



Health Care Appropriations Subcommittee

**Friday, April 9, 2021
11:30 AM - 2:30 PM
Morris Hall (17HOB)**

Committee Meeting Notice

HOUSE OF REPRESENTATIVES

Health Care Appropriations Subcommittee

Start Date and Time: Friday, April 09, 2021 11:30 am

End Date and Time: Friday, April 09, 2021 02:30 pm

Location: Morris Hall (17 HOB)

Duration: 3.00 hrs

Consideration of the following bill(s):

CS/HB 183 Office of Minority Health and Health Equity by Professions & Public Health Subcommittee, Brown, Joseph

HB 397 Cardiovascular Emergency Protocols and Training by DiCeglie, McClure

CS/HB 837 Harm to Children by Children, Families & Seniors Subcommittee, Byrd

CS/HB 1093 Abuse, Abandonment, or Neglect Education by Children, Families & Seniors Subcommittee, Valdés

CS/HB 1233 Genetic Counseling Patient Protection Act by Professions & Public Health Subcommittee, Silvers

HB 1235 Fees by Silvers

CS/HB 1373 Rare Disease Advisory Council by Professions & Public Health Subcommittee, DuBose, Plakon

CS/HB 1447 Commission on Mental Health and Substance Abuse by Children, Families & Seniors Subcommittee, Hunschofsky

This meeting will be live-streamed on <https://thefloridachannel.org/>. Persons who wish to attend must register at www.myfloridahouse.gov, and pick up a pass at the Legislative Welcome Center on the 4th Floor of the Capitol beginning one hour before the start of the meeting. Audience seating will be socially distanced and will be available on a first-come, first-served basis. Registration closes three hours before the meeting starts.

NOTICE FINALIZED on 04/07/2021 4:03PM by SXA

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 183 Office of Minority Health and Health Equity
SPONSOR(S): Professions & Public Health Subcommittee, Brown and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 404

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	17 Y, 0 N, As CS	Rahming	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In Florida, minority populations experience higher rates of illness and death from health conditions such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, mental health, asthma, and obesity. The Office of Minority Health and Health Equity (Office), housed within the Department of Health (DOH), is responsible for helping to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental, and other factors which impact health. Under current law, the Office is required to be headed by a Senior Health Equity Officer. The responsibilities of the Senior Health Equity Officer include, but are not limited to, administering the Closing the Gap grant program in a manner that maximizes the impact of the grants in achieving health equity.

CS/HB 183 requires the Office to develop and promote the statewide implementation of policies, programs, and practices that increase health equity for racial and ethnic minority populations in Florida. The bill requires the Office to work with other state agencies, organizations, and providers to improve the health of racial and ethnic minority populations through data analysis and the development of health policies and programs that will help eliminate health disparities.

The bill requires one representative from each county health department to serve as a minority health liaison (MHL) and requires MHLs to assist the Office in the implementation of the bill. The bill also authorizes the Office to serve as a liaison to and assist the federal Offices of Minority Health and Regional Health Operations, as appropriate.

The bill has an insignificant, negative fiscal impact on the DOH, which current resources are adequate to absorb, and no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

The Present Situation

Health disparities—inequities in the quality of health, health care and health outcomes experienced by groups based on social, racial, ethnic, economic and environmental characteristics—persist nationwide.¹

In Florida, minority populations experience higher rates of illness and death from health conditions such as heart disease, stroke, specific cancers, diabetes, HIV/AIDS, mental health, asthma, and obesity.² Poor health outcomes for Blacks, Hispanic Americans, American Indians, Alaska Natives, Asian Americans, Native Hawaiians, and Pacific Islanders are also apparent when comparing their health indicators to Florida's general population.³

The Office of Minority Health and Health Equity

In 2004, the Florida Legislature established the Office of Minority Health to serve as the coordinating office within the DOH for consultative services and training in the areas of cultural and linguistic competency, coordination, partnership building, program development and implementation, and other related comprehensive efforts to address the health needs of Florida's minority and underrepresented populations statewide.⁴

In 2016, the Florida Legislature renamed the office the Office of Minority Health and Health Equity (Office).⁵ The Office is responsible for helping to improve health and healthcare outcomes for racial and ethnic minority communities by developing or advancing policies, programs, and practices that address health, social, economic, environmental, and other factors which impact health.⁶

The DOH currently gathers, analyzes, and publishes data regarding disparities in health status and access to health care services on its Florida Health Community Health Assessment Resource Tool Set (FLHealthCHARTS) website, but not on quality of health care.⁷ However, the federal Agency for Healthcare Research and Quality does publish data on the quality of health care and provides a list of measures and supporting data that can be viewed by race and ethnicity at the state level.⁸

Under current law, the Office is not required to develop and promote statewide implementation of any policies, programs, and practices that may increase health equity for racial and ethnic minority populations in Florida. The Office is also not required to work with other state agencies, organizations, and providers or the federal government to improve the health of racial and ethnic minority populations through data analysis and the development of health policies and programs that will help eliminate health disparities. Rather, the Office is statutorily required to be headed by a Senior Health Equity Officer.⁹

¹ National Conference of State Legislatures (NCSL), Health Disparities Overview, <https://www.ncsl.org/research/health/health-disparities-overview.aspx> (last visited Feb. 3, 2021).

² Florida Department of Health (DOH), *Health Equity Profile 2019, Health Equity Profile - State Total, Florida 2019*, <http://www.flhealthcharts.com/ChartsReports/rdPage.aspx?rdReport=ChartsProfiles.HealthEquityMergeMHPProfile> (last visited Mar. 7, 2021).

³ *Id.*

⁴ Florida Department of Health (DOH), *Minority Health and Health Equity*, <http://www.floridahealth.gov/programs-and-services/minority-health/index.html> (last visited Mar. 7, 2021).

⁵ S. 20.43(9), Florida Statutes.

