HOUSE OF REPRESENTATIVES
FINAL BILL ANALYSIS

BILL #:	CS/CS/HB 1121	**FINAL HOUSE FLOOR ACTION:**	
SUBJECT/SHORT TITLE	Child Welfare	117 **Y's**	0 **N's**
SPONSOR(S):	Health & Human Services Committee; Children, Families & Seniors Subcommittee; Stevenson; Harrell and others	**GOVERNOR'S ACTION:**	Approved
COMPANION BILLS:	CS/SB 58; CS/CS/CS/SB 1044; CS/CS/HB 1183; SB 1400; CS/HB 7075		

SUMMARY ANALYSIS

CS/CS/HB 1121 passed the House on April 20, 2017. The bill was amended in the Senate on May 3, 2017, and was returned to the House on May 5, 2017. The House concurred in the Senate amendment and passed the bill as amended on May 5, 2017. The bill includes all of CS/HB 7075, CS/CS/HB 1183, and parts of CS/SB 58 and SB 1400.

CS/CS/HB 1121 makes multiple changes to statutes concerning the welfare of children. The bill:

- Changes the process that the Department of Children and Families (DCF) and the courts use to assess and order services for substance-exposed newborns and creates a pilot project for shared family care residential services to serve substance-exposed newborns;
- Changes the procedures the dependency court and DCF use to identify and locate prospective parents to require inquiry and search earlier in the dependency case;
- Requires an assessment to determine the best out-of-home placement that meets the needs of the child;
- Requires DCF to develop a statewide accountability system for providers of residential group care and to convene a workgroup on foster home quality;
- Allows DCF to use confidential abuse registry information and investigation records for residential group home employment screening;
- Permits hospitals and physician offices to release patient records to DCF for investigations;
- Requires DCF to develop a standard form for certain practitioners to certify unaccompanied homeless youth;
- Limits the use of state funds for salaries of administrative employees of community-based care lead agencies to 150 percent of the salary of the Secretary of DCF;
- Exempts Miami-Dade County from submitting the question of retention of its children's services council in the 2020 general election;
- Creates a pediatric cardiac technical advisory panel within the Agency for Health Care Administration (AHCA), to make recommendations on certain hospital rules;
- Requires a mental health receiving facility to initiate an involuntary examination of a minor within 12 hours of arrival;
- Creates a 12-member task force within DCF to make recommendations to reduce inappropriate involuntary examinations of minors; and
- Makes other changes to align statute with current practice.

The bill has indeterminate insignificant negative fiscal impacts on DCF, AHCA, Florida College System, and state universities that are able to be absorbed within current resources, and appropriates $250,000 from nonrecurring general revenue to DCF to implement the shared family care residential program pilot. The bill does not have a fiscal impact on local government.

The bill was approved by the Governor on June 23, 2017, ch. 2017-151, L.O.F., and will become effective on July 1, 2017.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Florida's Child Welfare System

Background

Chapter 39, F.S., creates Florida's child welfare system to protect children and prevent abuse, abandonment, and neglect.[1] The Department of Children and Families (DCF) Office of Child Welfare works in partnership with local communities and the courts to ensure the safety, timely permanency and well-being of children.

DCF's practice model is based on preserving and strengthening the child's family ties whenever possible, removing the child from his or her home only when his or her welfare and safety cannot be adequately safeguarded otherwise.[2] DCF contracts with community-based care lead agencies to coordinate case management and services for families within the dependency system.

Practice Model

DCF's child welfare practice model (model) standardizes the approach to risk assessment and decision making used to determine a child's safety.[3] The model seeks to achieve the goals of safety, permanency, and child and family well-being.[4] The model emphasizes parent engagement and empowerment as well as the training and support of child welfare professionals to assess child safety,[5] and emphasizes a family-centered practice with the goal of keeping children in their homes whenever possible.[6]

Community-Based Care Organizations and Services

DCF contracts for case management, out-of-home care, and related services with lead agencies, also known as community-based care organizations (CBCs). Using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.[7] DCF, through the CBCs, administers a system of care[8] for children with the goals of:

- Prevention of separation of children from their families;
- Intervention to allow children to remain safely in their own homes;
- Reunification of families who have had children removed from their care;
- Safety for children who are separated from their families;
- Well-being of children through emphasis on educational stability and timely health care;
- Achievement of permanency; and
- Effective transition to independence and self-sufficiency.

CBCs provide foster care and related services, including, but not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption.[9] A

[1] S. 39.001(8), F.S.
[2] S. 39.001(4), F.S.
[3] Department of Children and Families, *2013 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2013/page19.shtml (last accessed March 6, 2017).
[4] Department of Children and Families, *Florida's Child Welfare Practice Model*, available at: http://www.myflfamilies.com/service-programs/child-welfare/child-welfare-practice-model (last accessed March 7, 2017).
[5] Supra, FN 3.
[6] Department of Children and Families, *2012 Year in Review*, available at: http://www.dcf.state.fl.us/admin/publications/year-in-review/2012/page9.shtml (last accessed March 7, 2017).
[7] Community-Based Care, Department of Children and Families, accessible at http://www.myflfamilies.com/service-programs/community-based-care (last viewed February 12, 2016).
[8] S. 409.145(1), F.S.
[9] Id.

CBC must give priority to services that are evidence-based and trauma informed.[10] CBCs contract with a number of subcontractors for case management and direct care services to children and their families.[11] There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.[12]

Dependency Case Process

When child welfare necessitates that DCF remove a child from his or her home, a series of dependency court proceedings must occur to adjudicate the child dependent and place him or her in out-of-home care. If a child is unable to return home, other permanency options are explored, such as adoption. The dependency system judicial process is detailed in the chart below.

Proceeding	Description	Statute
Removal	The child's home is determined to be unsafe, and the child is removed	s. 39.401, F.S.
Shelter Hearing	A shelter hearing occurs within 24 hours after removal. The judge determines whether to keep the child out-of-home.	s. 39.401, F.S.
Petition for Dependency	A petition for dependency occurs within 21 days of the shelter hearing. This petition seeks to find the child dependent.	s. 39.501, F.S.
Arraignment Hearing and Shelter Review	An arraignment and shelter review occurs within 28 days of the shelter hearing. This allows the parent to admit, deny, or consent to the allegations within the petition for dependency and allows the court to review any shelter placement.	s. 39.506, F.S.
Dependency Adjudicatory Trial	An adjudicatory trial is held within 30 days of arraignment, to determine whether a child is dependent.	s. 39.507, F.S.
Disposition Hearing	Disposition occurs within 15 days of arraignment or 30 days of adjudication. The judge reviews and orders the case plan for the family and the appropriate placement of the child.	ss. 39. 506 and 39.521, F.S.
Judicial Review Hearings	The court must review the case plan and placement every 6 months, or upon motion of a party.	s. 39.701, F.S.
Petition for Termination of Parental Rights (TPR)	After 12 months, if DCF determines that reunification is no longer a viable goal, termination of parental rights is in the best interest of the child, and other requirements are met, a petition for TPR may be filed.	ss. 39.802, 39.8055, 39.806, and 39.810, F.S.
Advisory Hearing	This hearing is set as soon as possible after all parties have been served with the petition for TPR. The hearing allows the parent to admit, deny, or consent to the allegations within the petition for TPR.	s. 39.808, F.S.
TPR Adjudicatory Trial	An adjudicatory trial shall be set within 45 days after the advisory hearing. The judge determines whether to terminate parental rights to the child at this trial.	s. 39.809, F.S.

Throughout the dependency process, multiple child welfare stakeholders, including case managers, Guardians ad Litem, service providers, and the court monitor a child's well-being and safety.

[10] S. 409.988(3), F.S.
[11] Supra, FN 7.
[12] Community-Based Care Lead Agency Map, Department of Children and Families, available at: http://www.myflfamilies.com/service-programs/community-based-care/cbc-map (last accessed March 6, 2017).

Effect of the Bill – Child Welfare

CS/CS/HB 1121 makes multiple changes to the child welfare system to protect vulnerable children. The bill expedites permanency for children by making changes to the procedures DCF and the courts use to identify and locate prospective parents to require inquiry and search much earlier in the dependency case. The bill changes the process that DCF and the courts use to assess and order services for substance exposed newborns and children who enter households already under investigation or under the dependency court's jurisdiction to improve risk assessment. The bill also facilitates more participation by a child in his or her case planning, streamlines processes for child protective investigations, and aligns statute with current practice by moving away from using substantial compliance with a case plan as the standard to determine whether to place a child back in his or her home and instead using a Family Safety Assessment to determine whether conditions for return of the child are met and reunification can be safely achieved while the case plan is still ongoing. These changes are detailed in the analysis below.

Child Welfare – Paternity Determinations

Background

Current law defines "parent" as a woman who gives birth to a child and a man whose consent to the adoption[13] of the child would be required.[14] If a child has been legally adopted, the term "parent" means the adoptive mother or father of the child.[15] The term does not include an individual whose parental relationship to the child has been legally terminated, or a prospective parent.[16]

If the identity or location of a parent is unknown, the dependency court must conduct an inquiry to identify or locate that parent. This inquiry requirement is found in the sections of statute relating to dependency adjudication[17] and termination of parental rights (TPR),[18] but there is no requirement for this paternity inquiry during a shelter hearing. [19] In both sections where required, the court must inquire:[20]

- Whether the mother of the child was married at the probable time of conception of the child or at the time of birth of the child.
- Whether the mother was cohabiting with a male at the probable time of conception of the child.
- Whether the mother has received payments or promises of support with respect to the child or because of her pregnancy from a man who claims to be the father.
- Whether the mother has named any man as the father on the birth certificate of the child or in connection with applying for or receiving public assistance.
- Whether any man has acknowledged or claimed paternity of the child in a jurisdiction in which the mother resided at the time of or since conception of the child, or in which the child has resided or resides.

Current law requires a diligent search when the identity or location of a prospective parent is unknown. However, diligent search requirements under ss. 39.503(6) and 39.803(6) are not the same. A diligent search under s. 39.503(6), F.S., must include:

- A search of an electronic database designed for locating persons;
- Inquiries of all offices of program areas of DCF likely to have information about the parent or prospective parent;

[13] S. 63.062(1) F.S
[14] S. 39.01(49), F.S.
[15] Id.
[16] Id.
[17] S. 39.503, F.S.
[18] S. 39.803, F.S.
[19] S. 39.402(8), F.S.
[20] S. 39.503(1), F.S.

- Inquiries of other state and federal agencies likely to have information about the parent or prospective parent;
- Inquiries of appropriate utility and postal providers;
- A thorough search of at least one electronic database specifically designed for locating persons; and
- Inquiries of appropriate law enforcement agencies.

However, a diligent search under s. 39.803(6), F.S., does not require the search of an electronic database. In addition, a search of the Florida Putative Father Registry[21] is not currently required under either section.

