).
[7] *Supra n. 6* at p. 1663.
[8] Wallace Stephens, *Violence against Healthcare Workers: A Rising Epidemic*, AM J OF MANAGED CARE (May 12, 2019), *available at* https://www.ajmc.com/view/violence-against-healthcare-workers-a-rising-epidemic (last visited March 10, 2021).

Additionally, substance abuse, mental illness, or drug-seeking habits may contribute to such workplace violence.[9]

The healthcare and social service industries experience the highest rates of injuries caused by workplace violence and have a 20 percent higher chance of being a victim of workplace violence than other workers.[10] Healthcare workers accounted for 73 percent of all nonfatal workplace injuries and illnesses due to violence in 2018.[11] A 2017 report commissioned by the American Hospital Association estimated that violence against hospital employees resulted in $429 million in medical care, staffing, indemnity, and other costs.[12] Incidents of violence against healthcare workers are increasing.[13]

Chart 1. Incidence rate of nonfatal workplace violence to healthcare workers, 2011-18



Workplace violence committed against healthcare workers is typically underreported. Healthcare workers do not formally report all incidents for a variety of reasons, such as no serious injury

[9] Ashleigh Watson, M.D., Mohammad Jafari, HBSc , and Ali Seifi, M.D., *The Persistent Pandemic of Violence against Health Care Workers*, AM J OF MANAGED CARE 26(12) (December 11, 2020), pp. e377-e379, *available at* https://www.ajmc.com/view/the-persistent-pandemic-of-violence-against-health-care-workers (last visited March 10, 2021).
[10] U.S Bureau of Labor Statistics, *Fact Sheet: Workplace Violence in Healthcare, 2018*, (April 2020), *available at* https://www.bls.gov/iif/oshwc/cfoi/workplace-violence-healthcare-2018.htm#:~:text=Workplace%20violence%20in%20healthcare%20is,issue%20and%20a%20growing%20concern.&text=The%20health%20care%20and%20social,violence%20injury%20than%20workers%20overall and the Joint Commission, *Physical and Verbal Violence against Health Care Workers*, SENTINEL EVENT ALERT, 59 (April 17, 2018), *available at* https://www.jointcommission.org/-/media/documents/office-quality-and-patient-safety/sea_59_workplace_violence_4_13_18_final.pdf?db=web&hash=9E659237DBAF28F07982817322B99FFB (last visited March 10, 2021).
[11] *Id.*
[12] Jill Van Den Bos, ASA, MAAA et al., *Cost of Community Violence to Hospitals and Health Systems*, (July 26, 2017), p. 2, *available at* https://www.aha.org/system/files/2018-01/community-violence-report.pdf (last visited March 10, 2021).
[13] U.S. Bureau of Labor Statistics, s*upra* note 10.

was suffered, inconvenience, and the perception that violence comes with the job.[14] In fact, a study conducted in 2000, found that 82 percent of U.S. nurses had been assaulted at least once during their careers and 73 percent believed that assault was a part of their jobs.[15] The American College of Emergency Physicians reported the findings of a 2018 survey which found that 47 percent of emergency room physicians had been physically assaulted at work but only 3 percent pressed charges.[16] Additionally, employers may not always accurately report incidents of workplace violence.

The recent pandemic may have exacerbated violence against healthcare workers. Between February 1, 2020, and July 31, 2020, 611 incidents of violence, harassment, or stigmatization related to COVID-19 took place against healthcare workers, patients, and medical infrastructure, according to the International Committee of the Red Cross. Of these, 67 percent were directed at healthcare workers and more than 20 percent involved physical assault and 15 percent were verbal assaults or threats.[17]

Assault and Battery

Assault and Aggravated Assault

Section 784.011, F.S., provides that it is a second degree misdemeanor[18] to commit an assault, which is an intentional, unlawful threat by word or act to do violence to the person of another, coupled with an apparent ability to do so, and doing some act which creates a well-founded fear in such other person that such violence is imminent.

Section 784.021, F.S., provides that an aggravated assault is an assault:
- With a deadly weapon[19] without intent to kill; or
- With an intent to commit a felony.

Aggravated assault is a third degree felony[20] and is ranked in Level 6 of the Criminal Punishment Code offense severity level ranking chart.[21]

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[14] U.S. Government Accountability Office, *Workplace Health and Safety: Additional Efforts Needed to Help Protect Health Care Workers from Workplace Violence*, (March 2016), pp. 16-18, *available at* https://www.gao.gov/assets/680/675858.pdf (last visited March 10, 2021).
[15] Watson, s*upra* note 9.
[16] American College of Emergency Physicians, *Violence in the Emergency Department: Resources for a Safer Workplace***,** *available at* https://www.acep.org/administration/violence-in-the-emergency-department-resources-for-a-safer-workplace/ (last visited March 10, 2021).
[17] Sharmila Devi, *COVID-19 Exacerbates Violence against Healthcare Workers*, THE LANCET, 396(10252), p. 658 (Sept. 5, 2020), *available at* https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(20)31858-4/fulltext (last visited March 10, 2021).
[18] A second degree misdemeanor is punishable by up to 60 days in county jail and a fine not exceeding $500. Sections 775.082(4)(b) and 775.083(1)(e), F.S.
[19] When undefined in statute, Florida courts have defined a "deadly weapon" as an instrument that will likely cause death or great bodily harm when used in the ordinary and usual manner contemplated by its design or an object that is used or threatened to be used in a way likely to produce death or great bodily harm. *See Brown v. State*, 86 So.3d 569, 571 (Fla. 5th DCA 2012).
[20] A third degree felony is punishable by up to five years in state prison and a fine not exceeding $5,000. Sections 775.082(3)(e) and 775.083(1)(c), F.S.
[21] Section 921.0022(3)(g), F.S.

Battery and Aggravated Battery

Section 784.03, F.S., provides that the offense of battery occurs when a person:
- Actually and intentionally touches or strikes another person against the will of the other; or
- Intentionally causes bodily harm to another person.

Generally, a battery under this statute is punishable as a first degree misdemeanor[22] but a person commits a third degree felony if he or she has one prior conviction for battery, aggravated battery, or felony battery and commits any second or subsequent battery.[23]

Section 784.045, F.S., provides that a person commits aggravated battery who, in committing battery:
- Intentionally or knowingly causes great bodily harm, permanent disability, or permanent disfigurement;
- Uses a deadly weapon; or
- Knows or should have known that the victim of the battery was pregnant at the time of the offense.

Aggravated battery is a second degree felony and is ranked in Level 7 of the Criminal Punishment Code offense severity level ranking chart.[24]

Assault or Battery on a Law Enforcement Officers or Other Specified Professional

Section 784.07(2), F.S., reclassifies the misdemeanor or felony degree of assault, aggravated assault, battery, and aggravated battery when a person is charged with knowingly committing any of these offenses upon an officer or employee described as follows while that officer or employee is engaged in the lawful performance of his or her duties:
- A law enforcement officer;
- A firefighter;
- An emergency medical care provider;
- A railroad special officer;
- A traffic accident investigation officer;
- A nonsworn law enforcement agency employee who is certified as an agency inspector, a blood alcohol analyst, or a breath test operator while such employee is in uniform and engaged in processing, testing, evaluating, analyzing, or transporting a person who is detained or under arrest for DUI;
- A law enforcement explorer;
- A traffic infraction enforcement officer;
- A parking enforcement specialist;
- A person licensed as a security officer and wearing a uniform bearing at least one patch or emblem that is visible at all times and clearly identifies the person's employing agency and that the person is a licensed security officer;

[22] A first degree misdemeanor is punishable by up to a year in county jail and a fine not exceeding $1,000. Sections 775.082(4)(a) and 775.083(1)(d), F.S.
[23] Section 784.03(2), F.S.
[24] Section 921.0022(3)(g), F.S. A second degree felony is punishable by up to 15 years in state prison and a fine of up to $10,000. Sections 775.082(3)(d) and 775.083(1)(b), F.S.

- A security officer employed by the board of trustees of a community college; or
- A public transit employee or agent.

The reclassification of the degree of the offense is as follows:
- In the case of assault, from a second degree misdemeanor to a first degree misdemeanor;
- In the case of battery, from a first degree misdemeanor to a third degree felony;
- In the case of aggravated assault, from a third degree felony to a second degree felony, and any person convicted of aggravated assault upon a law enforcement officer is subject to a mandatory three-year minimum term of imprisonment; and
- In the case of aggravated battery, from a second degree felony to a first degree felony,[25] and any person convicted of aggravated battery of a law enforcement officer is subject to a mandatory five-year minimum term of imprisonment.[26]

Further, if the person, during the commission of a battery subject to reclassification as a third degree felony, possessed:
- A firearm or destructive device, the person is subject to a mandatory minimum term of imprisonment of three years; or
- A semiautomatic firearm and its high-capacity detachable box magazine or a machine gun, the person is subject to a mandatory minimum term of imprisonment of eight years.[27]

Reclassifying an offense has the effect of increasing the maximum sentence that can be imposed for an offense. The maximum sentence that can be imposed for a criminal offense is generally based on the degree of the misdemeanor or felony:
- Sixty days in a county jail for a second degree misdemeanor;
- One year in a county jail for a first degree misdemeanor;
- Five years in state prison for a third degree felony;
- Fifteen years in state prison for a second degree felony; and
- Generally, 30 years in state prison for a first degree felony.[28]

III. Effect of Proposed Changes:

The bill amends s. 784.07, F.S., to reclassify the degree of the offense when an individual knowingly commits an assault or battery against hospital personnel while that hospital personnel is engaged in the lawful performance of his or her duties. The bill defines "hospital personnel" as a health care practitioner as defined in s. 456.001, F.S.,[29] an employee, an agent, or a volunteer

[25] A first degree felony is generally punishable by up to 30 years in state prison and a fine not exceeding $10,000. Sections 775.082(3)(b) and 775.083(1)(b), F.S.
[26] Section 784.07(2), F.S.
[27] Section 784.07(3)(a) and (b), F.S. Additionally, adjudication of guilt or imposition of sentence shall not be suspended, deferred, or withheld, and the defendant is not eligible for statutory gain-time or any form of discretionary early release, other than pardon or executive clemency, or conditional medical release, prior to serving the minimum sentence. Section 784.07(3), F.S.
[28] Section 775.082, F.S. (maximum penalties). Fines may also be imposed, and those fines escalate based on the degree of the offense. Section 775.082, F.S., provides the following maximum fines: $500 for a second degree misdemeanor; $1,000 for a first degree misdemeanor; $5,000 for a third degree felony; and $10,000 for a second degree felony and a first degree felony.
[29] Section 456.001, F.S., defines "health care practitioner" as any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medical practice); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathy); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy);

who is employed, under contract, or otherwise authorized by a hospital, as defined in s. 395.002, F.S., to perform duties directly associated with the care and treatment rendered by any department of a hospital or with the security thereof.

The offenses are reclassified as follows:

- In the case of assault, from a second degree misdemeanor to a first degree misdemeanor;
- In the case of battery, from a first degree misdemeanor to a third degree felony;
- In the case of aggravated assault, from a third degree felony to a second degree felony; and
- In the case of aggravated battery, from a second degree felony to a first degree felony.

The reclassification of the offense has the effect of increasing the maximum sentence that may be imposed for the offense, as noted above.

The bill provides an effective date of October 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

This bill appears to be exempt from the requirements of Art. VII, s. 18(d) of the Florida Constitution, relating to unfunded mandates.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None identified.

ch. 466, F.S., (dentistry); ch. 467, F.S., (midwifery); parts I, II, III, V, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology and audiology, nursing home administration, occupational therapy, respiratory therapy, dietetics and nutrition practice, athletic trainers, or orthotics, prosthetics, and pedorthics, respectively); ch. 478, F.S., (electrolysis); ch. 480, F.S., (massage therapy); ch. 483, F.S., (clinical laboratory personnel or medical physicists); ch. 484, F.S., (optical devices and hearing aids); ch. 486, F.S., (physical therapy practice); ch. 490, F.S., (psychological services); or ch. 491, F.S., (clinical, counseling, and psychotherapy services).

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The Criminal Justice Impact Conference has not reviewed the bill; however, the Office of Economic and Demographic Research (EDR) did provided a preliminary estimate of the bill's impact. The EDR estimates that the bill will have a positive insignificant prison bed impact (i.e. increase of 10 or fewer prison beds).[30]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 784.07 of the Florida Statutes.

IX. Additional Information:

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

CS by Criminal Justice on February 16, 2021:
The committee substitute replaces the term "physician" with the broader term "health care practitioner as defined in s. 456.001" in the definition of health care personnel.

B. Amendments:

None.

[30] The EDR estimate is on file with the Senate Committee on Criminal Justice.

By the Committee on Criminal Justice; and Senator Rodriguez

591-02148-21 2021614c1

A bill to be entitled

An act relating to assault or battery on hospital personnel; amending s. 784.07, F.S.; defining the term "hospital personnel"; providing enhanced criminal penalties for persons who knowingly commit assault or battery upon hospital personnel; providing an effective date.

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

Section 1. Section 784.07, Florida Statutes, is amended to read:

784.07 Assault or battery of law enforcement officers, firefighters, emergency medical care providers, hospital personnel, public transit employees or agents, or other specified officers; reclassification of offenses; minimum sentences.—

(1) As used in this section, the term:

(a) "Emergency medical care provider" means an ambulance driver, emergency medical technician, paramedic, registered nurse, physician as defined in s. 401.23, medical director as defined in s. 401.23, or any person authorized by an emergency medical service licensed under chapter 401 who is engaged in the performance of his or her duties. The term "emergency medical care provider" also includes physicians, employees, agents, or volunteers of hospitals as defined in chapter 395, who are employed, under contract, or otherwise authorized by a hospital to perform duties directly associated with the care and treatment rendered by the hospital's emergency department or the

591-02148-21 2021614c1

security thereof.

(b) "Firefighter" means any person employed by any public employer of this state whose duty it is to extinguish fires; to protect life or property; or to enforce municipal, county, and state fire prevention codes, as well as any law pertaining to the prevention and control of fires.

(c) "Hospital personnel" means a health care practitioner as defined in s. 456.001, an employee, an agent, or a volunteer who is employed, under contract, or otherwise authorized by a hospital, as defined in s. 395.002, to perform duties directly associated with the care and treatment rendered by any department of a hospital or with the security thereof.

(d) ~~(c)~~ "Law enforcement explorer" means any person who is a current member of a law enforcement agency's explorer program and who is performing functions other than those required to be performed by sworn law enforcement officers on behalf of a law enforcement agency while under the direct physical supervision of a sworn officer of that agency and wearing a uniform that bears at least one patch that clearly identifies the law enforcement agency that he or she represents.

(e) ~~(d)~~ "Law enforcement officer" includes a law enforcement officer, a correctional officer, a correctional probation officer, a part-time law enforcement officer, a part-time correctional officer, an auxiliary law enforcement officer, and an auxiliary correctional officer, as those terms are respectively defined in s. 943.10, and any county probation officer; an employee or agent of the Department of Corrections who supervises or provides services to inmates; an officer of the Florida Commission on Offender Review; a federal law

enforcement officer as defined in s. 901.1505; and law enforcement personnel of the Fish and Wildlife Conservation Commission, the Department of Environmental Protection, or the Department of Law Enforcement.

(f)~~(e)~~ "Public transit employees or agents" means bus operators, train operators, revenue collectors, security personnel, equipment maintenance personnel, or field supervisors, who are employees or agents of a transit agency as described in s. 812.015(1)(l).

(g)~~(f)~~ "Railroad special officer" means a person employed by a Class I, Class II, or Class III railroad and appointed or pending appointment by the Governor pursuant to s. 354.01.

(2) Whenever any person is charged with knowingly committing an assault or battery upon a law enforcement officer, a firefighter, an emergency medical care provider, hospital personnel, a railroad special officer, a traffic accident investigation officer as described in s. 316.640, a nonsworn law enforcement agency employee who is certified as an agency inspector, a blood alcohol analyst, or a breath test operator while such employee is in uniform and engaged in processing, testing, evaluating, analyzing, or transporting a person who is detained or under arrest for DUI, a law enforcement explorer, a traffic infraction enforcement officer as described in s. 316.640, a parking enforcement specialist as defined in s. 316.640, a person licensed as a security officer as defined in s. 493.6101 and wearing a uniform that bears at least one patch or emblem that is visible at all times that clearly identifies the employing agency and that clearly identifies the person as a licensed security officer, or a security officer employed by the

board of trustees of a community college, while the officer, firefighter, emergency medical care provider, hospital personnel, railroad special officer, traffic accident investigation officer, traffic infraction enforcement officer, inspector, analyst, operator, law enforcement explorer, parking enforcement specialist, public transit employee or agent, or security officer is engaged in the lawful performance of his or her duties, the offense for which the person is charged shall be reclassified as follows:

(a) In the case of assault, from a misdemeanor of the second degree to a misdemeanor of the first degree.

(b) In the case of battery, from a misdemeanor of the first degree to a felony of the third degree.

(c) In the case of aggravated assault, from a felony of the third degree to a felony of the second degree. Notwithstanding any other provision of law, any person convicted of aggravated assault upon a law enforcement officer shall be sentenced to a minimum term of imprisonment of 3 years.

(d) In the case of aggravated battery, from a felony of the second degree to a felony of the first degree. Notwithstanding any other provision of law, any person convicted of aggravated battery of a law enforcement officer shall be sentenced to a minimum term of imprisonment of 5 years.

(3) Any person who is convicted of a battery under paragraph (2)(b) and, during the commission of the offense, such person possessed:

(a) A "firearm" or "destructive device" as those terms are defined in s. 790.001, shall be sentenced to a minimum term of imprisonment of 3 years.

(b) A semiautomatic firearm and its high-capacity detachable box magazine, as defined in s. 775.087(3), or a machine gun as defined in s. 790.001, shall be sentenced to a minimum term of imprisonment of 8 years.

Notwithstanding s. 948.01, adjudication of guilt or imposition of sentence shall not be suspended, deferred, or withheld, and the defendant is not eligible for statutory gain-time under s. 944.275 or any form of discretionary early release, other than pardon or executive clemency, or conditional medical release under s. 947.149, prior to serving the minimum sentence.

Section 2. This act shall take effect October 1, 2021.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr., Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 25, 2021

I respectfully request that **Senate Bill #614**, relating to Assault or Battery on Hospital Personnel, be placed on the:

☒ committee agenda at your earliest possible convenience.

☐ next committee agenda.

Senator Ana Maria Rodriguez
Florida Senate, District 39

File signed original with committee office

S-020 (03/2004)

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

614
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Assault or Battery on Hospital Personnel

Name Jason Rodriguez

Job Title State Government Relations Manager

Address 2985 Drew Street
Street

Phone (727)519-1885

Clearwater FL 33759
City *State* *Zip*

Email jason.rodriguez@baycare.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing BayCare

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 (10/14/14)

Duplicate

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

6 14
Bill Number (if applicable)

Topic _____
Amendment Barcode (if applicable)

Name David Mica, Jr.

Job Title Executive Vice President of Public Affairs

Address _____ Phone _____
Street

_____ Email davidm@fha.org
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital 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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

March 17, 21
Meeting Date

614
Bill Number (if applicable)

Topic Assault & Battery on Hospital Personnel

Amendment Barcode (if applicable)

Name Toni Large

Job Title

Address 1100 Brookwood DR
Street
Tallahassee, FL 32308
City *State* *Zip*

Phone (850) 556-1461

Email toni@largestrategies.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Respiratory Care

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 (10/14/14)

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 818
INTRODUCER:	Senator Burgess
SUBJECT:	Mental Health Professionals
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto Van Winkle	Brown	HP	**Favorable**
2.			CJ	
3.			RC	

I. Summary:

SB 818 deletes the current-law requirement that a licensed mental health professional must remain on the premises when clinical services are provided by a registered mental health counselor intern in a private practice setting. The bill also authorizes the appointment of physicians licensed under chs. 458 or 459, F.S., and mental health professionals licensed under ch. 491, F.S., as experts in criminal cases.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

The Department of Health

The Legislature created the Department of Health (DOH) to protect and promote the health of all residents and visitors in the state.[1] The DOH is charged with the regulation of health care practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[2] and professions within the DOH.[3]

[1] Section 20.43, F.S.

[2] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the MQA.

[3] Section 20.43, F.S.

Mental Health Counselors

Section 491.005, F.S., sets out the educational and examination requirements for a clinical social worker, marriage and family therapist, and mental health counselor to obtain a license by examination in Florida. An individual applying for licensure by examination who has satisfied the clinical experience requirements of s. 491.005, F.S., or an individual applying for licensure by endorsement pursuant to s. 491.006, F.S., intending to provide clinical social work, marriage and family therapy, or mental health counseling services in Florida, while satisfying coursework or examination requirements for licensure, must obtain a provisional license in the profession for which he or she is seeking licensure prior to beginning practice.[4]

An individual who has not satisfied the postgraduate or post-master's level of experience requirements under s. 491.005, F.S., must register as an intern in the profession for which he or she is seeking licensure before commencing the post-master's experience requirement. An individual who intends to satisfy part of the required graduate-level practicum, internship, or field experience outside the academic arena, must register as an intern in the profession for which he or she is seeking licensure before commencing the practicum, internship, or field experience.[5]

Section 491.005(4), F.S., relates to licensure by examination for mental health counselors. The DOH must issue a license to an applicant as a mental health counselor if the Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling (board) certifies that the applicant:

- Has submitted an application and appropriate fees;
- Has a minimum of a master's degree from:
  - A mental health counseling program accredited by the Council for the Accreditation of Counseling and Related Educational Programs (CACREP)[6] which includes clinical and didactic instruction, including courses in human sexuality and substance abuse; or
  - A non-CACREP accredited program related to the practice of mental health counseling, but with coursework and practicum, internship, or fieldwork that meet all of the following:
    - Thirty-three semester hours, or 44 quarter hours, which must include a minimum of three semester hours, or four quarter hours of graduate-level coursework in 11 content areas;[7]
    - Includes a minimum of three semester hours, or four quarter hours, of coursework in the diagnostic processes and emphasized the common core curricular experience; and

[4] Section 491.0046, F.S.
[5] Section 491.0045, F.S.
[6] Council for Accreditation of Counseling & Related Educational Programs, *2016 CACREP Standards, available at* http://www.cacrep.org/wp-content/uploads/2018/05/2016-Standards-with-Glossary-5.3.2018.pdf (last visited Mar. 8, 2021).
[7] See s. 491.005(4)(b)1.a., F.S. The graduate course work must include the following 11 content areas: counseling theories and practice; human growth and development; diagnosis and treatment of psychopathology; human sexuality; group theories and practice; individual evaluation and assessment; career and lifestyle assessment; research and program evaluation; social and cultural foundations; substance abuse; and legal, ethical, and professional standards issues in the practice of mental health counseling. Courses in research, thesis or dissertation work, practicums, internships, or fieldwork may not be applied toward this requirement.

- Includes at least 700 hours of university-sponsored supervised clinical practicum, internship, or field experience that includes 280 hours of direct client services, as required in the accrediting standards of the CACREP for mental health counseling programs; or the equivalent, as determined by the board;
- Has passed National Clinical Mental Health Counseling Examination (NCMHCE), clinical simulation examination by the National Board for Certified Counselors (NBCC);[8] and
- Has had at least two years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor who is a board qualified supervisor.

A licensed mental health professional is required to be on the premises when clinical services are provided by a registered intern in a private practice setting. Neither the statute, nor board rule, define a "private practice setting."

Section 491.005, F. S., contains the same provision for registered clinical social worker interns and registered marriage and family therapy interns.

In response to the COVID-19 pandemic,[9] the board revised Rule 64B4-2.002 of the Florida Administrative Code, defining supervision, to authorize registered interns to provide face-to-face psychotherapy by electronic methods (telehealth) if the intern establishes a written telehealth protocol and safety plan with their qualified supervisor. The protocol must include a provision that the supervisor remain readily available during electronic therapy sessions and that the registered intern and their qualified supervisor have determined that providing face-to-face psychotherapy by electronic methods is not detrimental to the patient, is necessary to protect the health, safety, or welfare of the patient, and does not violate any existing statutes or regulations.

Appointment of Experts

In criminal proceedings involving mentally ill and intellectually disabled persons, s. 916.115, F.S., authorizes a court to appoint no more than three experts to determine the mental condition of a defendant in a criminal case. Under current law, the appointed experts must be a psychiatrist, licensed psychologist, or physician.

III. Effect of Proposed Changes:

SB 818:

- Removes the requirement that a licensed mental health professional remain on the premises when clinical services are provided by a registered mental health counselor intern in a private practice setting; and
- Authorizes the appointment of mental health professionals licensed under ch. 491, F.S., as experts in criminal cases, in addition to psychiatrists, licensed psychologists, or physicians currently authorized to serve as experts.

The bill provides an effective date of July 1, 2021.

[8] Fla Admin. Code R. 64B4-3.003(2)(b), (2021).
[9] Florida Department of Health, State Surgeon General, *Emergency Order, DOH No.20-002,* filed Mar. 16, 2020, *available at* https://www.flhealthsource.gov/pdf/emergencyorder-20-002.pdf (last visited Mar. 8, 2021).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 491.005 and 916.115.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Burgess

20-00725-21 2021818__

A bill to be entitled

An act relating to mental health professionals; amending s. 491.005, F.S.; for purposes of clinical experience requirements for licensure as a mental health counselor, deleting a requirement that a licensed mental health professional be on the premises when a registered intern is providing clinical services in a private practice setting; amending s. 916.115, F.S.; authorizing courts to appoint mental health professionals licensed under ch. 491, F.S., as experts in criminal cases; providing an effective date.

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

Section 1. Paragraph (c) of subsection (4) of section 491.005, Florida Statutes, is amended to read:

491.005 Licensure by examination.—

(4) MENTAL HEALTH COUNSELING.—Upon verification of documentation and payment of a fee not to exceed $200, as set by board rule, plus the actual per applicant cost of purchase of the examination from the National Board for Certified Counselors or its successor organization, the department shall issue a license as a mental health counselor to an applicant who the board certifies:

(c) Has had at least 2 years of clinical experience in mental health counseling, which must be at the post-master's level under the supervision of a licensed mental health counselor or the equivalent who is a qualified supervisor as

20-00725-21 2021818__

determined by the board. An individual who intends to practice in Florida to satisfy the clinical experience requirements must register pursuant to s. 491.0045 before commencing practice. If a graduate has a master's degree with a major related to the practice of mental health counseling which did not include all the coursework required under sub-subparagraphs (b)1.a. and b., credit for the post-master's level clinical experience may not commence until the applicant has completed a minimum of seven of the courses required under sub-subparagraphs (b)1.a. and b., as determined by the board, one of which must be a course in psychopathology or abnormal psychology. A doctoral internship may be applied toward the clinical experience requirement. ~~A licensed mental health professional must be on the premises when clinical services are provided by a registered intern in a private practice setting.~~

Section 2. Paragraph (a) of subsection (1) of section 916.115, Florida Statutes, is amended to read:

916.115 Appointment of experts.—

(1) The court shall appoint no more than three experts to determine the mental condition of a defendant in a criminal case, including competency to proceed, insanity, involuntary placement, and treatment. The experts may evaluate the defendant in jail or in another appropriate local facility or in a facility of the Department of Corrections.

(a) To the extent possible, the appointed experts shall have completed forensic evaluator training approved by the department, and each shall be a psychiatrist or a physician licensed under chapter 458 or chapter 459, a ~~licensed~~ psychologist licensed under chapter 490, or a mental health

professional licensed under chapter 491 ~~physician~~.

Section 3. This act shall take effect July 1, 2021.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 5, 2021

I respectfully request that **Senate Bill #818**, relating to Mental Health Professionals, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Danny Burgess
Florida Senate, District 20

File signed original with committee office

S-020 (03/2004)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/13/2021
Meeting Date

818
Bill Number (if applicable)

Topic Mental Health Professionals

Amendment Barcode (if applicable)

Name Corinne Mixon

Job Title Lobbyist

Address 511 N. Adams St.
Street

Phone 8507665795

Tallahassee FL 32301
City *State* *Zip*

Email corinnemixon@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Mental Health Counselors 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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3-17-2021`
Meeting Date

818
Bill Number (if applicable)

Topic Mental Health Professionals

Amendment Barcode (if applicable)

Name Shane Messer

Job Title Government Affairs Director

Address 316 East Park Ave
Street

Phone 850-224-6048

TAllahassee FL 32301
City *State* *Zip*

Email shane@floridabha.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Council for Behavioral Healthcare

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 (10/14/14)

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 1142
INTRODUCER:	Health Policy Committee and Senator Rodrigues
SUBJECT:	Prohibited Acts by Health Care Practitioners
DATE:	March 17, 2021 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Brown	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1142 amends s. 456.072(1)(a), F.S., which provides grounds for discipline applicable to all licensed health care practitioners, to:

- Add the making of misleading, deceptive, or fraudulent representations related to a practitioner's specialty designation as grounds for discipline.
- Provide that the term "anesthesiologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S., or licensed as a dentist under ch. 466, F.S.
- Provide that the term "dermatologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S.

The bill requires that when the Department of Health (DOH) finds that a person has violated s. 456.072(1)(a), F.S., as amended by the bill, the department must issue an emergency cease and desist order and take disciplinary action if the person fails to comply with the order.

The bill also amends s. 456.072(1)(t), F.S., by providing for disciplinary action based on a licensed health care practitioner's failure to identify his or her specialty designation and requiring the DOH, not a practitioner regulatory board, to enforce s. 456.072(1)(t), F.S.

The bill takes effect upon becoming a law.

II. Present Situation:

The Department of Health

The Legislature created the DOH to protect and promote the health of all residents and visitors in the state.[1] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[2] and professions within the DOH.[3] Health care practitioners licensed by the DOH include the following:

- Acupuncturist;[4]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[5]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[6]
- Chiropractic physicians and physician assistants;[7]
- Podiatric physicians;[8]
- Naturopathic physicians;[9]
- Optometrists;[10]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses, and certified nursing assistants;[11]
- Pharmacists, pharmacy interns, and pharmacy technicians;[12]
- Dentists, dental hygienists, and dental laboratories;[13]
- Midwives;[14]
- Speech and language pathologists;[15]
- Audiologists;[16]
- Occupational therapists and occupational therapy assistants;[17]
- Respiratory therapists;[18]
- Dieticians and nutritionists;[19]
- Athletic trainers;[20]

[1] Section 20.43, F.S.
[2] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the department or, in some cases, within the MQA.
[3] Section 20.43, F.S.
[4] Chapter 457, F.S.
[5] Chapter 458, F.S.
[6] Chapter 459, F.S.
[7] Chapter 460, F.S.
[8] Chapter 461, F.S.
[9] Chapter 462, F.S.
[10] Chapter 463, F.S.
[11] Chapter 464, F.S.
[12] Chapter 465, F.S.
[13] Chapter 466, F.S.
[14] Chapter 467, F.S.
[15] Part I, Chapter 468, F.S.
[16] *Id.*
[17] Part III, Chapter 468, F.S.
[18] Part V, Chapter 468, F.S.
[19] Part X, Chapter 468, F.S.
[20] Part XIII, Chapter 468, F.S.

- Orthotists, prosthetists, and pedorthists;[21]
- Electrologists;[22]
- Massage therapists;[23]
- Clinical laboratory personnel;[24]
- Medical physicists;[25]
- Opticians;[26]
- Hearing aid specialists;[27]
- Physical therapists;[28]
- Psychologists and school psychologists;[29] and
- Clinical social workers, mental health counselors, and marriage and family therapists.[30]

For each profession under the jurisdiction of the DOH, the DOH appoints the board executive director, subject to board approval.[31] The duties of the boards do not include the enlargement, modification, or contravention of the scope of practice of a profession regulated by each board, unless expressly and specifically granted by statute, but the boards may take disciplinary action against a licensee or issue a declaratory statement.[32] Each board member is appointed by the Governor and accountable to the Governor for the proper performance of his or her duties as a member of a board.[33]

Board of Medicine (BOM)

The BOM was established to ensure that every medical doctor practicing in this state meets minimum requirements for safe practice. The practice of medicine is a privilege granted by the state. The BOM, through efficient and dedicated organization, is directed to license, monitor, discipline, educate, and, when appropriate, rehabilitate physicians and other practitioners to assure their fitness and competence.[34]

Board of Osteopathic Medicine (BOOM)

The BOOM was legislatively established to ensure that every osteopathic physician practicing in this state meets minimum requirements for safe practice. The BOOM is responsible for licensing, monitoring, disciplining, and educating osteopathic physicians to assure competency and safety to practice in Florida.[35]

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[21] Part XIV, Chapter 468, F.S.
[22] Chapter 478, F.S.
[23] Chapter 480, F.S.
[24] Part II, Chapter 483, F.S.
[25] Part III, Chapter 483, F.S.
[26] Part I, Chapter 484, F.S.
[27] Part II, Chapter 484, F.S.
[28] Chapter 486, F.S.
[29] Chapter 490, F.S.
[30] Chapter 491, F.S.
[31] Section 456.004, F.S.
[32] Section 456.003(6), F.S.
[33] Section 456.008, F.S.
[34] The Department of Health, *Board of Medicine*, *available at* https://flboardofmedicine.gov/ (last visited Mar. 9, 2021).
[35] The Department of Health, *Board of Osteopathic Medicine*, *available at* https://floridasosteopathicmedicine.gov/ (last visited Mar. 9, 2021).

Board of Dentistry (BOD)

The BOD was established to ensure that every dentist and dental hygienist practicing in this state meets minimum requirements for safe practice. The practice of the profession is a privilege granted by the state. The BOD is responsible for licensure, monitoring and ensuring the safe practice of dentists and dental hygienists.[36]

Board of Nursing (BON)

The BON licenses, monitors, disciplines, educates, and, when appropriate, rehabilitates its licensees to assure their fitness and competence in providing health care services for the people of Florida. The sole legislative purpose in enacting the Nurse Practice Act is to ensure that every nurse practicing in Florida meets minimum requirements for safe practice. It is the intent of the Legislature that nurses who fall below minimum competency or who otherwise present a danger to the public shall be prohibited from practicing in Florida.[37]

Section 464.015, F.S., clearly specifies the permissible nursing titles a person may use that holds a valid nursing license in this state, or a multistate license, as follows:

- Licensed Practical Nurse – L.P.N.;
- Registered Nurse – R.N.;
- Clinical Nurse Specialist – C.N.S.;
- Certified Registered Nurse Anesthetist – C.R.N.A. or nurse anesthetist;
- Certified Nurse Midwife – C.N.M. or nurse midwife; and
- Advanced Practice Registered Nurse – A.P.R.N.

A person may not practice or advertise as a registered nurse, licensed practical nurse, clinical nurse specialist, certified registered nurse anesthetist, certified nurse midwife, certified nurse practitioner, or advanced practice registered nurse, or use the abbreviation R.N., L.P.N., C.N.S., C.R.N.A., C.N.M., C.N.P., or A.P.R.N., or take any other action that would lead the public to believe that person was authorized by law to practice professional nursing, if the person is not licensed as such, and to do so is a first degree misdemeanor.[38]

Disciplinary Proceedings under Chapter 456, F.S.

Section 456.072, F.S., sets out grounds for discipline and due process that are applicable to all licensed health care practitioners, in addition to the grounds set out in each practice act, and includes:

- Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession;
- Intentionally violating any board or DOH rule;
- Being convicted or found guilty of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, and failing to report the violation within 30 days, including a crime:
    - Relating to practice, or ability to practice, a profession;

[36] The Department of Health, *Board of Dentistry*, *available at* https://floridasdentistry.gov/ (last visited Mar. 9, 2021).
[37] The Department of Health, *Board of Nursing*, *available at* https://floridasnursing.gov/ (last visited Mar. 9, 2021).
[38] Section 464.015, F.S.

  - Relating to Medicaid fraud; and
  - Relating to health care fraud.
- Using a Class III or Class IV laser device without having complied with registration rules for the devices;
- Failing to comply with the continuing education (CE) requirements for:
  - HIV/AIDS;
  - Domestic violence.
- Having a license revoked, suspended, or acted against, including denial, or by relinquishment, stipulation, consent order, or settlement, in any jurisdiction;
- Having been found civilly liable for knowingly filing a false report or complaint with the DOH against another licensee;
- Attempting to obtain, or renewing a license by bribery, fraudulent misrepresentation, or through DOH error;
- Failing to report to the DOH any person who the licensee knows is in violation of ch. 456, F.S., or the chapter and rules regulating the practitioner;
- Aiding, assisting, procuring, employing, or advising a person to practice a profession without a license;
- Failing to perform a statutory or legal obligation;
- Knowingly making or filing a false report;
- Making deceptive, untrue, or fraudulent representations in the licensee's practice;
- Exercising undue influence on the patient for financial gain;
- Knowingly practicing beyond his or her scope of practice or is not competent to perform;
- Delegating professional responsibilities to person licensee knows is not qualified to perform;
- Violating a lawful order of the DOH or a board, or failing to comply a DOH subpoena;
- Improperly interfering with an investigation, inspection, or disciplinary proceeding;
- Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient, the type of license under which the practitioner is practicing, including in advertisements;[39]
- Failing to provide patients information about their rights and how to file a complaint;
- Engaging or attempting to engage in sexual misconduct;
- Failing to comply with the requirements for profiling and credentialing;
- Failing to report within 30 days that the licensee has been convicted or found guilty of, or entered a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction;
- Using information from police reports, newspapers, other publications, or through a radio or television, for commercial purposes or solicitation;
- Being unable to practice with reasonable skill and safety because of illness or use of alcohol, drugs, narcotics, chemicals, or as a result of a mental or physical condition;
- Testing positive for any illegal drug on any pre-employment or employer-ordered screening when the practitioner does not have a prescription;
- Performing or attempting to perform health care services on the wrong patient, wrong-site, or an unauthorized procedure or medically unnecessary procedure;
- Leaving a foreign body in a patient;
- Violating any provision of the applicable practice act or rules;

[39] This ground does not apply to a practitioner while the practitioner is providing services in a facility licensed under chs. 394, 395, 400, or 429, F.S.

- Intentionally submitting a Personal Injury Protection (PIP) claim, that has been "upcoded;"
- Intentionally submitting a PIP claim for services not rendered;
- Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients;
- Being terminated from an impaired practitioner program for failing to comply;
- Failure to comply with controlled substance prescribing requirements;
- Intentionally entering any information concerning firearm ownership into the patient's medical record; and
- Willfully failing to authorize emergency care or services with such frequency as to indicate a general business practice.

The DOH, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:[40]

- In writing;
- Signed by the complainant;[41] and
- Legally sufficient.

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:

- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the DOH.[42]

The Consumer Services Unit receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners. Complaints that present an immediate threat to public safety are given priority; however, all complaints are investigated as timely as possible. When the complaint is assigned to an investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:

- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the DOH.[43]

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[40] Section 456.073(1), F.S.

[41] *Id.* The DOH may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the DOH has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.

[42] *Supra* note 40.

[43] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited Mar. 9, 2021).

The PSU is responsible for providing legal services to the DOH in the regulation of all health care boards and councils. The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the DOH, if there is no board, which may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[44]

If the ISU investigative file received by PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of guidance.[45,46]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within 60 days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[47]

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable cause panel meeting. When an AC is filed with the agency clerk, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH).[48] If this occurs, all parties may be asked to testify and the administrative law judge will issue a recommended order that will then go to the board, or the DOH if there is no board, for final agency action.
- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or the DOH if there is no board. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the DOH's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or the DOH if there is no

[44] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited Mar. 9, 2021).
[45] Section 456.073(2), F.S. The DOH may recommend a letter of guidance in lieu of finding probable cause if the subject has not previously been issued a letter of guidance for a related offense.
[46] *Id.*
[47] *Supra* note 45.
[48] *See* ss. 120.569 and 120.57, F.S.

board. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the DOH.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[49]

Final DOH action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the DOH if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does, appeal the final decision, PSU defends the final order before the appropriate appellate court.[50]

If the ISU investigative file received by the PSU presents evidence of an immediate threat to the health, safety, and welfare of the people of Florida, then PSU will present the file to the State Surgeon General and recommend one of two types of emergency orders – ESO or ERO – which are exclusively issued by the State Surgeon General against licensees who pose such a threat to the people of Florida.[51]

Whether the State Surgeon General issues an ERO or an ESO depends on the level of danger the licensee presents because the DOH is permitted to use only the "least restrictive means" to stop the danger.[52] The distinction between the two orders is:
- ESOs – Licensees are deemed to be a threat to the public at large; or
- EROs – Licensees are considered a threat to a segment of the population.[53]

The emergency order process is carried out without a hearing, restricting someone's right to work, and when the order is served on the licensee, it must contain a notice to the licensee of his or her right to an immediate appeal of the emergency order.[54] An ESO or ERO is not considered final agency action, and the DOH must file an AC on the underlying facts supporting the ESO or ERO within 20 days of its issuance.[55] The appeal of the emergency order and the normal disciplinary process under the AC, and regular prosecution can run simultaneously.[56]

Mandatory EROs and ESOs

Section 456.074, F.S., directs that in certain cases, the DOH must issue an ESO or ERO to certain license practitioners under certain circumstances, specifically:
- If any of the following practitioners have plead guilty to, been convicted of, found guilty of, or have entered a plea of *nolo contendere* to, regardless of adjudication, Medicare fraud,

[49] *Id.*
[50] *Supra* note 43.
[51] Section 456.073(8) and 120.60(6), F.S.
[52] Section 120.60(6)(b), F.S.
[53] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, Prosecution Services, *A Quick Guide to the MQA Disciplinary Process Discretionary Emergency Orders – 3 Things to Know, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process-discrtionary-emergency-orders.pdf (last visited Mar. 9, 2021).
[54] *See* Fla. Admin. Code R. 28-106.501(3) (2020), and ss. 120.569(2)(n) or 120.60(6), F.S.
[55] Fla. Admin. Code R. 28-106.501(3) (2020).
[56] Section 120.60(6)(c), F.S.

Medicaid fraud, health care fraud, or reproductive battery, they are subject to an ESO by the State Surgeon General:
  - Allopathic physician, physician assistants, anesthesiologist assistants, medical assistants;
  - Osteopathic physician, physician assistants, and anesthesiologist assistants;
  - Chiropractic physician and physician assistants;
  - Podiatric physicians;
  - Naturopathic physicians;
  - Optometrists - licensed and certified;
  - Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses and certified nursing assistants;
  - Pharmacists and pharmacy technicians;
  - Dentists, dental hygienist and dental laboratories; and
  - Opticians[57]
- The DOH may issue an ESO or ERO if the Board of Medicine (BOM) or Board of Osteopathic Medicine (BOOM) has previously found one of its physicians has committed medical malpractice,[58] gross medical malpractice, or repeated medical malpractice,[59] and the probable cause panel again finds probable of cause for another malpractice violation. In such cases, the State Surgeon General must review the matter to determine if an ESO or ERO is warranted;[60]
- The DOH may issue an ESO or ERO if any practitioner governed by ch. 456, F.S., tests positive for any drug on any government or private sector pre-employment or employer-ordered confirmed drug test,[61] when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug;[62]
- The DOH must issue an ESO if it receives information that a massage therapist, a person with an ownership interest in the establishment, or a massage corporate establishment corporation whose owners, officers, or individual are directly involved in the management of the establishment, has been convicted of, found guilty of, or has entered a guilty or *nolo contendere* plea to, regardless of adjudication, a felony under any of the following crimes anywhere:[63]
  - Prostitution;[64]
  - Kidnapping;[65]
  - False imprisonment;[66]

[57] Section 456.073(1), F.S.
[58] Section 456.50(1)(g), F.S., "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in law related to health care licensure.
[59] *Id.* "Repeated medical malpractice" is medical malpractice, and any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice, and will be considered medical malpractice, if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.
[60] Section 456.074(2), F.S.
[61] *See* s. 112.0445, F.S.
[62] Section 456.074(3), F.S. The practitioner must be given 48 hours from the time of notification of the confirmed test results to produce a lawful prescription for the drug before an emergency order is issued.
[63] 456.074(4), F.S.
[64] Section 796.07(1)(a), F.S., "Prostitution" means the giving or receiving of the body for sexual activity for hire, but excludes sexual activity between spouses. Prostitution that took place at massage establishment is reclassified to the next higher degree. *See* s. 796.07(2)(a), F.S., which is reclassified under s. 796.07(7), F.S.
[65] Section 787.01, F.S.
[66] Section 787.02, F.S.

- Luring or enticing a child;[67]
- Human trafficking;[68]
- Human smuggling;[69]
- Sexual battery;[70]
- Female genital mutilation;[71]
- Procuring a person under 18 for prostitution;[72]
- Selling or buying of minors into prostitution;[73]
- Forcing, compelling, or coercing another to become a prostitute;[74]
- Deriving support from the proceeds of prostitution;[75]
- Prohibiting prostitution and related acts;[76]
- Lewd or lascivious offenses committed upon or in the presence of persons under 16;[77]
- Lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person;[78]
- Sexual performance by a child;[79]
- Protection of minors;[80]
- Computer pornography;[81]
- Transmission of material harmful to minors, to a minor by electronic device or equipment;[82] and
- Selling or buying of minors.[83]

- The DOH must issue an ESO if a BOM or BOOM probable cause panel determines that the following constitutes a violation of the practice act and there exists an immediate danger to the public:
  - The registered surgery office where office surgery liposuction, or Level II or Level III office surgeries are being performed, or the physician practicing in the office, are not in compliance with the standards of practice for office surgery set by statute and board rule;[84] or
  - The physician is practicing beyond the scope of his or her education, training, and experience and is performing procedures the licensee knows, or has reason to know, that he or she is not competent to perform.[85,86]

[67] Section 787.025, F.S.
[68] Section 787.06, F.S.
[69] Section 787.07, F.S.
[70] Section 794.011, F.S.
[71] Section 794.08, F.S.
[72] Former s. 796.03, F.S.
[73] Former s. 796.035, F.S.
[74] Section 796.04, F.S.
[75] Section 796.05, F.S.
[76] Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, F.S.
[77] Section 800.04, F.S.
[78] Section 825.1025(2)(b), F.S.
[79] Section 827.071, F.S.
[80] Section 847.0133, F.S.
[81] Section 847.0135, F.S.
[82] Section 847.0138, F.S.
[83] Section 847.0145, F.S.
[84] *Id.* and Fla. Admin. Code Rs. 64B-9.009 and 64B15-14.007 (2020).
[85] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[86] Section 456.074(5), F.S.

Due Process Under Chapter 120, F.S.

Chapter 120, F.S., known as the Administrative Procedure Act, provides uniform procedures for the exercise of specified authority. Section 120.60, F.S., pertains to licensing and provides for due process for persons seeking government-issued licensure or who have been granted such licensure. Section 120.60(5), F.S., provides that:

- No revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of a final order, the governmental agency has served, by personal service or certified mail, an administrative complaint which affords reasonable notice to the licensee of facts or conduct which warrant the intended action and unless the licensee has been given an adequate opportunity to request a hearing under ss. 120.569 and 120.57, F.S.
- When personal service cannot be made and the certified mail notice is returned undelivered, the agency must cause a short, plain notice to the licensee to be published once each week for four consecutive weeks in a newspaper published in the county of the licensee's last known address as it appears on the records of the agency, or, if no newspaper is published in that county, the notice may be published in a newspaper of general circulation in that county.

Section 120.60(6), F.S., provides a process for cases in which a governmental agency finds that immediate serious danger to the public health, safety, or welfare requires emergency suspension, restriction, or limitation of a license. In such cases, the agency may take such action by any procedure that is fair under the circumstances if:

- The procedure provides at least the same procedural protection as is given by other statutes, the State Constitution, or the U.S. Constitution;
- The agency takes only that action necessary to protect the public interest under the emergency procedure; and
- The agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety, or welfare and its reasons for concluding that the procedure used is fair under the circumstances. The agency's findings of immediate danger, necessity, and procedural fairness are judicially reviewable. Summary suspension, restriction, or limitation may be ordered, but a suspension or revocation proceeding pursuant to ss. 120.569 and 120.57, F.S., must also be promptly instituted and acted upon.

Anesthesiology

Under chs. 458 and 459, F.S., "anesthesiology" is defined as the practice of medicine that specializes in the relief of pain during and after surgical procedures and childbirth, during certain chronic disease processes, and during resuscitation and critical care of patients in the operating room and intensive care environments.[87]

The term "anesthesiologist" is defined as an allopathic or osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's

[87] Sections 458.3475(1)(c) and 459.023(1)(c), F.S.

examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.[88]

Anesthesiologist Assistants

"Anesthesiologist assistant" means a graduate of an approved program who is licensed by the BOM or BOOM to perform medical services delegated and directly supervised by a supervising anesthesiologist, under a written protocol with an anesthesiologist or group of anesthesiologists.[89]

"Direct supervision" means the onsite, personal supervision by an anesthesiologist who is present in the office when the procedure is being performed in that office, or is present in the surgical or obstetrical suite when the procedure is being performed in that surgical or obstetrical suite and who is in all instances immediately available to provide assistance and direction to the anesthesiologist assistant while anesthesia services are being performed.[90]

An anesthesiologist assistant may assist an anesthesiologist in developing and implementing an anesthesia care plan for a patient. In providing assistance to an anesthesiologist, an anesthesiologist assistant may perform duties established by rule by the BOM or BOOM in any of various functions that are included in the anesthesiologist assistant's protocol while under the direct supervision of an anesthesiologist, including:[91]

- Obtain a comprehensive patient history and present the history to the supervising anesthesiologist.
- Pretest and calibrate anesthesia delivery systems and monitor, obtain, and interpret information from the systems and monitors.
- Assist the supervising anesthesiologist with the implementation of medically accepted monitoring techniques.
- Establish basic and advanced airway interventions, including intubation of the trachea and performing ventilatory support.
- Administer intermittent vasoactive drugs and start and adjust vasoactive infusions.
- Administer anesthetic drugs, adjuvant drugs, and accessory drugs.
- Assist the supervising anesthesiologist with the performance of epidural anesthetic procedures and spinal anesthetic procedures.
- Administer blood, blood products, and supportive fluids.
- Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.
- Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.
- Participate in management of the patient while in the post-anesthesia recovery area, including the administration of any supporting fluids or drugs.

[88] Sections 458.3475(1)(a) and 459.023(1)(a), F.S.
[89] Sections 458.3475(1)(b) and 459.023(1)(b), F.S.
[90] Sections 458.3475(1)(g) and 459.023(1)(g), F.S.
[91] Sections 458.3475(3)(a) and 459.023(3)(a), F.S.

- Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

Nurse Anesthetists

A certified registered nurse anesthetist (CRNA) is an advance practice registered nurse (APRN), licensed by the BON, who specializes in anesthetic services.

APRNs are regulated under part I of ch. 464, F.S., the Nurse Practice Act. The BON provides, by rule, the eligibility criteria for applicants to be licensed as APRNs and the applicable regulatory standards for APRN nursing practices.[92] Additionally, the BON is responsible for administratively disciplining an APRN who commits prohibited acts.[93]

In Florida "advanced or specialized nursing practice" includes, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the BON as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience.[94] Advanced or specialized nursing acts may only be performed if authorized under a supervising physician's protocol.[95] In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician's protocol.[96]

A CRNA may, to the extent authorized by established protocol approved by the medical staff of the facility in which the anesthetic service is performed, perform any or all of the following:

- Determine the health status of the patient as it relates to the risk factors and to the anesthetic management of the patient through the performance of the general functions.
- Based on history, physical assessment, and supplemental laboratory results, determine, with the consent of the responsible physician, the appropriate type of anesthesia within the framework of the protocol.
- Order pre-anesthetic medication under the protocol.
- Perform under the protocol procedures commonly used to render the patient insensible to pain during the performance of surgical, obstetrical, therapeutic, or diagnostic clinical procedures. These procedures include ordering and administering regional, spinal, and general anesthesia; inhalation agents and techniques; intravenous agents and techniques; and techniques of hypnosis.
- Order or perform monitoring procedures indicated as pertinent to the anesthetic health care management of the patient.
- Support life functions during anesthesia health care, including induction and intubation procedures, the use of appropriate mechanical supportive devices, and the management of fluid, electrolyte, and blood component balances.
- Recognize and take appropriate corrective action for abnormal patient responses to anesthesia, adjunctive medication, or other forms of therapy.

[92] *See* s. 464.004, F.S., and Fla. Admin. Code R. 64B9-3 (2020).
[93] *See* ss. 464.018 and 456.072, F.S.
[94] Section 464.003(2), F.S.
[95] Section 464.012(3)-(4), F.S.
[96] *Id.*

- Recognize and treat a cardiac arrhythmia while the patient is under anesthetic care.
- Participate in management of the patient while in the post-anesthesia recovery area, including ordering the administration of fluids and drugs.
- Place special peripheral and central venous and arterial lines for blood sampling and monitoring as appropriate.

"Nurse Anesthesiologist"

On August 8, 2019, at the general BON meeting, the BON considered requests for declaratory statements.[97] The second request for a declaratory statement was made by John P. McDonough, A.P.R.N., C.R.N.A., license number 3344982.[98]

For the meeting, McDonough's Petition for Declaratory Statement acknowledged that the type of Florida nursing license he held was as an *A.P.R.N.*, and that he was a certified registered nurse anesthetist (C.R.N.A.), but requested that he be permitted to use the phrase "nurse anesthesiologist" as a descriptor for him or his practice, and that the BON not subject him to discipline under ss. 456.072 and 464.018, F.S.,[99] based on the following grounds:

- A New Hampshire Board of Nursing's Position Statement that the nomenclature, *Nurse Anesthesiologist* and *Certified Registered Nurse Anesthesiologist*, are not title changes or an expansion of scope of practice, but are optional, accurate descriptors;[100] and
- Florida law grants no title protection to the words *anesthesiologist* or *anesthetist.*[101]

The Florida Association of Nurse Anesthetists (FANA) and the Florida Medical Association, Inc. (FMA), Florida Society of Anesthesiologists, Inc. (FSA), and Florida Osteopathic Medical

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[97] Section 120.565, F.S. Provides that, "[a]ny substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision as it applies to the petitioner's particular set of circumstances. The agency must give notice of the filing of a petition in the Florida Administrative Register, provide copies of the petition to the board, and issue a declaratory statement or deny the petition within 90 days after the filing. The declaratory statement or denial of the petition is then noticed in the next Florida Administrative Register, and disposition of a petition is a final agency action."

[98] The Florida Board of Nursing, Meeting Minutes, Disciplinary Hearings & General Business, *Declaratory Statements*, No. 2, Aug. 8, 2019, *available at* https://floridasnursing.gov/meetings/minutes/2019/08-august/08072019-minutes.pdf p. 28 (last visited Mar. 12, 2021).

[99] *Petition for Declaratory Statement Before the Board of Nursing, In re: John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, July 10, 2019 (on file with the Senate Committee on Health Policy).

[100] New Hampshire Board of Nursing, *Position Statement Regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)*, Nov. 20, 2018, *available at* https://static1.squarespace.com/static/5bf069ef3e2d09d0f4e0a54f/t/5f6f8a708d2cb23bb10f50a0/1601145457231/NH+BON+NURSE+ANESTHESIOLOGIST.pdf (last visited Mar. 12, 2021).

[101] *Id.*

Association, Inc. (FOMA), filed timely and legally sufficient[102] motions to intervene[103] pursuant to Florida Administrative Code Rule 28-106.205.[104] The FANA's petition[105] was in support of petitioner's Declaratory Statement while the motion filed jointly by the FMA, FSA, and FOMA was in opposition.

The FMA, FSA, and FOMA argued they were entitled to participate in the proceedings, on behalf of their members, as the substantial interests of their members – some 32,300 – could be adversely affected by the proceeding.[106, 107] Specifically, the FMA, FSA, and FOMA argued that the substantial interests of their respective members would be adversely affected by the issuance of a Declaratory Statement that petitioner could use the term "nurse anesthesiologist," without violating ss. 456.072 and 464.018, F.S., on the grounds that:

- A substantial number of their members use the term "anesthesiologist" with the intent and understanding that patients, and potential patients, would recognize the term to refer to them as physicians licensed under chs. 458 or 459, F.S., not "nurse anesthetists;"
- Sections 458.3475(1)(a) and 459.023(1)(a), F.S., both define the term "anesthesiologist" as a licensed allopathic or osteopathic physician and do not include in those definitions a "nurse anesthetist;"
- The Merriam-Webster Dictionary defines an "anesthesiologist" as a "physician specializing in anesthesiology," not as a nurse specializing in anesthesia; and
- The Legislature clearly intended a distinction between the titles to be used by physicians practicing anesthesiology and nurses delivering anesthesia, to avoid confusion, as s. 464.015(6), F.S., specifically states that:
  - Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title "Certified Registered Nurse Anesthetist" and the abbreviations "C.R.N.A." or "nurse anesthetist;" and
  - Petitioner is licensed as a "registered nurse anesthetist" under s. 464.012(1)(a), F.S., and the term "nurse anesthesiologist" is not found in statute.

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[102] Fla. Adm. Code R. 28-105.0027(2) and 28.106.205(2) (2019), both of which state that to be legally sufficient, a motion to intervene in a proceeding on a petition for a declaratory statement must contain the following information: (a) The name, address, the e-mail address, and facsimile number, if any, of the intervenor; if the intervenor is not represented by an attorney or qualified representative;(b) The name, address, e-mail address, telephone number, and any facsimile number of the intervener's attorney or qualified representative, if any; (c) Allegations sufficient to demonstrate that the intervenor is entitled to participate in the proceeding as a matter of constitutional or statutory right or pursuant to agency rule, or *that the substantial interests of the intervenor are subject to determination or will be affected by the declaratory statement;* (d) The signature of the intervener or intervener's attorney or qualified representative; and (e) The date.

[103] The Florida Medical Association, Inc., Florida Society of Anesthesiologists, Inc., and Florida Osteopathic Medical Association, Inc., *Motion to Intervene In Florida Board of Nursing's Consideration of the Petition for Declaratory Statement in Opposition of Petitioner John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.*, filed at the Department of Health, Aug. 1, 2019, (on file with the Senate Health Policy Committee).

[104] Fla. Adm. Code. R. 28-106.205 (2019), in pertinent part, provides, "Persons other than the original parties to a pending proceeding whose substantial interest will be affected by the proceeding and who desire to become parties may move the presiding officer for leave to intervene."

[105] *Florida Association of Nurse Anesthetists Motion to Intervene*, filed at the Department of Health, July 31, 2019, (on file with the Senate Committee on Health Policy).

[106] *Supra* note 104.

[107] *See Florida Home Builders Association, et al., Petitioners, v. Department of Labor And Employment Security, Respondent*, 412 S.2d 351 (Fla. 1982), holding that a trade association does have standing under s. 120.56(1), F.S., to challenge the validity of an agency ruling on behalf of its members when that association fairly represents members who have been substantially affected by the ruling.

At the hearing, the attorney for the BON advised the BON that, "[t]he first thing the Board need[ed] to do [was] determine whether or not the organizations that [had] filed petitions to intervene have standing in order to participate in the discussion of the Declaratory Statement"[108] and that:

> "Basically in order to make a determination of whether an organization has standing, they have to show that the members of their organization would have an actual injury in fact, or suffer an immediate harm of some sort of immediacy were the Board to issue this particular Declaratory Statement, and then the Board also has to make a determination of whether the nature of the injury would be within the zone of interest that the statute is addressing."[109]

However, the above special injury standard,[110] provided by board counsel to the BON to apply to determine the organizations' standing to intervene, based on their members' substantial interests being affected by the declaratory statement, was held inapplicable to trade associations in *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982). The Florida Supreme Court, in *Florida Home Build*ers, *Ass'n.*, held that a trade or professional association is able to challenge an agency action on behalf of its members, even though each member could individually challenge the agency action, if the organization could demonstrate that:

- A substantial number of the association members, though not necessarily a majority, would be "substantially affected" by the challenged action;
- The subject matter of the challenged action is within the association's scope of interest and activity; and
- The relief requested is appropriate for the association's members.[111]

The FANA's motion to intervene was granted, based on the application of an incorrect standard, without the BON making the findings required by *Florida Home Build*ers, *Ass'n.* The motion to intervene filed by the FMA, FSA, and FOMA was denied, also based on the application of an incorrect standard, on the grounds that:

- Their members are regulated by the Board of Medicine, not the Board of Nursing;
- Nursing disciplinary guidelines were being discussed;
- Their members' licenses and discipline would not be affected by an interpretation of nursing discipline;[112] and
- Their members are not regulated by the Nurse Practice Act.

A motion was made to approve McDonough's Petition for Declaratory Statement, and it passed unanimously. According to the BON's approval, McDonough may now use of the term "nurse anesthesiologist" as a descriptor, and such use is not grounds for discipline against his nursing

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[108] Record at p. 3, ll. 13-17. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).
[109] *Id.* p. 3-4, ll. 22- 25, 1-6.
[110] *United States Steel Corp. v. Save Sand Key, Inc.*, 303 So.2d 9 (Fla. 1974).
[111] *Florida Home Builders Ass'n. v. Department of Labor and Employment Security*, 412 So.2d 351 (Fla. 1982), pp. 353-354.
[112] Record at p. 7, ll. 1-13. Declaratory Statement, Dr. John P. McDonough, Before the Board of Nurses, State of Florida, Department of Health, Sanibel Harbor Marriott. (on file with the Senate Committee on Health Policy).

license. However, while s. 120.565, F.S., provides that any person may seek a declaratory statement regarding the potential impact of a statute, rule or agency opinion on a petitioner's particular situation, approval or denial of the petition only applies to the petitioner. It is not a method of obtaining a policy statement from a board of general applicability.[113] News media have reported that the BON's Declaratory Statement in favor of McDonough has created significant concern for patient safety and the potential for confusion in the use of the moniker "anesthesiologist" among Florida's medical professionals.[114,115,116]

III. Effect of Proposed Changes:

CS/SB 1142 amends s. 456.072(1)(a), F.S., which provides grounds for discipline applicable to all licensed health care practitioners, to:

- Add the making of misleading, deceptive, or fraudulent representations related to a practitioner's "specialty designation" as grounds for discipline, in addition to such representations related to the practice of practitioner's profession as under current law.
- Provide that the term "anesthesiologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S., or licensed as a dentist under ch. 466, F.S.
- Provide that the term "dermatologist" may be used only by a practitioner licensed under chs. 458 or 459, F.S.

The bill requires that when the DOH finds that a person has violated s. 456.072(1)(a), F.S., as amended by the bill, the department must issue an emergency order to the person to cease and desist using the name or title, or any other words, letters, abbreviations, or insignia indicating that he or she may practice under the specialty designation. The bill requires the DOH to send the emergency cease and desist order to the person by certified mail and email to his or her physical address and email address of record on file with the department and to any other mailing address or email address through which the department believes the person may be reached.

If the person does not cease and desist his or her actions in violation of s. 456.072(1)(a), F.S., as amended by the bill, immediately upon receipt of the emergency cease and desist order, the bill requires the DOH to enter an order imposing any of the following penalties, or a combination thereof, until the person complies with the cease and desist order:

- A citation and a daily fine.
- A reprimand or a letter of concern.
- Suspension of license.

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[113] Florida Department of Health, Board of Nursing, *What is a Declaratory Statement?, available at* https://floridasnursing.gov/help-center/what-is-a-declaratory-statement/ (last visited Mar. 9, 2021).
[114] Christine Sexton, The News Service of Florida, "*Nursing Board Signs Off On 'Anesthesiologist' Title,"* August 16, 2019, The Gainesville Sun, *available at*: https://www.gainesville.com/news/20190816/nursing-board-signs-off-on-anesthesiologist-title (last visited Mar. 9, 2021).
[115] Christine Sexton, The News Service of Florida, *"Florida Lawmaker Takes Aim At Health Care Titles*," October 10, 2019, Health News Florida, *available at* https://health.wusf.usf.edu/post/florida-lawmaker-takes-aim-health-care-titles (last visited Mar. 9, 2021).
[116] Christine Section, The News Service of Florida, "*What's In A Name? Health Panel Seeks Clarity on Health Care Providers,"* Nov. 14, 2019, *available at* https://health.wusf.usf.edu/post/what-s-name-health-panel-seeks-clarity-health-care-providers (last visited Mar. 9, 2021).

The bill also amends s. 456.072(1)(t), F.S., to provide that a licensed practitioner's failure to identify the specialty designation under which he or she is practicing – through written notice, which may include the wearing of a name tag, or orally to a patient – is grounds for disciplinary action. Under current law, such failure applies only to the type of license under which the practitioner is practicing. The bill also provides that the DOH, not a practitioner regulatory board, must enforce s. 456.072(1)(t), F.S., as amended by the bill.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

The bill's requirement for the DOH to enter an order imposing penalties if a person does not immediately comply with an emergency cease and desist order – in a manner that differs from procedures that provide due process under current law – may subject those provisions of the bill to challenge as a violation of the licensee's due process rights under the Florida Constitution and the U.S. Constitution.

Both the fifth and fourteenth amendments to the U.S. Constitution prohibit arbitrary deprivation of life, liberty, or property by the government except as authorized by law. The U.S. Supreme Court has interpreted these provisions broadly, ruling that they provide for procedural due process in civil and criminal proceedings and substantive due process, or a prohibition against vague laws. Article I, Section 9, of the Florida Constitution provides that no person shall be deprived of life, liberty, or property without due process of law.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

A licensed health care practitioner found to be in violation of s. 456.072(1)(a), F.S., as amended by the bill, may be subject to a daily fine imposed by the DOH if he or she fails to comply with a cease and desist order issued under the bill.

C. Government Sector Impact:

According to the DOH, the department may experience a recurring increase in workload associated with additional complaints, investigations, and prosecutions resulting from the bill. The extent to which such complaints, investigations, and prosecutions may materialize is unknown; therefore, the fiscal impact is indeterminate.[117]

VI. Technical Deficiencies:

Lines 101-106 of the bill provide that when the DOH finds that a person has violated s. 456.072(1)(a), F.S., the department must issue an emergency order to the person to cease and desist his or her behavior that indicates to patients that he or she may practice "under the specialty designation." However, violations relating to specialty designation are not the only violations included in paragraph (1)(a). Under current law and the bill, s. 456.072(1)(a), F.S., includes misrepresentations relating to "the practice of the licensee's profession," but, under the bill, such violations would technically trigger the bill's actions required of the DOH relating to specialty designations, even if the violations are unrelated to a specialty designation. To address this issue, an amendment to line 102 should be considered to change "paragraph (1)(a)" to "paragraph (1)(a) relating to a specialty designation."

Lines 106-120 direct the DOH to send emergency cease and desist orders to a person's physical and email address "of record," on file with the DOH. Those lines also provide actions the DOH must take if a person, upon receipt of an emergency cease and desist order, fails to immediately cease and desist, and such actions by the DOH include entering an order imposing one or more penalties on that person. However, if the person is not a licensed health care practitioner, the DOH is not likely to have a physical or email address "of record" on file for that person. Also, some of the penalties that the DOH may impose for such violations under the bill do not directly pertain to a person who is not a licensed health care practitioner, i.e. a reprimand, a letter of concern, or suspension of license. To address this issue, those lines of the bill could be amended to account for a person's status as a licensed health care practitioner or lack thereof.

VII. Related Issues:

The DOH advises that while the bill focuses on a practitioner's misuse of a specialty designation as grounds for discipline, the term "specialty designation" is not defined in the bill or in existing statute and is not a term used in the ordinary course of health care practitioner regulation. Absent a definition or guidelines about what constitutes a misrepresentation, the bill's new grounds for discipline are so vague as to be unenforceable, according to the DOH. While some physicians hold board certifications in their specialty areas from the American Board of Medical Specialties

[117] Department of Health, *Senate Bill 1142 Fiscal Analysis* (Mar. 5, 2021) (on file with the Senate Committee on Health Policy).

or the American Osteopathic Association, not all specialists hold or maintain such credentials. Health care providers who participate in Medicare typically have a specialty designation under which they bill for payment. It is unclear to the DOH what credentials a practitioner must hold to use a "specialty designation" under the bill and when the use of such designation would be considered misleading or fraudulent.[118]

The DOH also advises that, because the bill requires the department, not the applicable regulatory board, to impose discipline for violations of ss. 456.072(1)(a) and (t), F.S., the bill will require the creation of a new disciplinary process. The DOH will need to create a unique procedure and tracking system for these specific charges. For all other disciplinary grounds, it is the board that issued the license that takes disciplinary action against that license. The bill would authorize the DOH to suspend a practitioner's license without the involvement or input of the board that issued the license, which could be interpreted to conflict with current law regarding practitioner discipline.[119,120]

The DOH further advises that, under the bill's requirement for the DOH to issue an emergency order to cease and desist, the procedures for issuing such an order are unclear. Currently, when the DOH issues an emergency order, it must show that allowing the practitioner to continue to practice would constitute an immediate serious danger to the health, safety, or welfare of the citizens of Florida and that nothing short of the emergency action would protect citizens from that danger, as required under s. 120.60(6), F.S. It is unclear to the DOH how these requirements would be met under the circumstances specified in the bill.[121]

The DOH further advises that the bill's requirement for the department to enter an order imposing penalties if a person does not immediately comply with an emergency cease and desist order may conflict with s. 456.073(5), F.S., which provides that a formal hearing must be held before an administrative law judge in disciplinary matters if there are material issues of disputed fact. This portion of the bill may also conflict with s. 120.60(5), F.S., which provides that no revocation, suspension, annulment, or withdrawal of any license is lawful unless, prior to the entry of the order, the governmental agency has served, by personal service or certified mail, an administrative complaint which affords reasonable notice to the licensee of facts or conduct which warrant the intended action and the licensee has been given an adequate opportunity to request a proceeding pursuant to ss. 120.569 and 120.57, F.S.[122]

VIII. Statutes Affected:

This bill substantially amends section 456.072 of the Florida Statutes.

