

HOUSE OF REPRESENTATIVES STAFF FINAL BILL ANALYSIS

BILL #: CS/CS/HB 607 Direct Care Workers

SPONSOR(S): Health & Human Services Committee and Health Quality Subcommittee, Pigman and others

TIED BILLS: HB 7017 **IDEN./SIM. BILLS:**

FINAL HOUSE FLOOR ACTION: 107 Y's

8 N's

GOVERNOR'S ACTION: Approved

SUMMARY ANALYSIS

CS/CS/HB 607 passed the House on March 6, 2020, as amended. The bill was amended in Senate on March 10, 2020, and returned to the House. The House concurred in the Senate amendment and subsequently passed the bill as amended on March 11, 2020.

Florida law requires advanced practice registered nurses (APRNs) to practice under a written supervisory protocol with a physician and only to the extent that the protocol allows. The bill authorizes APRNs who meet certain criteria to practice primary care or midwifery without physician supervision or a protocol. The bill also authorizes an advisory council comprised of physicians, APRNs, and the state Surgeon General to make recommendations to the Board of Nursing on the standards of practice for such APRNs. The bill subjects such APRNs to disciplinary action if they commit specified prohibited acts related to unethical and substandard business practices. An APRN engaging in autonomous practice must report adverse incidents to the Department of Health (DOH), which must review each report to determine whether the APRN is subject to disciplinary action.

The bill prohibits an insurer from requiring an insured to access care from an APRN engaging in autonomous practice rather than a physician.

The bill authorizes DOH to award up to \$15,000 per year under the Medical Education Reimbursement and Loan Repayment Program to APRNs engaging in autonomous practice and practicing primary care in a public health program or that serves Medicaid recipients and other low-income patients in a primary care shortage area.

The bill authorizes registered nurses to delegate certain tasks to a certified nursing assistant (CNA) or home health aide (HHA), including medication administration. The bill authorizes CNAs and HHAs to assist with preventive skin care, applying bandages, and nebulizer treatments. The bill authorizes the Agency for Health Care Administration (AHCA) to adopt rules training paid feeding assistants in nursing homes and prohibits facilities from counting paid feeding assistants toward minimum staffing standards.

The bill requires all licensed nursing homes, home health agencies, hospices, and homemaker and companion services providers to complete a workforce survey at each biennial licensure renewal.

The bill creates the Excellence in Home Health and Nurse Registry Excellence programs to award designations to home health agencies and nurse registries that meet certain criteria. The home health agency or nurse registry may use the respective designation in marketing materials until such time it no longer holds, or qualifies for, the designation.

The bill has significant negative fiscal impacts on DOH and AHCA, and makes appropriations to address those impacts (see Fiscal Analysis). The bill has no fiscal impact on local governments.

The bill was approved by the Governor on March 11, 2020, ch. 2020-9, L.O.F., and will become effective on July 1, 2020, except as otherwise provided.

I. SUBSTANTIVE INFORMATION

A. EFFECT OF CHANGES:

Present Situation

Health Care Workforce

Health Care Professional Shortage

The U.S. has a current health care provider shortage.¹ As of December 31, 2019, the U.S. Department of Health and Human Services has designated 7,655 Primary Medical Health Professional Shortage Areas (HPSAs) (requiring 14,392 additional primary care physicians to eliminate the shortage), 6,520 Dental HPSAs (requiring 10,258 additional dentists to eliminate the shortage), and 6,117 Mental Health HPSAs (requiring 6,335 additional psychiatrists to eliminate the shortage).²

This shortage is predicted to continue into the foreseeable future and will likely worsen with the aging and growth of the U.S. population³ and ongoing efforts to expand access.⁴ Aging populations create a disproportionately higher health care demand due to seniors having a higher per capita consumption of health care services than younger populations.⁵ Additionally, as more individuals qualify for health care benefits, there will necessarily be greater demand for more health care professionals to provide these services.

Florida is not immune to this national problem and also has a health care provider shortage itself. Florida has 735 HPSAs just for primary care, dental care, and mental health.⁶ It would take 1,608 primary care, 1,230 dental care, and 376 mental health practitioners to eliminate these shortage areas.⁷

Health Care Workforce Data

Physician Workforce

The Association of American Medical Colleges Center for Workforce Studies estimates that the U.S. will face a physician shortage of between 46,900 and 121,900 across all specialties by 2032.⁸ In 2018, there were 277.8 physicians⁹ actively practicing per 100,000 population in the U.S., ranging from a high of 449.5 in Massachusetts to a low of 191.3 in Mississippi.¹⁰ The states with the highest number of physicians per 100,000 population are concentrated in the northeastern states. Regarding primary care physicians, there were 92.5 per 100,000 population.¹¹

¹ U.S. Department of Health and Human Services, Health Resources and Services Administration, *Designated Health Professional Shortage Area Statistics, Fourth Quarter of Fiscal Year 2019 Designated HPSA Quarterly Summary*, (Dec. 31, 2019), available at <https://data.hrsa.gov/topics/health-workforce/shortage-areas> (last visited February 20, 2020). Click on "Designated HPSA Quarterly Summary" to access the report.

² Id.

³ There will be an increase in the U.S. population, estimated to grow from just over 323 million in 2016 to approximately 355 million in 2030, eventually reaching just under 405 million in 2060. See U.S. Census Bureau, *2017 National Populations Projections Tables* available at <https://www.census.gov/data/tables/2017/demo/popproj/2017-summary-tables.html> (last visited February 20, 2020). Click on "Table 1. Projected population size and births, deaths, and migration."

⁴ Association of American Medical Colleges, *The Complexities of Physician Supply and Demand: Projections from 2017 to 2032*, (April 2019), available at https://www.aamc.org/system/files/c/2/31-2019_update_-_the_complexities_of_physician_supply_and_demand_-_projections_from_2017-2032.pdf (last visited February 20, 2020).

⁵ Id.

⁶ *Supra* note 1.

⁷ Id.

⁸ *Supra* note 4.

⁹ These totals include allopathic and osteopathic physicians.

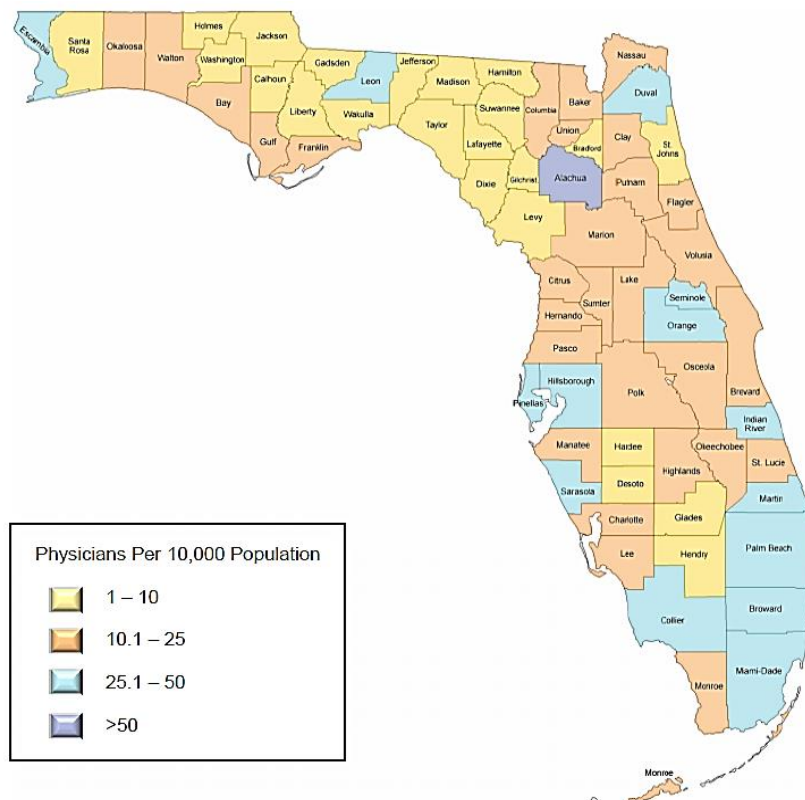
¹⁰ Association of American Medical Colleges, *2019 State Physician Workforce Data Book*, November 2019, pg. 5, available at <https://store.aamc.org/2019-state-physician-workforce-data-report.html> (last visited on February 21, 2020). The book must be downloaded to view its contents.

¹¹ Id.

Florida had 265.2 physicians actively providing direct patient care per 100,000 population in 2018.¹² Although Florida is the third most populous state in the nation,¹³ it ranks as having the 23rd highest physician to population ratio.¹⁴ In 2018, Florida had a ratio of 86.8 primary care physicians providing direct patient care per 100,000 population, ranking Florida 31st compared to other states.¹⁵

In its 2019 Physician Workforce Annual Report, the Department of Health (DOH) indicated that 12.5 percent of Florida's physicians reported that they were planning to retire within the next five years, which will exacerbate Florida's shortage of physicians.¹⁶ Additionally, 35 percent of practicing physicians are age 60 and older.¹⁷

The following map illustrates that not only does Florida have a shortage of physicians, but also there is a maldistribution of physicians and they are generally concentrated in urban areas.¹⁸



The U.S. is estimated to experience a primary care shortage of between 21,100 to 55,200 physicians by 2032.¹⁹ Currently, primary care physicians make up 28 percent of the physician workforce.²⁰ In 2018, 26 percent of new medical school graduates entered the workforce as primary care providers,

¹² *Supra* note 10, at pp. 7-8

¹³ As of July 1, 2017, the U.S. Census Bureau estimated Florida to have 21,299,325 residents, behind California (39,557,045) and Texas (28,701,845). U.S. Census Bureau, *Annual Estimates of the Resident Population: April 1, 2010 to July 1, 2018: 2018 Population Estimates*, available at: https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020).