If the court's inquiry and a subsequent diligent search identify a prospective parent, that person must be given the opportunity to become a party to the proceedings by completing a sworn affidavit of parenthood and filing it with the court or DCF.[22] A prospective parent who files a sworn affidavit of parenthood is considered a parent for all purposes under the statute unless the other parent contests the determination of parenthood.[23] When a prospective parent contests recognition as a parent, current law requires the dependency court to delay determination of maternity or paternity until a proceeding to determine parentage under ch. 742, F.S., is final. Proceedings under ch. 742, F.S., allow the court to establish paternity multiple ways, including an affidavit of acknowledgement of paternity and an administrative proceeding to establish paternity and child support by the Department of Revenue, pursuant to s. 409.256, F.S.[24]

Effect of the Bill – Paternity Determinations

The bill creates a definition of "legal father" to mean a man married to the mother at the time of conception or birth of the child, unless paternity has been otherwise determined by a court of competent jurisdiction. If no man was married to the mother at the time of birth or conception of the child, then "legal father" means a man named on the birth certificate of the child or determined to be the father of the child by a court order or by the Department of Revenue, pursuant to s. 409.256, F.S., in an administrative proceeding to establish paternity and child support. This change allows the dependency court to inquire and accept parentage determinations from other courts and processes without the delay of waiting on a separate proceeding, which will help expedite permanency for a child. The bill also revises the definition of "parent" to reflect this new language.

The bill requires the court, when conducting a paternity inquiry at adjudication of dependency and TPR, to do so under oath and to inquire whether a man is named on the birth certificate of the child or whether a man has been determined by a court order or administrative proceeding to be the father of the child. The bill also requires a trial court to conduct the same paternity inquiry under oath at the shelter hearing to determine the identity and location of the legal father. These changes will expedite permanency by requiring a paternity inquiry during the earliest step in the dependency process involving the court (the shelter hearing) and by including expanded instances of paternity determination to identify legal fathers sooner in the process.

The bill requires a search of the Florida Putative Father Registry when conducting a diligent search. The bill also aligns the various diligent search requirements in different sections of ch. 39, F.S. This requires a search of at least one electronic database, as well as the Florida Putative Father Registry, when conducting a diligent search for a prospective parent whose location or identity is unknown and

[21] A registry maintained within the Department of Health Office of Vital Statistics for unmarried biological fathers to register to preserve their right to notice and consent in the event of an adoption and file a notarized claim of paternity form to confirm their willingness and intent to support the child for whom paternity is claimed in accordance with state law; s. 63.054, F.S.; Florida Department of Health, *Putative Father Registry*, available at http://www.floridahealth.gov/certificates/certificates/birth/Putative_Father/index.html (last accessed May 18, 2017).
[22] S. 39.503(8), F.S.
[23] Id.
[24] S. 742.10, F.S.

specifies that DCF is the state agency administering Title IV-B and IV-E funds such that it shall be provided access to the federal and state locator services pursuant to federal law.[25] The bill also permits a trial court to proceed with a dependency case without further notice to any prospective parents if a diligent search fails to identify and locate them. The bill also allows the petition to terminate parental rights to proceed without requiring personal service and notice to that prospective parent.

The bill requires that, if there is not an identified legal father, notice of the petition for termination of parental rights must be provided to any prospective father that has been identified and located unless the prospective father executes, and the court accepts, an affidavit of non-paternity or a consent to termination of his parental rights.

These changes relating to paternity and diligent search will expedite permanency for children whose adoption or other permanency plans are delayed by the inability to identify or locate prospective parents by moving the initial inquiry of paternity to the start of the case and allowing more efficient procedures when DCF is unable to locate prospective parents.

Child Welfare – Supplemental Adjudication of Dependency

Background

Current law allows only one order of adjudication in a dependency case.[26] The order of adjudication establishes the legal status of the child as dependent and may be based on the conduct of one parent, both parents, or a legal custodian.[27] If the court holds a subsequent evidentiary hearing on allegations against the other parent, the court can supplement the adjudicatory order, the disposition order, and the case plan.[28] This supplemental order grants the court jurisdiction over the other parent and allows the court to order services for that parent.

In certain areas of the state,[29] based on a holding from the Fifth District Court of Appeal (DCA), [30] a child can be adjudicated dependent as to the first parent based upon evidence of *risk of harm* but cannot be adjudicated dependent as to the second parent unless *actual harm* is proven. The court held that a supplemental evidentiary hearing on dependency adjudication must address whether the parent had actually abused or neglected the child, not whether the child was at substantial risk of imminent abuse or neglect. [31]

In contrast, the Third DCA[32] rejected the Fifth DCA's reasoning and held that a court can supplement the adjudicatory order where a child is at substantial risk of abuse, abandonment, or neglect.[33] Without further guidance from the Legislature, or resolution by the Florida Supreme Court, these two cases create two different standards, depending on location, for what should be a consistent application of the law.

Effect of the Bill – Supplemental Adjudication of Dependency

The bill requires a court to determine whether each parent has engaged in conduct that places the child at substantial risk of imminent abuse, abandonment, or neglect. If an initial evidentiary hearing is conducted with only one parent present or having been served, the evidentiary hearing shall address the abuse, abandonment, or neglect alleged in the petition regardless of whether any of the allegations are made against the second parent.

[25] 42 U.S.C. s. 653(c)(4).
[26] S. 39.507(7)(a), F.S.
[27] Id.
[28] S. 39.507(7)(b), F.S.
[29] Including Circuits 5 (Hernando, Lake, Marion, Citrus, and Sumter), 7 (Flagler, Putnam, St. Johns, and Volusia), 9 (Orange and Osceola), and 18 (Brevard and Seminole).
[30] P.S. v. Department of Children and Families, 4 So. 3d 719 (Fla. 5th DCA 2009).
[31] Id.
[32] Including Miami-Dade and Monroe Counties.
[33] D.A. v. Department of Children & Family Services, 84 So. 3d 1136 (Fla. 3d DCA 2012).

The bill further clarifies that the petitioner is not required to show actual harm by the second parent in order for the court to make supplemental findings regarding the conduct of the second parent. This change, consistent with the Third DCA holding, will protect children by allowing risk of harm, the same standard required by the initial adjudication, by a second parent to be sufficient to supplement an order of adjudication and order services for the second parent.

Child Welfare – Safety Assessments for Children Born Into or Moving Into a Household

Background

DCF's current policy regarding new children in households with an active investigation or ongoing services requires the child protective investigator (CPI) or case manager to add any new child(ren) in a household to the child welfare case and assess the new child as part of the Family Functioning Assessment.[34] DCF requires an ongoing assessment as to how the parent will manage the care of the new child, the family conditions that led to the safety plan, how the birth of the child or addition of the child will affect those family conditions, and the new child's need for protection.[35] In the case of a child born into or entering a home with ongoing case management or judicial oversight, DCF must assess the family and plan services prior to the birth of the child. This must include an assessment for whether this new infant will be vulnerable to the identified danger in the home and what influences an infant will have on the management of the safety plan and whether the current level of intrusiveness is still appropriate.

Effect of the Bill – Safety Assessments

The bill requires DCF to add a child to a current investigation and assess that child's safety when he or she is born into or moves into a household with an active investigation. The bill also requires DCF to assess a child's safety and provide notice to the court if a child is born or moves into a family that is under the court's jurisdiction. DCF must complete an assessment of the family to determine how the addition of a child will impact family functioning at least 30 days before a child is expected to be born or move into a household. If the birth or addition will occur in fewer than 30 days, DCF must complete an assessment within 72 hours after learning of the pregnancy or potential addition. The assessment must be filed with the court. DCF is required to complete a progress update and file the progress update with the court once a child is born or moves into the household. The bill grants the court the discretion to hold a hearing on the progress update filed by DCF.

Additionally, the bill requires DCF to provide post-placement supervision for no less than 6 months in any home in which the child is reunified to align with the requirement that the dependency court maintain jurisdiction for 6 months after reunification.

Child Welfare – Conditions for Return of Children in Out-of-Home Care

Background

DCF began the transition in 2013 to a practice model that focused on child safety within the child's home and timely reunification for children removed from their homes when conditions allowed reunification with services.[36] In 2014, as part of a major effort to reform the child welfare system with SB 1666 (2014),[37] the Legislature required CPIs to implement an in-home safety plan whenever present or impending danger is identified within a home and a removal is not necessary,[38] and for

[34] Department of Children and Families, Proposed Bill Agency Analysis of 2017 "Pathway to Permanency", p. 3 (unpublished) (on file with Children, Families, & Seniors Subcommittee staff).
[35] Id.
[36] Supra, FN 3.
[37] Ch. 14-244, Laws of Fla.
[38] Ch. 14-244, Laws of Fla.; s. 39.301(9)(a)6., F.S.

cases with judicial oversight, required DCF to file all safety plans with the court.[39] In-home safety plans are required to be specific, sufficient, feasible and sustainable to ensure child safety while the child remains in the home.[40]

In addition to safety plans, DCF is required to file a predisposition study (PDS) with the court prior to the disposition hearing that details services that may have prevented removal or services that may be needed at the time of reunification.[41] The PDS does not specifically assess conditions for return or the potential use of an in-home safety plan to provide protections that would allow a child to be placed back in his or her home. DCF uses the Family Functioning Assessment as the PDS.

When determining whether to place a child back into his or her home or whether to move forward with another permanency option, the court uses the PDS and the case plan to determine whether a parent has achieved substantial compliance with the tasks ordered in the case plan to the extent that the safety, well-being, and the physical, mental and emotional health of the child is not endangered by the return of the child to the home.[42] Acceptable conditions for return with an in-home safety plan may occur much sooner than substantial compliance with a case plan, as substantial compliance with services may not occur until many months into the dependency case.

Effect of the Bill – Conditions for Return

This bill updates language to align with current practice and support the use and review of the Family Functioning Assessment and concurrent safety plan(s) by judges during the disposition hearing and judicial reviews so that a child may be reunited with his or her parent more quickly with the use of an in-home safety plan.

The bill removes reference to the term "predisposition study" and replaces it with "family functioning assessment." The bill requires that a written case plan and a family functioning assessment prepared by an authorized agent of DCF must be approved by the court. The bill requires DCF to file the case plan and the family functioning assessment with the court, serve a copy of the case plan on the parents of the child, and provide a copy of the case plan to the guardian ad litem program and to all other parties:

- Not less than 72 hours before the disposition hearing if the disposition hearing occurs on or after the 60th day after the child was placed in out-of-home care; or
- If the disposition hearing occurs before the 60th day after the child was placed in out-of-home care and a case plan has not been submitted, the case plan must be filed and served not less than 72 hours before the case plan acceptance hearing, which must occur within 30 days after the disposition hearing.

The bill updates what the family functioning assessment must contain, to include evidence and circumstances of maltreatment, active danger threats in the home, an assessment of adult functioning, an assessment of parenting practices, an assessment of child functioning, a safety analysis describing the capacity for an in-home safety plan, and conditions for return.