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[118] *Id.*

[119] *Id.*

[120] Sections 456.073(1) and (2), F.S., provide that the DOH investigates complaints and violations of the grounds for discipline and provides the completed investigative report to the probable cause panel of the appropriate regulatory board. The statute provides for the report to be sent to the department only when there is no board for the profession in question. Section 456.073(4), F.S., provides that the determination of the existence of probable cause is made by the probable cause panel and that the DOH determines probable cause only if there is no board. And, s. 456.073(6), F.S., provides that the appropriate board issues the final order in each health care professional disciplinary case, unless there is no board, in which case the DOH would issue the final order.

[121] *Supra*, note 117.

[122] *Id.*

IX. 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 March 17, 2021:
The CS changes the underlying bill's amendment to s. 456.072(1)(a), F.S., to remove the requirement for practitioners licensed under chs. 458 or 459, F.S., to be physicians in order to use the terms "anesthesiologist" or "dermatologist." This addresses a technical deficiency in the underlying bill which would have prevented anesthesiologist assistants, who are non-physicians licensed under chs. 458 or 459, from using the term "anesthesiologist," even though the term appears in their license.

B. Amendments:

None.

916046

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/17/2021	.	
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	.	

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

Senate Amendment

Delete lines 35 - 38
and insert:
may be used only if the practitioner is licensed under chapter 458 or chapter 459 or as a dentist under chapter 466, and the term "dermatologist" may be used only if the practitioner is licensed under chapter 458 or

By Senator Rodrigues

27-01297-21 20211142__

A bill to be entitled

An act relating to prohibited acts by health care practitioners; amending s. 456.072, F.S.; subjecting health care practitioners to discipline for making misleading, deceptive, or fraudulent representations related to their specialty designations; specifying that only certain licensed health care practitioners may use the terms "anesthesiologist" or "dermatologist"; subjecting health care practitioners to discipline for failing to provide written or oral notice to patients of their specialty designation; requiring the department, instead of applicable health care practitioner boards, to enforce the written or oral notice requirement; requiring the department to issue emergency cease and desist orders to certain persons under certain circumstances; providing requirements for the notice of such emergency orders; requiring the department to impose certain administrative penalties if such persons do not immediately comply with the emergency orders; providing an effective date.

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

Section 1. Paragraphs (a) and (t) of subsection (1) and subsection (2) of section 456.072, Florida Statutes, are amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which

27-01297-21 20211142__

the disciplinary actions specified in subsection (2) may be taken:

(a) Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession or specialty designation. The term "anesthesiologist" may be used only if the practitioner is licensed as a physician under chapter 458 or chapter 459 or as a dentist under chapter 466, and the term "dermatologist" may be used only if the practitioner is licensed as a physician under chapter 458 or chapter 459.

(t) Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license or specialty designation under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. This paragraph does not apply to a practitioner while the practitioner is providing services in a facility licensed under chapter 394, chapter 395, chapter 400, or chapter 429. The department shall enforce this paragraph ~~Each board, or the department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement~~.

(2)(a) When the board, or the department when there is no board, finds any person guilty of the grounds set forth in subsection (1) or of any grounds set forth in the applicable practice act, including conduct constituting a substantial violation of subsection (1) or a violation of the applicable practice act which occurred before ~~prior to~~ obtaining a license, it may enter an order imposing one or more of the following

penalties:

1.~~(a)~~ Refusal to certify, or to certify with restrictions, an application for a license.

2.~~(b)~~ Suspension or permanent revocation of a license.

3.~~(c)~~ Restriction of practice or license, including, but not limited to, restricting the licensee from practicing in certain settings, restricting the licensee to work only under designated conditions or in certain settings, restricting the licensee from performing or providing designated clinical and administrative services, restricting the licensee from practicing more than a designated number of hours, or any other restriction found to be necessary for the protection of the public health, safety, and welfare.

4.~~(d)~~ Imposition of an administrative fine not to exceed $10,000 for each count or separate offense. If the violation is for fraud or making a false or fraudulent representation, the board, or the department if there is no board, must impose a fine of $10,000 per count or offense.

5.~~(e)~~ Issuance of a reprimand or letter of concern.

6.~~(f)~~ Placement of the licensee on probation for a period of time and subject to such conditions as the board, or the department when there is no board, may specify. Those conditions may include, but are not limited to, requiring the licensee to undergo treatment, attend continuing education courses, submit to be reexamined, work under the supervision of another licensee, or satisfy any terms which are reasonably tailored to the violations found.

7.~~(g)~~ Corrective action.

8.~~(h)~~ Imposition of an administrative fine in accordance

with s. 381.0261 for violations regarding patient rights.

9.~~(i)~~ Refund of fees billed and collected from the patient or a third party on behalf of the patient.

10.~~(j)~~ Requirement that the practitioner undergo remedial education.

In determining what action is appropriate, the board, or department when there is no board, must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the practitioner. All costs associated with compliance with orders issued under this subsection are the obligation of the practitioner.

(b)1. When the department finds that a person has violated paragraph (1)(a), the department must issue an emergency order to the person to cease and desist from using the name or title, or any other words, letters, abbreviations, or insignia indicating that he or she may practice under the specialty designation. The department must send the emergency cease and desist order to the person by certified mail and e-mail to the person's physical address and e-mail address of record on file with the department and to any other mailing address or e-mail address through which the department believes the person may be reached.

2. If the person does not cease and desist his or her actions in violation of paragraph (1)(a) immediately upon receipt of the emergency cease and desist order, the department must enter an order imposing any of the following penalties, or

a combination thereof, until the person complies with the cease and desist order:

a. A citation and a daily fine.

b. A reprimand or a letter of concern.

c. Suspension of license.

Section 2. This act shall take effect upon becoming a law.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR RAY WESLEY RODRIGUES
27th District

COMMITTEES:
Governmental Oversight and Accountability, *Chair*
Appropriations Subcommittee on Agriculture, Environment, and General Government, *Vice Chair*
Appropriations Subcommittee on Health and Human Services
Banking and Insurance
Finance and Tax
Judiciary
Regulated Industries

JOINT COMMITTEES:
Joint Select Committee on Collective Bargaining, *Alternating Chair*
Joint Committee on Public Counsel Oversight

February 18, 2021

The Honorable Manny Diaz, Jr.
Senate Health Policy, Chair
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

RE: SB 1142 – Prohibited Acts by Health Care Practitioners

Dear Mr. Chair:

Please allow this letter to serve as my respectful request to place SB 1142, relating to Prohibited Acts by Health Care Practitioners, on the next committee agenda.

Your kind consideration of this request is greatly appreciated. Please feel free to contact my office for any additional information.

Sincerely,

Ray Rodrigues

Ray Rodrigues
Senate District 27

Cc: Allen Brown, Staff Director
Lynn Wells, Administrative Assistant

REPLY TO:
❒ 2000 Main Street, Suite 401, Fort Myers, Florida 33901 (239) 338-2570
❒ 305 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5027

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

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

2. McDonough, John P APRN 3344982, 1711/200008; Reference: Section 456.072, FS and Section 464.018, FS, regarding whether licensee, John McDonough, may describe himself as, or his professional duties as those of, a "nurse anesthesiologist" without subjecting his Florida nursing licenses to discipline under Section 456.072, FS or Section 464.018, FS. –Present with Attorney Cynthia Mikos and sworn in. A motion was made by Whitson that FANA does meet the standing as an intervenor. Motion passed unanimously. A motion was made by Glymph that FMA, FOMA, and FSA do not meet the standing as an intervenor because their members are not regulated by the Nurse Practice Act. Motion passed unanimously. A motion was made by Newman to approve the use of the term "nurse anesthesiologist" as a descriptor along with CRNA and that such use would not be grounds for discipline against his license. Motion passed unanimously.

F. Petition for Waiver and Variance

1. All State Home Health Institute, 1509, 4402/537; Reference: 64B9-15.007, FAC, regarding approval and renewal of New Certified Nursing Assistant Training Programs- A motion was made by Newman to deny the petition. Motion passed unanimously.

2. Agape Academy of Sciences, 1504, 4402/539; Reference: 64B9-15.005, FAC, regarding standards for Certified Nursing Assistant Training Programs- A motion was made by Paschall to deny the petition. Motion passed unanimously.

3. Livecchi, Vicente Julius; 1701/644190; Reference: 64B9-3.0025(2), FAC, regarding Remedial Courses for Re-Examination- Represented by Attorney Cynthia Mikos. A motion was made by Paschall to grant the petition. Motion failed with Paschall, Forst, Talmadge and Whitson for. A motion was made by Desmond to reconsider. Motion passed with Newman and Johnson opposed. A motion was made by Paschall to approve. Motion passed with Johnson and Newman opposed.

4. Hendricks, Sarah; 1702/199862; Reference: 64B9-3.002(3), FAC, regarding Qualifications for Examination-Present and sworn in. A motion was made by Newman to continue to October meeting. Motion passed unanimously.

The meeting was recessed at 6:15 PM

FLORIDA DEPARTMENT OF HEALTH
BOARD OF NURSING

Petition for Declaratory Statement
Before the Board of Nursing

In re: John P. McDonough, A.P.R.N., C.R.N.A., Ed.D.
_____/

Petitioner, John P. McDonough, A.P.R.N., C.R.N.A., Ed.D. ("Petitioner" or "Dr. McDonough") by and though the undersigned attorneys and pursuant to Florida Statutes §120.565 and Florida Administrative Code Rule 28-105.002, seeks the Florida Board of Nursing's ("Board") opinion as to whether he may describe himself as, or his professional duties as those of, a "nurse anesthesiologist" without subjecting his Florida nursing licenses to discipline under Section 456.072, Florida Statutes, or Section 464.018, Florida Statutes.

1. Dr. McDonough is an advanced practice registered nurse ("A.P.R.N.") who is nationally certified as a certified registered nurse anesthetist (C.R.N.A.) licensed by the Florida Board of Nursing pursuant to Florida Statutes Chapter 464 holding license numbers RN3344982 and APRN3344982 since 1999. He can be contacted through undersigned counsel.

2. Dr. McDonough is currently employed as a Professor of Nursing, Director of Graduate Programs for the School of Nursing, and the Director of Anesthesiology Nursing at the University of North Florida ("UNF") in Jacksonville, Florida, where he has served in these roles since 2005. His responsibilities include the development, accreditation, implementation, and administration of the anesthesia program. In addition to his academic responsibilities, Dr. McDonough also maintains a clinical anesthesia business. He holds clinical privileges in anesthesiology at Tampa General Hospital, in Tampa, Florida.

3. Involved in multiple professional associations and activities, Dr. McDonough devotes significant effort toward advancing the practice of C.R.N.A.s. He has published and presented internationally on nurse anesthesia and graduate nursing education. He is active nationally in the American Association of Nurse Anesthetists ("AANA") which has recognized the optional titles "nurse anesthesiologist" and "Certified Registered Nurse Anesthesiologist." Further, AANA is currently considering bylaw revisions to change its name to the American Association of Nurse Anesthesiologists. Additionally, Dr. McDonough is a member of the Committee for Proper Recognition of CRNAs, an entity that advocates for the adoption of the term "nurse anesthesiologist." Consequently, this is a subject of great professional interest to him. A copy of his *curriculum vita* detailing his complete professional background is attached as Exhibit 1.

4. Dr. McDonough acknowledges that the type of Florida license that he holds is as a C.R.N.A. is "certified registered nurse anesthetist." and further acknowledges that he will use the title of C.R.N.A. as required by Florida law. However, Dr. McDonough seeks the Board's determination as to whether he may describe himself as, or his professional duties as those of a "nurse anesthesiologist" without subjecting his Florida nursing licenses to potential discipline.

5. The New Hampshire Board of Nursing recently published a position statement on this subject entitled "Position Statement regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)." In the position statement, the New Hampshire Board of Nursing found that the descriptor of "nurse anesthesiologist" distinguishes nurse anesthesiologists, from physician anesthesiologists, dentist anesthesiologists, and anesthesiologist assistants. They also cited to evidence from the American Society of Anesthesiologists that confirmed 55% of the country does

not recognize an "anesthesiologist" as a physician and acknowledged that physicians have adopted a descriptor of "physician anesthesiologist." The New Hampshire Board of Nursing concluded that the optional use of "nurse anesthesiologist" would provide transparency, remove confusion, and recognize CRNAs as fully qualified anesthesia providers. Consequently, the New Hampshire Board of Nursing found the phrases of "nurse anesthesiologist" and certified registered nurse anesthesiologist" are optional, accurate descriptors that do not create an expanded or misleading scope of practice. It recognized the use of those terms as transparent and lawful terms for address, introduction and use on personal and professional communications. A copy of the New Hampshire Board of Nursing Position Statement is attached as Exhibit 2.

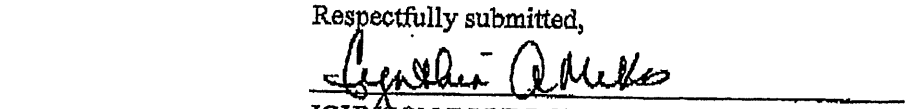
6. Florida law grants no title protection to the word "anesthesiologist." Similarly, there is no title protection for the word "anesthetist" although the term "nurse anesthetist" is protected by Section 464.015(6), Florida Statutes. In fact, the American Academy of Anesthesiologist Assistants utilize the URL of www.anesthetist.org. Moreover, in Dr. McDonough's experience, facilities are using the term "anesthetist" to refer to both CRNAs and anesthesiology assistants. This development muddles the distinction between Masters-prepared nurses who are nationally certified as CRNAs and anesthesiology assistants who may have completed only a two-year anesthesia training program. Thus, Dr. McDonough should be able to use either the phrase "nurse anesthetist" or "nurse anesthesiologist" to describe him or his professional duties. In all instances when describing his Florida nursing license, Dr. McDonough will use the title of C.R.N.A.

7. As a Florida licensed nurse, Dr. McDonough licenses to practice nursing may be sanctioned under a number of enumerated grounds for discipline found in Section 456.072, Florida Statutes and in Section 464.018, Florida Statutes. For instance, Section 456.072(1)(a) prohibits a health care practitioner from "making misleading, deceptive or fraudulent representations in or

related to the practice of the licensee's profession." Additionally, both Sections 456.072 and 464.018, Florida Statutes contain grounds for discipline related to violating any provision of the respective chapter, practice act, or rules. Section 464.018, Florida Statutes contains broad categories for potential discipline including subsection (1)(h) prohibiting "unprofessional conduct" and (1)(n) prohibiting "failing to meet minimal standards." Dr. McDonough would be substantially affected by discipline on his Florida nursing licenses which could mar his impeccable professional history or interfere in his ability to be appointed to a clinical staff or prevent his participation in third party payor contracts. Consequently, he is seeking the Board's review of his proposed conduct as outlined in this petition.

WHEREFORE, Dr. McDonough respectfully requests that the Board issue a declaratory statement opining that his use of the phrase "nurse anesthesiologist" as a descriptor of him or his practice does not subject his Florida nursing licenses to discipline under Section 456.072, Florida Statutes or Section 464.018, Florida Statutes.

Respectfully submitted,



JOHNSON POPE BOKOR RUPPEL & BURNS, LLP
Cynthia A. Mikos, Esq.
Florida Bar No.: 0984256
401 E. Jackson Street, Suite 3100
Tampa, FL 33602
Tel: (813) 225-2500
Fax: (813) 223-7118
E-Mail: cynthiam@jpfirm.com

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the fully executed foregoing instrument has been furnished via email to deborah.loucks@myfloridalegal.com and via U.S. Mail to Deborah

Loucks, Office of the Attorney General, The Capitol, PL-01, Tallahassee, FL 32399 and via facsimile (850) 413-8743 and U.S. Mail to the Florida Department of Health, Agency Clerk, 4052 Bald Cypress Way, Bin A02, Tallahassee, FL 32399 on this 10th day of July 2019

Cynthia A. Mikos

cc: Joe Baker, Executive Director, FBON (via email)

Curriculum Vita

John P. McDonough, CRNA, Ed.D, Dr.(habil.)NScA, ARNP, FRSM
Professor & Director, Graduate Nursing Programs
Director, Nurse Anesthetist Program
University of North Florida

Contact information:

Home:
86479 Meadowfield Bluffs Rd
Yulee, FL 32097
Tel (239) 272-0244
Fax (904) 225-1981
E-Mail: drjmcdonough@mindspring.com

Office:
University of North Florida
School of Nursing
1 UNF Drive
Jacksonville, FL 32224
john.mcdonough@unf.edu

Updated October 2018

EXHIBIT
1

Education
Greenfield Community College, Greenfield, Mass., A.S. (Nursing)
St. Anselm's College, Manchester, NH, B.S. (Nursing)
V.A. Medical Center, Des Moines, IA, Certificate in Nurse Anesthesia
Drake University, Des Moines, IA,
Master of Science (adult education)
Doctor of Education (counseling). Dissertation topic: Personality and Addiction Tendency (see "publications" for citation)
University of Tennessee, Memphis, TN, Master of Science in Nursing
State University of New York, Stony Brook, Post Master's Certificate, Family NP Program
Paracelsus Medical University, Salzburg, Austria, Doktor habilitatus (Privatdozent)
In the specialty: Pflegewissenschaft in der anesthesiologie [Nursing Science in Anesthesiology]

Memberships
American Association of Nurse Anesthetists (national Education Committee 2004-2005, national Nominating Committee 2007-2008)
Florida Association of Nurse Anesthetists, President 2016-2017 (Vice President 2002-03, President 2003-04, Director 2006-08)
District of Columbia Association of Nurse Anesthetists, former member & Past President
Iowa Association of Nurse Anesthetists, former member & Past President
District of Columbia Nurses' Association, former member
Florida Nurses' Association
Sigma Theta Tau (Lambda Rho at-large Chapter)
Academy of Clinical Hypnosis
American Board of Medical Psychotherapists (Fellow & Diplomate)

Appointments and Honors
Graduate Teaching Award, University of North Florida, 2013-2014
Fellow, Royal (UK) Society of Medicine, 2013
Florida Board of Nursing (Gubernatorial appointment with Senate confirmation), 2008-2012
Graduate Teaching Award, UNF Brooks College of Health, 2007
Consultant, Iowa Board of Nursing (former)
Named "First Distinguished Alumnus" and Commencement Speaker, Greenfield Community College, 1990
Outstanding Faculty Award, GSN, Uniformed Services University (USU), 1996
University Commendable Service Medal, USU, 1997
University Meritorious Service Medal, USU, 1998
Austrian Military Surgeon General's Distinguished Visitor Award 1997

Other professional activities (not directly related to responsibilities of primary academic Appointment):
Editor-in-Chief, *International Journal of Advanced Nursing Studies*
Member, editorial Board, American Journal of Medicine and Medical Sciences, (2011-present)
Member, National Advisory Board, Cadence Pharmaceuticals
Member, National Advisory Board, GlaxoSmithKline (former)
Member, Scientific Review Panel, Robert Bosch Foundation (Stuttgart, Germany)
Acute Pain, Member, International Editorial Board (former)
The Scientific World, Principal Editor, Anesthesiology Domain (former)

Internet Journal of Advanced Practice Nursing, Member, Editorial Review Panel (former)
Open Airways (formerly *Anesthesiology Bulletin*) Member, Editorial Board (former)
AANA Journal, Editorial Advisory Board (former)
Member, Scientific Advisory Committee, Hill-Rom Europe (former)
Hein u. Cie. Venture Management GmbH, Frankfurt, Germany, Wissenschafterlicher Beirat (scientific advisor) (former)
Member, Education Committee, American Association of Nurse Anesthetists 2004-2005
U.S. Public Health Service, HRSA, Division of Nursing Grant Reviewer 2003-2004
Adjunct Professor, Farleigh Dickinson University, Post-Doctoral Program in Psychopharmacology. Course Director, Biological Concepts II (2003)
FDA/NIH Pulmonary Artery Catheter Clinical Outcome Study Group, Member 1998-99
American Psychological Association, College of Professional Psychology, Member, Expert Working Group to develop knowledge base and certification examination in psychopharmacology 1999-present
Member, Department of Nurse Anesthesia COA Accreditation Self Study Task Force, USUHS
Member, Scientific Review Panel, Tri-Service Nursing Research Group. (Performed review of proposals competing for $ 5 million in TNRG funding, 1996)
AANA Foundation Clinical Research Scholars Program (competitive selection, 1996)
Chair, Faculty Council, USUHS, Graduate School of Nursing (1995-97)
Chair, Ad Hoc Committee on GSN faculty Bylaws
Senator, USUHS Faculty Senate, 1997-1998
Member, USUHS Faculty Welfare Committee, 1997-1998
Guest Faculty, USUHS Office of Continuing Health Professional Education Anesthetic considerations in perioperative nursing during endoscopic surgery: Oct 1994, Feb 1995.
Faculty, Department of Defense Psychopharmacology Demonstration Project, USUHS
Chair, Bylaws Committee, American Association of Nurse Anesthetists 1999-2000

Current Position:
June 2005-Present, Professor of Nursing (tenured)
School of Nursing, Director of Graduate programs
Director Anesthesiology Nursing
University of North Florida, School of Nursing
Responsible for the development, accreditation, implementation and administration of the anesthesia program including: didactic and clinical education for all graduate students at all clinical sites, resource management and faculty development. Coordinator of the curriculum, teaching and admission/progression in all master's and doctoral programs in nursing. In addition to academic responsibilities also maintains an active clinical practice administering anesthesia.

Clinical Privileges
Tampa General Hospital (1,200 beds multispecialty academic Level-I Trauma Center)
Garcia Surgery Institute (former)
UF/Shands Medical Center, Jacksonville, FL (former)
Medical Partners Surgery Center, Jacksonville, FL (former)
Miami Heart Institute, Miami, FL (former)
Mount Sinai Medical Center, Miami, FL (former)
Miami Baptist Medical Center, Miami, FL (former)
DeWitt Army Hospital, Fort Belvoir, VA (former)
Keller Army Community Hospital, United States Military Academy, West Point, NY (former)

Malcolm Grow USAF Medical Center, Andrews AFB, MD (former)
Naples Community Hospital, FL (former)
Greater Southeast Community Hospital, Washington, DC (former)
Dulles Pain Management Center, Sterling, VA (former)
National Naval Medical Center, Bethesda, MD (former)
Countryside Ambulatory Surgery Center, Sterling, VA (former)
Loudoun Hospital Center, Leesburg, VA (former)
Des Moines General Hospital, Des Moines, IA (former)
Tower Medical Clinic, Des Moines, IA (former)
Surgery Center of Des Moines, West Des Moines, IA (former)

Former Positions
January 2005- June 2005
Professor, Anesthesiology Nursing
Florida International University, School of Nursing

July 2000- December 2004
Professor & Director Anesthesiology Nursing
Florida International University, School of Nursing
Responsible for the development, implementation and administration of the program including: didactic and clinical education for all graduate students at all clinical sites, resource management and faculty development. In addition to academic responsibilities also maintains an active clinical practice administering both surgical and obstetrical anesthesia.

Nov 1999-June 2000
Private practice of clinical anesthesia & pain management
Clinical Practice at Miami Heart Institute, Miami, FL
Administrative Offices at Coastal Primary Care, P.L., Naples, FL
Jan 1999- Oct 1999

Professor & Program Director
M.S. in Anesthesiology Program
Barry University, Miami Shores, FL
Responsible for the administration of the program including: didactic and clinical education for all graduate students at all clinical sites, resource management and faculty development. In addition to academic responsibilities also maintains an active clinical practice administering both surgical and obstetrical anesthesia.

Sept 1994-Dec 1998
Director of Clinical Education, Associate Program Director & Associate Professor (tenure track)
Department of Nurse Anesthesia
Graduate School of Nursing
Uniformed Services University of the Health Sciences
Bethesda, MD
Primary responsibility included all clinical instruction of the graduate nurse anesthesia students at all 13 clinical sites and serve as thesis advisor and committee chair for graduate students. Didactic duties include teaching in the following graduate courses: Neuroscience I, Neuroscience II, Health Assessment, Clinical Pathophysiology of Advanced Nursing Practice I, and Role Development in Advanced Nursing Practice. Served as Course Director for the following graduate courses: Basic Principles of Nurse

Anesthesia Practice, Anesthesia Pharmacology, Advanced Principles of Nurse Anesthesia Practice I and Advanced Principles of Nurse Anesthesia Practice II and Operational Readiness. Administer clinical anesthesia on a regular basis.

1975-1994
Employed by Metro Anesthesia, Des Moines, IA, lastly as:
Director, Anesthesia Education & Attending Anesthetist at Des Moines General Hospital

The position of DAE includes a graduate faculty appointment at Mount Marty College. The DAE is the faculty member responsible for all (didactic & clinical) academic activities of the graduate nurse anesthesia students during their final four semesters of graduate study. Served as the chair of the thesis committees for four graduate students each year. Principle investigator of projects which involved human subjects and as such required IRB approval. Along with the graduate students, the DAE coordinated the clinical instruction and evaluation of house staff (MS 3 & 4 and PGY 1) as they rotate through the anesthesia department.

As an Attending Anesthetist, administered general and regional anesthesia to all categories of patients who are undergoing all types (excluding transplants) of surgery. In addition to surgical anesthesia, the department operates a very active pain consultation and management service. Provided consultation to recommend and perform the invasive and/or psychotherapeutic intervention.

Military Experience

Lieutenant Colonel, Nurse Corps, U.S. Army Reserve, retired
Assignments:
USAR, Individual Ready Reserve, 2002
114th Combat Support Hospital, 330th Med Brigade, USAR (wfat: NAAD) 1995-2002
830th Station Hospital USAR (wfat: NAAD) 1992-1995
Chief, Anesthesia Nursing
Active duty during Operation Desert Storm:
Chief, Anesthesia Nursing, USA MEDDAC, U.S. Military Academy, West Point, NY
IMA for Chief, Nurse Anesthesia Branch, (U.S. Army Graduate Program in Anesthesia Nursing)
U.S. Army Academy of Health Sciences, Ft Sam Houston, TX 1989-91. Served as designated RC replacement for, and trained with, the chief of the Army CRNA graduate program in case that AC officer were to be deployed.
Military Academy Liaison Officer (for Iowa), U.S. Military Academy, West Point, NY 1987-88.
Served as admissions representative for the academy on applicants from that area.
ROTC Bn, Iowa State University 1985-1986
Taught emergency medical care, role of RC forces and land navigation to cadets.
USAR Control Group, 1980-1984
830th Station Hospital, USAR, Des Moines, IA 1973-1980
1973-4 Ass't Chief Nurse
1975-80 Anesthetist (supplemental duty: alcohol & drug abuse control officer)
U.S. Army Medical Center, Ft. Gordon, GA (active duty)
1971-1973 1971-2 Head Nurse, Medical ICU
1972-3 Chief, Nursing Specialty Education & Training Section (critical care)
Military Education:
U.S. Army Command and General Staff College, graduate
Army Medical Department Officer Advanced Course (C.C.)
Army Medical Department Officer Basic Course, graduate
Decorations:

Meritorious Service Medal, Army Achievement Medal (2), National Defense Service Medal (2), Army Service Ribbon, Reserve Components Overseas Training Ribbon, Army Reserve Components Medal (w/ mobilization device), Reserve Components Achievement Medal.

Academic Activities

(appointed)

University of Gothenburg, Sweden 2018
Professor

Paracelsus Medical University, Salzburg, Austria 2007
Professor

University of North Florida, School of Nursing, 2004
Professor (tenured) & Director, Graduate Nursing Programs
Director, Nurse Anesthetist Program

Florida International University, School of Nursing (former)
Professor & Director, Anesthesiology Nursing
Chair, Faculty Search Committee, 2003
Member, PhD Program Development Task Force, 2003
Member, PhD Admissions Committee, 2004

Faculty member, Doctoral Study Committee
Institut für Pflegewissenshaft (Institute for Nursing Sciences) Universität Witten, Germany

Farleigh Dickinson University,
Adjunct Professor (post-doctoral program in psychopharmacology) (former)

Barry University, School of Natural & Health Sciences
Professor (former)

Uniformed Services University of the Health Sciences, Graduate School of Nursing
Associate Professor (former)

Mount Marty College, Department of Nurse Anesthesia (former)

Graduate Faculty (Clinical Coordinator) See "former position (DAE)"

University of Osteopathic Medicine & Health Sciences, Departments of Anesthesia & Psychiatry
Adjunct Associate Professor of Surgery (anesthesia): Provided a recurring series of Lectures to medical students (MS 1,2, & 3) for the Departments of Anesthesia & Psychiatry. These lectures dealt with pre-anesthesia evaluation, regional anesthesia techniques, acute & chronic pain, addiction theory and issues related to the psychodynamic view of the development of personality and psychopathology.

Drake University, College of Pharmacy (former)
Adjunct Assistant Professor: Developed and implemented an anesthesia rotation for 5th year students interested in clinical pharmacy. Each of these senior pharmacy students were expected to participate in the preanesthesia evaluation of patients with a view toward potential medication conflicts associated with anesthesia management. Directed the students' exposure to the acute action of drugs on the autonomic and central nervous systems.

(guest faculty)
Emory University, Georgetown University, University of Kansas, Wake Forest University (Bowman Gray School of Medicine)

Publications

Müller-Wolff, T., McDonough, J. (2019) Geschichte der Anästhesie: Spielte immer maßgebliche rolle (trans: The history of anesthesiology: Nurses have always played a significant role). *Anästhesiepflege* 2(19), 2-4

McDonough, J., Loriz, L., Niemczyk, M. (2016) Learning styles and their effect on clinical instruction. In Hendricks, B., Thompson, J. *A Resource for Nurse Anesthesia Educators.* (2nd Ed) Chicago: AANA Publishing

Mangar, D., Sprenker, C., Karlnoski, R., McDonough, J., Dodson, R., Brashears, B., Downes, K., Camporesi, E. (2013) Are anatomical landmark measurements accurate for predicting endotracheal tube depth? *International Journal of Advanced Nursing Studies,* 2 (2) (2013) 66-73.

Machan, M., Monaghan, W., Hogan, G., McDonough, J. (2013) Emerging evidence in infection control: Effecting change regarding use of disposable laryngoscopic blades. *AANA Journal.* (81) 2, 103-108.

Welliver, M., Cheek, D., Redfern, R., Osterbrink, J., McDonough, J. (2013) Worldwide experience with sugammadex sodium: Implications for the United States. *AANA Journal.* 2015 Apr;83(2):107-15.

Macha, K., McDonough, J. (2011) *Epidemiology in Advanced Practice Nursing.* Boston: Jones & Bartlett. ISBN-13: 9780763789961

McDonough, J. (2010) Der praxisorientierte pflegerische Doktorgrad (DNP) in den USA (The practice oriented nursing doctoral degree (DNP) in the USA). *PflegenIntensiv: Die Fachzeitschrift für Intensivpflege und Anästhesie.* 7:4/10 49-50.

McDonough, J., Macha, K., Loriz, L. (2010) Alpha and beta agonists and antagonists. In Oullette, R., & Joyce, J. (Ed) *Pharmacology for Nurse Anesthesiology.* (pp. 323-345) Boston: Jones & Bartlett. ISBN: 9780763786076

McDonough, J., Loriz, L., Macha, K. (2009) Learning styles and their effect on clinical instruction. In Hendricks, B., Thompson, J. *A Resource for Nurse Anesthesia Educators.* (pp. 189-200) Chicago: AANA Publishing

Welliver M, McDonough J, Kalynych N, Redfern R, (2009) The discovery, development, and implications of sugammadex, a selective relaxant Binding agent. *Drug Design, Development, and Therapy.* 2008. 2:49-59

Welliver, M., Groom, J., Pabalate, J, Kalynych, N., McDonough, J., Loriz, L. (2008) Tips for Using Video: Teleconferencing for Distance Education. *Nurse Educator.* 33(4) 149-150.

Harris, A., Welliver, M., Redfern, R., Kalynych, N., McDonough, J. (2007) Orthopaedic Surgery Implications Of A Novel Encapsulation Process That Improves Neuromuscular Blockade And Reversal. *The Internet Journal of Orthopedic Surgery.* Volume 7 Number 2.

McDonough, J., (2007) Die Rolle von CRNAs in Rahmen der schmerztherapeutischen Versorgung in den USA. *Der Schmerz.* Band 21, 34-35.

Welliver, M., McDonough, J. (2007). Anesthetic related advances with cyclodextrins. *TheScientificWorldJOURNAL.* 6, 364-371.

Boyd, A., Eastwood, V., Kalynych, N., McDonough, J. (2006) Clinician perceived barriers to the use regional anesthesia and analgesia. *Acute Pain.* 8(1), 23-27.

Kerns, A., McDonough, J. (2006)/ Tele-video conferencing: Is it as effective as "in person" lectures for nurse anesthesia education? *AANA Journal.* 74(2), 19-21.

Osterbrink, J., McDonough, J., Ewers, A.; Mayer, H. (2005). The occurrence of acute postoperative confusion in patients after cardiac surgery. *TheScientificWorldJOURNAL.* 5, 874-883.

McDonough, J., Osterbrink, J. (2005). Learning styles: An issue in clinical education? *AANA Journal.* 73(2), 89-93.

Osterbrink, J., Mayer, H., Ewers, A.... McDonough, J., *et al.*, (2004) Akute postoperative Verwirrtheit bei kardiochirurgischen Patienten. (Acute postoperative confusion in cardiac surgery patients. Trans.) *Z. Ärztl. Fortbild. Qual. Gesundheit Wes.* (J Quality Assurance in Medicine and Health Sciences.) 98, 761-765.

McDonough, J. (2004). Cardiac Pharmacology, In Nagelhut, J. (Ed), *Nurse Anesthesia.* (pp.196-221) Philadelphia: Elsevier Saunders.

McDonough, J. (2003). Pflegeeinsparungen haben sich in den USA als Fehlschlag erwiesen (Nurses have proven DRGs to be workable in the USA, Trans.) *Die Schwester, Der Pflege.* 42

Osterbrink, J., Mayer, M., Fiedler, C., McDonough, J (2002). Inzidenz und Prävalenz postoperativer akuter Verwirrtheit kardiochirurgischer Patienten nach Bypassoperationen sowie Herzklappenersatz. (Incidence and prevalence of acute postoperative confusion after cardiac surgery, Trans.). *Pflege: Die Wissenschaftliche Zeitschrift für Pflegeberufe* (Journal of Nursing Science) 15, 178-189.

McDonough, J. (1999). American universities and their relationship to venture capital. *Venture Capital: Das Zusammenwirken von Innovatoren und Investoren.* In Spiwoks, M. (Ed), *Sofia-Diskussionsbeiträge zur Institutionenanalyse.* (pp. 5-10), 99 (7).

Rayos, C., McDonough, J. (1999). A comparison of Air Force and U.S. hospitals regarding the availability of pain management services. *Military Medicine*, 164 (12), 900-905.

Bell, D.M., McDonough, J., Ellison, J.S. (1999). Controlled drug misuse by Certified Registered Nurse Anesthetists. *AANA Journal.* 64, 133-140.

Hartgerink, B., McMullin, P., McDonough, J., McCarthy, E. (1998). A guide to understanding informed consent. *CRNA. The Clinical Forum for Nurse Anesthetists.* 9 (4), 128-134.

McCarthy, E., Halliburton, J., Ikirt, J., McAuliffe, M., McDonough, J., et al. (1998). An analysis of a nurse anesthesia program curriculum by decomposition. *AANA Journal.* 65, 443-447.

Cutbush, C., McDonough, J., Clark, K., McCarthy, E. (1998). The effect of intrathecal and epidural analgesia on the length of labor. CRNA. *The Clinical Forum for Nurse Anesthetists.* 9, 106-112.

Malan, TP, Philip, BK, Agre P, McDonough, J. (1996). *The Guardian Series for Anesthesia Health Professionals. No I in a monograph series: Patient Fear of Anesthesia.* NC: Research Triangle Park, Glaxo Inc.

Malan, TP, Agre P, McDonough, J. (1996). *The Guardian Series for Anesthesia Health Professionals. No 2 in a monograph series: The healing power of communication.* NC: Research Triangle Park, Glaxo Inc.

McDonough, J., McMullen, P.C., Phillipsen, N. (1995). Informed Consent: An essential element of safe anesthesia practice. *CRNA: The Clinical Forum for Nurse Anesthetists.* 6, 64-69.

McDonough, J. (1994). *The treatment of postoperative nausea and vomiting. Wrote and presented this videotape used in a nation wide anesthesia CHE program series.* CA: Annenberg Center, Palm Springs.

McDonough, J. (1992). Personality and addiction: A response. *AA NA Journal.* 60.

McDonough, J. (1990). Personality, addiction and anesthesia. *AANA Journal.* 58, 193-200.

McDonough, J. & Quam, S.R. (1990). *General Anesthesia.* In Levy, L. (Ed), *Principles and Practice of Podiatric Medicine.* NY: L. Livingstone Churchill.

McDonough, J. (1989). Personality and Addiction Tendency: An Initial Comparison of graduate students of Nursing and Nurse Anesthesia. In Ann Arbor (Ed) *Doctoral dissertation.* Drake University.1989 (UMI order # 910402 1)

McDonough, J. (1986). Letter to the editor. *Hawkeye Osteopathic Journal.* 4(2), 3-4.

Quam S., McDonough, J. (1985). Spinal Opioids: A new approach to pain relief *Hawkeye Osteopathic Journal.* 3(3), 11-16.

McDonough, J.P.(1985). Anesthesia and infection control in the AIDS patient. In T. Stanley (Ed), *Epidemiology of AIDS.* Carbondale, IL: Educational Research Corp.

McDonough, J. (1976). Blood pressure changes in response to sodium indigotin disulphonate. *AANA Journal.* 44, 211-214.

Research and Project Activities

Principle or Co-Investigator

USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP31004 $80,260 (2018-2019)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP31004 $29,946 (2017-2018)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP29952 $29,697 (2016-2017)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP28650 $35,800 (2015-2016)

USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP27147 $43,544 (2014-2015)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP26019 $36,500 (2013-2014)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP24514 $32,336 (2012-2013)
USPHS, HRSA Nurse Anesthesia Traineeship grant # A22HP21706 $15,800 (2011-2012)
USPHS, HRSA AEN grant # 1D09 HP 09357 3rd yr funded at $476,680 (2010-2011)
USPHS, HRSA Nurse Anesthesia Traineeship grant $2,683 (2010-2011)
USPHS, HRSA AEN grant # 1D09 HP 09357 2nd yr funded at $481,589 (2009-2010)
USPHS, HRSA Nurse Anesthesia Traineeship grant $2,621 (2008-2009)
USPHS, HRSA grant # 1D09 HP 09357 1st yr funded at $618,150 (2008-2009)
USPHS, HRSA grant # 1D09 HP 09357. "Increasing diversity, cultural competence and clinical skills in a Nurse Anesthetist Program" 2008- Approved and funded (estimated at $1.6M).
USPHS, HRSA grant # 1D09 HP 00341 3rd yr funded at $363,639 (2004-2005)
USPHS, HRSA Nurse Anesthesia Traineeship grant $22,193 (2004-2005)
USPHS, HRSA grant # 1D09 HP 00341 2nd yr funded at $349,192 (2003-2004)
USPHS, HRSA Nurse Anesthesia Traineeship grant $7,042 (2002-2003)
USPHS, HRSA grant # 1D09 HP 00341 1st yr funded at $435,159 (2002-2003)
USPHS, HRSA grant # 1D09 HP 00341. "Expanding a Culturally Diverse Nurse Anesthesia Program" 2002-2005 Approved and funded (estimated at $1.15M).
A Double-Blind, Randomized, Placebo-Controlled Study Assessing the Efficacy, Safety, and Pharmacokinetics of Tigan(TM) Suppositories for the Prevention of Postoperative Nausea and Vomiting (PONV). (Co-I) Mt. Sinai Medical Center, 2003. funded at $490,000.
A Phase II, Randomized, Single-Blind, Controlled Clinical Trial Assessing the Efficacy and Safety of Hemolink™ (hemoglobin raffimer) in Subjects Undergoing High-Blood-Loss Orthopedic Surgical Procedures. (Co-I) Mt Sinai Medical Center, 2002. Funded at 55,500.
The Safety of Desflurane versus Isoflurane in Patients with Coronary Artery Disease Undergoing Peripheral Vascular Surgery. (Co-I) Protocol I-653-28. Mt Sinai Medical Center, 2002. Funded at $60,000.
A randomized, double-blind, placebo controlled, multicenter study of single dose ondansetron 8mg and single dose ondansetron 16 mg for the treatment of opioid-induced nausea and emesis in subjects experiencing acute pain. S3AA3013, USUHS, 1997.
Comparison of clinical experiences and outcomes in patients undergoing elective surgery under general anesthesia with remifentanil HCL v. hypnotic/inhalation-based anesthesia. USAA 400 1, USUHS, 1997.
Recovery after general anesthesia with remifentanil HCI v. Hypnotic based fentanyl in patients undergoing outpatient laparoscopic gynecologic surgery. USAA3134, USUHS, 1997.
Comparison of ondansetron and droperidol in the prevention of postoperative nausea and vomiting. J. Cavanaugh, co-investigator. Des Moines General Hospital, 1994.
Lumbar support and prevention of postoperative back pain. R. Cropp, co-investigator. DMGH, 1994.
Effect of intraoperative music on postoperative pain and anxiety. P. Sladky, co-investigator. DMGH, 1993
Comparison of intravenous and topically administered lidocaine in the prevention of postoperative sore throat. R. Hulett, co-investigator. DMGH, 1993.
Comparison of methods of prevention of intraoperative hypothermia. D. Cooper, co-investigator. DMGH, 1992.
Personality and addiction tendency: An initial comparison of graduate students of nursing and nurse anesthesia. Drake University, 1989.

Thesis Research Committees Chaired

(Master of Science in Nursing, GSN, USUHS)
Woods, R (1998). Double blind, placebo controlled study of acupressure to prevent postoperative

nausea and vomiting.
J. Shrader J., (1998). Double blind, placebo controlled study of oral magnesium as an adjunctive treatment for chronic pain.
Ricks, A. (1998). Comparing sedation of pediatric patients for radiological procedures.
Koonce, B.(1998). Compliance of anesthesia providers with universal precautions.
Killpack, J. (1998). Cost analysis of induction agents for outpatient anesthesia.
Burry, M. (1998). Noise and relationship to comfort in Recovery Room.
Moseley, G. (1997). Psychomotor functioning: Comparing remifentanil and fentanyl anesthetics.
Grasso, D. (1997). The relationship between Army CRNA job satisfaction and anticipated turnover.
Strand, K. (1996). *In vitro* determination of bicarbonate dosage to alkalinize local anesthetics to physiological pH.
Stamps, D. (1996). The relationship between Air Force anesthesia providers' satisfaction and anticipated turnover.
Rayos, C. (1996). Availability of pain management services in Air Force facilities and the role of the CRNA in these services.
Cutbush, C. 919960. The effect of epidural narcotics on the first and second stages of labor.
Swanagin, S. (1995). Effectiveness of oxygen delivery methods during transport to PACU.
Martineau, M. (1995). Practices of CRNAs in the Indian Health Service.
Bruening, W. (1995). Use of stethoscopes as intraoperative monitoring.
Moore, J. (1995). Patients' knowledge of who administered their anesthetic.

(Master of Science in Nurse Anesthesia, Mount Marty College)
Cavanaugh, J. (1994). Comparison of ondansetron and droperidol in the prevention of postoperative nausea and vomiting
Cropp, R. (1994). Lumbar support and prevention of postoperative back pain.
Sladky, P. (1994). Effect of intraoperative music on postoperative pain and anxiety.
Hulett, R. (1994). Comparison of intravenous and topically administered lidocaine in the prevention of postoperative sore throat.
Welch, T. (1994). Postoperative hypothermia: A retrospective study.
Toycin, D. (1994). Effect of envelope manipulation on survey response rates.
Cooper, D. (1993). Comparison of methods of prevention of intraoperative hypothermia.
Potter, J. (1992). A study of nurse anesthesia manpower needs in Iowa.

Major Educational Presentations (funded presentations, since 1990)
McCarthy, E., McDonough, J., Apatov, N., Hartgerink, A. (2018) September
USUHS and the history of military nurse anesthesia education. AANA, Boston, MA
McDonough, J. (2018) September
Nurse Anesthesia: Our past, present & future. ID-ANA, Kellogg, ID
Nestler, N., Osterbrink, J., McDonough, J. (2018) September
Pain assessment in patients with dementia. (poster) IASP World Congress. Boston, MA
McDonough, J. (2018) September
General anesthesia without vapors or opioids. University of Ludwigsburg, DE
McDonough, J (2018) (July)
Graduate education for advanced nursing practice. PMU Salzburg, AT
McDonough, J (2018) June
General anesthesia without vapors or opioids. (poster) IFNA World Congress, Budapest, HU
McDonough, J. (2018) May
The DNP: Can it solve your provider shortage? University of Gothenburg, SE

McDonough, J. (2018) May
Statistics: What they will (and will not) tell you about quality. PMU. Salzburg, AT
McDonough, J. (2018)
The role of the APN (CRNA) as an anesthesia provider in the U.S. Kensington University, London, UK
McDonough, J. (2018) April
When is "profound block" indicated? Hattiesburg, MS
McDonough, J. (2018) March
New developments in NMBD reversal. Shreveport, LA
McDonough, J. (2018) March
Non-opioid pain treatment. St. Petersburg, FL
McDonough, J. (2018) March
Monitoring NMBD: How much is enough? Ocala, FL
McDonough, J. (2016) December
Result enhancement with multi-modal anesthesia. Nurse anesthesia SIG. Daytona, FL
McDonough, J. (2016) July
Less opioids promotes better outcomes. MS Association of Nurse Anesthetists, Destin, FL
McDonough, J. (2016) May
Pain management in patients with cardiac disease. IPGE Conference. Las Vegas, NV
McDonough, J. (2016) May
Pain management in total knee arthroplasty. World Congress of Nurse Anesthetists, Glasgow, UK
McDonough, J. (2016) March
Less opioids promotes better outcomes. ID Association of Nurse Anesthetists, Boise, ID
McDonough, J. (2016) March
Less opioids promotes better outcomes. WA Association of Nurse Anesthetists, Seattle, WA
McDonough, J. (2016) March
The role of APRNs in healthcare in the U.S. PMU Institute for Nursing Science. Salzburg, AT
McDonough, J. (2016) February
Quality of APRN care: A potential solution. 12. Stuttgarter Intensivkongress. Stuttgart, Germany
McDonough, J. (2015) December
Result enhancement with multi-modal anesthesia. Nurse anesthesia SIG. New Orleans, LA
McDonough, J. (2015) November
Pain modulation with multi-modal anesthesia. IPGE Conference. Key West, FL
McDonough, J. (2015) October
Translating nursing research to nursing practice. PMU Institute for Nursing Science. Salzburg, AT
McDonough, J. (2015) October
Opioid sparing perioperative management. Georgia Association of Nurse Anesthetists. Savannah, GA
McDonough, J. (2015) September
History and future of nurse anesthesia in the US. University of Amsterdam, Amsterdam, NL
McDonough, J. (2015) September
Anesthesia without vapors or opioids. University of Gronigen. Gronigen, NL
McDonough, J. (2015) August
Analgesia without opioids American Assoc of Nurse Anesthetists, (satellite lect) Salt Lake City, UT
McDonough, J. Osterbrink, J., Kutcher, P. (2015) June
Evaluating pain in demented patients. ICN World Research Congress. Seoul, ROK
McDonough, J. (2015) June
Evaluation and treatment of pain. SC Association of Nurse Anesthetists. Myrtle Beach, SC
McDonough, J. (2015) May
Graduate education for APRNs in the US. International Patient Safety Symposium, Salzburg, AT
McDonough, J. (2015) March

Evaluation of the cardiac patient. Annual Anesthesia Conference, University of Michigan, Flint

McDonough, J. (2015) February
Centrally acting non-opioids. Assembly of Anesthesia School Faculty (satellite lect), New Orleans, LA

McDonough, J. (2015) February
Methods to disseminate research. Paracelsus Medical University, Salzburg, AT

McDonough, J. (2014) December
Multimodal approach to analgesia. Birmingham Nurse Anesthesia Society, Birmingham, AL

McDonough, J. (2014) September
Neuromuscular blocking drugs. University of Belize. Belize City, Belize, CA

McDonough, J. (2014) September
Analgesia without opioids American Association of Nurse Anesthetists, (satellite lecture) Orlando, FL

McDonough, J. (2014) August
Multi modal analgesia as a foundational treatment. Rutgers University, Newark, NJ

McDonough, J. (2014) April
Advanced practice nursing as a healthcare solution. Paracelsus Medical University, Salzburg, AT

McDonough, J. (2014) March
Pathophysiology of pain. UNF Conference on Anesthesia Safety. Amelia Island, FL

McDonough, J. (2014) March
Research methods in nursing. Paracelsus Medical University, Salzburg, AT

McDonough, J. (2014) February
The history and future of anesthesia nursing. Old Dominion University, Norfolk, VA

McDonough, J. (2014) January
Non-opioid anesthesia and analgesia. National internet based live "webinar"

McDonough, J. (2013) December
How can research drive pain treatment? Paracelsus Medical University, Salzburg, AT

McDonough, J. (2013) October
Opioid addiction in anesthesia specialists. University of Amsterdam, Amsterdam, NL

McDonough, J. (2013) September
Pain in the cardiac patient. Nebraska Association of Nurse Anesthetists, Lincoln, NE

McDonough, J. (2013 August
Applying the WHO ladder to acute pain. American Association of Nurse Anesthetists, (satellite lecture) Las Vegas, NV

McDonough, J. (2013) July
Quantitative research related to pain measurement. Salzburg Nursing Conference. Salzburg, AT

McDonough, J. (2013) April
Evaluation and management of pain across the life span. ICN World Congress, Melbourne, AU

McDonough, J. (2013) April
Evaluation and management of acute pain. Indiana Association of Nurse Anesthetists. Indianapolis, IN

McDonough, J. (2013) April
Multi-modal pain in practice. Coast to Coast Anesthesia Seminars, St. Petersburg, FL

McDonough, J. (2013) April
Multi-modal pain in practice. Ohio Association of Nurse Anesthetists. Columbus, OH

McDonough, J. (2013) April
Effective use of non-opiod analgesia. Arizona Association of Nurse Anesthetists. Scottsdale, AZ

McDonough, J. (2013) March
Effective use of non-opiod analgesia. Pennsylvania Association of Nurse Anesthetists. Pittsburgh, PA

McDonough, J. (2013) March
Multi-modal pain in practice. UNF Conference on Anesthesia Safety. Amelia Island, FL

McDonough, J. (2013) March
Interdisciplinary collaboration to improve patient safety. Paracelsus Medical University Conference. Salzburg, Austria.

McDonough, J. (2012) October
Graduate education as a driver of quality patient care. University of Amsterdam Anesthesiology Conference. Amsterdam, the Netherlands.
McDonough, J., (2012, October)
Pathophysiology as a driver of pain treatment. Pennsylvania Association of Nurse Anesthetists. Bedford Springs, PA.
McDonough, J., (2012, September)
Does academic education for nurses improve patient outcomes? Bavarian Conference on Nursing Education. Stuttgart, DE
McDonough, J., (2012, September)
Non-opioid pain therapy. Kentucky Association of Nurse Anesthetists. Louisville, KY
McDonough, J., (2012, September)
Pain evaluation in the cardiac patient after non-cardiac surgery. Massachusetts Association of Nurse Anesthetists. Plymouth, MA
McDonough, J., (2012, August)
Multimodal pain management in the acute patient. American Association of Nurse Anesthetists, San Francisco, CA.
McDonough, J., Loriz. L., Osterbrink, J. (2012, July)
Multimodal pain management across the lifespan. Workshop at STTI World Nursing Research Conference. Brisbane, AU
McDonough, J., (2012, May)
International Exchanges: Their value in nurse anesthesia education. IFNA World Congress. Ljubjana, Solvenia.
McDonough, J., (2012, May)
Pain Management Programs: What are appropriate goals? University of Amsterdam Anesthesia Conference. Amsterdam, the Netherlands.
McDonough, J., (2012, April)
Non-opiod, non-NSAID options for acute postoperative pain. District of Columbia Association of Nursing Anesthetists. Arlington, VA.
McDonough, J., (2012, March)
Improvement of patient outcomes associated with specialty nursing education. University of Regensburg, Southern Germany Clinical Nursing Conference.
McDonough, J., (2012, March).
How the concept of the "Pain Nurse" improves outcome. Pain Nurse Course. University Clinic of Münster, Germany.
McDonough, J., (2011, September)
The graduate education required to prepare Advanced Practice Nurses. University of Amsterdam Anesthesia Conference. Amsterdam, the Netherlands.
McDonough, J. (2011, September)
Post operative pain management in the elderly: Does cognitive status matter? European Society of Regional Anesthesia. Dresden, Germany.
McDonough, J. (2011, September)
Anesthesia and pain management as a nursing specialty. AMC, University of Amsterdam. Amsterdam, The Netherlands.
McDonough, J. (2011, August)

Multimodal pain therapy: Is narcotic sparing really possible? (satellite lecture) American Association of Nurse Anesthetists, Boston, MA

McDonough, J. (2011, June)
Multimodal pain therapy: How is it actually done? North Illinois Anes Conference, Skokie, IL

McDonough, J. (2011, June)
Non-opioid analgesia: Contemporary concepts. North Alabama Anes Conference. Birmingham. AL

McDonough, J. (2011, April) *Academic preparation for nursing: Why is it crucial?* Deutscher Berufsverband für Pflegeberufe (German Society for Nursing) Dusseldorf, Germany.

McDonough, J. (2011, January)
Cardiovascular evaluation of preoperative patients. FANA. Orlando, FL.

McDonough, J. (2010, December)
CRNAs und deren Tätigkeit im amerikanischen Gesundheitswesen. (The role of the CRNA in the US Healthcare System) Deutsche Interdisziplinäre Vereinigung für Intensiv- und Notfallmedizin. (German Interdisciplinary Society for Intensive and Emergency Medicine) Hannover, Germany.

McDonough, J. (2010, October)
Multimodal Pain management. International Transplant Nurses Society World Congress. Minneapolis, MN

McDonough, J. (2010, September)
Ansprüche an die akademische Bildung zu Advanced Practice Nurses. *The graduate education required to prepare Advanced Practice Nurses.* Deutsche Gesellschaft für Fachkrankenpflege (German Society of Nurse Specialists) Stuttgart, Germany

McDonough, J. (2010, May)
Akademische pflegerische Weiterbildungsstrukturen: amerikanische Perspektiven zur Sicherung des Fachkräftenachwuchses (Academic graduate education for nurses: The American perspective on securing the future of advanced practice) Deutscher Pflegekongress (German Nursing Congress), Berlin

McDonough, J. (2010, May)
Academic preparation of ARNPs in the US. , Medical University of Innsbruck Anesthesiology Conference, Austria

McDonough, J. (2010, January)
Evaluation and management of pain. Florida Association of Nurse Anesthetists. Orlando, FL.

McDonough, J. (2009 October)
Objectives of translational research. PMU, Salzburg, Austria.

McDonough, J. (2009, October)
Effective analgesia and sustained strength associated with femoral nerve sheath infusion with fentanyl in total knee replacement. European Society of Regional Anesthesia Congress. Salzburg, Austria.

McDonough, J. (2009, May)
Dementia: A growing drain on the U.S. healthcare system
National Dementia Symposium, PMU, Salzburg, Austria

McDonough, J. (2009, May)
Advanced practice nursing: Effects on improving patient care
Florence Nightingale Keynote Lecture, Austrian Day of Nursing, Salzburg, Austria

McDonough, J. (2009, January)
Anesthesia and trauma: A multisystem approach. Florida Assoc. of Nurse Anesthetists, Orlando, FL.

McDonough, J. (2009, January)
Case management: Improving patient care through coordination. Salzburg, AT

McDonough, J. (2008, October)
The scientific method: An essential component of nursing education. Salzburg, Austria

McDonough, J. (2008, July)

A graduate curriculum to prepare nurse anesthetists. St. Luke's College of Nursing, Tokyo, Japan
The role of the CRNA in the US healthcare system. St. Luke's International Medical Center, Tokyo, Japan

McDonough, J. (2008, June)
Psychiatric conditions: Effect on pain evaluation and management. Paracelsus Medical University, Salzburg, Austria.
McDonough, J. (2008, June)
The role distant education in international nursing education. Glasgow Caledonian University, Glasgow, Scotland, UK
McDonough, J. (2008, June)
Hypertension and tachycardia: Prevention and treatment during anesthesia
Medical errors: Causes and cures. California Association of Nurse Anesthetists, San Diego, CA
McDonough, J. (2008, April)
Addiction in nurse anesthesia: Current status of the problem. DC Association of Nurse Anesthetists, Washington, DC
McDonough, J. (2007, October)
Health Disparities Related to Culture: A Nursing Perspective. Symposium on Cultural Diversity. Paracelsus Medical University, Salzburg, AT.
McDonough, J. (2007, October)
The roll of the CRNA in pain treatment in the USA. German Pain Congress. Berlin, Germany
McDonough, J. (2007, July)
Influence of a Breathing Technique on Postoperative Incision Pain. Sigma Theta Tau International Nursing Research Conference, Vienna, Austria.
McDonough, J. (2007, June)
The diagnosis of cardiac disease in the preoperative patient. California Association of Nurse Anesthetists, San Diego, CA
McDonough, J. (2007, April)
The diagnosis or cardiac disease in the preoperative patient
Pain management: Why is it so important in cardiac patients?
Premiere Anesthesia Seminars, Acapulco, MX
McDonough, J. (2007, April)
Nurse anesthesia as a profession: Where have been and where are we now? DC Association of Nurse Anesthetists, Washington, DC
McDonough, J. (2007, March)
Anesthesia for cardiac patients for non-cardiac surgery. NV Assoc of Nurse Anesthetists, Las Vegas, NV
McDonough, J. (2007, March)
Addiction in anesthesiology. Nurse Anesthesia Faculty Associates Conference, Orlando, FL
McDonough, J. (2007, February)
Pain and the ramifications of management. Florida Association of Nurse Anesthetists, Orlando, FL
McDonough, J. (2006, October)
Community-based nursing in the US health care system: The role of advanced practice nurses
Ernst Moritz Arndt Universität, Greifswald, Germany
McDonough, J. (2006, August)
A Vision Realized: The vital link between past and present. American Association of Nurse Anesthetists, 75th Anniversary Meeting, Cleveland, OH
McDonough, J. (2006, July)
Acute and chronic pain management. Montana Association of Nurse Anesthetists, Billings, MT
McDonough, J. (2006, June)

Risk stratification for potential postoperative complications. Greater Washington Anesthesia Interest Group, Washington, DC

McDonough, J. (2006, June)
Barriers to the use Regional Anesthesia and Analgesia (poster). 8th World Congress of Nurse Anesthetists, Lausanne, CH

McDonough, J. (2006, June)
Risk stratification for potential postoperative complications
Establishing an acute pain treatment program in a community hospital setting
Management of chronic pain
Premier Anesthesia Seminars, Barcelona, Spain

McDonough, J. (2006, May)
Prevention of peri-anesthetic nausea and vomiting. North Carolina Association of Nurse Anesthetists, Charlotte, NC

McDonough, J.(2006, April)
Medical errors: Causes and cures. DC Association of Nurse Anesthetists, Anesthesia Safety Conference, Washington, DC

McDonough, J. (2006, March)
Prevention and treatment of common perioperative complications. Virginia Association of Nurse Anesthetists, Richmond, VA

McDonough, J. (2006, February)
Prevention and treatment of common perioperative complications. Florida Association of Nurse Anesthetists, Orlando, FL

McDonough, J. (2005, November)
Establishing an acute pain treatment program in a community hospital setting
Management of chronic pain
Arizona Association of Nurse Anesthetists, Scottsdale, AZ

McDonough, J. (2005, October)
Medical errors: Causes and cures
Evaluation of cardiac disease in patients for non-cardiac surgery
New Mexico Association of Nurse Anesthetists, Albuquerque, NM

McDonough, J. (2005, October)
Prevention of perioperative complications. Florida Association of Nurse Anesthetists, Jacksonville, FL

McDonough, J. (2005, September)
Prevention of perioperative complications. Illinois Association of Perianesthetic Nurses, Peoria, IL

McDonough, J. (2005, September)
The effect of DRGs on nurse managers: 25 years of US experience. Die Auswirkungen von DRGs auf das Pflegemanagement: 25 Jahre Erfahrung aus den USA.
Internationale Konferenz Pflege und Pflegewissenschaft (IKPP) (Trans: International Congress for Nursing and Nursing Science)

McDonough, J. (2005, August)
Multidisciplinary approaches in prevention of perianesthetic complication. American Association of Nurse Anesthetists Annual Meeting, Washington, DC

McDonough, J. (2005, June)
Anästhesiepflege in den USA – Ein Modell für die Anästhesiepflege in Europa? (Trans. Nurse Anesthetists in the USA: A Model for Nurse Anesthetists in Europe?) Europäischer Anästhesiepflegekongress, D-Weimar (2nd European Nurse Anesthesia Congress, Weimar, Germany)

McDonough, J. (2005, 2005, June)

Role of the nurse anesthetist in pain treatment in the US. "Pain Nurse" specialty course. Uni-Kinik Nürnberg, Germany

McDonough, J. (2005, April)
Risk stratification for potential postoperative complications. DC Association of Nurse Anesthetists, Anesthesia Safety Conference, Washington, DC

McDonough, J. (2004, December)
The anesthetic management of cardiac patients for non-cardiac surgery
Management of acute postoperative pain.
Nevada Association of Nurse Anesthetists, Las Vegas, NV

McDonough, J. (2004, November)
CRNAs und deren Tätigkeit im amerikanischen Gesundheitswesen (trans: The role of CRNAs in the American healthcare system.)
Der neue deutsche nationale „Expertenstandard" zur Behandlung von Schmerz (Trans: The new German national "expert standard" for the treatment of pain)
Deutsche Gesellschaft für Fachpflege (German Society of Nursing Specialties) Hanover Germany

McDonough, J. (2004, October)
Pflegewissenschaft als Praxisdisziplin aus dem Blickwinkel der USA (Insbesondere: Die Rolle von "Nursing Science" und "Nurse Specialists" in einem neuen Gesundheitsfürsorgemodell) (Trans: Nursing science as a practical foundation practice [Specifically: The role of nursing science and nurse specialists in a new healthcare system])
Europäischer Pflegekongress (European Nursing Congress) Munich, Germany

McDonough, J. (2004, September)
Chronic vs. acute pain: What are the differences?
Pain and its effect on cardiac physiology
Nebraska Association of Nurse Anesthetists, Lincoln, NE

McDonough, J. (2004, August)
Pain treatment: Preoperative and postoperative considerations
North Carolina Association of Nurse Anesthetists, Wilmington, NC

McDonough, J.(2004, August)
Increasing postop laparoscopy patient satisfaction. American Association of Nurse Anesthetists, (satellite lecture) Seattle, WA

McDonough, J. (2004, June)
Nurses' roles in the new DRG system. Hill-Rom Nursing Education Conference, Bad Sulza, Germany

McDonough, J. (2004, May)
Evaluation and management of acute postoperative pain
Blood pressure control during surgery
Surgical care of patients with cardiac disease
Institute for Post-Graduate Education Series, La Vegas, NV

McDonough, J. (2004, April)
Prevention of postoperative nausea
Anesthesia for chemical a biological casualties
DC Association of Nurse Anesthetists, Anesthesia Safety Conference. Washington, DC

McDonough, J. (2004, March)
Cardiac evaluation of the preoperative patient
Management of blood pressure during the perioperative period
Coast to Coast Anesthesia Seminars, St. Martin, NA

McDonough, J. (2004, February)

Neuromuscular blocking drugs: contemporary uses and safety. Florida Association of Nurse Anesthetists, Ocala, FL

McDonough, J. (2004, January)
Prevention of medical errors
Acute and chronic pain management
Institute for Post-Graduate Education Series, St. Thomas, USVI

McDonough, J. (2003, October)
Role of the nurse anesthetist: Future directions for healthcare in Belgium. Universitaire Ziekenhuizen, Catholic University of Leuvan, Belgium

McDonough, J. (2003, August)
Presiding Officer, Session on trauma anesthesia
Pain in the trauma patient. American Association of Nurse Anesthetists Annual Meeting, Boston, MA

McDonough, J. (2003, July)
Regional anesthesia in pain management
Control of hypertension in the perioperative period
Massachusetts Review Conference, Falmouth, MA

McDonough, J. (2003, April)
Pharmacoeconomic of PONV. American Society of Peri-anesthesia Nurses National Conference, Albuquerque, NM

McDonough, J. (2003, April)
Anesthesia for chemical and biological injury patients
Management of acute pain
Northwest Anesthesia Seminars, Miami, FL

McDonough, J. (2003, April)
Prevention of medical errors
Infectious disease and anesthesia, Institute for Post-Graduate Education Series, Charleston, SC

McDonough, J. (2003, January)
Pathophysiology of pain. Pain Management Conference, Uni-Kinik Nürnberg, Germany

McDonough, J. (2003, January)
Role of the nurse anesthetist in the US healthcare system. Universität Witten/Herrdecke, Germany

McDonough, J. (2003, January)
Role of the nurse anesthetist in the US healthcare system. Catholic University of Leuvan, Belgium

McDonough, J. (2003, January)
Prevention of medical errors
Anesthesia for chemical and biological injury patients
Nevada Association of Nurse Anesthetists, Lake Tahoe, NV

McDonough, J. (2002, October)
Anesthesia for chemical and biological injury patients
Management of acute pain
Evaluation f the cardiac patient for non-cardiac surgery
Kansas Association of Nurse Anesthetists Educational Conference, Wichita, KS

McDonough, J. (2002, October)
New options in PONV prevention and treatment
Anesthesia for chemical and biological injury patients
California Association of Nurse Anesthetists Educational Conference, Pasadena, CA

McDonough, J. (2002, October)
Cardiovascular pharmacology

Florida Association of Nurse Anesthetists Educational Conference, Sarasota, FL

McDonough, J. (2002, June)
Anesthesia for chemical and biological injury patients
Management of chronic pain
Evaluation f the cardiac patient for non-cardiac surgery
Institute for Post-Graduate Education Series, Orlando, FL

McDonough, J. (2002, June)
Reduction of medical errors
Prevention and treatment of PONV
Florida Association of Nurse Anesthetists Educational Conference, Sanibel, FL

McDonough, J. (2002, April)
Anesthesia for chemical and biological injury patients
Addiction in anesthesia providers
Cherry Blossom Anesthesia Conference, Washington, DC

McDonough, J. (2002, March)
Anesthesia for chemical and biological injury patients
Evaluation f the cardiac patient for non-cardiac surgery
Coast to Coast Anesthesia Seminars, Cozumel, MX

McDonough, J. (2002, January)
Management of chronic pain
Evaluation of the cardiac patient for non-cardiac surgery
Northwest Anesthesia Seminars, Las Vegas

McDonough, J. (2002, January)
Rational approach to NMBDs. Florida Association of Nurse Anesthetists Educational Conference, Daytona Beach, FL

McDonough, J. (2001, October)
Evaluation of the cardiac patient
Addiction in anesthesia providers
Management of chemical & biological casualties
Coast to Coast Anesthesia Seminars, Vail, CO

McDonough, J. (2001, September)
Management of chemical & biological casualties
Prevention & treatment of PONV
Regional anesthesia in pain management
Florida Association of Nurse Anesthetists Educational Conference, Palm Beach, FL

McDonough, J. (2001, June)
Control of blood pressure during surgery
Anesthesia care of chemical and biological injuries
Non-pharmacological treatment of pain
Northwest Anesthesia Seminars, Montreal, Canada

McDonough, J. (2001, June)
Florida Association of Nurse Anesthetists Educational Conference, Naples, FL
Recognition of domestic abuse
Cardiac evaluation of the preop patient
Florida Association of Nurse Anesthetists Educational Conference, Naples, FL

McDonough, J. (2001, June)
Management of chronic pain
Addiction in anesthesia providers
Anesthesia care of chemical and biological casualties

Northwest Anesthesia Seminars, Key West, FL

McDonough, J. (2001, April)
HIV and anesthesia
Cardiac evaluation
Management of acute pain
Northwest Anesthesia Seminars, Washington, DC

McDonough, J. (2001, March)
Evaluation and treatment of pain
Cardiac evaluation of the preop patient
Management of hypertension
Northwest Anesthesia Seminars, Panama City, FL

McDonough, J. (2001, March)
Prevention and treatment of PONV
Addiction in anesthesia providers
New England Assembly of Nurse Anesthetists, Nashua, NH

McDonough, J. (2001, March)
Prevention and treatment of PONV
Anesthesia care of chemical and biological casualties
Utah Association of Nurse Anesthetists, Salt Lake City, UT

McDonough, J. (2001, January)
Evaluation of the cardiac patient
Control of blood pressure
EKG evaluation in preop patients
Northwest Anesthesia Seminars, Lake Tahoe, NV

McDonough, J. (2000, October)
Evaluation of the cardiac patient
HIV disease and anesthesia implications
Recognition of domestic abuse
Addiction and personality in anesthesia providers
Florida Association of Nurse Anesthetists Educational Conference, St Petersburg, FL

McDonough, J. (2000, October)
Evaluation of the cardiac patient
Control of hypertension
Interpretation of the preoperative EKG
Coast to Coast Anesthesia Seminars, Plymouth, MA

McDonough, J. (2000, April)
HIV disease and anesthesia implications
Rapacuronium: What is the role its role in anesthesia practice today?
Cherry Blossom Anesthesia Conference, Washington, DC

McDonough, J. (2000, May)
Nonpharmacological treatment of pain. International Trauma Anesthesia & Critical Care Society, World Conference, Mainz, Germany

McDonough, J. (2000, January)
Management of acute & chronic pain
Intrathecal analgesia in obstetrics
Nonpharmacological treatment of pain
Institute for Post Graduate Education, Lake Tahoe, NV