¹⁴ *Supra* note 10, at pp. 7-8.

¹⁵ *Supra* note 10, at pp. 12-13.

¹⁶ Florida Department of Health, "2019 Physician Workforce Annual Report," (Nov. 2019), available at: <http://www.floridahealth.gov/provider-and-partner-resources/community-health-workers/physician-workforce-development-and-recruitment/2019DOHPhysicianWorkforceReport-10-30-19.pdf> (last visited on February 21, 2020).

¹⁷ *Id.* at p. 9.

¹⁸ *Id.* at p. 42.

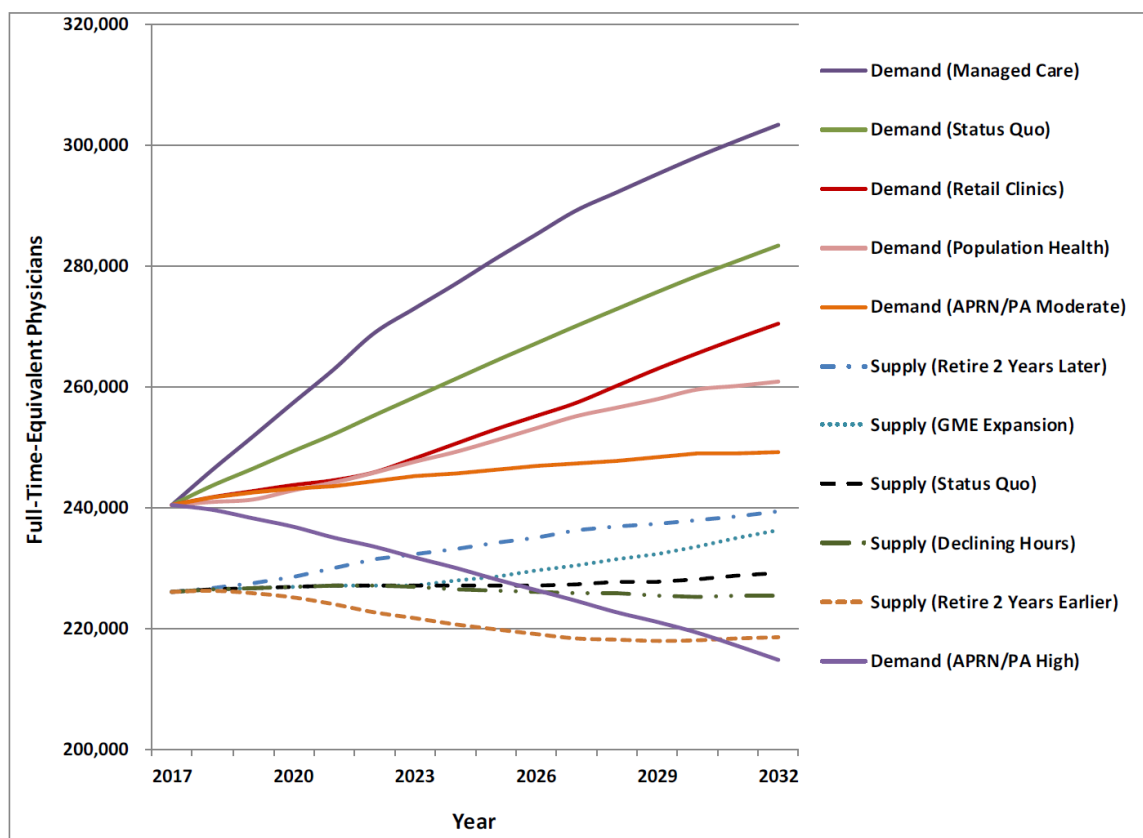
¹⁹ *Supra* note 4. Primary care consists of family medicine, general internal medicine, general pediatrics, and geriatric medicine.

²⁰ *Id.* at p. 45.

and this rate will maintain the status quo of the supply of primary care physicians.²¹ However, in almost any scenario, the projected supply and demand for primary care physicians demonstrate that demand will exceed supply except the scenario that reflects the highest use of APRNs and PAs.²²

The table below compares the effects of a moderate increase in the use of APRNs and PAs, greater use of alternate settings such as retail clinics, delayed physician retirement, expansion in graduate medical education, and changes in payment and delivery system, on the supply and demand for primary care physicians.²³

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



In Florida, more than a third of the practicing physicians are primary care physicians (34.9 percent).²⁴ Of these, 14.2 percent of family medicine physicians and 11.0 percent of general internal medicine physicians have expressed an intention to retire in the next five years and approximately 4.5 percent and 4.4 percent, respectively, have expressed an intention to relocate out of the state in the next five years.²⁵

Nurse Workforce

In 2018, there were approximately 189,100 certified nurse practitioners (CNPs), 45,000 certified registered nurse anesthetists (CRNAs), 6,500 certified nurse midwives (CNMs), and 3,059,800

²¹ Id. at p. 46.

²² Id at p. 18.

²³ Id.

²⁴ *Supra* note 16 at p. 24. Primary care consists of internal medicine, family medicine, and pediatrics.

²⁵ Id at p. 25.

registered nurses (RNs) employed in the U.S.²⁶ There were approximately 58 CNPs, 13.8 CRNAs, 2 CNMs, and 935 RNs per 100,000 population in 2018.²⁷

There are 32,877 advanced practice registered nurses (APRNs) actively licensed to practice in Florida.²⁸ There are also 309,761 actively licensed registered nurses. Based on those figures, Florida has approximately the following number of nurses per 100,000 population: 156 APRNs and 1,469 RNs.²⁹ The Florida Center for Nursing (Center) estimates that in 2016 and 2017, the number of APRNs who were actually working was 22,795,³⁰ and the number of RNs who were actually working was 208,870.³¹ Using these numbers the figures are: 108 APRNs and 990 RNs per 100,000 population.

The Center also reports that approximately 45 percent of Florida's RNs³² and 39 percent of the state's APRNs³³ are 51 years old or older, meaning there will be a large sector of Florida's nursing workforce retiring in the near future.³⁴

Advanced Practice Registered Nurses

Florida Advanced Practice Registered Nurses

In Florida, an advanced practice registered nurse (APRN)³⁵ is licensed in one of four roles: a certified nurse practitioner (CNP), certified nurse midwife (CNM), clinical nurse specialist (CNS), or certified registered nurse anesthetist (CRNA).³⁶ As of November 2019, Florida has 27,261 CNPs, 5,423 CRNAs, 892 CNMs, and 162 CNSs.³⁷

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

²⁶ U.S. Department of Labor, Bureau of Labor Statistics, "Employment Projections," available at: <http://data.bls.gov/projections/occupationProj> (last visited on February 21, 2020).

²⁷ These ratios were calculated using the U.S. Census Bureau's total population estimate for 2018, which was 327,167,434, which is available at:

http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=PEP_2014_PEPANNRES&prodType=table (last visited on February 21, 2020) and the U.S. Bureau of Labor Statistics 2018 employment projections. Id.

²⁸ Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long Range Plan, Fiscal Year 2018-2019*, available at <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/annual-report-1819.pdf> (last visited February 21, 2020).

²⁹ These ratios were calculated using population estimates as of April 1, 2019 provided by the Florida Office of Economic & Demographic Research, which is 21,091,609, and available at: http://edr.state.fl.us/Content/population-demographics/data/2019_Pop_Estimates.pdf (last visited February 21, 2020).

³⁰ Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Advanced Registered Nurse Practitioners*, (June 2018), available at

https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1611&PortalId=0&TabId=151 (last visited on February 21, 2020).

³¹ Florida Center for Nursing, *Florida's 2016-2017 Workforce Supply Characteristics and Trends: Registered Nurses*, (June 2018), available at

https://www.flcenterfornursing.org/DesktopModules/Bring2mind/DMX/API/Entries/Download?Command=Core_Download&EntryId=1608&PortalId=0&TabId=151 (last visited on February 21, 2020).

³² *Supra* note 31. Of working RNs in this state, 25.4 percent are 51 to 60 years old and 20.1 percent are 61 or older.

³³ *Supra* note 30. Of working APRNs in this state, 22.6 percent are 51 to 60 years old and 16.7 percent are 61 or older.

³⁴ Florida Center for Nursing, Presentation on Florida's Nurse Workforce, January 23, 2019, available at [https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting Packets&FileName=hqs 1-23-19.pdf](https://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=3021&Session=2019&DocumentType=Meeting%20Packets&FileName=hqs%201-23-19.pdf) (last visited on November 20, 2019).