⁶ DOH, *Minority Health Liaisons*, <http://www.floridahealth.gov/programs-and-services/minority-health/minority-health-liaisons.html> (last visited Feb. 28, 2021).

⁷ DOH, *Agency Legislative Bill Analysis for HB 183 (2021)*, at 7.

⁸ Agency for Healthcare Research and Quality, *National Healthcare Quality and Disparities Reports: Florida*, https://nhqrnet.ahrq.gov/inhqrdr/Florida/benchmark/summary/All_Measures/All_Topics (last visited February 28, 2021).

⁹ S. 20.43(9), Florida Statutes.

Minority Health Initiatives

Closing the Gap Grant Program

The Office administers multiple health promotion programs including the “Closing the Gap” (CTG) grant program.¹⁰ In 2000, the Legislature created the CTG grant program to improve health outcomes and eliminate racial and ethnic health disparities in Florida by providing grants to increase community-based health and disease prevention activities.¹¹

Grants are awarded for one year through a proposal process and may be renewed annually subject to the availability of funds and the grantee’s achievement of quality standards, objectives, and outcomes.¹² Proposals for grants must include:¹³

- The purpose and objectives of the proposed project, including the particular racial or ethnic disparity the project will address from one or more of the following priority areas:
 - o Increasing adult and child immunization rates in certain racial and ethnic populations;
 - o Improving neighborhood social determinates of health, such as transportation, safety, and food access, as outlined by the Centers for Disease Control and Prevention (CDC), or
 - o Decreasing racial and ethnic disparities in:
 - Maternal and infant mortality rates;
 - Morbidity and mortality rates relating to cancer;
 - Morbidity and mortality rates relating to HIV/AIDS;
 - Morbidity and mortality rates relating to cardiovascular disease;
 - Morbidity and mortality rates relating to diabetes;
 - Morbidity and mortality rates relating to sickle cell disease;
 - Morbidity and mortality rates relating to Lupus; or
 - Oral health care.
- The target population and its relevance;
- Methods for obtaining baseline health status data and assessment of community health needs;
- Mechanisms for mobilizing community resources and gaining local commitment;
- Development and implementation of health promotion and disease prevention interventions;
- Mechanisms and strategies for evaluating the project’s objectives, procedures, and outcomes;
- A proposed work plan, including a timeline for implementing the project; and
- The likelihood that project activities will occur and continue in the absence of funding.¹⁴

As the head of the Office, the Senior Health Equity Officer is required to:¹⁵

- Administer the CTG grant program in a manner that maximizes the impact of the grants in achieving health equity;
- Evaluate the awarded grants to assess the effectiveness and efficiency of the use of funds and to determine best practices;
- Disseminate information on best practices to stakeholders; and
- Ensure that the assessments inform future grant award decisions.

The Office’s CTG grant program responsibilities include:¹⁶

¹⁰ Florida Department of Health, *Minority Health*, <http://www.floridahealth.gov/%5C/programs-and-services/minority-health/index.html> (last visited Mar. 15, 2021).

¹¹ Ss. 381.7353–381.7356, F.S. See also, *Closing the Gap Grant*, <http://www.floridahealth.gov/programs-and-services/minority-health/closing-the-gap.html> (last visited Feb. 28, 2021).

¹² S. 381.7356(4), F.S.

¹³ S. 381.7355, F.S.

¹⁴ *Id.*

¹⁵ S. 20.43(9), F.S.

¹⁶ DOH, *supra* note 7, at 3.

- Publicizing the availability of funds and establishing an application process for submitting a grant proposal.
- Providing technical assistance and training, including a statewide meeting promoting best practice programs, as requested, to grant recipients.
- Developing uniform data reporting requirements for the purpose of evaluating the performance of the grant recipients and demonstrating improved health outcomes.
- Developing a monitoring process to evaluate progress toward meeting grant objectives.
- Coordinating with existing community-based programs, such as chronic disease community intervention programs, cancer prevention and control programs, diabetes control programs, the Healthy Start program, the Florida Kidcare Program, the HIV/AIDS program, immunization programs, and other related programs at the state and local levels, to avoid duplication of effort and promote consistency.

Implementation of the CTG grant program is subject to a specific appropriation provided in the General Appropriations Act.¹⁷

Minority Health Liaisons

The Office relies on county health departments and other programs within the DOH to achieve its goals.¹⁸ The minority health liaisons (MHLs), comprised of a representative from each of the 67 county health departments, are the link between local communities and the Office.¹⁹

The objective of the Office and the MHLs is to improve the health of all residents and visitors across Florida, primarily through increasing public awareness of the importance of minority health and partnering initiatives focused on minority health issues statewide.²⁰ The Office helps to facilitate these partnerships by coordinating with county health departments, central office divisions/bureaus, and statewide stakeholders, and providing technical assistance to the MHLs on issues related to minority health, health disparities, and other health issues within the state.²¹

Key components of the Office-MHL partnership include:²²

- Sharing information on minority health and health disparities;
- Coordinating events, such as Take a Loved One to the Doctor Day, National Minority Health Month, and other nationally recognized observances;
- Promoting state and local activities and events to raise awareness of programs and services available to minorities and the underserved populations; and
- Helping meet the mission of the DOH by achieving its primary responsibilities in eliminating health disparities.

The Office's Website

Currently, there are no statutory requirements relating to the maintenance of the Office's website, including what information should be maintained on it or how often it should be updated.

Effect of Proposed Bill

CS/HB 183 requires the Office of Minority Health and Health Equity to develop and promote the statewide implementation of policies, programs, and practices that increase health equity for racial and ethnic minority populations in Florida.

The bill also requires the Office to use all available resources and pursue funding opportunities to achieve the bill's purpose and work with other state agencies, organizations, and providers to:

¹⁷ *Id.*

¹⁸ DOH, *supra* note 6.