McDonough, J. (2000, January)
Management of acute postoperative pain

Intrathecal analgesia in obstetrics
Nonpharmacological treatment of pain
Anesthesiology and addiction
Coast to Coast Anesthesia Seminars, Las Vegas, NV

McDonough, J. (2000, January)
Recognition of domestic violence. Florida Association of Nurse Anesthetists, Daytona Beach, FL

McDonough, J. (1999, October)
Management of acute postoperative pain
Evaluation of chronic pain
Coast to Coast Anesthesia Seminars, Plymouth, MA

McDonough, J. (1999, September)
Anesthesia implication of chemical & biological injuries
Anesthesia providers to substance abusing patients: A comparison of traits
South Dakota Association of Nurse Anesthetists, Sioux Falls SD

McDonough, J. (1999, June)
Recognition of domestic violence
Addition in anesthetists
Florida Association of Nurse Anesthetists, Sanibel, FL

McDonough, J. (1999, June)
New narcotics in anesthesia
Anesthesia concerns in HIV & other infectious diseases
Coast to Coast Anesthesia Seminars, San Francisco, CA

McDonough, J. (1999, May)
Regional anesthesia techniques in pain management
Behavioral evaluation of pain patients
Management of acute postoperative pain
Anesthesia in HIV & other infectious diseases
Institute for Post-Graduate Education Series, Las Vegas, NV

McDonough, J. (1999, March)
Anesthesia in HIV & other infectious diseases
Preanesthesia evaluation of the cardiac patient
Nonpharmacologic treatment of pain
Anesthesia implication of chemical & biological injuries
DC Association of Nurse Anesthetists, Washington, DC

McDonough, J. (1999, March)
Prevention and treatment of PONV using $5HT_3$ blockade
Anesthesia providers to substance abusing patients: A comparison of traits
Utah Association of Nurse Anesthetists, Salt Lake City, UT

McDonough, J. (1999, February)
Nonpharmacological treatment of pain
Spinal and epidural narcotics
Anesthesia for childbirth
Institute for Post-Graduate Education Series, Puerto Vallarta, Mexico

McDonough, J. (1998, October)
American universities and their relation to venture capital (Trans)
Amerikanishe Universitäten und ihr verhältnis zu venture Kapital
Universität Frankfurt, Frankfurt, Germany

McDonough, J. (1998, August)
Evaluation of the CV system in perioperative patients

Treatment of acute and chronic pain
Arrowhead Region Anesthesia Conference, Duluth, MN

McDonough, J. (1998, August)
Personality and addiction tendency: Comparing students to substance abuse patients. AANA Annual Meeting, Nashville, TN

McDonough, J. (1998, May)
Personality and addictive tendency: A comparative study
Hypnosis as pain treatment
New Jazz in Anesthesia, NW Anesthesia Seminars, New Orleans, LA

McDonough, J. (1998, April)
Anesthesia for patients with biological & chemical injuries (trans)
Anästhesie bei Patienten mit Verletzungen nach biologischen und chemischen Ereignissen.
(XXXii. Internationaler Kongress für Wehrmedizin, Wien, Österreich)
32nd International Congress for Military Medicine, Vienna, Austria (trans)

McDonough, J. (1998, April)
Alternative methods of pain treatment. DC ANA Cherry Blossom Conference on Anesthesia Safety, Arlington, VA

McDonough, J. (1998, March)
New narcotics in anesthesia practice
Evaluation and management of pain
HIV and infectious disease in anesthesia
Utah Association of Nurse Anesthetists, Salt Lake City, UT

McDonough, J. (1997, October)
Evaluation and management of pain
Regional anesthesia techniques used in pain management
Non-pharmacological pain treatment
Intrathecal analgesia in obstetrics
New Mexico Association of Nurse Anesthetists, Albuquerque, NM

McDonough, J. (1997, September)
Assessment of pain: acute & chronic
Non-pharmacological methods of pain management
Spinal & epidural opioids in obstetrical anesthesia
Institute for Post-Graduate Education Series, Kiawah Island, SC

McDonough, J. (1997, August)
Ester hydrolyzed narcotics in anesthesia
Addiction in the anesthesia provider
Arrowhead Region Anesthesia Conference, Duluth, MN

McDonough, J. (1997, July)
Anesthesia for cardiac patients for non-cardiac surgery
Infection control: HIV and anesthesia
Addiction in the anesthesia provider
Hypnosis: It's place in anesthesia practice
Anesthesia Update Series, Padre Island, TX

McDonough, J. (1997, July)
Remifentanil: Implications of ultra-short acting narcotics
Prevention and treatment of PONV

Addiction in the anesthesia provider
Encore Symposium, Glacier Park, MT

McDonough, J. (1997, July)
Addiction in the anesthesia provider
Assessment of pain: physical & psychological
Controversies in anesthesia for cardiac surgery
Infectious disease and anesthesia practice
Anesthesia Update, Falmouth, MA

McDonough, J. (1997, June)
Infectious Disease (HIV & hepatitis) in anesthesia
Evaluation of the cardiac patient
Hypnosis and other alternative methods of pain management
Addiction and its relation to personality in anesthesia providers
NW Anesthesia Seminars, Key Largo, FL

McDonough, J. (1997, April)
The non-pharmacologic treatment of pain
World Congress of Nurse Anesthetists, Vienna, Austria

McDonough, J. (1997, April)
(Austrian Ministry of Defense, Surgeon General Guest Lecture, Austrian Army Hospital, Vienna)[trans]
Nichtmedikamentöse Schmerztherapie.
(The treatment of pain without medication) [trans]
Abteilung Sanitätswesen, Bundesministerium für Landesverteidigung, Österreich

McDonough, J. (1997, April)
The nonpharmacologic treatment of pain. DCANA Cherry Blossom Anesthesia Conference, Washington, DC

McDonough, J. (1997, April)
Uses of neuromuscular blocking drugs
Evaluation and management of patients with cardiovascular disease
Dannemiller Anesthesia Educational Foundation, San Antonio, TX

McDonough, J. (1997, March)
Addiction in anesthesia specialists
Bowman Gray School of Medicine, Wake Forest University, Visiting Professor Lecture

McDonough, J. (1996, November)
Keynotes in Anesthesia, Key West, FL 11/96
Evaluation of the cardiovascular patient
Evaluation and management of pain
Psychological factors effecting pain
Regional anesthesia update
Keynotes in Anesthesia, Key West, FL

McDonough, J. (1996, October)
Addiction in anesthesia providers
Spinal and epidural narcotics in pain
Oregon Association of Nurse Anesthetists, Eugene, OR

McDonough, J. (1996, August)
Newer concepts in neuromuscular blocking agents
Management of acute and chronic pain
Prevention and treatment of postoperative nausea

Northwest Anesthesia Seminars, San Francisco, CA

McDonough, J. (1996, August)
Spinal and epidural narcotics in obstetrics
American Association of Nurse Anesthetists Annual Meeting, Philadelphia, PA

McDonough, J. (1996, June)
Chronic pain management
Psychological factors in acute and chronic pain
Northwest Anesthesia Seminars, Washington, DC

McDonough, J. (1996, May)
New concepts in neuromuscular blockade Addiction in anesthesia providers. Utah Association of Nurse Anesthetists, Salt Lake City, UT

McDonough, J. (1996, May)
Addiction in anesthesia providers. University of Maryland, Shock Trauma Center

McDonough, J. (1996, February)
Addiction and personality in anesthesia providers
Evaluation and management of pain Hypnosis as an adjunct to anesthesia care
Prevention and treatment of PONV
HIV update
Northwest Anesthesia Seminars, Cancun, Mexico

McDonough, J. (1996, January)
Evaluation and management of acute and chronic pain
Prevention and treatment of PONV
Anesthesia Seminars, Breckenridge, CO

McDonough, J. (1996, January)
Evaluation and management of acute and chronic pain
Prevention and treatment of PONV
Encore Anesthesia Seminars, Park City, UT

McDonough, J. (1995, September)
Examination and assessment of the cardiovascular system
Use drugs affecting the cardiovascular system
Wisconsin Association of Nurse Anesthetists

McDonough, J. (1995, August)
Workshop on spinal and epidural anesthesia. American Association of Nurse Anesthetists, National Meeting, Minneapolis, MN

McDonough, J. (1995, July)
Hypnosis in anesthesia practice
Addiction in health care providers
Evaluation and treatment of acute pain
Northwest Anesthesia Seminars, Myrtle Beach, SC

McDonough, J. (1995, May)
Clinical evaluation of pain
Psychological evaluation of pain
Treatment of chronic pain
HIV and other infectious disease hazards in anesthesia practice
Addiction theory related to health care providers
Northwest Anesthesia Seminars, St. Petersburg, FL

McDonough, J. (1995, May)
Diagnosis and prevention of addiction in anesthesia providers
Prevention and treatment of postoperative nausea and vomiting

South Dakota Association of Nurse Anesthetists, Rapid City, SD

McDonough, J. (1995, May)
Use of serotonin blockade in treating nausea after surgery. Alabama Association of Nurse Anesthetists, Sandestin, FL

McDonough, J. (1995, April)
Prevention and treatment of post anesthesia nausea. Wisconsin Association of Nurse Anesthetists, Spring Pharmacology Conference, Madison, WI

McDonough, J. (1995, March)
Role of serotonin blockade in postoperative care. Chicago Society of Nurse Anesthetists, Chicago, IL

McDonough, J. (1995, January)
Causes & treatment of postoperative nausea. Madigan Army Medical Center, Tacoma, WA

McDonough, J. (1995, January)
New approaches to the prevention & treatment of postoperative vomiting. El Paso Area Association of Nurse Anesthetists, El Paso, TX

McDonough, J. (1995, January)
The use of serotonin blockade in the treatment of postoperative nausea. Southern Illinois. Association of Nurse Anesthetists, Mt. Vernon, IL

McDonough, J. (1994, December)
Prevention and treatment of postoperative nausea and vomiting. St Louis Area Nurse Anesthesia Meeting, St. Louis, MO

McDonough, J. (1994, October)
Use of 5HT3 blockers in the perioperative patient. Minnesota Association of Nurse Anesthetists, Minneapolis, MN

McDonough, J. (1994, October)
Prevention and treatment of postoperative nausea and vomiting. Houston Area PACU Nurses Association, Houston, TX

McDonough, J. (1994, July)
Workshop instructor for spinal and epidural anesthesia and analgesia.
American Association of Nurse Anesthetists Annual Meeting, Washington, DC

McDonough, J. (1994, July)
Created CHE teleconference for national broadcast on the prevention and management of postoperative nausea. Teleconference scheduled for periods from 10/94-5/95 to include approximately 200 anesthesia departments nationally. Annenberg Center, Palm Springs, CA

McDonough, J. (1994, June)
Anesthesia and infectious diseases (HIV & HBV)
Theories of addiction
Evaluation and management of acute and chronic pain.
Northwest Anesthesia Seminars, Padre Island, TX

McDonough, J. (1994, March)
Evaluation and management of pain
Prevention of addiction in anesthesia providers.
DC Association of Anesthetists, Arlington, VA

McDonough, J. ((1993, October)
Anesthesia member of a multidisciplinary program panel regarding the uses of antiemetic medications and their indications in surgical patients. Glaxo Pharmaceuticals National Meeting, Dallas, TX

McDonough, J. (1993, August)
Instructed at workshop on invasive monitoring and central line placement. American Association of Nurse Anesthetists, National Meeting, San Francisco, CA

McDonough, J. (1993, June)

Evaluation of acute and chronic pain
Workshop on hypnosis techniques.
American Association of Osteopathic Specialists National Meeting, New Orleans, LA

McDonough, J. (1993, April)
Impaired anesthesia provider and hypnosis techniques. DC Association of Nurse Anesthetists, Arlington, VA
McDonough, J. (1993, March)
Regional anesthesia techniques to treat pain
Addiction theory.
TX Association of Nurse Anesthetists, San Antonio, TX
McDonough, J. (1992, May)
Relationship between addiction and personality in anesthesia specialists. American Dental Society of Anesthesiologists National Meeting, Fort Worth, TX
McDonough, J. (1992, February)
Evaluation of pain
Addiction theory
Claims of fraud and abuse.
California Association of Nurse Anesthetists, Long Beach, CA
McDonough, J. (1991, March)
Stress management. Texas Association of Nurse Anesthetists, Ft Worth, TX
McDonough, J. (1990, August)
Lectured and presented research results on personality and addiction. American Association of Nurse Anesthetists, National Meeting, Atlanta, GA
McDonough, J. (1990, June)
Pain management.
Nurse Anesthesia Faculty Associates, National Meeting, Hilton Head, SC
McDonough, J. (1990, April)
Personality and addiction. Emory University Research Symposium on Impaired Nurses, Atlanta

Volunteer Professional/Community Service
Florida Board of Nursing, Chair, Probable Cause Panel
Florida Association of Nurse Anesthetists, President (2016-2017)
Florida Association of Nurse Anesthetists, President-Elect (2015-2016)
Florida Association of Nurse Anesthetists, President (former)
District of Columbia Association of Nurse Anesthetists, Former President & Vice President
Iowa Association of Nurse Anesthetists
Formerly, Chair Government Relations and Impaired Provider Committees, President, Vice-President, Chair, Education Committee.
Iowa Board of Nursing
Formerly, member, Advanced Practice Nursing Committee and consultant on nurse anesthesia affairs, chair of the task force (anesthesia) on legislative rules construction to implement advanced practice nursing in Iowa.
Governor's (Iowa) Health Care Reform Council
Former member, Committee of Health Law and Legal Barriers, Subcommittee on Anti-trust Issues
Des Moines General Hospital (former)
Member, Corporate Board, Des Moines General Hospital Company
Member, Intern & Resident Training Committee, Intensive Care Committee,

Transfusion Committee, Resuscitation Committee

Licensure, Certifications & Additional Training (certificate numbers available on request)

State of Florida
Registered Nurse & Advanced Practice Registered (Nurse Anesthetist)
State of Maryland (inactive)
Registered Nurse & Advanced Practice Registered (Nurse Anesthetist)
Commonwealth of Virginia (inactive)
Registered Nurse & Advanced Practice Registered Nurse (Nurse Anesthetist)
District of Columbia (inactive)
Registered Nurse & Advanced Practice Registered Nurse (Nurse Anesthetist)
State of Iowa (inactive)
Registered Nurse & Advanced Registered Nurse Practitioner (Nurse Anesthetist)
AANA, Council on Certification, Certified Registered Nurse Anesthetist
American Board of Medical Psychotherapy
Diplomate & Fellow
Advanced Cardiac Life Support
Pediatric Life Support
Advanced Trauma Life Support

Avocations

Sailing (USCG Merchant Mariner Credential: "Master of steam, motor and auxiliary sail vessels up to 50 tons, [domestic] including commercial towing assistance, on near [200 nm] coastal waters".), aviation (FAA certificates: commercial pilot; instrument rating; single and multiengine, land), skiing, music, reading,

NH Board of Nursing

Position Statement regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)

Information obtained from www.nurseanesthesiologistdescriptor.com (2018), MacKinnon, M., & Rodriguez, J.

Background:

In 1902, Dr. M.J. Seifert coined the term "anesthesiology" and defined it as "the science that treats the means and methods of producing various degrees of insensibility to pain with or without hypnosis. **An Anesthetist is a technician and an Anesthesiologist is the specific authority on anesthesia and anesthetics".** Given the graduate level academic preparation, advanced practice skill set, and autonomous level of responsibility, Certified Registered Nurse Anesthetists are not technicians.

In American society, over 160 different professions utilize the suffix "-ologist" to simply denote experts in a field of study and is not exclusively associated with a medical degree or physicians. Audiologist, cosmetologist, technologist, epidemiologist, histologist are just some of numerous examples.. John M. Wilke, Examining Attorney for the U.S. Patent and Trademark Office (USPTO), recently found that "anesthesiologist" alone was "descriptive in nature"[1].

Within a global context, "Anesthetist" or "Anaesthetist" is the professional term for those administering anesthesia throughout much of the western world, including Great Britain, Canada, and Australia. No country, except the United States utilizes two different titles for independently practicing professionals who offer the same service.

Clarity with professional descriptors:

Further confusion has arisen by Anesthesiologist Assistants (AAs) utilizing the term "Anesthetist", for both professional introductions and as evidenced by the URL of their professional website www.anesthetist.org. AAs meet the technical definition of the term "anesthetist" or "technician", however AAs have vastly different foundational training and experience when compared to Nurses and Physicians and therefore by educational preparation

[1] Mike MacKinnon attempted to trademark "nurse anesthesiologist" in 2018. Registration was refused because the applied-for mark merely describes the provider of applicant's services. Trademark Act Section 2. Wilke goes on to infer that "anesthesiologist" is generic while "physician" and "nurse" are specific, and that both physicians and nurses deliver anesthesia services.

EXHIBIT 2

and law, cannot function as independent providers. It is both confusing and inaccurate to use the term "Anesthetist" to equally identify a licensed and often autonomous provider with a non-licensed provider who has a restricted skillset and who can only practice with Physician Anesthesiologist direction and delegation.

Given the above, when the descriptor "Nurse Anesthesiologist" is used, audiences know that it is a professional nurse who is an expert in anesthesia and distinguishes nurse anesthesiologists, physician anesthesiologists, dentist anesthesiologists, from anesthesiologist assistants. It is paramount that patients and public know who is delivering their care and use of the nurse anesthesiologist descriptor does just that: It identifies the foundational education of the provider and further identifies them as an expert in anesthesiology.

Evidence:

Research from the American Society of Anesthesiologists confirms that 55% of the country does not recognize an "anesthesiologist" as a physician. Physicians who specialize in anesthesiology have recognized this and have adopted their own accurate descriptor of "Physician Anesthesiologist". Additionally, it is common for patients, surgeons, and even our perioperative colleagues to refer to CRNAs as an "anesthesiologist" while being fully cognizant of our Advanced Practice Registered Nurse education, advanced practice nurse licensure, and as credentialed members of medical staffs. In this context, the optional use of "Nurse Anesthesiologist" to describe CRNAs would provide transparency, remove confusion, and recognize CRNAs as fully qualified [and often autonomous] anesthesia providers.

National Association Recognition:

Given the clarity provided by the "Nurse Anesthesiologist" descriptor, the American Association of Nurse Anesthetists (AANA) has [by way of a thorough assessment by an Association selected task force] now recognizes "Nurse Anesthesiologist" as an optional descriptor for the profession. This title will be instrumental in accurately describing the profession, training, expertise, and scope of practice to the public. Furthermore, this transparent descriptor is essential for legislative progress, advocacy, and the continued safe and cost-effective care to the citizens of New Hampshire who would otherwise be unserved.

The optional "Nurse Anesthesiologist" descriptor does not seek to expand CRNA practice, demean another profession's practice, or misrepresent the position and foundational education of CRNAs. Rather, it provides a transparent term to accurately describe the CRNA's advanced practice nursing role, as well as our expertise in the provision of full-range and often autonomous anesthesia services.

Therefore:

The New Hampshire Board recognizes "Nurse Anesthesiologist" and "Certified Registered Nurse Anesthesiologist" as optional, accurate descriptors. It is not a title change and is not an attempt to create an expanded or misleading scope of practice. It is recognized at both the national and state level as a transparent and lawful term of address, introduction, and is permitted for use on personal and professional communications without sanction.

Final Order No. DOH-19-1500-DS-MQA
FILED DATE SEP 13 2019
Department of Health
By: Deputy Agency Clerk

STATE OF FLORIDA
BOARD OF NURSING

IN RE: PETITION FOR DECLARATORY STATEMENT OF

JOHN P. MCDONOUGH, A.P.R.N., C.R.N.A., Ed.D.,
/

FINAL ORDER

This matter came before the Board of Nursing (Board) on August 8, 2019, in Fort Myers, Florida, for consideration of the above-referenced Petition for Declaratory Statement. Petitioner was present with his counsel of record, Cynthia A. Mikos, Attorney at Law. The Notice of Petition for Declaratory Statement was published on July 16, 2019 in Vol. 45, No. 137, in the Florida Administrative Register. The petition, filed on behalf of John P. McDonough, APRN, CRNA, Ed.D., inquired as to whether the Board of Nursing would discipline him if he were to refer to himself as a "nurse anesthesiologist".

The petition and its attachments are hereby incorporated and attached to this Final Order as Exhibit A.

MOTIONS TO INTERVENE

The Florida Association of Nurse Anesthetists (FANA) filed a Motion to Intervene on July 31, 2019. Glenn Thomas, Attorney at Law, appeared on behalf of the FANA. After review and discussion, the Board granted the Florida Association of Nurse Anesthetists' Motion to Intervene.

The Florida Medical Association, Inc., Florida Society of Anesthesiologists, Inc., and Florida Osteopathic Medical Association, Inc. (Intervenors), filed a Motion to Intervene on August 1, 2019. After review and discussion, the Board denied Intervenors' Motion to Intervene based on

its determination that these organizations do not have standing to intervene. The Intervenors were represented at the hearing by Jason David Winn, Attorney at Law.

Intervenors argue that they will be substantially affected by the Board's decision as to whether the Board of Nursing would discipline one of its Certified Registered Nurse Anesthetist licensees for describing himself and his professional job duties as being a "nurse anesthesiologist". Intervenors state that their substantial interests would be affected because patients and potential patients use "anesthesiologists" because the patients recognize that the term refers to a physician licensed pursuant to Chapter 458 or 459, Florida Statutes. Intervenors state that they routinely participate in advocacy efforts on behalf of their members who are licensed physicians. After review and discussion, the Board voted to deny Intervenors Motion to Intervene citing the organizations' lack of standing.

The Board of Nursing has authority to issue this Final Order pursuant to Section 120.565, Florida Statutes, and Rule 28-105.0027, Florida Administrative Code.

Rule 28-105.0027, Florida Administrative Code, provides, in part, "Persons other than the original parties to a pending proceeding whose substantial interests will be affected by the disposition of the declaratory statement and who desire to become parties may move the presiding officer for leave to intervene."

In *Agrico Chemical Company v. Department of Environmental Regulation*, 406 So. 2d 478, 482 (Fla. 2d DCA 1981), the court held that to have standing the petitioner must demonstrate: an actual and immediate injury and that the injury is of a type or nature which the proceeding was designed to protect.

Intervenors failed to demonstrate an actual and immediate injury. Petitioners state that the public will be confused by a nurse describing him or herself as an anesthesiologist. However, this injury is speculative as there was no concrete injury described. Intervenors failed to describe how any confusion caused by the "nurse anesthesiologist" moniker would cause an actual and immediate injury to a patient to the physicians. Any injury that may be caused by the moniker is speculative and hypothetical.

The Petition for Declaratory Statement seeks the Board of Nursing's opinion on whether its licensee is subject to discipline for specified conduct. Neither the Florida Board of Medicine nor the Florida Board of Osteopathic Medicine has the authority to discipline a licensee who is licensed by the Florida Board of Nursing. Therefore, the Board's determination on whether or not it would subject one of its licensees to disciplinary action for describing himself or herself as a "nurse anesthesiologist" has no impact on an allopathic or osteopathic physician.

A review of the allopathic and osteopathic medicine practice acts (Chapter 458 and 459, Florida Statutes, respectively) does not reveal that the term "anesthesiologist" is protected and requires licensure from either of the two Medical Boards. The only time the term "anesthesiologist" is used in either practice act is when describing the duties of an anesthesiology associate (Section 458.3475 and Section 459.023, Florida Statutes) and both statutes specify that the definition of the term "anesthesiologist" applies only as the term is used in that particular and specific section of each of the medical practice acts. Therefore, it is not a protected term to be used exclusively by a physician licensed pursuant to either Chapter 458 or 459, Florida Statutes.

Based on the foregoing, the Board voted to deny Intervenors' Motion to Intervene.

PETITION FOR DECLARATORY STATEMENT (FINDINGS OF FACT)

The facts set forth in Exhibit A are hereby adopted and incorporated herein by reference as the findings of fact of the Board.

CONCLUSIONS OF LAW

1. The Board of Nursing has authority to issue this Final Order pursuant to Section 120.565, Florida Statutes, and Rule 28-105, Florida Administrative Code.

2. The Petition filed in this cause is in substantial compliance with the provisions of 120.565, Florida Statutes, and Rule 28-105.002, Florida Administrative Code.

3. Section 120.565, Florida Statutes, reads as follows:

> 120.565. Declaratory statement by agencies
> (1) Any substantially affected person may seek a declaratory statement regarding an agency's opinion as to the applicability of a statutory provision, or of any rule or order of the agency, as it applies to the petitioner's particular set of circumstances.
> (2) The petition seeking a declaratory statement shall state with particularity the petitioner's set of circumstances and shall specify the statutory provision, rule, or order that the petitioner believes may apply to the set of circumstances. (3) The agency shall give notice of the filing of each petition in the next available issue of the Florida Administrative Weekly and transmit copies of each petition to the committee. The agency shall issue a declaratory statement or deny the petition within 90 days after the filing of the petition. The declaratory statement or denial of the petition shall be noticed in the next available issue of the Florida Administrative Weekly. Agency disposition of petitions shall be final agency action

4. Rule 28-105.001, Florida Administrative Code, reads as follows:

> A declaratory statement is a means for resolving a controversy or answering questions or doubts concerning the applicability of statutory provisions, rules, or orders over which the agency has authority. A petition for declaratory statement may be used only to resolve questions or doubts as to how the statutes, rules, or orders may apply to the petitioner's particular circumstances. A declaratory statement is not the appropriate means for determining the conduct of another person or for obtaining a policy statement of general applicability from an agency.

5. Petitioner, John P. McDonough, APRN, CRNA, Ed.D., is licensed by the Board of Nursing and therefore, is a substantially affected person. As a licensed Advanced Practice Registered Nurse (APRN) and Registered Nurse (RN), Petitioner is subject to disciplinary action if he were to violate the Nurse Practice Act (Chapter 464, Florida Statutes) or a rule promulgated pursuant thereto in Rule Chapter 64B9, Florida Administrative Code.

6. Section 464.012, Florida Statutes, provides, in part, that any person who wishes to be licensed as an Advanced Practice Registered Nurse must be licensed as a registered nurse and hold specialty certification. Petitioner holds specialty certification in anesthesiology, and therefore, was licensed as a Certified Registered Nurse Anesthetist (CRNA).

7. In his Petition and testimony before the Board, Petitioner stated that he would continue to identify himself as a CRNA as required by Florida law. Petitioner stated that he would use the term "nurse anesthesiologist" when describing himself or his professional duties.

8. There are multiple grounds for disciplinary action enumerated in Section 456.072 and Section 464.018, Florida Statutes. The Board of Nursing is the sole authority for taking disciplinary action against its licensees, see Section 464.002, Florida Statutes.

9. After review of the Petition and attachments, the Board voted to approve Petitioner's use of the term "nurse anesthesiologist" as a descriptor for himself and his job duties; although Petitioner must continue to use the CRNA license designation in every circumstance in which it is required. This description does not change or modify the scope of practice of a CRNA.

10. The Board's response to this Petition addresses solely the question propounded by the Petitioner and only addresses the specific issue raised in the petition. The Board's conclusion is

based solely on the Board's application of the factual circumstances outlined in the Petition to the pertinent statutory and rule provisions set forth above.

DONE AND ORDERED this 12th day of September 2019.

BOARD OF NURSING

Joe R. Baker, Jr., Executive Director
for Kathryn L. Whitson, MSN., RN. Chair

NOTICE OF APPEAL RIGHTS

Pursuant to Section 120.569, Florida Statutes, Respondents are hereby notified that they may appeal this Final Order by filing one copy of a notice of appeal with the Clerk of the Department of Health and the filing fee and one copy of a notice of appeal with the District Court of Appeal within 30 days of the date this Final Order is filed.

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing has been furnished by **Certified Mail** to: **John P. McDonough, APRN, CRNA., Ed.D.**, c/o **Cynthia A. Mikos**, Attorney at Law, Johnson Pope Bokor Ruppel & Burns, LLP, 401 East Jackson Street, Suite 3100, Tampa, Florida 33602; **Christopher Nuland**, Attorney at Law, Law Offices of Christopher Nuland, P.A., 4427 Herschel Street, Jacksonville, Florida 32210; and **Jason Winn**, 2709 Killarney Way, Tallahassee, Florida 32309-6200; by email to: **Deborah B. Loucks**, Senior Assistant Attorney General, deborah.loucks@myfloridalegal.com; and **Louise R. St. Laurent**, General Counsel, Department of Health, Louise.StLaurent@flhealth.gov; on this 13th day of September, 2019.

John P. McDonough, APRN, CRNA.,Ed.D
c/o Cynthia A. Mikos, Esq.
Johnson Pope Bokor Ruppel & Burns, LLP
401 East Jackson St., Ste. 3100
Tampa, FL 33602

Certified Article Number
9414 7266 9904 2140 1018 02
SENDER'S RECORD

Angel Sanders
Deputy Agency Clerk

Christopher Nuland, Esq.
4427 Herschel Street
Jacksonville, FL 32210

Certified Article Number
9414 7266 9904 2140 1017 72
SENDER'S RECORD

Jason Winn
2709 Killarney Way
Tallahassee, FL 32309-6200

Certified Article Number
9414 7266 9904 2140 1017 89
SENDER'S RECORD

TO: Mark Whitten, Chief
Bureau of HCPR

FROM: Joe Baker, Jr., Executive Director
FBON

DATE: September 11, 2019

RE: Delegation of Authority

The following managers are delegated authority for the Board office on Thursday, September 12, 2019, through Tuesday, October 1, 2019:

9/12; 9/25; 9/27-30	Sherri Sutton-Johnson	Director, Nursing Education
9/13-24	Nicole Benson	Program Ops Administrator
9/26; 10/1	Dontavia Wilson	Regulatory Supervisor

Thank you.

JBjr/ms

NH Board of Nursing

Position Statement regarding the use of Nurse Anesthesiologist as a communication tool and optional descriptor for Certified Registered Nurse Anesthetists (CRNAs)

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August 1, 2019

Florida Board of Nursing
Attention: Executive Director
4052 Bald Cypress Way, Bin C-02
Tallahassee, FL 32399-3258
MQA.Nursing@flhealth.gov

FLORIDA MEDICAL ASSOCIATION, INC., FLORIDA SOCIETY OF ANESTHESIOLOGISTS, INC., AND FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION, INC. MOTION TO INTERVENE IN FLORIDA BOARD OF NURSING'S CONSIDERATION OF THE PETITION FOR DECLARATORY STATEMENT IN OPPOSITION OF PETITIONER JOHN P. MCDONOUGH, A.P.R.N., C.R.N.A., ED.D

The Florida Medical Association, Inc. (FMA), Florida Society of Anesthesiologists, Inc. (FSA), and Florida Osteopathic Medical Association, Inc. (FOMA), each by and through its undersigned counsel, hereby respectfully petition the Florida Board of Nursing to allow each of the Petitioners to intervene in the Board of Nursing's discussion of the above Petition in opposition to the Petitioner, pursuant to Rule 28.106.205, Florida Administrative Code. In support of the proposed Intervenors' motion, each of the proposed Intervenors hereby states:

1. The Florida Medical Association, Inc. is a Florida-based trade organization comprised of over 22,500 Florida physicians, many of whom are anesthesiologists. As a result, members of the FMA, as physicians, would be adversely affected if providers not licensed pursuant to Chapter 458 or 459 of the Florida Statutes were to employ the use of the term "anesthesiologist." The FMA routinely participates in advocacy efforts on

behalf of its members in matters concerning the rights and obligations of physicians, including efforts by other professions to dilute such rights.

2. FMA's address, phone number and facsimile number are as follows:

1430 Piedmont Drive East, Tallahassee, FL 32308

(850) 224-6496

Facsimile: (850) 224-6667

Email: legal@flmedical.org

3. Petitioner FMA's counsel's name, address, phone number, facsimile number, and email are Jeffery Scott, Esq., 1430 Piedmont Drive East, Tallahassee, Florida 32308. (850) 224-6496. Facsimile (850) 224-6667. Email: JScott@flmedical.org.

4. The Florida Society of Anesthesiologists, Inc. ("FSA") is a Florida-based trade organization comprised of approximately 2,300 Florida physicians specializing in Anesthesiology and its subspecialties, each of whom is referred to as an "anesthesiologist. Members of the FSA, as physicians, would be adversely affected if providers not licensed pursuant to Chapter 458 or 459 of the Florida Statutes were to employ the use of the term "anesthesiologist." The FSA routinely participates in advocacy efforts on behalf of its members in matters concerning the rights and obligations of physicians, including issues regarding the differentiation between anesthesiologists and nurse anesthetists.

5. FSA's address, phone number and facsimile number are as follows:

701 Brickell Avenue, Suite 550

Miami, FL 33131

(786) 300-3183

Facsimile: (310) 437-0585

Email: executiveoffice@fsahq.org

6. Petitioner FSA's counsel's name, address, phone number, facsimile number, and email are Christopher L. Nuland, Esq., 4427 Herschel Street, Jacksonville, FL 32204. (904) 355-1555. Facsimile (904) 355-1585. Email: nulandlaw@aol.com.

7. The Florida Osteopathic Medical Association (FOMA) is a Florida-based professional trade organization comprised of nearly 7,500 Florida physicians, each of whom practices medicine and would be entrusted with providing the direct supervision required by the Petition. Members of FOMA, as physicians, would be adversely affected if providers not licensed pursuant to Chapter 458 or 459 of the Florida Statutes were to employ the use of the term "anesthesiologist." FOMA routinely participates in advocacy efforts on behalf of its members in matters concerning the rights and obligations of physicians, including efforts by other professions to dilute such rights.

8. FOMA's address, phone number and facsimile number are as follows:

2544 Blairstone Pines Drive, Tallahassee, FL 32301

(850) 878-7363

Facsimile: (850) 942-7538

Email: admin@foma.org

9. Petitioner FOMA legal counsel's name, address, phone number, facsimile number, and email are Jason Winn, Esq., 2709 Killarney Way, Suite 4, Tallahassee FL 32309. (850) 222-7199. Facsimile (850) 222-1562. Email: jwinn@winnlaw.com.

10. A substantial number of the members of each of the Petitioners routinely use the term "anesthesiologist," with the understanding that patients and potential patients recognize the term to refer to a physician licensed pursuant to Chapter 458 or 459 of the Florida Statutes. Therefore, a substantial number of the members of each of the proposed Intervenors would be substantially affected by the Board's decision in this matter, as they have a unique and vested interest in the outcome of the subject Petition. Therefore, the substantial interests of the proposed Intervenors will be affected by the proceeding, and each of the proposed Intervenors therefore has standing to participate in these proceedings. *See Florida Home Builders Association v. Department of Labor and Employment Security,* 412 So.2d 351 (Fla. 1982).

11. The Petitioner is explicitly licensed as a "registered nurse anesthetist," pursuant to Florida Statute 464.012(1)(a). The use of the term "nurse anesthesiologist" is not found in statute and is therefore likely to mislead and/or confuse the public, in violation of Florida Statute 456.072(1)(a).

12. Contrary to the statements made in the Petition, Florida law does, in fact, make clear that the term "anesthesiologist" refers to physicians licensed

under Chapters 458 and 459. Florida Statute 458.3475(1)(a) defines an "anesthesiologist" thusly:

"Anesthesiologist" means an allopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education or its equivalent; and who is certified by the American Board of Anesthesiology, is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

13. Likewise, Florida Statute 459.023(1)(a) also defines "anesthesiologist" thusly:

"Anesthesiologist" means an osteopathic physician who holds an active, unrestricted license; who has successfully completed an anesthesiology training program approved by the Accreditation Council on Graduate Medical Education, or its equivalent, or the American Osteopathic Association; and who is certified by the American Osteopathic Board of Anesthesiology or is eligible to take that board's examination, is certified by the American Board of Anesthesiology or is eligible to take that board's examination, or is certified by the Board of Certification in Anesthesiology affiliated with the American Association of Physician Specialists.

14. Such definitions are consistent with the accepted definition of "anesthesiologist," as Merriam-Webster Dictionary defines an "anesthesiologist" as "a ***physician*** specializing in anesthesiology." (emphasis added).

15. Moreover, the Legislature has made clear its intention as to the acceptable terms by which CRNAs may refer to themselves, as Florida Statute 464.015(6) states that "Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title 'Certified Registered Nurse Anesthetist' and the abbreviations 'C.R.N.A.'" or 'nurse anesthetist.'"

16. Based upon the above, Petitioners aver that the intended conduct of Petitioner creates a term that is internally inconsistent, as an anesthesiologist is, by definition, a physician. As a result, any representation of Petitioner as a "nurse anesthesiologist" will necessarily confuse and mislead the public and thereby create a potential violation of Florida Statute 456.072 and/or Florida Statute 464.018.

17. Moreover, the Petition asks for a Statement that is likely to be interpreted as a general rule. Although an agency has an obligation to issue a declaratory statement explaining how a statute or rule applies in a petitioner's particular circumstances , even if the explanation would have a broader application than to the petitioner, if the statement has such a broad and general application that it meets the definition of a rule, the agency must initiate the rulemaking process. *International Society of Medical Hair Removal, Inc. v. Department of Health*, 183 So.2d 3d 1138, 1144 (Fla 1st DCA 2015).

18. The authority of an agency to issue a declaratory statement is limited by Florida Statute 120.565 to a determination "as to the applicability of a statutory provision...to the petitioner's particular set of circumstances. " *Lennar Homes, Inc. v. Department of Business and Professional Regulation, Division of Florida Land sales. Condominiums and Mobile Homes*, 888 So. 2d 50, 53 (Fla. 1st DCA 2004).

19. In the instant case, however, the Board is being asked to ascertain whether any certified registered nurse anesthetist who is appropriately

trained and licensed may use the term "nurse anesthesiologist." In essence, the Petitioner is requesting the Board to adopt a statutory interpretation that would be applicable to each and every certified registered nurse anesthetist in Florida to allow them to use the term "anesthesiologist."

20. When an agency is called upon to issue a declaratory statement "which would require a response of such a general and consistent nature as to meet the definition of a rule, the agency should either decline to issue the statement or comply with the provisions of Section 120.54 governing rulemaking." *Agency for Health Care Administration v. Wingo*. 697 So.2d 1231, 1233 (Fla. 1st DCA 1997). Because the question presented by the Petition is overly broad, granting the Petition would constitute an unlawful non-rule policy and should therefore be dismissed.

21. The Petitioners have conferred with the Petitioner's counsel, who indicates that she will object to the proposed intervention.

WHEREFORE, the FMA, FSA, and FOMA, each respectfully requests that, pursuant to s. 120.565, Florida Statutes, it be allowed to intervene in the subject proceeding in opposition to the Petitioner and that the Board of Nursing either issue a Declaratory Order in opposition to Petitioner or dismiss the Petition for Declaratory Statement.

Respectfully submitted this 1st day of August, 2019.

Christopher L. Nuland

Christopher L. Nuland, Esq.

FLORIDA BAR NO: 890332

LAW OFFICES OF CHRISTOPHER L. NULAND, P.A.

Counsel for Petitioner Florida Chapter, American College of Physicians, Services, Inc.

4427 Herschel Street

Jacksonville, FL 32210

(904) 355-1555

Facsimile: (904) 355-1585

nulandlaw@aol.com

Certificate of Service

I hereby certify that a copy of the foregoing was served upon the Petitioner, Joseph P. McDonough, APRN, CRNA, Ed.D, through his counsel, Cynthia A. Mikos, Esq., 401 East Jackson Street, Suite 3100, Tampa, FL 33602 by first-class mail and by email cyntham@jpfirm.com, to Deborah Loucks, Office of Attorney General, The Capitol, PL-01, Tallahassee 32399 by courier and via email to deborah.loucks@myfloridalegal.com, upon the Florida Department of Health, Agency Clerk, via U.S. Mail and courier to 4052 Bald Cypress Way, Bin A-02, Tallahassee, FL 32399, and upon the Board of Nursing by courier and email at 4052 Bald Cypress Way, Bin C-02, Tallahassee, FL 32399-3258, email Joe.Baker@flhealth.gov. on this 1st day of August, 2019.

Christopher L. Nuland

Christopher L. Nuland

STATE OF FLORIDA
DEPARTMENT OF HEALTH
BOARD OF NURSING

IN RE: PETITION FOR DECLARATORY STATEMENT BY JOHN MCDONOUGH, CRNA, APRN, Ed.D, BEFORE THE BOARD OF NURSING

_____/

FLORIDA ASSOCIATION OF NURSE ANESTHETISTS' MOTION TO INTERVENE

The **Florida Association of Nurse Anesthetists**, by and through the undersigned counsel and pursuant to Section 120.565, Florida Statutes, and Rule 28-105.0027, Florida Administrative Code, respectfully moves the State of Florida Board of Nursing for leave to intervene as a party in the above-styled proceeding, and alleges:

The Intervenor - Florida Association of Nurse Anesthetists

1. The Intervenor's name, address and telephone number: Florida Association of Nurse Anesthetists (hereinafter "FANA"), 222 South Westmonte Drive, Suite 101, Altamonte Springs, Florida 32714, (407) 774-7880. For purposes of this proceeding, all contact information for FANA is that of the undersigned counsel.

2. The Petition for Declaratory Statement (hereinafter the "Petition") by John McDonough, CRNA, APRN, Ed.D (hereinafter the "Petitioner") was filed with the Department of Health on July 10, 2019, and noticed in the Florida Administrative Register on July 16, 2019.

3. Founded in 1936, FANA's membership consists of more than 3,700 Certified Registered Nurse Anesthetists ("CRNAs") and student registered nurse anesthetists currently licensed in Florida. CRNAs practice in every setting in which anesthesia is delivered: traditional hospital surgical suites and obstetrical delivery rooms; critical access hospitals;

ambulatory surgical centers; the offices of dentists, podiatrists, ophthalmologists, plastic surgeons, and pain management specialists; and U.S. military, Public Health Services, and Department of Veterans Affairs healthcare facilities. Nurse anesthetists have been the main providers of anesthesia care to U.S. military personnel on the front lines since WWI, including current conflicts in the Middle East. CRNAs provide comprehensive anesthesia care to patients before, during and after surgical and obstetrical procedures, and are the primary anesthesia professionals in rural and medically underserved areas.

Substantial Interests of Intervenor

4. Petitioner asks whether he may describe himself as, or his professional duties as those of, a "nurse anesthesiologist" without subjecting his Florida nursing licenses to discipline under Section 456.072, Florida Statutes, or Section 464.018, Florida Statutes.

5. One of FANA's primary functions is to represent the common interests of its members before various regulatory agencies in the State of Florida, including the Board of Nursing. The Declaratory Statement requested by Petitioner seeks an interpretation of statutes and rules which govern the practice of CRNAs in Florida.

6. The issue described by Petitioner would substantially affect FANA's members, many of whom also work in both clinical and academic settings. The outcome of the proceedings will impact future conduct of FANA members and will indicate the likelihood of disciplinary action against those members.

7. Any substantially affected party can intervene in a declaratory statement proceeding before an agency. *See e.g., Chiles v. Dep't of State, Div. of Elections*, 711 So. 2d 151, 155 (Fla. 1st DCA 1998).

8. Based on the foregoing, FANA has standing to intervene in this Petition for Declaratory Statement on behalf of its members.

The Petition is Legally Sufficient

9. FANA anticipates an argument in opposition to the Petition on the grounds that the question presented exceeds the proper scope of a declaratory statement because it would constitute a broad policy statement by the Board, which amounts to an unpromulgated rule. FANA urges the Board to reject such an argument.

10. The authority of an agency to issue a declaratory statement is limited by section 120.565 to a determination "as to the applicability of a statutory provision ... to the petitioner's particular set of circumstances." *Society for Clinical & Medical Hair Removal, Inc. v. Department of Health*, 183 So. 3d 1138, 1142–44 (Fla. 1st DCA 2015).

11. The Court in *Society for Clinical & Medical Hair Removal* pointed out that prior to 1996, the authority of an agency to issue a declaratory statement was limited to issues that applied only to the party seeking the declaration because section 120.565 required the declaratory statement to set out the agency's opinion as to the applicability of a statute or rule "to the petitioner in his or her particular set of circumstances **only**." *Id.* at 1143 (emphasis added). However, the word "only" has been deleted from section 120.565, and in *Chiles v. Department of State*, 711 So.2d 151 (Fla. 1st DCA 1998), this change was construed to mean that "a petition for declaratory statement need not raise an issue that is unique" and that "there is no longer a requirement that the issue apply only to the petitioner." *Chiles* at 154.

12. In *Florida Department of Business and Professional Regulation, Division of Pari–Mutuel Wagering v. Investment Corp. of Palm Beach*, 747 So.2d 374 (Fla.1999), the Florida Supreme Court explained that the 1996 amendments to section 120.565 were "meant to

dispel any confusion that only the most narrowly drawn declaratory statement having an absolutely unique application was permissible." *Id.* at 383. In short, an agency has an obligation to issue a declaratory statement explaining how a statute or rule applies in the petitioner's particular circumstances even if the explanation would have a broader application than to the petitioner. *Society for Clinical and Medical Hair Removal, supra* at 1144.

13. In the present case, the Petitioner has set forth particular circumstances, which include his responsibilities related to the administration of the anesthesia program at the University of North Florida, his clinical practice and his involvement in multiple professional associations. He has not asked whether a CRNA in Florida, generally, may refer to themselves as a "nurse anesthesiologist"; he has asked whether *he* may refer to *himself* or *his* professional duties as those of a "nurse anesthesiologist."

14. As the Florida Supreme Court has stated, an agency has an obligation to issue a declaratory statement explaining how a statute or rule applies in the petitioner's particular circumstances even if the explanation would have a broader application than to the petitioner.

15. For the forgoing reasons, the Petition does not exceed the proper scope of a declaratory statement and it is legally sufficient.

The Petition Should be Approved

16. Although still rarely used in Florida, the descriptors "nurse anesthesiologist" and "certified registered nurse anesthesiologist" are used synonymously with "nurse anesthetist" and "certified registered nurse anesthetist" throughout the United States, and the use of the terms is continuing to expand. The titles are used in both clinical and academic settings by CRNAs.

17. As Petitioner points out, in a 2018 position statement, the New Hampshire Board of Nursing officially recognized "Nurse Anesthesiologist" and "Certified Registered Nurse Anesthesiologist" as "optional, accurate descriptors." However, at its July 2019 meeting, the Arizona

State Board of Nursing also voted to support usage of the term "nurse anesthesiologist" and "certified registered nurse anesthesiologist" as appropriate descriptors for the profession.

18. The American Association of Nurse Anesthetists (AANA) also recognizes "nurse anesthesiologist" and "certified registered nurse anesthesiologist" as valid descriptors. (*See, e.g.* two AANA Statement and July 25, 2019 letter to the Board of Nursing (attached as Exhibits 1, 2 and 3)).

19. The term "nurse anesthesiologist" appears frequently in federal civil and administrative matters. For example, CMS State Plan Amendment #17-106, dated January 24, 2018 states in part,

> The supplemental payments exclude payments from vaccine administration codes. Anesthesiology codes payments are sometimes split between a physician and a **Certified Registered Nurse Anesthesiologist** (CRNA), therefore all anesthesiology codes will be combined and payments are estimated by using the reduced rate to be conservative.

See State Plan Amendment (SPA) #: 17-016, 2018 WL 3817313, at *1.

20. Department of Health and Human Services, Departmental Appeals Board, Medicare Appeals Council summarized a case before it thusly,

> At issue in these cases is coverage of HCPCS code 00740 QK (physician directed general anesthesia services for upper gastrointestinal endoscopic procedures), HCPCS code 00740 QX (medically directed **Certified Registered Nurse Anesthesiologist** services for upper gastrointestinal endoscopic procedures), each billed at $740.00, and/or coverage of HCPCS code 00810 QK (physician directed general anesthesia services for lower intestinal endoscopic procedure), and HCPCS code 00810 QX (medically directed **Certified Registered Nurse Anesthesiologist** services for lower intestinal endoscopic procedures), each billed at $792.00. Exh. 1 - 4, and 6.1. The carrier and carrier hearing officer denied the claims pursuant to a Local Medical Review Policy (LMRP) which stated that these services were not covered for the stated diagnosis.

In the Case of Claim for Atl. Anesthesia Assocs., P.C. (Appellant) Supplementary Med. Ins. Benefits F.B. & 14 Others Empire Medicare Servs. (Carrier), 2004 WL 5702358, at *1 (H.H.S. June 17, 2004).

21. The Internal Revenue Service issued a Technical Advice Memorandum in 1979 addressing whether certain payments were deductible as a business expense. The Service described the business model of the anesthesiology group as follows: "Corp. X is a professional corporation that has a contract with *** Hospital to provide services in the practice of anesthesiology. Corp. X employs

approximately nine doctor anesthesiologists and **twelve registered nurse anesthesiologists.**" I.R.S. Tech. Adv. Mem. 8002007 (Sept. 24, 1979).

22. In 2017, HHS adopted Final Rules on CMS Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements. Federal agencies respond to input from interested parties during the rulemaking process. Several commenters stated that CMS should not 'crosswalk' non-physician specialties to the lowest physician risk factor specialty for which it has premium rates, which is Allergy Immunology. The commenters said this crosswalk would likely serve as an overestimate of professional liability for non-physician specialties. In response, CMS said,

> ...we did collect whatever data was available for non-physician specialties during our data collection process. This enabled us to find sufficient data for one major non-physician specialty—Nurse Practitioner, which received a blended risk factor of 1.95. Additionally, we note that not all non-physician specialties were mapped to Allergy/Immunology. For example, Certified Nurse Midwife was mapped to Obstetrics and Gynecology, **and Certified Registered Nurse Anesthesiologist** was mapped to Anesthesiology, which both reflect higher risk than Allergy/Immunology.

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program, 82 FR 52976-01. Next, CMS states "Another commenter expressed support for crosswalking **Certified Registered Nurse Anesthesiologist** (CRNA) to Anesthesiology...." *Id.*

23. These are only a sample of the documented usage of the terms, intended to illustrate the universal acceptance of the descriptors.

24. CRNAs are not alone in incorporating the terms "anesthesiology" and "anesthesiologist" into their title. "Dental Anesthesiology" is a specialty recognized by the National Commission on Recognition of Dental Specialties and Certifying Boards, even though it applies to dentists who are not licensed physicians. The specialty was recognized in 2018 following an application by the American Society of Dental Anesthesiologists. In Florida, the Florida Dental Society of Anesthesiology routinely

appears before the Board of Dentistry and participates in rulemaking, while referring to its members as dental anesthesiologists, without any apparent confusion or controversy.

25. Florida Board of Dentistry Anesthesia Rules (64B5-14, Florida Administrative Code) use the term "physician anesthesiologist" when referring to an anesthesiologist who is licensed as an allopathic or osteopathic physician, to distinguish between physician anesthesiologists and dental anesthesiologists. FANA is aware of no attempts by medical associations to curtail the use of the term "anesthesiologist" by non-physician dentists.

Relevant Statutory and Regulatory Provisions

26. The statutory provisions on which the declaration is sought are Chapters 456 and 464, Florida Statutes. The provisions of the Florida Administrative Code upon which the declaration is sought are under Rule 64B9, Florida Administrative Code.

27. Health care practitioners in Florida are required to identify the license under which they practice. Section 456.072(1)(t) provides for disciplinary action against any licensed health care practitioner who fails to:

> ... identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds.

28. Petitioner acknowledges that the type of license under which he practices is a CRNA license and that he will use this title as required by law. (Petition, par. 4).

29. Various provisions of Chapters 456 and 464 prohibit false or misleading statements related to health care practices. The Nurse Practice Act prohibits misleading, or deceptive advertising. Section 464.018(1)(g), Florida Statutes. Section 456.072(1)(a) prohibits "misleading, deceptive, or fraudulent representations in or related to the practice of the licensee's profession" and 456.072(1)(m) prohibits "deceptive, untrue, or fraudulent representations in or related to the practice of a profession or employing a trick or scheme in or related to the practice of a profession." All the above infractions are grounds for disciplinary action by the Board of Nursing, pursuant to Rule 64B9-8.006, Florida

Administrative Code. There is no provision of law expressly prohibiting the use of "anesthesiologist" in a descriptor.

30. While sections 458.3475 and 459.023 (anesthesiologist assistant practice act) include a definition of the term "anesthesiologist," both of these sections clearly state that the definitions only apply to those term as used in those sections. This means that the definition cannot be applied to other laws. To illustrate this point, the term "Direct supervision" is defined under sections 458.3475 and 459.023 as "the onsite, personal supervision by an anesthesiologist." It could hardly be argued that this definition is applicable to the direct supervision of say, a dental hygienist. Further, the term "board" is defined in both of those sections to mean "the Board of Medicine and the Board of Osteopathic Medicine." As with the definition of anesthesiologist and direct supervision, the definition of board has little logical applicability outside of these sections. These terms are narrowly defined by the legislature, because they are intended to apply in a very limited capacity. Moreover, if the term "anesthesiologist" was universally understood to mean a *physician* anesthesiologist, there would be no need to define the term within the anesthesiologist assistant practice act.

31. The definition of "anesthesiologist" in any rule, statute or dictionary would be irrelevant to a determination in this matter irrespective of the breadth of the application of that definition. Petitioner has not sought an opinion as to the use of the term "anesthesiologist"; he is seeking an opinion of the use of the term "nurse anesthesiologist," a term that clearly refers to a nurse who is highly trained in the field of anesthesiology. No health care consumer will confuse a "nurse anesthesiologist" with a physician, since the title begins with the word "nurse."

32. Section 464.015(6), Florida Statutes, states: "Only persons who hold valid certificates to practice as certified registered nurse anesthetists in this state may use the title "Certified Registered Nurse Anesthetist" and the abbreviations "C.R.N.A." or "nurse anesthetist." Section 464.015(10), Florida Statutes, makes it a crime for a person to use the protected CRNA titles in violation of the statute. But while the titles, "Certified Registered Nurse Anesthetist," "nurse anesthetist" and "C.R.N.A." are

expressly protected under Florida law, there is nothing under Chapters 456 or 464 to indicate those terms represent an exhaustive list of the acceptable descriptors for a CRNA.

33. Lacking an express statutory prohibition on the use of the term "nurse anesthesiologist," a finding that the term is deceptive or inherently misleading would be required in order to prohibit Petitioner's use of the term as a descriptor as described herein. As the term is already in use in other states and by the federal government, there are no reasonable grounds upon which such a finding could be based.

Constitutional Considerations in the Regulation of Commercial Speech

34. While FANA acknowledges that a regulatory Board will not generally consider or rule on Constitutional issues, any question concerning the regulation of speech necessarily invokes First Amendment principles, so an overview of relevant may be helpful.

35. The United States Constitution affords protection to both commercial and non-commercial speech, though somewhat different standards apply to each. As long as commercial speech describes a lawful activity and is truthful and not fraudulent or misleading, it is entitled to the protections of the first amendment. *See, e.g. Abramson v. Gonzalez*, 949 F.2d 1567, 1575 (11th Cir. 1992). A few cases in particular provide context as to how these Constitutional principles are applied to the regulation of professional titles.

36. An analysis of the constitutionality of commercial speech regulations consists of a threshold question followed by a three-prong test. The threshold question asks whether the expression is protected by the First Amendment at all, because speech concerning unlawful activity, or speech that is false, deceptive or inherently misleading is not protected. *Central Hudson Gas & Elec. Corp. v. Public Service Comm'n. of New York*, 447 U.S. 557 (1980).

37. If the commercial speech does not concern an unlawful activity, and is not false or inherently misleading, the government cannot regulate the speech unless it can demonstrate a substantial governmental interest, which is directly advanced by the restriction, and that there is a reasonable fit

between the state's ends and the narrowly tailored means chosen to accomplish those ends. *Central Hudson, supra* at 566.

38. *Abramson v. Gonzalez, supra* involves an attempt by the state of Florida to restrict the use of the title "psychologist." Although the state regulated the educational and testing requirements for the *licensing* of psychologists, it had not explicitly barred unlicensed individuals from *practicing* psychology. As a result, an unlicensed person could *practice* psychology in Florida, they just could not use the title "psychologist." Several practicing but unlicensed psychologists challenged the laws restricting their ability to identify their profession.

39. The restrictions were initially upheld by a trial court and the licensees appealed. On appeal, the United States Court of Appeals for the 11th Circuit considered whether allowing the plaintiffs to call themselves psychologists would be "actually misleading" or "potentially misleading." *Id.* at 1576. If the speech was actually misleading, it was not protected by the first amendment, but if only *potentially* misleading, "the state must craft some narrow restriction on the speech—short of the current outright ban—which will directly advance its interest in protecting the public while encouraging a free flow of commercial information." *Id.* at 1576-77.

40. The Court found the speech only potentially, not inherently, misleading conceding the "plaintiffs clearly would enjoy no right falsely to hold themselves out as 'licensed psychologists.'" But, the Court said, "under the laws of Florida, they may practice psychology without licenses, and truthful advertising which conveys this message would be neither false nor inherently misleading." *Id.*

41. The reasoning of the Court in *Abramson* is sound, and applicable to the facts in this Petition. While the State could potentially prohibit CRNAs from calling themselves "physician anesthesiologists" or perhaps even "anesthesiologists," because CRNAs are nurses with advanced expertise in anesthesiology, use of an accurate descriptor "which conveys this message would be neither false nor inherently misleading."

42. The United States Supreme Court considered a similar case involving professional advertising and the first amendment in *Peel v. Attorney Registration and Disciplinary Comm'n. of Illinois*, 496 U.S. 91 (1990). In *Peel*, the State of Illinois challenged an attorney's advertising practice of listing himself as a "Certified Civil Trial Specialist" on his letterhead after he received certification of his trial skills from the National Board of Trial Advocacy (NBTA), a private organization. The Illinois definition of "specialists" included only attorneys with patent, trademark or admiralty practices.

43. The Court held a state could prohibit "misleading" advertising entirely, but it could not prohibit *potentially* misleading information entirely, if the information could be presented in a way that is not deceptive. *Peel*, 110 S.Ct. at 2289. A majority of the justices rejected the "paternalistic assumption" that the "public would automatically mistake a claim of specialization for a claim of formal recognition by the State." *Id.* at 2290. The Court found that the particular advertising at issue in *Peel* was potentially misleading, but the possibility that truthful advertising would be misleading to the public is not enough to justify a categorical ban on all such speech. *Id.*

44. The state officials presented an argument similar to that advanced by Florida in *Abramson* - that allowing the plaintiff to hold himself out as a specialist would mislead the public. The Supreme Court rejected this argument, holding the state's own definition of a specialist cannot bar those who truthfully hold themselves out as specialists from doing so. *Id.* at 2289–90.

45. As there is no current law or rule expressly prohibiting the use of the term "nurse anesthesiologist," an opinion on the constitutionality of such a provision is not required to resolve the question posed by this Petition. However, the Court's discussion of what is "inherently misleading" is instructive for purposes of interpreting provisions of Florida law that prohibit misleading statements by health care practitioners.

46. In order for the State to prohibit the use of the term "nurse anesthesiologist," it would have to prove the title was inherently misleading, and thus entitled to no constitutional protection. Even assuming that some members of the public might associate the term "anesthesiologist" with a physician,

the inclusion of the prefatory term "nurse" adequately dispels any such association. It unmistakably denotes an advanced practice registered nurse who is highly trained and certified in the field of anesthesiology.

47. Given that the descriptor is used in other states and by federal agencies, and that dentists in Florida who are trained in anesthesia freely and routinely refer to themselves as "dental anesthesiologists" with no apparent confusion or controversy, the use of the term "nurse anesthesiologist" by a CRNA cannot be described as inherently misleading. Therefore, any prohibition on the use of the term would constitute an infringement on constitutionally-protected commercial speech.

Conclusion

48. While "Certified Registered Nurse Anesthetist," "nurse anesthetist" and "C.R.N.A." are all protected titles under Florida law, CRNAs are not prohibited under Florida law from using another title, so long as it is not fraudulent, misleading or deceptive.

49. Use of the term "anesthesiologist" within a descriptor, by a practitioner who is not licensed as an allopathic or osteopathic physician is also not expressly prohibited under any Florida law. Indeed, there is no law expressly prohibiting the use of the actual title "anesthesiologist." And while it may be argued that identification simply as an "anesthesiologist" in Florida could potentially be misleading or deceptive, any purportedly deceptive or misleading characteristic is entirely remedied by inclusion of the modifying term "nurse." It could not seriously be argued that health care consumers in Florida would be deceived into thinking the term "*nurse* anesthesiologist" referred to a physician, particularly when the title is accepted for use in other states, apparently with no such confusion.

50. The titles "Nurse Anesthesiologist" and "Certified Registered Nurse Anesthesiologist" are not misleading, deceptive or fraudulent when used by a CRNA. The descriptors are acknowledged and used without confusion at both the state and federal level. It is the position of FANA, that as long as Petitioner indicates to patients that he is *licensed* as an CRNA (or APRN), it is not misleading for him to

accurately describe his specialty using terms that are generally accepted in the field, including "nurse anesthesiologist" and "certified registered nurse anesthesiologist."

WHEREFORE, the Florida Association of Nurse Anesthetists respectfully requests that this Motion to Intervene be granted, and that the Petition for Declaratory Statement be approved.

LEWIS LONGMAN & WALKER, P.A.

Glenn E. Thomas
Florida Bar No. 489174
James W. Linn
Florida Bar No. 312916
315 South Calhoun Street, Suite 830
Tallahassee, Florida 32301
Telephone: (850) 222-5702
E-Mail: gthomas@llw-law.com

Attorneys for the Florida Association of Nurse Anesthetists

Certificate of Service

I HEREBY CERTIFY that a copy of the foregoing has been provided by U.S. Mail and electronic mail to Cynthia Mikos, Esq., counsel for Petitioner, John McDonough, 401 E. Jackson Street, Suite 3100, Tampa, FL 33602, (cynthiam@jpfirm.com); by U.S. Mail and electronic mail to Deborah Loucks, Senior Assistant Attorney General, Administrative Law Bureau, Office of the Attorney General, PL-01, The Capitol, Tallahassee, Florida 32399-1050 (deborah.loucks@myfloridalegal.com); and by U.S. Mail and facsimile to the Department of Health Agency Clerk, Office of the General Counsel, Florida Department of Health, 4052 Bald Cypress Way, Bin A02, Tallahassee, Florida 32399, (facsimile 850-413-8743), this 31st day of July 2019.

Glenn E. Thomas

AANA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

222 South Prospect Avenue
Park Ridge, Illinois 60068-4001
847.692.7050
AANA.com

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for every patient.

CRNAs: We are the Answer

As advanced practice nurses, Certified Registered Nurse Anesthetists (also recognized by the titles CRNA, nurse anesthetist, Certified Registered Nurse Anesthesiologist, and nurse anesthesiologist) are proud to be part of America's most trusted profession. Patients who require anesthesia for surgery, labor and delivery, emergency care, or pain management know they can count on a CRNA to stay with them throughout their procedure, advocate on their behalf, and provide high-quality, patient-centered care. Likewise, healthcare facilities depend on CRNAs to serve the most patients for the least cost; deliver quality care to rural and other medically underserved areas; and positively impact the nation's growing healthcare cost crisis. CRNAs are *the* answer to achieving a safer healthcare environment and more cost-efficient healthcare economy.

This document was prepared by the American Association of Nurse Anesthetists (AANA) on behalf of its 53,000 members and the patients they serve to define the increasing role and value of CRNAs and provide an accurate description of anesthesia practice in today's U.S. healthcare system.

Looking Back

Nurse anesthetists have been the backbone of anesthesia delivery in the United States since the American Civil War. The first U.S. healthcare providers to specialize in anesthesiology, these pioneering nurses introduced a grateful public to a world of previously unimagined healthcare possibilities. Since the late 1800s, anesthesiology has been recognized as the practice of nursing; it wasn't until nearly 50 years later that physicians entered the field and anesthesiology also gained recognition as the practice of medicine. Over the years, despite numerous legal challenges by organized medicine, the courts have consistently upheld the doctrine of anesthesiology as nursing practice. For a timeline of nurse anesthesia history, see https://www.aana.com/history.

Provider Types

CRNAs and physician anesthesiologists are the predominant anesthesia professionals in the United States. Another anesthesia provider type is anesthesiologist assistants (AAs). These healthcare workers serve as assistants to physician anesthesiologists, and by law can only practice under the direct supervision of a physician anesthesiologist.

Anesthesia services are provided the same way by nurses and physicians; in other words, when anesthesia is provided by a CRNA or by a physician anesthesiologist, it is impossible to tell the difference between them. Both CRNAs and physician anesthesiologists provide anesthesia for the same types of surgical and other procedures, in the same types of facilities, for patients young to old; one provider type is not required over the other in any given situation. In fact, *most* of the hands-on anesthesia patient care in the United States is delivered by CRNAs. Yet, while CRNAs are not required by federal or state law to work with physician anesthesiologists (except in New Jersey, which requires CRNAs to enter into a joint protocol with a physician anesthesiologist), in many healthcare settings CRNAs and physician anesthesiologists work together to provide quality patient care. Landmark research, however, has confirmed that anesthesia is equally safe regardless of whether it is provided by a CRNA working solo, a physician anesthesiologist

Exhibit 1

working solo, or a CRNA and physician anesthesiologist working together (see https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2008.0966).
The practice of anesthesiology for CRNAs and physician anesthesiologists includes, but is not limited to, the following:

- Patient care before, during and after surgery
- Patient care before, during and after labor and delivery
- Diagnostic and therapeutic procedures
- Trauma stabilization and critical care interventions
- Acute and chronic pain management
- Management of systems and personnel that support these activities

These skills and responsibilities fall within the scope of practice of both CRNAs and physician anesthesiologists, regardless of credentials (see https://www.aana.com/crnaqualifications).

Education

The preparation of CRNAs for practice enables them to provide every type of anesthesia-related service and anesthetic drug, practice in every type of setting and participate in every type of procedure where anesthesia is required, and handle emergency situations. Because of their extensive knowledge base and robust clinical experience prior to becoming a CRNA, these anesthesia experts are well-equipped to have an immediate impact as healthcare professionals upon graduation.

The nursing- and anesthesiology-focused education and training required to become a CRNA is extensive and in many ways similar to the education and training of a physician anesthesiologist. It takes **7-8 ½ years of coursework and clinical hours** for a student registered nurse anesthetist (also known as SRNA, nurse anesthesia resident, nurse anesthesiology resident) to attain a master's or doctoral degree in nurse anesthesia; during that time the SRNA will, on average, amass **nearly 9,400 hours of clinical experience.**

To be accepted into a nurse anesthesia educational program, an applicant must attain a minimum of one year of experience as a registered nurse in a critical care setting within the United States, its territories, or a U.S. military hospital outside of the United States. However, **the average experience of RNs entering nurse anesthesia educational programs is 2.9 years. CRNAs are the *only* anesthesia professionals required to attain clinical experience prior to entering an educational program.**

All CRNAs are board certified, while only 75 percent of physician anesthesiologists are board certified, according to the Anesthesia Quality Institute (AQI) report titled **Anesthesia in the United States 2013.**

The medical- and anesthesiology-focused education and training required to become a physician anesthesiologist is also extensive and not unlike the education and training of a CRNA. It takes approximately 8 years of medical- and anesthesiology-focused education and training to attain a degree as a physician specializing in anesthesiology prior to sitting for the medical board examination—**roughly the same amount of time it takes to become a CRNA.** Anesthesiology residents graduate with approximately **12,120 hours of clinical experience,** not significantly more than the number attained by CRNAs during their education and training.

However, the American Society of Anesthesiologists (ASA) inflates years of schooling to 12-14 by including a four-year bachelor's degree attained prior to entering medical school, and a post-residency fellowship in an anesthesiology subspecialty such as chronic pain management, which many physician anesthesiologists do not pursue. The bachelor's degree is typically not healthcare-focused. **The ASA also inflates the number of clinical hours** attained by residents to approximately 14,000-16,000, which is 2,000-4,000 hours more than the actual number of 12,120. An important difference between clinical education hours attributed to nurse

anesthesia students and anesthesiology residents is that the hours claimed by SRNAs are those actually spent providing patient care, while the hours claimed by anesthesiology residents are all hours spent in the facility, including those hours not involved in patient care. (See https://www.aana.com/journalonline for a comparison of CRNA and physician anesthesiologist education and training.)

The education and training of an AA lags far behind that of CRNAs and physician anesthesiologists, hence the "assistant" title. It only takes two years of anesthesiology-focused education and approximately 2,500 hours of clinical training to attain a master's degree as an AA prior to sitting for the certification examination. Unlike CRNAs, but exactly like physician anesthesiologists, AAs are *not* required to have any patient care experience before applying to an AA program. (For more information, see (https://www.aana.com/aa-toolkit.)

Barrier to SRNA Education

An increasingly common barrier to CRNA practice created by physician anesthesiologists is intended to impede SRNA preparation by limiting their access to clinical training sites and procedures. Other restrictive measures that have specifically resulted from the ASA's 2018 publication of its amended Anesthesia Care Team (ACT) Statement include facilities requiring restrictive 1:1 CRNA-to-student-nurse anesthetist supervision ratios that prevent CRNAs from leaving the operating room to allow students the ability to develop independently. The ASA's stated rationale is to protect employment opportunities for physician anesthesiologists. In the AANA's view, this sort of blatant protectionism is, at a minimum, unethical. All anesthesia students should be afforded the required clinical training opportunities necessary to become fully prepared for entry into practice. Patients depend on this.

Licensure

CRNAs are licensed by the states and authorized by law and regulation to practice nurse anesthesia in all 50 states and the District of Columbia; they are the only independently licensed practitioners required to be board certified to practice. Physician anesthesiologists are licensed by the states and authorized by law and regulation to practice anesthesiology in all 50 states and the District of Columbia; however, they are not required to be board certified. Unlike CRNAs or physician anesthesiologists, AAs are not licensed to practice *independently* in any state. Due to this limitation, AAs do not help improve patient access to surgical, labor and delivery, and emergency care; however, they do increase costs for anesthesia services paid by facilities and patients due to two anesthesia providers needing to be involved in the care of a single patient.