³⁵ Section 464.003(3), F.S.

³⁶ Section 464.012(4), F.S. In 2018, the Florida Legislature changed the occupational title from "Advanced Registered Nurse Practitioner" to "Advanced Practice Registered Nurse," and reclassified a CNS as a type of APRN (see ch. 2018-106, Laws of Fla.).

³⁷ Email correspondence from DOH dated November 25, 2019, on file with committee staff.

Section 464.003(2), F.S., defines the term “advanced or specialized nursing practice” to include, in addition to practices of professional nursing that registered nurses are authorized to perform, advanced-level nursing acts approved by the Board as appropriate for APRNs to perform by virtue of their post-basic specialized education, training, and experience. Advanced or specialized nursing acts may only be performed if authorized under a supervising physician’s protocol.³⁸ In addition to advanced or specialized nursing practices, APRNs are authorized to practice certain medical acts, as opposed to nursing acts, as authorized within the framework of an established supervisory physician’s protocol.³⁹

To be eligible to be licensed as an APRN, an applicant must be licensed as a registered nurse, have a master’s degree in a nursing clinical specialty area with preparation in specialized practitioner skills, and submit proof that the applicant holds a current national advanced practice certification from a board-approved nursing specialty board.⁴⁰ A nursing specialty board must:⁴¹

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

Pursuant to s. 456.048, F.S., all APRNs must carry malpractice insurance or demonstrate proof of financial responsibility. Any applicant for licensure must submit proof of coverage or financial responsibility within sixty days of licensure and prior to each biennial licensure renewal. The APRN must have professional liability coverage of at least \$100,000 per claim with a minimum annual aggregate of at least \$300,000 or an unexpired irrevocable letter of credit in the amount of at least \$100,000 per claim with a minimum aggregate availability of at least \$300,000 and which is payable to the APRN as beneficiary.⁴² By comparison, physicians must establish some method of financial responsibility with the same coverage amounts and can choose one of three options for doing so: malpractice insurance, an escrow account, or a letter of credit. However, physicians who agree to pay adverse judgments, up to certain statutory limits, are exempt from this requirement but must notify patients that they have chosen not to carry malpractice insurance.⁴³

Prior to 2016, the Board was authorized to establish a joint committee to identify and approve acts of medical diagnosis and treatment that APRNs may perform. The joint committee was comprised of physicians, APRNs, and the State Surgeon General or his or her designee. However, in 2016, the Legislature eliminated the joint committee and instead, authorized physicians and APRNs to determine the medical acts the APRN could perform within the supervisory protocol.⁴⁴

APRN Practice Autonomy

APRN practice autonomy varies by state. Generally, states align with four types of autonomy:⁴⁵

1. Independent, unsupervised nursing practice;
2. Transitory period in which an APRN is supervised by a physician or independent APRN prior to authority to engage in independent nursing practice;

³⁸ Section 464.012(3)-(4), F.S.

³⁹ Section 464.003, F.S., and s. 464.012, F.S.

⁴⁰ Section 464.012(1), F.S., and Rule 64B9-4.002, F.A.C.

⁴¹ Rule 64B9-4.002(3), F.A.C.

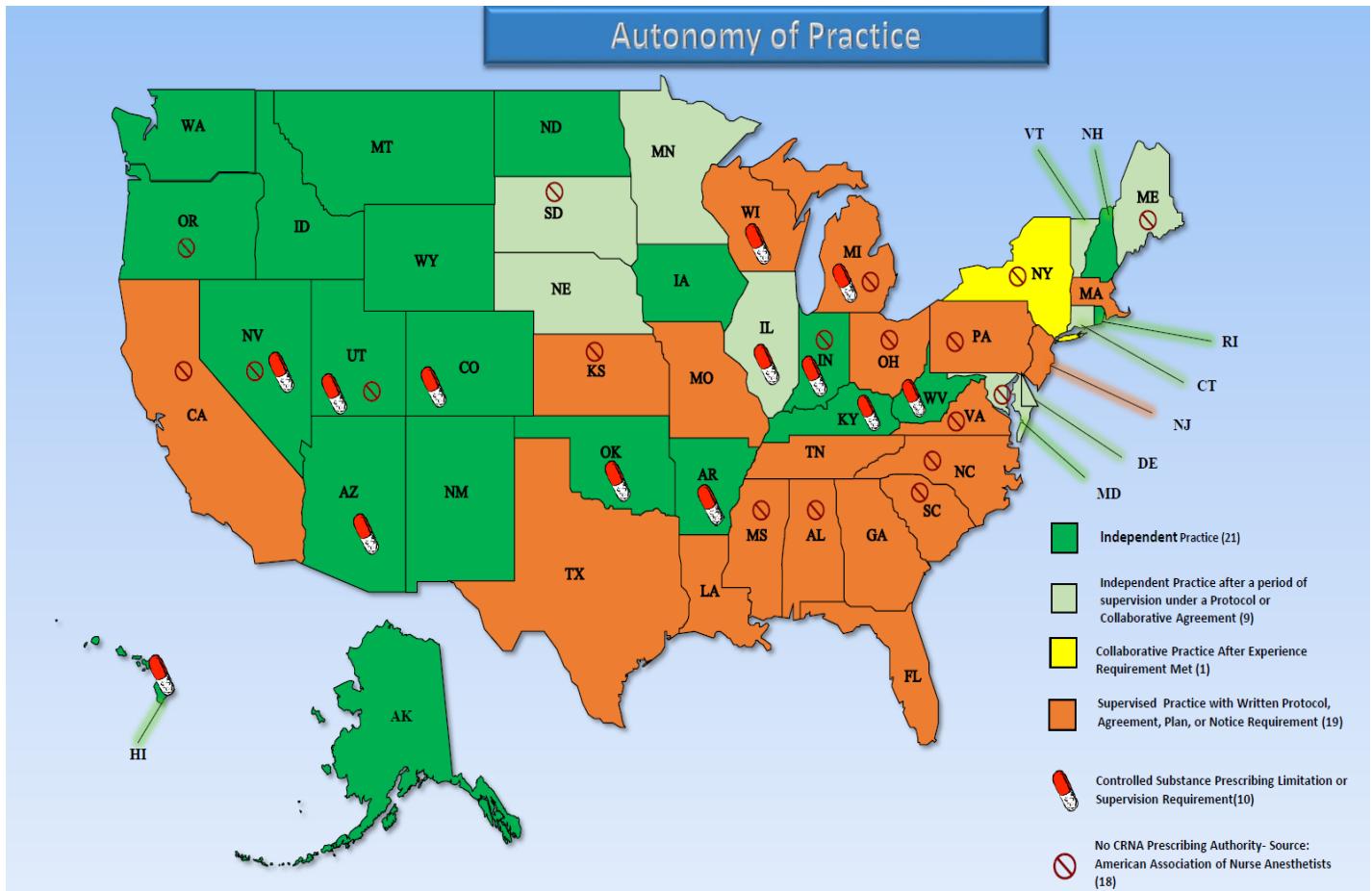
⁴² Rule 64B9-4.002, F.A.C. DOH Form DH-MQA 1186, 01/09. Licensees who practice exclusively for governments, practice only in conjunction with teaching, or have no malpractice exposure in Florida are exempt from the financial responsibility requirements.

⁴³ If allopathic and osteopathic physicians meet certain eligibility criteria and post signage at their medical office disclosing to the public that they do not carry medical malpractice insurance, they are exempt from medical malpractice or proof of financial responsibility requirements provided in ss. 458.320 and 459.0085, F.S., respectively.

⁴⁴ Chapter 2016-224, Laws of Fla.

⁴⁵ Findings based on research conducted by professional staff of the Health and Human Services Committee.

3. Collaborative nursing practice that requires physician collaboration without a specific requirement for a written agreement; or
4. Supervised nursing practice or prescribing that requires physician supervision with a written agreement, protocol, notice, or plan signed by the physician, who has discretion as to what practices are authorized, including controlled substance prescribing.



APRN Autonomy in Veterans Health Administration Facilities

The U.S. Department of Veterans Affairs (VA) adopted a rule in December 2016, which permits APRN full practice authority.⁴⁶ Under the rule, an APRN working within the scope of his or her VA employment is authorized to perform specified services within the scope of his or her training, education, and certification without the clinical oversight of a physician, regardless of state law restrictions. However, the rule expressly provides that the full practice of an APRN is subject to state law with regard to the prescribing or administration of controlled substances. The rule is limited to CNPs, CNMs, and CNSs, and does not apply to CRNAs. In Florida, 59 VA medical centers and health care clinics are affected by this policy change.⁴⁷

APRN Autonomy in Florida

⁴⁶ U.S. Department of Veterans Affairs, Office of Public and Intergovernmental Affairs, "VA Grants Full Practice Authority to Advanced Practice Registered Nurses," (December 14, 2016), available at <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847> (last visited February 21, 2020). The final rule can be found at <https://www.gpo.gov/fdsys/pkg/FR-2016-12-14/pdf/2016-29950.pdf> (last visited on February 21, 2020).