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

- Gather and analyze data regarding disparities in health status, health outcomes, quality of health care, and access to health care services for racial and ethnic minority populations in Florida;
- Develop mechanisms that support better information dissemination and education about health disparities which lead to improved access to and delivery of health care services to racial and ethnic minority populations in Florida;
- Support the MHLs by facilitating access to and the exchange of information related to health promotion, preventive health services, and education in the appropriate use of care;
- Promote evaluations of demonstration projects and disseminate the evaluations findings to enhance the success and sustainability of policies, programs, and practices that increase health equity in Florida;
- Promote the use of community health workers to improve the cultural competency of services and build individual and community self-sufficiency; and
- Promote the development of programs that improve access to health care services for individuals with limited proficiency in the English language, including persons with disabilities.

CS/HB 183 requires the DOH to maintain and annually update the following information on its website:

- Current state data on health disparities and issues affecting racial and ethnic minority populations;
- Information about and links to resources available to racial and ethnic minority populations in Florida;
- Resources for providers who wish to improve cultural competency, understand health disparities, and increase the quality of and access to health care services for racial and ethnic minority populations in Florida; and
- Contact information for local minority health liaisons.

The bill requires one representative from each county health department to serve as the MHL and requires MHLs to assist the Office in implementation of the bill. The bill also authorizes the Office to serve as a liaison to and assist the federal Offices of Minority Health and Regional Health Operations, as appropriate.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 381.735, F.S., relating to the Office of Minority Health and Health Equity.

Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The DOH will experience an increase in workload and operational costs to implement this bill, which current resources are adequate to absorb. Currently, each county health department has one minority health liaison.²³ The existing minority health liaison infrastructure is sufficient to carry out the bill's requirements.

²³ DOH, *supra* note 7, at 5.
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DATE: 4/8/2021

The DOH will incur costs associated with rulemaking and publishing information on its website, which current resources are adequate to absorb.

For Fiscal Year 2020-2021, the Office of Minority Health and Health Equity received \$4,850,354 in General Revenue Funds. The House proposed GAA for Fiscal Year 2021-2022 includes \$4,743,271 in General Revenue funds and \$4,256,729 in County Health Department Trust Fund double budget authority. These funds will be used for strategies to reduce minority morbidity and mortality in the Closing the Gap grant program priority areas. The additional funding includes 4 FTE and 15 OPS positions. This additional funding will complement the existing appropriation to the Office to implement the requirements of the bill.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rule-making authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2021, the Professions & Public Health Subcommittee adopted an amendment to HB 183 and reported the bill favorably as a committee substitute. The amendment:

- Required the Office of Minority Health and Health Equity (Office) to coordinate with agencies, organizations, and providers across the state to gather and analyze specified data, including disparities in health outcomes;
- Required the Office to promote, rather than conduct, develop, or implement, specified activities;
- Removed Office requirements that are outside of the Department of Health's (DOH) statutory authority; and

- Required the DOH, rather than the Office, to maintain and annually update specified information on its website.

The analysis is drafted to the committee substitute as passed by the Professions & Public Health Subcommittee.

1 A bill to be entitled

2 An act relating to the Office of Minority Health and
3 Health Equity; creating s. 381.735, F.S.; requiring
4 the Office of Minority Health and Health Equity to
5 develop and promote the statewide implementation of
6 certain policies, programs, and practices; requiring
7 one representative from each county health department
8 to serve as a minority health liaison for a specified
9 purpose; requiring the office to use all available
10 resources and pursue funding opportunities to achieve
11 this purpose; specifying duties for the office;
12 requiring the Department of Health to maintain
13 specified information on its website; requiring the
14 office to serve as a liaison to and assist certain
15 federal offices; authorizing the department to adopt
16 rules; providing an effective date.

17
18 Be It Enacted by the Legislature of the State of Florida:

19
20 Section 1. Section 381.735, Florida Statutes, is created
21 to read:

22 381.735 Office of Minority Health and Health Equity.—
23 (1) The Office of Minority Health and Health Equity
24 established under s. 20.43(9) shall develop and promote the
25 statewide implementation of policies, programs, and practices

26 that increase health equity in this state, including, but not
27 limited to, increased access to and quality of health care
28 services for racial and ethnic minority populations. One
29 representative from each county health department shall serve as
30 a minority health liaison to assist the office in implementing
31 this section. The office shall use all available resources and
32 pursue opportunities for increased funding to achieve the
33 purpose of this section.

34 (2) The office shall coordinate with agencies,
35 organizations, and providers across this state to do all of the
36 following:

37 (a) Gather and analyze data regarding disparities in
38 health status, health outcomes, quality of health care, and
39 access to health care services for racial and ethnic minority
40 populations in this state.

41 (b) Develop mechanisms that support better information
42 dissemination and education about health disparities which lead
43 to improved access to and delivery of health care services to
44 racial and ethnic minority populations in this state.

45 (c) Support minority health liaisons by facilitating
46 access to and the exchange of information related to health
47 promotion, preventive health services, and education in the
48 appropriate use of care.

49 (d) Develop and promote synergistic initiatives between
50 programs, including, but not limited to, programs related to

51 maternal and child health and human immunodeficiency virus and
52 acquired immune deficiency syndrome, to mitigate health
53 disparities for racial and ethnic minority populations in this
54 state.

55 (e) Promote evaluations of demonstration projects and
56 disseminate the evaluation findings to enhance the success and
57 sustainability of policies, programs, and practices that
58 increase health equity in this state.

59 (f) Promote the use of community health workers to improve
60 the cultural competency of services and build individual and
61 community self-sufficiency.

62 (g) Promote the development of programs that improve
63 access to health care services for individuals with limited
64 proficiency in the English language, including individuals with
65 disabilities.

66 (3) The Department of Health shall maintain all of the
67 following on its website, updated at least annually:

68 (a) Current data on health disparities and issues
69 affecting racial and ethnic minority populations in this state.