Anesthesia Delivery Models

There are four CRNA/physician anesthesiologist anesthesia delivery models commonly used by healthcare facilities in the United States: CRNA-only; physician anesthesiologist supervision of CRNAs; physician anesthesiologist direction of CRNAs; and physician anesthesiologist-only (see https://www.aana.com/PracticeModels). Despite the variety of anesthesia delivery models, CRNAs are not required by federal or state laws (except in New Jersey as noted earlier) to be supervised or directed by, or even work with, a physician anesthesiologist.

For AAs, there is only one anesthesia delivery model: medical direction by a physician anesthesiologist.

While a healthcare facility *cannot* employ an AA without also employing a costly physician anesthesiologist who earns nearly three times as much as an AA or CRNA, a facility *can* employ a CRNA in place of both, thereby ensuring quality patient care is delivered and the facility's bottom line is favorably impacted.

CRNA-only Model
In this model, the CRNA is the sole anesthesia provider. The CRNA-only model may vary by state. In some states, CRNAs work without physician supervision; in other states, they are required to be supervised by a physician. The physician could be, but is not required to be, a physician anesthesiologist. Often the supervising physician is a surgeon or other proceduralist.

Currently, there are 17 states that have no physician supervision requirement for CRNAs whatsoever, meaning these states have opted out of the federal Medicare physician supervision requirement for CRNAs. Without any burdensome supervision requirement for CRNAs, healthcare facilities in these states can structure and staff their anesthesia departments to function as efficiently, cost-effectively, and safely as possible. Physician supervision of CRNAs is not and never has been a matter of patient safety. Its requirement has always been tied to the ability of a facility to receive reimbursement from the Centers for Medicare & Medicaid Services (CMS) for anesthesia care provided to Medicare patients.

Physician Supervision of CRNAs
Medical supervision is a billing term under Medicare which pertains to when one physician anesthesiologist oversees more than four CRNAs (or AAs) concurrently administering anesthesia to patients undergoing surgical or other procedures. In this model, the physician anesthesiologist doesn't provide hands-on care, but is available in case he/she is needed to assist in any of the concurrent cases. Research has confirmed that patient safety is not enhanced by this anesthesia delivery model, and that the cost of having a physician anesthesiologist available "just in case" is often greater than the cost of adding two additional CRNAs to the anesthesia department (see http://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf).

Physician Anesthesiologist Direction of CRNAs
Medical direction is a billing term under Medicare which pertains to when a physician anesthesiologist directs the anesthesia care of up to four CRNAs (or AAs) providing anesthesia for four different cases concurrently; however, for medical direction to be achieved legally and the physician anesthesiologist to be compensated, the physician anesthesiologist must meet seven requirements of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97–248 (TEFRA) for each case. For obvious reasons, medical direction, with its TEFRA requirements, is the model in which physician anesthesiologist billing fraud occurs most frequently. It is virtually impossible for a physician anesthesiologist to meet the seven TEFRA requirements in concurrent cases (regardless of whether there are two, three or four concurrent cases) without significant delays occurring in each of the cases as the physician anesthesiologist moves from room to room. In 2012, research by Epstein et al and published in the journal *Anesthesiology* examined this problem relative to delayed case starts (see https://www.ncbi.nlm.nih.gov/pubmed/22297567).

Aside from the potential for fraudulent billing practices, in most scenarios medical direction comes at an increased cost to the facility of at least one physician anesthesiologist for every four CRNAs. This translates to more than $1 million per year for an average-sized U.S. hospital with four operating rooms. The increased cost of the medical direction model is generally not sustainable, and typically the hospital subsidizes the anesthesia department to cover the cost which is then passed on to consumers of the hospital's services. (Massie, M. [2017]. *Determinants of Hospital Administrators' Choice of Anesthesia Practice Model* [Doctoral dissertation]. Retrieved from ProQuest Dissertation and Theses. [Accession Order No. 11669]. MB)

Physician Anesthesiologist-only Model
In this model, the physician anesthesiologist is the sole anesthesia provider. The physician anesthesiologist provides hands-on patient care and stays with the patient throughout the procedure—exactly the way a CRNA functions all the time whether working solo or with a physician anesthesiologist. The physician anesthesiologist-only model is the least commonly used delivery model in the United States. While it is more

economical than the medical-direction and medical-supervision models, research has confirmed that it is far less cost-effective and no safer than the CRNA-only model (see http://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf).

Military

Nurses first gave anesthesia to wounded soldiers on the battlefields of the American Civil War; now, more than 150 years later, service members in all branches of the U.S Armed Forces rely on independently practicing CRNAs for anesthesia care, especially on the front lines of American military actions around the world. In these austere settings where physician anesthesiologists are rarely deployed, CRNAs typically are the sole anesthesia professionals caring for U.S. service men and women.

Research

Since 2000, numerous published research studies have confirmed the safety and quality of care provided by CRNAs and that CRNAs are the most cost-effective anesthesia providers by a wide margin. One such study, conducted by the Research Triangle Institute (RTI) and published in the August 2010 issue of *Health Affairs*, determined that anesthesia care is equally safe when delivered by a CRNA working solo, a CRNA supervised by a physician anesthesiologist, or a physician anesthesiologist working solo. In fact, the RTI study showed that a CRNA working solo is actually the safest scenario, although the data supporting that conclusion was not statistically significant. Another study published in the May/June 2010 issue of *Nursing Economic$* and updated in May 2016 showed that a CRNA working solo is 25 percent more cost effective than the next most cost-effective anesthesia delivery model (see http://www.future-of-anesthesia-care-today.com/research.php).

Liability and Compliance

For a multitude of reasons, facility administrators are wise to build their anesthesia departments around CRNAs. Peer-reviewed research has confirmed numerous times the safety record of these highly qualified anesthesia experts; other studies have demonstrated that a CRNA working solo is by far the most cost-effective anesthesia delivery model. Another CRNA value proposition is what they *don't* bring to the table, such as increased surgeon liability and Medicare fraud.

Surgeon Liability

The misconception that surgeons and other proceduralists assume increased liability when working with CRNAs persists to this day despite nearly four decades of court precedent to the contrary. In reality, surgeon liability is directly related to how much, if any, control they exert on the anesthesia process that may result in an adverse outcome, regardless of the degree or title held by the anesthesia providers they work with (see https://www.aana.com/surgeonliability.)

Physician Anesthesiologists, TEFRA Compliance, and Fraud

As noted earlier, for a physician anesthesiologist to be reimbursed for cases in which he/she does not personally perform the anesthesia but instead medically directs up to four CRNAs providing anesthesia in separate cases concurrently, the physician anesthesiologist must personally meet the seven requirements of the TEFRA Act for each case. As demonstrated by the research of Epstein et al (2012), TEFRA compliance is exceedingly difficult for two or more concurrent cases. This study strongly suggests that physician anesthesiologists often commit Medicare billing fraud when medically directing multiple CRNAs providing patient care concurrently (see https://www.ncbi.nlm.nih.gov/pubmed/22297567). Facility administrators are wise to evaluate the risk/reward of running an anesthesia department based on the unrealistic, costly medical direction model, as it presents an easy target for regulators.

Cost Containment

Overcompensation of Physician Anesthesiologists

The current trend toward transparency in healthcare delivery costs has created significant opportunity for facility administrators, anesthesia companies, billers, and other stakeholders to take a closer look at various anesthesia delivery options to identify cost savings. According to the 2016 Medical Group Management Association (MGMA) provider compensation report, physician anesthesiologists' median total compensation package nationally was $453,687 per year as opposed to CRNAs at $172,000. MGMA further determined that a cost savings of 62 percent can prevent facility closure and maintain community access to care. By carefully examining overcompensation of physician anesthesiologists for services that can be provided as safely and more cost-effectively by CRNAs, a substantial portion of this percentage can be realized.

Tearing Down Barriers to CRNA Practice

To assist in improving access to healthcare across the United States, the National Academy of Medicine (formerly known as the Institute of Medicine) stated in its 2010 landmark report The Future of Nursing that "advanced practice registered nurses (APRNs) should be able to practice to the full extent of their education and training" (see http://www.academicprogression.org/about/future-of-nursing.shtml). However, regulatory barriers continue to exist, preventing CRNAs from attaining full scope of practice and increased reimbursement. In 2018, a report published by the U.S. Department of Health and Human Services (HHS) identified barriers to market competition at the federal and state levels that stifle innovation in healthcare cost containment delivery solutions. These barriers create higher prices and disincentivize administrators and providers who might otherwise seek to enhance healthcare quality. One of the report's main recommendations is to encourage policies that allow healthcare professionals to practice to their full scope to ensure workforce mobility and increase access to care while solving economic challenges without impacting value or safety (see https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html).

The Federal Trade Commission (FTC) weighs in on cases where APRN scope of practice has been restricted and patients' ability to receive care from the providers of their choice has been limited. Anticompetitive legislation and regulation proposed by the medical community, and especially physician anesthesiologists, to protect their turf and compensation at the expense of their patients' best interests is becoming commonplace.

Conclusion

For more than 150 years, CRNAs have fulfilled a highly valued role in the U.S. healthcare system. Today, CRNAs help ensure patient access to proven safe, high-quality, cost-effective anesthesia and related services, meeting the needs of countless healthcare facilities and the communities they serve across the country. Going forward, CRNAs will continue to be *the* answer to achieving a safer healthcare environment and more cost-efficient healthcare economy.

AANA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
222 South Prospect Avenue
Park Ridge, Illinois 60068-4001
847.692.7050
AANA.com

Safe and effective anesthesia
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America's Anesthesia Workforce: Current Status and Emerging Trends

Certified Registered Nurse Anesthetists, also known by the titles CRNA, nurse anesthetist, Certified Registered Nurse Anesthesiologist, and nurse anesthesiologist, have been the backbone of anesthesia delivery in the United States since the American Civil War.

As healthcare spending in the 21st Century continues to grow, delivery systems struggle under the weight of increasing costs, declining reimbursement, and a continually changing legislative and regulatory environment. The specialty of anesthesiology has not been immune to this volatility; however, all current research and socio-economic evidence points to CRNAs as the answer to a more efficient and economical approach to providing patients access to safe, high-quality anesthesia care and pain management. This document, prepared by the American Association of Nurse Anesthetists (AANA), defines the increasing role and value of CRNAs in the U.S. healthcare system and explores barriers to CRNA practice and patient access to care by examining the past, present, and future of the profession. The following subject areas are covered:

- History of anesthesia delivery
- Provider types
- Anesthesia delivery models
- Compliance and medico-legal liability issues for anesthesia practice
- Emerging trends
- Barriers to anesthesia delivery: evolution and cost containment

History of Anesthesia Delivery

Not long after the first demonstration of anesthesia for surgery was conducted in 1846 by American dentist William Thomas Green Morton, nurses became the first healthcare providers to specialize in anesthesiology. The advent of anesthesia to mitigate the pain and improve the quality of surgery quickly resulted in increased demand for surgical intervention in the United States, but surgeons soon had a new problem to contend with: the lack of vigilance by physician anesthesia providers who were more interested in observing surgery than paying attention to the patients they rendered unconscious with powerful drugs. This led prominent surgeons to recruit responsible, dedicated nurses eager to learn the techniques required to safely administer anesthetic drugs and keep patients asleep and pain free on the operating table. By the late 1800s, respected nurses such as Alice Magaw, who was bestowed the title "Mother of Anesthesia" by Dr. Charles Mayo, and Agatha Hodgins, who founded the AANA, were being identified and trained by surgeons to be their exclusive anesthetists. It wasn't long before these nurses were actively advancing the specialty of nurse anesthesia through published research and formal instruction in anesthesiology.

Back in the profession's infancy, five requirements were viewed as essential to becoming a nurse anesthetist: satisfaction with a subordinate role, focus or interest solely on anesthesia, no intent to learn surgical techniques, acceptance of low wages, and possessing skills to provide "smooth relaxation anesthesia." By comparison, today's CRNA is a well-compensated, highly skilled anesthesia expert with graduate-level education and training who may work independent of physician supervision in a variety of specialized roles including clinician, researcher, educator, administrator, and business owner.

The beginning of World War I heightened the demand for nurse anesthetists. Nearly 100 years later, service members in all branches of the U.S. Armed Forces continue to rely on independently

practicing CRNAs for anesthesia care, especially on the front lines of American military actions around the world. In these austere settings, CRNAs are typically the sole anesthesia professionals caring for U.S. service men and women.

By the end of World War II, there were 17 nurse anesthetists to every one physician anesthesiologist, the medical counterpart to nurse anesthetists. Physicians had entered the field in the early 1900s and tried to claim it as their own to no avail. Because nurse anesthetists pioneered the specialty and became highly respected by surgeons and other proceduralists for the quality care they provided, anesthesiology was originally viewed as the practice of nursing, not medicine; today it is viewed as both the practice of nursing and the practice of medicine (see https://www.aana.com/practice/practice-manual?tab7). This has been upheld as law in the United States for decades by courts in multiple jurisdictions. Two primary examples are the cases *Frank v. South* and *Nelson v. Chalmers-Frances* which clearly defined anesthesiology as the practice of nursing or medicine depending on who is providing the service. Since 1970, various healthcare associations and government boards have corroborated this fact. For a timeline of nurse anesthesia history, see https://www.aana.com/history.

What makes the anesthesia profession unique is that the services provided do not fit into the cure model of medicine. Anesthesia facilitates the care and management of a patient's health issues. Its delivery is, principally, an ancillary service to surgery and diagnostic procedures in traditional perioperative settings, although anesthesia professionals also facilitate diagnosis and therapy in other care settings including, but not limited to, labor and delivery units, emergency rooms, critical care units, outpatient clinics, and office-based practices. The primary purpose of anesthesia in any care setting, whether provided by a CRNA or a physician anesthesiologist, is to render a patient insensitive to pain. The provision of these services requires an anesthesia professional who has undergone extensive specialized education and training.

The term "anesthesiologist" refers to an expert in the provision of anesthesia and related services, such as a physician anesthesiologist, nurse anesthesiologist (better known as a Certified Registered Nurse Anesthetist or CRNA), and dental anesthesiologist.

The practice of anesthesiology includes patient care before, during and after surgery; patient care before, during, and after labor and delivery; and diagnostic and therapeutic procedures. In addition, anesthesia experts oversee the management of systems and personnel that support these activities. The practice of anesthesiology also includes:

- The preanesthetic optimization of the patient through assessment and evaluation of health history, including the identification of new medical conditions,
- The perioperative management of wellbeing, hemodynamics, and pre-existing conditions,
- The administration of anesthesia and sedation and comprehensive management of discomfort,
- The management of postanesthetic recovery,
- The prevention and management of perioperative complications,
- The practice of acute and chronic pain management, and
- The practice of trauma stabilization and critical care interventions.

These skills and responsibilities fall within the scope of practice of all the anesthesia professionals listed above, regardless of credentials. For more information, see https://www.aana.com/practice.

Provider Types

This section discusses the various types of anesthesia providers with emphasis on CRNAs, physician anesthesiologists, and anesthesiologist assistants (AAs). Education, work roles, and responsibilities are covered.

General Terminology

Anesthesiologist: An expert in the provision of anesthesia and related services. Anesthesiologists (nurse, physician, dentist) are educated and trained to practice both independently and in collaboration with other healthcare providers. The standard of care is the same for all types of anesthesiologists, and these providers are legally responsible for the services they provide. (NOTE: Also known as "qualified anesthesia providers/professionals.")

Anesthetist: Broadly, one who administers anesthesia, including nurses, physicians, dentists, and AAs. In most countries other than the United States, a physician who provides anesthesia is known as an "anaesthetist" or "anesthetist." (NOTE: Also known as "qualified anesthesia providers/professionals.")

Fellow: A licensed anesthesiology professional (nurse, physician, dentist) who has obtained an additional year or more of education in a subdiscipline of anesthesiology. (NOTE: Also known as "qualified anesthesia providers/professionals.")

Resident: A registered nurse, dental student, or medical student who is in process of obtaining an advanced degree as a nurse anesthetist, physician anesthesiologist, or dental anesthesiologist. These specialists will exit their programs as fully prepared anesthesia professionals; nurse anesthesia program graduates will complete the National Certification Examination post-graduation to become CRNAs.

Independently Licensed Practitioners

Certified Registered Nurse Anesthetist (also CRNA, nurse anesthetist, Certified Registered Nurse Anesthesiologist, nurse anesthesiologist): A nurse educated and licensed to practice anesthesia in the United States. Overall, it takes 7-8 ½ years of nursing- and anesthesiology-focused education and training to attain a degree in nurse anesthesia prior to sitting for the National Certification Examination to become a CRNA. Graduates of nurse anesthesia educational programs have an average of 9,369 hours of clinical experience (see https://www.aana.com/journalonline). All CRNAs are board certified. The extensive education requirements to become a CRNA, and the title itself, are unique to the United States.

The minimum education and experience required to become a CRNA include the following:

- A baccalaureate or graduate degree in nursing or other appropriate major.
- An unencumbered license as a registered professional nurse and/or APRN in the United States or its territories and protectorates.
- A minimum one year of full-time work experience, or its part-time equivalent, as a registered nurse in a critical care setting within the United States, its territories, or a U.S. military hospital outside of the United States. The average experience of RNs entering nurse anesthesia educational programs is 2.9 years. Prior to entering a nurse anesthesia educational program, an applicant must have developed independent decision-making skills, the ability to manage critical patients who need continuous life-sustaining treatments, knowledge of invasive interventions, and a clear understanding of how to use and interpret advanced monitoring techniques based on knowledge of physiological and pharmacological principles.
- Graduation with a minimum of a master's degree from a nurse anesthesia educational program accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs. Beginning Jan. 1, 2022, all students matriculating into an accredited program must be enrolled in a doctoral program.
- Nurse anesthesia educational programs range from 24-51 months, depending on university requirements. Programs include clinical settings and experiences. As noted, graduates of nurse anesthesia educational programs have attained 7-8 ½ years of nursing- and anesthesiology-focused education and training including 9,369 hours of clinical experience.
- CRNAs may go on to pursue a fellowship in a specialized area of anesthesiology such as chronic pain management.

- CRNAs follow a path of lifelong learning through the Continued Professional Certification (CPC) Program of the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).

CRNAs are licensed by the states and authorized by law and regulation to practice nurse anesthesia in all 50 states and the District of Columbia; they are the only independently licensed practitioners required to be board certified to practice. By comparison, nearly 25 percent of practicing physician anesthesiologists are not board certified, according to the Anesthesia Quality Institute (AQI) report titled Anesthesia in the United States 2013. In most states, CRNAs are licensed or recognized as advanced practice registered nurses (APRNs), advanced practice nurses (APNs), or advanced practice registered nurse practitioners (ARNPs). For more information, see https://www.aana.com/crnaqualifications.

Physician Anesthesiologist (also medical doctor, MD, doctor of osteopathy, DO): A physician educated and licensed to practice medicine and anesthesia in the United States. Overall, it takes approximately eight years of medical- and anesthesiology-focused education and training to attain a degree as a physician specializing in anesthesiology prior to sitting for the medical board examination. (NOTE: The American Society of Anesthesiologists [ASA] typically inflates years of schooling to 12-14, which includes a four-year bachelor's degree attained prior to entering medical school, and a post-residency fellowship in an anesthesiology subspecialty such as chronic pain management, which many anesthesiologists do not pursue. The bachelor's degree, while inclusive of some course and lab work in anatomy, physiology, and other related sciences, is typically not healthcare-focused. Therefore, a physician anesthesiologist legitimately can lay claim to attaining eight years of medical- and anesthesiology-focused education and training in the process of becoming an anesthesiologist, which is comparable to the amount of nursing- and anesthesiology-focused education and training attained by CRNAs. Additionally, the ASA typically inflates the number of clinical hours attained by physician anesthesiology residents to approximately 14,000-16,000; however, the actual number of hours is closer to 12,120 (see https://www.aana.com/journalonline). It is important to note that a singular difference between clinical education hours attributed to nurse anesthesia and physician anesthesiology residents is that the hours claimed by nurse anesthesia residents are those actually spent providing patient care, while the hours claimed by physician anesthesiology residents are all hours spent in the facility, including those hours not involved in patient care.

The minimum education and experience required to become a physician anesthesiologist include the following:

- Graduation with a bachelor's degree in an unspecified course of study prior to acceptance into medical school. (NOTE: Medical school applicants are not required to attain any healthcare experience prior to applying for admission. By comparison, nurse anesthesia residents are required to attain a minimum of one year of critical care nursing experience; most applicants attain an average of 2.9 years of critical care nursing experience CRNAs are the only anesthesia professionals in the United States who are required to attain related healthcare experience before entering an anesthesia program.) For more information see https://www.aana.com/journalonline.
- Completion of a four-year medical degree.
- Completion of a four-year anesthesiology residency.
- As noted, physician anesthesiologists attain approximately eight years of medical- and anesthesia-focused education and training including 12,120 hours of clinical experience.
- Some physician anesthesiologists go on to pursue a fellowship in a subspecialty of anesthesiology such as chronic pain management.
- Physician anesthesiologists follow a path of lifelong learning including various continuing education requirements; however, as previously noted, physician anesthesiologists are not required to be board certified, and approximately 25 percent of them are not.
- Physician anesthesiologists are licensed by the states and authorized by law and regulation to practice anesthesiology in all 50 states and the District of Columbia.

Dependent Anesthesia Providers

Anesthesiologist Assistant (AA, certified anesthesiologist assistant, CAA): An allied health professional educated and licensed to provide anesthesia in the United States exclusively under the medical direction of a physician anesthesiologist. As their title attests, AAs are assistants to physician anesthesiologists. Overall, it takes just two years of anesthesiology-focused education and training to attain a degree as an AA prior to sitting for the certification examination. Graduates of AA educational programs average more than 2,500 hours of clinical experience. All states that license AAs require that they are certified by the National Commission for Certification of Anesthesiologist Assistants.

The minimum education and experience required to become an AA include the following:

- Graduation with a bachelor's degree prior to admission to an AA program. (NOTE: According to the Commission on Accreditation of Allied Health Education Programs, no specific bachelor's degree is required for AAs to complete their graduate school training.)
- Unlike CRNAs, but exactly like physician anesthesiologists, AAs are not required to have any patient care experience before applying to an AA program.
- Attain a two-year master's degree to be able to assist physician anesthesiologists in providing anesthesia care to patients.

CRNAs are not permitted by law to oversee the work of AAs. Consistent with this, the AANA's Position Statement on AA Training advises CRNAs not to supervise the training of AAs.

Unlike other anesthesia professionals, AAs are not licensed to practice independently in any state. Currently, AAs are explicitly recognized under state law in only 13 states and the District of Columbia. In one additional state, Kentucky, AAs must also be certified physician assistants to practice, which significantly restricts the ability of AAs to practice in that state. These limitations do nothing to help improve patient access to surgical, labor and delivery, and emergency care; however, they do increase costs for anesthesia services paid by facilities and patients due to two anesthesia providers needing to be involved in the care of a single patient. For more information, see https://www.aana.com/aa-toolkit.

Other Providers of Anesthesia or Sedation

Dental Anesthesiologist (DA): A dentist educated and licensed to practice dental anesthesia in the United States. Similar to physician anesthesiologists, it takes approximately eight years of dental- and anesthesiology-focused education and training to attain a degree as a dentist specializing in anesthesiology prior to sitting for the dental board examination. Dental anesthesiologists are not required to have any healthcare experience prior to entering dental school, nor are they required to be board certified. For more information, see https://www.asdahq.org/about.

Oral and Maxillofacial Surgeons (OMS): A dentist who completes a 4-6 year residency after dental school that includes five months of dedicated anesthesia education and training. Typically, an OMS is allowed by state law to provide anesthesia services to adult and pediatric patients under dental or oral surgical care. For further information on OMS anesthesia care, see https://www.aaoms.org/docs/govt_affairs/advocacy_white_papers/advocacy_office_based_anesthesia_whitepaper.pdf.

Certified Registered Sedation Nurses (CRSNs): A registered nurse licensed in the United States who obtains additional training to provide moderate sedation under the supervision of an anesthesiologist (nurse, physician, dentist), other physician, dentist, or podiatrist. CRSNs take advanced curriculum in the areas of patient assessment, pharmacology, airway management, monitoring, equipment, managing emergencies, clinical judgment, and critical thinking in the provision of patient care.

Anesthesia Delivery Models

There are four CRNA/physician anesthesiologist anesthesia delivery models commonly used by healthcare facilities in the United States: CRNA-only; physician anesthesiologist supervision of CRNAs; physician anesthesiologist direction of CRNAs; and physician anesthesiologist-only (see https://www.aana.com/PracticeModels). It is important to note that despite the variety of anesthesia delivery models involving CRNAs and physician anesthesiologists, CRNAs are not required by federal or state laws to be supervised by, directed by, or even work with a physician anesthesiologist regardless of the delivery model. The exception is New Jersey, which requires CRNAs to enter into a joint protocol with an anesthesiologist.

For AAs, there is only one anesthesia delivery model: medical direction by a physician anesthesiologist.

CRNA-only Model

Due to its proven safety record and high degree of cost-effectiveness, the CRNA-only model is found throughout the United States. In this model, the CRNA is the sole anesthesia provider; more specifically, the CRNA works without any involvement by a physician anesthesiologist.

The CRNA-only model may vary by state. In some states, CRNAs work without physician supervision; in other states, they are required to be supervised by a physician. The physician *could* be, but is not *required* to be, a physician anesthesiologist. Often the supervising physician is a surgeon or other proceduralist.

Currently, there are 17 states that have no physician supervision requirement for CRNAs whatsoever: Iowa, Nebraska, Idaho, Minnesota, New Hampshire, New Mexico, Kansas, North Dakota, Washington, Alaska, Oregon, Montana, South Dakota, Wisconsin, California, Colorado, and Kentucky. What this means is that these states don't have a supervision requirement in state statutes, board of nursing or medicine rules and regulations, or any other state agency rules and regulations, plus they have opted out of the federal Medicare physician supervision requirement for CRNAs. Without any burdensome supervision requirement for CRNAs, healthcare facilities in these states can structure and staff their anesthesia departments to function as efficiently, cost-effectively, and safely as possible, to the benefit of their—and their patients'—bottom line.

Physician supervision of CRNAs is not and never has been a matter of patient safety. Its requirement has always been tied to the ability of a facility to receive reimbursement from the Centers for Medicare & Medicaid Services (CMS) for anesthesia care provided to Medicare patients.

Since 2000, numerous published research studies have confirmed the safety and quality of care provided by CRNAs and also that CRNAs are the most cost-effective providers by a wide margin (see http://www.future-of-anesthesia-care-today.com/research.php). For example, a study conducted by the Research Triangle Institute (RTI) and published in the August 2010 issue of *Health Affairs* determined that anesthesia care is equally safe when delivered by a CRNA working solo, a CRNA supervised by a physician anesthesiologist, or a physician anesthesiologist working solo. In fact, the RTI study showed that a CRNA working solo is actually the safest scenario, although the data supporting that conclusion was not statistically significant. Another study published in the May/June 2010 issue of *Nursing Economic$* and updated in May 2016 showed that a CRNA working solo is 25 percent more cost effective than the next most cost-effective anesthesia delivery model.

All statements about anesthesia safety, cost and access made by the AANA for patient education, advocacy, and interview purposes are supported by published scientific evidence, unlike the unsubstantiated claims made by the ASA that the highest level of anesthesia care always involves an anesthesiologist.

Physician Anesthesiologist Supervision of CRNAs

Medical supervision is a billing term under Medicare which pertains to when one physician anesthesiologist oversees more than four CRNAs concurrently administering anesthesia to patients undergoing surgical or other procedures. (NOTE: Physician anesthesiologists can also supervise up to four AAs concurrently administering anesthesia to patients.) In this model, the physician anesthesiologist doesn't provide hands-on care, but is available in case he/she is needed to assist in any of the concurrent cases. Even if the physician anesthesiologist never takes an active role in any of the cases being managed by the CRNAs, the anesthesiologist can still bill for "services provided" for each case. Research has confirmed that patient safety is not enhanced by this anesthesia delivery model, and that the cost of having a physician anesthesiologist available "just in case" is often greater than the cost of adding two additional CRNAs to the anesthesia department. In fact, due to billing regulations, most facilities where this model is used will, on average, experience a 23 percent reduction in overall revenue compared to facilities where CRNAs provide and bill for services without the physician anesthesiologist "supervision" component (see http://www.lewin.com/content/dam/Lewin/Resources/AANA-CEA-May2016.pdf).

Physician Anesthesiologist Direction of CRNAs

Medical direction is a billing term under Medicare which pertains to when a physician anesthesiologist directs the anesthesia care of up to four CRNAs (or AAs) providing anesthesia for four different cases concurrently; however, for medical direction to be achieved legally, the physician anesthesiologist must meet seven requirements of the Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. 97-248 (TEFRA) for each case, including: 1) Perform a pre-anesthetic examination and evaluation and document it in the medical record. 2) Prescribe the anesthesia plan. 3) Personally participate in the most demanding procedures in the anesthesia plan—including induction and emergence, if applicable—and document this. 4) Ensure that any procedures in the anesthesia plan are performed by a qualified anesthetist. 5) Monitor the course of anesthesia administration at frequent intervals and document that they were present during some portion of the anesthesia monitoring. 6) Remain physically present and available for immediate diagnosis and treatment of emergencies. 7) Provide indicated post-anesthesia care and document it. In other words, the physician anesthesiologist is required to personally perform certain aspects of each anesthetic procedure to be able to receive reimbursement for any portion of the case. If the seven requirements are met, the physician anesthesiologist is eligible to receive 50 percent of the total reimbursement for each case; the other 50 percent of the reimbursement for each case would be received by the CRNA or AA who is involved. As always, when a CRNA is the anesthesia professional being medically directed by a physician anesthesiologist, the CRNA provides most of the hands-on patient care and stays with the patient throughout the procedure.

For obvious reasons, medical direction, with its TEFRA requirements, is the model in which anesthesiologist billing fraud occurs most frequently. It is virtually impossible for an anesthesiologist to meet the seven TEFRA requirements in concurrent cases (regardless of whether there are two, three or four concurrent cases) without significant delays occurring in each of the cases as the anesthesiologist moves from room to room. In 2012, research by Epstein et al and published in the journal *Anesthesiology* examined this problem relative to delayed case starts (see https://www.ncbi.nlm.nih.gov/pubmed/22297567).

Aside from the potential for fraudulent billing practices, in most scenarios medical direction results in the same reimbursement per case as billing in the CRNA-only model, but it comes at an increased cost to the facility of at least one physician anesthesiologist for every four CRNAs. This translates to more than $1 million per year for an average-sized U.S. hospital with four operating rooms. The increased cost of the medical direction model is generally not sustainable, and typically the hospital subsidizes the anesthesia department to cover the cost which is then passed on to consumers of the hospital's services. Recent data shows that more than 80 percent of all hospitals currently subsidize anesthesia departments due to inefficient staffing models. (Massie, M. [2017]. *Determinants of Hospital Administrators' Choice of Anesthesia Practice Model* [Doctoral dissertation]. Retrieved from ProQuest Dissertation and Theses. [Accession Order No. 11669]. MB)

Additional information about the medical-direction model and billing fraud is provided in the Compliance and Medico-legal Liability Issues for Anesthesia Practice section later in this paper. A cost analysis of the different anesthesia staffing models can be found at https://www.aana.com/docs/default-source/research-aana.com-web-documents-(all)/nec_mj_10_hogan.pdf.

Physician Anesthesiologist-only Model

In this model, the physician anesthesiologist is the sole anesthesia provider. The anesthesiologist provides hands-on patient care and stays with the patient throughout the procedure—exactly the way a CRNA functions all the time whether working solo or with a physician anesthesiologist. In contrast to the other models in which a physician anesthesiologist is supervising or directing CRNAs and available on a limited basis or only "if needed," in this model the physician anesthesiologist actually performs the anesthesia. The physician anesthesiologist-only model is the least commonly used delivery model in the United States. While it is more economical than the medical-direction and medical-supervision models, research has confirmed that it is far less cost-effective and no safer than the CRNA-only model (see https://www.aana.com/docs/default-source/research-aana.com-web-documents-(all)/nec_mj_10_hogan.pdf).

Compliance and Medico-legal Liability Issues for Anesthesia Practice

Surgeon Liability

The misconception that surgeons, dentists, podiatrists, and other proceduralists assume increased liability when working with CRNAs persists to this day despite nearly four decades of court precedent to the contrary. In reality, the liability of these providers is directly related to how much, if any, control they exert on the anesthesia process that may result in an adverse outcome, regardless of the degree or title held by the anesthesia providers they work with. In other words, if a surgeon exerts control over the anesthesia care being provided by a CRNA *or* by a physician anesthesiologist, that surgeon's liability will increase according to the degree of control exerted regardless of the type of anesthesia professional involved with the case. Case law has repeatedly supported this doctrine. For additional information, see https://www.aana.com/surgeonliability.

Physician Anesthesiologists and TEFRA Compliance

In today's healthcare environment, the three main areas of risk for anesthesia professionals, particularly physician anesthesiologists, are: compliance with the TEFRA requirements for reimbursement, observance of the Anti-Kickback Statute, and failure to follow Stark Law conditions related to staffing models.

As noted earlier in this paper, for a physician anesthesiologist to be reimbursed for cases in which he/she does not personally perform the anesthesia but instead medically directs up to four CRNAs providing anesthesia in separate cases concurrently, the anesthesiologist must personally meet the seven requirements of the TEFRA Act for each case. As demonstrated by the research of Epstein et al (2012), TEFRA compliance is exceedingly difficult for two concurrent cases, and 99 percent impossible for three or four cases without incurring significant case delays.

The Epstein study suggests that physician anesthesiologists often commit Medicare billing fraud when medically directing multiple CRNAs providing patient care concurrently. Not surprisingly, Medicare claims compliance is routinely under scrutiny from auditors, relators, Qui Tam attorneys, and the CMS Office of the Inspector General (OIG). Facility administrators are wise to evaluate the risk/reward of running an anesthesia department based on the unrealistic, costly medical direction model, as it presents an easy target for regulators.

For more information on anesthesia billing fraud, see https://www.aana.com/publications/aana-journal/legal-briefs?tab3.

The "Company Model" and the Anti-Kickback Statute and Stark Law

Also under scrutiny by the OIG and Department of Justice (DOJ) is the "company model" for anesthesia care delivery and whether it violates the Anti-Kickback Statute and Stark Law. Under the company model, a physician-owned facility incorporates a separate anesthesia company under the same ownership as the facility to provide anesthesia services for the facility. Since the company is a separate corporation, it can bill for both facility and anesthesia service fees. After the anesthesia providers' salaries, billing expenses and other costs are extracted, the anesthesia company's profits are distributed back to the owners of the facility. Because the fees paid to the anesthesia providers are less than they could earn if they billed independently, it is estimated that these profits can equal 40 percent or more of the anesthesia fee (see https://www.beckershospitalreview.com/anesthesia/3-core-models-for-delivering-anesthesia-services-trends-legal-issues-and-observations.html).

The Anti-Kickback Statute (42 U.S.C. Section 1320a-7b(b)) makes it a criminal offense to knowingly and willfully offer, pay, solicit, or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal healthcare program. Stark Law is a set of U.S. federal laws that prohibit physician self-referral—specifically referral by a physician of a Medicare or Medicaid patient to an entity providing designated health services if the physician (or an immediate family member) has a financial relationship with that entity.

The company model and related complex schemes are typically created by non-anesthesia physicians to gain profits from the referral of their patients to an anesthesia business they own, thus creating the potential for physician self-referral. These models are created to permit the referring physician such as a surgeon, gastroenterologist, ophthalmologist, et al, to *indirectly* gain profits from their referrals to anesthesia providers because it is fraudulent to do so *directly*. Physicians and CRNAs involved in a company model arrangement should evaluate their legal relationship relative to OIG and DOJ queries. For more information, see https://www.aana.com/companymodel.

Emerging Trends

The current trend toward transparency in healthcare delivery costs has created significant opportunity for facility administrators, anesthesia companies, billers, and other stakeholders to take a closer look at various anesthesia delivery options. Surgery has always been the main profit center for hospitals and ASCs, but without anesthesia services, surgical services do not exist. Therefore, finding cost savings in anesthesia delivery services is a growing priority across the country, particularly in rural and medically underserved facilities that are at greater risk for closure due to unmanageable overhead and provider costs. According to the 2016 Medical Group Management Association (MGMA) provider compensation report, physician anesthesiologists' median total compensation package nationally was $453,687 per year as opposed to CRNAs at $172,000. MGMA further determined that a cost savings of 62 percent can prevent facility closure and maintain community access to care. By carefully examining overcompensation of physician anesthesiologists for services that can be provided as safely and more cost-effectively by CRNAs, a substantial portion of this percentage can be realized.

Opioid Crisis

As anesthesia experts, CRNAs are uniquely qualified to help mitigate the opioid crisis by utilizing and promoting non-opioid and opioid-sparing pain management techniques for both acute and chronic pain. The AANA and its members strongly advocate for the use of enhanced recovery after surgery protocols to reduce opioid use during surgery and other procedures requiring anesthesia care to help

prevent post-surgical opioid dependency and abuse. Additionally, in October 2018, the SUPPORT Act added CRNAs to the list of providers permitted to prescribe medication-assisted treatment (MAT) to individuals already suffering from opioid dependence.

The AANA's commitment to rethinking pain management to reduce or eliminate the use of opioids while maintaining patient comfort and safety and helping to prevent post-surgical dependence on powerful narcotics is an ongoing initiative. Research has shown that approximately 3 million Americans become persistent opioid users after surgery, and 83 percent of heroin users began by using prescription pain medications.

The AANA believes that acute and chronic pain is best treated and managed by an interdisciplinary team that actively engages the patient to diagnose and manage their pain for improved well-being, functionality, and quality of life.

- As members of the interdisciplinary team, CRNAs provide holistic, patient-centered, multimodal pain treatment and management across the continuum of pain and in all clinical settings (e.g., hospitals, ambulatory surgical centers, offices, and pain management clinics).
- Patient-centric pain management offers patients greater transparency, understanding and engagement in their own care. Patients need to be encouraged to play an active role in their healthcare and pain management plan by talking to their healthcare team, informing the team of any concerns they have, and asking questions to ensure everyone has the information they need.
- CRNAs integrate multimodal pain management as an element of enhanced recovery after surgery protocols to manage pain. Enhanced recovery pathways use multimodal pain management to reduce the use of opioids and shorten overall hospital length of stay. Management occurs from pre-procedure to post discharge using opioid sparing techniques such as regional anesthesia, peripheral nerve blocks, non-pharmacologic approaches, and non-opioid based pharmacologic measures.
- Careful assessment and treatment of acute pain, which may include appropriate opioid prescribing, can decrease the risk of acute pain transitioning to chronic pain and the possible development of opioid dependency and abuse.

As the primary point of contact for pre- and post-operative patients, CRNAs are doing their part to end the opioid crisis by utilizing a holistic, patient-centric approach to pain management and opioid prescription, offering patients greater transparency, understanding and engagement in their care.

Barriers to Anesthesia Delivery: Evolution and Cost Containment

To assist in improving access to healthcare across the United States, the National Academy of Medicine (formerly known as the Institute of Medicine) stated in its 2010 landmark report *The Future of Nursing* that "advanced practice registered nurses (APRNs) should be able to practice to the full extent of their education and training" (see http://www.academicprogression.org/about/future-of-nursing.shtml). However, regulatory barriers continue to exist, preventing CRNAs from attaining full scope of practice and increased reimbursement. Recently, a 119-page report published in 2018 by the U.S. Department of Health and Human Services (HHS) identified barriers to market competition at the federal and state levels that stifle innovation in healthcare cost containment delivery solutions. These barriers create higher prices and disincentivize administrators and providers who might otherwise seek to enhance healthcare quality. One of the report's main recommendations is to encourage policies that allow healthcare professionals to practice to their full scope to ensure workforce mobility and increase access to care while solving economic challenges without impacting value or safety (see https://www.hhs.gov/about/news/2018/12/03/reforming-americas-healthcare-system-through-choice-and-competition.html).

The Federal Trade Commission (FTC) weighs in on cases where APRN scope of practice has been restricted and patients' ability to receive care from the providers of their choice has been limited. Anticompetitive legislation and regulation proposed by the medical community, and especially physician

anesthesiologists, to protect their turf and compensation at the expense of their patients' best interests is becoming commonplace.

Another barrier to CRNA practice created by physician anesthesiologists is intended to impede nurse anesthesia residents' preparation by limiting their access to clinical training sites and procedures. The ASA's stated rationale is to protect employment opportunities for anesthesiologists. In the AANA's view, this sort of blatant protectionism is, at a minimum, unethical. *All* anesthesiology residents should be afforded the required clinical training opportunities necessary to become fully prepared for entry into practice. Patients depend on this.

For more information on barriers to practice see https://www.aana.com/publications/aana-journal/legal-briefs?tab3 and https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

AANA
AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

222 South Prospect Avenue
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July 25, 2019

Derrick C. Glymph, DNAP, CRNA, APRN
Chair, Florida Board of Nursing
4052 Bald Cypress Way Bin C-02
Tallahassee, FL 32399-3252

Re: Descriptor "nurse anesthesiologist"

Dear Members of the Florida Board of Nursing:

I am the President of the American Association of Nurse Anesthetists (AANA), which represents more than 54,000 nurse anesthetists (including Certified Registered Nurse Anesthetists (CRNAs) and student nurse anesthetists) nationwide. The AANA submits the following comments and information regarding the "nurse anesthesiologist" descriptor for CRNAs. In May of 2019 the AANA Board of Directors, after careful and thoughtful consideration, voted to recognize "nurse anesthesiologist" as a descriptor synonymous with "nurse anesthetist." The AANA now recognizes the following descriptors to identify nurse anesthetists: "Certified Registered Nurse Anesthetist," "Certified Registered Nurse Anesthesiologist," "CRNA," "nurse anesthetist," and "nurse anesthesiologist." Further, the AANA believes the term "nurse anesthesiologist" enhances public understanding of the nurse expert in anesthesiology consistent with the AANA's mission, since 1939, of advancing the art and science of anesthesiology.

"Nurse anesthesiologist" now appears in the following AANA documents:

- Certified Registered Nurse Anesthetists, Advance Practice Registered Nurses Position Statement;
- Corresponding AANA Fact Sheet;
- CRNAs at a Glance;
- "CRNAs - We are the Answer" position statement; and
- America's Anesthesia Workforce: Current Status and Emerging Trends

While the AANA recognizes "nurse anesthesiologist" as a proper descriptor for CRNAs, it remains the responsibility of each individual CRNA to remain aware of and comply with the legal requirements of any state or facility in which they practice.

Please do not hesitate to contact Anna Polyak, RN, JD, the AANA's Senior Director, State Government Affairs, at 847-655-1131 or apolyak@aana.com if you have any questions or require further information.

Sincerely,

Garry Brydges

Garry Brydges, DNP, MBA, ACNP-BC, CRNA, FAAN
AANA President

Exhibit 3

DECLARATORY STATEMENT

DR. JOHN P. McDONOUGH

BEFORE THE

BOARD OF NURSES, STATE OF FLORIDA DEPARTMENT OF HEALTH

August 8, 2019

Sanibel Harbor Marriott

17620 Harbor Pointe Drive

Fort Myers, Florida 33908

Reported by: Gerard "Bo" Kriegshauser, RPR

MARTINA-MIKULICE REPORTING SERVICES
2069 First Street -- Suite 201
Fort Myers, Florida 33901
(239)334-6545

MS. SUTTON-JOHNSON: John P. McDonough, Bates 26056. 26056.

CHAIR WHITSON: Good afternoon.

DR. McDONOUGH: Good afternoon.

CHAIR WHITSON: If you all could state your name, please.

DR. McDONOUGH: I'm sorry, I didn't hear you.

CHAIR WHITSON: If you all could state your names for the record, please.

DR. McDONOUGH: Oh. I'm Dr. John McDonough, the Petitioner.

CHAIR WHITSON: Thank you.

MS. MIKOS: I'm Cynthia Mikos with the Law Firm of Johnson Pope on behalf of Dr. McDonough.

MR. WINN: Jason Winn on behalf of the Florida Osteopathic Medical Association, the Florida Medical Association, and the Florida Society of Anesthesiologists.

MR. THOMAS: Glen Thomas on behalf of the Florida Association of Nurse Anesthetists.

CHAIR WHITSON: Thank you. And Dr. McDonough needs to be sworn in.

DR. JOHN McDONOUGH ADMINISTERED OATH

MS. LOUCKS: Board members, this is a

Petition for a Declaratory Statement that you received that you did have two petitions to intervene, and Dr. McDonough or Ms. Mikos, if I misstate what the petition is, please let me know. But basically Dr. McDonough is submitting a petition to the Board asking if he would be subject to disciplinary action by the Board were he to identify himself as a nurse anesthesiologist. It's my understanding from the petition that you're going to refer to yourself with your CRNA nurse anesthetist designation in addition to calling yourself a nurse anesthesiologist.

DR. McDONOUGH: That is correct, Counselor.

MS. LOUCKS: The first thing that the Board needs to do is determine whether or not the organizations that have filed the petitions to intervene have standing in order to participate in the discussion of the Declaratory Statement, and since we have two intervenors, the first petition to intervene was received by the Florida Association of Nurse Anesthetists, so I guess we'll go by order in which they were received.

Basically in order to make a determination of whether an organization has standing, they have to show that they're the members of their organization, would have an actual injury in fact, or suffer an

immediate harm of some sort of immediacy were the Board to issue this particular Declaratory Statement, and then they to -- the Board also has to make a determination of whether the nature of the injury would be within the zone of interest that the statute is addressing.

I know that -- I don't believe, Ms. Mikos, that you've filed any sort of objection to the Florida Association of Nurse Anesthetists participating in this.

MS. MIKOS: That's correct, I did not.

MS. LOUCKS: So, Board members, the first thing you need to do is make the determination of whether you believe that the Florida Association of Nurse Anesthetists would have standing to serve as intervenors in this particular petition.

CHAIR WHITSON: Do we need to do that with a vote? Or how do we --

MS. LOUCKS: Yes, you would need to make that in a form of a motion. If you were to deny it, you would need to specify why you believe that they don't have standing because we're looking at the standing issue first.

DR. GLYMPH: I make motion that they meet the standing.

MS. FORST: Second.

CHAIR WHITSON: All those in favor. Seeing none in opposition, the motion passes.

MS. LOUCKS: And the next petition that was received was a Petition to Intervene on behalf of the Florida Medical Association, the Florida Society of Anesthesiologists, and the Florida Osteopathic Medicine -- I'm sorry, Medical Association. Mr. Winn, did you want to make a presentation? I'm sorry, Mr. Thomas, I didn't give you the opportunity to make a presentation if you had wanted to, but did you want to make a presentation?

MR. THOMAS: Not anymore.

MS. LOUCKS: Mr. Winn, did you want to make a presentation on the standing issue?

MR. WINN: We'll stand by our petition.

MS. LOUCKS: And, Ms. Mikos, did you file an objection to their Petition to Intervene?

MS. MIKOS: I did file an objection to their Petition to Intervene, and since all of this happened in the last seven to ten days I'm not sure if the Board members have copies of that objection.

CHAIR WHITSON: We do.

MS. MIKOS: Okay. So I think it would suffice to say that we would object on two grounds as

to their standing. No. 1, they are not -- physicians are not governed by the Board of Nursing, and the question that we're asking is on behalf -- we're asking the Board of Nursing to discuss its rules and its laws related to one of its licensees and how that licensee may describe himself.

And, secondly, I would point out that we're not asking to use the term anesthesiologist as a freestanding term. We are asking that Dr. McDonough be able to describe himself as a nurse anesthesiologist, and therefore we do not believe that that falls within the realm of the members of the FMA, the FSA or the FOMA. thank you.

CHAIR WHITSON: Thank you. Do we need a motion?

MS. LOUCKS: Yes, you would need a motion as to whether the FMA, FSA and FOMA, that's just easier, sorry, whether they have standing to participate in the Petition to Intervene.

CHAIR WHITSON: We need a motion.

MS. LOUCKS: Yes.

DR. GLYMPH: I make a motion that they don't.

MS. FORST: Second.

CHAIR WHITSON: All those in favor.

MS. LOUCKS: And -- I'm sorry, and just to clarify, Dr. Glymph, the reasons that they don't have standing are the reasons that were articulated by Ms. Mikos?

DR. GLYMPH: Yeah, they're Board of Medicine, not Board of Nursing.

MS. LOUCKS: And these are nursing disciplinary guidelines that are being discussed?

DR. GLYMPH: Yes.

MS. LOUCKS: So their licensees and members wouldn't be affected by nursing discipline?

DR. GLYMPH: Yes.

MS. LOUCKS: Okay. Thank you.

Mr. Winn, did you have any additional comments you would want to make at this point, or do you want to...

MR. WINN: Well, we would argue that we have standing based upon the term that they're looking to use -- or the question to you about nurse anesthesiologists, and how anesthesiologist is defined in Florida statute in 459 and in 458. Any individual, whether it's before this Board or any other Board, that wants to use a term that's already in statute and the M.D. and D.O. statute would be in violation of that statute, it would then confuse the public,

mislead the public, and affect our members that are anesthesiologists that are M.D.s and D.O.s. Thank You.

CHAIR WHITSON: Thank you.

MS. LOUCKS: And, Board members, if you want to reconsider your vote on the standing for the FMA, FOMA and the anesthesiologists, you can do that. If not, then we can proceed with the Petition for Declaratory Statement.

CHAIR WHITSON: Shall we proceed or would you all like to --

MS. FORST: No, I think we can proceed.

CHAIR WHITSON: Okay. Mr. McDonough -- Dr. McDonough, excuse me, would you like to address the Board.

DR. McDONOUGH: Thank you. Madam Chair, if it pleases the Board, I would like to present a very brief historical background why I consider this petition to be important. Contrary to what some people believe who are uninformed regarding anesthesia, people believe that the administration is the practice of medicine. It its absolutely not. Never has been. It's the practice of medicine only when it's done by physicians. It's a practice dentistry when it's done by dentists. It's done --

when it is done by nurses, it is the practice of nursing. There is a very long tradition. The first nurse recorded in the United States to administer anesthesia was Katherine Lawrence who administered ether and chloroform to soldiers during the Civil War. The first nurse who limited her nursing practice exclusively to the administration of anesthesia was in 1887, Sister Mary Bernard, at St. Vincent's Hospital in Erie, Pennsylvania. The first organized educational program of any kind to teach the administration of anesthesia was established in 1915 at the Lakeside Hospital School of Anesthesia in Cleveland, Ohio. The first class was six months long. It cost $50. And the first class of graduates were two dentists, six physicians, and 12 nurses. The American Association of Nurse Anesthetists was founded in 1931. In 1936 the physicians who administered anesthesia established a group called the American Society of Anesthetists.

In 1939 a professor at the University of Illinois College of Medicine sent a letter to the American Society of Anesthetists stating that he claims to have coined the term anesthesiology and defined it as, and I quote, "The science that treats the means and methods of producing various degrees of

insensibility to pain with or without hypnosis. An anesthetist is a technician, and an anesthesiologist is an expert scientific authority on anesthesia and anesthetics. I cannot understand why your group does not term themselves the American Society of Anesthesiologists. Sincerely M.J. Syfert, M.D."

If the Board wishes, I have copies of these documents. I'll be happy to submit them as part of the record.

In 1945 the organization, which was then the American Society of Anesthetists, changed their name to the American Society of Anesthesiologists. Regarding Dr. Syfert's opinion, I would like to state that I am not a technician. I am not an extender of anybody else's professional activity. I am not an assistant to any other profession. I am not a mid-level anything. I am an advanced practiced registered nurse whose speciality is anesthesiology. The fact that anesthesiology is not the practice of medicine was, in fact, ruled decades ago exactly on January the 18th, 2001, the Department of Health and Human Services in the Federal Register as part of the final rule governing participation in Part A, conditions of participation, Part A of Medicare in hospitals, and I quote partially, and if you wish I

have the entire document which we can supply to you as part of the record, "Anesthesia administration by nurse anesthetists have a long history in this country, including independent practice in Department of Defense hospitals. We cannot agree that the administration of anesthesia is the practice of medicine." Close quotes, period.

So although other people may claim that the word anesthesiology means physician, it does not. Never has, never will. In fact, 55 percent of the people in the country when surveyed by the American Society of Anesthesiologists didn't realize an anesthesiologist was a physician. So, if this petition is granted, I don't think anybody is going to be confused. I think it will be, in fact, a benefit to the public to understand the person taking care of them is in fact a scientific expert in anesthesia. All of our people are now minimally trained at the Master's level. The vast majority of our programs are now doctoral programs. They will all be doctoral programs by 2023.

If -- thank you, Counselor. I am in fact a member of the Committee for Proper Recognition of CRNAs. It is a group which is moving forward towards the descriptor change and the title change. The

American Association of Nurse Anesthetists has approved this title effective this year. Other states have already taken this action. The New Hampshire Board of Nursing has ruled that nurse anesthesiologists is an acceptable description for CRNAs, and as of last Friday Arizona Board of Nursing took precisely the same action. I am also prepared to submit documentation of these acts to the Board should you wish to have it in the record. I am open to any questions the Board may have.

CHAIR WHITSON: Board members. Dr. Glymph.

DR. GLYMPH: So you plan on using this in the facility, Tampa General, where you practice at.

DR. McDONOUGH: I practice clinically at Tampa General. I am professor and chair of the Nurse Anesthesiology Program at the University of North Florida in Jacksonville, and there as well.

CHAIR WHITSON: Are you -- so you're planning on using this just as a description of the services you provide. Not necessarily titling yourself --

DR. McDONOUGH: No, no, this --

CHAIR WHITSON: -- as an anesthesiologist?

DR. McDONOUGH: -- is a descriptor. This is not a title. A title is --

CHAIR WHITSON: It's just --

DR. McDONOUGH: A title is governed by statute, --

CHAIR WHITSON: Right.

DR. McDONOUGH: -- administrative rule. This is a descriptor.

CHAIR WHITSON: Right -- as if you're trying to explain your services or the differentiation to a patient.

DR. McDONOUGH: Exactly. Physician's Assistant, for instance, in this state now routinely tell people that they are their anesthetist. Excuse me, anesthesiology assistants tell patients that they are anesthetists. The American Academy of Anesthesiologists assistants has a website, their website, which is called anesthetist.org. When they had their national meeting in Florida last year the theme of the meeting was Meet Your New Anesthetist. And organized physician anesthesiologists are now referring -- they don't refer to nurse anesthetist as nurse anesthetist or CRNAs, they refer to them as anesthetist, and they refer to AAs as anesthetist as well, and I think this is causing a tremendous amount of confusion, and I for one would like to be sure that I am safe within the disciplinary guidelines of the

Board to try and bring some clarity to this by referring to -- to my role and my services of that as a nurse anesthesiologist.

CHAIR WHITSON: Are your plans to use this in conversation? Or printed? Thoughts. I mean, are you...

DR. McDONOUGH: In conversation I believe would be correct.

CHAIR WHITSON: Ms. McKeen.

MS. McKEEN: I'm not sure why at this point you would seek this statement from the Board.

DR. McDONOUGH: Well, because I don't want to risk getting into trouble by calling myself, discussing the fact that I'm a nurse anesthesiologist and then having someone raise a complaint with the Board of Nursing against me doing that.

MS. McKEEN: I think I meant your motivation, why the title is important.

DR. McDONOUGH: Well, the title is important because there's a lot of confusion on the part of the public because anesthesiologist's assistants are referring to themselves as anesthetists. This is the national trend. It has been approved at the national level by the American Association of Nurse Anesthetists that nurse anesthesiologist is an

appropriate descriptor. Other Boards of Nursing have changed, and I'm asking for permission for me to do that here in Florida.

MS. McKEEN: Thank you.

DR. McDONOUGH: You're welcome.

CHAIR WHITSON: I have another question on that. Just bouncing off your idea --

MS. NEUMAN: Ms. Whitson?

CHAIR WHITSON: Yes.

MS. NEUMAN: I'm sorry.

CHAIR WHITSON: Carry on.

MS. NEUMAN: Dr. McDonough, did I -- I think I read in your literature that is -- is it New Hampshire has already recognized -- I believe the State of New Hampshire?

DR. McDONOUGH: Yes, ma'am. The national -- our National Association the AANA has recognized the change. The New Hampshire Board of Nursing recognized the change. I believe it was last month and last Friday the Arizona Board of Nursing also recognized the change.

MS. McKEEN: When you reference the change, do you mean the ability to use the phrase, the descriptor nurse anesthesiologist?

DR. McDONOUGH: Yes, that's what I was

referring to. The ability to use it as a descriptor.

MS. McKEEN: Right.

DR. McDONOUGH: I'm not asking for a title change. I'm asking for a descriptor.

MS. NEUMAN: It was very clear in the literature.

DR. McDONOUGH: Thank you.

MS. NEUMAN: Thank you.

MS. McKEEN: Ms. Whitson, you were saying?

CHAIR WHITSON: Do you think it would be better served for this to come out through the professional organizations as opposed to --

DR. McDONOUGH: It already has.

CHAIR WHITSON: -- us making a ruling on it?

DR. McDONOUGH: Well, the professional organization has in fact ruled on it. They have decided that nurse anesthesiologists is an acceptable -- they actually use it as a title as well as a descriptor. However, my concern is I want to be safe in terms of the Board of Nursing. I have great respect for the Board and I don't want to do anything that's going to get me in trouble with the Board. So this is a matter of self-protection from my point of view. I think this is an appropriate thing to do, but I want to have the approval of the Board to do it

before so, before I would fully do it.

MS. JOHNSON: Ms. Whitson?

CHAIR WHITSON: Ms. Johnson.

MS. JOHNSON: May we hear from the other gentleman.

(Inaudible)

MS. JOHNSON: Oh, no, we voted one.

CHAIR WHITSON: The Association of Nurse Anesthetists.

MS. JOHNSON: There were two and we voted that one could, so I would like to hear from him, please.

MR. THOMAS: Sure. I just had a couple of legal points that I wanted to point out. The first is there was some mention that there is --

UNIDENTITFED: We can't hear.

CHAIR WHITSON: Mr. Thomas, will you speak into the microphone, please?

MR. THOMAS: Okay. So there was some mention that the word of anesthesiologist is defined in statute. That's true. But if look at how it's defined, it's defined within the Anesthesiologist Assistant Practice Act, and those definitions are clear. These terms only apply to the use in this particular section. In other words, that -- you can't

use the term anesthesiologist to mean that outside of this. This is only what it means for the AA Practice Act which is where it's needed because only an anesthesiologist can supervise an AA to just -- in that statute it also says -- the term direct supervision says, it is defined as on-site personal supervision by an anesthesiologist. Now, we all know that the term "direct supervision" doesn't mean supervision by an anesthesiologist. It does in that -- in that one section of law. That's why those terms only apply in that very narrow section. So even though it is defined in those, it doesn't apply to any other section of law. And like Dr. McDonough said, even if it did apply, what we're seeking is the use of the term nurse anesthesiologist, not anesthesiologist by itself.

And I think to clarify, one of the -- one of the -- there is no law that directly governs what a CRNA can call themselves or directly governs whether they can use the term nurse anesthesiologist. The law prohibits the use of a term that's misleading, deceptive or fraudulent. In this case, we have the use of the word -- the term nurse anesthesiologist, the term ologist, the suffix applies to an expert in a scientific area, and the term anesthesiology refers to

a branch of medical science dealing with anesthesia. So I don't think you can say it's deceptive to use the term nurse anesthesiologist, which literally means a nurse who is an expert in the area of anesthesia. So, under Florida law I don't think this would be a violation so long as the practitioner advised a patient of their license under which they practice.

MS. MIKOS: And I would just like to add a couple of things that were in the petition but we haven't said here today that I just want make sure I understood. There is no title protection for the word anesthesiologist in any statute. The definition that's included, as Mr. Thomas just said, is a limited section governing anesthesia assistants and who they report to. But there is no title protection in either 458 or 459, or anywhere else in Florida statutes for the term anesthesiologist. Thank you.

DR. McDONOUGH: If I may recognize, Madam Chair?

CHAIR WHITSON: Just a moment. Mr. Baker has a question.

MR. BAKER: The actions by New Hampshire and Arizona, were those based upon a petition or more of a blanket?

DR. McDONOUGH: They were based upon a

petition --

MR. BAKER: Petition? Thank you.

DR. McDONOUGH: -- from licensees.

I would also like to point out that the -- the -- the addition of nurse anesthesiologists as a permissible phrase to describe what I do is very consistent with the other types of anesthesiologists, the two other types of anesthesiologists who are not physicians. One is a dentist. We use in Florida the term dental anesthesiologist all the time. The Board of Dentistry talks about it. I believe it's also in some administrative rule, but I'm not positive about that. I can check on that. And veterinary anesthesiologist. So to be an anesthesiologist does not mean you're a physician. It means you're a specialist in anesthesia, and than be preceded by dental anesthesiologist, veterinary anesthesiologist. In fact, the American Society of Anesthesiologists, the physicians specialty group, now has routinely started referring to themselves physician anesthesiologist.

CHAIR WHITSON: Ms. Desmond.

MS. DESMOND: I would just say that Dr. McDonough has made a very good presentation and it's a reasonable presentation in my mind that I don't feel

like there would be any Board action on my part. I mean, that is the concern. I don't see that there would be an issue with the Board with you using that descriptor. It's been approved in other places. It's used in other disciplines. And the professional organization has also condoned it. So, for me I don't -- I think he's made a very good presentation here to support his request.

MS. NEUMAN: Board counsel, I have a question just to reiterate. Now, Dr. McDonough is asking this in keeping with the rules of Declaratory Statement Request for himself only; is that correct?

DR. McDONOUGH: That is correct.

MS. LOUCKS: That's correct. And if the Board were to grant his petition, it wouldn't necessarily stop a complaint being filed or an investigation being opened on him. Using that term it would allow him individually to say I received this answer to my Declaratory Statement from the Board and the Board says it's okay for me to use it. Another CRNA who might have a complaint filed against them could make the argument that, "Well, the board said it was okay for Dr. McDonough," but it wouldn't put a stop on that particular investigation as it would for Dr. McDonough.

MS. NEUMAN: Exactly, because this is for just Dr. McDonough who obviously has the credentials to --

MS. LOUCKS: Right, right. If that was another CRNA that used that title and there was a complaint open, then they would have to demonstrate that they, you know, to the Probable Cause Panel or to whomever was reviewing it that they would have requirements that the Board would be satisfied with that they would be an anesthesiologist.

MS. DESMOND: But just to clarify, he's asking for a descriptor, --

MS. LOUCKS: He's only --

MS. DESMOND -- not a title.

MS. NEUMAN: Right. And he'll use that only to apply to himself as he describes for his clients.

MR. BAKER: I have a question.

CHAIR WHITSON: Mr. Baker.

MR. BAKER: I just want to get counsel's input as part of the discussion with the Board members that if granted, it's permissible for this type of Declaratory Statement to be binding on a future Board.

MS. LOUCKS: Yes.

MR. BAKER: Say ten years from now when none of these folks may be sitting here, a decision they

made can bind future appointees of this Board on what they might view as their role.

MS. LOUCKS: That's correct, as it relates to Dr. McDonough.

CHAIR WHITSON: Can I ask Dr. Glymph to -- have you found any issues in your own practice with regard to that.

DR. GLYMPH: Yeah, I would say no. I mean, I think it's very clear what Dr. McDonough presented, especially with the prefix nurse anesthesiologist. No confusion whatsoever. So -- and, like I said, it's a descriptor. It's been approved by the national Board as well as other Boards have now approved it. So I think it's nothing in a stretch for Florida to do it.

CHAIR WHITSON: I make a motion to approve.

DR. GLYMPH: Second.

MS. LOUCKS: Just to clarify, you're approving that he can use that -- the term nurse anesthesiologist as a descriptor, but he still needs to identify himself additionally as a CRNA?

MS. NEUMAN: Yes.

MS. LOUCKS: Okay.

CHAIR WHITSON: So it's been moved and seconded. All those in favor.

Those opposed.

Seeing none, the motion passes.

MS. LOUCKS: Ms. Mikos, I can e-mail the order to you. Is that acceptable?

MS. MIKOS: That would be great. Thank you, very much.

MS. LOUCKS: Thank you.

CHAIR WHITSON: Thank you.

DR. McDONOUGH: Thank you.

DR. GLYMPH: Mr. Baker, let me ask you a question. So the Arizona and the -- so the blanket statement of the petition, that would affect the whole body of the profession, right?

MR. BAKER: Well, I asked that question because some Boards of Nursing have legal authority that have policy statements.

DR. GLYMPH: Ahhhh.

MR. BAKER: And that's why I was curious if they had responded to a petition or if they had granted a policy statement.

DR. McDONOUGH: Mr. Baker, I have an answer regarding New Hampshire for that. The answer is somewhat hyper, and the reason I know the answer is the petitioner was one of my graduates, Dr. Dwayne, Thibault, Dwayne, D-W-A-Y-N-E, Thibault, T-H-I-B-A-U-L-T, CRNA, petitioned the Board and they

actually changed -- the Board has the authority in New Hampshire to actually change the title. In fact, now in New Hampshire you can choose to be licensed in New Hampshire as an APRN with the title Certified Registered Nurse Anesthetist, or Certified Registered Nurse Anesthesiologist. There is a checkmark for each of those titles on the APRN application. So New Hampshire process is different from ours. He -- he actually asked for a title change and got it, and they have the authority to do that in New Hampshire. We do not here. So I'm just asking for me.

MS. MIKOS: And just to be clear, the New Hampshire document is labeled "A Position Statement". Thank you.

CHAIR WHITSON: Thank you.

o-O-o

CERTIFICATE OF REPORTER

I, Gerard "Bo" Kriegshauser, Notary Public, State of Florida, do hereby certify that I was authorized to and did stenographically report the foregoing declaratory statement of Dr. John P. McDonough consisting of pages 2 through 25.

I further certify that I am not a relative, employee, attorney or counsel of any of the parties, nor am I a relative or employee of any of the parties' attorney or counsel connected with this action, nor am I financially interested in this action.

Dated this 5th day of October, 2019.

_____

Gerard "Bo" Kriegshauser

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Florida Department of Health

BILL INFORMATION	
BILL NUMBER:	1142
BILL TITLE:	Prohibited Acts by Health Care Practitioners
BILL SPONSOR:	Rodrigues (R)
EFFECTIVE DATE:	Upon becoming a law

COMMITTEES OF REFERENCE
1) Health Policy
2) Appropriations Subcommittee on Health and Human Services
3) Appropriations
4) Click or tap here to enter text.
5) Click or tap here to enter text.

CURRENT COMMITTEE
Health Policy

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

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

IDENTICAL BILLS	
BILL NUMBER:	721
SPONSOR:	Massullo, Jr.

Is this bill part of an agency package?
No

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	2/20/2021
LEAD AGENCY ANALYST:	Kama Monroe
ADDITIONAL ANALYST(S):	Click or tap here to enter text.
LEGAL ANALYST:	Louise St. Laurent
FISCAL ANALYST:	Jonathan Sackett

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

The bill prohibits a licensed health care practitioner from using the terms “anesthesiologist” or “dermatologist” unless licensed as a physician under Chapter (ch.) 458 or 459, Florida Statutes (F.S.), or a dentist under ch.466, F.S. The bill adds, as grounds for discipline, the making of misleading, deceptive, or fraudulent representations related to a practitioner’s specialty designation. It instructs the Department of Health to issue emergency orders to cease and desist and take disciplinary action against practitioners licensed by a Board who violate these provisions. The bill includes rulemaking authority and takes effect upon becoming a law.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Section 456.072, F.S., provides a generalized list of grounds for discipline, which allows the Board, or the Department where there is not a Board, to take disciplinary action against a licensee, up to and including revocation of his or her license. The list of grounds for discipline includes:

- Paragraph 456.072(1)(a), F.S., "Making misleading, deceptive, or fraudulent representations in or related to the practice of the licensee’s profession."
- Paragraph 456.072(1)(t), F.S., “Failing to identify through written notice, which may include the wearing of a name tag, or orally to a patient the type of license under which the practitioner is practicing. Any advertisement for health care services naming the practitioner must identify the type of license the practitioner holds. Each board, or the department where there is no board, is authorized by rule to determine how its practitioners may comply with this disclosure requirement.”

Many Practice Acts governing health care practitioners include provisions which specify that it is a misdemeanor to identify one’s activities by using certain terms which are considered specific to that licensed profession, if one does not hold that license. For example, section 466.026, F.S., specifies that a person who does not hold a license under ch. 466, F.S., may not refer to themselves as a Dentist.

However, these provisions do not include all terms that may be used by a licensed professional to refer to their practice or specialty. Physicians licensed under ch. 458 or 459, F.S., are not required to provide any information to the Department about their specific area of practice. Physicians are not required to list any specialty or Board Certifications on their professional profile or notify the Boards or Department of their area of practice. As such, there is no specific statutory restriction against any licensed professional using a term such as “Obstetrician,” “Pediatrician,” “Anesthesiologist,” or “Dermatologist” to indicate their area of practice.

For professionals where the license was issued by a Board, disciplinary actions against that license are taken by the Board. The Department is only responsible for taking disciplinary actions against practitioners in professions without a regulatory Board. However, for all professions Emergency Actions (emergency suspension or emergency restriction} are taken by the Department, while the cases progress through the disciplinary process.

2. EFFECT OF THE BILL:

This bill amends s. 456.072, F.S., which specifies grounds for discipline, applicable to all licensed health care practitioners.

The bill amends s. 456.072(1)(a) to prohibit a licensed health care practitioner from using the term “anesthesiologist” unless he or she is licensed as a physician under ch. 458 or 459, F.S., or a dentist under ch. 466, F.S. Similarly, only practitioners licensed under ch, 458 or 459, F.S., may use the term “dermatologist.” The bill adds, as grounds for professional discipline the making of misleading, deceptive, or fraudulent representations related to a practitioner’s specialty designation.