The bill allows the court to grant an exception to the requirement for a family functioning assessment to be filed upon finding that all of the family and child information required in the assessment is available in other documents filed with the court.

When determining whether a child should be reunified with a parent, the bill requires the court to determine whether the circumstances that caused the out-of-home placement have been remedied to the extent that the safety, well-being and physical, and mental and emotional health of the child are not

[39] Ch. 14-244, Laws of Fla.; s. 39.501(3)(a), F.S.
[40] S. 39.301(9)(a)6.a., F.S.
[41] S. 39.521(1), F.S.
[42] S. 39.522, F.S.

endangered by the return of the child with an in-home safety plan. This moves away from the lengthier standard of substantial compliance and allows faster reunification by allowing a child to be returned as soon as the cause of the out-of-home placement is addressed and the parent is able to be safely reunified with an in-home safety plan.

This bill also provides expanded judicial enforcement by allowing the court to issue an order to show cause to DCF as to why it should not return the child to the custody of the parents upon the presentation of evidence that the conditions for return of the child have been met.

The bill allows the dependency court to approve a case plan with the permanency goal of "maintain and strengthen" in the child's home by adding "maintain and strengthen" to the list of permanency options that a dependency court may order under s. 39.621(2), F.S.[43] This terminology is regularly used as a case plan goal but is not included in statute among the permanency goals the dependency court may order. This change aligns statute with current practice and DCF's practice model. The bill also revises the definition of "permanency goal" to remove provisions already in substantive law detailing what permanency goals the dependency court may order.

Child Welfare – Domestic Violence and Injunctions

Background

In the case of domestic violence, child protective investigators are required to implement a separate safety plan for the perpetrator of the domestic violence and must seek a protective injunction if the perpetrator is not the parent, guardian, or legal custodian of the child.[44] This injunction protects the child victims of domestic violence by allowing the court to order the perpetrator to:[45]

- Refrain from further abuse and domestic violence;
- Participate in treatment;
- Limit contact and communication with the child victim or other children in the home;
- Refrain from contact with the child;
- Require supervision of contact with the child;
- Vacate the home; and/or
- Comply with a safety plan.

There are instances where a perpetrator of domestic violence is unable to be located to receive or participate in a safety plan or receive service for an injunction. There are also instances where dependency proceedings and injunction proceedings regarding the same children are heard by different judges. This may require DCF to take the same witness testimony on two separate occasions in front of two separate judges, increasing the chance for differing court findings and results.

Effect of the Bill – Domestic Violence

The bill would require CPIs to implement a safety plan for the domestic violence perpetrator only if the CPI is able to locate the perpetrator. The bill would relieve CPIs of the requirement to seek an injunction if DCF intends to file a shelter or dependency petition. This shelter or dependency petition would protect a child victim of domestic violence, as a dependency court is able to order all of the same protections provided by an injunction once a shelter or dependency petition is filed. The bill allows the court, after DCF files an affidavit of diligent search regarding their inability to locate the alleged perpetrator, to issue an injunction based on the sworn petition and affidavits.

[43] Permanency options under s. 39.621(2), F.S., include reunification, adoption, permanent guardianship, permanent placement with a fit and willing relative, and placement in another planned permanent living arrangement.
[44] S. 39.301(9)(a), F.S.
[45] S. 39.504(4), F.S.

For cases with dependency court involvement, the bill requires the same judge to preside over both the dependency and the injunction proceeding and allow the court to consider a sworn petition, testimony, or an affidavit. HB 1121 also allows the court to hear all relevant and material evidence at the injunction hearing, including oral and written reports, to the extent of its probative value even though it would not be competent evidence at an adjudicatory hearing. These changes would align current procedure with the concept of the unified family court.[46]

Child Welfare – Case Planning

Background

Current law requires DCF to develop a case plan with input from all parties to the dependency case that details the problems being addressed as well as the goals, tasks, services, and responsibilities required to ameliorate the concerns of the state.[47] The case plan follows the child from the provision of voluntary services through dependency or termination of parental rights.[48] Once a child is found dependent, a judge reviews the case plan, and if the judge accepts the case plan as drafted, orders the case plan to be followed.[49]

Section 39.6011, F.S., details the development of the case plan and who must be involved, such as the parent, guardian ad litem, and if appropriate, the child. This section also details what must be in the case plan, such as descriptions of the identified problems, the permanency goal, timelines, and notice requirements.

Recent changes in federal law require children age 14 years and older to have the opportunity to participate in the development of their case plans.[50] However, the new federal language does not protect confidential information that might be shared at a case planning conference. There are currently no statutory safeguards in Florida law related to the confidentiality of information shared at a case planning conference.

Effect of the Bill – Case Planning

The bill allows DCF to discuss confidential information during the case planning conference in the presence of individuals who participate in the staffing and requires all individuals who participate in the staffing to maintain the confidentiality of all information shared.

Child Welfare – Termination of Parental Rights

Background

When a parent fails to remedy the family problems that brought a child into the dependency system, DCF may file a petition for termination of parental rights (TPR).[51] This step must be taken for a child to be adopted, as the legal ties to his or her parents must be severed before an adoption can take place. DCF has grounds to terminate a parent's rights if his or her conduct caused the child to be placed in out-of-home care in Florida on three or more occasions.[52] A child's prior placements in out-of-home care in a state other than Florida cannot serve as a basis for the termination of parental rights.

[46] In 2001, the Florida Supreme Court requested a steering committee to develop recommendations on the characteristics of a model family court. The steering committee emphasized the coordination and maximization of court resources in one unified family division to avoid conflicting decisions and minimize inconvenience to families. This coordination should include proceedings like dissolution of marriage, custody, child support, adoption, truancy, paternity, domestic violence, dependency, and adoptions; *See* In re: Report of the Family Court Steering Committee, 794 So. 2d 518 (Fla. 2001)("Family Courts IV").
[47] Ss. 39.6011 and 39.6012, F.S.
[48] S. 39.01(11), F.S.
[49] S. 39.521, F.S.
[50] 42 U.S.C. s. 675(1)(B).
[51] S. 39.8055, F.S.
[52] S. 39.806(1)(l), F.S.

While TPRs are usually filed against both parents, a single-parent TPR is permitted when certain grounds for termination are proven, such as incarceration, egregious conduct, and chronic substance abuse.[53] A single-parent TPR severs the legal relationship between one parent and his or her child, while maintaining the child's legal relationship with the other parent. Certain current TPR grounds which may be used to terminate both parents' rights, such as parental conduct that demonstrates that continued involvement with the child threatens the child's life, safety, well-being, or physical, mental, or emotional health,[54] and a conviction that requires the parent to register as a sexual predator,[55] may not be grounds in a single-parent termination.

Effect of the Bill – Termination of Parental Rights

The bill expands s. 39.806(1)(l) F.S., to establish a ground for termination of parental rights where on three or more occasions the child or another child of the parent has been placed in out-of-home care pursuant to the law of any state, territory, or jurisdiction of the United States that is substantially similar to Ch. 39, F.S. The bill also expands the grounds for a single-parent termination to include both conduct that demonstrates continued involvement threatens the child and a conviction that requires registration as a sexual predator. These changes will further protect and expedite permanency for children by expanding the grounds for two-parent and single-parent TPR.

Child Welfare – Services for Parents of Substance-Exposed Newborns

Background

Abuse of certain drugs during pregnancy creates adverse health effects in newborns termed Neonatal Abstinence Syndrome (NAS).[56] Newborns with NAS suffer from withdrawal symptoms such as tremors, abdominal pain, weight loss, sweating, incessant crying, rapid breathing, sleep disturbance and seizures.[57] The incidence of NAS has increased substantially in the past decade.[58]

In 2012 the Legislature created the Statewide Task Force on Prescription Drug Abuse and Newborns to begin addressing the growing problem of NAS.[59] The 15-member Task Force was composed of medical professionals, law enforcement, prevention experts and state legislators. This Task Force was charged to examine the scope of NAS in Florida, its long-term effects, the costs associated with caring for substance-exposed babies, and which drug prevention and intervention strategies work best with pregnant mothers.[60] The task force made multiple policy recommendations including education initiatives, drug screening initiatives for pregnant women, immunity provisions for pregnant women, and collaboration with communities and social welfare agencies.[61]

Dependency courts have wide discretion as to what case plan tasks and services in which a parent may be ordered to participate based on the particular case and facts.[62] This means a dependency court may choose not to order a substance abuse disorder assessment or compliance with treatment in some cases in which there is evidence of a parental substance abuse disorder.

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[53] S. 39.811(6), F.S.
[54] S. 39.806(1)(c), F.S.
[55] S. 39.806(1)(n), F.S.
[56] McQueen, K. and Murphy-Oikonen, J., *Neonatal Abstinence Syndrome*, The New England Journal of Medicine, Review Article, December 22, 2016, available at: http://www.nejm.org/doi/pdf/10.1056/NEJMra1600879 (last accessed March 10, 2017).
[57] Id.
[58] Id.
[59] Id.
[60] Id.
[61] Florida Office of the Attorney General, Statewide Task Force on Prescription Drug Abuse & Newborns, 2014 Progress Report, available at: http://myfloridalegal.com/webfiles.nsf/WF/RMAS-9GUKBJ/$file/Progress-Report-Online-2014.pdf (last accessed March 10, 2017).
[62] *See* s. 39.521, F.S.

Shared Family Care for Substance-Exposed Newborns

In Shared Family Care (SFC), parents and children are placed together in the home of a family who is trained to mentor and support the parents as they develop the skills and supports necessary to care for their children independently. SFC can also be used to prevent out-of-home placement, provide a safe environment for the reunification of a family that has been separated, or help parents consider other permanency options, including relinquishment of parental rights.[63]

SFC recognizes that many parents involved in the child welfare system do not intentionally harm their children but lack the skills and/or resources to adequately care for them. SFC addresses this issue by temporarily placing whole families in the homes of community mentors who, along with a team of professionals, help the families to gain the skills and resources they need to move toward self-sufficiency and adequately care for their children.[64]

As an alternative to traditional in-home and out-of-home child welfare services, SFC is based on the following premises:

- Families are more likely to become stable and self-sufficient if their basic needs are met and a mentor helps them to establish a positive network of community resources and support;
- By nurturing and "reparenting" parents, and modeling and teaching them appropriate parenting and home management skills, SFC helps parents better protect and care for their children and helps families interact in a healthier manner; and
- If SFC is successful at keeping families together and preventing subsequent out-of-home placements, the long-term cost of the program will be less than traditional foster care.[65]

Effect of the Bill – Substance-Exposed Newborns

The bill requires the court to order any parent whose actions relating to substance abuse have caused harm to a child, such as being born substance-exposed, to submit to a substance abuse disorder evaluation or assessment and participate and comply with treatment services identified by the assessment or evaluation. The bill also makes adjudication of a child as dependent based upon evidence of harm as defined in s. 39.01(30) (g), F.S.,[66] good cause for such order. This removes discretion from a dependency court to order substance abuse assessments and treatment in circumstances when an adjudication of dependency is based on harm caused by substance abuse. The bill also requires DCF to include an evaluation or assessment of substance abuse and compliance with substance abuse treatment services identified by the assessment or evaluation, as required case plan tasks.