⁴⁷ U.S. Department of Veterans Affairs, Veterans Health Administration, "Locations: Florida," available at: <http://www.va.gov/directory/guide/state.asp?STATE=FL&dnum=1> (last visited February 21, 2020).

Florida is a supervisory state. Under s. 464.012(3), F.S., APRNs may perform only those nursing and medical practices delineated in a written physician protocol. A physician providing primary health care services may supervise APRNs in up to four medical offices,⁴⁸ in addition to the physician's primary practice location. If the physician provides specialty health care services, then only two medical offices in addition to the physician's primary practice location may be supervised.⁴⁹ Furthermore, a special limitation applies to dermatology services. If the physician offers services primarily related to dermatologic or skin care services (including aesthetic skin care services other than plastic surgery), at a medical office that is not the physician's primary practice location, then the physician may only supervise one medical office.⁵⁰

APRN Scope of Practice

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

Twenty of the 30 independent practice states authorize an APRN to prescribe controlled substances to a patient without physician supervision. Several independent practice states, such as Arkansas, Kentucky, Michigan, Oklahoma, and Wisconsin, require APRNs to enter into a collaboration or delegation agreement with a physician in order to prescribe controlled substances.⁵¹ In 2016, the legislature passed the "Barbara Lumpkin Prescribing Act" which authorizes APRNs in Florida to prescribe controlled substances beginning January 2017.⁵² The law maintained the existing supervisory structure and limited the prescribing authority for Schedule II substances,⁵³ as well as required continuing education related to controlled substances prescribing. Seventeen states prohibit CRNAs from prescribing drugs.⁵⁴ The map on p. 7 illustrates the varying controlled substance prescribing requirements throughout the U.S.

Thirty-nine states, including Florida, recognize APRNs as "primary care providers".⁵⁵ Recognizing APRNs as primary care providers assists them with being able to directly bill public or private payers for services provided, order certain tests, and establish independent primary care practices.⁵⁶ Insurers may be unwilling to contract directly with a provider who is supervised by another provider.

⁴⁸ The supervision limitations do not apply in certain facilities such as hospitals, colleges of medicine or nursing, nonprofit family-planning clinics, rural and federally qualified health centers, nursing homes, assisted living facilities, continuing care facilities, retirement communities, clinics providing anesthesia services, rural health clinics, community-based health care settings, student health care centers, school health clinics, or other government facilities. Sections 458.348(3)(e), and 459.025(3)(e), F.S.

⁴⁹ Sections 458.348, and 459.025, F.S.

⁵⁰ *Id.*

⁵¹ *Supra* note 45. The remaining states have some type of restriction or limitation on prescribing controlled substances regardless of supervision.

⁵² Chapter 2016-224, Laws of Fla.

⁵³ Pursuant to s. 893.03(2), a schedule II substance has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. In Florida, an APRN may only prescribe a 7-day supply of a schedule II controlled substance, except the limitation does not apply to certain psychiatric prescribing psychiatric medications. Section 456.42, F.S., limits the amount of schedule II opioids that may be prescribed for acute pain by any prescriber to a 3-day supply, with certain exceptions.

⁵⁴ *Supra* note 45.

⁵⁵ Scope of Practice Policy, *Nurse Practitioners: Nurse Practitioner as Primary Care Provider*, available at <http://scopeofpracticepolicy.org/practitioners/nurse-practitioners/> (last visited February 21, 2020). APRNs may practice as a primary care provider in states that do not specifically recognize them as such.

⁵⁶ Tine Hansen-Turton, BA, MGA, et. al., "Insurers' contracting policies on nurse practitioners as primary care providers: the current landscape and what needs to change," *POLICY, POLITICS & NURSING PRACTICE*, 7:3 (Aug. 2006), pp. 216-226.

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

- Prescribe, dispense, administer, or order any drug;⁵⁷;
- Initiate appropriate therapies for certain conditions;
- Perform additional functions as may be determined by Board rule;
- Order diagnostic tests and physical and occupational therapy; and
- Perform certain acts within his or her specialty.⁵⁸

APRNs in Florida are not authorized to sign certain documents; rather, Florida law requires them to be signed by a physician. For example, APRNs are not authorized to sign a certificate to initiate the involuntary examination of a person under the Baker Act, to sign for the release of persons in receiving facilities under the Baker Act, or to sign death certificates.⁵⁹

Reports and Studies Related to Advanced Practice Nurses

Patient Health Care Outcomes

Despite concerns that APRNs provide a different quality of care than physicians,⁶⁰ a multitude of reports and studies suggest treatment by an APRN is just as safe as treatment by a physician. In 2018, the Cochrane Collaboration updated a review of the findings of 25 articles comparing physician and APRN patient outcomes, which was first published in 2009. The review found that, in general, compared to primary care physicians, APRNs:⁶¹

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

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

Similar to the Cochrane review, the National Governors Association performed a review of various studies to determine whether there were differences in the quality of care provided by CNPs compared to physicians. The studies measured quality of care components such as patient satisfaction, time spent with patients, and prescribing accuracy. The review of those studies found that CNPs provided at least equal quality of care to patients as compared to physicians and, in fact, CNPs were found to have equal or higher patient satisfaction rates and tended to spend more time with patients during clinical visits.⁶²

⁵⁷ Controlled substances may only be prescribed or dispensed if the APRN has graduated from a program leading to a master's or doctoral degree in a clinical specialty area with training in specialized practitioner skills.

⁵⁸ Sections 464.012(3)-(4), and 464.003, F.S.

⁵⁹ Sections 394.463(2) and 382.008, F.S.

⁶⁰ When 972 clinicians, including 467 nurse practitioners and 505 physicians, were surveyed in a study as to whether physicians provide a higher quality of examination and consultation, the respondents were diametrically opposed. Approximately 66.1% of physicians agreed with the statement and 75.3% of nurse practitioners disagreed with the statement. Donelan, K., Sc.D., DesRoches, C., Dr. P.H., Dittus, R., M.D., M.P.H., and Buerhaus, P., R.N., Ph.D., "Perspectives of Physicians and Nurse Practitioners on Primary Care Practice," N. ENGL. J. MED. 2013, 368:1898-1906, available at <http://www.nejm.org/doi/full/10.1056/NEJMsa1212938> (last visited on February 21, 2020).

⁶¹ Laurant, M., et al., The Cochrane Collaboration, "Nurses as Substitute for Doctors in Primary Care," July 16, 2018, available at <https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD001271.pub3/full> (last visited on February 21, 2020).

⁶² National Governors Association, "The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care," December 2012, available at <http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf> (last visited on February 21, 2020).

A recent study of medically complex patients within the VA health care system found that patients of primary care APRNs and physician assistants (PAs) incurred lower outpatient, pharmacy, and total expenditures than patients of physicians.⁶³ This same study found that patients of APRNs and PAs also sought care at hospital emergency departments less frequently than patients of physicians. A 2013 study, found that allowing CNPs to practice and prescribe drugs without physician oversight leads to increased primary health care utilization and improvements in health outcomes.⁶⁴

Cost Savings

The rising cost of health care is a concern for individuals, families, businesses, government entities, and society as a whole. These rising costs will only be intensified by the increasing number of persons with health care coverage and the shortage of health care workers.⁶⁵

A 2012 Texas analysis of APRN practice concluded that more efficient use of APRNs in the provision of patient care, especially primary care, would improve patient outcomes, reduce overall health care costs, and increase access to health care.⁶⁶ The report estimated savings of \$16.1 billion in total expenditures and \$8 billion in output (gross product) each year.⁶⁷ Additionally, it was estimated that 97,205 permanent jobs would be added to Texas' workforce. Finally, the report estimated that Texas would receive additional tax receipts of up to \$483.9 million to the state and \$233.2 million to local government entities each year.⁶⁸

Another study found that states that allow APRNs to practice and prescribe without physician supervision experience 16-35% increases in health care utilization, increases in care quality, and reductions in inappropriate emergency room use.⁶⁹ The researchers concluded these advances were primarily due to elimination of supervision time (10%) and lower indirect costs (such as better appointment availability and lower patient travel costs).⁷⁰

Finally, a study found that individuals treated by primary care APRNs who were dually-eligible for Medicaid and Medicare had a lower risk of preventable hospitalizations and emergency department use than those cared for by primary care physicians.⁷¹ The study also found that primary care APRNs treating those with chronic illnesses received the same health care services consistent with established guidelines as those treated by primary care physicians.⁷²

The U.S. Federal Trade Commission (FTC) advocates for broader APRN scope of practice laws, including elimination of physician supervision requirements, as appropriate.⁷³ The FTC finds scope of practice restrictions anti-competitive, reduce competitive market pressures, increase out-of-pocket

⁶³ Perri A. Morgan, et. al. "Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients," *HEALTH AFFAIRS*, 38:6 (2019), available at <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2019.00014> (last visited February 21, 2020).

⁶⁴ Udalova, V., Traczynski, J., "Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes," May 4, 2014, available at http://www2.hawaii.edu/~jtraczyn/paperdraft_050414_ASHE.pdf (last visited on February 21, 2020).