The bill does not provide any definition of the term "specialty designation."

If a licensed health care practitioner violates section 456.072(1)(a), F.S., the licensing Board will no longer be able to discipline the licensee. Instead, the Department must issue to the practitioner an emergency order to cease and desist and send the order to the practitioner by certified mail and email, or to any other mailing address or email address where the Department believes the person may be reached. If the practitioner does not immediately cease and desist his or her actions upon receipt of the emergency cease and desist order, one or more of the following penalties must be imposed by the Department until the practitioner complies:

- A citation and a daily fine.
- A reprimand or a letter of concern.
- Suspension of the license.

The bill does not provide any requirements or procedures for the Department to issue the required emergency order to cease and desist.

The bill also amends section 456.072(1)(t), F.S., and adds, as grounds for professional discipline, the failure to identify to a patient the type of specialty designation under which a practitioner is practicing. The bill specifies that the Department, not the licensing Board, shall enforce this paragraph.

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

If yes, explain:	Each Board will need to review their disciplinary guidelines and amend them as necessary to account for the fact that they can no longer take certain disciplinary actions. The Department will need to create a disciplinary process under which they can impose discipline on health care practitioners who are licensed by a Board and have violated specific statutory provisions. In addition, new procedures for issuing an emergency order to cease and desist will need to be devised.
Is the change consistent with the agency's core mission?	Y☐ N☒
Rule(s) impacted (provide references to F.A.C., etc.):	To be determined by each board.

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

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

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

If yes, provide a description:	N/A

Date Due:	N/A
Bill Section Number(s):	N/A

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

Board:	N/A
Board Purpose:	N/A
Who Appoints:	N/A
Changes:	N/A
Bill Section Number(s):	N/A

FISCAL ANALYSIS

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

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

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

Revenues:	None
Expenditures:	DOH/MQA will incur non-recurring cost for rulemaking, yet current budget authority is adequate to absorb. DOH will incur non-recurring cost for rulemaking, yet current budget authority is adequate to absorb. DOH may experience a recurring increase in workload associated with additional complaints, investigation, and prosecution due to the provisions in this legislation. The impact is indeterminate; therefore, the fiscal impact cannot be calculated.

Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

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

Revenues:	None
Expenditures:	Healthcare Practitioners in violation of the restrictions in this bill, may be subject to disciplinary actions and fines.
Other:	N/A

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

If yes, explain impact.	Healthcare Practitioners in violation of the restrictions in this bill, may be subject to disciplinary actions and fines.
Bill Section Number:	Section 1.

TECHNOLOGY IMPACT

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

If yes, describe the anticipated impact to the agency including any fiscal impact.	N/A

FEDERAL IMPACT

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

If yes, describe the anticipated impact including any fiscal impact.	N/A

ADDITIONAL COMMENTS

The bill includes new disciplinary grounds that are related to misrepresentation of a practitioner's "specialty designation." However, there is no definition of the term "specialty designation" nor is there any information about what constitutes misrepresentation. While some physicians hold Board Certifications in their specialty areas from the American Board of Medical Specialties or the American Osteopathic Association, not all specialists hold or maintain such credentials. Health care providers who participate in the Medicare system typically have a specialty designation that they bill under. It is unclear what credentials a practitioner must hold to use a "specialty designation" and when the use of such a term would be considered misleading or fraudulent.

Under the provisions of this bill, the Department, not the applicable Board, is to impose discipline for violations of paragraphs 456.072(1)(a) and (t), F.S. (see lines 37-40 and 91-110) This will require an entirely new disciplinary process allowing the Department to discipline health care practitioners licensed by a Board.

This will require the creation of a unique disciplinary procedure and tracking system for these specific charges. For all other disciplinary grounds, it is the Board that issues the license that takes disciplinary action against that license. This would set up a unique situation where the Department would suspend the license of a practitioner without the involvement or input of the Board that issued the license.

The bill specifies that the Department shall issue an emergency order to cease and desist using certain terms and specialty designations. How this emergency order would be issued and the circumstances surrounding the order are not specified. Currently, when the Department issues an emergency order it must show that allowing the practitioner to continue to practice will constitute an immediate serious danger to the health, safety, or welfare of the citizens of the State of Florida and that nothing short of the proposed emergency action will protect the citizens from that danger. It is unclear how these requirements would be met under the circumstances specified by the bill.

LEGAL - GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	Line 31 of the proposed legislation adds failing to identify or making misleading, deceptive or fraudulent representations regarding a health care practitioner's "specialty designation" as a ground for discipline, however, the term "specialty designation" is not defined in the bill or in existing statute and is not a term used in the ordinary course of health care practitioner regulation. Absent any definition or guideline, the new ground for discipline is so vague as to be unenforceable. Line 37 of the proposed legislation provides that the department enforces violations of the ground for discipline related to the statements regarding the licensee's profession or specialty designation. This appears to conflict with provisions of section 456.073, Florida Statutes. Sections 456.073(1) and (2), Florida Statutes, provide that the department investigates complaints and violations of the grounds for discipline and provides the completed investigative report to the probable cause panel of the appropriate regulatory board. The report is sent to the department only when there is no board. Section 456.073(4), Florida Statutes, provides that the determination of the existence of probable cause is made by the probable cause panel of the appropriate regulatory board. The department determines probable cause only if there is no board. Finally, section 456.073(6), Florida Statutes, provides that the appropriate board issues the final order in each health care professional disciplinary case, unless there is no board in which case the department would issue the final order. Lines 102-110 of the proposed legislation provide for specific penalties if the health care practitioner does not immediately comply with the emergency cease and desist order. The lack of specificity with respect to determining when service on the licensee has been perfected makes it difficult to determine when a failure to comply has occurred. The legislation provides that if the licensee does not immediately comply with the emergency order the department must enter an order that imposes penalties, which include a citation and continuing fine, reprimand, letter of concern or suspension, until the licensee complies with the cease and desist order. This may subject the legislation to challenge as a violation of the licensee's due process rights under the State and U.S. Constitutions. It may also conflict with section 456.073(5), Florida Statutes, which provides that a formal hearing must be held before an administrative law judge in disciplinary matters if there are material issues of disputed fact. Also, section 120.60(5), Florida Statutes provides that no revocation, suspension, annulment or withdrawal of any license is lawful unless prior to the entry of the order the agency has served, by personal service or certified mail, an administrative complaint which affords reasonable notice to the licensee of facts or conduct which warrant the intended action and the licensee has been given an adequate

	opportunity to request a proceeding pursuant to sections 120.569 and 120.57, Florida Statutes. Line 110 of the proposed legislation provides for suspension of a license without notice, a right to respond, or the opportunity to be heard. This may conflict with section 120.60(6), Florida Statutes, which provides that a license may be suspended on an emergency basis only after the agency finds an immediate serious danger to the public health, safety or welfare and the suspension procedure provides at least the same procedural protections as given by other statutes, the State Constitution or the United States Constitution. Further section 120.60(6) Florida Statutes provides that the action taken is narrowly construed, and the agency states in writing at the time of, or prior to, its action the specific facts and reasons for finding an immediate danger to the public health, safety or welfare and its reasons for concluding that the procedure used is fair under the circumstances, which are judicially reviewable by de novo review.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Lyon

Job Title _____

Address _____ Phone 222-5702
Street

_____ Email _____
City *State* *Zip*

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Florida Assn. of Nurse Anesthetists

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

1142
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 4427 Herschel St
Street

Jacksonville, FL 32210
City *State* *Zip*

Phone 904-233-3051

Email _____

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Plastic Surgeons

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

1142
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Prohibited Acts by Health Care Practitioners

Name Jon Johnson

Job Title Lobbyist

Address 527 E Park Ave
Street

Phone 850-224-1900

Tallahassee — *City* | FL — *State* | 32301 — *Zip*

Email jon@ teamjb.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Society of Anesthesiologists

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

S-001 (10/14/14)

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 1442
INTRODUCER:	Senator Boyd
SUBJECT:	Substance Abuse Prevention
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 1442 amends and creates several sections of the Florida statutes related to substance abuse prevention. The bill amends s. 381.887, F.S., to allow a pharmacist[1] to dispense an emergency opioid antagonist without a prescription to any person specified by the bill and to allow such person to store, possess, and, in an emergency situation, administer the opioid antagonist. The bill provides immunity from civil and criminal liability related to the administering of an opioid antagonist to emergency responders, crime laboratory personnel, law enforcement personnel, and any person dispensed an opioid antagonist pursuant to the above provision.

The bill requires the Department of Health (DOH) to develop and implement a statewide awareness campaign to educate the public regarding the risk factors and signs and symptoms of opioid overdoses as well as how to respond to such overdoses, including the safe storage and administration of emergency opioid antagonists.

The bill creates s. 381.888, F.S., to require the DOH, in coordination with the Board of Pharmacy (BOP), to establish and administer the At-home Drug Deactivation and Disposal System Program (Program) for the purpose of identifying and distributing a suitable at-home drug deactivation and disposal system which pharmacies must co-dispense with each opioid prescription. The DOH, in coordination with the BOP, must develop relevant educational materials for the program and adopt rules to implement the program. The bill amends ss. 456.44 and 465.0276, F.S., to require the concurrent prescription of the at-home deactivation and disposal system with the prescription of an opioid drug listed as a schedule II controlled substance.

The bill also amends s. 401.253, F.S., to require a health care facility, a basic life support service (BLS), or an advanced life support service (ALS) to report the treatment and release or transport

[1] Licensed under ch. 465, F.S.

of a person in response to an emergency call for a suspected or actual overdose of a controlled substance. Currently, reporting of such incidents is authorized, but not required, for ALS and BLS.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

History of the Opioid Crisis in Florida

According to the National Institute on Drug Abuse:[2]

- "In the late 1990s, pharmaceutical companies reassured the medical community that patients would not become addicted to prescription opioid pain relievers, and health care providers began to prescribe them at greater rates" and
- "This subsequently led to widespread diversion and misuse of these medications before it became clear that these medications could indeed be highly addictive."

Between the early 2000s and the early 2010s, Florida was infamous as the "pill mill capital" of the country. At the peak of the pill mill crisis, doctors in Florida bought 89 percent of all the oxycodone sold in the county.[3]

Between 2009 and 2011, the Legislature enacted a series of reforms to combat prescription drug abuse. These reforms included strict regulation of pain management clinics; creating the Prescription Drug Monitoring Program (PDMP); and stricter regulation on selling, distributing, and dispensing controlled substances.[4] "In 2016, the opioid prescription rate was 75 per 100 persons in Florida. This rate was down from a high of 83 per 100."[5]

As reported by the Florida Attorney General's Opioid Working Group:

> Drug overdose is now the leading cause of non-injury related death in the United States. Since 2000, drug overdose death rates increased by 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioids. In 2015, over 52,000 deaths in the U.S. were attributed to drug poisoning, and over 33,000 (63 percent) involved an opioid. In 2015, 3,535 deaths occurred in Florida where at least one drug was identified as the cause of death. More specifically, 2,535 deaths were caused by at least one opioid in 2015. Stated differently, seven lives per day were lost to opioids in Florida in 2015. Overall the state had a rate of opioid-caused deaths of 13 per 100,000. The three counties with the highest

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[2] National Institute on Drug Abuse, *Opioid Overdose Crisis* (Rev. Jan. 2019), *available at* https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis (last visited Mar. 12, 2021).
[3] Lizette Alvarez, *Florida Shutting 'Pill Mill' Clinics*, The New York Times (Aug. 31, 2011), *available at* http://www.nytimes.com/2011/09/01/us/01drugs.html (last visited Mar. 12, 2021).
[4] *See* Chapters 2009-198, 2010-211, and 2011-141, Laws of Fla.
[5] Attorney General's Opioid Working Group, *Florida's Opioid Epidemic: Recommendations and Best Practices*, 7 (Jan. 25, 2021), *available at* https://myfloridalegal.com/webfiles.nsf/WF/TDGT-B9UTV9/$file/AG+Opioid+Working+Group+Report+Final+2-28-2019.pdf (last visited Mar. 12, 2021).

opioid death rate were Manatee County (37 per 100,000), Dixie County (30 per 100,000), and Palm Beach County (22 per 100,000).[6]

Early in 2017, the federal Centers for Disease Control and Prevention (CDC) declared the opioid crisis an epidemic.[7] Shortly thereafter, on May 3, 2017, Governor Rick Scott signed Executive Order 17-146 declaring the opioid epidemic a public health emergency in Florida.[8]

House Bill 21 (2018)

In 2018, the Florida Legislature passed CS/CS/HB 21 (Chapter 2018-13, Laws of Florida) to combat the opioid crisis. CS/CS/HB 21:

- Required additional training for practitioners on the safe and effective prescribing of controlled substances;
- Restricted the length of prescriptions for Schedule II opioid medications to three days or up to seven days if medically necessary;
- Reworked the PDMP statute to require that prescribing practitioners check the PDMP prior to prescribing a controlled substance and to allow the integration of PDMP data with electronic health records and the sharing of PDMP data between Florida and other states; and
- Provided for additional funding for treatment and other issues related to opioid abuse.

Opioid Antagonists

Opioid receptor antagonists block one or more of the opioid receptors in the central or peripheral nervous system. Opioid receptors are specific transmembrane neurotransmitter receptors that couple G-proteins, which upon stimulation by endogenous or exogenous opioids, leading to the intracellular process of signal transduction. The two most commonly used centrally acting opioid receptor antagonists are naloxone and naltrexone. Naloxone comes in intravenous, intramuscular, and intranasal formulations and is FDA-approved for the use in an opioid overdose and the reversal of respiratory depression associated with opioid use. Naltrexone is available in both oral and long-acting injectable formulations and is FDA-approved for the treatment of opioid and/or alcohol maintenance treatment. The most commonly used peripheral opioid receptor antagonist is methylnaltrexone, which is a potent competitive antagonist acting at the digestive tract and is also FDA-approved for the treatment of opioid-induced constipation.[9]

Prescription Drug Disposal

Currently, the recommended method of disposing of unused prescription medications is to take them to a drug take-back location.[10] However, if there is not a drug take-back location in the area

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[6] *Id.*
[7] *See* Exec. Order No. 17-146, *available at* https://www.flgov.com/wp-content/uploads/2017/05/17146.pdf. (last visited Mar. 12, 2021).
[8] *Id.*
[9] *Opioid Antagonists*, Theriot, Jonathan, et. al., (last updated July 27, 2020), *available at* https://www.ncbi.nlm.nih.gov/books/NBK537079/#:~:text=3%5D%5B4%5D-,The%20two%20most%20commonly%20used%20centrally%20acting%20opioid%20receptor%20antagonists,depression%20associated%20with%20opioid%20use. (last visited March 12, 2021).
[10] *See* https://www.fda.gov/drugs/safe-disposal-medicines/disposal-unused-medicines-what-you-should-know (last visited Mar. 12, 2021).

or if the person cannot go to one promptly, the U.S. Food and Drug Administration (FDA) provides two recommendations:

- That drugs on the drug flush list be disposed of immediately by being flushed down a toilet. The FDA has identified and created a list of drugs that are either dangerous to be kept unused for an extended period of time or are sought-after for their misuse and abuse potential. Many of the drugs on the flush list are prescription opioids.[11]
- If the drug is not on the flush list, the FDA recommends that the drug be mixed with an unappealing substance in a sealed container and thrown away in the trash.[12]
- In either case, the FDA also recommends that all personal information on the prescription label be deleted before throwing away or recycling the drug container.

Drug Disposal Products

There are numerous drug disposal products available, many of which are sold directly to consumers. A 2019 report from the San Francisco Department of the Environment examined and compared ten of these products, eight of which are available for consumers to buy for use in the home.[13, 14] The report prefaces its findings by stating that "none of the medicine disposal products [looked at] are approved by any federal agency; no federal agency endorses such products, and none appear to be actively evaluating these products at this time."[15] The report looked at each product with four questions in mind:

- Is the product safe for use?
- Are the drugs disposed of made undesirable?
- Are the drugs disposed of made non-retrievable?[16]
- Is the product safe for solid waste disposal?

The products used a variety of methods to dispose of drugs and make them non-retrievable, including activated carbon, bentonite clay, mixtures of calcium hypochlorite with other ingredients, and other proprietary methods not fully described by the products.

Activated Carbon

Four of the eight products are available for home purchase. Deterra, Drug Buster, Narc X, and Rx Destroyer identify activated carbon as a key active ingredient.[17] These products works with a process called adsorption in which the chemicals in the drugs attach to the surface of the

[11] *See* https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-fdas-flush-list-certain-medicines (last visited Mar. 12, 2021).
[12] *See* https://www.fda.gov/drugs/disposal-unused-medicines-what-you-should-know/drug-disposal-dispose-non-flush-list-medicine-trash (last visited Mar. 12, 2021).
[13] *Medicine Disposal Products: An Overview of Products and Performance Questions*, Community Environmental Health Strategies LLC, March 2019, *available at* https://sfenvironment.org/sites/default/files/fliers/files/medicinedisposalproducts_march2019.pdf (last visited Mar. 15, 2021).
[14] The products available for home use include Deterra, DisposeRx, Drug Buster, Element MDS, NarcX, Pill Catcher, Pill Terminator, and Rx Destroyer.
[15] Id. at p. 2.
[16] The report used the U.S. Drug Enforcement Agency final rule definition of non-retrievable which is identical to the definition in 21 C.F.R. s. 1300.05(b).
[17] Id. n. 13 at p. 26.

activated carbon in the disposal product.[18] The process of adsorption typically takes between eight hours and several days. However the products using this process typically recommend the placement of the drug into the trash within two hours of placement of the drug into the carbon solution.[19] Testing of these products (reviewed but not conducted by the study) showed that the rate and amount of adsorption of drugs placed into the products varied from product to product and with different kinds of drugs tested.[20] Additionally, it is unclear whether the adsorption process renders the drugs non-retrievable.[21]

Bentonite Clay

The product Pill Catcher is the only product listed which uses a chemically altered sodium bentonite clay. Bentonite clay interacts with chemicals through an adsorption process, similar to that of activated carbon.[22] The product manufacturer cites testing of the product for environmental soundness but not for the non-retrievability of the drugs on which the product is used. Other testing of similar methods of disposal show that it is unlikely that bentonite clay treatment without other agents could achieve the DEA's non-retrievable standard of permanent physical or chemical alteration of a controlled substance.[23]

Calcium Hypochlorite

The product Pill Terminator lists calcium hypochlorite as an ingredient on its Material Safety Data Sheet (MSDS), which also lists Fuller's earth and a proprietary "absorbent polymer."[24] Because calcium hypochlorite is a strong oxidizing agent, the Pill Terminator product must carry a warning label about its toxicity through skin contact, eye exposure or ingestion, and a warning to keep away from children. If combined with other substances, calcium hypochlorite can release chlorine gas and can also react explosively with ammonia and metals. As an oxidizing agent, hypochlorite will react with and chemically alter some pharmaceuticals, depending on their chemical composition. The degree of chemical degradation and resulting chemical byproducts will depend on the pharmaceuticals being treated.[25]

The Pill Terminator website provides analysis by an independent test laboratory that the product renders aspirin pills unpalatable and foul smelling. Unpublished test results from academic researchers on treatment of morphine show release of 45 percent of the morphine by simple water extraction after 48 hours of treatment by the Pill Terminator. The testing did not fully characterize the chemical composition of the product-drug mixture as it would be disposed. *See* the Pill Terminator's profile in Section V of this analysis for more details.[26]

[18] Id.
[19] Supra n. 13 at p. 27.
[20] Id. at p. 29.
[21] Id. at p. 28.
[22] Id. at p. 30.
[23] Id.
[24] Id.
[25] Id. at p. 31.
[26] Id.

Unknown Mechanisms of Action

The other products available for consumer use, DisposeRX and Element MDS, use methods of destruction that are not fully specified by the product manufacturers.

DisposeRx's mechanism of action is described as "chemically and physically sequester(ing) medications in a viscous gel" that becomes solid over time. The product ingredients are described as safe and approved for use in oral medications and food.[27]

V23, LLC, the manufacturer of Element MDS, describes the mechanism of action on medicines as "holds the medication in suspension and forms a solid gel making the medication undesirable." Descriptions on the Element MDS website do not claim that it makes drugs non-retrievable but indicate the medicines become "undesirable." Descriptions of the product's ingredients as an "organic, plant-based powder" seem out of sync with the product label's warnings about avoiding skin and eye contact and "Caution: harmful if swallowed." Element MDS recommends trash disposal of the product-drug mixture but does not provide any waste determination data.[28]

III. Effect of Proposed Changes:

SB 1442 amends and creates several sections of the Florida statutes related to substance abuse prevention.

Availability of Opioid Antagonists

The bill amends s. 381.887, F.S., to expand the section to provide for the ordering and dispensing, in addition to prescribing, of emergency opioid antagonists to persons who may come in contact with a controlled substance or who are at risk of experiencing an opioid overdose. The bill requires the DOH to develop and implement a statewide awareness campaign to educate the public regarding the risk factors of opioid overdoses, the signs and symptoms of opioid overdoses, and how to respond to such overdoses, including the safe storage and administration of emergency opioid antagonists.

The bill allows pharmacists licensed under ch. 465, F.S., to order or dispense emergency opioid antagonists without a prescription to any person who:

- Is at risk of an opioid overdose due to his or her medical condition or history;
- Is a caregiver of someone who is at risk of an opioid overdose;
- Is in a position to assist another person who is at risk of an opioid overdose; or
- May come into contact with a controlled substance.

The bill provides authorization for such persons to store, possess, and administer the opioid antagonist to a person believed in good faith to be experiencing an opioid overdose in an emergency situation when a physician is not immediately available. The bill also provides immunity from civil and criminal liability stemming from the administering of an emergency opioid antagonist. Such immunity is provided to:

[27] Supra n. 13 at p. 31.
[28] Id.

- Emergency responders, including, but not limited to, law enforcement officers, paramedics, and emergency medical technicians.
- Crime laboratory personnel for the statewide criminal analysis laboratory system as described in s. 943.32, F.S., including, but not limited to, analysts, evidence intake personnel, and their supervisors.
- Personnel of a law enforcement agency or other agency, including, but not limited to, correctional probation officers and child protective investigators who, while acting within the scope or course of employment, come into contact with a controlled substance or a person who is at risk of experiencing an opioid overdose.
- A person who is dispensed an emergency opioid antagonist pursuant to the provisions added by the bill and comes into contact with a controlled substance or a person who is at risk of experiencing an opioid overdose.

The bill also amends s. 401.253, F.S., to require BLS, ABS, and health care facilities to report the treatment and release of a suspected or actual overdose of a controlled substance to the DOH.

Drug Deactivation and Disposal System Program

SB 1442 creates s. 381.888, F.S., to establish the At-home Drug Deactivation and Disposal System Program. The bill defines the terms:
- "Board" to mean the Board of Pharmacy.
- "Department" to mean the Department of Health.
- "Nonretrievable" with the same meaning as provided in 21 C.F.R. s. 1300.05(b), as that definition exists on the bill's effective date.[29]
- "Pharmacy" with the same meaning as provided in s. 465.003(11), F.S.
- "Program" to mean the At-home Drug Deactivation and Disposal System Program.

The Program requires the DOH, in coordination with the BOP, to establish and administer the Program for the purpose of identifying and distributing a suitable at-home drug deactivation and disposal system that pharmacies must co-dispense with each opioid prescription. The at-home drug deactivation and disposal system must permanently render the active pharmaceutical ingredient nonretrievable, nonusable, and fully nontoxic at the point it enters the state's municipal waste systems. The DOH and the BOP must develop relevant educational materials and a plan for distribution of the at-home drug deactivation and disposal systems and educational materials to Florida pharmacies and adopt rules to administer the Program.

The bill also amends ss. 456.44 and 465.0276, F.S., to require an at-home drug deactivation and disposal system to be prescribed in conjunction with any schedule II controlled substance prescribed for the treatment of specified level of pain resulting from a traumatic injury.

[29] The definition of non-retrievable in 21 CFR s. 1300.05(b) is "Non-retrievable means, for the purpose of destruction, the condition or state to which a controlled substance shall be rendered following a process that permanently alters that controlled substance's physical or chemical condition or state through irreversible means and thereby renders the controlled substance unavailable and unusable for all practical purposes. The process to achieve a non-retrievable condition or state may be unique to a substance's chemical or physical properties. A controlled substance is considered "non-retrievable" when it cannot be transformed to a physical or chemical condition or state as a controlled substance or controlled substance analogue. The purpose of destruction is to render the controlled substance(s) to a non-retrievable state and thus prevent diversion of any such substance to illicit purposes."

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

SB 1442 may have an indeterminate negative fiscal impact on ALS, BLS, and health care facilities that are required to report suspected and actual controlled substance overdoses under the bill.

C. Government Sector Impact:

Lines 130-138 of SB 1442 appear to require the state to purchase and distribute an at-home drug deactivation and disposal system to pharmacies that must co-dispense such a system with each opioid prescription filled. Such a system may cost, on average, between $1.60 and $16, depending on the size of the system provided.[30] According to the CDC, the opioid dispensing rate in Florida in 2019 was 45.4 prescriptions dispensed per 100 residents.[31] Florida's current population estimate, as of 2019, is approximately 21.5

[30] Supra n. 13 at p. 44.
[31] *See* US State Opioid Dispensing Rates, 2019, *available at* https://www.cdc.gov/drugoverdose/maps/rxstate2019.html, (last visited Mar. 15, 2021).

million.[32] Based on these numbers, the number of opioid prescriptions dispensed in 2019 was approximately 9.75 million.

Given the estimated cost of $1.60 to $16 per drug disposal system and assuming that opioid prescription rates remain steady, to provide a drug disposal system for every opioid prescription dispensed may cost between $15.6 and $156 million dollars annually.

VI. Technical Deficiencies:

SB 1442 amends s. 401.253, F.S., to add health care facilities to the providers who must report controlled substance overdoses. However, the section requiring reporting of such overdoses is specific to ALS and BLS providers and does not contain a definition of the term "health care facility." It may be advisable to define health care facility within the context of this change.

VII. Related Issues:

Lines 95-97 of SB 1442 provide immunity "from any civil liability or criminal liability as a result of administering an emergency opioid antagonist." Although the bill specifies on lines 85-92 when such opioid antagonists may be administered, it does not appear that the immunity from liability is limited to the instances specified by the bill. It may be advisable to limit the immunity from liability to those instances in which the opioid antagonist is administered according to the limitations established in the bill.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.887, 401.253, 456.44, and 465.0276.

This bill creates section 381.888 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[32] *See* https://www.census.gov/quickfacts/FL (last visited Mar. 15, 2021).

By Senator Boyd

21-01592-21 20211442__

A bill to be entitled

An act relating to substance abuse prevention; amending s. 381.887, F.S.; revising provisions relating to the prescribing, ordering, and dispensing of emergency opioid antagonists to certain persons; requiring the Department of Health to develop and implement a statewide awareness campaign to educate the public regarding opioid overdoses and the safe storage and administration of emergency opioid antagonists; authorizing licensed pharmacists to dispense an emergency opioid antagonist to certain persons without a prescription, under certain circumstances; authorizing certain persons dispensed opioid antagonists without a prescription to store and possess and, in certain emergency situations, to administer opioid antagonists; providing certain authorized persons immunity from civil and criminal liability for administering emergency opioid antagonists under certain circumstances; authorizing personnel of law enforcement agencies and other agencies and certain other persons to administer emergency opioid antagonists under certain circumstances; creating s. 381.888, F.S.; defining terms; requiring the department, in coordination with the Board of Pharmacy, to establish and administer the At-home Drug Deactivation and Disposal System Program for a specified purpose; providing requirements for the at-home drug deactivation and disposal systems; requiring the department, in coordination with the

21-01592-21 20211442__

board, to develop relevant educational materials and a plan for distribution of the at-home drug deactivation and disposal systems and educational materials; requiring the department, in consultation with the board, to adopt rules; amending s. 401.253, F.S.; requiring certain health care facilities, basic life support services, or advanced life support services to report incidents involving a suspected or actual overdose of a controlled substance; conforming provisions to changes made by the act; amending ss. 456.44 and 465.0276, F.S.; requiring prescribing and dispensing practitioners to concurrently prescribe or dispense an at-home drug deactivation and disposal system along with certain controlled substances; providing an effective date.

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

Section 1. Subsections (2), (3), and (4) of section 381.887, Florida Statutes, are amended to read:

381.887 Emergency treatment for suspected opioid overdose.—

(2)(a) The purpose of this section is to provide for the prescribing, ordering, and dispensing ~~prescription~~ of emergency opioid antagonists ~~an emergency opioid antagonist~~ to patients, ~~and~~ caregivers, and any other persons who may come into contact with a controlled substance or a person who is at risk of experiencing an opioid overdose and to encourage the prescribing, ordering, and dispensing ~~prescription~~ of emergency opioid antagonists by authorized health care practitioners.

(b) The Department of Health shall develop and implement a statewide awareness campaign to educate the public regarding the risk factors of opioid overdoses, the signs and symptoms of opioid overdoses, and how to respond to such overdoses, including the safe storage and administration of emergency opioid antagonists.

(3)(a) An authorized health care practitioner may prescribe and dispense an emergency opioid antagonist to a patient or caregiver for use in accordance with this section, and pharmacists may dispense an emergency opioid antagonist pursuant to such a prescription or pursuant to paragraph (b) ~~a non-patient-specific standing order for an autoinjection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use~~. Such patient or caregiver is authorized to store and possess approved emergency opioid antagonists and, in an emergency situation when a physician is not immediately available, administer the emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist.

(b) A pharmacist licensed under chapter 465 may order or dispense an emergency opioid antagonist without a prescription to any person who is at risk of an opioid overdose due to his or her medical condition or history, is a caregiver of someone who is at risk of an opioid overdose, is in a position to assist another person who is at risk of an opioid overdose, or may come into contact with a controlled substance. Such patient or caregiver is authorized to store and possess approved emergency opioid antagonists and, in an emergency situation when a

physician is not immediately available, to administer the emergency opioid antagonist to a person believed in good faith to be experiencing an opioid overdose, regardless of whether that person has a prescription for an emergency opioid antagonist.

(4) The following persons are authorized to possess, store, and administer emergency opioid antagonists as clinically indicated and are immune from any civil liability or criminal liability as a result of administering an emergency opioid antagonist:

(a) Emergency responders, including, but not limited to, law enforcement officers, paramedics, and emergency medical technicians.

(b) Crime laboratory personnel for the statewide criminal analysis laboratory system as described in s. 943.32, including, but not limited to, analysts, evidence intake personnel, and their supervisors.

(c) Personnel of a law enforcement agency or other agency, including, but not limited to, correctional probation officers and child protective investigators who, while acting within the scope or course of employment, come into contact with a controlled substance or a person who is at risk of experiencing an opioid overdose.

(d) A person who is dispensed an emergency opioid antagonist pursuant to paragraph (3)(b) and comes into contact with a controlled substance or a person who is at risk of experiencing an opioid overdose.

Section 2. Section 381.888, Florida Statutes, is created to read:

381.888 At-home Drug Deactivation and Disposal System Program.—

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

(a) "Board" means the Board of Pharmacy.

(b) "Department" means the Department of Health.

(c) "Nonretrievable" has the same meaning as provided in 21 C.F.R. s. 1300.05(b), as that definition exists on the effective date of this act.

(d) "Pharmacy" has the same meaning as provided in s. 465.003(11).

(e) "Program" means the At-home Drug Deactivation and Disposal System Program.

(2) PROGRAM ESTABLISHED.—

(a) The department, in coordination with the board, shall establish and administer the At-home Drug Deactivation and Disposal System Program for the purpose of identifying and distributing a suitable at-home drug deactivation and disposal system that pharmacies must co-dispense with each opioid prescription. The at-home drug deactivation and disposal system must permanently render the active pharmaceutical ingredient nonretrievable, nonusable, and fully nontoxic at the point it enters the state's municipal waste systems.

(b) The department, in coordination with the board, shall develop relevant educational materials and a plan for distribution of the at-home drug deactivation and disposal systems and educational materials to pharmacies in this state.

(3) RULEMAKING AUTHORITY.—The department, in consultation with the board, shall adopt rules to administer the program.

Section 3. Paragraph (a) of subsection (1) and subsections

(3) and (5) of section 401.253, Florida Statutes, are amended to read:

401.253 Reporting of controlled substance overdoses.—

(1)(a) A health care facility, a basic life support service, or an advanced life support service that ~~which~~ treats and releases, or transports to a medical facility, a person in response to an emergency call for a suspected or actual overdose of a controlled substance must ~~may~~ report such incidents to the department. Such reports must be made using the Emergency Medical Service Tracking and Reporting System or other appropriate method with secure access, including, but not limited to, the Washington/Baltimore High Intensity Drug Trafficking Overdose Detection Mapping Application Program or other program identified by the department in rule. If a health care facility, a basic life support service, or an advanced life support service reports such incidents, it must ~~shall~~ make its best efforts to make the report to the department within 120 hours after it responds to the incident.

(3) A health care facility, a basic life support service, or an advanced life support service that reports information to or from the department pursuant to this section in good faith is not subject to civil or criminal liability for making the report.

(5) The department shall produce a quarterly report to the Statewide Drug Policy Advisory Council, the Department of Children and Families, and the Florida FUSION Center summarizing the raw data received pursuant to this section. Such reports shall also be made immediately available to the county-level agencies described in paragraph (1)(b). The Statewide Drug

Policy Advisory Council, the Department of Children and Families, and the department may use these reports to maximize the utilization of funding programs for health care facilities, licensed basic life support service providers, or advanced life support service providers, and for the dissemination of available federal, state, and private funds for local substance abuse services in accordance with s. 397.321(4).

Section 4. Subsection (6) of section 456.44, Florida Statutes, is amended to read:

456.44 Controlled substance prescribing.—

(6) EMERGENCY OPIOID ANTAGONIST.—For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a prescriber who prescribes a Schedule II controlled substance listed in s. 893.03 or 21 U.S.C. s. 812 must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1), and an at-home drug deactivation and disposal system pursuant to s. 381.888.

Section 5. Paragraph (b) of subsection (1) of section 465.0276, Florida Statutes, is amended to read:

465.0276 Dispensing practitioner.—

(1)

(b) A practitioner registered under this section may not dispense a controlled substance listed in Schedule II or Schedule III as provided in s. 893.03. This paragraph does not apply to:

1. The dispensing of complimentary packages of medicinal drugs which are labeled as a drug sample or complimentary drug as defined in s. 499.028 to the practitioner's own patients in the regular course of her or his practice without the payment of

a fee or remuneration of any kind, whether direct or indirect, as provided in subsection (4).

2. The dispensing of controlled substances in the health care system of the Department of Corrections.

3. The dispensing of a controlled substance listed in Schedule II or Schedule III in connection with the performance of a surgical procedure.

a. For an opioid drug listed as a Schedule II controlled substance in s. 893.03 or 21 U.S.C. s. 812:

(I) For the treatment of acute pain, the amount dispensed pursuant to this subparagraph may not exceed a 3-day supply, or a 7-day supply if the criteria in s. 456.44(5)(a) are met.

(II) For the treatment of pain other than acute pain, a practitioner must indicate "NONACUTE PAIN" on a prescription.

(III) For the treatment of pain related to a traumatic injury with an Injury Severity Score of 9 or greater, a practitioner must concurrently prescribe an emergency opioid antagonist, as defined in s. 381.887(1), and an at-home drug deactivation and disposal system pursuant to s. 381.888.

b. For a controlled substance listed in Schedule III, the amount dispensed pursuant to this subparagraph may not exceed a 14-day supply.

c. The exception in this subparagraph does not allow for the dispensing of a controlled substance listed in Schedule II or Schedule III more than 14 days after the performance of the surgical procedure.

d. For purposes of this subparagraph, the term "surgical procedure" means any procedure in any setting which involves, or reasonably should involve:

(I) Perioperative medication and sedation that allows the patient to tolerate unpleasant procedures while maintaining adequate cardiorespiratory function and the ability to respond purposefully to verbal or tactile stimulation and makes intra- and postoperative monitoring necessary; or

(II) The use of general anesthesia or major conduction anesthesia and preoperative sedation.

4. The dispensing of a controlled substance listed in Schedule II or Schedule III pursuant to an approved clinical trial. For purposes of this subparagraph, the term "approved clinical trial" means a clinical research study or clinical investigation that, in whole or in part, is state or federally funded or is conducted under an investigational new drug application that is reviewed by the United States Food and Drug Administration.

5. The dispensing of methadone in a facility licensed under s. 397.427 where medication-assisted treatment for opiate addiction is provided.

6. The dispensing of a controlled substance listed in Schedule II or Schedule III to a patient of a facility licensed under part IV of chapter 400.

7. The dispensing of controlled substances listed in Schedule II or Schedule III which have been approved by the United States Food and Drug Administration for the purpose of treating opiate addictions, including, but not limited to, buprenorphine and buprenorphine combination products, by a practitioner authorized under 21 U.S.C. s. 823, as amended, to the practitioner's own patients for the medication-assisted treatment of opiate addiction.

Section 6. This act shall take effect July 1, 2021.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Banking and Insurance, *Chair*
Agriculture
Appropriations Subcommittee on Agriculture, Environment, and General Government
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Criminal Justice
Judiciary

JOINT COMMITTEE:
Joint Legislative Auditing Committee

SENATOR JIM BOYD
21st District

February 24, 2021

Senator Manny Diaz
Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399

Dear Chairman Diaz:

I respectfully request that SB 1442: Substance Abuse Prevention, be scheduled for a hearing in the Committee on Health Policy, at your earliest convenience.

If I may be of assistance to you on this or any other matter, please do not hesitate to contact me.

Thank you for your consideration of this matter.

Best regards,

Jim Boyd

cc: Allen Brown
Lynn Wells

REPLY TO:
☐ 717 Manatee Avenue West, Bradenton, Florida 34205 (941) 742-6445
☐ 312 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5021

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

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

Duplicate

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

1442
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Substance Abuse Prevention

Name Robert Stuart

Job Title Government Consultant

Address 301 S Bronough Street, Suite 600
Street

Phone 850-577-9090

Tallahassee — *City* | FL — *State* | 32301 — *Zip*

Email robert.stuart@gray-robinson.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Project Opioid

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 (10/14/14)

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 532
INTRODUCER:	Education Committee and Senator Burgess
SUBJECT:	Workforce Education
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Sagues	Bouck	ED	**Fav/CS**
2.	Smith	Brown	HP	**Favorable**
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Technical Changes

I. Summary:

CS/SB 532 authorizes school district career centers to offer an associate in applied science or associate in science degree program in nursing but restricts offering the degree program to graduates of a licensed practical nursing program offered at that same career center.

The bill has no impact on state revenues or expenditures.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Workforce Education

Workforce education includes adult general education and career education and may consist of a course or a program of study leading to an occupational completion point (OCP),[1] a career certificate, an applied technology diploma, or a career degree.[2] Specifically, workforce education includes:[3]

[1] An "occupational completion point" (OCP) means the occupational competencies that qualify a person to enter an occupation that is linked to a career and technical program. *See* s. 1004.02(21), F.S.
[2] Section 1004.02(25), F.S.
[3] Section 1011.80(1), F.S.

- Adult general education programs;[4]
- Career certificate programs;[5]
- Applied technology diploma (ATD) programs;[6]
- Continuing workforce education courses;[7]
- Degree career education programs;[8] and
- Apprenticeship[9] and preapprenticeship[10] programs.

Any workforce education program may be conducted by a Florida College System (FCS) institution or a school district, except that college credit in an associate in applied science (AAS) or an associate in science (AS) degree may be awarded only by an FCS institution. However, if an AAS or an AS degree program contains an OCP that confers a certificate or an ATD, that portion of the program may be conducted by a school district career center.[11]

Career Centers

A district school board may, as a part of the district school system, operate a career center.[12] A career center is an educational institution offering terminal courses of a technical nature and courses for out-of-school youth and adults. A career center is administered by a director responsible through the district school superintendent to the local district school board.[13]

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[4] "Adult general education" means comprehensive instructional programs designed to improve the employability of the state's workforce through adult basic education, adult secondary education, English for Speakers of Other Languages, applied academics for adult education instruction, and instruction for adults with disabilities. Section 1004.02(3), F.S.
[5] A "career certificate program" means a course of study that leads to at least one OCP. The program may also confer credit that may articulate with a diploma or career degree education program. Section 1004.02(20), F.S.
[6] An "applied technology diploma (ATD) program" means a course of study that is part of a technical degree program, is less than 60 credit hours, and leads to employment in a specific occupation. An ATD program may consist of either technical credit or college credit. A public school district may offer an ATD program only as technical credit, with college credit awarded to a student upon articulation to a Florida College System (FCS) institution. Section 1004.02(7), F.S.
[7] "Continuing workforce education" means instruction that does not result in a technical certificate, diploma, associate in applied science (AAS) degree, or associate in science (AS) degree. Continuing workforce education is for: (1) individuals who are required to have training for licensure renewal or certification renewal by a regulatory agency or credentialing body; (2) new or expanding businesses; (3) business, industry, and government agencies whose products or services are changing so that retraining of employees is necessary or whose employees need training in specific skills to increase efficiency and productivity; or (4) individuals who are enhancing occupational skills necessary to maintain current employment, to cross train, or to upgrade employment. Section 1004.02(12), F.S.
[8] A "degree career education program" or "technical degree education program" means a course of study that leads to an AAS degree or an AS degree. A technical degree program may contain within it one or more program progression points and may lead to certificates or diplomas within the course of study. Section 1004.02(13), F.S.
[9] Registered apprenticeship programs enable employers to develop and apply industry standards to training programs for registered apprentices that can increase productivity and improve the quality of the workforce. Apprentices who complete registered apprenticeship programs are accepted by the industry as journey workers. Florida Department of Education, *Apprenticeship Programs, available at* http://fldoe.org/academics/career-adult-edu/apprenticeship-programs/ (last visited Mar. 12, 2021).
[10] Registered pre-apprenticeship programs provide an avenue for both adults and youth who are at least 16 years old to become qualified to enter registered apprenticeship programs. Pre-apprenticeship programs are sponsored and operated by registered apprenticeship programs in the same trade or trades. Florida Department of Education, *Preapprenticeship, available at* http://fldoe.org/academics/career-adult-edu/apprenticeship-programs/preapprenticeship.stml (last visited Mar. 12, 2021).
[11] Section 1011.80(2), F.S.
[12] Section 1001.44(1), F.S.
[13] Section 1001.44(3)(a), F.S.

Currently, there are 48 career centers accredited by the Council on Occupational Education (COE) operating in 32 school districts in Florida.[14] The COE accredits postsecondary occupational institutions that offer career certificate, diploma, or applied associate degree programs. The associate degree includes both an AAS and AS degree.[15] The COE does not accredit institutions that offer credentials above an applied associate degree.[16] The COE is one of the national accrediting agencies recognized by the U.S. Department of Education for eligibility to offer federal student financial aid.[17]

Florida College System Institutions

The FCS is composed of 28 colleges and 72 campuses that serve each of Florida's counties.[18] The purpose of the FCS is to maximize open access for students, respond to community needs for postsecondary academic education and career degree education, and provide associate and baccalaureate degrees that will best meet the state's employment needs.[19] The State Board of Education supervises the FCS, and each FCS institution is governed by a local board of trustees.[20] Each FCS institution is accredited by the Southern Association of Colleges and Schools Commission on Colleges.[21]

Articulation of Career Education to Degree Programs

Florida law guarantees that students who complete specified career certificate programs or ATDs at a career center or FCS institution are able to articulate the non-college-credit program into a college-credit AAS or AS degree program at an FCS institution.[22] There are currently 33 career certificate program to AAS/AS degree articulation agreements, and eight ATD program to

[14] Florida Department of Education, *District Postsecondary Institutions*, *available at* http://www.fldoe.org/core/fileparse.php/5398/urlt/DistPSInstMap.pdf (last visited Mar. 12, 2021).
[15] Council on Occupational Education, *Handbook of Accreditation* (2020), *available at* https://council.org/wp-content/uploads/2020/07/2020-Handbook-of-Accreditation_Generic_FINAL-w-Covers_7-26-20.pdf, at 58 (last visited Mar. 12, 2021).
[16] Council on Occupational Education, *FAQs*, *available at* https://council.org/accreditation-frequently-asked-questions/ (last visited Mar. 12, 2021).
[17] *Id.*
[18] Florida Department of Education, *Division of Florida Colleges*, *available at* http://www.fldoe.org/schools/higher-ed/fl-college-system/ (last visited Mar. 12, 2021). Each Florida College System institution is assigned one or more counties as a part of its service delivery area. Section 1000.21(3), F.S.
[19] Section 1001.60(1), F.S.
[20] FLA. CONST. art. IX, s. 8.
[21] The Southern Association of Colleges and Schools Commission on Colleges (SACSCOC) is the regional body for the accreditation of degree-granting higher education institutions in the southern states. It serves as the common denominator of shared values and practices among the diverse institutions in Alabama, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Texas, Virginia and Latin America and other international sites approved by the SACSCOC Board of Trustees that award associate, baccalaureate, master's, or doctoral degrees. Southern Association of Colleges and Schools Commission on Colleges, *available at* http://sacscoc.org/ (last visited Mar. 12, 2021). All FCS institutions except Hillsborough Community College are accredited to the baccalaureate degree level. SACSCOC, *Florida*, *available at* https://sacscoc.org/institutions/?state=FL&results_per_page=25&curpage=1 (last visited Mar. 12, 2021).
[22] Section 1007.23(4), F.S. The statewide articulation agreement guarantees the statewide articulation of appropriate workforce development programs and courses between school districts and FCS institutions and specifically provide that every ATD graduate must be granted the same amount of credit upon admission to an AAS or AS degree program.

AAS/AS degree articulation agreements.[23] The amount of credit applied to the degree program varies by program and is determined by school district career center and FCS institution college faculty. According to the Practical Nursing certificate program articulation agreement, students who complete the 1,350-clock-hour Practical Nursing program are guaranteed 10 college credits upon entrance into the 72-credit AS degree program in Nursing.[24] Twenty-eight districts offered licensed practical nursing (LPN) career certificate programs with close to 4,000 students enrolled in 2018-2019.[25]

Florida Public Postsecondary Nursing Programs

Any educational institution that wishes to conduct a program in Florida for the pre-licensure education of professional or practical nurses must apply to the Department of Health and be approved by the Florida Board of Nursing.[26]

Each FCS institution offers a 72-credit-hour AS degree in nursing to prepare students for employment as registered nurses (RN).[27] FCS institutions enrolled 13,619 students in the AS nursing degree program in 2018-2019.[28]

Each AS degree must also include a minimum of 15 college credits of general education coursework.[29] The standards for all Florida AS degree programs, including nursing, are determined in the curriculum frameworks maintained by the Department of Education (DOE).[30] All Florida AS nursing degree programs are accredited by the Accreditation Commission for

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[23] Florida Department of Education, *Career Certificate Program to AAS/AS Degree*, *available at* http://www.fldoe.org/academics/career-adult-edu/career-technical-edu-agreements/psav-to-aas-as-degree.stml (last visited Mar. 12, 2021), and *Applied Technology Diploma to Associate in Science or Associate in Applied Science Program Articulation* (Feb. 2020), *available at* http://www.fldoe.org/core/fileparse.php/7525/urlt/atd-to-asandaas-articulationagreemts.pdf (last visited Mar. 12, 2021).

[24] Florida Department of Education, *Postsecondary Adult Vocational (PSAV) to AAS/AS Degree Articulation, Statewide Agreement Worksheet Summary* (Feb. 28, 2018), *available at* http://www.fldoe.org/core/fileparse.php/7525/urlt/p1-practicalnursing.rtf (last visited Mar. 12, 2021).

[25] Department of Education, *2020 Legislative Bill Analysis of SB 418* (Oct. 8, 2019) at 3.

[26] Section 464.019, F.S. The Florida Board of Nursing is a 13-member board within the Department of Health that licenses, monitors, disciplines, educates and, when appropriate, rehabilitates its licensees to assure their fitness and competence in providing health care services for the people of Florida. Section 464.004, F.S., and Florida Board of Nursing, *available at* https://floridasnursing.gov/ (last visited Mar. 12, 2021).

[27] Twenty-seven FCS institutions are approved to offer the bachelor of science degree for nursing (BSN). In 2018-2019, 6,429 students were enrolled in FCS BSN programs. Department of Education, *2020 Legislative Bill Analysis of SB 418* (Feb 22, 2021) at 3.

[28] *Id.*

[29] Fla. Admin. Code R. 6A-14.030(4) (2021).

[30] The Career & Technical Education (CTE) Programs section in the DOE is responsible for developing and maintaining educational programs that prepare individuals for occupations important to Florida's economic development. These programs are organized into 17 different career clusters and are geared toward middle school, high school, district technical school, and FCS students throughout the state. With the help of partners in education, business and industry, and trade associations, each program includes the academic and technical skills required to be successful in today's economy. Florida Department of Education, *Career & Technical Education*, *available at* http://www.fldoe.org/academics/career-adult-edu/career-tech-edu/ (last visited Mar. 12, 2021).

Education in Nursing (ACEN).[31] There is currently no curriculum framework for an AAS degree in nursing, and no AAS degree programs in nursing are offered by FCS institutions.[32]

Occupational Outlook

There were 49,549 LPNs employed in Florida in 2020. By 2028, it is expected that there will be a need for 56,043 LPNs, growing the profession by 13.1 percent.[33] Total job openings over this period is expected to be 38,674.[34] It is further estimated that 1,984 practical nursing students will annually complete a program to fill 4,165 LPN job openings through 2027, placing the profession in the "moderate" supply gap category.[35]

There were 194,146 RNs employed in Florida, in 2020. By 2028, it is expected that there will be a need for 215,063 RNs, growing the profession by 10.8 percent.[36] Total job openings over this period is expected to be 108,324.[37] It is further estimated that 15,011 professional nursing students will annually complete an educational program to fill 14,094 RN job openings through 2027, placing the profession in the "very low or none" supply gap category.[38]

III. Effect of Proposed Changes:

CS/SB 532 amends s. 1011.80, F.S., to authorize school district career centers to offer an associate in applied science (AAS) or associate in science (AS) degree program but restricts offering the degree program to graduates of a licensed practical nursing (LPN) program offered at that same career center.

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[31] The purpose of the ACEN is to provide specialized accreditation for all levels of nursing education and transition-to-practice programs. The ACEN accredits nursing education programs in secondary, postsecondary, and hospital-based governing organizations that offer certificates, diplomas, or degrees. The ACEN serves as a Title IV gatekeeper for all types of nursing education programs offered by certain institutions that are eligible to participate in financial aid programs administered by the United States Department of Education or other federal agencies. Accreditation Commission for Education in Nursing, *Mission, Purpose, Goals*, *available at* https://www.acenursing.org/about/mission-purpose-goals/ (last visited Mar. 12, 2021).

[32] In 2012, Florida nursing programs were leveled at the AS degree level in order the facilitate student transfer to aligned baccalaureate degrees. Florida Department of Education, *2020 Agency Analysis of SB 418* (Oct. 8, 2019).

[33] Florida Department of Economic Opportunity, *Employment Projections*, *available at* https://floridajobs.org/workforce-statistics/data-center/statistical-programs/employment-projections (last visited Mar. 12, 2021).

[34] *Id*.

[35] The Workforce Potential Supply Gap Analysis groups occupations into categories (high, moderate, low, very low/no potential gaps) based on the relative difference between employment demand and potential supply as provided from Florida educational and training institutions. The annual occupational job opening is the main source of demand and based on the annualized 10-year projections. This number takes into account occupational growth, transfers between occupations, and exits from an occupation. Supply data are based on completion tabulations from programs within the District Postsecondary, Florida College System, Commission for Independent Education, Independent Colleges & Universities of Florida, and the State University System institutions. Supply counts do not represent the total availability of labor for a given occupation. Other sources of labor supply may include individuals currently employed in similar occupations, migration, military separations or others currently outside the labor force. Florida Department of Economic Opportunity, *Supply and Demand*, *available at* https://floridajobs.org/workforce-statistics/products-and-services/supply-and-demand (last visited Mar. 12, 2021).

[36] Florida Department of Economic Opportunity, *Employment Projections*, *available at* https://floridajobs.org/workforce-statistics/data-center/statistical-programs/employment-projections (last visited Mar. 12, 2021).

[37] *Id*.

[38] *Supra* note 36.

The bill may expand the number of institutions that may offer an associate degree in nursing and may therefore increase access to such programs for students. If more students complete such programs and become licensed, the supply of nurses in Florida may also increase. Career centers that implement associate degree programs under the bill will be required to comply with additional requirements related to college credit programs and to institution and program accreditation, as follows.

Associate Degree Program Requirements

Students entering a college-credit nursing program who are not otherwise exempt would be required to complete a common placement test to assess basic mathematics and communication skills.[39] In addition, a career center offering an AS nursing degree would be required to include in the program 15 credit hours of general education coursework. This general education coursework requirement would also apply to an AAS nursing program. However, since there is currently no curriculum framework for an AAS degree program in nursing, there is no mechanism to offer an AAS program.

In addition, the career center that offers the college-credit (professional) nursing program would be required to meet faculty qualifications that are more rigorous than those required for a practical nursing program.[40]

Approval and Accreditation

A career center seeking to offer an associate degree in nursing would need approval from the Board of Nursing. In addition, the career center would be required to obtain accreditation for its associate degree (professional) nursing program by a specialized nursing accrediting agency that is nationally recognized by the United States Secretary of Education to accredit nursing education programs.[41] Florida law requires a nursing education program that prepares students for the practice of professional nursing to become an accredited program within five years after the date of enrolling the program's first students.[42]

A career center would not, however, be required to seek institutional accreditation other than its existing accreditation by the Council on Occupational Education (COE). COE accreditation authorizes member institutions to offer both the AAS and AS degree.

[39] *Id.* Section 1008.30, F.S. The State Board of Education, in conjunction with the Board of Governors, is required to develop and implement a common placement test for the purpose of assessing the basic computation and communication skills of students who intend to enter a degree program at any public postsecondary educational institution. A student who entered 9th grade in a Florida public school in the 2003-2004 school year, or any year thereafter, and earned a Florida standard high school diploma or a student who is serving as an active duty member of any branch of the United States Armed Services is not be required to take the common placement test.

[40] An associate degree program requires the program director and at least 50 percent of the faculty to be registered nurses who have a master's or higher degree in nursing or a bachelor's degree in nursing and a master's or higher degree in a field related to nursing; a practical nursing program requires similar faculty to have bachelor's degrees. Section 464.019(1)(a), F.S.

[41] Sections 464.003(1) and 464.019(11), F.S.

[42] *Id.*

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

School district career centers that choose to implement an associate degree nursing program would likely incur expenses related Board of Nursing approval and nursing program accreditation. For example:

- There is a $1,000 application fee to the Board of Nursing.
- Accreditation Commission for Education in Nursing fees include $3,500 for candidacy and initial accreditation, plus additional fees for site visits and full accreditation.[43]

VI. Technical Deficiencies:

None.

[43] Accreditation Commission for Education in Nursing, *2020 Schedule of Fees*, *available at* https://www.acenursing.org/for-programs/general-resources/2020-schedule-of-fees/ (last visited Mar. 12, 2021).

VII. Related Issues:

Florida law[44] specifies tuition that applies to students enrolled in workforce education programs who are reported for funding. College credit fees for associate degree programs are determined in law and are specific only to Florida College System (FCS) institutions.[45] It is unclear if such fees currently applied to FCS institution college-credit programs would be applied to school district career center college-credit degree programs.

VIII. Statutes Affected:

This bill substantially amends section 1011.80 of the Florida Statutes.

IX. Additional Information:

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

CS by Education on March 9, 2021:
The committee substitute makes a technical change and conforms language in the bill to clarify that a career center offering an Associate in Applied Science degree in nursing may offer such degree to graduates of a licensed practical nursing program at that career center.

B. Amendments:

None.

44 Section 1009.22, F.S. The tuition for programs leading to a career certificate or an ATD is $2.33 per contact hour for residents and nonresidents and the out-of-state fee is $6.99 per contact hour. Adult general education programs have a block tuition of $45 per half year or $30 per term. Fees are determined by the district school board or FCS institution.

By the Committee on Education; and Senator Burgess

581-02632-21 2021532c1

A bill to be entitled

An act relating to workforce education; amending s. 1011.80, F.S.; revising the workforce education programs that school district career centers are authorized to conduct; providing an effective date.

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

Section 1. Subsection (2) of section 1011.80, Florida Statutes, is amended to read:

1011.80 Funds for operation of workforce education programs.—

(2) Any workforce education program may be conducted by a Florida College System institution or a school district, except that college credit in an associate in applied science or an associate in science degree may be awarded only by a Florida College System institution. However, a school district career center may conduct the following:

(a) Portions of ~~if~~ an associate in applied science or an associate in science degree program which contain ~~contains within it~~ an occupational completion point that confers a certificate or an applied technology diploma.

(b) An associate in applied science or an associate in science nursing degree program if the career center offering the associate in applied science or associate in science nursing degree program offers it only to graduates of a licensed practical nursing program offered by the same~~, that portion of the program may be conducted by a school district career~~ center. Any instruction designed to articulate to a degree program is

Florida Senate - 2021 **CS for SB 532**

581-02632-21 2021532c1

subject to guidelines and standards adopted by the State Board of Education pursuant to s. 1007.25.

Section 2. This act shall take effect July 1, 2021.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 10, 2021

I respectfully request that **Senate Bill #532**, relating to Workforce Education, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Danny Burgess
Florida Senate, District 20

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

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

03-17-21
Meeting Date

532
Bill Number (if applicable)

Topic SB 532

Amendment Barcode (if applicable)

Name Damian Jané

Job Title

Address
Street

Phone

City *State* *Zip*

Email djane@dadeschools.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Miami-Dade County Public Schools

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 (10/14/14)

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 1934
INTRODUCER:	Senators Book and Taddeo
SUBJECT:	Health Care Practitioner Discipline
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto Van-Winkle	Brown	HP	**Favorable**
2.			CJ	
3.			RC	

I. Summary:

SB 1934:

- Amends s. 456.072, F.S., to add to the list of offenses that are grounds for disciplinary action against the license of a health care practitioner regulated by the Department of Health (DOH), for:
  - Being convicted, found guilty, pleading guilty, or pleading *nolo contendere*,[1] regardless of adjudication, to any of the crimes listed in s. 456.074(5), F.S., as amended; or
  - Attempting, soliciting, or conspiring to commit an act that would constitute a crime listed in s. 456.074(5), F.S., or similar crime in another jurisdiction.
- Amends s. 456.074, F.S., to add to the offenses, for which if committed by a licensed practitioner, the DOH must consider issuing an Emergency Suspension Order (ESO) or an Emergency Restriction Order (ERO) of the license of that practitioner. The bill requires the DOH to issue an ESO suspending the license of an allopathic or osteopathic pediatrician, or physician who treats children, if the physician is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any one of the listed criminal offenses involving a child or similar offense in another jurisdiction.
- Directs the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze state laws and rules relating to grounds for health care practitioner discipline and ESOs of licenses, specifically with respect to criminal offenses, and to report to Executive and Legislative Branch leadership by January 1, 2022.

The bill provides an effective date of July 1, 2021.

[1] Black's Law Dictionary, Pocket Edition, St. Paul, 1976, West Publishing Company. *Nolo Contendere* is Latin for "I do not wish to contend."

II. Present Situation:

The Department of Health

The Legislature created the DOH to protect and promote the health of all residents and visitors in the state.[2] The DOH is charged with the regulation of health practitioners for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the boards[3] and professions within the DOH.[4] The health care practitioners licensed by the DOH include the following:

- Acupuncturist;[5]
- Allopathic physicians, physician assistants, anesthesiologist assistants, and medical assistants;[6]
- Osteopathic physicians, physician assistants, and anesthesiologist assistants;[7]
- Chiropractic physicians, and physician assistants;[8]
- Podiatric physicians;[9]
- Naturopathic physicians;[10]
- Optometrists;[11]
- Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses and certified nursing assistants;[12]
- Pharmacists, pharmacy interns, and pharmacy technicians;[13]
- Dentists, dental hygienists, and dental laboratories;[14]
- Midwives;[15]
- Speech and language pathologists;[16]
- Audiologists;[17]
- Occupational therapists and occupational therapy assistants;[18]
- Respiratory therapists;[19]
- Dieticians and nutritionists;[20]
- Athletic trainers;[21]

[2] Section 20.43, F.S.
[3] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH MQA.
[4] Section 20.43, F.S.
[5] Chapter 457, F.S.
[6] Chapter 458, F.S.
[7] Chapter 459, F.S.
[8] Chapter 460, F.S.
[9] Chapter 461, F.S.
[10] Chapter 462, F.S.
[11] Chapter 463, F.S.
[12] Chapter 464, F.S.
[13] Chapter 465, F.S.
[14] Chapter 466, F.S.
[15] Chapter 467, F.S.
[16] Part I, Ch. 468, F.S.
[17] *Id.*
[18] Part III, Chapter 468, F.S.
[19] Part V, Chapter 468, F.S.
[20] Part X, Chapter 468, F.S.
[21] Part XIII, Chapter 468, F.S.

- Orthotists, prosthetists, and pedorthists;[22]
- Electrologists;[23]
- Massage therapists;[24]
- Clinical laboratory personnel;[25]
- Medical physicists;[26]
- Opticians;[27]
- Hearing aid specialists;[28]
- Physical therapists;[29]
- Psychologists and school psychologists;[30] and
- Clinical social workers, mental health counselors and marriage and family therapists.[31]

Disciplinary Proceeding under Chapters 456 and 120, F.S.

Section 456.072, F.S., enumerates at least 43 specific acts that constitute grounds for disciplinary action against licensed health care practitioners in Florida. In addition, each health care practitioner's respective practice act contains specific statutory provisions on prohibited acts, disciplinary actions, grounds for discipline, and actions by the applicable board.

The DOH, on behalf of the boards, investigates any complaint that is filed against a health care practitioner if the complaint is:[32]

- In writing;
- Signed by the complainant;[33] and
- Legally sufficient.

A complaint is legally sufficient if it contains allegations of ultimate facts that, if true, show that a regulated practitioner has violated:

- Chapter 456, F.S.;
- His or her practice act; or
- A rule of his or her board or the DOH.[34]

The Consumer Services Unit receives the complaints and refers them to the closest Investigative Services Unit (ISU) office. The ISU investigates complaints against health care practitioners. Complaints that present an immediate threat to public safety are given priority; however, all

[22] Part XIV, Chapter 468, F.S.
[23] Chapter 478, F.S.
[24] Chapter 480, F.S.
[25] Part II, ch. 483, F.S.
[26] Part III, ch. 483, F.S.
[27] Part I, ch. 484, F.S.
[28] Part II, ch. 484, F.S.
[29] Chapter 486, F.S.
[30] Chapter 490, F.S.
[31] Chapter 491, F.S.
[32] Section 456.073(1), F.S.
[33] *Id.* The DOH may also investigate an anonymous complaint, or that of a confidential informant, if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the DOH has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true.
[34] *Supra* note 32.

complaints are investigated as timely as possible. When the complaint is assigned to an investigator, the complainant will be contacted and given the opportunity to provide additional information. A thorough investigation will be conducted. The steps taken in the investigation are determined by the specifics of the allegations, but generally include the following:

- Obtaining medical records, documents, and evidence;
- Locating and interviewing the complainant, the patient, the subject, and any witnesses; and
- Drafting and serving subpoenas for necessary information.

The ISU includes a staff of professional investigators and senior pharmacists who conduct interviews, collect documents and evidence, prepare investigative reports for the Prosecution Services Unit (PSU), and serve subpoenas and official orders for the DOH.[35]

The PSU is responsible for providing legal services to the DOH in the regulation of all health care boards and councils. The PSU will review the investigative file and report from ISU and recommend a course of action to the State Surgeon General (when an immediate threat to the health, safety, and welfare of the people of Florida exists), the appropriate board's probable cause panel, or the DOH, if there is no board, which may include:

- Having the file reviewed by an expert;
- Issuing a closing order (CO);
- Filing an administrative complaint (AC); or
- Issuing an emergency order (ERO or ESO).[36]

If the ISU investigative file received by PSU does not pose an immediate threat to the health, safety, and welfare of the people of Florida, then the PSU attorneys review the file and determine, first, whether expert review is required and, then, whether to recommend to the board's probable cause panel:

- A CO;
- An AC; or
- A Letter of Guidance (LOG).[37,38]

A CO is recommended if the investigation and/or the expert opinion does not support the allegation(s). The subject and the complainant are notified of the results. The complainant may appeal the decision within sixty (60) days of notification by providing additional information for consideration. Cases closed with no finding of probable cause are confidential and are not available through a public records request.[39]

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[35] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Investigative Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/isu.html (last visited Mar. 9, 2021).
[36] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, *Prosecution Services, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/psu.html (last visited Mar. 9, 2021).
[37] Section 456.073(2), F.S. The DOH may recommend a LOG in lieu of finding probable cause if the subject has not previously been issued a LOG for a related offense.
[38] *Id.*
[39] *Supra* note 37.

An AC is recommended when the investigation and/or the expert opinion supports the allegation(s). The subject is entitled to a copy of the complete case file prior to the probable cause panel meeting. When an AC is filed with the agency clerk, the subject has the right to choose one of the following options:

- *An Administrative Hearing Involving Disputed Issues of Material Fact* – The subject disputes the facts in the AC and elects to have a hearing before the Division of Administrative Hearings (DOAH). If this occurs, all parties may be asked to testify and the administrative law judge will issue a recommended order that will then go to the board or the DOH for final agency action.
- *A Settlement/Stipulation/Consent Agreement* – The subject enters into an agreement to be presented before the board or DOH. Terms of this agreement may impose penalties negotiated between the subject or the subject's attorney and the DOH's attorney.
- *A Hearing Not Involving Disputed Issues of Material Fact* – The subject of the AC does not dispute the facts. The subject elects to be heard before the board or DOH. At that time, the subject will be permitted to give oral and/or written evidence in mitigation or in opposition to the recommended action by the DOH.
- *Voluntary Relinquishment of License* – The subject of the AC may elect to surrender his or her license and to cease practice.[40]

Final DOH action, including all of the above, as well as cases where the subject has failed to respond to an AC, are presented before the applicable board, or the DOH if there is no board. The subject may be required to appear. The complainant is notified of the date and location of the hearing and may attend. If the subject is entitled to, and does, appeal the final decision, PSU defends the final order before the appropriate appellate court.[41]

If the ISU investigative file received by the PSU presents evidence of an immediate threat to the health, safety, and welfare of the people of Florida, then PSU will present the file to the State Surgeon General and recommend one of two types of emergency orders – ESO or ERO – which are exclusively issued by the State Surgeon General against licensees who pose such a threat to the people of Florida.[42]

Whether the State Surgeon General issues an ERO or an ESO depends on the level of danger the licensee presents because the DOH is permitted to use only the "least restrictive means" to stop the danger.[43] The distinction between the two orders is:

- ESOs – Licensees are deemed to be a threat to the public at large; or
- EROs – Licensees are considered a threat to a segment of the population.[44]

The emergency order process is carried out without a hearing, restricting someone's right to work, and when the order is served on the licensee, it must contain a notice to the licensee of his

[40] *Id.*
[41] *Supra* note 35.
[42] Section 456.073(8) and 120.60(6), F.S.
[43] Section 120.60(6)(b), F.S.
[44] Department of Health, Licensing and Regulation, Enforcement, Administrative Complaint Process, Prosecution Services, *A Quick Guide to the MQA Disciplinary Process Discretionary Emergency Orders – 3 Things to Know, available at* http://www.floridahealth.gov/licensing-and-regulation/enforcement/admin-complaint-process/_documents/a-quick-guide-to-the-mqa-disciplinary-process-discrtionary-emergency-orders.pdf (last visited Mar. 9, 2021).

or her right to an immediate appeal of the emergency order.[45] An ESO or ERO is not considered final agency action, and the DOH must file an AC on the underlying facts supporting the ESO or ERO within 20 days of its issuance.[46] The appeal of the emergency order and the normal disciplinary process under the AC, and regular prosecution can run simultaneously.[47]

Mandatory EROs and ESOs

Section 456.074, F.S., directs that in certain cases, the DOH must issue an ESO or ERO to certain license practitioners under certain circumstances, specifically:

- If any of the following practitioners have plead guilty to, been convicted of, found guilty of, or have entered a plea of *nolo contendere* to, regardless of adjudication, Medicare fraud, Medicaid fraud, health care fraud, or reproductive battery, they are subject to an ESO by the State Surgeon General:
  - Allopathic physician, physician assistants, anesthesiologist assistants, medical assistants;
  - Osteopathic physician, physician assistants, and anesthesiologist assistants;
  - Chiropractic physician and physician assistants;
  - Podiatric physicians;
  - Naturopathic physicians;
  - Optometrists - licensed and certified;
  - Autonomous advanced practice registered nurses, advanced practice registered nurses, registered nurses, licensed practical nurses and certified nursing assistants;
  - Pharmacists and pharmacy technicians;
  - Dentists, dental hygienist and dental laboratories; and
  - Opticians;[48]
- The DOH may issue an ESO or ERO if the Board of Medicine (BOM) or Board of Osteopathic Medicine (BOOM) has previously found one of its physicians has committed medical malpractice,[49] gross medical malpractice, or repeated medical malpractice,[50] and the probable cause panel again finds probable of cause for another malpractice violation. In such cases, the State Surgeon General must review the matter to determine if an ESO or ERO is warranted;[51]
- The DOH may issue an ESO or ERO if any practitioner governed by ch. 456, F.S., tests positive for any drug on any government or private sector pre-employment or employer-ordered confirmed drug test,[52] when the practitioner does not have a lawful prescription and legitimate medical reason for using such drug;[53]

[45] *See* Fla. Admin. Code R. 28-106.501(3) (2020), and ss. 120.569(2)(n) or 120.60(6), F.S.
[46] Fla. Admin. Code R. 28-106.501(3) (2020).
[47] Section 120.60(6)(c), F.S.
[48] Section 456.073(1), F.S.
[49] Section 456.50(1)(g), F.S., "Medical malpractice" means the failure to practice medicine in accordance with the level of care, skill, and treatment recognized in law related to health care licensure.
[50] *Id.* "Repeated medical malpractice" is medical malpractice, and any similar wrongful act, neglect, or default committed in another state or country which, if committed in this state, would have been considered medical malpractice, and will be considered medical malpractice, if the standard of care and burden of proof applied in the other state or country equaled or exceeded that used in this state.
[51] Section 456.074(2), F.S.
[52] *See* s. 112.0445, F.S.
[53] Section 456.074(3), F.S. The practitioner must be given 48 hours from the time of notification of the confirmed test results to produce a lawful prescription for the drug before an emergency order is issued.