Shared Family Care for Substance Exposed Newborns

The bill creates s. 409.16742, F.S., requiring DCF to establish a pilot program based on the shared family care model to serve substance exposed newborns and their families. The bill allows DCF to contract with either a community-based care lead agency or a private entity with the capacity to provide residential care that satisfies the requirements of the bill. DCF is required to specify services that should be available for newborns and their families through the pilot program.

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[63] Child Welfare Information Gateway, Shared Family Care, *available at*: https://www.childwelfare.gov/topics/supporting/support-services/familycare/. (last visited May 9, 2017).
[64] Price, A. and Wichterman, L., *Shared Family Care: Fostering the Whole Family to Promote Safety and Stability*, Journal of Family Social Work, Vol. 7(2) 2003.
[65] Id.
[66] Exposes a child to a controlled substance or alcohol. Exposure to a controlled substance or alcohol is established by:
1. A test, administered at birth, which indicated that the child's blood, urine, or meconium contained any amount of alcohol or a controlled substance or metabolites of such substances, the presence of which was not the result of medical treatment administered to the mother or the newborn infant; or
2. Evidence of extensive, abusive, and chronic use of a controlled substance or alcohol by a parent when the child is demonstrably adversely affected by such usage.

Child Welfare – Relative Caregiver Program

Background

Temporary Assistance for Needy Families (TANF)

Under the federal welfare reform legislation of 1996, the Temporary Assistance for Needy Families (TANF) program replaced the welfare programs known as Aid to Families with Dependent Children, the Job Opportunities and Basic Skills Training program, and the Emergency Assistance program. The law ended federal entitlement to assistance and instead created TANF as an annual block grant of federal funds to states, territories, and tribes. These funds cover benefits, administrative expenses, and services targeted to needy families. TANF became effective July 1, 1997, and was reauthorized in 2006 by the Deficit Reduction Act of 2005. Federal law requires states to submit a state plan, detailing the structure of the state's program, to the Social Security Administration for approval to receive TANF block grants to operate their individual programs.[67]

Florida's Temporary Cash Assistance Program

Florida's state plan creates the Temporary Cash Assistance (TCA) Program, administered by DCF, to provide cash assistance to families with children under the age of 18 (or under age 19[68] if full time secondary school students), that meet the technical, income, and asset requirements. The purpose of the TCA Program is to help families become self-supporting while allowing children to remain in their own homes. In November 2016, 12,517 adults and 65,855 children received TCA.[69]

Florida law specifies two categories of families who are eligible for TCA: those families that are work-eligible and may receive TCA for the full-family, and those families who are eligible to receive child-only TCA. The majority of cash assistance benefits are child-only or work-eligible cases where the adult is ineligible due to sanction for failure to meet TCA work requirements. In November 2016, 35,350 of the 47,204 families receiving TCA were child-only cases.[70] There are two types of child-only TCA:

- Where the child has not been adjudicated dependent, but is living with a relative,[71] or still resides with his or her custodial parent, but that parent is not eligible to receive TCA;[72] and
- The Relative Caregiver Program (RCP), where the child has been adjudicated dependent and has been placed with relatives by the dependency court. [73]

The intent of the RCP is to provide relative caregivers, who could not otherwise afford to take the child into their homes, a means to avoid exposing the child to the trauma of shelter or foster care. These relatives are eligible for a payment that is higher than the typical child-only TCA.

DCF ceases to provide child-only RCP benefits when the parent or step-parent resides in the home with the relative caregiver and the child. DCF terminates the benefits in this situation based on the requirement in s. 414.095(2)(a)5., F.S., that parents who live with their minor children be included in the eligibility determination and that households containing a parent be considered work-eligible households. This child-only eligibility requirement for the RCP is detailed in the federally approved

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[67] 42 U.S.C. s. 602.
[68] Parents, children, and minor siblings who live together must apply together. Additionally, pregnant women may also receive TCA, either in the third trimester of pregnancy if unable to work, or in the 9th month of pregnancy.
[69] Department of Children and Families, *Monthly Flash Report Caseload Data: November 2016*, available at: http://eww.dcf.state.fl.us/ess/reports/docs/flash2005.xls (last visited April 3, 2017).
[70] Supra, FN 69.
[71] Grandparents or other relatives receiving child-only payments are not subject to the TANF work requirement or the TANF time limit.
[72] Child-only families also include situations where a parent is receiving federal Supplemental Security Income (SSI) payments, situations where the parent is not a U.S. citizen and is ineligible for TCA due to their immigration status, and situations where the parent has been sanctioned for noncompliance with work requirements.
[73] S. 39.5085(2), F.S.; Rule 65C-28.008(2)(g), F.A.C.

TANF state plan.[74] Under rule 65C-28.008(2)(d), F.A.C., DCF terminates payments through the RCP if the parent is in the home for 30 consecutive days.[75] However, at least one court has ruled that caregivers may continue to receive the RCP benefits while the parent resides in the home, because the prohibition against the parent residing in the home is not in statute and DCF rules cannot be used to establish an eligibility guideline not included in the statute.[76] Court orders in such cases require DCF to make federally disallowed TANF payments, thereby violating the eligibility requirements for the RCP in Florida's approved state plan.

Effect of the Bill – Relative Caregiver Program

The bill places in statute a prohibition against RCP benefits being paid into a household in which a parent or stepparent of the dependent child lives. The bill maintains the possibility for payment if the relative or nonrelative caregiver is caring for both a minor parent and the minor parent's child. If ineligible for the RCP, the caregiver may still be eligible for other assistance programs.

This bill also clarifies that the program will be established, implemented and operated by rule as deemed necessary by DCF, and that DCF determines eligibility for the RCP.

Child Welfare – Extended Foster Care

Background

Previously, youth did not have the option to remain in foster care after their 18th birthday. In 2014, the Legislature provided foster youth the option to extend foster care until they turn 21, or 22 if the young adult has a disability.[77] Young adults are also eligible to receive financial assistance as they continue pursuing academic and career goals if enrolled in an eligible post-secondary institution.[78] In extended foster care, young adults continue to receive case management services and other supports to provide them with a sound platform for success as independent adults. While current law allows a young adult with a disability to remain in extended foster care until age 22 under s. 39.6251, F.S., the court's jurisdiction over that child only extends to age 21, under s. 39.013, F.S.

Transition Plans

During the 6-month period immediately after a dependent child reaches 17 years of age, DCF and the CBCs, in collaboration with the child, his or her caregiver, and any other person the child would like to include, must develop a transition plan.[79] These transition plans must address services, housing, health insurance, education, workforce support and employment services, and the maintenance of mentoring relationships and other personal supports.[80] The plan is designed to help transition a child in the dependency system to adulthood. A child's transition plan must be approved by the court "if a child is planning to leave care upon reaching 18 years of age . . . before the child leaves care".[81]

[74] Department of Children and Families, *Temporary Assistance for Needy Families State Plan Renewal*, October 1, 2014 – September 20, 2017, pg. 46, available at: http://www.dcf.state.fl.us/programs/access/docs/TANF-Plan.pdf (last accessed April 3, 2017).
[75] However, a relative may receive the RCP payment for a minor parent who is in his or her care, as well as for that minor parent's child, if both children have been adjudicated dependent and meet all other eligibility requirements.
[76] Fla. Dep't of Children & Families v. S.B., 176 So. 3d 283 (Fla. 3d DCA 2015); The trial court final order is part of a sealed dependency file.
[77] S. 39.6251, F.S.; The Department of Children and Families, *Extended Foster Care – My Future My Choice*, available at: http://www.myflfamilies.com/service-programs/independent-living/extended-foster-care (last accessed March 7, 2017).
[78] Id.
[79] S. 39.6035(1), F.S.
[80] Id.
[81] S. 39.6035(4), F.S.

Effect of the Bill – Extended Foster Care

The bill extends the jurisdiction of the dependency court over young adults with a disability until the age of 22, unless the young adult chooses to leave foster care. The bill updates the section of law detailing whom the court has jurisdiction over to align with the extended foster care statute.[82] The bill requires the court to approve a child's transition plan before the 18th birthday, regardless of whether the child is choosing to leave care at age 18. The bill also requires DCF to update the transition plan and attach it to the case plan before each judicial review. This change in transition plan procedure will ensure that a young adult's transition plan will be completed before his or her 18th birthday, regardless of the decision to leave care or stay in extended foster care. This will provide the court and other parties more time for input and planning.

Child Welfare – Out-of-Home Care Quality

Background

Out-of-Home Care

When a child protective investigator determines that in-home services are not enough to allow a child to safely remain in his or her home, the investigator removes the child from his or her home and places the child with a safe and appropriate temporary out-of-home placement, such as a family foster home or residential group care (RGC).

A family foster home is a licensed private residence in which children who are unattended by a parent or legal guardian are provided 24-hour care. Such homes include emergency shelter family homes and specialized foster homes for children with special needs.[83] Foster homes are inspected and licensed and foster parents go through an interview and screening process before being approved.[84]

Some children have extraordinary needs, such as multiple placement disruptions, mental or behavioral health problems, juvenile justice involvement, or disabilities, which may lead case managers to place them in RGC. The primary purpose of RGC is to provide a setting that addresses the unique needs of children and youth who require more intensive services than a family setting can provide.[85] RGC placements are licensed by DCF as residential child-caring agencies[86] that provide staffed 24-hour care for children in facilities maintained for that purpose, regardless of whether operated for profit or whether a fee is charged.[87] These include maternity homes, runaway shelters, group homes, and emergency shelters.[88] The two primary models of group care are the shift model, with staff working in shifts providing 24-hour supervision, and the family model, which has a house parent or parents that live with and are responsible for 24-hour care of children in the group home.[89]

By law, CBCs must assess any child that meets the following criteria for placement in RGC:

- The child is 11 or older;
- The child has been in licensed family foster care for six months or longer and removed from family foster care more than once; and

[82] S. 39.6251(5)(a), F.S.
[83] S. 409.175, F.S.
[84] Id.; Florida Department of Children and Families, *Fostering Definitions*, available at: http://www.myflfamilies.com/service-programs/foster-care/definitions (last accessed March 7, 2017).
[85] Office of Program Policy and Government Accountability, Research Memorandum, Florida's Residential Group Care Program for Children in the Child Welfare System (December 22, 2014) (on file with the Health and Human Services Committee).
[86] Id.
[87] S. 409.175, F.S.
[88] Id.
[89] Supra, at FN 85.