70 (b) Information about and links to resources available to
71 racial and ethnic minority populations in this state.

72 (c) Resources for providers who wish to improve cultural
73 competency, understand health disparities, and increase the
74 quality of and access to health care services for racial and
75 ethnic minority populations in this state. These resources must

76 include, but need not be limited to, minority health literature,
77 research, and referrals; capacity-building and technical
78 assistance services; and training materials for implementing
79 nationally recognized evidence-based practices for culturally
80 and linguistically appropriate health care services.

81 (d) Contact information for local minority health
82 liaisons.

83 (4) The office shall serve as a liaison to and assist the
84 federal Offices of Minority Health and Regional Health
85 Operations, as appropriate.

86 (5) The department may adopt rules to implement this
87 section.

88 Section 2. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 397 Cardiovascular Emergency Protocols and Training

SPONSOR(S): DiCeglie and others

TIED BILLS: **IDEN./SIM. BILLS:** SB 766

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	18 Y, 0 N	Guzzo	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked. If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attack treatment is most effective if provided when symptoms first occur. Emergency assistance to a person having a heart attack is usually provided by emergency medical technicians (EMTs), paramedics, or a bystander who attempts to administer cardiopulmonary resuscitation (CPR).

Current law requires the medical director of an emergency medical services (EMS) provider to issue standing orders and protocols to its EMTs and paramedics to ensure that patients are transported to facilities that offer a type and level of care appropriate to the patient's medical condition.

The Department of Health (DOH) is responsible for certifying 911 public safety telecommunicators (911 PSTs). To become certified as a 911 PST an applicant is required to receive 232 hours of training, which must include successful completion of a CPR certification class. A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal. Current law does not require the 20-hours of continuing education to include CPR training.

HB 397 requires DOH to annually send a list of providers of adult cardiovascular services to the medical director of each licensed EMS provider. It further requires DOH to develop a sample heart attack triage assessment tool to be posted on its website and distributed to each licensed EMS provider. In addition, the bill requires EMS providers to use a substantially similar assessment tool and requires EMS medical directors to develop and implement assessment, treatment, and transport protocols to ensure heart attack patients are transported to the most appropriate hospital.

The bill also requires a 911 PST to receive biennial telecommunicator CPR training in order to have their certification renewed. Further, the bill requires DOH to establish a procedure to monitor compliance with the training requirements and authorizes DOH to adjust state revenue funds to a public safety agency based on its employees' compliance with the requirements.

The bill has a significant, negative fiscal impact on DOH and an indeterminate fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Heart Attacks

A heart attack occurs when the flow of oxygen-rich blood to a section of heart muscle suddenly becomes blocked.¹ If blood flow is not restored quickly, the section of heart muscle begins to die. Heart attacks most often occur as a result of ischemic heart disease – also known as coronary heart disease or coronary artery disease, which is caused by plaque build-up inside the coronary arteries. Eventually, an area of plaque can rupture inside of an artery causing a blood clot to form on the plaque's surface. If the blood clot becomes large enough, it can mostly or completely block blood flow through a coronary artery. If the blockage isn't treated quickly, the portion of heart muscle fed by the artery begins to die. Heart attack treatment is most effective if provided when symptoms first occur.²

911 Public Safety Telecommunicators

Out-of-hospital cardiac arrest (OHCA) describes the sudden, unexpected loss of heart function, breathing, and consciousness.³ Every year an estimated 350,000 people have cardiac arrest in the United States in an out-of-hospital environment and only one out of 10 victims survive.⁴ 911 public safety telecommunicators (911 PSTs) along with the 911-caller are often the first responders and it is the 911 PST's job to transform the caller into a lay rescuer by instructing them how to perform CPR.⁵

The Department of Health (DOH) is responsible for certifying 911 PSTs.⁶ To become certified as a 911 PST an applicant is required to receive 232 hours of training, which must include successful completion of a CPR certification class.⁷ A 911 PST must renew their certification every two years and must receive 20 hours of continuing education prior to renewal, which does not currently include CPR training.⁸

There are currently 8,861 certified 911 PSTs.⁹

Emergency Medical Transport Services

Prehospital life support transport services fall into two general categories – basic life support services (BLS) and advanced life support services (ALS).

BLS services include the assessment or treatment by a person qualified under part III of ch. 401, F.S., through the use of techniques described in the EMT-Basic National Standard Curriculum or the National Emergency Medical Services (EMS) Education Standards of the U.S. Department of Transportation.¹⁰ The term includes the administration of oxygen and other techniques that have been

¹ U.S. Department of Health & Human Services, National Heart, Lung, and Blood Institute, *Heart Attack*, available at <https://www.nhlbi.nih.gov/health-topics/heart-attack> (last visited Mar. 20, 2021).

² Id.

³ Michael Christopher, *Telecommunicator Cardiopulmonary Resuscitation – A Policy Statement from the American Heart Association*, AHA Journals, Mar. 24, 2020, available at <https://www.ahajournals.org/doi/10.1161/CIR.0000000000000744> (last visited Mar. 20, 2021).

⁴ Id.

⁵ Id.

⁶ Section 401.465(2), F.S.

⁷ Rule 64J-3.001, F.A.C.

⁸ Rule 64J-3.003, F.A.C.

⁹ Florida Department of Health, Agency Analysis of 2021 HB 397, (Feb. 24, 2021).