- The DOH must issue an ESO if it receives information that a massage therapist, a person with an ownership interest in the establishment, or a massage corporate establishment corporation whose owners, officers, or individual are directly involved in the management of the establishment, has been convicted of, found guilty of, or has entered a guilty or *nolo contendere* plea to, regardless of adjudication, a felony under any of the following crimes anywhere:[54]
  - Prostitution;[55]
  - Kidnapping;[56]
  - False imprisonment;[57]
  - Luring or enticing a child;[58]
  - Human trafficking;[59]
  - Human smuggling;[60]
  - Sexual battery;[61]
  - Female genital mutilation;[62]
  - Procuring a person under 18 for prostitution;[63]
  - Selling or buying of minors into prostitution;[64]
  - Forcing, compelling, or coercing another to become a prostitute;[65]
  - Deriving support from the proceeds of prostitution;[66]
  - Prohibiting prostitution and related acts;[67]
  - Lewd or lascivious offenses committed upon or in the presence of persons under 16;[68]
  - Lewd or lascivious offenses committed upon or in the presence of an elderly or disabled person;[69]
  - Sexual performance by a child;[70]
  - Protection of minors;[71]
  - Computer pornography;[72]
  - Transmission of material harmful to minors, to a minor by electronic device or equipment;[73] and

[54] 456.074(4), F.S.
[55] Section 796.07(1)(a), F.S. "Prostitution" means the giving or receiving of the body for sexual activity for hire, but excludes sexual activity between spouses. Prostitution that took place at massage establishment is reclassified to the next higher degree. *See* s. 796.07(2)(a), F.S., which is reclassified under s. 796.07(7), F.S.
[56] Section 787.01, F.S.
[57] Section 787.02, F.S.
[58] Section 787.025, F.S.
[59] Section 787.06, F.S.
[60] Section 787.07, F.S.
[61] Section 794.011, F.S.
[62] Section 794.08, F.S.
[63] Former s. 796.03, F.S.
[64] Former s. 796.035, F.S.
[65] Section 796.04, F.S.
[66] Section 796.05, F.S.
[67] Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, F.S.
[68] Section 800.04, F.S.
[69] Section 825.1025(2)(b), F.S.
[70] Section 827.071, F.S.
[71] Section 847.0133, F.S.
[72] Section 847.0135, F.S.
[73] Section 847.0138, F.S.

- Selling or buying of minors.[74]

- The DOH must issue an ESO if a BOM or BOOM probable cause panel determines that the following constitutes a violation of the practice act and there exists an immediate danger to the public:
  - The registered surgery office where office surgery level liposuction, or Level II or Level III office surgeries are being performed; or the physician practicing in the office, are not in compliance with the standards of practice for office surgery set by statute and board rule;[75] or
  - The physician is practicing beyond the scope of his or her education, training and experience, and performing procedures the licensee knows, or has reason to know, that he or she is not competent to perform.[76,77]

III. Effect of Proposed Changes:

SB 1934:

- Amends s. 456.072, F.S., to add to the list of offenses that are grounds for disciplinary action against the license of a health care practitioner regulated by the Department of Health (DOH). The bill adds the following to that list: being convicted or found guilty of, entering a plea of guilty or nolo contendere to, regardless of adjudication, or committing or attempting, soliciting, or conspiring to commit an act that would constitute a violation of any of the offenses listed in s. 456.074(5), F.S., or a similar offense in another jurisdiction.
- Creates a new subsection (5) of s. 456.074, F.S., to require the DOH to issue an emergency order suspending the license of any allopathic or osteopathic physician who is a pediatrician or who otherwise treats children in his or her practice if the physician is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses involving a child in Florida or similar offenses in another jurisdiction:
  - Sexual misconduct against an individual with a developmental disability;[78]
  - Sexual misconduct against a patient of a receiving or treatment facility or in the custody of the Department of Children and Families;[79]
  - Kidnapping;[80]
  - False imprisonment;[81]
  - Luring or enticing a child;[82]
  - Human trafficking for commercial sexual activity;[83]
  - Human trafficking of a child under 5 for commercial sexual activity;[84]
  - Human smuggling;[85]

[74] Section 847.0145, F.S.
[75] Id. and Fla. Admin. Code Rs. 64B-9.009 and 64B15-14.007 (2020).
[76] Sections 458.331(1)(v) and 459.015(1)(z), F.S.
[77] Section 456.074(5), F.S.
[78] Section 393.135(2), F.S.
[79] Section 394.4593(2), F.S,
[80] Section 787.01, F.S.
[81] Section 787.02, F.S.
[82] Section 787.025(2), F.S.
[83] Section 787.06(3)(b),(d), (f), or (g), F.S.
[84] Former s. 787.06(3)(h), F.S.
[85] Section 787.07, F.S.

- Sexual battery, excluding a person falsely accused;[86]
- Sexual activity with certain minors;[87]
- Female genital mutilation;[88]
- Procuring a person under 18 for prostitution;[89]
- Selling or buying of minors into prostitution;[90]
- Forcing, compelling, or coercing another to become a prostitute;[91]
- Deriving support from the proceeds of prostitution;[92]
- Prohibiting prostitution and related acts;[93]
- Lewd or lascivious offenses committed upon or in the presence of persons under 16;[94]
- Video voyeurism of a minor;[95]
- Sexual performance by a child;[96]
- Prohibited acts in connection with obscene, lewd, and other materials;[97]
- Materials harmful to minors;[98]
- Exposing minors to harmful motion pictures, exhibitions, shows, presentations, or representations;[99]
- Protection of minors from obscene materials;[100]
- Computer pornography, prohibited computer usage, or traveling to meet minors, excluding owners or operators of computer services;[101]
- Transmission of child pornography by electronic device or equipment;[102]
- Transmission of material harmful to minors to a minor by electronic device or equipment;[103]
- Selling or buying of minors;[104]
- Loitering or prowling in close proximity to children;[105]
- Racketeering activity;[106]
- Sexual misconduct against a forensic client of a civil or forensic facility for defendants who have a mental illness or an intellectual disability;[107]

[86] Section 794.011, F.S.
[87] Section 794.05, F.S.
[88] Section 794.08, F.S.
[89] Former s. 796.03, F.S.
[90] Former s. 796.035, F.S.
[91] Section 796.04, F.S.
[92] Section 796.05, F.S.
[93] Section 796.07(4)(a)3., F.S., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, F.S.
[94] Section 800.04, F.S.
[95] Section 810.145(8), F.S.
[96] Section 827.071, F.S.
[97] Section 847.011, F.S.
[98] Section 847.012, F.S.
[99] Section 847.013, F.S.
[100] Section 847.0133, F.S.
[101] Sections 847.0135, and 847.0135(6), F.S.
[102] Section 847.0137, F.S.
[103] Section 847.0138, F.S.
[104] Section 847.0145, F.S.
[105] Section 856.022, F.S.
[106] Section 895.03, F.S., if the court makes a written finding that the racketeering activity involved at least one sexual offense listed in this subsection or at least one offense listed in this subsection which was committed with sexual intent or motive.
[107] Section 916.1075(2), F.S.

- Sexual misconduct against a juvenile offender;[108] and
- Any similar offense committed in this state which has been redesignated from a former statute number to one of those listed above.

- Section 3 of the bill directs the OPPAGA to analyze state laws and rules relating to grounds for health care practitioner discipline and immediate suspension of licenses, specifically with respect to criminal offenses, and report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2022. The analysis must identify all health care professions regulated by the DOH, and for each profession:
  - Indicate all sections of the Florida Statutes, and related rules, that subject practitioners to discipline or an ESO of his or her license;
  - Identify which criminal offenses are specifically listed as grounds for disciplinary action or a ESO suspending a practitioner's license, distinguishing whether the DOH may take such action upon a health care practitioner's arrest for the criminal offense or conduct or only if the health care practitioner is found guilty or convicted of, or enters a plea of nolo contendere to, the criminal offense;
  - Compare all of the information obtained and determine:
    - Whether there are disparities between the professions as to which criminal offenses are grounds for disciplinary action or grounds for an ESO; and
    - Whether there are disparities between the disciplinary guidelines adopted by the boards or the DOH for the different professions;
  - Review historical disciplinary action data from the DOH, including all of the disciplinary actions taken or immediate suspensions issued by the DOH for a health care practitioner's arrest for, conviction of, or entering a plea to a criminal offense, and identifying the types of offenses and details of the corresponding disciplinary action taken, if any; and
  - To the extent possible, determine how many health care practitioners in the past 10 years (or in prior years if older data are available) have been arrested for, been convicted of, or have entered a plea to a criminal offense listed in s. 456.074(5), F.S., as amended by the bill, and, for such practitioners, determine how many have had administrative complaints filed or disciplinary action taken against their license or have had their license immediately suspended by the DOH for such arrest, conviction, or criminal plea, noting the final disposition of their case with the DOH, if any; and;
  - Compare all of the information obtained under the analysis and determine if Florida's current laws and rules, relating to discipline and ESOs of practitioners licenses, are creating discrepancies relating to practitioners who are arrested, convicted, or entering pleas to criminal offenses, that pose a danger to the health, safety, and welfare of the public, but are not being subjected to disciplinary action or ESOs of their licenses.
- Requires that, upon the OPPAGA's request, all state agencies must assist the OPPAGA in its analysis and preparation of the report, including, but not limited to, providing technical assistance and any relevant information or data the OPPAGA requests.

The bill provides an effective date of July 1, 2021.

[108] Section 985.701(1), F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill might result in increased expenses borne by the OPPAGA to cover the costs associated with producing the report required under the bill.

VI. Technical Deficiencies:

None.

VII. Related Issues:

To potentially give the OPPAGA more time to conduct the analysis required under section 3 of the bill, an amendment should be considered to make that section effective upon the bill becoming law.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 456.072 and 456.074.

This bill creates a non-statutory section of the Laws of Florida.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Book

32-01089C-21 20211934__

A bill to be entitled

An act relating to health care practitioner discipline; amending s. 456.072, F.S.; subjecting health care practitioners to disciplinary action for specified offenses; amending s. 456.074, F.S.; requiring the Department of Health to issue emergency orders to suspend certain physicians' licenses if they are arrested for committing or attempting, soliciting, or conspiring to commit acts that would constitute violations of specified criminal offenses involving a child; requiring the Office of Program Policy Analysis and Government Accountability (OPPAGA) to analyze certain laws and rules and their application; providing requirements for the analysis; requiring all state agencies, upon OPPAGA's request, to assist OPPAGA and provide requested information and data; requiring OPPAGA to submit a report to the Governor and the Legislature by a specified date; providing for future repeal; providing an effective date.

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

Section 1. Paragraph (rr) is added to subsection (1) of section 456.072, Florida Statutes, to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(rr) Being convicted or found guilty of, entering a plea of

32-01089C-21 20211934__

guilty or nolo contendere to, regardless of adjudication, or committing or attempting, soliciting, or conspiring to commit an act that would constitute a violation of any of the offenses listed in s. 456.074(5) or a similar offense in another jurisdiction.

Section 2. Present subsection (5) of section 456.074, Florida Statutes, is redesignated as subsection (6), and a new subsection (5) is added to that section, to read:

456.074 Certain health care practitioners; immediate suspension of license.—

(5) The department shall issue an emergency order suspending the license of any physician licensed under chapter 458 or chapter 459 who is a pediatrician or who otherwise treats children in his or her practice if the physician is arrested for committing or attempting, soliciting, or conspiring to commit any act that would constitute a violation of any of the following criminal offenses involving a child in this state or similar offenses in another jurisdiction:

(a) Section 393.135(2), relating to sexual misconduct against an individual with a developmental disability.

(b) Section 394.4593(2), relating to sexual misconduct against a patient of a receiving or treatment facility or otherwise in the custody of the Department of Children and Families.

(c) Section 787.01, relating to kidnapping.

(d) Section 787.02, relating to false imprisonment.

(e) Section 787.025(2), relating to luring or enticing a child.

(f) Section 787.06(3)(b),(d), (f), or (g), relating to

human trafficking for commercial sexual activity.

(g) Former s. 787.06(3)(h), relating to human trafficking of a child under the age of 15 for commercial sexual activity.

(h) Section 787.07, relating to human smuggling.

(i) Section 794.011, relating to sexual battery, excluding s. 794.011(10).

(j) Section 794.05, relating to unlawful sexual activity with certain minors.

(k) Section 794.08, relating to female genital mutilation.

(l) Former s. 796.03, relating to procuring a person under the age of 18 for prostitution.

(m) Former s. 796.035, relating to the selling or buying of minors into prostitution.

(n) Section 796.04, relating to forcing, compelling, or coercing another to become a prostitute.

(o) Section 796.05, relating to deriving support from the proceeds of prostitution.

(p) Section 796.07(4)(a)3., relating to a felony of the third degree for a third or subsequent violation of s. 796.07, relating to prohibiting prostitution and related acts.

(q) Section 800.04, relating to lewd or lascivious offenses committed upon or in the presence of persons younger than 16 years of age.

(r) Section 810.145(8), relating to video voyeurism of a minor.

(s) Section 827.071, relating to sexual performance by a child.

(t) Section 847.011, relating to prohibited acts in connection with obscene, lewd, and other materials.

(u) Section 847.012, relating to materials harmful to minors.

(v) Section 847.013, relating to exposing minors to harmful motion pictures, exhibitions, shows, presentations, or representations.

(w) Section 847.0133, relating to the protection of minors from obscene materials.

(x) Section 847.0135, relating to computer pornography, prohibited computer usage, or traveling to meet minors, excluding s. 847.0135(6).

(y) Section 847.0137, relating to transmission of child pornography by electronic device or equipment.

(z) Section 847.0138, relating to the transmission of material harmful to minors to a minor by electronic device or equipment.

(aa) Section 847.0145, relating to the selling or buying of minors.

(bb) Section 856.022, relating to loitering or prowling in close proximity to children.

(cc) Section 895.03, relating to racketeering activity, if the court makes a written finding that the racketeering activity involved at least one sexual offense listed in this subsection or at least one offense listed in this subsection which was committed with sexual intent or motive.

(dd) Section 916.1075(2), relating to sexual misconduct against a forensic client of a civil or forensic facility for defendants who have a mental illness or an intellectual disability.

(ee) Section 985.701(1), relating to sexual misconduct

against a juvenile offender.

(ff) Any similar offense committed in this state which has been redesignated from a former statute number to one of those listed in this subsection.

Section 3. Health care practitioner study.—

(1) The Office of Program Policy Analysis and Government Accountability (OPPAGA) shall analyze this state's laws and rules relating to grounds for disciplinary actions against and immediate suspension of health care practitioner licenses and the application of such laws and rules, specifically with respect to criminal offenses.

(2) In its analysis, OPPAGA shall do all of the following, at a minimum:

(a) Identify all of the health care professions regulated by the Department of Health and, for each health care profession, indicate all sections of the Florida Statutes and related rules that subject practitioners of that health care profession to discipline or immediate suspension of licensure.

(b) For each health care profession, identify which criminal offenses are specifically enumerated as grounds for disciplinary action against or immediate suspension of the health care practitioner's license. This information must distinguish whether the department may take such action upon a health care practitioner's arrest for the criminal offense or conduct or only if the health care practitioner is found guilty or convicted of or enters a plea of nolo contendere to the criminal offense. OPPAGA shall also review the corresponding disciplinary guidelines adopted by rule of the applicable board, or the department if there is no board, for each health care

profession.

(c) Compare all of the information obtained under paragraph (b) and determine whether there are disparities between health care professions as to which criminal offenses are grounds for disciplinary action against or immediate suspension of licensure and whether there are disparities between the corresponding disciplinary guidelines adopted by the board or the department, as applicable, for the different health care professions.

(d) Review historical disciplinary action data from the department which includes all of the disciplinary actions taken or immediate suspensions issued by the department for a health care practitioner's arrest for, conviction of, or entering a plea to a criminal offense, identifying the types of offenses and details of the corresponding disciplinary action taken, if any.

(e) To the extent possible, determine how many health care practitioners in the past 10 years have been arrested for, been convicted of, or have entered a plea to a criminal offense enumerated in s. 456.074(5), Florida Statutes, as amended by this act. OPPAGA may review such instances that occurred more than 10 years ago if such information is available.

(f) For the health care practitioners identified in paragraph (e), determine how many have had administrative complaints filed or disciplinary action taken against their license or have had their license immediately suspended by the department for such arrest, conviction, or criminal plea, noting the final disposition of their case with the department, if any.

(g) Compare all of the information obtained under this subsection and determine if this state's current laws and rules

relating to discipline and immediate suspension of health care practitioner licenses are creating discrepancies relating to health care practitioners who are arrested for, are convicted of, or enter pleas to criminal offenses that pose a danger to the health, safety, and welfare of the public but are not subjected to disciplinary action or immediate suspension of their licenses.

(3) Upon OPPAGA's request, all state agencies shall assist in conducting its analysis and preparing its report under this section, including, but not limited to, providing technical assistance and any relevant information or data OPPAGA requests.

(4) OPPAGA shall submit a report of its findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2022.

(5) This section is repealed January 2, 2022.

Section 4. This act shall take effect July 1, 2021.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: March 5, 2021

I respectfully request that **Senate Bill 1934**, relating to Health Care Practicioner Discipline, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Thank you for your consideration.

Lauren Book

Senator Lauren Book
Florida Senate, District 32

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:	CS/SB 716
INTRODUCER:	Health Policy Committee and Senator Book
SUBJECT:	Consent for Pelvic Examinations
DATE:	March 18, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			JU	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 716:

- Amends and simplifies the definition of "pelvic examination;"
- Amends current law requiring written consent for all pelvic examinations performed by health care practitioners and trainees to require written consent only for anesthetized or unconscious patients, with exceptions;
- Directs that written consent for a pelvic examination may be obtained as part of a general consent form if it has its own provision on the form; and
- Directs that one written consent form may be used to authorize multiple health care practitioners or students to perform a pelvic examination.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

The Department of Health

The Legislature created the Department of Health (DOH) to protect and promote the health of all residents and visitors in the state.[1] The DOH is charged with the regulation of health practitioners

[1] Section 20.43, F.S.

for the preservation of the health, safety, and welfare of the public. The Division of Medical Quality Assurance (MQA) is responsible for the regulatory boards[2] and professions within the DOH.[3]

Pelvic Examinations

In Florida, allopathic and osteopathic physicians, autonomous advanced practice registered nurses (autonomous APRNs), APRNs working under a protocol with a supervising physician which includes a pelvic examination, licensed midwives, and physician assistants supervised by a physician whose practice includes pelvic examinations, may perform pelvic examinations and are subject to regulation by their respective board or council.[4]

Pelvic Examinations on Unconscious or Anesthetized Patients

In recent years, articles have detailed reports of medical students performing pelvic examinations, without consent, on women who are anesthetized.[5] This practice has been common since the late 1800s, and in 2003, a study reported that 90 percent of medical students who completed obstetrics and gynecology rotations at four Philadelphia-area hospitals performed pelvic examinations on anesthetized patients for educational purposes.[6]

Several medical organizations have taken positions that pelvic examinations under anesthesia by students in a teaching environment should require the patient's informed consent:

- The American Medical Association Council on Ethical and Judicial Affairs recommends that, in situations where the patient will be temporarily incapacitated (e.g., anesthetized) and where student involvement is anticipated, involvement should be discussed before the procedure is undertaken, whenever possible.[7]

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[2] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH, MQA.
[3] Section 20.43, F.S.
[4] *Supra*, note 2; and chs. 458, 459, 464, and 467, F.S.
[5] For examples, *see:* Paul Hsieh, *Pelvic Exams on Anesthetized Women Without Consent: A Troubling and Outdated Practice*, FORBES (May 14, 2018), *available at* https://www.forbes.com/sites/paulhsieh/2018/05/14/pelvic-exams-on-anesthetized-women-without-consent-a-troubling-and-outdated-practice/#74d152df7846 (last visited Mar. 8, 2021); Dr. Jennifer Tsai, *Medical Students Regularly Practice Pelvic Exams on Unconscious Patients. Should They?*, ELLE (June 24, 2019), *available at* https://www.elle.com/life-love/a28125604/nonconsensual-pelvic-exams-teaching-hospitals/ (last visited Mar. 8, 2021); Lorelei Laird, *Pelvic Exams Performed without Patients' Permission Spur New Legislation*, ABA JOURNAL (Sept. 2019), *available at* http://www.abajournal.com/magazine/article/examined-while-unconscious (last visited Mar. 8, 2020); and Amanda Eisenberg, *New Bills Would Ban Pelvic Exams without Consent*, POLITICO (March, 2019), *available at* https://www.politico.com/states/new-york/albany/story/2019/03/13/new-bills-would-ban-pelvic-exams-without-consent-910976 (last visited Mar. 8, 2021).
[6] John Duncan, Dan Luginbill, Matthew Richardson, Robin Fretwell Wilson, *Using Tort Law to Secure Patient Dignity: Often Used as Teaching Tools for Medical Students, Unauthorized Pelvic Exams Erode Patient Rights, Litigation Can Reinstate Them*, 40 TRIAL 42 (Oct. 2004), *available at* https://www.researchgate.net/publication/256066192_Using_Tort_Law_to_Secure_Patient_Dignity (last visited Mar. 8, 2021).
[7] AMA Council on Ethical and Judicial Affairs, *Medical Student Involvement in Patient Care: Report of the Council on Ethical and Judicial Affairs*, AMA Journal of Ethics (March 2001), *available at* https://journalofethics.ama-assn.org/article/medical-student-involvement-patient-care-report-council-ethical-and-judicial-affairs/2001-03 (last visited Mar. 8, 2021).

- The Association of American Medical Colleges, reversing its prior policy position, offered that "performing pelvic examinations on women under anesthesia, without their knowledge or approval … is unethical and unacceptable."[8]
- The Committee on Ethics of the American College of Obstetricians and Gynecologists resolved that "pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teaching purposes should be performed only with her specific informed consent obtained before her surgery."[9]

Forty-two states do not require the informed consent to pelvic examinations under anesthesia by students and residents. California, Hawaii, Illinois, Iowa, Maryland, Oregon, Utah, and Virginia prohibit unauthorized pelvic examinations.[10]

The Association of American Medical Colleges (AAMC) has found that most teaching hospitals inform patients that trainees will be involved in their care and, generally, patients approve of the trainees' involvement.[11] The chief health care officer for the AAMC notes that recent articles on unauthorized pelvic examinations rely on studies from more than 10 years ago and before more detailed informed consent forms were used.[12] Typically, students and residents practice pelvic examinations with special mannequins and standardized patients who are specifically trained for this purpose.[13]

Informed Consent

Informed consent for medical treatment is fundamental in both ethics and law.[14] Informed consent is a process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention.[15] A patient must be competent to make a voluntary decision about whether to undergo a procedure.

The idea of informed consent was established in 1914 in a case in which a patient was operated on without her consent.[16] In determining whether she had a cause of action against the hospital in which the operation was formed, the judge in the case opined that "every human being of adult years and sound mind has a right to determine what shall be done to his own body, and a surgeon

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[8] Robin Fretwell Wilson, *Autonomy Suspended: Using Female Patients to Teach Intimate Exams Without Their Knowledge or Consent*, 8 J OF HEALTH CARE LAW AND POLICY 240, *available at* https://papers.ssrn.com/sol3/papers.cfm?abstract_id=880120 (last visited Mar. 8, 2021).
[9] American College of Obstetricians and Gynecologists, Committee on Ethics, *Professional Responsibilities in Obstetric-Gynecologic Medical Education and Training* (Aug. 2011), *available at* https://www.acog.org/Clinical-Guidance-and-Publications/Committee-Opinions/Committee-on-Ethics/Professional-Responsibilities-in-Obstetric-Gynecologic-Medical-Education-and-Training?IsMobileSet=false (last visited Mar. 8, 2021).
[10] Lorelei Laird, *Pelvic Exams Performed without Patients' Permission Spur New Legislation*, ABA JOURNAL (September 2019), *available at* http://www.abajournal.com/magazine/article/examined-while-unconscious (last visited Mar. 8, 2021).
[11] Stacy Weiner, *What "Informed Consent" Really Means* (Jan. 24, 2019), *available at* https://www.aamc.org/news-insights/what-informed-consent-really-means (last visited Mar. 8, 2021).
[12] *Id.*
[13] *See* note 11.
[14] American Medical Association, *Informed Consent: Code of Medical Ethics Opinion 2.1.1*, *available at* https://www.ama-assn.org/delivering-care/ethics/informed-consent (last visited Mar. 8, 2021).
[15] William Gossman, Imani Thornton, John Hipskind, *Informed Consent* (Aug. 22, 2020), *available at* https://www.ncbi.nlm.nih.gov/books/NBK430827/ (last visited Mar. 8, 2021).
[16] *Schloendorff v. Society of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914).

who performs an operation without his patient's consent commits an assault, for which he is liable for damages."[17]

Informed Consent Relating to Forensic Examinations

When sexual assault occurs, the effective collection of evidence is of paramount importance to the successful prosecution of sex offenders.[18]

Florida law mandates the reporting of abuse and neglect of both adults and children.[19,20] When the abuse or neglect involves sexual abuse or violence, human trafficking, sexual battery, prostitution, lewdness, indecent exposure, or obscenity, a forensic medical examination, sometimes including a pelvic examination, is often involved.

A forensic medical examination serves two purposes. The first is to address the medical needs of individuals disclosing sexual assault. This is accomplished, with the patient's consent, by:[21]

- Evaluating and treating injuries;
- Conducting prompt examinations;
- Providing support, crisis intervention, and advocacy;
- Providing prophylaxis against sexually transmitted infections;
- Assessing female patients for pregnancy risk and discussing treatment options, including reproductive health services; and
- Providing follow-up care for medical and emotional needs.

The other purpose is to address justice system needs through forensic evidence collection. This is accomplished by:

- Obtaining a history of the assault;
- Documenting exam findings;
- Properly collecting, handling, and preserving evidence;
- Interpreting and analyzing findings; and
- Subsequently presenting findings and providing factual and expert opinion related to the exam and evidence collection.

Victims of sexual violence, like any other individual, must give informed consent to a forensic medical examination before the examination may be performed. A health care practitioner, a medical student, or any other student receiving training as a health care practitioner may not perform a pelvic examination on a patient without the written consent of the patient or the patient's legal representative executed specific to, and expressly identifying, the pelvic examination, unless:

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[17] *Id.*

[18] *United States Department of Justice A National Protocol for Sexual Assault Medical Forensic Examinations Adults/Adolescents*, 2nd. Ed., Apr. 2013, *available at* https://www.ojp.gov/pdffiles1/ovw/241903.pdf (last visited Mar. 18, 2021).

[19] Section 39.201, F.S.

[20] Section 415.1034, F.S.

[21] State of Florida, Office of Attorney General, 2015, *Adult and Child Sexual Assault Protocols: Initial Forensic Physical Examination, available at http://myfloridalegal.com/webfiles.nsf/WF/JFAO-77TKCT/$file/ACSP.pdf* (last visited Mar. 18, 2021).

- A court orders performance of the pelvic examination for the collection of evidence; or
- The pelvic examination is immediately necessary to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the patient.[22]

In the event that the victim is a child, or an adult who lacks the capacity to give consent, the victim's legal representative may sign the consent forms. If the victim is unable to consent due to being incapacitated, the examiner may not commence with the examination without a court order.[23]

Florida Requirements for Informed Consent

In Florida the only general law on medical consent appears in ch. 766, F.S., Medical Malpractice and Related matters.[24] However, Florida physicians and physicians practicing within a postgraduate training program approved by the Board of Medicine (BOM) and the Board of Osteopathic Medicine (BOOM) must explain the medical or surgical procedure to be performed to the patient and obtain the informed consent of the patient. The physician is not required to obtain or witness the signature of the patient on a written form evidencing informed consent, and there is no requirement that the patient must use a written document, although hospitals and facilities where procedures are performed typically require consent in writing.[25,26]

In 2020 the Florida Legislature created s. 456.51, F.S., *Consent for pelvic examination,*[27] in response to media reports that medical students may be performing pelvic examinations on anesthetized or unconscious women without obtaining informed consent from the woman prior to anesthesia or from any other person who can provide consent.[28]

Section 456.51(1), F.S., defines a "pelvic examination" to include a series of tasks that encompass an examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation. Under current law, a health care practitioner, medical student, or any other student receiving training as a health

[22] Section 456.51, F.S.
[23] *Id.*
[24] Section 766.103, F.S., provides: No recovery shall be allowed in any court in this state against any physician, chiropractor, podiatric physician, dentist, APRN, or PA in an action brought for treating, examining, or operating on a patient without his or her informed consent when: 1) The action of the practitioner in obtaining the consent of the patient, or another person authorized to give consent for the patient, was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community; and 2) A reasonable person, from the information provided under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, recognized among practitioners in the same or similar community who perform similar treatments or procedures; or 3) The patient would reasonably, under all the surrounding circumstances, have undergone the treatment or procedure had he or she been advised by practitioner in accordance with the provisions of the first.
[25] Fla. Adm. Code R. 64B8-9.007, and 64B15-14.006 (2019).
[26] *See* The Joint Commission, Advisory on Safety Issues, Issue 21, (Feb. 2016), I*nformed Consent: More than Getting a Signature*, *available at* https://www.jointcommission.org/-/media/tjc/documents/newsletters/quick_safety_issue_twenty-one_february_2016pdf.pdf (last visited Mar. 8, 2021).
[27] CS/CS/SB 698, Ch. 2020-31, s. 3, Laws of Fla.
[28] *See* New York Times, *She Didn't Want a Pelvic Exam. She Received One Anyway*, Feb 17, 2020, updated Feb. 19, 2020, *available at* https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html (last visited Mar. 8, 2021).

care practitioner is not permitted to perform a pelvic examination on a patient without the written consent of the patient or the patient's legal representative, executed specific to, and expressly identifying, the pelvic examination, unless:

- A court orders the performance of the examination for the collection of evidence; or
- The pelvic examination is immediately necessary to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function.

Following the enactment of ch. 2020-31, s. 3, Laws of Florida (2020), conflicts in the medical community arose as to how the law's language should be interpreted, and a Petition for Declaratory Statement[29] was filed with the Florida Board of Medicine (BOM), requesting a determination of:

- Whether the definition of pelvic examination applies only to female patients or to males as well;
- Whether performance of surgery on the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs constitutes a pelvic examination;
- Whether a discrete visual examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs constitutes a pelvic examination;
- Whether a pelvic examination requires separate written consents every time a pelvic exam was performed during a course of treatment; and
- Whether a pelvic examination in emergent circumstances required a written consent when the patient or a legal representative were unable to give consent.

The BOM, in a Final Order[30] to a Petition for Declaratory Statement filed by numerous physician organizations, answered the above questions regarding what constitutes a pelvic examination under s. 456.51, F.S., as follows:

- A pelvic examination applies only to female patients;
- Surgery on the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs does not constitute a pelvic examination; and
- Discrete visual examination of the vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs does not constitute a pelvic examination.

The BOM declined to answer the questions regarding informed consent.

III. Effect of Proposed Changes:

CS/SB 716:

- Amends and simplifies the definition of "pelvic examination" to specify that the term means an examination of the organs of the female internal reproductive system;
- Amends current law requiring written consent for all pelvic examinations performed by health care practitioners, medical students, and trainees, to require written consent only for anesthetized or unconscious patients, and provides two new exceptions, in addition to those found in current law, for cases in which the examination is administered pursuant to:

[29] See Florida Department of Health, Board of Medicine, Final Order NO DOH-20-1553-DS-MQA filed Oct. 9, 2020, *available at* https://s3.amazonaws.com/thenewsserviceofflorida/web/dist/downloads/2020/10/DOH_20-1553_DS_Doug_Murphy__FMA__etc__1_.pdf (last visited Mar. 8, 2021).
[30] *Id.*

  - A child protective investigation under ch. 39, F.S.
  - A criminal investigation of an alleged violation, related to child abuse or neglect, of statutes that address human trafficking, sexual battery, prostitution, lewdness, indecent exposure, or obscenity.
- Amends the current-law exception pertaining to cases in which a pelvic examination is immediately necessary to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function, to instead pertain to cases in which the examination is necessary for the provision of emergency services and care as defined in s. 395.002, F.S.;[31]
- Directs that written consent for a pelvic examination may be obtained as part of a general consent form if it is included as its own provision on the form; and
- Directs that one written consent form may be used to authorize multiple health care practitioners or students to perform a pelvic examination.

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[31] Under s. 395.002(9), F.S., "emergency services and care" means medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition exists and, if it does, the care, treatment, or surgery by a physician necessary to relieve or eliminate the emergency medical condition, within the service capability of the facility.

B. Private Sector Impact:

None.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.51 of the Florida Statutes.

IX. 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 March 17, 2021:
The CS provides two new exceptions to the requirement that written consent must be obtained before a pelvic examination may be performed, in addition to those found in current law, for cases in which the examination is administered pursuant to:

- A child protective investigation under ch. 39, F.S.; and
- A criminal investigation of an alleged violation, related to child abuse or neglect, of statutes that address human trafficking, sexual battery, prostitution, lewdness, indecent exposure, or obscenity.

B. Amendments:

None.

762882

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/17/2021	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 36 - 37
and insert:
~~the patient~~;
(c) The pelvic examination is administered pursuant to a child protective investigation under chapter 39;
(d) The pelvic examination is administered pursuant to a criminal investigation of an alleged violation related to child abuse or neglect under s. 787.06(3)(b), (d), (f), or (g), chapter 794, chapter 796, chapter 800, chapter 827, or chapter

762882

847; or

(e) The pelvic examination is indicated in the standard of

By Senator Book

32-00225A-21 2021716__

A bill to be entitled

An act relating to consent for pelvic examinations; amending s. 456.51, F.S.; revising the definition of the term "pelvic examination"; revising the circumstances under which a pelvic examination may be performed without written consent; authorizing written consent for a pelvic examination to be obtained as a part of a general consent form and to allow multiple health care practitioners or students to perform the examination; providing an effective date.

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

Section 1. Section 456.51, Florida Statutes, is amended to read:

456.51 Consent for pelvic examinations.—

(1) As used in this section, the term "pelvic examination" means ~~the series of tasks that comprise~~ an examination of the organs of the female internal reproductive system ~~vagina, cervix, uterus, fallopian tubes, ovaries, rectum, or external pelvic tissue or organs using any combination of modalities, which may include, but need not be limited to, the health care provider's gloved hand or instrumentation~~.

(2) A health care practitioner, a medical student, or any other student receiving training as a health care practitioner may not perform a pelvic examination on an anesthetized or unconscious ~~a~~ patient without the written consent of the patient or the patient's legal representative ~~executed specific to, and expressly identifying, the pelvic examination~~, unless:

32-00225A-21 2021716__

(a) A court orders performance of the pelvic examination for the collection of evidence; ~~or~~

(b) The pelvic examination is ~~immediately~~ necessary for the provision of emergency services and care as defined in s. 395.002 ~~to avert a serious risk of imminent substantial and irreversible physical impairment of a major bodily function of the patient~~; or

(c) The pelvic examination is indicated in the standard of care for a procedure to which the patient or the patient's legal representative has consented.

(3) Written consent for a pelvic examination may be obtained as part of a general consent form if it is included as its own provision. One written consent form may be used to authorize multiple health care practitioners or students to perform a pelvic examination.

Section 2. This act shall take effect July 1, 2021.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 4, 2021

I respectfully request that **Senate Bill 716**, relating to Consent for Pelvic Examinations, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Thank you for your consideration.

Lauren Book

Senator Lauren Book
Florida Senate, District 32

File signed original with committee office

S-020 (03/2004)

THE FLORIDA SENATE

APPEARANCE RECORD

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

03/12/21
Meeting Date

716
Bill Number (if applicable)

762882
Amendment Barcode (if applicable)

Topic Consent for Pelvic Examinations

Name Andrew Kalel

Job Title Legislative Affairs Director

Address 227 N Bronough Street
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850 999 4655

Email

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Office of Criminal Conflict & Civil Regional Counsel, 5th Region

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

716
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name David Mica, Jr.

Job Title Executive Vice President of Public Affairs

Address _____ Phone _____
Street

_____ Email davidm@fha.org
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

March 17, 21 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

716

Bill Number (if applicable)

Topic written ~~pat~~ consent for pelvic exams

Amendment Barcode (if applicable)

Name Toni Large

Job Title

Address 1100 Brookwood DR

Street

Tallahassee, FL 32308

City *State* *Zip*

Phone 556-1461

Email toni@largestrategies.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against

(The Chair will read this information into the record.)

Representing Florida College of Emergency Physicians

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

716
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Consent for Pelvic Examinations

Name Jason Rodriguez

Job Title State Government Relations Manager

Address 2985 Drew Street
Street

Phone (727)519-1885

Clearwater FL 33759
City *State* *Zip*

Email jason.rodriguez@baycare.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing BayCare

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

716
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Consent for Pelvic Examination

Name Jan Gorrie

Job Title Lobbyist

Address 201 E. Park Ave, 5th floor
Street

Phone 813-334-5288

Tallahassee FL 32301
City *State* *Zip*

Email Jan@ballardpartner

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Tampa General Hospital

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21 (Health Policy)
Meeting Date

716
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Consent for Pelvic Examinations

Name Steve Winn

Job Title Executive Director

Address 2544 Blairstone Pines Dr
Street

Phone 878-7364

Tallahassee FL 32301
City *State* *Zip*

Email winnsr@eartlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Osteopathic Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-17-21
Meeting Date

716
Bill Number (if applicable)

Topic Consent for Pelvic Exams

Amendment Barcode (if applicable)

Name Barbara DeRose

Job Title

Address 625 E Brevard St
Street

Tall FL 32308
City *State* *Zip*

Phone 257-4280

Email barbaraderose10@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL NOW

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

716
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title _____

Address 4427 Herschel St
Street

Jacksonville, FL 32210
City *State* *Zip*

Phone 904-233-3051

Email nulandlawe aol.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Gastroenterologic Society

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

716
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Jared Willis

Job Title Mgr Ca Relations, Stratgos

Address 200 W College Ave Ste 201
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 284-1996

Email jwillis@stratgosgroup.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Nemours Children's Hospital

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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

S-001 (10/14/14)

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 874
INTRODUCER:	Senator Brodeur and others
SUBJECT:	Alzheimer's Disease Awareness
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 874 creates s. 381.825, F.S., to require the Department of Health (DOH), in collaboration with the Department of Elder Affairs (DOEA) and the Alzheimer's Association, to use existing, relevant, public health, and community outreach programs to incorporate and disseminate information to health care practitioners licensed under chs. 458,[1] 459,[2] and 464,[3] F.S., to educate them on and increase their understanding and awareness of Alzheimer's disease and other types of dementia. The information must cover, at a minimum:

- The importance of early detection and timely diagnosis of cognitive impairment.
- Utilization of a validated cognitive assessment tool.
- The value of Medicare annual wellness visits for cognitive health.
- The use of the Medicare billing code for care planning for individuals with cognitive impairment.
- Methods to detect early warning signs of Alzheimer's disease and other types of dementia.
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and other types of dementia.

The bill provides an effective date of July 1, 2021.

[1] Medicine.
[2] Osteopathic medicine.
[3] Nursing.

II. Present Situation:

Alzheimer's Disease and Dementia

Dementia is the loss of cognitive functioning—thinking, remembering, and reasoning—and behavioral abilities to such an extent that it interferes with a person's daily life and activities. These functions include memory, language skills, visual perception, problem solving, self-management, and the ability to focus and pay attention. Some people with dementia cannot control their emotions, and their personalities may change. Dementia ranges in severity from the mildest stage, when it is just beginning to affect a person's functioning, to the most severe stage, when the person must depend completely on others for basic activities of living.[4]

Alzheimer's disease is the most common type of dementia. It is a progressive disease that begins with mild memory loss and can lead to loss of the ability to carry on a conversation and respond to one's environment. Alzheimer's disease affects parts of the brain that control thought, memory, and language. It can seriously affect a person's ability to carry out daily activities. Although scientists are studying the disease, the cause of Alzheimer's disease is unknown.[5]

There are an estimated 580,000 individuals living with Alzheimer's disease in the state of Florida.[6] By 2025, it is projected that 720,000 Floridians will have Alzheimer's disease.[7] Most individuals with Alzheimer's can live in the community with support, often provided by spouses or other family members. In the late stages of the disease, many patients require care 24 hours per day and are often served in long-term care facilities.

Dementia Care and Cure Initiative

The DOEA announced the Dementia Care and Cure Initiative (DCCI) in 2015 to engage communities across the state to be more dementia-caring, promote better care for Floridians affected by dementia, and support research efforts to find a cure. In collaboration with Florida's 11 Area Agencies on Aging and 17 memory disorder clinics, participating DCCI communities organize task forces consisting of community professionals and stakeholders who work to bring about education, awareness of, and sensitivity regarding the needs of those affected by dementia.[8] The goals of the DCCI include:

- Increasing awareness of dementia, services, and supports.
- Providing assistance to dementia-caring communities.
- Continuing advocacy for care and cure programs.[9]

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[4] *What is Dementia? Symptoms, Types, and Diagnosis*, National Institute on Aging, *available at* https://www.nia.nih.gov/health/what-dementia-symptoms-types-and-diagnosis, (last visited Mar. 10, 2021).
[5] Centers for Disease Control and Prevention, Alzheimer's Disease and Healthy Aging website *available at* https://www.cdc.gov/aging/aginginfo/alzheimers.htm#AlzheimersDisease, (last visited Mar. 10, 2021).
[6] Alzheimer's Association *available at* https://www.alz.org/media/Documents/florida-alzheimers-facts-figures-2018.pdf, (last visited Mar. 10, 2021).
[7] *Id.*
[8] *See* http://elderaffairs.state.fl.us/doea/dcci.php (last visited March 10, 2021).
[9] *See* http://elderaffairs.state.fl.us/doea/docs/dcci/DCCI_Info_Sheet.pdf (last visited March 10, 2021).

III. Effect of Proposed Changes:

SB 874 creates s. 381.825, F.S., to require the DOH, in collaboration with the DOEA and the Alzheimer's Association, to use existing, relevant, public health, and community outreach programs to incorporate and disseminate information to health care practitioners licensed under chs. 458,[10] 459,[11] and 464,[12] F.S., to educate them on and increase their understanding and awareness of Alzheimer's disease and other types of dementia. The information must cover, at a minimum:

- The importance of early detection and timely diagnosis of cognitive impairment.
- Utilization of a validated cognitive assessment tool.
- The value of Medicare annual wellness visits for cognitive health.
- The use of the Medicare billing code for care planning for individuals with cognitive impairment.
- Methods to detect early warning signs of Alzheimer's disease and other types of dementia.
- Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and other types of dementia.

The bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

[10] Medicine.
[11] Osteopathic medicine.
[12] Nursing.

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. Statutes Affected:

This bill creates section 381.825 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

By Senator Brodeur

9-01153A-21 2021874__

A bill to be entitled

An act relating to Alzheimer's disease awareness; creating s. 381.825, F.S.; requiring the Department of Health, in collaboration with the Department of Elderly Affairs and the Alzheimer's Association, to consolidate and disseminate certain information to certain health care practitioners for a specified purpose; specifying minimum requirements for such information; providing an effective date.

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

Section 1. Section 381.825, Florida Statutes, is created to read:

381.825 Alzheimer's disease awareness.—The Department of Health, in collaboration with the Department of Elderly Affairs and the Alzheimer's Association, shall use existing, relevant public health and community outreach programs to incorporate and disseminate information to health care practitioners licensed under chapters 458, 459, and 464 to educate them on and increase their understanding and awareness of Alzheimer's disease and other types of dementia. This information must cover, at a minimum, all of the following:

(1) The importance of early detection and timely diagnosis of cognitive impairment.

(2) Utilization of a validated cognitive assessment tool.

(3) The value of Medicare annual wellness visits for cognitive health.

(4) The use of the Medicare billing code for care planning

9-01153A-21 2021874__

for individuals with cognitive impairment.

(5) Methods to detect early warning signs of Alzheimer's disease and other types of dementia.

(6) Methods to reduce the risk of cognitive decline, particularly among individuals in diverse communities who are at greater risk of developing Alzheimer's disease and other types of dementia.

Section 2. This act shall take effect July 1, 2021.

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr., Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 4, 2021

I respectfully request that **Senate Bill 874**, relating to Alzheimer's Disease Awareness, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Jason Brodeur

Senator Jason Brodeur
Florida Senate, District 9

File signed original with committee office

S-009 (03/2004)

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

SB 874
Bill Number (if applicable)

Topic In support of SB 874

Amendment Barcode (if applicable)

Name Jon Conley

Job Title State Affairs Director

Address 3311 Dartmouth Drive
Street

Phone (850) 566-7478

Tallahassee FL 32317
City *State* *Zip*

Email

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing The Alzheimer's Association

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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S-001 (10/14/14)

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 852
INTRODUCER:	Senator Brodeur
SUBJECT:	Medicaid Modernization
DATE:	March 16, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Favorable**
2.			AHS	
3.			AP	

I. Summary:

SB 852 authorizes the Agency for Health Care Administration (AHCA) to reimburse for remote patient monitoring and store-and-forward services as optional services in the Florida Medicaid program, subject to specific appropriations. If the services are rendered, the bill would have a minor operational and indeterminate fiscal impact on Florida Medicaid. *See* section V of this analysis.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Telehealth

Relevant Terminology

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

Store-and-forward allows for the electronic transmission of medical information, such as digital images, documents, and pre-recorded videos through telecommunications technology to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service after the data has been collected.[1] The transfer of X-rays or MRI images from one health care provider to another health care provider for review in the future would be considered asynchronous telehealth through store-and-forward technology.

"Remote patient monitoring" refers to the collection, transmission, evaluation, and communication of individual health data to a health care provider from the patient's location through technology such as wireless devices, wearable sensors, implanted health monitors, smartphones, and mobile apps.[2] Remote monitoring is used to monitor physiologic parameters, including weight, blood pressure, blood glucose, pulse, temperature, oximetry, respiratory flow rate, and more. Remote monitoring can be useful for ongoing condition monitoring and chronic disease management. Depending upon the patient's needs, remote monitoring can be synchronous or asynchronous.

Florida Telehealth Providers

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created section 456.47, F.S. The bill became effective on July 1, 2019.[3] It authorized Florida-licensed health care providers[4] to use telehealth to deliver health care services within their respective scopes of practice.

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board[5] and meet certain eligibility requirements.[6] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[7] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst
- Acupuncturist

[1] Center for Connected Health Policy, National Telehealth Policy Resource Center, *Store-and-Forward (Asynchronous) available at* https://www.cchpca.org/about/about-telehealth/store-and-forward-asynchronous (last visited Feb. 13, 2021).
[3] Chapter 2019-137, s. 6, Laws of Fla.
[3] Chapter 2019-137, s. 6, Laws of Fla.
[4] Section 467.47(1)(b), F.S.
[5] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance.
[6] Section 467.47(4), F.S.
[7] Section 467.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist
- Dentist
- Dental Hygienist
- Midwife
- Speech Therapist
- Occupational Therapist
- Radiology Technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical Physicist
- Emergency Medical Technician
- Paramedic
- Massage Therapist
- Optician
- Hearing Aid Specialist
- Clinical Laboratory Personnel
- Respiratory Therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic Trainer
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law.[8]

On March 16, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-002 authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register

[8] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Feb. 14, 2021).

as a telehealth provider under s. 456.47(4), F.S.[9] This emergency order was extended[10] and will remain in effect until the expiration of the Governor's Executive Order No. 20-52 and extensions thereof.[11]

Five days later, the Surgeon General executed DOH Emergency Order 20-003[12] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. This emergency order was also extended[13] and will remain in effect until the expiration of Executive Order No. 20-52 and extensions thereof.

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[14] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[15]

A Medicaid state plan is an agreement between a state and the federal government describing how the state administers its Medicaid programs. The state plan establishes groups of individuals covered under the Medicaid program, services that are provided, payment methodologies, and other administrative and organizational requirements.

In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives states the flexibility to cover other population groups (optional eligibility groups). States set individual eligibility criteria within federal minimum standards. The AHCA may seek an amendment to the state plan as necessary to comply with

[9] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Feb. 14, 2021).
[10] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020) *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Feb. 14, 2021).
[11] Under s. 252.36(2), F.S., no state of emergency declared pursuant to the Florida Emergency Management Act, may continue for more than 60 days unless renewed by the Governor. The state of emergency declared in Executive Order 20-52, was extended by Executive Orders 20-114, 20- 166, 20-192, 20-213, 20-276, 20-316, and 21-45. Executive Order 21-45 will remain in effect until Apr. 27, 2021. Office of the Governor, State of Florida, *Executive Order 20-316* (Dec. 29, 2020) *available at* https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-316.pdf (last visited Feb. 9, 2021).
[12] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Feb. 14, 2021).
[13] Department of Health, State of Florida, *Emergency Order DOH No. 20-005* (Apr. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/04/DOH-Emergency-Order-20-005-extending-20-003.pdf (last visited Feb. 14, 2021).
[14] Medicaid.gov, *Medicaid, available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 3, 2021).
[15] Section 20.42, F.S.

federal or state laws or to implement program changes. States send state plan amendments to the federal CMS for review and approval.[16]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan.

In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[17] The SMMC program has two components, the Managed Medical Assistance (MMA) program and the Long-term Care program. Florida's SMMC offers a health care package covering both acute and long-term care.[18] The SMMC benefits are authorized by federal authority and are specifically required in ss. 409.973 and 409.98, F.S.

The AHCA contracts with managed care plans on a regional basis to provide services to eligible recipients. The MMA program, which covers most medical and acute care services for managed care plan enrollees, was fully implemented in August 2014, and was re-procured for a period beginning December 2018 and ending in 2023.[19]

Medical Necessity Requirements

Florida Medicaid covers services that are medically necessary, as defined in its Medicaid state plan pursuant to Rule 59G-1.010 of the Florida Administrative Code. The AHCA routinely reviews new health services, products, and supplies to assess potential coverage under Florida Medicaid which depends on whether that service, product, or supply is medically necessary.[20] Pursuant to Rule 59G-1.010 of the Florida Administrative Code care, goods, and services are medically necessary if they are:

- Necessary to protect life, to prevent significant illness or significant disability, or to alleviate severe pain;
- Individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the patient's needs;
- Consistent with generally accepted professional medical standards as determined by the Medicaid program, and not experimental or investigational;
- Reflective of the level of service that can be safely furnished, and *for which no equally effective and more conservative or less costly treatment is available statewide*; and
- Furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

[16] Medicaid.gov, *Medicaid State Plan Amendments, available at* https://www.medicaid.gov/medicaid/medicaid-state-plan-amendments/index.html (last visited Mar. 3, 2021).
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Supra* note 6.

Telemedicine Coverage under the Florida Medicaid Program

Florida Medicaid covers telemedicine in both the managed care and fee-for-service delivery systems.

Medicaid health plans have broad flexibility in covering telemedicine services.[21] In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the state, including remote patient monitoring and store-and-forward services.[22] Services provided through these additional telemedicine modalities are not included in the capitation rates the AHCA pays to the plans.[23] Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face.[24] For example, a health plan may not require the prior authorization of a service delivered via telemedicine if it does not require prior authorization of that service delivered face-to-face.[25]

Under the fee-for service delivery system and in times of non-emergency, Florida Medicaid generally reimburses only for synchronous telemedicine services provided through the use of audio-visual equipment.[26] On March 18, 2020, the AHCA issued a Florida Medicaid Health Care Alert to provide telemedicine guidance for all medical and behavioral health care providers during the COVID-19 public health emergency.[27] Throughout the duration of the state of emergency, the AHCA has expanded telehealth to include and provide for the reimbursement of certain store-and-forward and remote patient monitoring modalities rendered by licensed physicians, APRNs, and PAs functioning within their scope of practice.[28] The AHCA has also expanded services provided through telemedicine that may be reimbursed under the FFS delivery system to include certain therapies, medication management, behavioral health, and medication-assisted treatment services.[29]

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[21] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers* (Mar. 18, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Feb. 15, 2021).
[22] Agency for Health Care Administration, *Senate Bill 852 Fiscal Analysis* (Feb. 1, 2021) (on file with the Senate Committee on Health Policy).
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Supra* note 20.
[28] *Id.*
[29] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Flexibilities for Behavioral Health Providers During the COVID-19 State of Emergency* (Apr. 16, 2020) *available at* http://portal.flmmis.com/FLPublic/Provider_ProviderServices/Provider_ProviderSupport/Provider_ProviderSupport_ProviderAlerts/tabId/48/Default.aspx (last visited Mar. 12, 2021).

The Federal Health Insurance Portability and Accountability Act (HIPAA)[30]

HIPAA Privacy Rule[31]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed.

Only certain entities and their business associates are subject to HIPAA's provisions. These "covered entities" include: health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their protected PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. Also, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

HIPAA Security Rule[32]

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

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[30] Centers for Medicare & Medicaid Services, *Medicare Learning Network Fact Sheet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules* (Sept. 2018) *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurityTextOnly.pdf (last visited Feb. 14, 2021).

[31] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

[32] 45 C.F.R. Part 160 and Subparts A and C of Part 164.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities;
- Technical, hardware, and software infrastructure;
- The costs of security measures; and
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

HIPAA Breach Notification Rule[33]

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[34]

On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the

[33] 45 C.F.R. Subpart D.

[34] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (last visited Feb. 14, 2021).

public health emergency.[35] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes protected health information from a telehealth session.[36]

Jurisdiction and Venue for Telehealth-related Actions[37]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider, may be located in the patient's county of residence or in Leon County.

III. Effect of Proposed Changes:

Section 1 amends s. 409.906, F.S., to authorize the AHCA to reimburse under the Florida Medicaid program for the following optional services:

- Remote patient monitoring services. This includes:
  - Remote monitoring of physiologic parameters;
  - The supply of devices with daily recording or programmed alert transmission;[38] and
  - Remote physiologic monitoring treatment management services that require interactive communication between the recipient and provider.
- Remote evaluation of recorded video and images[39], including interpretation and follow-up with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment." This text mirrors national billing codes.[40] In practice, the AHCA would

[35] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Feb. 14, 2021).
[36] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (last visited Feb. 14, 2021).
[37] Section 456.47(5), F.S.
[38] The devices must meet the definition of "medical device" as defined in the federal Food, Drug, and Cosmetic Act, 21 U.S.C. s. 321(h), and be capable of generating and transmitting either daily recordings of the patient's physiologic data or an alert if the patient's values fall outside pre-determined parameters. BioIntelliSense, *Q&A Guide: providing and Billing Medicare for Remote Patient Monitoring and Treatment Management* (Feb. 2021) *available at* https://biointellisense.com/assets/providing-and-billing-medicare-for-remote-patient-monitoring.pdf (last visited Mar. 12, 2021).
[39] This is often referred to as "store-and-forward."
[40] *See* Centers for Medicare & Medicaid Services, *Medicare Telemedicine Health Care Provider Fact Sheet* (Mar. 27, 2020) *available at* https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet (last visited Mar. 12, 2021). Nathaniel Lacktman, Foley & *Lardner, Understanding Medicare's New Remote Evaluation of Pre-Recorded Patient Information (Asynchronous Telemedicine)* (Nov. 6, 2018) *available at* https://www.foley.com/en/insights/publications/2018/11/understanding-medicares-new-remote-evaluation-of-p (last visited Mar. 12, 2021). Coding Intel, Virtual communication: HCPCS codes G2010 and G2012 *available at* https://codingintel.com/virtual-communication-new-hcpcs-codes-g2010-and-g2012/ (last visited Mar. 12, 2021).

implement it according to those national billing codes and corresponding guidelines.[41] This means that the AHCA would be authorized to reimburse for the remote evaluation of recorded video and images with the interpretation of the video and images and follow-up communicated to the patient within 24 business hours of the evaluation. Under the authority of this paragraph, the AHCA may not reimburse for the remote evaluation of recorded video and images if the remote evaluation:

- Takes place during an in-person visit;
- Takes place within seven days after an in-person visit; or
- Triggers an in-person visit within 24 hours or at the soonest available appointment.

Like all Medicaid services, these remote patient monitoring and store-and-forward services may be provided only when medically necessary.[42]

Section 2 provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[41] E-mail from AHCA staff to Committee on Health Policy (Mar. 12, 2021) (on file with Senate Committee on Health Policy).
[42] Section 409.906, F.S.

B. Private Sector Impact:

None.

C. Government Sector Impact: [43]

If the optional Medicaid services authorized in the bill are rendered, then the bill would have a minor operational and indeterminate fiscal impact on the Florida Medicaid program. The bill could lead to an increase in the use of telemedicine for the provision of diagnostic, preventive, and treatment services. The number of additional telehealth services that would be provided is unknown. The bill poses an indeterminate fiscal impact on Medicaid managed care plan capitation rates.

Additionally, the AHCA would need to revise the telemedicine State Plan Amendment that is currently in effect, update its rules, update the Florida Medicaid Management Information System, and communicate changes to enrolled providers and managed care plans, all of which are part of the AHCA's routine business practices.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 409.906 of the Florida Statutes.

IX. Additional Information:

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

None.

B. Amendments:

None.

[43] *Supra* note 21.

By Senator Brodeur

9-00564A-21 2021852__

A bill to be entitled

An act relating to Medicaid modernization; amending s. 409.906, F.S.; authorizing Medicaid to reimburse for certain remote evaluation and patient monitoring services; providing an effective date.

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

Section 1. Subsection (28) is added to section 409.906, Florida Statutes, to read:

409.906 Optional Medicaid services.—Subject to specific appropriations, the agency may make payments for services which are optional to the state under Title XIX of the Social Security Act and are furnished by Medicaid providers to recipients who are determined to be eligible on the dates on which the services were provided. Any optional service that is provided shall be provided only when medically necessary and in accordance with state and federal law. Optional services rendered by providers in mobile units to Medicaid recipients may be restricted or prohibited by the agency. Nothing in this section shall be construed to prevent or limit the agency from adjusting fees, reimbursement rates, lengths of stay, number of visits, or number of services, or making any other adjustments necessary to comply with the availability of moneys and any limitations or directions provided for in the General Appropriations Act or chapter 216. If necessary to safeguard the state's systems of providing services to elderly and disabled persons and subject to the notice and review provisions of s. 216.177, the Governor may direct the Agency for Health Care Administration to amend

9-00564A-21 2021852__

the Medicaid state plan to delete the optional Medicaid service known as "Intermediate Care Facilities for the Developmentally Disabled." Optional services may include:

(28) REMOTE EVALUATION AND MONITORING SERVICES.—

(a) The agency may pay for remote evaluation of recorded video and images, including interpretation and followup with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

(b) The agency may pay for remote patient monitoring services, including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

Section 2. This act shall take effect July 1, 2021.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR JASON BRODEUR
9th District

COMMITTEES:
Environment and Natural Resources, *Chair*
Health Policy, *Vice Chair*
Appropriations Subcommittee on Agriculture, Environment, and General Government
Appropriations Subcommittee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs

SELECT COMMITTEE:
Select Committee on Pandemic Preparedness and Response

JOINT COMMITTEE:
Joint Administrative Procedures Committee

February 4, 2021

Honorable Manny Diaz, Jr.
306 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Diaz,

I am writing to request that SB 852, Medicaid Modernization, be placed on the agenda to be heard in the Health Policy Committee.

I appreciate your consideration in this matter.

Sincerely,

Jason Brodeur

Cc: Allen Brown, Staff Director
Lynn Wells, Administrative Assistant

REPLY TO:
❒ 311 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

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

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 852
BILL TITLE:	Medicaid Modernization
BILL SPONSOR:	Senator Brodeur
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 1, 2021
LEAD AGENCY ANALYST:	Jesse Bottcher
ADDITIONAL ANALYST(S):	Erica Floyd Thomas
LEGAL ANALYST:	
FISCAL ANALYST:	Ana Rivas

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 852 amends section 409.906, Florida Statutes (F.S.) by adding subsection (28) allowing the Agency to pay, through Medicaid, for remote evaluation of recorded video and images and remote patient monitoring.

The bill describes remote evaluation of recorded video and images as including interpretation and follow up with the recipient within business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

The bill describes remote patient monitoring as including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

SB 852 poses a minor operational and indeterminate fiscal impact on the Florida Medicaid program.

SB 852 has an effective date of July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS).

Together, states and the federal government fund Medicaid. As of December 2020, over 4.5 million Floridians were enrolled in the Medicaid program.

Medicaid Telemedicine

The Agency covers telemedicine in both the managed care and fee-for-service delivery systems. Florida Medicaid defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. The Medicaid program only reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the State. These modalities include asynchronous remote patient monitoring and store-and-forward services. Health plans covering Medicaid services to plan enrollees via these additional telemedicine modalities are not included in the capitation rates the Agency pays the plans. In addition, Medicaid health plans are required to cover telemedicine services in “parity” with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face. For example, they cannot require prior authorization of a service delivered via telemedicine if they do not require prior authorization of that service when delivered face-to-face.

Currently, Florida Medicaid reimburses only for services delivered via synchronous telemedicine in in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location separate from their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not pay for telehealth services such chart reviews, telephone conversations, and fax transmissions. The Agency allowed

for an exception during the Covid-19 state of emergency to allow audio-only telemedicine for services such as behavioral health in both managed care and fee-for-service delivery systems.

2. EFFECT OF THE BILL:

Senate Bill 852 amends s. 409.906, F.S., optional Medicaid services, to allow for remote evaluation and monitoring services. The bill states that the Agency may reimburse for recorded video and images, interpretation and follow up with recipients. Additionally, the proposed legislation states that the Agency may pay for remote patient monitoring as a covered benefit. To establish these services as covered benefits in the Medicaid program, the Agency would need to revise the telemedicine State Plan Amendment and rule. These requirements do have an operational impact but can be accomplished with current Agency resources.

SB 852 poses an indeterminate fiscal impact on the Florida Medicaid program if the Agency adds these services. While this legislation is unlikely to increase overall costs to the Medicaid program, it may lead to sustained additional utilization of telemedicine for diagnostic, preventive and treatment service.

SB 852 has an effective date of July 1, 2021.

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

If yes, explain:	
Is the change consistent with the agency's core mission?	Y __ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

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

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

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X___

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	

Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A
Expenditures:	SB 852 poses an indeterminate fiscal impact on the Florida Medicaid Program. The number of recipients and additional telehealth services that would be received under this bill is unknown. Reasonable costs to comply with mandates must be built into the capitation rates paid to the plans, and therefore increase the cost to the State. SB 852 poses and indeterminate fiscal impact on the capitation rates.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

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

If yes, describe the anticipated impact to the agency including any fiscal impact.	This bill requires minor system updates in FLMMIS that can be accomplished with current Agency resources.

FEDERAL IMPACT

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

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

From: Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>
Sent: Friday, March 12, 2021 11:09 AM
To: Smith, Kelly
Subject: RE: SB 852

Kelly- I have confirmed with policy staff that we would implement as you described, based on the national codes and guidelines from which this language comes.

From: Smith, Kelly <Smith.Kelly@flsenate.gov>
Sent: Friday, March 12, 2021 9:22 AM
To: Sokoloski, Kristin <Kristin.Sokoloski@ahca.myflorida.com>
Subject: [External] SB 852

(a)?The agency may pay for remote evaluation of recorded video and images, including interpretation and followup with the recipient within 24 business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

Kelly Kibbey Smith | Senior Attorney
Senate Committee on Health Policy
Room 530, Knott Building
850-487-5334

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 864
INTRODUCER:	Health Policy Committee and Senator Brodeur
SUBJECT:	Telehealth
DATE:	March 17, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Smith	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 864 expands the definition of "telehealth" to include audio-only telephone calls. The bill also provides an exemption from out-of-state telehealth provider registration requirements for an out-of-state health care professional to provide services via telehealth to patients in Florida if the services are provided in consultation with any health care professional licensed in this state who has authority over the diagnosis and care of the patient.

The bill does not pose a direct impact on Florida Medicaid but would allow Medicaid to elect to reimburse for audio-only telephone calls after the COVID-19 state of emergency ends.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Telehealth

Relevant Terminology

Section 456.47, F.S., defines the term "telehealth" as the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health

services; and health administration. The term does not include audio-only telephone calls, e-mail messages, or facsimile transmissions.

"Synchronous" telehealth refers to the live, real-time, or interactive transmission of information between a patient and a health care provider during the same time period. The use of live video to evaluate and diagnosis a patient would be considered synchronous telehealth.

"Asynchronous" telehealth refers to the transfer of data between a patient and a health care provider over a period of time and typically in separate time frames. This is commonly referred to as "store-and-forward."

Florida Telehealth Providers

In 2019, the Legislature passed and the Governor approved CS/CS/HB 23, which created section 456.47, F.S. The bill became effective on July 1, 2019.[1] It authorized Florida-licensed health care providers[2] to use telehealth to deliver health care services within their respective scopes of practice.

The bill also authorized out-of-state health care providers to use telehealth to deliver health care services to Florida patients if they register with the Department of Health (DOH) or the applicable board[3] and meet certain eligibility requirements.[4] A registered out-of-state telehealth provider may use telehealth, within the relevant scope of practice established by Florida law and rule, to provide health care services to Florida patients but is prohibited from opening an office in Florida and from providing in-person health care services to patients located in Florida.

Telehealth providers who treat patients located in Florida must be one of the licensed health care practitioners listed below[5] and be either Florida-licensed, licensed under a multi-state health care licensure compact of which Florida is a member state, or registered as an out-of-state telehealth provider:

- Behavioral Analyst
- Acupuncturist
- Allopathic physician
- Osteopathic physician
- Chiropractor
- Podiatrist
- Optometrist
- Nurse
- Pharmacist

[1] Chapter 2019-137, s. 6, Laws of Fla.
[2] Section 467.47(1)(b), F.S.
[3] Under s. 456.001(1), F.S., the term "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the DOH or, in some cases, within the DOH's Division of Medical Quality Assurance.
[4] Section 467.47(4), F.S.
[5] Section 467.47(1)(b), F.S. These are professionals licensed under s. 393.17; part III, ch. 401; ch. 457; ch. 458; ch. 459; ch. 460; ch. 461; ch. 463; ch. 464; ch. 465; ch. 466; ch. 467; part I, part III, part IV, part V, part X, part XIII, and part XIV, ch. 468; ch. 478; ch. 480; part II and part III, ch. 483; ch. 484; ch. 486; ch. 490; or ch. 491.

- Dentist
- Dental Hygienist
- Midwife
- Speech Therapist
- Occupational Therapist
- Radiology Technician
- Electrologist
- Orthotist
- Pedorthist
- Prosthetist
- Medical Physicist
- Emergency Medical Technician
- Paramedic
- Massage Therapist
- Optician
- Hearing Aid Specialist
- Clinical Laboratory Personnel
- Respiratory Therapist
- Psychologist
- Psychotherapist
- Dietician/Nutritionist
- Athletic Trainer
- Clinical Social Worker
- Marriage and Family Therapist
- Mental Health Counselor

The Legislature also passed HB 7067 in 2019 that would have required an out-of-state telehealth provider to pay an initial registration fee of $150 and a biennial registration renewal fee of $150, but the bill was vetoed by the Governor and did not become law.[6]

On March 16, 2020, Surgeon General Scott Rivkees executed DOH Emergency Order 20-002 authorizing certain out-of-state physicians, osteopathic physicians, physician assistants, and advanced practice registered nurses to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S.[7] This emergency order was extended[8] and will remain in effect until the expiration of the Governor's Executive Order No. 20-52 and extensions thereof.[9]

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[6] Transmittal Letter from Governor Ron DeSantis to Secretary of State Laurel Lee (June 27, 2019) *available at* https://www.flgov.com/wp-content/uploads/2019/06/06.27.2019-Transmittal-Letter-3.pdf (last visited Feb. 14, 2021).
[7] Department of Health, State of Florida, *Emergency Order DOH No. 20-002* (Mar. 16, 2020) *available at* http://floridahealthcovid19.gov/wp-content/uploads/2020/03/filed-eo-doh-no.-20-002-medical-professionals-03.16.2020.pdf (last visited Feb. 14, 2021).
[8] Department of Health, State of Florida, *Emergency Order DOH No. 20-011* (June 30, 2020) *available at* https://floridahealthcovid19.gov/wp-content/uploads/2020/06/DOH-Emergency-Order-DOH-No.-20-011.pdf (last visited Feb. 14, 2021).
[9] Under s. 252.36(2), F.S., no state of emergency declared pursuant to the Florida Emergency Management Act, may continue for more than 60 days unless renewed by the Governor. The state of emergency declared in Executive Order 20-52, was

Five days later, the Surgeon General executed DOH Emergency Order 20-003[10] to also authorize certain out-of-state clinical social workers, marriage and family therapists, mental health counselors, and psychologists to provide telehealth in Florida without the need to register as a telehealth provider under s. 456.47(4), F.S. This emergency order was also extended[11] and will remain in effect until the expiration of Executive Order No. 20-52 and extensions thereof.