- The child has serious behavioral problems or has been determined to be without the options of either family reunification or adoption. [90]

In addition, the CBC must consider psychological evaluations, information provided by professionals with knowledge of the child, and the desires of the child concerning placement.[91] Children who do not meet the specified criteria may still be placed in RGC if it is determined that such placement is the most appropriate for the child.[92]

RGC placement can also serve as a treatment component of the children's mental and behavioral health care. [93] Children in RGC with behavioral health needs receive mental health, substance abuse, and support services that are provided through Medicaid-funded Behavioral Health Overlay Services.[94] Residential group homes also directly employ or contract with therapists and counselors to provide services within the group home setting.[95]

Research and Recommendations

The Florida Institute for Child Welfare (FICW) published a technical report titled "Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations" in July of 2015. This report looked at the current trends and evidence related to residential group care (RGC), finding that:

> "Although the appropriate use of RGC has been a subject of longstanding debate, most child welfare experts, including practitioners, researchers, and advocacy groups, acknowledge that for some youth involved in the child welfare system, high quality group care is an essential and even lifesaving intervention."[96]

Based on reviews of current trends and issues, findings from research, and reviews of recommendations proposed by child welfare experts and advocacy groups, the FICW made the following seven recommendations.[97]

1. Develop and implement a basic set of common quality standards for RGC.
2. Increase evaluation efforts to identify and support evidence-based RGC services.
3. Support RGC providers in strengthening efforts to engage families.
4. Explore innovative approaches, including those that are trauma-informed and relationship-based.
5. Increase efforts to identify and implement culturally competent practices that are supported by research.
6. Continue to build upon efforts to strengthen the child welfare workforce.
7. Explore flexible funding strategies that can help facilitate higher quality services and innovative uses of RGC that are consistent with systems of care principles.

The recommendations made by the FICW focus mainly on developing quality standards and implementing strategies to facilitate high quality services within RGC.

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[90] S. 39.523(1), F.S.
[91] Id.
[92] S. 39.523(4), F.S.
[93] Richard Barth, *Institutions vs. Foster Homes: The Empirical Base for the Second Century of Debate*. Chapel Hill, NC: University of North Carolina, School of Social Work, Jordan Institute for Families (June 17, 2002), available at: http://www.researchgate.net/publication/237273744_vs._Foster_Homes_The_Empirical_Base_for_a_Century_of_Action.
[94] Office of Program Policy and Government Accountability, Research Memorandum, Florida's Child Welfare System: Out-of Home Care (November. 12, 2015) (on file with the Children, Families, and Seniors Subcommittee).
[95] Id.
[96] Boel-Studt, S. M. (2015). *Improving the Quality of Residential Group Care: A Review of Current Trends, Empirical Evidence, and Recommendations* (Florida Institute for Child Welfare).
[97] Id.

Group Care Quality Standards Workgroup

In 2015, DCF and the Florida Coalition for Children (FCC) established the Group Care Quality Standards Workgroup (workgroup), with representation from group care providers, CBCs, and DCF. The workgroup reviewed standards-related literature to establish consensus and ensure high quality through group care standards.[98] The workgroup identified eight specific categories for quality standards with 251 distinct quality standards for residential group care.[99] Building on this work, DCF, in collaboration with the FICW and in consultation with other child welfare stakeholders such as the workgroup, the FCC, and child advocates, began the Quality Standards for Group Care Initiative, which consists of 6 project phases:[100]

1. Development of core quality standards.
2. Development of a quality assessment tool.
3. Pilot test of the quality assessment tool.
4. Field test of the quality assessment tool.
5. Implementation of the quality assessment tool.
6. Validation of the quality assessment tool.

In September 2015, DCF reviewed and approved the core quality standards, completing phase 1.[101] The FICW developed a quality assessment tool shortly thereafter, completing phase 2.[102]

On October 31, 2016, a rating scale pilot (phase 3) was initiated in DCF's Central service region with 11 group homes.[103] Once the field test is completed in July 2017, the data will be analyzed and the quality assessment tool will be finalized. Statewide implementation (phase 5) is scheduled for September of 2017 with validation (phase 6) scheduled 1 and 2 years after that.[104]

Effect of the Bill – Out-of-Home Care Quality

Residential Group Care Quality

The bill requires DCF to develop, in collaboration with CBCs, service providers, and other community stakeholders, a statewide quality accountability system for providers of residential group care. The accountability system must promote high quality services and accommodations, differentiating between shift and family-style models and programs and services for children with specialized or extraordinary needs. The accountability system must include a quality measurement system with domains such as admissions, treatment planning, and living environment, and clearly defined levels of quality. The accountability system must consider the level of availability of trauma-informed care; mental health and physical health services; the level of engagement the provider has with the schools children in their care attend; and opportunities for children to be involved in extracurricular activities. The accountability system must be implemented by July 1, 2022.

DCF must also submit a report to the Governor, President of the Senate, and Speaker of the House of Representatives on October 1, 2017, and by October 1 of each year thereafter. The initial report must

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[98] Group Care Quality Standards Workgroup, *Quality Standards for Group Care*, Florida Department of Children and Families and the Florida Coalition for Children (2015), available at http://www.boystown.org/quality-care/Documents/quality-standards-for-residential-group-care.pdf (last accessed May 15, 2017).
[99] Id.
[100] Boel-Studt, S., et al., (2016). *Group Care Quality Standards Assessment: Pilot Test Orientation* [PowerPoint slides], available at http://centervideo.forest.usf.edu/video/center/groupcarequality/Group%20Care%20Quality%20Standards%20Assessment%20Presentation.pdf (last accessed May 15, 2017).
[101] Florida Institute of Child Welfare, Quality Standards for Residential Group Care, *A Pilot Test and Initial Validation of a Quality Rating Scale for Florida's Residential Group Homes*, available at: http://ficw.fsu.edu/technical-assistance-training/quality-standards-residential-group-care (last accessed March 11, 2017).
[102] Id.
[103] Id.
[104] Supra, FN 100.

include an update on implementation and a plan for implementation oversight. After the system's implementation, the report must include a description of the system, including measures and any tools developed; a description of how the information is being used by DCF and lead agencies; an assessment of placement of children in residential group care using data from the system; and recommendations to further improve quality in residential group care. The bill also grants DCF rulemaking authority to implement the accountability system.

The bill also allows DCF to use confidential abuse registry information and investigation records for residential group home employment screening, to align with foster home screening requirements. Currently, rule 65C-13.023 requires DCF to conduct a records check of abuse registry information for licensure of a family foster home and s. 39.202(2)(a)5., F.S., grants an exception to the confidentiality of reports and records related to child abuse and neglect investigations for the purpose of family foster home licensure. However, the law does not clearly authorize access to this information for group home employee employment screening.

Foster Home Quality

The bill requires DCF to convene a workgroup on increasing the number of high quality foster homes for out-of-home placement. The workgroup must identify measures of foster home quality, review current efforts by CBCs to enhance foster home quality, identify barriers to high-quality foster homes, and recommend strategies for assessing and increasing quality in foster homes. The bill requires the FICW to provide the workgroup with relevant research on foster homes and quality measures. The bill requires a report to the Governor and Legislature by November 15, 2017, that describes the important dimensions of quality for foster homes, current foster home quality enhancement efforts by CBCs, barriers to high-quality foster homes, and presents a plan for developing and implementing strategies to increase the availability of high-quality foster homes. This workgroup would start the process of assessing and increasing the quality of foster homes, aligning with the efforts of the Legislature to increase quality and accountability in the child welfare system, particularly in out-of-home placements.

Child Welfare – Permanent Guardianship

Background

When reunification with a parent or adoption is not in the best interest of the child as a permanency option, the dependency court may place the child in a permanent guardianship, if certain conditions are met.[105] Permanent guardianships are intended to be permanent placements while the legal parent-child relationship is maintained, including the child's inheritance rights, the parents' right to consent to a child's adoption, and the parents' responsibility to provide financial, medical, and other support to the child.[106] Once a case closes in permanent guardianship, the court terminates supervision of the case while maintaining jurisdiction.[107] The law is silent regarding a permanent guardian moving from his or her current geographical location.

In 2015, the Fourth DCA held that the provisions of s. 61.13001, F.S., which relate to parental relocation in dissolution of marriage or time-sharing cases, apply to permanent guardianship

[105] S. 39.6221, F.S. These conditions include:
- The child has been in the placement for not less than the preceding 6 months.
- The permanent guardian is suitable and able to provide a safe and permanent home for the child.
- The court determines that the child and the relative or other adult are not likely to need supervision or services of the department to ensure the stability of the permanent guardianship.
- The permanent guardian has made a commitment to provide for the child until the child reaches the age of majority and to prepare the child for adulthood and independence.
- The permanent guardian agrees to give notice of any change in his or her residential address or the residence of the child by filing a written document in the dependency file of the child with the clerk of the court.

[106] S. 39.6221(6), F.S.
[107] S. 39.6221(5), F.S.

placements.[108] As a result, if a permanent guardian in the Fourth District wishes to relocate more than 50 miles from his or her current residence, the guardian must either obtain the parents' agreement to the relocation or file with the circuit court a petition to relocate and potentially present his or her case at a hearing. Under limited circumstances, a parent may petition the court to reopen a case closed in permanent guardianship and request reunification. However, under Ch. 39, F.S., permanent guardians are not considered parties to the dependency case and are unable to file any pleadings.[109]

Effect of the Bill – Permanent Guardianship

The bill states that for any child placed in permanent guardianship under Ch. 39, F.S., the requirements of s. 61.13001, F.S., do not apply. This allows the permanent guardian of a child to move freely.