⁶⁵ The Perryman Group, "The Economic Benefits of More Fully Utilizing Advanced Practice Registered Nurses in the Provision of Health Care in Texas," May 2012, available at <https://cdn.ymaws.com/www.texasnp.org/resource/resmgr/Advocacy/Perryman%20APRN%20Utilization%20Economic%20Impact%20Report%20May%202012.pdf> (last visited on February 21, 2020).

⁶⁶ *Id.*

⁶⁷ *Id.*

⁶⁸ *Id.*

⁶⁹ *Supra* note 64.

⁷⁰ *Id.*

⁷¹ Peter Buerhaus, American Enterprise Institute, *Nurse Practitioners: A Solution to America's Primary Care Crisis*, (Sept. 2018), available at <https://www.aei.org/research-products/report/nurse-practitioners-a-solution-to-americas-primary-care-crisis/> (last visited February 21, 2020).

⁷² *Id.*

⁷³ Federal Trade Commission, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, (Mar. 2014), available at <https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicy.pdf> (last visited February 21, 2020).

prices, limit service hours, and reduce the distribution of services.⁷⁴ The FTC poses that if such constraints were eliminated, not only would access to services be increased, but also there would be benefits to price competition that would help contain health care costs.⁷⁵

Medical Education Reimbursement and Loan Repayment Program

In 2002, the Legislature created the Medical Education Reimbursement and Loan Repayment Program (program) within DOH, to encourage health care professionals to practice in underserved areas where there are shortages of such personnel.⁷⁶ The program makes payments to offset loans and educational experiences incurred in nursing or medical studies or licensure. Health care professionals eligible to participate in the program include:⁷⁷

- Allopathic physicians with primary care specialties;
- Osteopathic physicians with primary care specialties;
- Physician assistants;
- Licensed practical nurses;
- Registered nurses; and
- Advanced practice registered nurses with primary care specialties such as certified nurse midwives.

As funds are available, DOH may award up to:⁷⁸

- \$4,000 per year to eligible licensed practical nurses and registered nurses;
- \$10,000 per year to eligible APRNs and physician assistants; and
- \$20,000 per year to eligible physicians.

The practitioner must provide proof of primary care practice in an underserved area designated by DOH or a rural hospital, and must accept Medicaid reimbursement.⁷⁹

The Legislature has never appropriated funds for the program.⁸⁰ Therefore, DOH has not made any disbursements.

Florida's Aging Population

In the U.S. in 2015, nearly 19 million people under the age of 65 and nearly 14 million people over the age of 65 reported that they had difficulty taking care of themselves or living independently.⁸¹

Florida ranks first in the nation in the percentage of residents who are age 65 or older.⁸² It is estimated that 20.5 percent of the state's population is over the age of 65.⁸³ Florida ranks fourth in the nation in the percentage of residents who are 60 and older,⁸⁴ and there are 21 counties in which residents aged 60 and older comprise at least 25 percent of the population.⁸⁵

⁷⁴ Id.

⁷⁵ Id.

⁷⁶ Section 1009.65(1), F.S.

⁷⁷ Id. Primary care specialties for physicians include obstetrics, gynecology, general and family practice, internal medicine, pediatrics, and other specialties identified by DOH.

⁷⁸ Section 1009.65(2), F.S.

⁷⁹ Id.

⁸⁰ E-mail correspondence with DOH, dated March 26, 2020, (on file with the Health Quality Subcommittee).

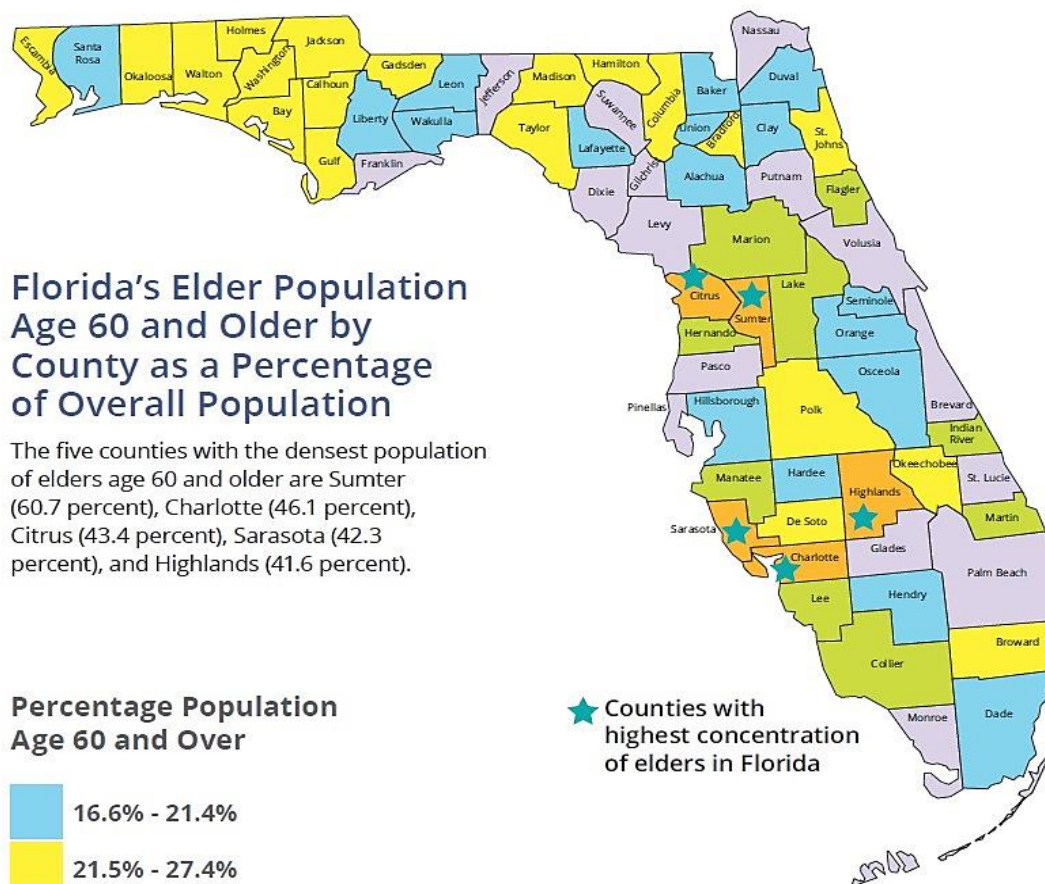
⁸¹ Paul Osterman, WHO WILL CARE FOR US: LONG-TERM CARE AND THE LONG-TERM CARE WORKFORCE 3 (2017).

⁸² Department of Elder Affairs, *2019 Summary of Programs and Services*, (Jan. 2019), available at http://elderaffairs.state.fl.us/doea/pubs/pubs/sops2019/2019_SOPS_A.pdf (last visited January 10, 2020).

⁸³ U.S. Census Bureau, *Quick Facts: Florida*, (July 1, 2019), available at <https://www.census.gov/quickfacts/FL> (last visited January 10, 2020). Florida's population is estimated to be 21,477,737.

⁸⁴ *Supra* note 1 at p. 8.

⁸⁵ Id.



Someone turning 65 today has almost a 70 percent chance of needing some type of long term care services and supports in their remaining years.⁸⁶ As Florida grays, individuals with disabilities who need assistance with activities of daily living, such as eating, grooming, and making meals, may also lose their caretakers. Direct care workers may provide such care and enable these individuals to remain in the community.

Direct Care Workers

Direct care workers assist older individuals and those with disabilities with daily tasks, such as dressing, bathing, and eating.⁸⁷ They work in many different settings, such as private homes, group homes, residential care facilities, assisted living facilities, skilled nursing facilities, and hospitals.⁸⁸

⁸⁶ U.S. Department of Health and Human Services, *How Much Care Will You Need?*, (last rev. Oct. 2017), available at <https://longtermcare.acl.gov/the-basics/how-much-care-will-you-need.html> (last visited January 20, 2020).

⁸⁷ Paraprofessional Healthcare Institute, *Understanding the Direct Care Workforce*, available at <https://phinational.org/policy-research/key-facts-faq/> (last visited January 20, 2020).

⁸⁸ Paraprofessional Healthcare Institute, *Direct Care Workforce 2018 Year in Review*, <https://phinational.org/resource/the-direct-care-workforce-year-in-review-2018/> (last visited January 14, 2020), and Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?* <https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf> (last visited January 14, 2020).

Direct care workers account for 70 to 80 percent of all paid hands-on long-term care and personal assistance for the elderly or disabled.⁸⁹

Florida Direct Care Workers

Nursing Assistants or Nursing Aides

Nursing assistants or nursing aides generally work in nursing homes, although some work in assisted living facilities, other community-based settings, or hospitals.⁹⁰ The Florida Board of Nursing, within the Department of Health, certifies nursing assistants (CNAs) who must, among other things, hold a high school diploma or equivalent, complete a 120-hour board-approved training program, and pass a nursing assistant competency exam, which includes written and practical portions.⁹¹ A CNA must biennially complete 24 hours of inservice training to maintain certification.⁹²

The Board of Nursing establishes the general scope of practice for CNAs. A CNA performs services under the general supervision⁹³ of a registered nurse or licensed practical nurse.⁹⁴ A CNA may perform the following services:⁹⁵

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

A CNA may not work independently and may not perform any tasks that require specialized nursing knowledge, judgment, or skills.⁹⁶

Home Health Aides

Home health aides (HHA) provide essentially the same care and services as nursing assistants, but they assist people in their homes or in community settings under the supervision of a nurse or a

⁸⁹ Id.