Florida Medicaid Program

The Medicaid program is a joint federal-state program that finances health coverage for individuals, including eligible low-income adults, children, pregnant women, elderly adults and persons with disabilities.[12] The Centers for Medicare & Medicaid Services (CMS) within the U.S. Department of Health and Human Services (HHS) is responsible for administering the federal Medicaid program. Florida Medicaid is the health care safety net for low-income Floridians. Florida's program is administered by the AHCA and financed through state and federal funds.[13]

Medicaid enrollees generally receive benefits through one of two service-delivery systems: fee-for-service (FFS) or managed care. Under FFS, health care providers are paid by the state Medicaid program for each service provided to a Medicaid enrollee. Under managed care, the AHCA contracts with private managed care plans for the coordination and payment of services for Medicaid enrollees. The state pays the managed care plans a capitation payment, or fixed monthly payment, per recipient enrolled in the managed care plan. In Florida, the majority of Medicaid recipients receive their services through a managed care plan contracted with the AHCA under the Statewide Medicaid Managed Care (SMMC) program.[14]

Telemedicine Coverage under the Florida Medicaid Program

Florida Medicaid covers telemedicine in both the managed care and fee-for-service delivery systems.

Medicaid health plans have broad flexibility in covering telemedicine services.[15] Beginning on April 3, 2020, and throughout the COVID-19 state of emergency, the AHCA has provided for the reimbursement of audio-only telehealth services in the managed care and fee-for-service delivery systems when rendered by licensed physicians (including psychiatrists), advanced

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extended by Executive Orders 20-114, 20- 166, 20-192, 20-213, 20-276, 20-316, and 21-45. Executive Order 21-45 will remain in effect until Apr. 27, 2021. Office of the Governor, State of Florida, *Executive Order 20-316* (Dec. 29, 2020) *available at* https://www.flgov.com/wp-content/uploads/orders/2020/EO_20-316.pdf (last visited Feb. 9, 2021).

[10] Department of Health, State of Florida, *Emergency Order DOH No. 20-003* (Mar. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/03/DOH-EO-20-003-3.21.2020.pdf (last visited Feb. 14, 2021).

[11] Department of Health, State of Florida, *Emergency Order DOH No. 20-005* (Apr. 21, 2020) *available at* https://s33330.pcdn.co/wp-content/uploads/2020/04/DOH-Emergency-Order-20-005-extending-20-003.pdf (last visited Feb. 14, 2021).

[12] Medicaid.gov, *Medicaid*, *available at* https://www.medicaid.gov/medicaid/index.html (last visited Mar. 3, 2021).

[13] s. 20.42, F.S.

[14] *Id.*

[15] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Guidance for Medical and Behavioral Health Providers* (Mar. 18, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Feb. 15, 2021).

practice registered nurses, and physician assistants.[16,17] During the state of emergency, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face.[18]

Under the fee-for service delivery system and in times of non-emergency, Florida Medicaid generally reimburses only for synchronous telemedicine services provided through the use of audio-visual equipment.[19] Beginning on April 16, 2020, and throughout the state of emergency, the AHCA has provided for the reimbursement of audio-only behavioral health services for Medicaid reimbursement under the fee-for service and managed care delivery systems when video capability is not available.[20] To be reimbursed, a behavioral health provider must document that the enrollee did not have access to audio and video technology necessary for the service to be fully provided via telemedicine.[21]

The Federal Health Insurance Portability and Accountability Act (HIPAA)[22]

HIPAA Privacy Rule[23]

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects personal health information. The HIPAA Privacy Rule sets national standards for when protected health information (PHI) may be used and disclosed.

Only certain entities and their business associates are subject to HIPAA's provisions. These "covered entities" include: health plans, health care providers; and health care clearinghouses.

The Privacy Rule gives individuals privacy and confidentiality rights with respect to their protected PHI, including rights to examine and obtain a copy of their health records in the form and manner they request, and to ask for corrections to their information. Also, the Privacy Rule permits the use and disclosure of health information needed for patient care and other important purposes.

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[16] Agency for Health Care Administration, *Statewide Medicaid Managed Care (SMMC) Policy Transmittal: 2020-20* (Apr. 3, 2020) *available at* https://ahca.myflorida.com/Medicaid/statewide_mc/pdf/2018-23_plan_comm/PT_2020-20_COVID-19_State-of-Emergency_Telemedicine_Services.pdf (last visited Mar. 11, 2021).
[17] Agency for Health Care Administration, *Senate Bill 700 Analysis* (Feb. 15, 2021) (on file with the Senate Committee on Health Policy).
[18] *Id.*
[19] Agency for Health Care Administration, *Senate Bill 852 Analysis* (Feb. 1, 2021) (on file with the Senate Committee on health Policy).
[20] Agency for Health Care Administration, Florida Medicaid Health Care Alert, *Medicaid Telemedicine Flexibilities for Behavioral Health Providers During the COVID-19 State of Emergency* (Apr. 16, 2020) *available at* https://ahca.myflorida.com/Medicaid/pdffiles/provider_alerts/2020_03/Medicaid_Telemedicine_Guidance_20200318.pdf (last visited Mar. 11, 2021).
[21] *Id.*
[22] Centers for Medicare & Medicaid Services, Medicare Learning Network Fact Sheet, HIPAA Basics for Providers: Privacy, Security, and Breach Notification Rules (Sept. 2018) *available at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HIPAAPrivacyandSecurityTextOnly.pdf (last visited Feb. 14, 2021).
[23] 45 C.F.R. Part 160 and Subparts A and E of Part 164.

The Privacy Rule protects PHI held or transmitted by a covered entity or its business associate, in any form, whether electronic, paper, or verbal. PHI includes information that relates to any of the following:

- The individual's past, present, or future physical or mental health or condition;
- The provision of health care to the individual; or
- The past, present, or future payment for the provision of health care to the individual.

***HIPAA Security Rule*[24]**

The HIPAA Security Rule specifies safeguards that covered entities and their business associates must implement to protect electronic PHI (ePHI) confidentiality, integrity, and availability.

Covered entities and business associates must develop and implement reasonable and appropriate security measures through policies and procedures to protect the security of ePHI they create, receive, maintain, or transmit. Each entity must analyze the risks to ePHI in its environment and create solutions appropriate for its own situation. What is reasonable and appropriate depends on the nature of the entity's business as well as its size, complexity, and resources.

Under the Security Rule, covered entities must:

- Ensure the confidentiality, integrity, and availability of all ePHI they create, receive, maintain, or transmit;
- Identify and protect against reasonably anticipated threats to the security or integrity of the ePHI;
- Protect against reasonably anticipated, impermissible uses or disclosures; and
- Ensure compliance by their workforce.

When developing and implementing Security Rule compliant safeguards, covered entities and their business associates may consider all of the following:

- Size, complexity, and capabilities;
- Technical, hardware, and software infrastructure;
- The costs of security measures; and
- The likelihood and possible impact of risks to ePHI.

Covered entities must review and modify security measures to continue protecting ePHI in a changing environment.

***HIPAA Breach Notification Rule*[25]**

The HIPAA Breach Notification Rule requires covered entities to notify affected individuals; the federal HHS; and, in some cases, the media of a breach of unsecured PHI. Generally, a breach is an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of PHI.

The impermissible use or disclosure of PHI is presumed to be a breach unless the covered entity demonstrates a low probability that the PHI has been compromised based on a risk assessment of, at a minimum, the following factors:

[24] 45 C.F.R. Part 160 and Subparts A and C of Part 164.
[25] 45 C.F.R. Subpart D.

- The nature and extent of the PHI involved, including the types of identifiers and the likelihood of re-identification;
- The unauthorized person who used the PHI or to whom the disclosure was made;
- Whether the PHI was actually acquired or viewed; and
- The extent to which the risk to the PHI has been mitigated.

Most notifications must be provided without unreasonable delay and no later than 60 days following the breach discovery. Notifications of smaller breaches affecting fewer than 500 individuals may be submitted to HHS annually. The Breach Notification Rule also requires business associates of covered entities to notify the covered entity of breaches at or by the business associate.

Notification of Enforcement Discretion during Public Health Emergency

Covered health care providers acting in good faith will not be subject to penalties for violations of the HIPAA Privacy Rule, the HIPAA Security Rule, or the HIPAA Breach Notification Rule that occur in the good faith provision of telehealth during the public health emergency.[26]

On March 17, 2020, the federal Department of Health & Human Services (HHS) Office for Civil Rights (OCR) issued a Notification of Enforcement of Discretion, meaning that the OCR may exercise its enforcement discretion and not pursue penalties for HIPPA violations against health care providers that serve patients through everyday communication technologies during the public health emergency.[27] If a provider follows the terms of the Notification and any applicable OCR guidance, it will not face HIPAA penalties if it experiences a hack that exposes protected health information from a telehealth session.[28]

Jurisdiction and Venue for Telehealth-related Actions[29]

For purposes of s. 456.47, F.S., any act that constitutes the delivery of health care services is deemed to occur at the place where the patient is located at the time the act is performed or in the patient's county of residence. Venue for a civil or administrative action initiated by the DOH, the appropriate board, or a patient who receives telehealth services from an out-of-state telehealth provider, may be located in the patient's county of residence or in Leon County.

[26] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Feb. 14, 2021).
[27] Press Release, U.S. Department of Health and Human Services, *OCR Announces Notification of Enforcement Discretion for Telehealth Remote Communications During the COVID-19 Nationwide Public Health Emergency* (Mar. 17, 2021) *available at* https://www.hhs.gov/about/news/2020/03/17/ocr-announces-notification-of-enforcement-discretion-for-telehealth-remote-communications-during-the-covid-19.html (last visited Feb. 14, 2021).
[28] U.S. Department for Health and Human Services Office for Civil Rights, *FAQs on Telehealth and HIPAA during the COVID-10 nationwide public health emergency* (Mar. 2020) *available at* https://www.hhs.gov/sites/default/files/telehealth-faqs-508.pdf (Feb. 14, 2021).
[29] Section 456.47(5), F.S.

III. Effect of Proposed Changes:

Section 1 of the bill amends s. 456.47(1)(a), F.S., to expand the definition of "telehealth" to include audio-only telephone calls. Currently, the term does not include audio-only telephone calls.

Section 1 of the bill also amends s. 456.47(6), F.S., to remove a limitation on an exception to out-of-state telehealth provider registration requirements.

Currently, an out out-of-state health care professional who uses telehealth to provide services to patients in Florida is not required to register as an out-of-state telehealth provider under s. 456.47(4), F.S., only if the services are provided:

- In response to an emergency medical condition as defined in s. 395.002, F.S.,[30] or
- In consultation with a health care professional licensed in this state who has ultimate authority over the diagnosis and care of the patient.

The bill deletes the word "ultimate" from the second exemption. This would mean that an out-of-state health care professional who uses telehealth to provide services to patients in Florida is not required to register as an out-of-state telehealth provider under s. 456.47(4), F.S., if the provider is in consultation with any health care professional licensed in this state who has *any* authority over the diagnosis and care of the patient.

The applicable board, or the DOH if there is no board, may adopt rules to administer this section of statute.[31]

Section 2 of the bill provides an effective date of July 1, 2021.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

[30] "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to patient health, including a pregnant woman or fetus, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. With respect to a pregnant woman, an emergency medical condition means that there is inadequate time to effect safe transfer to another hospital prior to delivery, that a transfer may pose a threat to the health and safety of the patient or fetus; or that there is evidence of the onset and persistence of uterine contractions or rupture of the membranes.

[31] Section 456.47(7), F.S.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The bill does not pose a direct impact on Florida Medicaid but would allow the AHCA to elect to reimburse for audio-only telephone calls after the COVID-19 state of emergency ends. If the AHCA decides to authorize the reimbursement of audio-only telemedicine services at that time, it will need to update Rule 59G-1.057, F.A.C., and communicate the changes to enrolled providers and health plans, both of which are part of the AHCA's routine business practices.[32] The vast majority of Medicaid recipients are already covered for audio-only telehealth services through the Medicaid health plans, so the bill is unlikely to increase overall costs to the Florida Medicaid program.[33]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 456.47 of the Florida Statutes.

[32] Agency for Health Care Administration, Senate Bill 864 Bill Analysis & Economic Impact Statement (Mar. 11, 2021) (on file with the Senate Committee on Health Policy).
[33] Senate Bill 700 also expands the definition of telehealth in s. 456.47, F.S., to include audio-only telephone calls. Agency for Health Care Administration, *Senate Bill 700 Fiscal Analysis* (Feb. 15, 2021) (on file with the Senate Committee on Health Policy).

IX. 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 March 17, 2021:
The underlying bill would have deleted the words "who has the ultimate authority over the diagnosis and care of the patient" to revise an exemption from out-of-state telehealth provider registration requirements. The CS reinstates this language, removing only the word "ultimate." Under the CS, an out-of-state telehealth health care professional who uses telehealth to provide services to patients in Florida is not required to register as an out-of-state telehealth provider under s. 456.47(4), F.S., if the services are provided in consultation with a health care professional licensed in this state who has *any* authority over the diagnosis and care of the patient.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/17/2021	.	
	.	
	.	
	.	

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

Senate Amendment

Delete lines 32 - 33
and insert:
licensed in this state who has ~~ultimate~~ authority over the diagnosis and care of the patient.

By Senator Brodeur

9-00985A-21 2021864__

A bill to be entitled

An act relating to telehealth; amending s. 456.47, F.S.; revising the definition of the term "telehealth"; revising an exemption from telehealth registration requirements; providing an effective date.

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

Section 1. Paragraph (a) of subsection (1) and subsection (6) of section 456.47, Florida Statutes, are amended to read:

456.47 Use of telehealth to provide services.—

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

(a) "Telehealth" means the use of synchronous or asynchronous telecommunications technology by a telehealth provider to provide health care services, including, but not limited to, assessment, diagnosis, consultation, treatment, and monitoring of a patient; transfer of medical data; patient and professional health-related education; public health services; and health administration. The term does not include ~~audio-only telephone calls,~~ e-mail messages~~,~~ or facsimile transmissions.

(6) EXEMPTIONS.—A health care professional who is not licensed to provide health care services in this state but who holds an active license to provide health care services in another state or jurisdiction, and who provides health care services using telehealth to a patient located in this state, is not subject to the registration requirement under this section if the services are provided:

(a) In response to an emergency medical condition as

9-00985A-21 2021864__

defined in s. 395.002; or

(b) In consultation with a health care professional licensed in this state ~~who has ultimate authority over the diagnosis and care of the patient~~.

Section 2. This act shall take effect July 1, 2021.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Environment and Natural Resources, *Chair*
Health Policy, *Vice Chair*
Appropriations Subcommittee on Agriculture, Environment, and General Government
Appropriations Subcommittee on Health and Human Services
Children, Families, and Elder Affairs
Community Affairs

SELECT COMMITTEE:
Select Committee on Pandemic Preparedness and Response

JOINT COMMITTEE:
Joint Administrative Procedures Committee

SENATOR JASON BRODEUR
9th District

February 4, 2021

Honorable Manny Diaz, Jr.
306 Senate Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Chair Diaz,

I am writing to request that SB 864, Telehealth, be placed on the agenda to be heard in the Health Policy Committee.

I appreciate your consideration in this matter.

Sincerely,

Jason Brodeur

Cc: Allen Brown, Staff Director
Lynn Wells, Administrative Assistant

REPLY TO:
❒ 311 Senate Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

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

WILTON SIMPSON
President of the Senate

AARON BEAN
President Pro Tempore

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 700
BILL TITLE:	Telehealth
BILL SPONSOR:	Senator Rodriguez
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1) Health Policy (HP)
2) Appropriations Subcommittee on Health and Human Services (AHS)
3) Appropriations (AP)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 15, 2021
LEAD AGENCY ANALYST:	Tim Buehner, Matt Brackett
ADDITIONAL ANALYST(S):	DD Pickle
LEGAL ANALYST:	
FISCAL ANALYST:	Maureen Castaño

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 700 (Telehealth) amends sections 409.908 and 456.47, Florida Statutes (F.S.). These changes revise the state's definition of telehealth and add requirements for Florida Medicaid's reimbursement of telemedicine services. In addition, the bill makes changes to chapter 465, F.S., permitting telehealth providers acting within their scope of practice to prescribe certain controlled substances via telehealth and allowing physician supervisory arrangements of non-physician practitioners to take place via telehealth. Federal statutes do not allow the prescribing of controlled substances via telehealth. The bill also creates the term "remote-site pharmacy" and provides direction related to remote site pharmacy permits, operation, and oversight. SB 700's other changes align chapters 458, 459 and 893, F.S. with the amended language in section 409.908 and 456.47, F.S.

This bill poses operational impacts that are part of the agency's routine business practices and do not require an appropriation. This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans. This bill takes effect on July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security Act. This authority includes establishing and maintaining a Medicaid state plan, approved by the Centers for Medicare and Medicaid Services (CMS).

Telemedicine under Florida Medicaid

By allowing patients to consult their practitioners remotely, telemedicine has the ability to improve health care access both nationally and at the state level. Telemedicine or telehealth has two primary categories, synchronous and asynchronous. The former involves the use of two-way, interactive audio-visual equipment to allow for real-time communication between a practitioner and patient, and the latter consists of practices such as store-and-forward that allows for the transmission of records or data for evaluation at a later time.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities. These modalities include asynchronous remote patient monitoring and store-and-forward services. In addition, Medicaid health plans are required to cover telemedicine services in "parity" with face-to-face services, meaning the health plan must cover services via telemedicine, where appropriate, in a manner no more restrictive than the health plan would cover the service face-to-face.

Currently, Florida Medicaid reimburses for services delivered via asynchronous telemedicine in the managed care delivery system, but not in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location other than their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not reimburse for telehealth services such as chart reviews, telephone conversations, and email or fax transmissions. In response to the COVID-19 state of emergency, the Agency took multiple steps to expand telemedicine to prevent recipients from having lapses in treatment due to access issues. One of those changes was to allow audio-only telehealth services in both managed care and fee-for-service delivery systems.

Federal Telemedicine Requirements

CMS does not impose any significant requirements on how state Medicaid programs implement telemedicine, granting a high degree of flexibility provided that such service delivery is compliant with their state plan authorities. However, the U.S. Drug Enforcement Agency prohibits the prescription of controlled substances (e.g., opioids) via telemedicine consults, although it has made an exception to this policy during the COVID-19 pandemic.

2. EFFECT OF THE BILL:

Senate Bill (SB) 700 (Telehealth) amends sections 409.908 and 456.47, Florida Statutes (F.S.). These changes revise the state's definition of telehealth and add requirements for Florida Medicaid's telemedicine services.

SB 700 amends the definition of telehealth in s. 456.47 to include audio-only telephone calls, personal email messages, facsimile transmission, and any other non-public facing telecommunications technology. SB 700 amends section 409.908, F.S. to require Florida Medicaid to reimburse telemedicine as defined in 456.47, including store-and-forward and remote patient monitoring. While Medicaid health plans cover remote patient monitoring and store and forward, this bill would mandate coverage for all Medicaid recipients, including those in the fee-for-service delivery system. The bill also permits out-of-state physicians who are registered with the Florida Department of Health as a telehealth provider to enroll in Florida Medicaid as an out-of-state provider for the purpose of providing telehealth services.

These changes pose operational impacts to update Medicaid Florida Administrative Code rules, seek federal approval for an amendment to the state plan, enroll new providers, and program the claims payment and enrollment systems. These actions are part of the Agency's routine business practices and do not require an appropriation. This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans. It has the potential increase utilization of telemedicine instead of face-to-face visits for diagnostic, preventive and treatment services.

SB 700 make additional changes that do not directly affect the Agency:

- Permits telehealth providers acting within their scope of practice to prescribe certain controlled substances via telehealth visit. This conflicts with federal regulations as stated above.
- Allows physician supervisory arrangements of non-physician practitioners (e.g., physician assistants and advanced practice registered nurses) to take place via telehealth
- Creates the term "remote site pharmacy" and provides direction related to remote site pharmacy permits, operation, and oversight.

This bill takes effect on July 1, 2021.

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

If yes, explain:	
Is the change consistent with the agency's core mission?	Y ___ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

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

Proponents and summary of position:	NA
Opponents and summary of position:	NA

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N __x__

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _x__

Board:	
Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A	
Expenditures:	N/A	
Does the legislation increase local taxes or fees? If yes, explain.	No	
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A	

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A	
Expenditures:	This legislation is unlikely to increase overall costs to the Medicaid program, as the vast majority of Medicaid recipients are already covered for these services through the Medicaid health plans.	

Does the legislation contain a State Government appropriation?	No	
If yes, was this appropriated last year?	N/A	

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A	
Expenditures:	N/A	
Other:	N/A	

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A	
Bill Section Number:	N/A	

TECHNOLOGY IMPACT

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

If yes, describe the anticipated impact to the agency including any fiscal impact.	Additional billing codes will need to be programmed. This is part of routine operations of the Agency.

FEDERAL IMPACT

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

If yes, describe the anticipated impact including any fiscal impact.	See comment on conflict with DEA prohibitions on prescribing controlled substances via telemedicine.

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

2021 AGENCY LEGISLATIVE BILL ANALYSIS

AGENCY: Agency for Health Care Administration

BILL INFORMATION	
BILL NUMBER:	SB 852
BILL TITLE:	Medicaid Modernization
BILL SPONSOR:	Senator Brodeur
EFFECTIVE DATE:	July 1, 2021

COMMITTEES OF REFERENCE
1)
2)
3)
4)
5)

CURRENT COMMITTEE

SIMILAR BILLS	
BILL NUMBER:	
SPONSOR:	

PREVIOUS LEGISLATION	
BILL NUMBER:	
SPONSOR:	
YEAR:	
LAST ACTION:	

IDENTICAL BILLS	
BILL NUMBER:	
SPONSOR:	

Is this bill part of an agency package?
Y ___ N _X__

BILL ANALYSIS INFORMATION	
DATE OF ANALYSIS:	February 1, 2021
LEAD AGENCY ANALYST:	Jesse Bottcher
ADDITIONAL ANALYST(S):	Erica Floyd Thomas
LEGAL ANALYST:	
FISCAL ANALYST:	Ana Rivas

POLICY ANALYSIS

1. EXECUTIVE SUMMARY

Senate Bill (SB) 852 amends section 409.906, Florida Statutes (F.S.) by adding subsection (28) allowing the Agency to pay, through Medicaid, for remote evaluation of recorded video and images and remote patient monitoring.

The bill describes remote evaluation of recorded video and images as including interpretation and follow up with the recipient within business hours, not originating from a related evaluation and monitoring service provided within the previous 7 days or leading to an evaluation and monitoring service or a procedure within the next 24 hours or at the soonest available appointment.

The bill describes remote patient monitoring as including remote monitoring of physiologic parameters, supply of devices with daily recording or programmed alert transmission, and remote physiologic monitoring treatment management services requiring interactive communication with the recipient and provider.

SB 852 poses a minor operational and indeterminate fiscal impact on the Florida Medicaid program.

SB 852 has an effective date of July 1, 2021.

2. SUBSTANTIVE BILL ANALYSIS

1. PRESENT SITUATION:

Florida Medicaid Program

The Agency for Health Care Administration (Agency) is the single state agency responsible for the administration of the Florida Medicaid program, authorized under Title XIX of the Social Security. This authority includes establishing and maintaining a Medicaid state plan, approved by the federal Centers for Medicare and Medicaid Services (CMS).

Together, states and the federal government fund Medicaid. As of December 2020, over 4.5 million Floridians were enrolled in the Medicaid program.

Medicaid Telemedicine

The Agency covers telemedicine in both the managed care and fee-for-service delivery systems. Florida Medicaid defines telemedicine as the practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment. The Medicaid program only reimburses for telemedicine services using interactive telecommunications equipment that includes, at a minimum audio and video equipment permitting two-way, real time, interactive communication between a recipient and a practitioner.

Florida Medicaid services are delivered to Medicaid recipients through either the fee-for-service delivery system or a managed care delivery system, with most Medicaid recipients receiving their services through a Medicaid managed care plan.

In the 2018 negotiations for the re-procurement of Medicaid health plan contracts, health plans agreed to cover additional telemedicine modalities at no cost to the State. These modalities include asynchronous remote patient monitoring and store-and-forward services. Health plans covering Medicaid services to plan enrollees via these additional telemedicine modalities are not included in the capitation rates the Agency pays the plans. In addition, Medicaid health plans are required to cover telemedicine services in “parity” with face-to-face services, meaning the health plan must cover services via telemedicine in a manner no more restrictive than the health plan would cover the service face-to-face. For example, they cannot require prior authorization of a service delivered via telemedicine if they do not require prior authorization of that service when delivered face-to-face.

Currently, Florida Medicaid reimburses only for services delivered via synchronous telemedicine in in the fee-for-service delivery system. To qualify for payment, practitioners must be in a location separate from their patients and be using appropriate audio-visual equipment. Florida Medicaid currently does not pay for telehealth services such chart reviews, telephone conversations, and fax transmissions. The Agency allowed

for an exception during the Covid-19 state of emergency to allow audio-only telemedicine for services such as behavioral health in both managed care and fee-for-service delivery systems.

2. EFFECT OF THE BILL:

Senate Bill 852 amends s. 409.906, F.S., optional Medicaid services, to allow for remote evaluation and monitoring services. The bill states that the Agency may reimburse for recorded video and images, interpretation and follow up with recipients. Additionally, the proposed legislation states that the Agency may pay for remote patient monitoring as a covered benefit. To establish these services as covered benefits in the Medicaid program, the Agency would need to revise the telemedicine State Plan Amendment and rule. These requirements do have an operational impact but can be accomplished with current Agency resources.

SB 852 poses an indeterminate fiscal impact on the Florida Medicaid program if the Agency adds these services. While this legislation is unlikely to increase overall costs to the Medicaid program, it may lead to sustained additional utilization of telemedicine for diagnostic, preventive and treatment service.

SB 852 has an effective date of July 1, 2021.

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

If yes, explain:	
Is the change consistent with the agency's core mission?	Y __ N ___
Rule(s) impacted (provide references to F.A.C., etc.):	

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

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

5. ARE THERE ANY REPORTS OR STUDIES REQUIRED BY THIS BILL? Y ___ N _X___

If yes, provide a description:	
Date Due:	
Bill Section Number(s):	

6. ARE THERE ANY GUBERNATORIAL APPOINTMENTS OR CHANGES TO EXISTING BOARDS, TASK FORCES, COUNCILS, COMMISSION, ETC.? REQURIED BY THIS BILL? Y ___ N _X__

Board:	

Board Purpose:	
Who Appointments:	
Appointee Term:	
Changes:	
Bill Section Number(s):	

FISCAL ANALYSIS

1. DOES THE BILL HAVE A FISCAL IMPACT TO LOCAL GOVERNMENT? Y ___ N _X__

Revenues:	N/A
Expenditures:	N/A
Does the legislation increase local taxes or fees? If yes, explain.	No
If yes, does the legislation provide for a local referendum or local governing body public vote prior to implementation of the tax or fee increase?	N/A

2. DOES THE BILL HAVE A FISCAL IMPACT TO STATE GOVERNMENT? Y _X__ N ___

Revenues:	N/A
Expenditures:	SB 852 poses an indeterminate fiscal impact on the Florida Medicaid Program. The number of recipients and additional telehealth services that would be received under this bill is unknown. Reasonable costs to comply with mandates must be built into the capitation rates paid to the plans, and therefore increase the cost to the State. SB 852 poses and indeterminate fiscal impact on the capitation rates.
Does the legislation contain a State Government appropriation?	No
If yes, was this appropriated last year?	N/A

3. DOES THE BILL HAVE A THE FISCAL IMPACT TO THE PRIVATE SECTOR? Y ___N _X__

Revenues:	N/A
Expenditures:	N/A
Other:	N/A

4. DOES THE BILL INCREASE OR DECREASE TAXES, FEES, OR FINES? Y ___ N _X__

If yes, explain impact.	N/A
Bill Section Number:	N/A

TECHNOLOGY IMPACT

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

If yes, describe the anticipated impact to the agency including any fiscal impact.	This bill requires minor system updates in FLMMIS that can be accomplished with current Agency resources.

FEDERAL IMPACT

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

If yes, describe the anticipated impact including any fiscal impact.	

ADDITIONAL COMMENTS

LEGAL – GENERAL COUNSEL'S OFFICE REVIEW

Issues/concerns/comments:	

2021 AGENCY SUMMARY BILL ANALYSIS & ECONOMIC IMPACT STATEMENT

AGENCY: Agency for Health Care Administration

BILL#:	**SB 864**
RELATING TO:	**Telehealth**
SPONSOR(S):	**Senator Brodeur**
COMPANION BILLS:	**SB 660**

ANALYST/REVIEWER NAME:	**Matt Brackett**
DIVISION/UNIT:	**Bureau of Medicaid Policy**
CONTACT NUMBER:	**850-412-4151**

COORDINATED WITH:	
DIVISION/UNIT:	
CONTACT NUMBER:	

I. SUMMARY:

Senate Bill (SB) 864 amends section 456.47, Florida Statutes (F.S.) removing language from the definition of "telehealth" that prohibits audio-only telephone calls. Although this change does not require any actions by Florida Medicaid, it does allow for the Agency to continue allowing audio-only telemedicine in Medicaid, which was enacted during the COVID-19 state of emergency. If the Agency decides to allow audio-only telemedicine after the end of the public health emergency, it will need to update its Medicaid telemedicine policy (Rule 59G-1.057, F.A.C.) and communicate the change to enrolled providers and the health plans participating in the Statewide Medicaid Managed Care program, both of which are part of its routine business practices.

The bill also amends a telehealth exemption for licensed health care practitioners that are not licensed in Florida that allows them to not have to register with the State. The bill grants and exception to telehealth registration through the Department of Health if they provide the services in consultation with a health care professional licensed in the state. Without the change in this bill, the exemption required that the service be provided in consultation with a Florida-licensed provider that has "ultimate authority over the diagnosis and care of the patient." This change does not pose an impact to Florida Medicaid. It could expand the number of out of state providers that have the option of using telemedicine to deliver services without having to register.

This bill takes effect on July 1, 2021.

II. Does this bill impact the Agency? If yes, please provide a brief explanation of the impact:

SB 864 does not pose a direct impact on Florida Medicaid but would allow Medicaid elect to reimburse for audio-only telephone calls after the COVID public health emergency ends.

III. FISCAL COMMENTS:

N/A

IV. SUGGESTED AMENDMENTS:

N/A

Suggested amendment language:

Justification:

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/2021
Meeting Date

SB 864
Bill Number (if applicable)

788640
Amendment Barcode (if applicable)

Topic Telehealth

Name Joy M. Ryan

Job Title Lobbyist

Address PO Box 11247
Street

Phone 8504254000

Tallahassee FL 32302
City *State* *Zip*

Email joy@meenanlawfirm.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Teladoc Health, Inc.

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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/2021
Meeting Date

SB 864
Bill Number (if applicable)

788640
Amendment Barcode (if applicable)

Topic Telehealth

Name Robert Baratta

Job Title Public Relations

Address 50 Pear Street
Street

Phone 8047715309

Richmond VA 23223
City *State* *Zip*

Email robert@capresults.net

Speaking: ☐ For ☐ Against ☑ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Teladoc Health, Inc.

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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21 (Health Policy)
Meeting Date

864
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Telehealth

Name Steve Winn

Job Title Executive Director

Address 2544 Blairstone Pines Dr
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 878-7364

Email winnsr@eartlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

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 (10/14/14)

Duplicate

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THE FLORIDA SENATE

APPEARANCE RECORD

3-17-2021
Meeting Date

864
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Telehealth

Name Shane Messer

Job Title Government Affairs Director

Address 316 East Park Ave
Street

Phone 850-224-6048

Tallahassee FL 32309
City *State* *Zip*

Email shane@floridabha.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Council for Behavioral Healthcare

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 (10/14/14)

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 1132
INTRODUCER:	Health Policy Committee and Senator Bean
SUBJECT:	Personal Care Attendants
DATE:	March 17, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Looke	Brown	HP	**Fav/CS**
2.			CF	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1132 amends ss. 400.141 and 400.211, F.S., to allow nursing homes to employ personal care attendants (PCA) and to allow a PCA to work as a nursing assistant (and count as a certified nursing assistant (CNA) for the purposes of staffing requirements) for a period of up to four months if the PCA is participating in the PCA training program established by the Agency for Health Care Administration (AHCA) in consultation with the Board of Nursing (BON).

The bill defines a PCA as a person who provides care to and assists residents with tasks related to the activities of daily living[1] and who meets specified training requirements. The bill requires the AHCA, in consultation with the BON, to develop a training program for PCAs, in accordance with 42 C.F.R. ss. 483.151-483.154,[2] which must consist of a minimum of 16 hours of education and which will lead to the PCA becoming a CNA. The bill also prohibits a PCA from performing any task that requires clinical assessment, interpretation, or judgment, or from working as a PCA for more than one nursing home before becoming a CNA.

[1] Although not defined in nursing home statutes, activities of daily living are defined in other health care and facility statutes. For example, for assisted living facilities activities of daily living are defined as "the functions and tasks for self-care, including eating bathing grooming, dressing, ambulating, and other similar tasks. *See* s. 429.65(1), F.S., and for home health care activities of daily living are included in the definition of personal care and include bathing, dressing, eating, personal hygiene, assistance in physical transfer, ambulation, and in administering medications permitted by rule. *See* s. 400.462(23), F.S.

[2] These sections establish requirements for state training programs for nurse aides. (Under Florida law, nurse aides are certified as nursing assistants.)

The bill provides that, should the Governor's Emergency Order 20-52 or its extension expire or be terminated before the AHCA is able to adopt rules to implement the PCA training program, the PCA program as it is operating currently may continue to operate until the AHCA adopts such rules.

The bill takes effect upon becoming law.

II. Present Situation:

Nursing Home Staffing Standards

Section 400.23(3), F.S., requires the AHCA to adopt rules[3] providing minimum staffing requirements for nursing home facilities. The requirements must include:

- A minimum weekly average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants (CNA) and licensed nursing staff. A week is defined as Sunday through Saturday.
- A minimum of 2.5 hours of direct care per resident per day provided by CNA staff. A facility may not staff at a ratio of less than one CNA per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.
- Nursing assistants employed under s. 400.211(2), F.S., may be included in computing the staffing ratio for certified nursing assistants if their job responsibilities include only nursing-assistant-related duties.
- Each nursing home facility must document compliance with staffing standards and post daily the names of staff on duty for the benefit of facility residents and the public.
- Licensed nurses may be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.
- Non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing standards.

COVID-19 Personal Care Attendant Program

On March 28, 2020, in response to a request from the Florida Health Care Association to help with a shortage of skilled nursing services during the COVID-19 pandemic, the AHCA approved skilled nursing facilities to temporarily use PCAs to perform resident care procedures usually delivered by CNAs. The goal is to provide nursing centers with additional staff to care for residents during the COVID-19 state of emergency and to train new workers to obtain skills necessary to become a CNA. The Temporary COVID-19 Personal Care Attendant Program is an 8-Hour Preservice Course (5-Hour Classroom and 3-Hour Simulation/Competency Check-Off) with continued on-the-job training. The program has been extended to correspond with COVID-

[3] AHCA rule 59A-4.108(4), F.A.C., simply requires that "in accordance with the requirements outlined in subsection 400.23(3)(a), F.S., the nursing home licensee must have sufficient nursing staff, on a 24-hour basis to provide nursing and related services to residents in order to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care."

19 state of emergency, or until such time AHCA finds it necessary to extend or discontinue the program to meet needs of crisis.[4]

Federal Requirements for Nurse Aide Training

42 C.F.R. Subpart D establishes requirements that must be met by states and state agencies for nurse aide training programs and competency evaluations. 42 C.F.R. s. 483.151 establishes general requirements for states to approve nurse aide training programs and specifies that the state cannot approve training programs in certain nursing homes that are operating under specified waivers of federal requirements or that have had certain penalties assessed against them. 42 C.F.R. s. 483.152 establishes specific requirements for such training programs including at least 75 clock hours of training, the inclusion of specific subjects, at least 16 hours of supervised practical training, supervision requirements, and 16 hours of training prior to direct contact with a resident. 42 C.F.R. s. 483.154 establish requirements for competency evaluations including written and oral exams and demonstrations of skills.

Florida Requirements for Certification as a Nursing Assistant

Section 464.203, F.S., requires the BON to issue a certificate to practice as a CNA to any person who demonstrates the minimum competency to read and write, successfully passes the required background screening, and has met either of the following requirements:

- Has successfully completed an approved training program[5] and achieved a minimum score, established by rule of the BON, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion approved by the BON and administered at a site and by personnel approved by the department;
- Has achieved a minimum score, established by rule of the BON, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the BON and administered at a site and by personnel approved by the department and:
  - Has a high school diploma, or its equivalent; or
  - Is at least 18 years of age.
- Is currently certified in another state or territory of the United States or in the District of Columbia; is listed on that jurisdiction's certified nursing assistant registry; and has not been found to have committed abuse, neglect, or exploitation in that jurisdiction; or
- Has completed the curriculum developed under the Enterprise Florida Jobs and Education Partnership Grant and achieved a minimum score, established by rule of the BON, on the nursing assistant competency examination, which consists of a written portion and skills-demonstration portion, approved by the BON and administered at a site and by personnel approved by the department.

If the applicant fails to pass the certification examination in three attempts the applicant is not eligible to take the exam again until he or she completes an approved training course.

[4] *See* https://www.fhca.org/facility_operations/pcaprogram, (last visited Mar. 8, 2021).
[5] Curriculum requirements for CNA training programs are established in rule 64B9-15.006, F.A.C., and include 80 hours of classroom training and 40 hours of clinical instruction. Additionally the rule requires 16 hours of classroom instruction on specified topics prior to any direct contact with a resident.

III. Effect of Proposed Changes:

CS/SB 1132 amends s. 400.141, F.S., to allow a nursing home to employ PCAs if the PCA is participating in the PCA training program developed by the AHCA, in consultation with the BON and in accordance with 42 C.F.R. ss. 483-151-483-154. The bill requires the training program to be at least 16 hours in length and include at least the following topics:

- Residents' rights.
- Confidentiality of residents' personal information and medical records.
- Control of contagious and infectious diseases.
- Emergency response measures.
- Assistance with activities of daily living.
- Measuring vital signs.
- Skin care and pressure sore prevention.
- Portable oxygen use and safety.
- Nutrition and hydration.
- Dementia care.

The bill prohibits a PCA from performing any task that requires clinical assessment, interpretation, or judgment; requires a PCA to work exclusively for one nursing home facility; and prohibits a PCA from working for more than one nursing home facility before becoming a CNA.

The bill allows the AHCA to adopt rules to implement the program and requires the current PCA program to continue regardless of whether the Governor's Emergency Order 20-52 or its extension expires or is terminated prior to the AHCA adopting rules until such time that the AHCA adopts rules to implement the program. The bill requires the AHCA to notify the Division of Law Revision on the date the implementing rules take effect and the subparagraph extending the current PCA program expires upon the AHCA adopting such rules.

The bill also amends s. 400.211, F.S., to allow a nursing home to hire a PCA, who has completed the training as detailed above, to work as a nursing assistant (and count as a CNA for the purposes of staffing requirements) for a period of up to four months. The bill defines a PCA as a person who meets the above training requirements and who provides care to residents and assists residents with tasks related to the activities of daily living.

The bill takes effect upon becoming law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may have an indeterminate fiscal impact on nursing homes that utilize the PCA program created under the bill. The bill may also positively impact persons in a fiscal sense who are employed as PCAs under the program.

C. Government Sector Impact:

CS/SB 1132 may have an indeterminate negative fiscal impact on the AHCA related to developing the PCA training program.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 400.141 and 400.211.

IX. Additional Information:

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

CS by Health Policy on March 17, 2021:
The CS expands the hours of training required to work as a PCA from 8 to 16 and ties the PCA training program to federal requirements for nurse aide training in 42 C.F.R. ss.

483.151-483.154. The CS prohibits PCAs from performing tasks that require clinical assessment, interpretation, or judgment; specifies that a PCA must work exclusively for one nursing home; and prohibits a PCA from working as a PCA for more than one nursing home before being certified as a CNA.

The CS also specifies that the current PCA program will continue until the AHCA adopts rules to implement the PCA training program established by the bill regardless of whether Emergency Order 20-52 or its extension expires or is terminated. The bill requires the AHCA to notify the Division of Law Revision of the date that the rules take effect. These requirements expire on the effective date of the AHCA's rules.

B. Amendments:

None.

473940

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/17/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 25 - 41

and insert:

are participating in the personal care attendant training program developed by the agency, in accordance with 42 C.F.R. ss. 483.151-483.154, in consultation with the Board of Nursing.

1. The personal care attendant training program must consist of a minimum of 16 hours of education and must include training in all of the topics and lessons specified in the program curriculum.

473940

2. The program curriculum for the personal care attendant training program must include, but need not be limited to, all of the following content areas:

a. Residents' rights.

b. Confidentiality of residents' personal information and medical records.

c. Control of contagious and infectious diseases.

d. Emergency response measures.

e. Assistance with activities of daily living.

f. Measuring vital signs.

g. Skin care and pressure sore prevention.

h. Portable oxygen use and safety.

i. Nutrition and hydration.

j. Dementia care.

3. A personal care attendant may not perform any task that requires clinical assessment, interpretation, or judgment.

4. A personal care attendant must work exclusively for one nursing home facility and may not work as a personal care attendant for more than one nursing home facility before becoming a certified nursing assistant.

5. The agency may adopt rules to implement this paragraph.

6. If the Governor's Emergency Order 20-52 or an extension thereof expires or is terminated before the completion of the agency's rulemaking process to implement this paragraph, any personal care attendant program that is operating pursuant to agency approval that was issued during the time in which the executive order was effective may continue to operate as authorized until the agency's rulemaking process is completed, at which time the program must comply with agency rule. The

473940

agency shall notify the Division of Law Revision of the date such rules take effect. This subparagraph expires on the effective date of such rules.

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

And the title is amended as follows:

Delete lines 4 - 8

and insert:

to employ personal care attendants if they are participating in a certain training program developed by the Agency for Health Care Administration, in consultation with the Board of Nursing; providing minimum requirements for such program; providing limitations on such personal care attendants' practice; authorizing the agency to adopt rules; authorizing certain personal care attendant programs to continue operating during the agency's rulemaking process under certain circumstances; requiring the agency to notify the Division of Law Revision of the date certain rules take effect; providing for future repeal; amending s. 400.211, F.S.; authorizing

By Senator Bean

4-01415-21 20211132__

A bill to be entitled

An act relating to personal care attendants; amending s. 400.141, F.S.; authorizing nursing home facilities to employ personal care attendants if they complete a certain training program developed by the Agency for Health Care Administration, in consultation with the Board of Nursing; providing minimum requirements for such program; amending s. 400.211, F.S.; authorizing certain persons to be employed by a nursing home facility as personal care attendants for a specified period if a certain training requirement is met; defining the term "personal care attendants"; providing an effective date.

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

Section 1. Paragraph (w) is added to subsection (1) of section 400.141, Florida Statutes, to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(w) Be allowed to employ personal care attendants as defined in s. 400.211(2)(d), if such personal care attendants have successfully completed the personal care attendant training program developed by the agency, in consultation with the Board of Nursing, which must consist of a minimum of 8 hours of education. The program must include training in the content areas and lessons specified in the program curriculum, which

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must include, but need not be limited to:

1. Residents' rights.

2. Confidentiality of residents' personal information and medical records.

3. Control of contagious and infectious diseases.

4. Emergency response measures.

5. Assistance with activities of daily living.

6. Measuring vital signs.

7. Skin care and pressure sores prevention.

8. Portable oxygen use and safety.

9. Nutrition and hydration.

10. Dementia care.

Section 2. Subsection (2) of section 400.211, Florida Statutes, is amended to read:

400.211 Persons employed as nursing assistants; certification requirement.—

(2) The following categories of persons who are not certified as nursing assistants under part II of chapter 464 may be employed by a nursing facility for a period of 4 months:

(a) Persons who are enrolled in, or have completed, a state-approved nursing assistant program.~~;~~

(b) Persons who have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state.~~; or~~

(c) Persons who have preliminarily passed the state's certification exam.

(d) Persons who are employed as personal care attendants and who have completed the personal care attendant training program developed pursuant to s. 400.141(1)(w). As used in this

paragraph, the term "personal care attendants" means persons who meet the training requirement in s. 400.141(1)(w) and provide care to and assist residents with tasks related to the activities of daily living.

The certification requirement must be met within 4 months after initial employment as a nursing assistant in a licensed nursing facility.

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

The Florida Senate

Committee Agenda Request

To: Senator Manny Diaz, Jr., Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: February 18, 2021

I respectfully request that **Senate Bill #1132**, relating to Personal Care Attendants, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Aaron Bean

Senator Aaron Bean
Florida Senate, District 4

File signed original with committee office

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-12-21
Meeting Date

1132
Bill Number (if applicable)

Topic Personal Attendant Issues / Nursing Homes

Amendment Barcode (if applicable)

Name Barbara DeRoche

Job Title

Address 1625 E Brevard
Street

Tall, FL 32308
City *State* *Zip*

Phone 257-4280

Email barbaraderoche1@yahoo.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FL NOW & FL Alliance for Retired Americans

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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

1132
Bill Number (if applicable)

Topic Personal Care Attendents

Amendment Barcode (if applicable)

Name Foyt Ralston

Job Title

Address 9167 Shoal Creek Drive
Street

Phone 8502945390

Tallahassee — Fl — 32312
City — *State* — *Zip*

Email foyt@foytralston.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Florida Justice 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.

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S-001 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/21
Meeting Date

1132
Bill Number (if applicable)

Topic Personal Care Attendants

Amendment Barcode (if applicable)

Name Michael Phillips

Job Title State Ombudsman

Address 4040 Esplanade Way
Street

Phone (850)414-2331

Tallahassee FL 32300
City *State* *Zip*

Email phillips.michael@elderaffairs.org

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Long-Term Care Ombudsman Program

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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

SB 1132
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Personal Care Attendants

Name Tanya C. Jackson

Job Title Managing Partner

Address 150 S. Monroe St., Suite 303
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-445-0107

Email Tanya@PinPointResults.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing SEIU1199 Healthcare Workers

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

1132
Bill Number (if applicable)

Topic Personal Care Assistants

Amendment Barcode (if applicable)

Name Ken Kniepmann (Ka-neep-man)

Job Title Associate

Address 201 W Park
Street

Tallahassee
City *State* *Zip*

Phone 850-510-0552

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing FLORIDA CONFERENCE Catholic Bishops

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/2021
Meeting Date

SB 1132
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Personal Care Attendants

Name Steve Bahmer

Job Title President & CEO

Address 1812 Riggins Road
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850/671-3700

Email sbahmer@leadingageflorida.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing LeadingAge Florida

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

1132
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Personal Care Attendant

Name Shantia Carter

Job Title Personal Care Attendant

Address 1771 Edgewood Avenue west
Street
Jacksonville FL 32208
City *State* *Zip*

Phone 904-766-7436

Email

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

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Self

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

Lobbyist registered with Legislature: [ ] Yes [X] 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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

1132
Bill Number (if applicable)

Topic Personal Care Attendants

Amendment Barcode (if applicable)

Name Jessica Collins

Job Title Administrator

Address 1771 Edgewood Ave W
Street
Jax FL 32208
City *State* *Zip*

Phone 904-766-7436

Email jcollins@sterling-healthcare.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Edgewood Nursing Center

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-17-21
Meeting Date

1132
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Personal Care Attendants

Name Deborah Franklin

Job Title Sr Dir of Quality

Address 307 W Park Ave
Street
Tallahassee FL 32309
City *State* *Zip*

Phone 850-224-3907

Email dfranklin@fhca.org

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

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Florida Health Care Assoc

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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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

SB 1132
Bill Number (if applicable)

Topic Personal Care Attendants

Amendment Barcode (if applicable)

Name Brewster Bevis

Job Title Senior Vice President

Address 516 N. Adams St
Street

Phone 224-7173

Tallahassee FL 32301
City *State* *Zip*

Email bbevis@aif.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Associated Industries of Florida

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 (10/14/14)

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 894
INTRODUCER:	Health Policy Committee and Senator Diaz
SUBJECT:	Physician Assistants
DATE:	March 19, 2021
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Brown	HP	**Fav/CS**
2.			AHS	
3.			AP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 894 revises the practice acts for physician assistants (PAs) in chs. 458 and 459, F.S., and expands the scope of practice for PAs. The bill:

- Repeals the current-law restriction on the number of PAs that a physician may supervise at any one time;
- Repeals the current-law requirement that a PA must inform a patient that the patient has the right to see a physician before a prescription is prescribed or dispensed by the PA;
- Authorizes a fully licensed PA to procure medical devices and drugs unless he or she is prohibited from prescribing the drug under the negative formulary process in effect under current law;
- Repeals the authority of the Department of Health (DOH) to issue a prescriber number to a PA upon the PA's completion of certain requirements;
- Repeals the provision in current law that prohibits a PA from prescribing a psychiatric mental health controlled substance for a minor;
- Provides that a PA may authenticate any document with his or her signature that a physician may authenticate, including, but not limited to, the date of maximum medical improvement[1]

[1] Under s. 440.02(10), F.S., the "date of maximum medical improvement" means the date after which further recovery from, or lasting improvement to, an injury or disease can no longer reasonably be anticipated, based upon reasonable medical probability.

for a workers' compensation medical evaluation as defined in ch. 440, F.S., and a list of other orders and documents;
- Authorizes a PA to supervise medical assistants as that term is defined in chs. 458 and 459, F.S.;
- Provides the following relating to third-party payors:
  - Payment for services within a PA's scope of practice must be made when ordered or performed by a PA if the same service would have been covered if ordered or performed by a physician; and
  - PAs are authorized to bill for and receive direct payment for the services they deliver.
- Repeals the current-law requirement for the Board of Medicine (BOM) and Board of Osteopathic Medicine (BOOM) to publish standards to ensure that PA educational programs operate in a manner that does not endanger the health or welfare of patients who receive services within the scope of the programs and repeals the boards' responsibility to review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of the PA practice acts are being met;
- Limits the boards' authority to approve PA programs to those in the United States and its territories or possessions and to those accredited by specific entities;
- Amends various requirements for PA licensure;
- Repeals the requirement for a licensed PA to notify the DOH in writing within 30 days of employment or after any change in his or her supervising physician; and
- Makes conforming changes to current law.

The bill provides an effective date of July 1, 2021.

II. Present Situation:

Physician Assistants (PAs)

History of the Physician Assistant Profession

In 1965 physicians and educators recognized there was a shortage of primary care physicians, so Duke University Medical Center, put together the first class of PAs. Duke selected four Navy Vietnam-era hospital corpsmen who had received considerable medical training during their military service. The first PA class graduated from the Duke program in 1967.[2]

Physicians were first authorized to use PAs in their practice in Florida in 1979. There was no PA license. The legislative intent for recognizing the PA profession was to allow physicians to delegate the performance of "medical services" to qualified PAs when such delegation was consistent with the patient's health and welfare; freeing physicians to more effectively utilize their superior medical education, training, and experience. Physicians were required to apply to their board[3] to utilize and supervise a PA in their practice. PAs were required to be graduates of board-approved programs, or the equivalent, and to be approved by the Department of Health

[2] American Association of Physician Assistants, About, History, *History of the PA Profession*, *available at* https://www.aapa.org/about/history/ (last visited Mar. 5, 2021).
[3] Under s. 456.001(1), F.S., "board" is defined as any board, commission, or other statutorily created entity, to the extent such entity is authorized to exercise regulatory or rulemaking functions within the Department of Health or, in some cases, within the department's Division of Medical Quality Assurance.

(DOH) to perform "medical services" under the supervision of a physician, who was certified by the board to supervise the PA. Physicians utilizing PAs were liable for any act or omissions of the PAs while under the physicians supervision.[4]

Physician Assistant Education

Currently there are 17 universities in Florida offering PA programs accredited by the Accreditation Review Commission on Education (ARC-PA),[5] and, while each program is unique, most require the following for admission:

- Bachelor's degree with minimum GPA 3.0, 3.0 math/science, and 20 to 28 hours of prerequisite courses in:
  - Human anatomy and physiology with labs;
  - Microbiology with lab;
  - General chemistry with lab;
  - Statistics; and
  - Medical terminology.
- GRE scores 300, 3.5 or above;
- Previous health care experience: 500 to 2,000 patient contact hours;
- Three to five letters of recommendation; and
- A Computer-Based Assessment for Sampling Personal Characteristics (CASPer) test score.

PA programs are on average 24 to 27 months, or six or seven semesters, requiring 96 to 111 plus clinical and classroom credit hours to graduate. The programs are designed to prepare students to practice as part of a Physician-PA team. Upon completion, graduates receive a Master of Science in PA Practice degree or a Master of PA Studies, or similar degree. Most PA programs require students to complete the following requirements:

- Earn a passing grade, defined as a "C" or better, in each required course/clinical;
- Graduate with a 3.0 cumulative GPA;
- Demonstrate successful completion of a summative evaluation, which includes:
  - A comprehensive written examination;
  - An objective structured clinical exam; and
  - A professional behavior assessment.[6]

Following graduation, a PA candidate must take and pass the PA National Certifying Examination (PANCE) given by the National Commission on Certification of PAs (NCCPA) to

[4] Chapter 79-230, s. 1., and ch. 79-320, s. 1., Laws of Fla. (Creating ss. 459.018 and 458.017, F.S., effective Jul. 1, 1979).
[5] Florida Academy of PAs, *For Students - PA Programs in Florida, available at* https://www.fapaonline.org/page/studentprograms (last visited Mar. 4, 2021). This was not a degree from Duke University, but a certificate.
[6] *See* Florida State University, College of Medicine, *Physician Assistant, available at* https://med.fsu.edu/pa/home (last visited Mar. 4, 2021); University of Florida, College of Medicine, *School of Physician Assistant Studies, available at* https://pa.med.ufl.edu/ (last visited Mar. 4, 2021). Florida International University, *Master in Physician Assistant Studies (MPAS), available at* https://medicine.fiu.edu/academics/degrees-and-programs/master-in-physician-studies/index.html (last visited Mar. 4, 2021).

become certified. It is a five-hour exam with 300 multiple-choice questions, with no didactic components.[7]

The Council of Physician Assistants

Under current-law, PAs are regulated within the DOH by the Florida Council on Physician Assistants (Council) in conjunction with either the Board of Medicine (BOM) for PAs licensed under ch. 458, F.S., or the Board of Osteopathic Medicine (BOOM) for PAs licensed under ch. 459, F.S.[8]

The Council consists of five members, appointed as follows:[9]

- The chairperson of the BOM appoints one member who is a physician and member of the BOM who supervises a PA in his or her practice;
- The chairperson of the BOOM appoints one member who is a physician and member of the BOOM who supervises a PA in his or her practice; and
- The State Surgeon General, or his or her designee, appoints three PAs licensed under chs. 458 or 459, F.S.

The Council is responsible for:[10]

- Recommending PAs to the DOH for licensure;
- Developing rules for the boards' consideration[11] regulating the use of PAs by physicians;
- Developing rules to ensure the continuity of supervision in each practice setting;
- Making recommendations to the boards on matters relating to PAs;
- Addressing the concerns and problems of practicing PAs in order to improve safety in the clinical practices of PAs;[12] and
- Denying, restricting, or placing conditions on the license of a PA who fails to meet the licensing requirements.[13]

Physician Assistant Licensure

An applicant for a PA license must be at least 18 years of age. The DOH must issue a license to a person who has been certified by the Council as having met all of the following requirements:[14]

- Completed an approved PA training program;[15]
- Obtained a passing score on the NCCPA PONCE exam;
- Acknowledged any prior felony convictions;

[7] The National Commission on Certification of PA (NCCPA), Become Certified, *Becoming Certified available at* https://www.nccpa.net/BecomingCertified (last visited Mar. 4, 2021). The NCCPA is the only certifying organization for PAs in the United States. As of Dec. 31, 2020, there were approximately 148,500 certified PAs in the United States.
[8] Sections 458.347 and 459. 022, F.S.
[9] Sections 458.347(9) and 459.022(9), F.S. Members of the Board of Medicine and the Board of Osteopathic Medicine are appointed by the Governor and confirmed by the Senate. *See* ss. 458.307 and 459.004, F.S., respectively.
[10] *Id.*
[11] *See* ss. 458.347(9)(c)2. and 459.022(9)(c)2., F.S.
[12] *Id.*
[13] Sections 458.347(9)(d) and 459. 022(9)(d), F.S.
[14] Sections 458.347(7) and 459.022(7), F.S.
[15] *See* Fla. Admin. Code R. 64B8-30.012 and 64B15.004 (2020).

- Submitted to a background screening and have no disqualifying offenses;[16]
- Acknowledged any previous revocation or denial of licensure in any state; and
- Provided a copy of course transcripts and a copy of the course descriptions from the PA's training program describing the course content in pharmacotherapy if the applicant is seeking prescribing authority.

PAs must renew their licenses biennially. During each biennial renewal cycle, a PA must complete 100 hours of continuing medical education or must demonstrate current certification issued by the NCCPA.[17] To maintain certification, a PA must earn at least 100 hours of continuing medical education biennially, and must take and pass a re-certification examination every 10 years.[18]

Physician Assistant Scope of Practice and Physician Supervision

A PA is licensed to perform only those medical services delegated to him or her by a supervising allopathic or osteopathic physician.[19] PAs may only practice under the direct or indirect supervision of a physician with whom they have a working relationship.[20]

A supervising physician may only delegate tasks and procedures to the PA that are within the supervising physician's scope of practice. A supervising physician decides whether to permit a PA to perform a task or procedure under direct or indirect supervision based on his or her reasonable medical judgment regarding the probability of morbidity and mortality to the patient, and the physician must be certain the PA has the knowledge and skills to perform the task or procedure assigned.[21]

Current law requires a supervising physician to exercise "responsible supervision" and control and, except in cases of emergency, requires the easy availability or physical presence of the physician for consultation and direction of the actions of the PA. The BOM and BOOM establish rules as to what constitutes responsible supervision.[22]

The boards have established by rule that "responsible supervision" of a PA means the ability of the supervising physician to exercise control and provide direction over the services or tasks performed by the PA. Whether the supervision of a PA is adequate is dependent upon the:
- Complexity of the task;
- Risk to the patient;
- Background, training, and skill of the PA;
- Adequacy of the direction in terms of its form;
- Setting in which the tasks are performed;
- Availability of the supervising physician;

[16] Sections 456.0135, F.S.
[17] Sections 458.347(7)(c) and 459.022(7)(c), F.S.
[18] National Commission on Certification of Physician Assistants, *Maintaining Certification*, *available at* https://www.nccpa.net/CertificationProcess (last visited Mar. 4, 2021).
[19] Sections 458.347(4) and 459.022(4), F.S.
[20] Sections 458.347(2)(f) and 459.022(2)(f), F.S.
[21] Fla. Adm. Code R. 64B8-30.012(2) and 64B15-6.010(2) (2021).
[22] Sections 458.347(2)(f) and 459.022(2)(f), F.S.

- Necessity for immediate attention; and
- Number of other persons that the supervising physician must supervise.[23]

Responsible supervision and control also require the supervising physician to periodically review the PA's performance[24] and to determine the level of supervision the PA requires for every task or procedure delegated to a PA as to whether it will be under:[25]

- *Direct supervision:* Requires the physical presence of the supervising physician on the premises so that the physician is immediately available to the PA when needed; or
- *Indirect supervision:* Requires the supervising physician to be within reasonable physical proximity, and easily availability, to the PA for communication with the PA, including via telecommunication.

A supervising physician may also delegate to a PA his or her authority to:

- Prescribe or dispense any medicinal drug used in the supervising physician's practice unless such medication is listed in the negative formulary established by the Council, but only under the following circumstances:
  - The PA identifies himself or herself as a PA and advises the patient of his or her right to see a physician before the prescription is written or dispensed;
  - The supervising physician must be registered as a dispensing practitioner and have notified the DOH on an approved form of his or her intent to delegate prescriptive authority or to change prescriptive authority; and
  - The PA must have completed 10 hours of continuing medical education in the specialty practice in which the PA has prescriptive authority with each licensure renewal, and three of the 10 hours must be on the safe and effective prescribing of controlled substances.
- Order any medication for administration to the supervising physician's patient in a hospital or other facility licensed under ch. 395, F.S., or a nursing homes licensed under Part II, ch. 400, F.S.; and
- Perform any other service that is not expressly prohibited in the PA Practice Acts, or the rules adopted thereunder.

A supervising physician is responsible and liable for any acts or omissions of the PAs he or she supervises and may not supervise more than four PAs at any time.[26]

Upon employment as a PA, a licensed PA must notify the DOH of his or her supervising physician in writing within 30 days after such employment or after any subsequent changes of his or her supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.[27]

[23] Fla. Admin. Code R. 64B8-2.001, 64B8-30.001, and 64B15-6.001 (2020).
[24] Fla. Adm. Code R. 64B8-30.001(3) and 64B15-6.001(3) (2021).
[25] Fla. Adm. Code R. 64B8-30.001(4)(5) and 64B15-6.001(4)(5) (2021).
[26] Sections 458.347(15) and 459.022(15), F.S.
[27] Sections 458.458.347(7) and 459.022(7), F.S.

Health Care Reimbursement for PA Services

Medicare

Medicare generally pays for medical and surgical services provided by PAs at 85 percent of the physician fee schedule. This rate generally applies to all practice settings, including hospitals, nursing facilities, homes, offices, and clinics. However, when acting as a surgical assistant, the PA's reimbursement rate is only 13.6 percent of the primary surgeon's allowable fee, and no payment is made for a PAs assisting at surgery at an approved and accredited teaching hospital unless no residents are available, the surgeon does not use residents with his patients, or trauma surgery is required. To be eligible for Medicare reimbursement for PA services, a PA must:

- Have graduated from an accredited PA program or passed the national certification exam;
- Be state-licensed;
- Obtain a National Provider Identifier (NPI); and
- Enroll in Medicare through PECOS.[28]

A PA's required level of supervision under Medicare for reimbursement generally requires access to the collaborating physician or supervising physician by reliable electronic communication. Personal presence of the physician is generally not required. Medicare policies will not override state law guidelines or facility policies.[29] Medicare does allow PAs to submit claims under their own NPI as the rendering provider but does not allow PAs to "direct bill" (receive payment directly). Reimbursement is made to the PA's employer.[30]

Notable restrictions on a PA's scope of practice under Medicare include:

- PAs may not order home health services or sign a patient's home health plan of care;
- PAs may not perform the initial comprehensive visit for patients in skilled nursing facilities;
- PAs are not reimbursed for certifying terminal illness;
- PAs may not delegate the performance of diagnostic tests requiring direct or personal supervision to ancillary staff; and
- PAs cannot be directly reimbursed for covered Medicare services, currently.[31]

Medicaid

Unlike the Medicare program, which has federal laws mandating the coverage of medical services provided by PAs, the state determines whether PAs are eligible providers under its Medicaid program and which services PAs are able to provide. In Florida, if a PA performs a service for a Medicaid enrollee, the PA must have his or her own provider number, and the service must be billed using the PA's number unless the physician performs the majority of the service.[32] Medicaid services provided by PA within his or her scope of practice may be billed

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[28] American Association of Physician Assistants, *Basic Concepts of Reimbursement: a Primer, available at* https://www.aapa.org/wp-content/uploads/2018/04/WEB-18.066-Program-Director-Page-Redesign-Reimbursement-101-v2.pdf (last viewed Mar. 8, 2021).
[29] *Id.*
[30] *Supra* note 24.
[31] *See* 42 U.S.C. 1395u(b)(6)(C), 2021, which will allow services provided by PA to be directly billed and paid to PAs only when no other facility or provider services are billed the same day after Jan. 1, 2022.
[32] Agency for Health Care Administration, *Florida Medicare Provider Reimbursement Handbook available at* https://ahca.myflorida.com/medicaid/review/Reimbursement/RH_08_080701_CMS-1500_ver1_4.pdf (last visited Mar. 8, 2021).

under a physician's Medicaid provider number when the physician is in the building and able to render assistance as needed. These services are reimbursed at the physician-allowable amount. Services provided within the PA's scope of practice that are performed when the physician is not in the building must be billed under the rendering PA's Medicaid provider number and are reimbursed at 80 percent of the allowable amount.[33]

Commercial Health Insurance

Commercial insurers have their own rules that are similar, the same, or completely different than those policies found under Medicare and Medicaid. Many choose not to enroll PAs and instruct a PA to bill under the physician' number. For those that enroll PAs, billing and coverage policies must be clearly ascertained by every individual practice for every individual payer with whom they contract.

III. Effect of Proposed Changes:

CS/SB 894 revises the practice acts for PAs in chs. 458 and 459, F.S., and expands the scope of practice for PAs. The bill:

- Amends the legislative intent for the PA practice acts for PAs to be authorized, with their education, training, and experience in the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers, while eliminating from legislative intent the concept of a PA assisting a physician;
- Amends the definition of an "approved program" for PAs to include programs formally approved by the BOM and BOOM that are:
  - Programs in the United States or its territories or possessions;
  - Accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities:
    - The Committee on Allied Health Education and Accreditation; or
    - The Commission on Accreditation of Allied Health Education Programs;
- Repeals the definition of "proficiency examination;"
- Designates the "physician assistant national certification examination" as the PANCE administered by the NCCPA or its successor agency;
- Amends the list of PA program accrediting entities that PA programs must be accredited by for the PA Council to recommend to the boards for approval, to include:
  - The Accreditation Review Commission on Education for the Physician Assistant or its successor entity; or
  - Before 2001:
    - The Committee on Allied Health Education and Accreditation; or
    - The Commission on Accreditation of Allied Health Programs.
- Limits the boards' authority to approve PA programs to those in the United States and its territories or possessions and to those accredited by:
  - The Accreditation Review Commission on Education for the Physician Assistant; or
  - For programs before 2001:

[33] Agency for Health Care Administration, *Practitioner Fee Schedule, available at* https://ahca.myflorida.com/medicaid/review/Reimbursement/2020-01-01_Fee_Sched_Billing_Codes/Practitioner_Fee_Schedule_2020.pdf (last visited Mar. 15, 2021).

    - Committee on Allied Health Education and Accreditation; or
    - The Commission on Accreditation of Allied Health Education Programs.
- Repeals the current-law requirement for the BOM and BOOM to publish standards to ensure that PA educational programs operate in a manner that does not endanger the health or welfare of patients who receive services within the scope of the programs and repeals the boards' responsibility to review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of the PA practice acts are being met;
- Amends PA licensure requirements to require the DOH to issue a license to each applicant recommended by the Council that meets all of the following additional requirements:
    - Submits an application which must include:
        - A diploma from an approved PA program, not a copy, evidencing graduation from an approved PA program, with an appropriate degree based on the date of graduation:
            - After December 31, 2020, must have a master's degree from an approved program;
            - Before January 1, 2020, must have obtained a bachelor's or master's degree from an approved program;
            - Before July 1, 1994, must have graduated from an approved program of instruction in primary health care or surgery;
            - Before July 1, 1983, must have obtained certification as a PA by the boards; and
            - For applicants who do not meet any of the educational requirements specified above, but who have passed the PANCE examination administered by the NCCPA before 1986, the board may also grant a license.
        - Obtaining a passing score established by the NCCPA on the PANCE examination administered by the NCCPA;[34]and
        - Providing acknowledgments of any prior felony convictions or previous revocations of licenses or certifications in any state.
- Repeals the requirements that applicants for PA licensure must submit with their application:
    - A PA program verification form; and
    - A copy of course transcripts and course descriptions from the PA program describing course content in pharmacotherapy, if the applicant intends to apply for prescribing authority.
- Repeals current law requiring that a licensed PA must notify the DOH within 30 days after starting employment, or after any changes in supervising physician, including the full name, medical license number, specialty, and address of the supervising physician;
- Authorizes PAs to procure medical devices and drugs unless listed in the negative formulary established by the Council and adopted by the BOM and the BOOM;
- Authorizes PAs to directly bill and receive payment from public and private insurance companies for services rendered;[35]
- Repeals the current-law prohibition against a physician supervising more than four PAs at any one time;
- Repeals current law providing that a physician supervising a PA may not be required to review and co-sign charts or medical records prepared by such PA;

[34] The bill further requires that if an applicant does not hold a current NCCPA certificate and has not actively practiced as a PA within the preceding four years, the applicant must retake and successfully pass the NCCPA be eligible for licensure.
[35] *See* note 28.

- Repeals the current-law requirement that PAs must inform patients that they have the right to see the physician before a prescription is prescribed or dispensed by the PA;
- Repeals current law requiring the name, address and telephone number of the supervising physician be on PA prescriptions and requires PAs' name, address, and telephone number on prescription forms;
- Repeals the presumption that the inclusion of the PA prescriber number on a prescription indicates the PA is authorized to prescribe the medicinal drug and that the prescription is valid;
- Repeals the DOH's authority to issue to a PA a prescriber number to prescribe medicinal drugs;
- Repeals the provision in current law that prohibits a PA from prescribing a psychiatric mental health controlled substance for a minor;
- Authorizes PAs to supervise medical assistants;[36]
- Authorizes licensed PAs to authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if the document may be authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician.[37] Such documents include, but are not limited to:
  - Initiation of an involuntary examination under the Baker Act;[38]
  - Do-not-resuscitate (DNR) orders or orders for life-sustaining treatment;
  - Death certificates;
  - School physical examinations;
  - Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02, F.S.;[39]
  - Orders for:
    - Physical therapy;
    - Occupational therapy;
    - Speech-language therapy;
    - Home health services; and
    - Durable medical equipment.
- Amends current law on death, fetal death, and nonviable birth registration[40] and authorizes PAs to:
  - File the certificate of death or fetal death in the absence of a funeral director; and
  - Correct a permanent death certificate.

The bill makes conforming changes to the sections of current law relating to the involuntary examinations under the Baker Act[41]and the signing of DNR orders.

The bill provides an effective date of July 1, 2021.