¹⁰ United States Department of Transportation, National Highway Traffic Safety Administration, *National Emergency Medical Services Education Standards*, (January 2009), available at <https://www.ems.gov/pdf/National-EMS-Education-Standards-FINAL-Jan-2009.pdf> (last visited March 20, 2021).

approved and are performed under specific conditions.¹¹ BLS services are usually performed by EMTs.¹²

ALS services include patient assessment or treatment including the implementation of advanced medical skills such as endotracheal intubation, the administration of drugs or intravenous fluids, telemetry, cardiac monitoring, cardiac defibrillation, and other techniques described in the EMT-Paramedic National Standard Curriculum or the National EMS Education Standards.¹³ ALS services can be performed on site and are usually provided by physicians or paramedics.¹⁴

The medical director of an EMS provider is required to issue standing orders and protocols to its EMTs and paramedics to ensure that patients are transported to facilities that offer a type and level of care appropriate to the patient's medical condition.¹⁵ There is currently no express statutory requirement for EMS medical directors to develop and implement transport protocols for heart attack patients.

Adult Cardiovascular Services

There are two levels of hospital program licensure for Adult Cardiovascular Services (ACS). A Level I program is authorized to perform adult percutaneous cardiac intervention (PCI)¹⁶ without onsite cardiac surgery and a Level II program is authorized to perform PCI with onsite cardiac surgery.¹⁷

For a hospital seeking a Level I ACS program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:¹⁸

- Provided a minimum of 300 adult inpatient and outpatient diagnostic cardiac catheterizations; or
- Discharged or transferred at least 300 inpatients with the principal diagnosis of ischemic heart disease;¹⁹ and that it has formalized, written transfer agreement with a hospital that has a Level II program.

For a hospital seeking a Level II ACS program license, it must demonstrate that, for the most recent 12-month period as reported to AHCA, it has:

- Performed a minimum of 1,100 adult inpatient and outpatient cardiac catheterizations, of which at least 400 must be therapeutic catheterizations; or
- Discharged at least 800 patients with the principal diagnosis of ischemic heart disease.

The Agency for Health Care Administration currently maintains a list on its website of hospitals with Level I and Level II ACS programs.²⁰

¹¹ Sections 401.23(7) and (8), F.S.

¹² Ryyanen, et. al, *Is advanced life support better than basic life support in prehospital care? A systematic review*, Scand J Trauma Resusc. Emerg. Med. 2010; 18: 62, (November 23, 2010), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001418/> (last visited March 11, 2021).

¹³ Sections 401.23(1) and (2), F.S.

¹⁴ Ryyanen, et. al, *supra* note 18.

¹⁵ Rule 64J-1.004, F.A.C.

¹⁶ Percutaneous cardiac intervention (PCI), commonly known as coronary angioplasty or angioplasty, is a nonsurgical technique for treating obstructive coronary artery disease.

¹⁷ Section 395.1055(18)(a), F.S.

¹⁸ S. 408.0361(3)(b), F.S.

¹⁹ Heart condition caused by narrowed heart arteries. This is also called "coronary artery disease" and "coronary heart disease."

²⁰ Agency for Health Care Administration, Hospital & Outpatient Services Unit, Reports, Cardiovascular – Level I and II ACS, available at https://ahca.myflorida.com/MCHQ/Health_Facility_Regulation/Hospital_Outpatient/Reports.shtml (last visited Mar. 20, 2021).

Effect of the Bill

HB 397 requires DOH to annually send a list of providers of adult cardiovascular services to the medical director of each licensed EMS provider. It further requires DOH to develop a sample heart attack triage assessment tool to be posted on its website and distributed to each licensed EMS provider. In addition, the bill requires EMS providers to use a substantially similar assessment tool and requires EMS medical directors to develop and implement assessment, treatment, and transport protocols to ensure heart attack patients are transported to the most appropriate hospital.

The bill also requires a 911 PST to receive biennial telecommunicator CPR training in order to have their certification renewed. Further, the bill requires DOH to establish a procedure to monitor compliance with the training requirements and authorizes DOH to adjust state revenue funds to a public safety agency based on its employees' compliance with the requirements.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 395.3042, F.S., relating to emergency medical services providers; triage and transportation of heart attack victims to an adult cardiovascular services provider.

Section 2: Amends s. 401.465, F.S., relating to 911 public safety telecommunicator certification.

Section 3: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

DOH will incur costs associated with monitoring 911 PST adherence to the new CPR training requirement. It is estimated one FTE will be required at an annual cost of \$91,708 to monitor the completion of the required training. Additionally, DOH will be required to create a method of tracking completion of the training and it is estimated this one-time cost will be \$200,000.

DOH will also incur costs associated with rulemaking and developing the sample heart attack-triage assessment tool, which current resources are adequate to absorb.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

Local government emergency medical services providers may incur costs associated with creating a heart attack-triage assessment tool and developing assessment, treatment, and transport-destination protocols for heart attack patients.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Private emergency medical services providers may incur costs associated with creating a heart attack-triage assessment tool and developing assessment, treatment, and transport-destination protocols for heart attack patients.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

DOH has sufficient rule-making authority to implement the provisions of the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

The bill requires DOH to establish a procedure to monitor adherence to the training requirements created by the bill and authorizes DOH to adjust state grant or shared revenue funds to a public safety agency as defined in s. 365.171(3)(d), F.S., based on its employees' adherence or failure to adhere to such requirements.²¹ DOH does not currently have regulatory authority over public safety agencies as defined in s. 365.171(3)(d), F.S.²²

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

²¹ Public safety agency means a functional division of a public agency which provides firefighting, law enforcement, medical, or other emergency services.

²² *Supra* note 9.

1 A bill to be entitled
2 An act relating to cardiovascular emergency protocols
3 and training; creating s. 395.3042, F.S.; requiring
4 the Department of Health to send a list of certain
5 providers of adult cardiovascular services to
6 specified persons and entities annually; requiring the
7 department to develop a sample heart attack-triage
8 assessment tool to be posted on its website and
9 distributed to licensed emergency medical services
10 providers; requiring such providers to use the
11 assessment tool; requiring medical directors of such
12 providers to develop and implement certain specified
13 protocols; requiring that such protocols include the
14 development and implementation of certain plans;
15 requiring the compliance of certain licensed emergency
16 medical services providers; amending s. 401.465, F.S.;
17 providing a definition for the term "telecommunicator
18 cardiopulmonary resuscitation training"; conforming
19 cross-references; requiring certain 911 public safety
20 telecommunicators to receive biannual telecommunicator
21 cardiopulmonary resuscitation training; requiring the
22 department to establish a procedure to monitor
23 adherence to the training requirements; authorizing
24 the department to adjust state grants or shared
25 revenue funds to certain entities based on their

employees' adherence or failure to adhere to the training requirements; providing an effective date.