⁹⁰ Paraprofessional Healthcare Institute, *Who Are Direct-Care Workers?*, (Feb. 2011), available at <https://phinational.org/wp-content/uploads/legacy/clearinghouse/NCDCW%20Fact%20Sheet-1.pdf> (last visited January 14, 2020).

⁹¹ Section 464.203, F.S., and r. 64B9-15.006, F.A.C. Eighty hours must be classroom instruction and 40 hours must be clinical instruction, 20 of which must be in long term care clinical instruction in a licensed nursing home. 42 C.F.R. § 483.95 requires 75 hours of training; Florida training requirements exceed the federal minimum training requirements.

⁹² Section 464.203(7), F.S.

⁹³ Under general supervision, the registered nurse or licensed practical nurse does not need to be present but must be available for consultation and advice, either in person or by a communication device. Rule 64B9-15.001(5), F.A.C

⁹⁴ Rule 64B9-15.002, F.A.C.

⁹⁵ *Supra* note 94.

⁹⁶ *Supra* note 94.

physical, speech, occupational, or respiratory therapist.⁹⁷ In Florida, HHAs are not licensed or certified. However, the Agency for Health Care Administration (AHCA) licenses home health agencies and establishes training requirements for HHAs employed by home health agencies. A HHA must complete at least 75 hours of training and/or successfully pass a competency evaluation by the home health agency.⁹⁸ HHAs who work for a home health agency that is not certified by Medicare or Medicaid or who work for a nurse registry must complete 40 hours of training or pass an AHCA-developed competency examination.⁹⁹

AHCA establishes the scope of practice for HHAs performing services under a licensed home health agency. A HHA performs services delegated by and under the supervision of a registered nurse, which include:¹⁰⁰

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

A HHA may not change sterile dressings, irrigate body cavities, irrigate a colostomy or wound, perform gastric irrigation or enteral feeding, catheterize a patient, administer medication, apply heat by any method, care for a tracheotomy tube, or any other services that has not been included in the patient's plan of care.¹⁰¹

Personal Care Assistants

Personal care assistants (PCAs) work in either private or group homes.¹⁰² They have many titles, including personal care attendant, home care worker, homemaker/companion, and direct support professional.¹⁰³ (The latter work with people with intellectual and developmental disabilities). In addition to providing assistance with activities of daily living, they also help individuals go to work and remain engaged in their communities.¹⁰⁴ A growing number of these workers are employed and supervised directly by consumers.

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

⁹⁷ *Supra* note 90. If the only service the home health agency provides, is physical, speech, or occupational therapy, in addition to the home health aide or CNA services, the licensed therapist may provide supervision.

⁹⁸ Agency for Health Care Administration, *Home Health Aides*, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Lab_HomeServ/HHA/Home_health_aides.shtml (last visited January 20, 2020).

⁹⁹ Rules 59A-8.0095(5)

¹⁰⁰ *Id.*, and 64B9-15.002, F.A.C.

¹⁰¹ Rule 59A-8.0095(5)(p), F.A.C.

¹⁰² *Supra* note 90.

¹⁰³ *Id.*

¹⁰⁴ *Id.*

A PCA does not have a clearly defined scope of practice because it is not a regulated profession. However, the Florida Medicaid program defines personal care services as medically necessary assistance with activities of daily living to enable an individual to accomplish tasks they would normally be able to do for themselves if they did not have a medical condition or disability.¹⁰⁵ Florida Medicaid authorizes the following personal care services for Medicaid reimbursement:¹⁰⁶

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

Medication Administration and Assistance with Self-Administration

Medication Administration

Medication administration is to obtain and provide a single dose of a medication to a patient for his or her consumption.¹⁰⁷ Currently, neither CNAs nor HHAs may administer medication to a patient. However, the Medicaid home- and community-based services program for the developmentally disabled authorizes unlicensed direct care personnel who complete a 6-hour training course to administer medication to program clients.¹⁰⁸ Many other states authorize HHAs or CNAs who complete additional training to administer medication.¹⁰⁹ For example, Texas authorizes home health medication aides.¹¹⁰ Arizona, Georgia, Illinois, Minnesota, and North Arizona authorize CNAs to administer medication upon completion of specialized training.¹¹¹ Connecticut has a stand-alone medication administration technician profession.¹¹²

Assistance with Self-Administration

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

HHAs must complete two hours of training to assist with self-administration of medication.¹¹³ The training must include state law and rule requirements for assistance with self-administration of medication in the home, procedures for assisting the patient with self-administration, common medications, recognition of side effects and adverse reactions, and procedures to follow if patients appear to be experiencing side effects or adverse reactions.¹¹⁴ This 2-hour training may be included in the initial 75-hour or 40-hour HHA training.

¹⁰⁵ Agency for Health Care Administration, Florida Medicaid, *Personal Care Services Coverage Policy*, (Nov. 2016), adopted in r. 59G-4.215, F.A.C.

¹⁰⁶ *Id.*

¹⁰⁷ Section 465.003, F.S.

¹⁰⁸ Section 393.506, F.S.

¹⁰⁹ Some states specifically certify or license medication aides.

¹¹⁰ See TEX. HEALTH & SAFETY CODE 242 and 26 TEX. ADMIN. CODE 557.128.

¹¹¹ See ARIZ. REV. STAT. §32-1650, GA. CODE ANN. 31-7-12.2, 225 ILL. COMP. STAT. 65 (pilot program), MINN. R. 4658.1360, N.C. GEN. STAT. § 131E-114.2, respectively.

¹¹² See CONN. GEN. STAT. §17a-210-1, et. seq.

¹¹³ *Supra* note 99.

¹¹⁴ *Id.*

Assistance with self-administration of medication includes:¹¹⁵

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

A HHA with the authority to assist with self-administration of medication may not:¹¹⁶

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

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

Direct Care Workforce Challenges

The federal Bureau of Labor Statistics estimate that home health aides and personal care assistants are in the top five occupations with the fastest job growth in the U.S. economy.¹¹⁷ The demand for home health aides and nursing assistants is expected to increase by 34 percent by 2025.¹¹⁸ However, the turnover rate in long term care professions is projected to be between 45 and 66 percent.¹¹⁹

Many factors contribute to the high turnover rate, including compensation, lack of full-employment, and low job satisfaction.¹²⁰ Direct care workers also often have substantial family caregiving obligations, which adds to the stress of the job and contribute to the days missed from work.¹²¹

¹¹⁵ Section 400.488(3), F.S.

¹¹⁶ Section 400.488(4), F.S.

¹¹⁷ U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Workforce, National Center for Health Workforce Analysis, *Long-Term Services and Supports: Direct Care Worker Demand Projections 2015-2030*, (March 2018), available at <https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/hrsa-ltss-direct-care-worker-report.pdf> (last visited January 14, 2020).

¹¹⁸ *Id.*

¹¹⁹ Kezia Scales, PhD, *Staffing in Long-Term Care is a National Crisis*, (June 8, 2018), available at <https://phinational.org/recruitment-retention-long-term-care-national-perspective/> (last visited January 14, 2020).

¹²⁰ *Supra* note 81, at pp. 27-37.

¹²¹ U.S. Department of Health and Human Services, *Understanding Direct Care Workers: A Snapshot of Two of America's Most Important Jobs – Certified Nursing Assistants and Home Health Aides*, (March 2011), available at https://www.ahcancal.org/quality_improvement/Documents/UnderstandingDirectCareWorkers.pdf (last visited January 20, 2020).