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[36] *See* s. 458.3485, F.S., A medical assistant is a professional multi-skilled person dedicated to assisting in all aspects of medical practice under the direct supervision and responsibility of a physician.
[37] *See* s. 381.986, F.S. This could include certifications for the use of medical marijuana if certain requirements are met by the PA.
[38] *See* s 384.463, F.S.
[39] *See* note 1.
[40] Section 382.008, F.S.
[41] Section 394.463, F.S.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

D. State Tax or Fee Increases:

None.

E. Other Constitutional Issues:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill might result in increased costs borne by a private health insurer or health maintenance organization that covers the additional PA services authorized under the bill with the expanded scope of practice.

C. Government Sector Impact:

The bill might result in increased costs for PA services under state group health insurance and under Medicaid, to the extent a PA's additional authorized medical services would be covered similar to physician services under those respective benefit packages. The fiscal impact is indeterminate at this time.

VI. Technical Deficiencies:

Lines 244-245 indicate that medical assistants are defined in chs. 458 and 459, F.S. However, medical assistants are defined and regulated only in ch. 458, F.S.

VII. Related Issues:

The bill authorizes PAs to "authenticate" medical evaluations for workers' compensation claims, including date of maximum medical improvement (MMI) as defined in s. 440.02, F.S. However:

- The bill does not authorize PAs to perform the workers' compensation medical evaluations.
- It is unclear whether the intent of the bill is to:
  - Authorize PAs to perform workers' compensation medical examinations and determine a date of MMI as delegated by supervising physicians; or
  - Authorize the PA to sign the report for the physician who actually performs the workers' compensation medical evaluation and makes the determination of the MMI date;
- Under current-law PAs are not authorized under ch. 440, F.S.,[42] Florida Administrative Code Chapter 69L,[43] or the Florida Workers' Compensation Health Care Provider Reimbursement Manual[44] to perform medical evaluations for worker's compensation claims or to make a determination of MMI. Only physicians or expert medical advisors may perform such medical evaluations;[45]

The bill authorizes PAs to bill for and receive direct payment for the services they deliver. However:

- Nothing in the bill requires public or private insurers to pay PAs directly for those services;
- Health insurance policies, and contracts with providers, are negotiated between the parties involved and they dictate how and to whom payment for services and benefits are made, in accordance with the provisions of the policy or contract;
- Any insurer who has contracted with a preferred provider for the delivery of health care services to its insureds must make payments directly to the preferred provider for such service, and insurers traditionally contract with supervising physicians and include PA services, not directly with PAs;[46] and
- Workers' compensation carriers do not pay PAs directly, as they are not authorized under workers' compensation law.[47]

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[42] Section 440.13(1)(h) and (i), F. S., An "independent medical examiner" is a physician selected by either an employee or a carrier to render one or more independent medical examinations in connection with a dispute arising under this chapter. An "independent medical examination" is an objective evaluation of the injured employee's medical condition, including, but not limited to, impairment or work status, performed by a physician or an expert medical advisor at the request of a party, a judge of compensation claims, or the department to assist in the resolution of a dispute arising under this chapter.

[43] Fla. Admin. Code R. 69L-30.002(4),(2021), an "Expert Medical Advisor" (EMA) is a physician certified by the Department of Financial Services, or appointed by a Judge of Compensation Claims (JCC) under paragraph 440.13(9)(c), F.S., to render peer review or expert medical consultation, opinions, and testimony, within the advisor's specialty area, concerning issues related to reimbursement, differing opinions of health care providers, and physician and health care services rendered under the Florida Workers' Compensation health care delivery system.

[44] *See* also Fla. Admin. Code R., 69L-7020 (2021), Florida Workers' Compensation Health Care Provider Reimbursement Manual, 2016 Ed., ch. 2, Medical Services, Independent Medical Examinations, pp 33-34.

[45] *Id.*

[46] Section 627.628, F.S.

[47] *See note* 43.

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 458.347, 459.022, 382.008, 394.463, and 401.45.

IX. 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 March 17, 2021:
The CS eliminates certain provisions from the underlying bill, including authority for PAs to practice primary care autonomously, after meeting certain requirements, without physician supervision, and other provisions, including:

- The legislative intent for PAs to practice medicine;
- A provision to prohibit PAs from authenticating certifications for a patient to use medical marijuana;
- A requirement that for PAs to authenticate death certificates, the PA must have had training on the completion of death certificates; and
- A requirement that applicants for a PA licensure must submit:
  - A PA program verification form; and
  - An evidence-quality copy of course transcripts and a copy of the course description from a PA training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority.

The CS inserts the following into the bill:

- Repeals the provision in current law that prohibits a PA from prescribing a psychiatric mental health controlled substance for a minor;
- Provides the following relating to third-party payors:
  - Payment for services within a PA's scope of practice must be made when ordered or performed by a PA if the same service would have been covered if ordered or performed by a physician; and
  - PAs are authorized to bill for and receive direct payment for the services they deliver.
- Repeals the current-law requirement that a licensed PA must notify the DOH within 30 days after starting employment, or after any changes in supervising physician, including the full name, medical license number, specialty, and address of the supervising physician;
- Repeals current law requiring the name, address and telephone number of the supervising physician on PAs prescriptions, but requires PAs' name, address and telephone number on prescriptions;
- Repeals the presumption that the inclusion of the PA prescriber number on a prescription indicates the PA is authorized to prescribe the medicinal drug and the prescription is valid.
- Authorizes PAs to include date of MMI when authenticating medical evaluations for workers' compensation claims;

- Repeals the current-law requirement that PAs must inform patients that they have the right to see the physician before a prescription is prescribed or dispensed by the PA; and
- Authorizes licensed PA to procure medical devices and drugs unless the drug is listed on the negative formulary.

B. Amendments:

None.

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LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
03/17/2021	.	
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	.	
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The Committee on Health Policy (Diaz) recommended the following:

Senate Amendment (with title amendment)

Delete lines 48 - 1238
and insert:
Section 1. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 458.347, Florida Statutes, are amended to read:
458.347 Physician assistants.—
(1) LEGISLATIVE INTENT.—
~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in

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the field of medicine, to practice medicine to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that he or she can operate efficiently and effectively in the specialty areas in which he or she has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

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(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant


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must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

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

(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.

(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.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 ~~and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and 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. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to paragraph (f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered

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by a statewide professional association of physicians in this state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising 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 inclusion 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.

(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 general anesthetics and

radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. ~~The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.~~

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, a deletion, or a 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 (e).

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the

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supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(k) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish~~


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~~standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met.~~

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect.~~

(6) ~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

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1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician


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assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, who expects to take the first examination


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administered by the National Commission on Certification of Physician Assistants available for registration after the applicant's graduation, a temporary license. The temporary license shall expire 30 days after receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment ~~but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the

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application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

Section 2. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 459.022, Florida Statutes, are amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in the field of medicine, to practice medicine to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program

in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.


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~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c)~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

(b) This chapter does not prevent third-party payors from reimbursing employers of physician assistants for covered

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services rendered by licensed physician assistants.

(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.

(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.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 ~~and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

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

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registered as a dispensing practitioner in compliance with s. 465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to s. 458.347(4)(f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising 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

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chapter 465, and must be dispensed in that pharmacy by a pharmacist licensed under chapter 465. ~~The inclusion 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.

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(g) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(h) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the

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administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(i) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(j) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on

Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

(6)~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

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c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of~~


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~~a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, a temporary license to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice to physician assistant applicants based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before ~~prior to~~ employment~~, but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent

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licensure. An applicant failing the proficiency examination is no longer temporarily licensed, but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until she or he passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

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

And the title is amended as follows:

Delete lines 10 - 39

and insert:

supervision; deleting a requirement that a physician assistant inform his or her patients that they have the right to see a physician before the physician assistant prescribes or dispenses a prescription;


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authorizing physician assistants to procure drugs and medical devices; providing an exception; conforming provisions to changes made by the act; revising requirements for a certain formulary; authorizing physician assistants to authenticate documents that may be authenticated by a physician; authorizing physician assistants to supervise medical assistants; authorizing third-party payors to reimburse employers of physician assistants for services rendered; providing requirements for such payment for services; authorizing physician assistants to bill for and receive direct payment for services they deliver; revising provisions relating to approved programs for physician assistants; revising provisions relating to physician assistant licensure requirements; amending ss.

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LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
03/17/2021	.	
	.	
	.	
	.	

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

Senate Amendment (with title amendment)

Delete lines 48 - 1238
and insert:
Section 1. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 458.347, Florida Statutes, are amended to read:
458.347 Physician assistants.—
(1) LEGISLATIVE INTENT.—
~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in

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the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that he or she can operate efficiently and effectively in the specialty areas in which he or she has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled

in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician

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assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

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

(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.

(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.

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(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 ~~and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and 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. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to paragraph (f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a statewide professional association of physicians in this

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state accredited to provide educational activities designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising 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 inclusion 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.

(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 general anesthetics and radiographic contrast materials and must limit the prescription

of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. ~~The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.~~

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, a deletion, or a 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 (e).

(g) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician’s patient in a facility licensed under

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chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(j) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(k) This chapter authorizes third-party payors to reimburse

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employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that~~

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~~does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met.~~

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect.~~

(6) ~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

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2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the

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applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection (6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, who expects to take the first examination administered by the National Commission on Certification of

Physician Assistants available for registration after the applicant's graduation, a temporary license. The temporary license shall expire 30 days after receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment ~~but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to

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subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

Section 2. Subsections (1) through (6), paragraphs (a), (d), and (e) of subsection (7), and subsection (13) of section 459.022, Florida Statutes, are amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to authorize physician assistants, with their education, training, and experience in the field of medicine, to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which


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is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program,~~ formally approved by the boards~~,~~ for the education of physician assistants.

(b) "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(d) ~~(c)~~ "Council" means the Council on Physician Assistants.

(h) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(e) "Physician assistant" means a person who is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician.

(f) "Physician assistant national certifying examination" means the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants or its successor agency.

(g) "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

~~(g) "Proficiency examination" means an entry-level~~


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~~examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants.~~

(c) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

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

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(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.

(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.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 ~~and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant~~.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and 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.

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465.0276.

3. A fully licensed physician assistant may procure medical devices and drugs unless the medication is listed on the formulary created pursuant to s. 458.347(4)(f).

4. The physician assistant must complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

~~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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.~~

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain the physician assistant's~~, in addition to the supervising 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 inclusion 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.

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(g) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(h) A physician assistant may authenticate any document with his or her signature, certification, stamp, verification, affidavit, or endorsement if such document may be so authenticated by the signature, certification, stamp, verification, affidavit, or endorsement of a physician. Such documents include, but are not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Do-not-resuscitate orders or physician orders for the administration of life-sustaining treatment.

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3. Death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims, including date of maximum medical improvement as defined in s. 440.02.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

(i) A physician assistant may supervise medical assistants as defined in this chapter and chapter 459.

(j) This chapter authorizes third-party payors to reimburse employers of physician assistants for covered services rendered by licensed physician assistants. Payment for services within the physician assistant's scope of practice must be made when ordered or performed by a physician assistant if the same service would have been covered if ordered or performed by a physician. Physician assistants are authorized to bill for and receive direct payment for the services they deliver.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its successor entity


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or, before 2001, from the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Programs ~~or its successor organization~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

(6) ~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall issue a license to any person certified by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved program.

a. For an applicant who graduated after December 31, 2020, has received a master's degree in accordance with the Accreditation Review Commission on Education for the Physician Assistant or, before 2001, its equivalent or predecessor organization.

b. For an applicant who graduated on or before December 31, 2020, has received a bachelor's or master's degree from an approved program.

c. For an applicant who graduated before July 1, 1994, has

graduated from an approved program of instruction in primary health care or surgery.

d. For an applicant who graduated before July 1, 1983, has received a certification as a physician assistant from the boards.

e. The board may also grant a license to an applicant who does not meet the educational requirement specified in this subparagraph but who has passed the Physician Assistant National Certifying Examination administered by the National Commission on Certification of Physician Assistants before 1986.

3. Has obtained a passing score as ~~satisfactorily passed a proficiency examination by an acceptable score~~ established by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has been nationally certified. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants or its equivalent or successor organization and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the entry-level examination of the National Commission on Certification of Physician Assistants or its equivalent or successor organization to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a physician assistant training~~ program ~~specified in subsection~~

~~(6)~~.

b. Acknowledgment of any prior felony convictions.

c. Acknowledgment of any previous revocation or denial of licensure or certification in any state.

~~d. A copy of course transcripts and a copy of the course description from a physician assistant training program describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority. These documents must meet the evidence requirements for prescribing authority.~~

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (5) ~~(6)~~, a temporary license to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice to physician assistant applicants based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before ~~prior to~~ employment~~, but must comply with paragraph (d)~~. An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is

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no longer temporarily licensed, but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until she or he passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(13) RULES.—The boards shall adopt rules to implement this section, including rules detailing the contents of the application for licensure and notification pursuant to subsection (6) ~~(7)~~ and rules to ensure both the continued competency of physician assistants and the proper utilization of them by physicians or groups of physicians.

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

And the title is amended as follows:

Delete lines 10 - 39

and insert:

supervision; deleting a requirement that a physician assistant inform his or her patients that they have the right to see a physician before the physician assistant prescribes or dispenses a prescription; authorizing physician assistants to procure drugs and


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medical devices; providing an exception; conforming provisions to changes made by the act; revising requirements for a certain formulary; authorizing physician assistants to authenticate documents that may be authenticated by a physician; authorizing physician assistants to supervise medical assistants; authorizing third-party payors to reimburse employers of physician assistants for services rendered; providing requirements for such payment for services; authorizing physician assistants to bill for and receive direct payment for services they deliver; revising provisions relating to approved programs for physician assistants; revising provisions relating to physician assistant licensure requirements; amending ss.

By Senator Diaz

36-00596A-21 2021894__

A bill to be entitled

An act relating to physician assistants; amending ss. 458.347 and 459.022, F.S.; revising legislative intent; defining and redefining terms; deleting a limitation on the number of physician assistants a physician may supervise at one time; deleting a provision prohibiting a requirement that a supervising physician review and cosign charts or medical records prepared by a physician assistant under his or her supervision; revising physician assistant continuing education requirements related to prescribing controlled substance medications; providing construction; allowing physician assistants to provide certain authorizations that are otherwise provided by physicians, with an exception; revising provisions relating to approved programs for physician assistants; revising provisions relating to physician assistant licensure requirements; revising provisions relating to temporary licensure of physician assistants; requiring the Board of Medicine and the Board of Osteopathic Medicine to register physician assistants as autonomous physician assistants if they meet specified criteria; requiring the Department of Health to distinguish autonomous physician assistants and include specified information in their practitioner profiles; providing functions an autonomous physician assistant may perform without physician supervision; providing for registration renewal; requiring the Council on Physician Assistants

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to develop certain rules; requiring autonomous physician assistants to provide specified written information to new patients when engaging in autonomous practice; requiring autonomous physician assistants to report adverse incidents to the department; authorizing physician assistants to directly bill and receive payment from public and private insurance companies; providing criminal penalties; providing for disciplinary action; revising rules to be adopted by the boards; amending ss. 382.008, 394.463, and 401.45, F.S.; conforming provisions relating to certificates of death, certificates for involuntary examinations, and orders not to resuscitate, respectively, to changes made by the act; providing an effective date.

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

Section 1. Section 458.347, Florida Statutes, is amended to read:

458.347 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to allow physician assistants to practice medicine in collaboration with physicians and other health care practitioners to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers in this state. Given their education, training, and experience in the practice of medicine, physician assistants are competent to provide these medical

services ~~encourage more effective utilization of the skills of physicians or groups of physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that he or she can operate efficiently and effectively in the specialty areas in which he or she has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program, formally approved by the boards, for the education of physician assistants~~.

(b) "Autonomous physician assistant" means a physician assistant who meets the requirements of subsection (9) to practice primary care without physician supervision.

(c) ~~(b)~~ "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(e) ~~(c)~~ "Council" means the Council on Physician Assistants.

(i) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(g) ~~(c)~~ "Physician assistant" means a person who is licensed as a physician assistant under this chapter or chapter 459 and is qualified by academic and clinical training to provide medical services, under physician supervision and in collaboration with other health care practitioners, to patients, including, but not limited to, diagnosing illnesses, developing and managing treatment plans, performing medical procedures, and prescribing and dispensing medications ~~is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician~~.

(h) ~~(f)~~ "Supervision" means responsible supervision and control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

(f) ~~(g)~~ "National certification" ~~"Proficiency examination"~~ means a postgraduate certification ~~an entry-level~~ examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants or its equivalent or successor entity.

(d) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of

Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

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

(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.

(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.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 and inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant.

2. The supervising physician must notify the department of his or her intent to delegate, on a department-approved form, before delegating such authority and 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 complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a

continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider approved by the American Academy of Physician Assistants and which is ~~a statewide professional association of physicians in this state accredited to provide educational activities~~ designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.

5. The prescription may be in paper or electronic form but must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain, in addition to the supervising 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 inclusion 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.

(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 general anesthetics and radiographic contrast materials and must limit the prescription of Schedule II controlled substances as listed in s. 893.03 to a 7-day supply. The formulary must also restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.

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, a deletion, or a 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 (e).

(g) A supervisory physician may delegate to a licensed

physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(h) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 459, or rules adopted under this chapter or chapter 459.

(i) Nothing in this chapter prohibits a supervising physician from delegating his or her roles under s. 458.3485 to a licensed physician assistant.

(j) Except for a physician certification under s. 381.986, a licensed physician assistant may provide a signature, certification, stamp, verification, affidavit, or any other endorsement that is otherwise required by law to be provided by a physician, including, but not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Orders not to resuscitate or orders for life-sustaining treatment.

3. Death certificates, if the physician assistant has received training on the completion of death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

7. Pronouncements of death.

(5) ~~PERFORMANCE BY TRAINEES. Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its equivalent or successor organization ~~Commission on Accreditation of Allied Health Programs or its successor organization. Any educational institution offering a physician assistant program approved by the boards pursuant to this paragraph may also offer the physician assistant program authorized in paragraph (c) for unlicensed physicians~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is~~

~~necessary to determine that the purposes of this section are being met.~~

~~(c) Any community college with the approval of the State Board of Education may conduct a physician assistant program which shall apply for national accreditation through the American Medical Association's Committee on Allied Health, Education, and Accreditation, or its successor organization, and which may admit unlicensed physicians, as authorized in subsection (7), who are graduates of foreign medical schools listed with the World Health Organization. The unlicensed physician must have been a resident of this state for a minimum of 12 months immediately prior to admission to the program. An evaluation of knowledge base by examination shall be required to grant advanced academic credit and to fulfill the necessary requirements to graduate. A minimum of one 16-week semester of supervised clinical and didactic education, which may be completed simultaneously, shall be required before graduation from the program. All other provisions of this section shall remain in effect.~~

(6)~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall ~~issue a~~ license each applicant recommended ~~to any person certified~~ by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved physician assistant program.

a. Applicants who matriculate after December 31, 2020, must

have obtained a master's degree from an approved program.

b. Applicants who matriculated before January 1, 2020, must have obtained a bachelor's or master's degree from an approved program.

c. Applicants who matriculated before July 1, 1994, must have graduated from an approved program of instruction in primary health care or surgery.

d. Applicants who matriculated before July 1, 1983, must have obtained certification as a physician assistant by the board.

3. Has been nationally certified by obtaining a passing score on the national certification ~~satisfactorily passed a proficiency~~ examination ~~by an acceptable score~~ established by the National Commission on Certification of Physician Assistants. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the initial certification ~~entry-level~~ examination of the National Commission on Certification of Physician Assistants to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a~~ physician assistant ~~training~~ program specified in subsection (5)~~(6)~~.

b. A physician assistant program verification form.

c.~~b.~~ Acknowledgment of any prior felony convictions.

d.~~c.~~ Acknowledgment of any previous revocation or denial of licensure or certification in any state.

e.~~d.~~ A copy of course transcripts and ~~a copy of the~~ course descriptions ~~description~~ from a physician assistant ~~training~~ program.

f. If applying for prescribing authority, a copy of the transcript and description of the course in pharmacotherapy which the applicant completed at a physician assistant program ~~describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority~~. These documents must meet the evidence requirements for prescribing authority.

(b) A physician assistant must notify the board in writing within 30 days after gaining or changing employment or after any change of the physician assistant's supervising physician. The notification must include the supervising physician's full name, Florida medical license number, specialty, and address.

(7) TEMPORARY LICENSURE.—

(a) Notwithstanding subsection (6), the department may grant a temporary license to practice as a physician assistant to an applicant who meets all of the following criteria:

1. Is a recent graduate of an approved program as specified in subsection (5).

2. Has satisfied the licensure requirements of paragraph (6)(a) except for passage of the national certification examination administered by the National Commission on Certification of Physician Assistants.

3. Is registered or intends to register for the first

available national certification examination after the applicant's graduation.

(b) An applicant with a temporary license must comply with the notification requirements of paragraph (6)(b).

(c) A temporary license expires 30 days after the department's receipt of the applicant's score on the national certification examination.

(d) The department may grant a full license to an applicant who passes the national certification examination.

(e) An applicant who fails the national certification examination no longer holds a temporary license to practice as a physician assistant, but may reapply for a 1-year extension of the temporary license. The department may not grant an applicant more than one extension of the temporary license.

(f) An applicant may not be licensed as a physician assistant until he or she passes the national certification examination.

(g) As prescribed by board rule, the council may require an applicant who does not pass the national certification examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(8) LICENSURE RENEWAL.—

(a)~~1.~~ The license must be renewed biennially. Each renewal must include:

1.~~a.~~ A renewal fee not to exceed $500 as set by the boards.

2.~~b.~~ Acknowledgment of no felony convictions in the previous 2 years.

3.~~c.~~ A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 458.3191 and must contain the same information required in s. 458.3191(1) and (2).

(b)~~2.~~ Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the physician assistant workforce surveys to the boards.

~~3. The department shall adopt rules to implement this paragraph.~~

(c) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants.

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

~~(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (6), who expects to take the first examination administered by the National Commission on Certification of Physician Assistants available for registration after the applicant's graduation, a temporary license. The temporary license shall expire 30 days after receipt of scores of the proficiency examination administered by the National Commission~~

~~on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed before employment but must comply with paragraph (d). An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two temporary licenses and may not be licensed as a physician assistant until he or she passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.~~

(d)~~(f)~~ The Board of Medicine may impose any of the penalties authorized under ss. 456.072 and 458.331(2) upon an autonomous physician assistant or a physician assistant if the autonomous physician assistant, physician assistant, or ~~the~~ supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(9) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

(a) The boards shall register a physician assistant as an autonomous physician assistant if the applicant demonstrates that he or she satisfies all of the following requirements:

1. Holds an active, unencumbered license to practice as a physician assistant in this state.

2. Has not been subject to any disciplinary action as specified in s. 456.072, s. 458.331, or s. 459.015 or any similar disciplinary action in any jurisdiction of the United States within the 5 years immediately preceding the registration request.

3. Has completed, in any state, jurisdiction, or territory of the United States, at least 3,000 clinical practice hours within the 5 years immediately preceding the submission of the registration request while practicing as a physician assistant under the supervision of an allopathic or osteopathic physician who held an active, unencumbered license issued by any state, the District of Columbia, or a territory or possession of the United States during the period of such supervision. Clinical instructional hours provided by the applicant may count toward the clinical practice hour requirement. For purposes of this subparagraph, the term "clinical instruction" means education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in physician assistant practice.

4. Has completed a graduate-level course in pharmacology and differential diagnosis.

5. Obtains and maintains professional liability coverage at the same level and in the same manner as in s. 458.320(1)(b) or

(c). However, the requirements of this subparagraph do not apply to:

a. Any person registered under this subsection who practices exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or subdivisions.

b. Any person whose license has become inactive and who is not practicing as an autonomous physician assistant in this state.

c. Any person who practices as an autonomous physician assistant only in conjunction with his or her teaching duties at an accredited school or its main teaching hospital. Such practice is limited to that which is incidental to and a necessary part of duties in connection with the teaching position.

d. Any person who holds an active registration under this subsection who is not practicing as an autonomous physician assistant in this state. If such person initiates or resumes any practice as an autonomous physician assistant, he or she must notify the department of such activity and fulfill the professional liability coverage requirements of this subparagraph.

(b) The department shall distinguish an autonomous physician assistant license if he or she is registered under this subsection and shall include the registration in the physician assistant's practitioner profile created pursuant to s. 456.041.

(c) An autonomous physician assistant may do all of the following without physician supervision:

1. Render only primary care services as defined by rule of the boards.

2. Provide any service that is within the scope of the autonomous physician assistant's education and experience and provided in accordance with rules adopted by the boards.

3. Prescribe, dispense, administer, or order any medicinal drug as authorized by the formulary adopted under paragraph (4)(f).

4. Provide a signature, a certification, a stamp, a verification, an affidavit, or any other endorsement that is otherwise required by law to be provided by a physician, except for a physician certification under s. 381.986.

5. For patients requiring services in a health care facility as defined in s. 408.032:

a. Admit a patient to the facility;

b. Manage the care received by the patient at the facility; and

c. Discharge the patient from the facility, unless prohibited by federal law or rule.

(d) An autonomous physician assistant must biennially renew his or her registration under this subsection. The biennial renewal must coincide with the autonomous physician assistant's biennial renewal period for physician assistant licensure.

(e) The council shall develop rules defining the primary care practice of autonomous physician assistants, including, but not limited to, internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology practices.

(f) When engaging in autonomous practice, an autonomous

physician assistant must provide to a new patient, during or before the initial patient encounter, written information explaining his or her qualifications and the nature of autonomous practice.

(g) An autonomous physician assistant must report adverse incidents to the department in accordance with s. 458.351.

(10) ELECTRONIC SUBMISSIONS.—An application or other documentation required to be submitted to the department under this section ~~subsection~~ may be submitted electronically.

(11) DIRECT BILLING AND REIMBURSEMENT.—A physician assistant may directly bill and receive payment from public and private insurance companies for medical services rendered.

(12) ~~(8)~~ DELEGATION OF POWERS AND DUTIES.—The boards may delegate such powers and duties to the council as they may deem proper.

(13) ~~(9)~~ COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on Physician Assistants is created within the department.

(a) The council shall consist of five members appointed as follows:

1. The chairperson of the Board of Medicine shall appoint one member who is a physician and member of the Board of Medicine who supervises a physician assistant in the physician's practice.

2. The chairperson of the Board of Osteopathic Medicine shall appoint one member who is a physician and member of the Board of Osteopathic Medicine who supervises a physician assistant in the physician's practice.

3. The State Surgeon General or his or her designee shall appoint three fully licensed physician assistants licensed under

this chapter or chapter 459.

(b) Members shall be appointed to terms of 4 years, except that of the initial appointments, two members shall be appointed to terms of 2 years, two members shall be appointed to terms of 3 years, and one member shall be appointed to a term of 4 years, as established by rule of the boards. Council members may not serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

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

2. Develop all rules regulating the use of physician assistants by physicians under this chapter and chapter 459, except for rules relating to the formulary developed under paragraph (4)(f). The council 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 developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council 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 submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all matters relating to physician assistants.

4. Address concerns and problems of practicing physician assistants in order to improve safety in the clinical practices of licensed physician assistants.

(d) When the council finds that an applicant for licensure has failed to meet, to the council's satisfaction, each of the requirements for licensure set forth in this section, the council may enter an order to:

1. Refuse to certify the applicant for licensure;

2. Approve the applicant for licensure with restrictions on the scope of practice or license; or

3. Approve the applicant for conditional licensure. Such conditions may include placement of the licensee on probation for a period of time and subject to such conditions as the council may specify, including but not limited to, requiring the licensee to undergo treatment, to attend continuing education courses, to work under the direct supervision of a physician licensed in this state, or to take corrective action.

(14) ~~(10)~~ INACTIVE AND DELINQUENT STATUS.—A license on inactive or delinquent status may be reactivated only as provided in s. 456.036.

(15) ~~(11)~~ PENALTY.—Any person who has not been registered or licensed by the council and approved by the department and who holds himself or herself out as an autonomous physician assistant or a physician assistant or who uses any other term in indicating or implying that he or she is an autonomous physician assistant or a physician assistant commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.084 or by

a fine not exceeding $5,000.

(16) ~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—The boards may deny, suspend, or revoke the registration of an autonomous physician assistant or the license of a physician assistant ~~license~~ if a board determines that the autonomous physician assistant or physician assistant has violated this chapter.

(17) ~~(13)~~ RULES.—The boards shall adopt rules to implement this section, including, but not limited to, rules:

(a) Detailing the contents of the application for licensure and notification under subsection (6);

(b) Relating to the registration of autonomous physician assistants under subsection (9);

(c) Regulating the primary care practice of autonomous physician assistants; ~~pursuant to subsection (7)~~ and ~~rules to ensure both~~

(d) Ensuring the continued competency of autonomous physician assistants and physician assistants and the proper utilization of them by physicians or groups of physicians.

(18) ~~(14)~~ EXISTING PROGRAMS.—This section does not eliminate or supersede existing laws relating to other paramedical professions or services and is supplemental to all such existing laws relating to the licensure and practice of paramedical professions.

(19) ~~(15)~~ LIABILITY.—Each supervising physician using a physician assistant is liable for any acts or omissions of the physician assistant acting under the physician's supervision and control.

(20) ~~(16)~~ LEGAL SERVICES.—Legal services shall be provided

to the council pursuant to s. 456.009(1).

(21) ~~(17)~~ FEES.—The department shall allocate the fees collected under this section to the council.

Section 2. Section 459.022, Florida Statutes, is amended to read:

459.022 Physician assistants.—

(1) LEGISLATIVE INTENT.—

~~(a)~~ The purpose of this section is to allow physician assistants to practice osteopathic medicine in collaboration with osteopathic physicians and other health care practitioners to provide increased efficiency of and access to high-quality medical services at a reasonable cost to consumers in this state. Given their education, training, and experience in the practice of osteopathic medicine, physician assistants are competent to provide these medical services ~~encourage more effective utilization of the skills of osteopathic physicians or groups of osteopathic physicians by enabling them to delegate health care tasks to qualified assistants when such delegation is consistent with the patient's health and welfare.~~

~~(b) In order that maximum skills may be obtained within a minimum time period of education, a physician assistant shall be specialized to the extent that she or he can operate efficiently and effectively in the specialty areas in which she or he has been trained or is experienced.~~

~~(c) The purpose of this section is to encourage the utilization of physician assistants by osteopathic physicians and to allow for innovative development of programs for the education of physician assistants~~.

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

(a) "Approved program" means a physician assistant program in the United States or in its territories or possessions which is accredited by the Accreditation Review Commission on Education for the Physician Assistant or, for programs before 2001, accredited by its equivalent or predecessor entities the Committee on Allied Health Education and Accreditation or the Commission on Accreditation of Allied Health Education Programs ~~program, formally approved by the boards, for the education of physician assistants~~.

(b) "Autonomous physician assistant" means a physician assistant who meets the requirements of subsection (9) to practice primary care without physician supervision.

(c) ~~(b)~~ "Boards" means the Board of Medicine and the Board of Osteopathic Medicine.

(e) ~~(c)~~ "Council" means the Council on Physician Assistants.

(i) ~~(d)~~ "Trainee" means a person who is currently enrolled in an approved program.

(g) ~~(e)~~ "Physician assistant" means a person who is licensed as a physician assistant under this chapter or chapter 458 and is qualified by academic and clinical training to provide medical services, under physician supervision and in collaboration with other health care practitioners, to patients, including, but not limited to, diagnosing illnesses, developing and managing treatment plans, performing medical procedures, and prescribing and dispensing medications ~~is a graduate of an approved program or its equivalent or meets standards approved by the boards and is licensed to perform medical services delegated by the supervising physician~~.

(h) ~~(f)~~ "Supervision" means responsible supervision and

control. Except in cases of emergency, supervision requires the easy availability or physical presence of the licensed physician for consultation and direction of the actions of the physician assistant. For the purposes of this definition, the term "easy availability" includes the ability to communicate by way of telecommunication. The boards shall establish rules as to what constitutes responsible supervision of the physician assistant.

(f) ~~(g)~~ "National certification" ~~"Proficiency examination"~~ means a postgraduate certification ~~an entry-level~~ examination approved by the boards, including, but not limited to, those examinations administered by the National Commission on Certification of Physician Assistants or its equivalent or successor entity.

(d) ~~(h)~~ "Continuing medical education" means courses recognized and approved by the boards, the American Academy of Physician Assistants, the American Medical Association, the American Osteopathic Association, or the Accreditation Council on Continuing Medical Education.

(3) PERFORMANCE OF SUPERVISING PHYSICIAN.—Each physician or group of physicians supervising a licensed physician assistant must be qualified in the medical areas in which the physician assistant is to perform and shall be individually or collectively responsible and liable for the performance and the acts and omissions of the physician assistant. ~~A physician may not supervise more than four currently licensed physician assistants at any one time. A physician supervising a physician assistant pursuant to this section may not be required to review and cosign charts or medical records prepared by such physician assistant.~~

(4) PERFORMANCE OF PHYSICIAN ASSISTANTS.—

(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.

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

(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.

(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.

(e) A supervising physician may delegate to a fully licensed physician assistant the authority to prescribe or dispense any medication used in the supervising 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 and must inform the patient that the patient has the right to see the physician before a prescription is prescribed or dispensed by the physician assistant.

2. The supervising physician must notify the department of her or his intent to delegate, on a department-approved form, before delegating such authority and 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 complete a minimum of 10 continuing medical education hours in the specialty practice in which the physician assistant has prescriptive privileges with each licensure renewal. Three of the 10 hours must consist of a continuing education course on the safe and effective prescribing of controlled substance medications which is offered by a provider that has been approved by the American Academy of Physician Assistants and which is designated for the American Medical Association Physician's Recognition Award Category 1 credit or designated by the American Academy of Physician Assistants as a Category 1 credit.

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 requirements of this paragraph. The physician assistant is not required to independently register pursuant to s. 465.0276.

5. The prescription may be in paper or electronic form but

must comply with ss. 456.0392(1) and 456.42(1) and chapter 499 and must contain, in addition to the supervising 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 inclusion 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.

(f) A supervisory physician may delegate to a licensed physician assistant the authority to, and the licensed physician assistant acting under the direction of the supervisory physician may, order any medication for administration to the supervisory physician's patient in a facility licensed under chapter 395 or part II of chapter 400, notwithstanding any provisions in chapter 465 or chapter 893 which may prohibit this delegation.

(g) A licensed physician assistant may perform services delegated by the supervising physician in the physician assistant's practice in accordance with his or her education and training unless expressly prohibited under this chapter, chapter 458, or rules adopted under this chapter or chapter 458.

(h) Nothing in this chapter prohibits a licensed physician assistant from supervising a medical assistant in accordance with s. 458.3485.

(i) Except for a physician certification under s. 381.986,

a licensed physician assistant may provide a signature, a certification, a stamp, a verification, an affidavit, or any other endorsement that is otherwise required by law to be provided by a physician, including, but not limited to, any of the following:

1. Initiation of an involuntary examination pursuant to s. 394.463.

2. Orders not to resuscitate or orders for life-sustaining treatment.

3. Death certificates, if the physician assistant has received training on the completion of death certificates.

4. School physical examinations.

5. Medical evaluations for workers' compensation claims.

6. Orders for physical therapy, occupational therapy, speech-language therapy, home health services, or durable medical equipment.

7. Pronouncements of death.

(5) ~~PERFORMANCE BY TRAINEES.—Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program.~~

~~(6)~~ PROGRAM APPROVAL.—

(a) The boards shall approve programs, based on recommendations by the council, for the education and training of physician assistants which meet standards established by rule of the boards. The council may recommend only those physician assistant programs that hold full accreditation or provisional accreditation from the Accreditation Review Commission on Education for the Physician Assistant or its equivalent or successor organization ~~Commission on Accreditation of Allied~~

~~Health Programs or its successor organization~~.

(b) Notwithstanding any other law, a trainee may perform medical services when such services are rendered within the scope of an approved program ~~The boards shall adopt and publish standards to ensure that such programs operate in a manner that does not endanger the health or welfare of the patients who receive services within the scope of the programs. The boards shall review the quality of the curricula, faculties, and facilities of such programs and take whatever other action is necessary to determine that the purposes of this section are being met~~.

(6)~~(7)~~ PHYSICIAN ASSISTANT LICENSURE.—

(a) Any person desiring to be licensed as a physician assistant must apply to the department. The department shall ~~issue a~~ license each applicant recommended ~~to any person certified~~ by the council as having met all of the following requirements:

1. Is at least 18 years of age.

2. Has graduated from an approved physician assistant program.

a. Applicants who matriculate after December 31, 2020, must have obtained a master's degree from an approved program.

b. Applicants who matriculated before January 1, 2020, must have obtained a bachelor's or master's degree from an approved program.

c. Applicants who matriculated before July 1, 1994, must have graduated from an approved program of instruction in primary health care or surgery.

d. Applicants who matriculated before July 1, 1983, must

have obtained certification as a physician assistant by the board.

3. Has been nationally certified by obtaining a passing score on the national certification ~~satisfactorily passed a proficiency~~ examination ~~by an acceptable score~~ established by the National Commission on Certification of Physician Assistants. If an applicant does not hold a current certificate issued by the National Commission on Certification of Physician Assistants and has not actively practiced as a physician assistant within the immediately preceding 4 years, the applicant must retake and successfully complete the initial certification ~~entry-level~~ examination of the National Commission on Certification of Physician Assistants to be eligible for licensure.

4.~~3.~~ Has completed the application form and remitted an application fee not to exceed $300 as set by the boards. An application for licensure as ~~made by~~ a physician assistant must include:

a. A diploma from an approved ~~certificate of completion of a~~ physician assistant ~~training~~ program specified in subsection (5)~~(6)~~.

b. A physician assistant program verification form.

c.~~b.~~ Acknowledgment of any prior felony convictions.

d.~~c.~~ Acknowledgment of any previous revocation or denial of licensure or certification in any state.

e.~~d.~~ A copy of course transcripts and ~~a copy of the~~ course descriptions ~~description~~ from a physician assistant ~~training~~ program.

f. If applying for prescribing authority, a copy of the

transcript and description of the course in pharmacotherapy which the applicant completed at a physician assistant program ~~describing course content in pharmacotherapy, if the applicant wishes to apply for prescribing authority~~. These documents must meet the evidence requirements for prescribing authority.

(b) A physician assistant must notify the board in writing within 30 days after gaining or changing employment or after any change in the physician assistant's supervising physician. The notification must include the supervising physician's full name, Florida medical license number, specialty, and address.

(7) TEMPORARY LICENSURE.—

(a) Notwithstanding subsection (6), the department may grant a temporary license to practice as a physician assistant to an applicant who meets all of the following criteria:

1. Is a recent graduate of an approved program as specified in subsection (5).

2. Has satisfied the licensure requirements of paragraph (6)(a) except for passage of the national certification examination administered by the National Commission on Certification of Physician Assistants.

3. Is registered or intends to register for the first available national certification examination after the applicant's graduation.

(b) An applicant with a temporary license must comply with the notification requirements of paragraph (6)(b).

(c) A temporary license expires 30 days after the department's receipt of the applicant's score on the national certification examination.

(d) The department may grant a full license to an applicant

who passes the national certification examination.

(e) An applicant who fails the national certification examination no longer holds a temporary license to practice as a physician assistant, but may reapply for a 1-year extension of the temporary license. The department may not grant an applicant more than one extension of the temporary license.

(f) An applicant may not be licensed as a physician assistant until he or she passes the national certification examination.

(g) As prescribed by board rule, the council may require an applicant who does not pass the national certification examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.

(8) LICENSURE RENEWAL.—

(a) ~~1.~~ The licensure must be renewed biennially. Each renewal must include:

1. ~~a.~~ A renewal fee not to exceed $500 as set by the boards.

2. ~~b.~~ Acknowledgment of no felony convictions in the previous 2 years.

3. ~~c.~~ A completed physician assistant workforce survey, which shall be administered in the same manner as the physician survey established in s. 459.0081 and must contain the same information required under s. 459.0081(1) and (2).

(b) ~~2.~~ Beginning July 1, 2018, and every 2 years thereafter, the department shall report the data collected from the

physician assistant workforce surveys to the boards.

~~3. The department shall adopt rules to implement this paragraph.~~

(c) Each licensed physician assistant shall biennially complete 100 hours of continuing medical education or shall hold a current certificate issued by the National Commission on Certification of Physician Assistants.

~~(d) Upon employment as a physician assistant, a licensed physician assistant must notify the department in writing within 30 days after such employment or after any subsequent changes in the supervising physician. The notification must include the full name, Florida medical license number, specialty, and address of the supervising physician.~~

~~(e) Notwithstanding subparagraph (a)2., the department may grant to a recent graduate of an approved program, as specified in subsection (6), a temporary license to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician Assistants. Between meetings of the council, the department may grant a temporary license to practice to physician assistant applicants based on the completion of all temporary licensure requirements. All such administratively issued licenses shall be reviewed and acted on at the next regular meeting of the council. The recent graduate may be licensed prior to employment, but must comply with paragraph (d). An applicant who has passed the proficiency examination may be granted permanent licensure. An applicant failing the proficiency examination is no longer temporarily licensed, but may reapply for a 1-year extension of temporary licensure. An applicant may not be granted more than two~~

~~temporary licenses and may not be licensed as a physician assistant until she or he passes the examination administered by the National Commission on Certification of Physician Assistants. As prescribed by board rule, the council may require an applicant who does not pass the licensing examination after five or more attempts to complete additional remedial education or training. The council shall prescribe the additional requirements in a manner that permits the applicant to complete the requirements and be reexamined within 2 years after the date the applicant petitions the council to retake the examination a sixth or subsequent time.~~

(d) ~~(f)~~ The Board of Osteopathic Medicine may impose any of the penalties authorized under ss. 456.072 and 459.015(2) upon an autonomous physician assistant or a physician assistant if the autonomous physician assistant, physician assistant, or ~~the~~ supervising physician has been found guilty of or is being investigated for any act that constitutes a violation of this chapter or chapter 456.

(9) PERFORMANCE OF AUTONOMOUS PHYSICIAN ASSISTANTS.—

(a) The boards shall register a physician assistant as an autonomous physician assistant if the applicant demonstrates that he or she satisfies all of the following requirements:

1. Holds an active, unencumbered license to practice as a physician assistant in this state.

2. Has not been subject to any disciplinary action as specified in s. 456.072, s. 458.331, or s. 459.015 or any similar disciplinary action in any jurisdiction of the United States within the 5 years immediately preceding the registration request.

3. Has completed, in any state, jurisdiction, or territory of the United States, at least 3,000 clinical practice hours within the 5 years immediately preceding the submission of the registration request while practicing as a physician assistant under the supervision of an allopathic or osteopathic physician who held an active, unencumbered license issued by any state, the District of Columbia, or a territory or possession of the United States during the period of such supervision. Clinical instructional hours provided by the applicant may count toward the clinical practice hour requirement. For purposes of this subparagraph, the term "clinical instruction" means education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in physician assistant practice.

4. Has completed a graduate-level course in pharmacology and differential diagnosis.

5. Obtains and maintains professional liability coverage at the same level and in the same manner as in s. 458.320(1)(b) or (c). However, the requirements of this subparagraph do not apply to:

a. Any person registered under this subsection who practices exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or subdivisions.

b. Any person whose license has become inactive and who is not practicing as an autonomous physician assistant in this state.

c. Any person who practices as an autonomous physician assistant only in conjunction with his or her teaching duties at

an accredited school or its main teaching hospital. Such practice is limited to that which is incidental to and a necessary part of duties in connection with the teaching position.

d. Any person who holds an active registration under this subsection who is not practicing as an autonomous physician assistant in this state. If such person initiates or resumes any practice as an autonomous physician assistant, he or she must notify the department of such activity and fulfill the professional liability coverage requirements of this subparagraph.

(b) The department shall distinguish an autonomous physician assistant license if he or she is registered under this subsection and include the registration in the physician assistant's practitioner profile created pursuant to s. 456.041.

(c) An autonomous physician assistant may do all of the following without physician supervision:

1. Render only primary care services as defined by rule of the boards.

2. Provide any service that is within the scope of the autonomous physician assistant's education and experience and provided in accordance with rules adopted by the boards.

3. Prescribe, dispense, administer, or order any medicinal drug as authorized by the formulary adopted pursuant to s. 458.347(4)(f).

4. Provide a signature, a certification, a stamp, a verification, an affidavit, or any other endorsement that is otherwise required by law to be provided by a physician, except for a physician certification under s. 381.986.

5. For patients requiring services in a health care facility as defined in s. 408.032:

a. Admit a patient to the facility;

b. Manage the care received by the patient at the facility; and

c. Discharge the patient from the facility, unless prohibited by federal law or rule.

(d) An autonomous physician assistant must biennially renew his or her registration under this subsection. The biennial renewal must coincide with the autonomous physician assistant's biennial renewal period for physician assistant licensure.

(e) The council shall develop rules defining the primary care practice of autonomous physician assistants, including, but not limited to, internal medicine, general pediatrics, family medicine, geriatrics, and general obstetrics and gynecology practices.

(f) When engaging in autonomous practice, an autonomous physician assistant must provide to a new patient, during or before the initial patient encounter, written information explaining his or her qualifications and the nature of autonomous practice.

(g) An autonomous physician assistant must report adverse incidents to the department in accordance with s. 458.351.

(10) ELECTRONIC SUBMISSIONS.—An application or other documentation required to be submitted to the department under this section ~~subsection~~ may be submitted electronically.

(11) DIRECT BILLING AND REIMBURSEMENT.—A physician assistant may directly bill and receive payment from public and private insurance companies for medical services rendered.

(12) ~~(8)~~ DELEGATION OF POWERS AND DUTIES.—The boards may delegate such powers and duties to the council as they may deem proper.

(13) ~~(9)~~ COUNCIL ON PHYSICIAN ASSISTANTS.—The Council on Physician Assistants is created within the department.

(a) The council shall consist of five members appointed as follows:

1. The chairperson of the Board of Medicine shall appoint one member who is a physician and member of the Board of Medicine who supervises a physician assistant in the physician's practice.

2. The chairperson of the Board of Osteopathic Medicine shall appoint one member who is a physician and member of the Board of Osteopathic Medicine who supervises a physician assistant in the physician's practice.

3. The State Surgeon General or her or his designee shall appoint three fully licensed physician assistants licensed under chapter 458 or this chapter.

(b) Members shall be appointed to terms of 4 years, except that of the initial appointments, two members shall be appointed to terms of 2 years, two members shall be appointed to terms of 3 years, and one member shall be appointed to a term of 4 years, as established by rule of the boards. Council members may not serve more than two consecutive terms. The council shall annually elect a chairperson from among its members.

(c) The council shall:

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

2. Develop all rules regulating the use of physician

assistants by physicians under chapter 458 and this chapter, except for rules relating to the formulary developed under s. 458.347. The council 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 developed by the council at the regularly scheduled meeting immediately following the submission of the proposed rule by the council. A proposed rule submitted by the council 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 submitted by the council must be approved by both boards pursuant to each respective board's guidelines and standards regarding the adoption of proposed rules. If either board rejects the council's proposed rule, that board must specify its objection to the council with particularity and include any recommendations it may have for the modification of the proposed rule.

3. Make recommendations to the boards regarding all matters relating to physician assistants.

4. Address concerns and problems of practicing physician assistants in order to improve safety in the clinical practices of licensed physician assistants.

(d) When the council finds that an applicant for licensure has failed to meet, to the council's satisfaction, each of the requirements for licensure set forth in this section, the council may enter an order to:

1. Refuse to certify the applicant for licensure;

2. Approve the applicant for licensure with restrictions on the scope of practice or license; or

3. Approve the applicant for conditional licensure. Such conditions may include placement of the licensee on probation for a period of time and subject to such conditions as the council may specify, including but not limited to, requiring the licensee to undergo treatment, to attend continuing education courses, to work under the direct supervision of a physician licensed in this state, or to take corrective action.

(14) ~~(10)~~ INACTIVE AND DELINQUENT STATUS.—A license on inactive or delinquent status may be reactivated only as provided in s. 456.036.

(15) ~~(11)~~ PENALTY.—Any person who has not been registered or licensed by the council and approved by the department and who holds herself or himself out as an autonomous physician assistant or a physician assistant or who uses any other term in indicating or implying that she or he is an autonomous physician assistant or a physician assistant commits a felony of the third degree, punishable as provided in s. 775.082 or s. 775.084 or by a fine not exceeding $5,000.

(16) ~~(12)~~ DENIAL, SUSPENSION, OR REVOCATION OF LICENSURE.—The boards may deny, suspend, or revoke the registration of an autonomous physician assistant or the license of a physician assistant ~~license~~ if a board determines that the autonomous physician assistant or physician assistant has violated this chapter.

(17) ~~(13)~~ RULES.—The boards shall adopt rules to implement this section, including, but not limited to, rules:

(a) Detailing the contents of the application for licensure and notification under subsection (6);

(b) Relating to the registration of autonomous physician

assistants under subsection (9);

(c) Regulating the primary care practice of autonomous physician assistants; ~~pursuant to subsection (7)~~ and ~~rules to ensure both~~

(d) Ensuring the continued competency of autonomous physician assistants and physician assistants and the proper utilization of them by physicians or groups of physicians.

(18)~~(14)~~ EXISTING PROGRAMS.—This section does not eliminate or supersede existing laws relating to other paramedical professions or services and is supplemental to all such existing laws relating to the licensure and practice of paramedical professions.

(19)~~(15)~~ LIABILITY.—Each supervising physician using a physician assistant is liable for any acts or omissions of the physician assistant acting under the physician's supervision and control.

(20)~~(16)~~ LEGAL SERVICES.—Legal services shall be provided to the council pursuant to s. 456.009(1).

(21)~~(17)~~ FEES.—The department shall allocate the fees collected under this section to the council.

Section 3. Paragraph (a) of subsection (2) and subsections (3) and (5) of section 382.008, Florida Statutes, are amended to read:

382.008 Death, fetal death, and nonviable birth registration.—

(2)(a) The funeral director who first assumes custody of a dead body or fetus shall file the certificate of death or fetal death. In the absence of the funeral director, the physician, physician assistant, advanced practice registered nurse

registered under s. 464.0123, or other person in attendance at or after the death or the district medical examiner of the county in which the death occurred or the body was found shall file the certificate of death or fetal death. The person who files the certificate shall obtain personal data from a legally authorized person as described in s. 497.005 or the best qualified person or source available. The medical certification of cause of death shall be furnished to the funeral director, either in person or via certified mail or electronic transfer, by the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or medical examiner responsible for furnishing such information. For fetal deaths, the physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, midwife, or hospital administrator shall provide any medical or health information to the funeral director within 72 hours after expulsion or extraction.

(3) Within 72 hours after receipt of a death or fetal death certificate from the funeral director, the medical certification of cause of death shall be completed and made available to the funeral director by the decedent's primary or attending practitioner or, if s. 382.011 applies, the district medical examiner of the county in which the death occurred or the body was found. The primary or attending practitioner or the medical examiner shall certify over his or her signature the cause of death to the best of his or her knowledge and belief. As used in this section, the term "primary or attending practitioner" means a physician, physician assistant, or advanced practice registered nurse registered under s. 464.0123 who treated the

decedent through examination, medical advice, or medication during the 12 months preceding the date of death.

(a) The department may grant the funeral director an extension of time upon a good and sufficient showing of any of the following conditions:

1. An autopsy is pending.

2. Toxicology, laboratory, or other diagnostic reports have not been completed.

3. The identity of the decedent is unknown and further investigation or identification is required.

(b) If the decedent's primary or attending practitioner or the district medical examiner of the county in which the death occurred or the body was found indicates that he or she will sign and complete the medical certification of cause of death but will not be available until after the 5-day registration deadline, the local registrar may grant an extension of 5 days. If a further extension is required, the funeral director must provide written justification to the registrar.

(5) A permanent certificate of death or fetal death, containing the cause of death and any other information that was previously unavailable, shall be registered as a replacement for the temporary certificate. The permanent certificate may also include corrected information if the items being corrected are noted on the back of the certificate and dated and signed by the funeral director, physician, physician assistant, advanced practice registered nurse registered under s. 464.0123, or district medical examiner of the county in which the death occurred or the body was found, as appropriate.

Section 4. Paragraph (a) of subsection (2) of section

394.463, Florida Statutes, is amended to read:

394.463 Involuntary examination.—

(2) INVOLUNTARY EXAMINATION.—

(a) An involuntary examination may be initiated by any one of the following means:

1. A circuit or county court may enter an ex parte order stating that a person appears to meet the criteria for involuntary examination and specifying the findings on which that conclusion is based. The ex parte order for involuntary examination must be based on written or oral sworn testimony that includes specific facts that support the findings. If other less restrictive means are not available, such as voluntary appearance for outpatient evaluation, a law enforcement officer, or other designated agent of the court, shall take the person into custody and deliver him or her to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The order of the court shall be made a part of the patient's clinical record. A fee may not be charged for the filing of an order under this subsection. A facility accepting the patient based on this order must send a copy of the order to the department within 5 working days. The order may be submitted electronically through existing data systems, if available. The order shall be valid only until the person is delivered to the facility or for the period specified in the order itself, whichever comes first. If a time limit is not specified in the order, the order is valid for 7 days after the date that the order was signed.

2. A law enforcement officer shall take a person who appears to meet the criteria for involuntary examination into

custody and deliver the person or have him or her delivered to an appropriate, or the nearest, facility within the designated receiving system pursuant to s. 394.462 for examination. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, which must be made a part of the patient's clinical record. Any facility accepting the patient based on this report must send a copy of the report to the department within 5 working days.

3. A physician, a physician assistant, a clinical psychologist, a psychiatric nurse, an advanced practice registered nurse registered under s. 464.0123, a mental health counselor, a marriage and family therapist, or a clinical social worker may execute a certificate stating that he or she has examined a person within the preceding 48 hours and finds that the person appears to meet the criteria for involuntary examination and stating the observations upon which that conclusion is based. If other less restrictive means, such as voluntary appearance for outpatient evaluation, are not available, a law enforcement officer shall take into custody the person named in the certificate and deliver him or her to the appropriate, or nearest, facility within the designated receiving system pursuant to s. 394.462 for involuntary examination. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and certificate shall be made a part of the patient's clinical record. Any facility accepting the patient based on this certificate must send a copy of the certificate to the department within 5 working days. The document may be submitted electronically through existing data

systems, if applicable.

When sending the order, report, or certificate to the department, a facility shall, at a minimum, provide information about which action was taken regarding the patient under paragraph (g), which information shall also be made a part of the patient's clinical record.

Section 5. Paragraphs (a) and (c) of subsection (3) of section 401.45, Florida Statutes, are amended to read:

401.45 Denial of emergency treatment; civil liability.—

(3)(a) Resuscitation may be withheld or withdrawn from a patient by an emergency medical technician or paramedic if evidence of an order not to resuscitate by the patient's physician or physician assistant is presented to the emergency medical technician or paramedic. An order not to resuscitate, to be valid, must be on the form adopted by rule of the department. The form must be signed by the patient's physician or physician assistant and by the patient or, if the patient is incapacitated, the patient's health care surrogate or proxy as provided in chapter 765, court-appointed guardian as provided in chapter 744, or attorney in fact under a durable power of attorney as provided in chapter 709. The court-appointed guardian or attorney in fact must have been delegated authority to make health care decisions on behalf of the patient.

(c) The department, in consultation with the Department of Elderly Affairs and the Agency for Health Care Administration, shall develop a standardized do-not-resuscitate identification system with devices that signify, when carried or worn, that the possessor is a patient for whom a physician or physician

assistant has issued an order not to administer cardiopulmonary resuscitation. The department may charge a reasonable fee to cover the cost of producing and distributing such identification devices. Use of such devices shall be voluntary.

Section 6. This act shall take effect July 1, 2021.

YOU MUST PRINT AND DELIVER THIS FORM TO THE ASSIGNED TESTIMONY ROOM

THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

894
Bill Number (if applicable)

Topic Physician Assistants

Amendment Barcode (if applicable)

Name Doug Bell

Job Title

Address 119 South Monroe Street
Street

Phone 850-510-7146

Tallahassee FL 32312
City *State* *Zip*

Email doug.bell@mhdfirm.com

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Chapter of the American Academy of Pediatrics

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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21
Meeting Date

SB 894
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name Richard Thacker D.O.

Job Title _____

Address 1430 Piedmont Dr. E. *Street*

Phone 850 224-6941

Tallahassee *City* FL *State* 32308 *Zip*

Email _____

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Academy of Family Physicians, Florida Medical Association, 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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/21 (Health Policy)
Meeting Date

894
Bill Number (if applicable)

Topic Physician Assistants

Amendment Barcode (if applicable)

Name Steve Winn

Job Title Executive Director

Address 2544 Blairstone Pines Dr
Street

Phone 878-7364

Tallahassee FL 32301
City *State* *Zip*

Email winnsr@eartlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/17/21
Meeting Date

894
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic _____

Name Chris Nuland

Job Title _____

Address 4427 Herschel St
Street
Jacksonville, FL
City *State* *Zip*

Phone 904-233-3051

Email nulandlaw@aol.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Florida Chapter, American College of Physicians

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 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-19-21
Meeting Date

894
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Physicians Assistants

Name Marnie George

Job Title Sr. Advisor - Buchanan Ingersoll & Rooney

Address 101 N. Monroe St
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-510-8566

Email marnie.george@bipc.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing Fl Chapter Am College of Cardiology

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 (10/14/14)

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Duplicate

THE FLORIDA SENATE

APPEARANCE RECORD

03/17/2021
Meeting Date

894
Bill Number (if applicable)

Topic _____

Amendment Barcode (if applicable)

Name David Mica, Jr.

Job Title Executive Vice President of Public Affairs

Address _____ Phone _____
Street

_____ Email davidm@fha.org
City *State* *Zip*

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital 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 (10/14/14)

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THE FLORIDA SENATE

APPEARANCE RECORD

3/17/2021
Meeting Date

894
Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Physician Assistants

Name Corinne Mixon

Job Title Lobbyist

Address 511 N. Adams St.
Street

Phone 8507665795

Tallahassee FL 32301
City *State* *Zip*

Email corinnemixon@gmail.com

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Academy of Physician Assistants

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 (10/14/14)

CourtSmart Tag Report

Room: KB 412 **Case No.:** - **Type:**
Caption: Senate Health Policy Committee **Judge:**

Started: 3/17/2021 9:02:54 AM
Ends: 3/17/2021 11:06:34 AM Length: 02:03:41

9:02:53 AM Meeting called to order by Chair Diaz
9:02:56 AM Roll call by CAA Lynn Wells
9:03:08 AM Quorum present
9:03:14 AM Comments from Chair Diaz
9:03:58 AM Introduction of Tab 4, SB 1442 by Chair Diaz
9:04:10 AM Explanation of SB 1442, Substance Abuse Prevention by Senator Boyd
9:06:00 AM Comments from Chair Diaz
9:06:06 AM Question from Senator Cruz
9:06:48 AM Response from Senator Boyd
9:07:47 AM Follow-up question from Senator Cruz
9:07:54 AM Response from Senator Boyd
9:08:08 AM Comments from Chair Diaz
9:08:22 AM Senator Cruz in debate
9:09:29 AM Senator Boyd in closure
9:09:38 AM Roll call by CAA
9:10:10 AM SB 1442 reported favorably
9:10:27 AM Introduction of Tab 8, SB 874 by Chair Diaz
9:10:50 AM Explanation of SB 874, Alzheimer's Disease Awareness by Senator Brodeur
9:11:16 AM Comments from Chair Diaz
9:11:36 AM Speaker John Conley, Alzheimer's Society in support
9:12:03 AM Comments from Chair Diaz
9:12:08 AM Closure waived
9:12:11 AM Roll call by CAA
9:12:15 AM SB 874 reported favorably
9:12:31 AM Introduction of Tab 10, SB 864 by Chair Diaz
9:12:58 AM Explanation of SB 864, Telehealth by Senator Brodeur
9:13:11 AM Comments from Chair Diaz
9:13:42 AM Introduction of Amendment Barcode 788640 by Chair Diaz
9:13:51 AM Explanation of Amendment by Senator Brodeur
9:14:02 AM Comments from Chair Diaz
9:14:25 AM Amendment adopted
9:14:34 AM Comments from Chair Diaz
9:14:45 AM Speaker Joy Ryan, Teladoc Health, Inc. in support
9:14:58 AM Steve Winn, Florida Osteopathic Medical Association waives in support
9:15:14 AM Comments from Chair Diaz
9:15:18 AM Closure waived
9:15:22 AM Roll call by CAA
9:15:28 AM CS/SB 864 reported favorably
9:15:37 AM Introduction of Tab 9, SB 852 by Chair Diaz
9:15:52 AM Explanation of SB 852, Medicaid Modernization by Senator Brodeur
9:16:33 AM Comments from Chair Diaz
9:16:54 AM Closure waived
9:16:56 AM Roll call by CAA
9:17:02 AM SB 852 reported favorably
9:17:16 AM Chair passed to Senator Brodeur
9:17:33 AM Introduction of SB 894, Physician Assistants by Chair Brodeur
9:17:56 AM Introduction of Amendment Barcode 188076 by Chair Brodeur
9:18:02 AM Explanation of Amendment by Senator Diaz
9:19:22 AM Comments from Chair Brodeur
9:19:28 AM Question from Senator Cruz
9:19:36 AM Response from Senator Diaz
9:20:12 AM Follow-up question from Senator Cruz

9:20:19 AM Response from Senator Diaz
9:20:28 AM Follow-up question from Senator Cruz
9:20:35 AM Response from Senator Diaz
9:21:04 AM Follow-up question from Senator Cruz
9:21:13 AM Response from Senator Diaz
9:21:37 AM Comments from Chair Brodeur
9:21:47 AM Amendment adopted
9:22:01 AM Speaker Doug Bell, Florida Chapter of the American Academy of Pediatrics in opposition
9:22:45 AM Speaker Dr. Richard Thacker, Florida Academy of Family Physicians, Florida Medical Association, Florida Osteopathic Medical Association in opposition
9:26:51 AM Steve Winn, Florida Osteopathic Medical Association waives in opposition
9:27:18 AM Chris Nuland, Florida Chapter, American College of Physicians waives in opposition
9:27:38 AM Speaker Corrine Mixon, Florida Academy of Physician Assistants in support
9:30:22 AM Comments from Chair Brodeur
9:31:21 AM Senator Book in debate
9:32:24 AM Senator Albritton in debate
9:34:29 AM Senator Jones in debate
9:35:17 AM Senator Farmer in debate
9:36:31 AM Senator Garcia in debate
9:36:52 AM Closure by Senator Diaz
9:36:56 AM Roll call by CAA
9:37:41 AM CS/SB 894 reported favorably
9:38:09 AM Chair returned to Senator Diaz
9:38:24 AM Introduction of Tab 6, SB 1934 by Chair Diaz
9:38:41 AM Explanation of SB 1934, Health Care Practitioner Discipline by Senator Book
9:42:55 AM Comments from Chair Diaz
9:43:29 AM Senator Cruz in debate
9:44:10 AM Senator Book in closure
9:44:20 AM Roll call by CAA
9:44:42 AM SB 1934 reported favorably
9:45:01 AM Introduction of Tab 11, SB 1132 by Chair Diaz
9:49:11 AM Explanation of SB 1132, Personal Care Attendants by Senator Bean
9:50:12 AM Introduction of Amendment Barcode 473940 by Chair Diaz
9:50:27 AM Explanation of Amendment by Senator Bean
9:52:08 AM Comments from Chair Diaz
9:52:12 AM Question from Senator Albritton
9:52:19 AM Response from Senator Bean
9:53:02 AM Follow-up question from Senator Albritton
9:53:15 AM Response from Senator Bean
9:53:30 AM Follow-up question from Senator Albritton
9:53:37 AM Response from Senator Bean
9:54:44 AM Question from Senator Cruz
9:54:54 AM Response from Senator Bean
9:55:35 AM Follow-up question from Senator Cruz
9:56:10 AM Response from Senator Bean
9:56:56 AM Follow-up question from Senator Cruz
9:57:03 AM Response from Senator Bean
9:57:53 AM Follow-up question from Senator Cruz
9:58:03 AM Response from Senator Bean
9:59:17 AM Comments from Chair Diaz
9:59:35 AM Closure waived
9:59:39 AM Amendment adopted
9:59:43 AM Comments from Chair Diaz
9:59:50 AM Question from Senator Garcia
10:01:01 AM Response from Senator Bean
10:02:25 AM Question from Senator Farmer
10:02:36 AM Response from Senator Bean
10:03:06 AM Follow-up question from Senator Farmer
10:03:44 AM Response from Senator Bean
10:04:12 AM Follow-up question from Senator Farmer
10:04:18 AM Response from Senator Bean
10:05:23 AM Follow-up question from Senator Farmer

10:05:29 AM Response from Senator Bean
10:06:18 AM Question from Senator Book
10:06:30 AM Response from Senator Bean
10:07:00 AM Follow-up question from Senator Book
10:07:20 AM Response from Senator Bean
10:07:31 AM Speaker Barbara DeVane, FL NOW & Florida Alliance for Retired Americans in opposition
10:09:50 AM Foyt Ralston, Florida Justice Association waives in opposition
10:10:52 AM Speaker Michael Phillips, Florida Long-Term Care Ombudsman Program in opposition
10:13:42 AM Speaker Tanya Jackson, SEIU1199 Healthcare Workers in opposition
10:16:38 AM Speaker Deborah Franklin, Florida Healthcare Association in support
10:19:50 AM Speaker Steve Bahmer, LeadingAge Florida in support
10:21:40 AM Speaker Shantia Carter in support
10:23:20 AM Speaker Jessa Collins, Edgewood Nursing Center in support
10:25:27 AM Speaker Ken Kniepmann, Florida Conference of Catholic Bishops in support
10:27:36 AM Comments from Chair Diaz
10:27:49 AM Senator Farmer in debate
10:32:08 AM Senator Cruz in debate
10:38:47 AM Senator Jones in debate
10:41:03 AM Senator Bean in closure
10:42:00 AM Roll call by CAA
10:43:00 AM CS/SB 1132 reported favorably
10:43:26 AM Introduction of Tab 1, CS/SB 614 by Chair Diaz
10:43:41 AM Explanation of CS/SB 614, Assault or Battery on Hospital Personnel by Senator Rodriguez
10:44:28 AM Comments from Chair Diaz
10:44:35 AM Closure by Senator Rodriguez
10:44:43 AM Roll call by CAA
10:45:09 AM CS/SB 614 reported favorably
10:45:13 AM Introduction of Tab 2, SB 818 by Chair Diaz
10:45:20 AM Explanation of SB 818, Mental Health Professionals by Senator Burgess
10:47:13 AM Comments from Chair Diaz
10:47:36 AM Closure waived
10:47:41 AM Roll call by CAA
10:47:45 AM SB 818 reported favorably
10:47:59 AM Introduction of Tab 5, CS/SB 532 by Chair Diaz
10:48:11 AM Explanation of CS/SB 532, Workforce Education by Senator Burgess
10:49:37 AM Comments from Chair Diaz
10:50:04 AM Closure waived
10:50:06 AM Roll call by CAA
10:50:10 AM CS/SB 532 reported favorably
10:50:31 AM Introduction of Tab 7, SB 716 by Chair Diaz
10:50:56 AM Explanation of SB 716, Consent for Pelvis Examinations by Senator Book
10:51:30 AM Introduction of Amendment Barcode 762882 by Chair Diaz
10:51:44 AM Explanation of Amendment by Senator Book
10:51:53 AM Comments from Chair Diaz
10:52:05 AM Amendment adopted
10:52:08 AM Comments from Chair Diaz
10:52:14 AM Steve Winn, Florida Osteopathic Medical Association waives in support
10:52:21 AM Barbara DeVane, FL NOW waives in support
10:52:25 AM Chris Nuland, Florida Gastroenterologic Society waives in support
10:52:49 AM Chris Nuland, Florida Gastroenterologic Society in support
10:53:01 AM Jared Willis, Nemours Children's Hospital waives in support
10:53:16 AM Speaker Jan Gorrie, Council of Medical School Deans in support
10:53:40 AM Speaker Jason Rodriguez, BayCare in support
10:53:54 AM Comments from Chair Diaz
10:53:58 AM Closure waived
10:54:01 AM Roll call by CAA
10:54:05 AM CS/SB 716 reported favorably
10:54:20 AM Introduction of Tab 3, SB 1142 by Chair Diaz
10:54:35 AM Explanation of SB 1142, Prohibited Acts by Health Care Practitioners, presented by Senator Brodeur on behalf of Senator Rodrigues
10:56:36 AM Introduction of Amendment Barcode 916046 by Chair Diaz
10:56:50 AM Explanation of Amendment by Senator Brodeur

10:57:02 AM Comments from Chair Diaz
10:57:08 AM Amendment adopted
10:57:12 AM Comments from Chair Diaz
10:57:22 AM Speaker Chris Lyon, Florida Association of Nurse Anesthetists in opposition
11:00:32 AM Speaker Chris Nuland, Florida Society of Plastic Surgeons in support
11:01:21 AM Comments from Chair Diaz
11:01:30 AM Senator Farmer in debate
11:02:59 AM Senator Cruz in debate
11:04:05 AM Comments from Chair Diaz
11:04:15 AM Senator Brodeur in closure
11:04:22 AM Roll call by CAA
11:04:42 AM CS/SB 1142 reported favorably
11:05:00 AM Comments from Chair Diaz
11:05:12 AM Senator Bean would like to be shown voting in the affirmative on SB 532
11:05:20 AM Senator Garcia would like to be shown voting in the affirmative on CS/SB 1442, SB 874, SB 852 and CS/SB 864
11:05:40 AM Senator Farmer would like to be shown voting in the affirmative on CS/SB 1442, SB 874, CS/SB 864
11:06:00 AM Senator Bean moves to adjourn
11:06:09 AM Meeting adjourned