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

Section 1. Section 395.3042, Florida Statutes, is created to read:

395.3042 Emergency medical services providers; triage and transportation of heart attack victims to an adult cardiovascular services provider.-

(1) By June 1 of each year, the department shall send a list of providers of Level I and Level II adult cardiovascular services to the medical director of each licensed emergency medical services provider in the state.

(2) The department shall develop a sample heart attack-triage assessment tool. The department must post this sample assessment tool on its website and provide a copy of the assessment tool to each licensed emergency medical services provider. Each licensed emergency medical services provider must use a heart attack-triage assessment tool that is substantially similar to the sample heart attack-triage assessment tool provided by the department.

(3) The medical director of each licensed emergency medical services provider shall develop and implement assessment, treatment, and transport-destination protocols for

51 heart attack patients with the intent to assess, treat, and
52 transport heart attack patients to the most appropriate
53 hospital. Such protocols must include the development and
54 implementation of plans for the triage and transport of patients
55 with acute heart attack symptoms.

56 (4) Each emergency medical services provider licensed
57 under chapter 401 must comply with this section.

58 Section 2. Subsections (3) and (4) of section 401.465,
59 Florida Statutes, are renumbered as subsections (4) and (5),
60 respectively, paragraphs (d) and (j) of subsection (2) of that
61 section are amended, paragraph (d) is added to subsection (1) of
62 that section, and a new subsection (3) is added to that section,
63 to read:

64 401.465 911 public safety telecommunicator certification.—

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

66 (d) "Telecommunicator cardiopulmonary resuscitation
67 training" means specific training, including continuous
68 education, that is evidence based and contains nationally
69 accepted guidelines for high-quality telecommunicator
70 cardiopulmonary resuscitation with the recognition of out-of-
71 hospital cardiac arrest over the telephone and the delivery of
72 telephonic instructions for treating cardiac arrest and
73 performing compression-only cardiopulmonary resuscitation.

74 (2) PERSONNEL; STANDARDS AND CERTIFICATION.—

75 (d) The department shall determine whether the applicant

76 meets the requirements specified in this section and in rules of
77 the department and shall issue a certificate to any person who
78 meets such requirements. Such requirements must include the
79 following:

80 1. Completion of an appropriate 911 public safety
81 telecommunication training program;

82 2. Certification under oath that the applicant is not
83 addicted to alcohol or any controlled substance;

84 3. Certification under oath that the applicant is free
85 from any physical or mental defect or disease that might impair
86 the applicant's ability to perform his or her duties;

87 4. Submission of the application fee prescribed in
88 subsection (4) ~~(3)~~;

89 5. Submission of a completed application to the department
90 which indicates compliance with subparagraphs 1., 2., and 3.;
91 and

92 6. Effective October 1, 2012, passage of an examination
93 approved by the department which measures the applicant's
94 competency and proficiency in the subject material of the public
95 safety telecommunication training program.

96 (j)1. The requirement for certification as a 911 public
97 safety telecommunicator is waived for a person employed as a
98 sworn state-certified law enforcement officer, provided the
99 officer:

100 a. Is selected by his or her chief executive to perform as

101 a 911 public safety telecommunicator;

102 b. Performs as a 911 public safety telecommunicator on an
103 occasional or limited basis; and

104 c. Passes the department-approved examination that
105 measures the competency and proficiency of an applicant in the
106 subject material comprising the public safety telecommunication
107 program.

108 2. A sworn state-certified law enforcement officer who
109 fails an examination taken under subparagraph 1. must take a
110 department-approved public safety telecommunication training
111 program prior to retaking the examination.

112 3. The testing required under this paragraph is exempt
113 from the examination fee required under subsection (4) ~~(3)~~.

114 (3) TELECOMMUNICATOR CARDIOPULMONARY RESUSCITATION
115 TRAINING.—

116 (a) In addition to the certification and recertification
117 requirements contained in this section, 911 public safety
118 telecommunicators who take telephone calls and provide dispatch
119 functions for emergency medical conditions shall also receive
120 telecommunicator cardiopulmonary resuscitation training every 2
121 years.

122 (b) The department shall establish a procedure to monitor
123 adherence to the training requirements of this subsection and
124 may adjust state grant or shared revenue funds to a public
125 safety agency as defined in s. 365.171(3)(d) based on its

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2021

126 | employees' adherence or failure to adhere to such requirements.

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

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 397 (2021)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ☐ (Y/N)
ADOPTED AS AMENDED ☐ (Y/N)
ADOPTED W/O OBJECTION ☐ (Y/N)
FAILED TO ADOPT ☐ (Y/N)
WITHDRAWN ☐ (Y/N)
OTHER ☐

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative DiCeglie offered the following:

Amendment (with title amendment)

Remove lines 119-126 and insert:
functions for emergency medical conditions shall be required to complete telecommunicator cardiopulmonary resuscitation training every 2 years.

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

Remove lines 20-27 and insert:
telecommunicators to complete biannual telecommunicator cardiopulmonary resuscitation training; providing an

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Published On: 4/8/2021 10:08:43 AM

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. HB 397 (2021)

Amendment No.