High turnover rates have a negative impact on both employers and patients. Turnover may have a negative impact on patient care and employers must incur costs for continuous recruitment and training of new employees.¹²² Indirect costs to employers include lost productivity, lost revenue, and reduced service quality.¹²³ Employers must pay costs related to filling vacancies and training new employees. It is estimated that turnover costs direct care employers approximately \$4.1 billion per year.¹²⁴ Turnover can cause a break in continuity of care and a reduction in the quality of care, which may ultimately affect the patient's quality of life.¹²⁵

Approximately two-thirds of HHAs and PCAs work part time.¹²⁶ This may be due to personal needs; however, many home care workers receive several assignments to work in a day the total of which does not amount to a full work day. For example, a HHA may be scheduled to see two separate clients for three hours each, but due to the time to travel between patients, the HHA is unable to achieve a full 8-hour work day. Many direct workers also face other obstacles to remaining in their jobs, including challenges with transportation, family commitments, or health care.¹²⁷ Some states or regions have launched matching service registries to make it easier for workers to find clients and build schedules to suit individual needs and commitments.¹²⁸

Low job satisfaction, which in turn leads to higher turnover, results from inadequate training and lack of opportunities for advancement.¹²⁹ Many direct care workers chose the career because they wanted to help people, and this motivation also plays a role in retaining workers in direct care.¹³⁰ However, many direct care workers leave the career field for other entry-level jobs in the food and hospitality industry that pay similarly, are less mentally and physically strenuous, and provide opportunities for advancement.¹³¹ In fact, one in four CNAs and one in five HHAs report that they are actively seeking another job.¹³²

Direct care workers are also at an increased risk of work-related injuries.¹³³ Direct care workers have an injury rate of 144 injuries per 10,000 workers among PCAs, 116 among HHAs, and 337 among CNAs.¹³⁴ By contrast, the injury rate across all occupations is 100 per 10,000 workers.¹³⁵

In order to meet the future demand for direct care worker, employers will need to consider options such as offering better compensation, full-time hours, better training and advancement opportunities, and improved working conditions.¹³⁶

¹²² Institute of Medicine, Committee on the Future Health Care Workforce for Older Americans, Board on Health Care Services, *Retooling for an Aging America: Building the Health Care Workforce*, (2008), available at https://www.ncbi.nlm.nih.gov/books/NBK215401/pdf/Bookshelf_NBK215401.pdf (last visited January 14, 2020).

¹²³ Dorie Seavey, Better Jobs Better Care, *The Cost of Frontline Turnover in Long-Term Care*, (Oct. 2004), available at <https://phinational.org/wp-content/uploads/legacy/clearinghouse/TOCostReport.pdf> (last visited January 25, 2020).

¹²⁴ *Supra* note 122.

¹²⁵ *Id.*

¹²⁶ Paraprofessional Healthcare Institute, *U.S. Home Care Workers: Key Facts*, available at https://phinational.org/wp-content/uploads/2017/09/phi_homecare_factsheet_2017_0.pdf (last visited January 14, 2020).

¹²⁷ Paraprofessional Healthcare Institute, *Growing a Strong Direct Care Workforce: A Recruitment and Retention Guide for Employers*, available at <https://phinational.org/wp-content/uploads/2018/05/RRGuide-PHI-2018.pdf> (last visited January 20, 2020).

¹²⁸ Allison Cook, Paraprofessional Healthcare Institute, *Issue Brief: Localized Strategies For Addressing the Workforce Crisis in Home Care*, (Oct. 2019), available at <https://phinational.org/wp-content/uploads/2019/11/Localized-Strategies-2019-PHI.pdf> (last visited January 20, 2020).

¹²⁹ *Supra* note 121.

¹³⁰ *Supra* note 121, at p. 48.

¹³¹ *Supra* note 122.

¹³² *Id.*

¹³³ *Supra* note 121.

¹³⁴ Stephen Campbell, Paraprofessional Healthcare Institute, *Issue Brief: Workplace Injuries and the Direct Care Workforce*, (April 2018), available at <https://phinational.org/wp-content/uploads/2018/04/Workplace-Injuries-and-DCW-PHI-2018.pdf> (last visited January 20, 2020).

¹³⁵ *Id.*

¹³⁶ *Supra* note 126, at p. 8.

Direct Care Workforce Data

In 2009, the federal Centers for Medicare and Medicaid Services (CMS) issued a report acknowledging that there was a lack of ongoing, reliable state-based information about the direct care workforce.¹³⁷ This lack of information has hampered the ability to develop policy to ensure that a stable and quality direct care workforce is available to meet the increasing demand for long term care services.¹³⁸

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

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

Collecting this minimum data on the direct care workforce enables states to, among other things:¹³⁹

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

This information will also enable states to determine the most useful deployment of state resources, anticipate increased demand for services, and assess trends in workforce turnover and related costs.¹⁴⁰

In addition to direct care workers who are employed by entities, like home health agencies and nursing homes, there is a growing “gray market” comprised of independent providers. These independent providers are directly employed by the individuals to whom they provide care¹⁴¹ and some may be employed by individuals through government-funded programs, such as Medicaid.¹⁴² However, since these individuals are directly employed by patients, it is difficult to quantify the size of this market.

Regulation of Long Term Care Providers

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

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

In addition to provider-specific requirements listed in the authorizing statutes for each provider type listed above, the Health Care Licensing Procedures Act (Act), in part II of ch. 408, F.S., establishes uniform licensing procedures and statutes for 29 provider types regulated by HQA. The Act authorizes

¹³⁷ Centers for Medicare and Medicaid Services, National Direct Service Workforce Resource Center, *The Need for Monitoring Long-Term Direct Service Workforce and Recommendations for Data Collection*, (Feb. 2009), available at <https://www.medicaid.gov/sites/default/files/2019-12/monitoring-dsw.pdf> (last visited January 8, 2020).

¹³⁸ *Id.*

¹³⁹ *Id.* at p. 8.

¹⁴⁰ *Id.*

¹⁴¹ *Supra* note 81 at 18.

¹⁴² For example, see *supra* note 105.

HQA to inspect facilities, verify compliance with licensure requirements, identify deficiencies or violations, and impose fines and penalties for noncompliance.

Nursing Home Staffing

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

- A minimum weekly¹⁴³ average of 3.6 hours of direct care per resident per day provided by a combination of certified nursing assistants and licensed nursing staff.
- A minimum of 2.5 hours of direct care per resident per day provided by certified nursing assistant staff. A facility may not staff at a ratio of less than one certified nursing assistant per 20 residents.
- A minimum of 1.0 hour of direct care per resident per day provided by licensed nursing staff. A facility may not staff at a ratio of less than one licensed nurse per 40 residents.

When computing the staffing ratio for certified nursing assistants, nursing homes are allowed to use nursing assistants who have not yet obtained certification under certain conditions to satisfy the staffing ratio requirements so long as their job duties only include nursing assistant-related duties.¹⁴⁴ If approved by AHCA, licensed nurses may also be used to meet staffing requirements for CNAs if the licensed nurses are performing the duties of a CNA and the facility otherwise meets minimum staffing requirements for licensed nurses.¹⁴⁵ Additionally, non-nursing staff providing eating assistance to residents do not count toward compliance with minimum staffing requirements.¹⁴⁶

Paid Feeding Assistants

Under federal Medicare regulations, nursing homes may employ trained feeding assistants to help residents who have no complicated feeding problems but need some assistance in eating or drinking.¹⁴⁷ Such feeding assistants must complete a state-approved training course, which must, at minimum, be eight hours and provide training on:¹⁴⁸

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

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

¹⁴³ A week is defined as Sunday through Saturday.

¹⁴⁴ Sections 400.23(3)(a)2. and 400.211(2), F.S. Nursing facilities may employ uncertified nursing assistants for up to 4 months if they are enrolled in, or have completed, a state-approving nursing assistant program, have been positively verified as actively certified and on the registry in another state with no findings of abuse, neglect, or exploitation in that state, or have preliminarily passed the state's certification exam.

¹⁴⁵ Section 400.23(3)(a)4., F.S., and r. 59A-4.108(7), F.A.C. The hours of a licensed nurse with dual job responsibilities may not be counted twice.

¹⁴⁶ Sections 400.23(3)(b), F.S.

¹⁴⁷ 42 C.F.R. s. 483.60(h). Complicated feeding problems include, but is not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

¹⁴⁸ 42 C.F.R. s. 483.160.

Effect of Proposed Changes

APRN Autonomous Practice

CS/CS/HB 607 authorizes an APRN who meets certain eligibility criteria to engage in autonomous practice and practice primary care and midwifery without a supervisory protocol or supervision by a physician.

Registration Requirements

To register to engage in autonomous practice, an APRN must register with the Board of Nursing. To register, an APRN must hold an active and unencumbered Florida license and must have:

- Completed at least 3,000 clinical practice hours or clinical instructional hours¹⁴⁹ supervised by an actively licensed physician within the 5-year period immediately preceding the registration request;
- Not been subject to any disciplinary action during the five years immediately preceding the application;
- Completed three graduate-level semester hours in pharmacology and three graduate-level semester hours in differential diagnosis within the 5-year period preceding the registration request; and
- Any other appropriate requirement adopted by rule by the Board.

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

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

The registration must be renewed biennially and the renewal will coincide with the licensure renewal period for the APRN. To maintain registration, an APRN must complete at least 10 hours of continuing education approved by the Board for each biennial renewal in addition to the 30 hours of continuing education required for renewal of the APRN license.¹⁵⁰

The bill directs DOH to conspicuously distinguish the practitioner profiles of APRNs registered to engage in autonomous practice. An APRN registered to engage in autonomous practice must provide each new patient written information about his or her qualifications before or during the initial patient encounter.

Scope of Practice

¹⁴⁹ The bill defines "clinical instruction" as education provided by faculty in a clinical setting in a graduate program leading to a master's or doctoral degree in a clinical nursing specialty area.

¹⁵⁰ The bill provides an exception to the 10 hours of continuing education in pharmacology for an APRN whose biennial renewal is due before January 1, 2020. However, this requirement must be met during the subsequent biennial renewal periods.