Child Welfare – CBC Administrative Compensation

Background

The Internal Revenue Code sets the rules governing compensation at public nonprofits, including those known as 501(c)(3) organizations, and specifies that no part of the net earnings of a section 501(c)(3) organization may inure to the benefit of any private shareholder or individual.[110] However, the IRS gives each nonprofit's board of directors latitude in determining how much to pay top employees. The IRS requires a nonprofit board to have an objective process for setting executive salaries, including use of comparisons with salaries paid by similar organizations for similar services. However, a nonprofit that normally pays no taxes may be taxed for paying excess benefits to an insider.[111]

In Florida, each CBC is required to post on its website the current budget for the lead agency, including salaries, bonuses, and other compensation paid, by position, for the agency's chief executive officer, chief financial officer, and chief operating officer, or their equivalents.[112] However, state law does not specify or limit their compensation. CBC Chief Executive Officer salaries charged to their CBC contracts range from $82,000 to $337,771.[113]

In 2015, during an operational audit of CBCs, the Auditor General found instances where salary payments, including bonuses, selected perquisites, and severance pay, or leave balances did not appear to be properly supported or calculated in accordance with established community-based care policy or state law.[114]

Effect of the Bill – Lead Agency Administrative Salary

The bill amends s. 409.992, F.S., to prohibit the use of state-appropriated funds to pay the salaries of administrative employees of lead agencies in amounts in excess of 150% of the salary of the secretary of DCF, or $210,000.[115] Three of 18 lead agencies pay their CEOs in excess of this amount.[116] To the

[108] T.B. v. Department of Children and Families, 189 So. 3d 150 (Fla. 4th DCA 2015).
[109] S. 39.01(51), F.S.; "party" means the parent or parents of the child, the petitioner, the department, the guardian ad litem or the representative of the guardian ad litem program when the program has been appointed, and the child.
[110] 26 U.S.C. s. 501. Exemption from tax on corporations, certain trusts, etc.
[111] Id.
[112] S. 409.988(1)(d), F.S.
[113] St. Johns County Government, *409.988 F.S. Compliance*, available at http://www.co.st-johns.fl.us/FIP/Organizational.aspx#.VsTdnZMrJTY (last accessed on May 15, 2017); Big Bend Community Based Care, *Budget*, available at http://www.bigbendcbc.org/About-Us/Financials/Budget (last accessed May 15, 2017).
[114] Office of the Auditor General, *Department of Children and Families and Selected Community-Based Care Lead Agencies Oversight of Foster Care and Related Service*. Report No. 2015-156, pg. 1 (March 2015).
[115] The base salary for the Secretary of DCF is $140,000; Florida Has a Right to Know, *State of Florida Employee Salaries*, available at http://salaries.myflorida.com/ (last accessed May 14, 2017).
[116] Big Bend Community Based Care - $337,771, available at http://www.bigbendcbc.org/About-Us/Financials/Budget; CBC of Central Florida - $222,138, available at http://www.cbccfl.org/wp-content/uploads/2014/02/CBCCF-Form-990-FY1516.pdf (pg. 7); and ChildNet Broward and Palm Beach Counties - $209,391 ($142,512 for Broward County and $66,879 for Palm Beach County), available at https://www.childnet.us/portal/performance-measures-scorecard.

degree that administrative salaries are paid in excess of $210,000 from state funds, CBCs may take actions such as replacing funding in excess of the limit by reallocating or raising funds that are not state-appropriated.

Other Child Welfare System Changes

Child Welfare Trainers

The bill defines a "child welfare trainer" as a person providing training for child welfare professionals earning certification and grants DCF rulemaking authority to implement the section, including creating requirements for child welfare trainers. The Joint Administrative Procedures Committee had previously indicated that DCF did not have sufficient rule authority to create such requirements.[117]

Release of Physician Records for Abuse Investigations

The bill permits hospitals licensed under Ch. 395, F.S. and physician's offices to release patient records to DCF to investigate cases of abuse, neglect, exploitation of children, or vulnerable adults or to provide services related to an investigation. DCF has reported that some providers have been hesitant to release these records without additional statutory authority.[118]

Repeal of Obsolete Sections of Law

The bill repeals obsolete sections of law related to residential group care, including provisions dealing with equitable reimbursement for group care services and reimbursement methodology and makes conforming cross reference changes based on the provisions of the bill.

Unaccompanied Homeless Youth

Background

Unaccompanied homeless youth are children, most often teenagers, experiencing homelessness while not in the physical custody of a parent or guardian. It is estimated that 1.6 to 1.7 million youth experience homelessness on their own each year, living in a variety of unsafe and temporary situations, including cars, parks, the homes of other people, shelters, and motels.[119] Most of these young people have left home due to severe dysfunction in their families, including abuse and neglect.[120] Studies have found that 20-40 percent of unaccompanied homeless youth were abused sexually in their homes, while 40-60 percent were abused physically. Over two-thirds of unaccompanied homeless youth report that at least one of their parents abuses drugs or alcohol. Other youth are thrown out of their homes because they are pregnant, gay or lesbian, or because their parents believe they are old enough to take care of themselves.[121]

In 2012, the Legislature enacted s. 743.067, F.S., to give unaccompanied homeless youth ages 16 and older the ability to request and receive their birth certificate from the state. Without a birth certificate, minors who are not in the physical custody of a parent or guardian cannot obtain other forms of identification, such as a Social Security card, driver's license or state identification card. Without such documentation, they face barriers that hinder their ability to recover from homelessness.

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[117] Letter from Jowanna N. Oates, Chief Attorney, Joint Administrative Procedures Committee, *RE: Department of Children and Families Rules 65C-33.001-.015* (July 23, 2015), (on file with Health and Human Services Committee staff).
[118] Email from Rachel Moscoso, Deputy Director of Legislative Affairs, Department of Children and Families, RE: Proposed Language to authorize medical record release by certain entities for investigation and provision of services (April 3, 2017).
[119] National Association for the Education of Homeless Children and Youth, Unaccompanied Homeless Youth, *available at*: http://www.naehcy.org/educational-resources/youth, (last visited May 8, 2017).
[120] Id.
[121] Id.

In 2014, the Legislature expanded the 2012 law to enable unaccompanied homeless youth to seek medical care for themselves or their children without parental consent.[122]

The law requires certain enumerated professionals, to include a homeless shelter director or school district's liaison for homeless children, to issue a written letter on official letterhead or stationary that the youth is an unaccompanied homeless youth pursuant to law. The letter must include the date of the finding, a citation to s. 743.067, F.S., and the signature of the individual making the finding. This letter may be used to petition a circuit court to have the disabilities of nonage removed, allowing the unaccompanied homeless youth to enter into certain contracts such as leases, insurance, and financial services; and consent to medical, dental, psychological, substance abuse, and surgical treatment.[123]

Continuum of Care Lead Agencies

The federal Continuum of Care (CoC) program awards federal money to lead agencies (state, local, and nonprofit providers) in the form of competitive Housing and Urban Development grants.[124] The program is designed to promote communitywide commitment to the goal of ending homelessness; provide funding for efforts by lead agencies to quickly rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness; promote access to and effect utilization of mainstream programs by homeless individuals and families; and optimize self-sufficiency among individuals and families experiencing homelessness.[125]

Fee Exemption for Homeless Students

Current law also allows students who lack fixed, regular, and adequate nighttime residence or whose primary nighttime residence meets certain criteria an exemption from tuition and fees at certain school districts, a Florida College System institution, or state university.[126]

Effect of Bill – Unaccompanied Homeless Youth

The bill requires DCF to develop a standard form to be used by certain enumerated professionals when certifying a youth as an unaccompanied homeless youth for purposes of s. 743.067, F.S. The bill also removes a clinical social worker and circuit judge from the list of professionals who may certify an unaccompanied homeless youth, while adding a Continuum of Care lead agency or its designee. This change standardizes the form used to identify unaccompanied homeless youth, and revises the statute to reflect those professionals that have contact with this population. The bill also allows a certified unaccompanied homeless youth to use the completed form to apply for an identification card at no charge pursuant to s. 322.051(9).

Fee Exemption for Homeless Students

The bill also specifies that students who live in public or private transitional living programs or who would otherwise meet the requirements of the fee exemption section, but for his or her residence in college or university dormitory housing, are eligible for fee exemption.

[122] S. 743.067(2), F.S.
[123] S. 743.067(3), F.S.
[124] HUD Exchange, *Continuum of Care Program*, available at: https://www.hudexchange.info/programs/coc/ (last accessed May 17, 2017).
[125] Id.
[126] S. 1009.25, F.S.

Special Taxing Districts for Children's Services

Background

In 1986, the Legislature authorized Florida counties to create children's services councils as countywide special districts to fund children's services. Counties may create independent special districts, for which the county governing body must seek voter approval to levy annual ad valorem property taxes, or dependent special districts, which are supported by appropriations and are authorized to accept grants and donations from public and private sources.[127]

Children's services councils may exercise the following powers and functions:

- Provide preventive, developmental, treatment, rehabilitative, and other services for children;
- Provide funds to other agencies that operate for the benefit of children, with the exception of the public school system;
- Collect data and conduct research to determine the needs of the children in the county;
- Coordinate with providers of children's services to prevent duplication of services; and
- Lease or buy necessary real estate, equipment and personal property.[128]

Eight counties currently have children's services councils organized as special districts: Brevard, Broward, Hillsborough, Martin, Miami-Dade, Okeechobee, Palm Beach, and St. Lucie.[129]

Section 125.901, F.S, requires the governing body of a county to submit to the electorate the question of retention or dissolution of a children's services council established as a special taxing district in a general election according to the following schedule:

- By 2014, for a district in existence on July 1, 2010, and serving a county having a population of 400,000 or fewer persons as of that date.
- By 2020, for a district in existence on July 1, 2010, and serving a county with a population of 2 million or more persons as of that date.[130]

The Children's Trust of Miami is the only council in a county having a population of 2 million or more. The trust was created in 2002 and was renewed by referendum in 2008.[131]

Effect of the Bill – Special Taxing Districts for Children's Services

The bill exempts the governing body of counties with a special taxing district in existence on July 1, 2010, and serving a county with a population of 2 million or more persons as of that date from submitting the question of retention or dissolution of the special district in the general election, if that question has been submitted voluntarily for a 2nd time since 2005. The Children's Trust of Miami in Miami-Dade County is the only children's services council to which this exemption would apply.

[127] Chapter 86-197, L.O.F.; s. 125.901(1), (7), F.S.
[128] Section 125.901(2), F.S.
[129] Florida Department of Economic Opportunity, Division of Community Development, *Official List of Special Districts Online*, available at: https://dca.deo.myflorida.com/fhcd/sdip/OfficialListdeo/criteria.cfm (last accessed April 20, 2017).
[130] Section 125.901(4), F.S.
[131] The Children's Trust of Miami-Dade County, *available at*: https://www.thechildrenstrust.org/about (last accessed April 20, 2017).

Involuntary Mental Health Examinations of Minors

Background

Mental Illness

Mental illness affects millions of people in the United States each year. Only about 17% of adults in the United States are considered to be in a state of optimal mental health.[132] One in five adults (43.8 million people) experiences mental illness in a given year, [133] and one in five children ages 13-18 have or will have a serious mental illness.[134] Half of all lifetime cases of mental illness begin by age 14, and scientists are discovering that changes in the body leading to mental illness may start much younger, before any symptoms appear.[135]

Baker Act

The Florida Mental Health Act, otherwise known as the Baker Act, was enacted in 1971 to revise the state's mental health commitment laws. [136] The Act provides legal procedures for mental health examination and treatment, including voluntary and involuntary examinations. It additionally protects the rights of all individuals examined or treated for mental illness in Florida.[137]

Individuals in an acute mental or behavioral health crisis may require emergency treatment to stabilize their condition. Emergency mental health examination and stabilization services may be provided on a voluntary or involuntary basis.[138] An involuntary examination is required if there is reason to believe that the person has a mental illness and because of his or her mental illness[139]:

- The person has refused voluntary examination after conscientious explanation and disclosure of the purpose of the examination or is unable to determine for himself or herself whether examination is necessary; **and**
- Without care or treatment, the person is likely to suffer from neglect or refuse to care for himself or herself; such neglect or refusal poses a real and present threat of substantial harm to his or her well-being; and it is not apparent that such harm may be avoided through the help of willing family members or friends or the provision of other services; **or**
- There is a substantial likelihood that without care or treatment the person will cause serious bodily harm to himself or herself or others in the near future, as evidenced by recent behavior.