17 | effecctive date.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 837 Harm to Children

SPONSOR(S): Children, Families & Seniors Subcommittee, Byrd

TIED BILLS: **IDEN./SIM. BILLS:** SB 948

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	16 Y, 0 N, As CS	Woodruff	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

To protect Florida's children from child abuse, abandonment, or neglect, the Department of Children and Families (DCF) operates the Florida central abuse hotline (hotline), which accepts reports 24 hours a day, 7 days a week. Any person who knows or suspects that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare must report such information or suspicion to the hotline. If reports meet the statutory criteria for abuse, abandonment, or neglect, a child protective investigation is commenced.

A child protection team (CPT) is a medically directed, multidisciplinary team contracted by the Department of Health (DOH) that supplements the child protective investigation efforts of DCF and local sheriffs' offices in cases of child abuse or neglect. Certain cases reported to the hotline must be referred to CPTs.

The bill expands the definition of "harm" to include situations where a person responsible for a child's welfare fails to use a child restraint or seat belt required by law or leaves a child younger than 6 years of age unattended or unsupervised in a vehicle. In these situations, a child protective investigation would be required if a physician, licensed under ch. 458 or 459, F.S., substantiates that the failure to use a child restraint or seatbelt or leaving a child younger than 6 in a vehicle unattended or unsupervised resulted in the child's injury or death. The bill also requires a mandatory referral of these cases from DCF to CPTs.

Additionally, the bill requires DCF to refer cases to CPTs if the report is from an emergency room physician.

The bill has an indeterminate, but likely insignificant, fiscal impact on DCF, DOH, and the community-based care lead agencies. There is no fiscal impact on local governments. See fiscal comments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Child Welfare System

The child welfare system identifies families whose children are in danger of suffering or have suffered abuse, abandonment, or neglect and works with those families to address the problems that are endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

Florida Central Abuse Hotline

The Department of Children and Families (DCF) operates the Florida central abuse hotline (hotline), which accepts reports 24 hours a day, 7 days a week of known or suspected child abuse, abandonment, or neglect.¹ A child protective investigation begins with a report by any person to the hotline. Statute mandates any person who knows or suspects that a child is abused, abandoned, or neglected by a parent, legal custodian, caregiver, or other person responsible for the child's welfare, or that a child is in need of supervision and care and has no parent, legal custodian, or responsible adult relative immediately known and available to provide supervision and care, to report such knowledge or suspicion to the hotline.²

Once the hotline obtains information from a reporter, the allegations must meet the statutory definition required to trigger a child protective investigation. For the report to be accepted for an investigation there must be reasonable cause to believe that the child was harmed by abuse, abandonment, or neglect, or the child is at risk of harm.³

Under s. 39.01(35), F.S., "harm" to a child's health or welfare can occur when any person:

- Inflicts or allows to be inflicted upon the child physical, mental, or emotional injury, which include, but is not limited to, willful acts that produce specific injuries specified in statute.
- Purposely giving a child poison, alcohol, drugs, or other substance that substantially affects the child's behavior or that results in sickness or internal injury.
- Leaving a child without proper adult supervision.
- Inappropriate or excessively harsh disciplinary action that is likely to result in physical, mental, or emotional injury.
- Commits or allows to be committed sexual battery or lewd or lascivious acts against the child.
- Allows, encourages, or forces the sexual exploitation of a child.
- Exploits a child or allows a child to be exploited as provided in s. 450.151, F.S.
- Abandons or neglects a child.
- Exposes the child to a controlled substance or alcohol.
- Uses mechanical devices, unreasonable restraints, or an extended period of isolation to control the child.
- Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.
- Negligently fails to protect a child in his or her care from physical, mental, or sexual injury caused by the acts of another.
- Has allowed a child's sibling to die as a result of abuse, abandonment, or neglect.
- Makes the child unavailable for a protective investigation unless fleeing from domestic violence.

¹ S. 39.201(5), F.S.

² S. 39.201(1)(a), F.S.

³ S. 39.201(2), F.S.

If the allegations meet the statutory requirements for a child protective investigation, an investigation must be commenced either immediately or within 24 hours after the report is received, depending on the nature of the allegation.⁴

Case Management and Child Welfare Services

If a child protective investigation results in verified findings of abuse or neglect, the dependency court will approve a case plan for the parent, and services are provided to the family to address the problems that are endangering the child. DCF contracts for case management, out-of-home care, and related services with community-based care organizations (CBCs). The model of using CBCs to provide child welfare services is designed to increase local community ownership of service delivery and design.⁵

CBCs are responsible for providing foster care and related services including, but not limited to, counseling, domestic violence services, substance abuse services, family preservation, emergency shelter, and adoption. CBCs contract with a number of subcontractors for case management and direct care services to children and their families. There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.⁶

Child Protection Teams

A child protection team (CPT) is a medically directed, multidisciplinary team that supplements the child protective investigation efforts in cases of child abuse and neglect.⁷ CPTs are independent community-based programs contracted by the Department of Health (DOH) Children's Medical Services that provide expertise in evaluating alleged child abuse or neglect, assess risk and protective factors, and provide recommendations for interventions to protect children and enhance a caregiver's capacity to provide a safer environment when possible.⁸ The state is divided into 15 circuits and DOH assigns a CPT to each. CPTs serve all 67 counties by utilizing satellite offices and telemedicine services.⁹ Each of the 15 circuits served by CPTs are supervised by one or multiple CPT directors, depending on the size and subdivision of the particular circuit.¹⁰

DCF must refer the following reports of child abuse, abandonment, or neglect to CPTs for assessment and other appropriate available support services:

- Injuries to the head, bruises to the neck, or head, burns or fractures in a child of any age.
- Bruises anywhere on a child 5 years of age or under.
- Any report alleging sexual abuse of a child.
- Any sexually transmitted disease in a prepubescent child.
- Reported malnutrition of a child and failure of a child to thrive.
- Reported medical neglect of a child.
- A sibling or other child remaining in a home where one or more children have been pronounced dead on arrival or have been injured and later died as a result of suspected abuse, abandonment, or neglect.
- Symptoms of serious emotional problems in a child when emotional or other abuse, abandonment, or neglect is suspected.
- A child who does not live in this state who is currently being evaluated in a medical facility in this state.¹¹

⁴ S. 39.301(1), F.S.