Under the bill, an APRN registered to engage in autonomous practice is authorized to engage in primary care practice, which includes family medicine, general pediatrics, and general internal medicine, as defined by Board rule. Additionally, the bill authorizes a registered APRN to autonomously, and without supervision or written protocol, perform the following acts:

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

A certified nurse midwife may only perform midwifery services if the certified nurse midwife has a written patient transfer agreement with a hospital and a written referral agreement with a Florida-licensed physician. An APRN may not perform any surgical procedures except subcutaneous surgical procedures.

Council on Advanced Practice Registered Nurse Autonomous Practice

The bill established the Council on Advanced Practice Registered Nurse Autonomous Practice (Council), to recommend standards of practice for APRNs who practice autonomously to the Board. The bill requires the Board may choose to adopt a recommendation, reject a recommendation, or otherwise act on it as the Board deems appropriate. If the Board rejects a recommendation, it must state with particularity its reason for such rejection. The Board must provide the Council an opportunity to modify its recommendation, and the Board must also consider the modified recommendation. The 9-member Council is to be composed of:

- Four APRNs appointed by the Board of Nursing who have experience practicing advanced or specialized nursing;
- Two physicians appointed by the Board of Medicine who are physicians and members of the Board of Medicine;
- Two physicians appointed by the Board of Osteopathic Medicine who are physicians and members of the Board of Osteopathic Medicine; and
- The State Surgeon General or his or her designee, who serves as chair of the Council.

Council members are appointed for 4-year terms, and may not serve more than two consecutive terms. The bill for staggering of the initial appointments, and requires the initial physician appointees to have experience practicing with APRNs under a protocol in their respective practices.

Accountability

The bill imposes safeguards to ensure APRNs registered to engage in autonomous practice do so safely, similar to those for physicians.¹⁵¹ The bill defines an adverse incident as an event over which the APRN could exercise control and which is associated with a nursing intervention, rather than a condition for which such intervention occurred, which results in at least one of the following:

- A condition that requires the transfer of the patient to a hospital;

¹⁵¹ See ss. 458.351 and 459.026, F.S.

- Permanent physical injury to the patient; or
- Death of the patient.

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

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

- Paying or receiving any commission, bonus, kickback, rebate, or engaging in a split-fee arrangement with a health care practitioner, organization, agency, or person for patient referrals;
- Exercising influence over a patient for the purpose of engaging in sexual activity;
- Making deceptive, untrue, or fraudulent representation related to advanced or specialized nursing practice;
- Soliciting patients, personally or through an agent, using fraud, intimidation, undue influence, or overreaching or vexatious conduct;
- Failing to keep legible medical records;
- Exercising influence over a patient for the purpose of exploiting the patient for financial gain;
- Performing professional services that have not been authorized by the patient or his or her representative except as provided by the Medical Consent Law¹⁵² and the Good Samaritan Act;¹⁵³
- Performing any procedure or prescribing any therapy that would constitute experimentation on a human subject, without full, informed, and written consent of the patient;
- Delegating professional responsibilities to an unqualified or unlicensed person;
- Conspiring with another person to commit an act or committing an act that would tend to coerce, intimidate, or preclude another APRN from advertising his or her services;
- Advertising or holding oneself out as having a certification in a specialty that the APRN has not received;
- Failing to inform patients about patient rights and how to file a patient complaint; and
- Providing deceptive or fraudulent expert witness testimony related to advanced or specialized nursing practice.

Insurance

The bill requires AHCA to pay for services provided to a Medicaid recipient by an APRN registered to engage in autonomous practice. The bill prohibits a health insurer, health maintenance organization, or a health benefit plan covering small employers from requiring an insured to receive services from an APRN engaging in autonomous practice, instead of a physician.

Medical Education Reimbursement and Loan Repayment Program

The bill authorizes DOH pay up to \$15,000 per year to an APRN engaging in autonomous practice and who is employed to provide primary care in a public health program or an independent or group practice located in a primary care health professional shortage area that serves Medicaid recipients

¹⁵² Section 766.103, F.S.

¹⁵³ Section 768.13, F.S.

and other low-income individuals.¹⁵⁴ DOH may cover costs associated with tuition, books, medical equipment and supplies, uniforms, and living expenses.

The bill appropriates \$5 million dollars in recurring General Revenue funds to DOH for this purpose.

Direct Care Workers

Nurse Delegation in Home Health Agencies

The bill authorizes a registered nurse to delegate any task, including medication administration, to a HHA¹⁵⁵ who do not work in a nursing home, if the registered nurse determines that the HHA is competent to perform the task, the task is delegable under federal law, and the task:

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

Medication Administration

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

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

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

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

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

¹⁵⁴ The bill defines "public health program" as a county health department, the Children's Medical Services program, a federally funded community health center, a federally funded migrant health center, or any other publicly funded or nonprofit health care program designated by DOH; and "primary care health professional shortage area" as a geographic area, an area having a special population, or a facility with a score of at least 18, as designated and calculated by the Federal Health Resources and Services Administration or a rural area as defined by the federal Office of Rural Health Policy.

¹⁵⁵ Home health aide includes those CNAs who work in positions that work as home health aides or equivalent positions.

The bill authorizes the Board of Nursing to adopt rules, in consultation with AHCA, on delegation of duties. The bill also makes delegating responsibilities to an individual the nurse knows or has reason to know the individual is not qualified to perform grounds for licensure discipline.

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

Self-Administration of Medication

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

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

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

Paid Feeding Assistants

The bill authorizes nursing homes to use paid feeding assistants who successfully complete a 12-hour training course developed by AHCA. The course must include instruction on:

- Feeding techniques;
- Assistance with feeding and hydration;
- Communication and interpersonal skills;
- Appropriate responses to resident behavior;
- Safety and emergency procedures, including first aid procedures used to treat upper airway obstructions;
- Infection control;
- Residents' rights; and
- Recognizing changes in residents which are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

The bill prohibits paid feeding assistants from counting towards minimum staffing requirements.

Direct Care Workforce Survey

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

- Number of registered nurses and direct care workers employed by the licensee;
- Turnover and vacancy rates of registered nurses and direct care workers and contributing factors;
- Average wage for registered nurses and each category of direct care worker for employees and contractors of the licensee;

- Employment benefits for registered nurses and direct care workers and average cost to the employer and employee; and
- Type and availability of training for registered nurses and direct care workers.

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

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

Excellence in Home Health and Nursing Registry Excellence Award Programs

The bill creates gold seal programs to designate home health agencies and nurse registries that meet certain criteria. The home health agency or nurse registry must have been actively licensed and operating for at least 24 months and have had no licensure denials revocations, or serious deficiencies during the preceding 24 months to be considered for the award. AHCA must adopt rules establishing standards for the award for home health agencies, which must include those relating to:

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

AHCA must also adopt rules establishing standards for the award for nurse registries, which must include those relating to:

- Patient or client satisfaction;
- Patients or clients requiring emergency care for wound infections;
- Patients or clients admitted or re-admitted to an acute care hospital;
- Patient or client longevity with the nurse registry;
- Independent contractor satisfaction;
- Independent contractor longevity with the nurse registry; and
- High performance under federal Medicaid electronic visit verification requirements.

Medicaid electronic visit verification applies only to those entities that provide Medicaid-funded personal care services or home health services.¹⁵⁶ Therefore, the standard will not apply to a home health agency or a nurse registry that does not provide such Medicaid-funded services.

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

- Has not been awarded the designation;
- Fails to review the award upon expiration of an award designation;
- Has undergone a change in ownership;

¹⁵⁶ Centers for Medicare and Medicaid Services, *Frequently Asked Questions: Section 12006 of the 21st Century Cures Act Electronic Visit Verification (EVV) Systems for Personal Care Services (PCS) and Home Health Care Services*, available at <https://www.medicaid.gov/sites/default/files/federal-policy-guidance/downloads/faq051618.pdf> (last visited February 26, 2020).

- Has been notified that it no longer meets the criteria for the award upon re-application after expiration of the award designation.

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

The bill provides an effective date of July 1, 2020, except those provisions related to direct care workers which become effective upon the act becoming a law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

For the 2020-2021 fiscal year, the bill authorizes 3.5 FTE, with associated salary rate of 183,195, and appropriates \$219,089 in recurring and \$17,716 in nonrecurring funds from the Medical Quality Assurance Trust Fund to DOH for the registration and regulation of autonomous APRNs. The bill also appropriates \$5 million in recurring General Revenue funds to the DOH for the Medical Education Reimbursement and Loan Repayment Program for APRNs registered to engage in autonomous practice.

The bill also authorizes 2.0 full-time equivalent positions, with associated salary rate of 82,211, and appropriates the sums of \$320,150 in recurring and \$232,342 in nonrecurring funds from the Health Care Trust Fund to AHCA for implementing the direct care workforce survey and the Excellence in Home Health and Nurse Registry Excellence award programs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

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

APRNs who pay physicians for supervision will achieve cost-savings if they qualify for and register to practice autonomously since supervision will no longer be needed. APRNs who register to practice autonomously must pay for the additional continuing education hours required by the bill.

D. FISCAL COMMENTS:

None.