Involuntary patients must be taken to either a public or a private facility that has been designated by DCF as a Baker Act receiving facility. The purpose of receiving facilities is to receive and hold or refer, as appropriate, involuntary patients under emergency conditions for mental health or substance abuse evaluation and to provide treatment or transportation to the appropriate service provider.[140] A public receiving facility is a facility that has contracted with a managing entity to provide mental health services to all persons, regardless of their ability to pay, and is receiving state funds for such

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[132] Id. Mental illness can range in severity from no or mild impairment to significantly disabling impairment. Serious mental illness is a mental disorder that has resulted in a functional impairment which substantially interferes with or limits one or more major life activities. National Institute of Mental Health, *Any Mental Illness (AMI) Among Adults*, available at http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml (last viewed on May 8, 2017).
[133] National Alliance on Mental Illness, *Mental Health Facts in America,* available at http://www.nami.org/NAMI/media/NAMI-Media/Infographics/GeneralMHFacts.pdf (last visited May 8, 2017).
[134] National Alliance on Mental Illness *Mental Health Facts: Children & Teens*, available at http://www.nami.org/NAMI/media/NAMI-Media/Infographics/Children-MH-Facts-NAMI.pdf (last visited May 8, 2017).
[135] National Institute of Mental Health, *Treatment of Children with Mental Illness*, (rev. 2009), available at https://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml (last visited May 9, 2017).
[136] SS. 394.451-394.47892, F.S.
[137] S. 394.459, F.S.
[138] SS. 394.4625 and 394.463, F.S.
[139] S. 394.463(1), F.S.
[140] S. 394.455(39), F.S. This term does not include a county jail.

purpose.[141] Funds appropriated for Baker Act services may only be used to pay for services to diagnostically and financially eligible persons, or those who are acutely ill, in need of mental health services, and the least able to pay.[142]

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding to provide services to individuals showing acute mental health disorders. CSUs screen, assess, and admit for stabilization individuals who voluntarily present themselves to the unit, as well as individuals who are brought to the unit on an involuntary basis.[143] CSUs provide patients with 24-hour observation, medication prescribed by a physician or psychiatrist, and other appropriate services.[144] The purpose of a crisis stabilization unit is to stabilize and redirect a client to the most appropriate and least restrictive community setting available, consistent with the client's needs.[145] Individuals often enter the public mental health system through CSUs.[146] For this reason, crisis services are a part of the comprehensive, integrated, community mental health and substance abuse services established by Legislature in the 1970s to ensure continuity of care for individuals.[147]

As of November 2015, there are 122 Baker Act receiving facilities in this state, including 53 public receiving facilities and 69 private receiving facilities.[148] Of the 53 public receiving facilities, 39 are also contracted to provide CSU services.[149]

Under the Baker Act, a receiving facility must examine an involuntary patient within 72 hours of arrival.[150] Within that 72-hour examination period, or if the 72 hours ends on a weekend or holiday, no later than the next business day, one of the following must happen:

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement will assume custody;
- The patient must be released for voluntary outpatient treatment;
- The patient, unless charged with a crime, must give express and informed consent to a placement as a voluntary patient and admitted as a voluntary patient; or
- A petition for involuntary placement must be filed in circuit court for involuntary outpatient or inpatient treatment.[151]

Receiving facilities must give prompt notice[152] of the whereabouts of a patient who is being involuntarily held for examination to the patient's guardian,[153] guardian advocate,[154] health care surrogate or proxy, attorney, or representative.[155] If the patient is a minor, the receiving facility must give prompt notice to the minor's parent, guardian, caregiver, or guardian advocate. Notice for an adult may be provided within 24 hours of arrival; however, notice for a minor must be provided immediately after the minor's arrival at the facility. The facility may delay the notification for a minor for up to 24 hours if it has

[141] S. 394.455(37), F.S
[142] Rule 65E-5.400(2), F.A.C.
[143] S. 394.875(1)(a), F.S.
[144] Id
[145] Id.
[146] Florida Senate, Budget Subcommittee on Health and Human Services Appropriations, *Crisis Stabilization Units*, (Interim Report 2012-109) (Sept. 2011), available at https://www.flsenate.gov/PublishedContent/Session/2012/InterimReports/2012-109bha.pdf (last visited May 8, 2017).
[147] Id.; SS.394.65-394.9085, F.S.
[148] Department of Children and Families, *Crisis Stabilization Services Utilization Data Implementation Status Report*, (Feb. 29, 2016), available at http://www.dcf.state.fl.us/programs/samh/publications/CSSUReport.pdf (last visited May 8, 2017).
[149] Id.
[150] S. 394.463(2)(g), F.S.
[151] Id.
[152] Notice may be provided in person or by telephone; however, in the case of a minor, notice may also be provided by other electronic means; s. 394.455(2), F.S.
[153] "Guardian" means the natural guardian of a minor, or a person appointed by a court to act on behalf of a ward's person if the ward is a minor or has been adjudicated incapacitated. Section 394.455(17), F.S.
[154] "Guardian advocate" means a person appointed by a court to make decisions regarding mental health treatment on behalf of a patient who has been found incompetent to consent to treatment. Section 394.455 (18), F.S.
[155] S. 394.4599(2)(b), F.S.

submitted a report to the DCF central abuse hotline. The receiving facility must attempt to notify the minor's parent, guardian, caregiver, or guardian advocate until it receives confirmation that the notice has been received. Attempts must be repeated at least once every hour during the first 12 hours after the minor's arrival and then once every 24 hours thereafter until confirmation is received, the minor is released, or a petition for involuntary services is filed with the court.[156]

There were 194,354 involuntary examinations initiated at hospitals and CSUs between July 1, 2015, and June 30, 2016. Of those, 32,475 involuntary examinations were initiated for individuals under the age of 18.[157]

Effect of the Bill – Involuntary Mental Health Examinations of Minors

The bill requires a receiving facility to initiate an involuntary examination under the Baker Act of a minor within 12 hours of arrival at the facility.

The bill creates a 12-member task force within DCF to address the issue of involuntary examinations of minors. The task force must:

- Analyze data on the initiation of involuntary examinations of children;
- Research the root causes of trends in such examinations;
- Identify and evaluate options for expediting examinations for children; and
- Identify recommendations for encouraging alternatives to these examinations.

The task force is comprised of stakeholders from the education, mental health, law enforcement, and legal fields. The bill authorizes the Secretary of DCF to add additional members, if appropriate. The task force must submit a report of its findings and recommendations to the Governor, the President of the Senate, and the Speaker of the House of Representatives by November 15, 2017.

Pediatric Cardiac Technical Advisory Panel

Background

Pediatric cardiac catheterization and pediatric open-heart surgery are subject to certificate of need (CON) review and approval prior to implementation of services pursuant to ss. 408.036(1) and 408.032(17), F.S. As conditions of CON approval, the Agency for Health Care Administration (AHCA) requires that:

- The program director for a pediatric cardiac catheterization program be board-eligible or board-certified in pediatric cardiology;[158]
- Pediatric cardiac catheterization programs be located in a hospital in which pediatric open-heart surgery is being performed;[159] and
- Pediatric open-heart surgery programs have at least one physician who is board-eligible or board-certified as a pediatric cardiac surgeon on the staff of a hospital.[160]

Licensure standards do not include pediatric cardiac service standards that exist within the CON process. There is no authority to maintain compliance with pediatric cardiology standards as a condition of licensure.[161]

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[156] S. 394.4599(c), F.S.
[157] Christy, A., et al., Baker Act Reporting Center, Louis de la Parte Florida Mental Health Institute, Department of Mental Health Law & Policy, University of South Florida, *Fiscal Year 2015/2016 Report Annual Report* (March 2017), available at http://www.usf.edu/cbcs/baker-act/documents/annual_report.pdf (last visited May 11, 2017).
[158] Rule 59C-1.032(5)(b)1., F.A.C.
[159] Rule 59C-1.032(6)(c), F.A.C.
[160] Rule 59C-1.003(5)(b), F.A.C.

Pediatric Cardiac Catheterization

Pediatric cardiac catheterization is a nonsurgical procedure used in infants, children, and teens to determine if there is a problem with the heart or repair a problem.[162] Cardiac catheterization in children is performed by inserting a catheter into an artery and vein, usually in the groin, and threading it through the bloodstream into the heart and its large blood vessels to measure pressures and blood oxygen levels and take X-rays of the heart and blood vessels. [163] Pediatric diagnostic cardiac catheterization is a test that's done to determine the exact details of a child's heart and how it functions.[164] An interventional catheterization is performed like a diagnostic catheterization and allows the pediatric cardiologist to perform procedures such as:

- Closure of abnormal connections inside and outside the heart;
- Closure of holes between upper or lower chambers of the heart;
- Closing off an abnormal blood vessel between the aorta and lung artery with a small coil or a special plug;
- Balloon angioplasty;[165]
- Balloon valvuloplasty;[166] and
- Stent implantation.

Pediatric Heart Surgery

Pediatric heart surgery may treat either congenital heart defects, which are heart diseases present at birth, or heart problems developed later in childhood, called acquired heart disease.[167] Surgery may be either open-heart or closed-heart.[168] In a closed-heart surgery, sometimes called a thoracotomy, an incision is made on the side of the chest, between the ribs.[169] In an open-heart surgery:

- An incision is made through sternum while the child is under general anesthesia;
- Tubes are used to re-route the blood through a special pump called a heart-lung bypass machine;[170]
- The heart is then stopped while the surgeon repairs the heart muscle itself, the heart valves, or the blood vessels outside the heart:;
- After the repair is done, the heart is started again, and the machine is removed;
- The breastbone and the skin incision are then closed.[171]

High Mortality Rate at St. Mary's Medical Center Pediatric Surgery Unit

In 2009 St. Mary's Medical Center in West Palm Beach was awarded a CON to operate a pediatric cardiovascular center.[172] Dr. Gerold Schiebler, a former director of Children's Medical Services (CMS),

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[161] Agency for Health Care Administration, Agency Analysis of 2017 SB 62, p. 2, (Nov. 30, 2016) (on file with Health and Human Services Committee staff).
[162] Nemours, *Cardiac Catheterization in Children,* https://www.nemours.org/service/medical/delaware-valley-pediatric-cardiac-center/treatment-and-testing/cardiac-catheterization-in-children.html?location=naidhc, (last visited on March 19, 2017).
[163] Id.
[164] Id.
[165] Id. In a balloon angioplasty a small balloon is inflated inside the blood vessel to stretch narrowed arteries and veins.
[166] Id. In a balloon valvulplasty a small balloon is used to stretch the opening of heart valves.
[167] Nemours, *Pediatric Cardiac Surgery,* https://www.nemours.org/service/medical/delaware-valley-pediatric-cardiac-center/treatment-and-testing/pediatric-cardiac-surgery.html (last visited May 9, 2017).
[168] U.S. National Library of Medicine, *Pediatric Heart Surgery*, https://medlineplus.gov/ency/article/007363.htm (last visited May 9, 2017).
[169] Id.
[170] This machine adds oxygen to the blood and keeps the blood warm and moving through the rest of the body while the surgeon is repairing the heart.
[171] Supra, FN 168.
[172] Letter from Dr. Gerold L. Schiebler to Mary Beth Vickers, Director, Division of CMS, Florida Department of Health, RE: Certificate of Need (CON) # 10055 awarded to Tenent St. Mary's Inc. for a Pediatric Open Heart Surgery Program (Jul. 12, 2103), available at https://assets.documentcloud.org/documents/2094703/gerold-schiebler-letter-to-cms.pdf (last visited May 9, 2017).

raised concerns about St. Mary's to the division's then director in 2013. Generally, he was concerned that St. Mary's was not working under the training and expertise of the University of Miami, which ran its own pediatric heart surgery program, which was initially a condition of CON but was later removed by AHCA. He also raised concerns about the low volume of pediatric open-heart surgeries St. Mary's performed.

In April 2014, the CMS Cardiac Technical Advisory Panel (CTAP)[173] visited St. Mary's to conduct a voluntary peer-review of the program and found many of the program's vital tests and services for children's hearts lacking.[174] The CTAP expressed concerns about the volume of cases, noting that "[t]he number of cardiac surgical procedures performed [at St. Mary's] seems to be too low for the institution and its staff to acquire and maintain proficiency in these types of challenging procedures," and reported that it was "common knowledge that multiple pediatric cardiac surgeons ... have expressed serious concern about babies having complex pediatric cardiac surgery [at] St. Mary's Medical Center." The CTAP recommended that St. Mary's not perform any heart surgeries on babies under 6 months of age and not perform any complex procedure on older children. DOH sent St. Mary's a copy of the CTAP review in June 2014.[175] Following the review by the CTAP, DOH told the CTAP that it had overstepped its authority in its site visits to hospital cardiac programs and in enforcing existing standards.

In June 2015, an investigation by CNN found that the mortality rate at St. Mary's pediatric open-heart surgery program was three times the national average in 2011-2013 with at least eight babies dying after having surgery in the hospital's program.[176] The program's mortality rate was 12.5 percent, as compared to the national average of 3.3 percent.[177] St. Mary's closed its pediatric cardiothoracic surgery program in August 2015.[178]

Children's Medical Services Cardiac Technical Advisory Panel

Children's Medical Services (CMS) is a group of programs that serve children with special health care needs under the supervision of the Department of Health (DOH). Within CMS, individual services or programs are designed to address specific conditions or family needs such as the newborn screening program, early intervention screenings, or its Medicaid managed care plan known as the CMS Plan. CMS is created under ch. 391, F.S.

The State Surgeon General also has authority under s. 391.223, F.S., to establish technical advisory panels to assist with the development of specific policies and procedures for the CMS program. On October 21, 2013, then State Surgeon General John Armstrong created the CMS Cardiac Technical Advisory Panel (CTAP) to provide both programmatic and technical advice to DOH and the CMS program.[179] The enabling document charged the CTAP with:

- Developing recommended standards for personnel and facilities rendering pediatric congenital cardiac services as well as heart disease;

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[173] The CTAP provided programmatic and technical advice about pediatric cardiac programs to DOH and the CMS program from 2013 through 2015. *See* pp. 9-10, *infra.*

[174] Letter from Dr. Celeste Philip, Deputy Secretary of Health, Florida Department of Health, to Davide Carbone, CEO, Palm Beach Children's Hospital, St. Mary's Medical Center, and Dr. Michael Black, Director of Pediatric Cardiovascular Surgery, Palm Beach Children's Hospital, St. Mary's Medical Center, RE: CMS Program Evaluation and Development Peer Review Palm Beach Children's Hospital (St, Mary's Hospital) (Jun. 26, 2014), available at https://assets.documentcloud.org/documents/2083890/program-evaluation-reviews.pdf (last visited May 9, 2017).

[175] Id.

[176] CNN, *Secret deaths: CNN finds high surgical death rate for children at a Florida hospital*, Jun. 15, 2015, http://www.cnn.com/2015/06/01/health/st-marys-medical-center/ (last visited May 9, 2017).

[177] Id.

[178] Palm Beach Post, *St. Mary's closes disparaged pediatric heart surgery program*, Aug. 17, 2015, http://www.mypalmbeachpost.com/news/local/mary-closes-disparaged-pediatric-heart-surgery-program/wfQsK6WOV48nnmigdwEioM/ (last visited May 9, 2017).

[179] Florida Department of Health, *Creation of the Children's Medical Services Cardiac Technical Advisory Panel,* (Oct. 2013), available at http://www.cmsctap.com/_files/documents/CTAP-Creation.pdf (last visited May 9, 2017).

- Developing recommendations for legislative initiatives, including appropriation items, related to the cardiac program and developing rules;
- Developing recommendations for statewide cardiac initiatives, including identifying panel members who will collaborate with other DOH councils or committees or state agencies;
- Assisting the AHCA, or as requested by individual hospitals, or as outlined in their individual contract with CMS, with the ongoing evaluation and development of congenital cardiovascular programs;
- Giving priority status to weight control programs and their implementation in all pediatric cardiovascular centers and clinics; and
- Developing recommendations to the DOH and the AHCA for congenital heart disease quality improvement to improve patient care and health and decrease the cost of care.[180]

The CTAP is non-operational; its last meeting was October 30, 2015.[181]

Advisory Councils

Chapter 20, F.S., authorizes the creation of a number of different types of entities to assist state government in the efficient performance of its duties and functions. Under s. 20.03(7), F.S., a "council" or "advisory council" is defined as an advisory body created by statute to study problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives.

Advisory bodies, commissions, and boards may only be created by statute in furtherance of a public purpose and must meet a statutorily defined purpose.[182] The Legislature must terminate these advisory bodies, commissions, and boards once they notify the Legislature that they are no longer necessary or beneficial to the furtherance of a public purpose.[183] The advisory bodies, commissions, and boards are required to keep Legislature and the public informed of their numbers, purposes, memberships, activities, and expenses.[184]

Effect of the Bill – Pediatric Cardiac Technical Advisory Panel

The bill requires AHCA to adopt rules for pediatric cardiac catheterization programs and pediatric open-heart surgery programs which, at a minimum, must establish:

- Outcome standards specifying expected levels of performance in pediatric cardiac programs, using a risk adjustment procedure that accounts for the variations in severity and case mix. Such standards may include, but are not limited to, in-hospital mortality, infection rates, nonfatal myocardial infarctions, length of postoperative bleeds, and returns to surgery; and
- Specific steps to be taken by the agency and licensed facilities that do not meet the outcome standards within specified time periods, including time periods for detailed case reviews and development and implementation of corrective action plans.

The bill creates a Pediatric Cardiac Technical Advisory Panel to develop procedures and standards for measuring outcomes for certain pediatric cardiac programs and directs AHCA to base the pediatric cardiac program rules on the panel's recommendations. The panel must include three at-large members appointed by the Secretary of AHCA who meet certain criteria, including one cardiologist who is board-certified in caring for adults with congenital heart disease, two board-certified pediatric cardiologists, and 10 members, each of whom is a pediatric cardiologist or a pediatric cardiovascular

[180] Id.
[181] Department of Health, Agency Analysis of 2017 SB 62, p. 2 (Jan. 17, 2017) (on file with Health and Human Services Committee staff).
[182] S. 20.052, F.S.
[183] S. 20.052(2), F.S.
[184] S. 20.052(3), F.S.

surgeon, from the following pediatric cardiac centers:

- Johns Hopkins All Children's Hospital in St. Petersburg;
- Arnold Palmer Hospital for Children in Orlando;
- Joe DiMaggio Children's Hospital in Hollywood;
- Nicklaus Children's Hospital in Miami;
- St. Joseph's Children's Hospital in Tampa;
- University of Florida Health Shands Hospital in Gainesville;
- University of Miami, Holtz Children's Hospital in Miami;
- Wolfson Children's Hospital in Jacksonville;
- Florida Hospital for Children in Orlando; and
- Nemours Children's Hospital in Orlando.

The panel sunsets on July 1, 2022.

The bill provides an effective date of July 1, 2017, except for the bill's provisions regarding an out-of-home placement assessment, which are effective January 1, 2018.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   None.

2. Expenditures:

   Statewide Accountability System for Residential Group Care

   The bill has an indeterminate negative fiscal impact upon DCF and CBCs. The bill requires DCF, the CBCs, and other stakeholders to develop a statewide accountability system for providers of residential group care. The General Appropriations Act for Fiscal Year 2017-18 includes $18.0 million ($10.4 million nonrecurring) for CBC core service functions,[185] which could be applied towards this effort. The increased workload for DCF may be absorbed within existing resources since DCF is currently piloting a residential group care rating system with the Florida Institute for Child Welfare.

   Abuse Registry Checks for Residential Group Care Employee Screening

   The bill has an indeterminate negative fiscal impact on DCF to develop a process to perform these abuse registry checks. DCF estimates the increased workload can be absorbed by existing staff.

   Shared Family Care Residential Program Pilot

   The bill appropriates $250,000 in nonrecurring general revenue to DCF for the 2017-2018 fiscal year to implement the shared family care residential program pilot.

[185] S. 3, SB 2500 (2017), Family Safety and Preservation Services. Subject to the Governor's veto powers, the effective date of the General Appropriations Act is July 1, 2017.

Involuntary Mental Health Examination Task Force

The bill has an indeterminate insignificant negative fiscal impact on DCF for costs associated with the task force created in the bill. However, the bill directs DCF to use existing and available resources to administer and support the task force.

Pediatric Cardiac Technical Advisory Panel

The bill has an indeterminate insignificant negative fiscal impact on AHCA to staff the panel and to adopt and implement rules based on recommendations of the panel. This impact can be absorbed within existing resources.

Fee Exemption for Homeless Students

The bill has an indeterminate insignificant negative fiscal impact on the Florida College System and state universities. Both report that the increase in fee exemptions is likely insignificant and can be absorbed within existing resources.[186]

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Involuntary Mental Health Examination Task Force

The bill requires receiving facilities to initiate involuntary examinations of minors within 12 hours. Depending on an individual facility's staffing levels and the number of minors that require an involuntary examination, a receiving facility may incur increased costs to meet the bill's requirements.

D. FISCAL COMMENTS:

None.

[186] Email from Renee Fargason, Assistant Director of Public Policy and Advocacy, State University System of Florida Board of Governors, RE: SB1044 – s. 1009.25 Fee Exemption changes (April 4, 2017) (on file with Health and Human Services Committee staff); Email from Madeline Pumariega, Chancellor, Florida College System, Re. Fee Exemption Language from SB 1044 for homeless students in dorms (April 30, 2017) (on file with Health and Human Services Committee staff).