⁵ Florida Department of Children and Families, *Community-Based Care*, <http://www.dcf.state.fl.us/service-programs/community-based-care/> (last visited Mar. 15, 2021).

⁶ Florida Department of Children and Families, *Community Based Care Lead Agency Map*, <https://www.myflfamilies.com/service-programs/community-based-care/lead-agency-map.shtml> (last visited Mar. 15, 2021).

⁷ Children's Medical Services, *Child Protection Teams*, http://www.cms-kids.com/families/child_protection_safety/child_protection_teams.html (last visited Mar. 15, 2021).

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ S. 39.303(4), F.S.

Currently, child abuse and neglect reports to the hotline from emergency room physicians are assessed and a case may be accepted for CPT services based on the information provided.

When a CPT accepts a referral from DCF or law enforcement, it may provide one or more of the following services:

- Medical diagnosis and evaluation.
- Telephone consultation services during emergencies and other situations.
- Psychological and psychiatric evaluations.
- Expert court testimony.
- Multidisciplinary staffings.
- Case service coordination and assistance.
- Community awareness campaigns.
- Child forensic interviews, family psychosocial interviews, or specialized clinical interviews.¹²

CPT staff also train child protective investigators, community providers of child welfare services, and emergency room staff and other medical providers in the community to develop and maintain their professional skills and abilities in handling child abuse, abandonment, and neglect cases.¹³

State Laws Protecting Children in Motor Vehicles

Child Restraint and Safety Belts

Florida law requires the use of seat belts and child restraint devices, if applicable, by drivers, all front seat passengers, and all children under the age of 18 riding in a motor vehicle.

Currently, the hotline accepts reports of children who are harmed due to the failure of a parent to use a child restraint required by law. These reports are accepted under the maltreatment of “inadequate supervision”.¹⁴ Previously, DCF required two mitigating criteria before accepting the report: either the parent had to be cited for reckless driving or under the influence of drugs or alcohol, in addition to the child not being properly restrained.¹⁵ However, in 2018, DCF updated its rule to allow investigations based solely on the parent’s or legal guardian’s failure to properly safeguard a child if the omission resulted in serious harm or death of the child.¹⁶

Under s. 316.613, F.S., the driver of a motor vehicle transporting a child through 5 years of age must properly use a crash-tested, federally-approved child restraint device for the child. For children through age 3, such restraint device must be a separate carrier or a vehicle manufacturer’s integrated child seat.¹⁷

For children age 4 through age 5, a separate carrier, an integrated child seat, or a child booster seat may be used.¹⁸ However, the requirements to use a child restraint device for children in this age range do not apply when a safety belt is being used and the child is being transported:

- gratuitously by a driver who is not a member of the child’s immediate family;
- in a medical emergency situation involving the child; or
- has a medical condition diagnosed by a health care professional that necessitates an exception.¹⁹

¹² S. 39.303(3), F.S.

¹³ S. 39.303(3)(h), F.S.

¹⁴ DCF’s operating procedures define “inadequate supervision” as a parent or caregiver leaving a child without adult supervision or arrangement appropriate for the child’s age, maturity, developmental level or mental or physical condition so that the child is unable to care for the child’s own needs or another basic need, or is unable to exercise sufficient judgement in responding to a physical or emotional crisis.

¹⁵ Florida Department of Children and Families, *2020 Agency Bill Analysis for HB 413* (Nov. 19, 2019)(on file with the Children, Families, and Seniors Subcommittee).

¹⁶ *Id.*

¹⁷ S. 316.613(1)(a)1., F.S.

¹⁸ S. 316.613(1)(a)2., F.S.

¹⁹ *Id.*

Florida law gives the option for children six years of age or older to continue to use a booster seat or begin wearing safety belts.

Additionally, under s. 316.614, F.S., it is unlawful for any person to drive a motor vehicle or an autocycle²⁰ in Florida unless the driver and each passenger under the age of 18 are restrained by a safety belt or a child restraint device pursuant to s. 316.613, F.S.²¹ The requirements of s. 316.614, F.S., do not apply to motor vehicles that are not required to be equipped with safety belts under federal law.²²

Under ss. 316.613 and 316.614, F.S., a motor vehicle does not include a:

- School bus;
- Bus used for the transportation of persons for compensation, unless the bus is regularly used to transport children to or from school or in conjunction with school activities;
- Farm tractor or implement of husbandry;
- Truck having a gross vehicle weight rating or more than 26,000 pounds; or
- Motorcycle, moped, or bicycle.

The child restraint requirements imposed by s. 316.613, F.S., do not apply to a chauffeur-driven taxi, limousine, sedan, van, bus, motor coach, or other passenger vehicle if the driver and the vehicle were hired and used for transportation.²³ It is the caregiver's responsibility to comply with the child restraint requirements in these situations.²⁴

Any person violating ch.316, F.S., commits a moving violation and is charged with a noncriminal infraction and must be cited for such an infraction²⁵ and cited to appear before a judge authorized by law to preside over a court or hearing adjudicating traffic infractions.²⁶ If another person dies because of the noncriminal infraction, the person cited is required to appear at a mandatory hearing (instead of having the option to pay a penalty in lieu of a hearing), perform 120 community service hours in a trauma center or hospital that regularly receives victims of vehicle accidents, and may be subjected to other civil or criminal penalties, such as if there's a negligence claim or the person is charged with a crime.²⁷

In 2019, there were 127,285 crashes in Florida involving children under the age of 18, resulting in 1,361 serious injuries and 142 fatalities.²⁸ The Florida Department of Highway Safety and Motor Vehicles (DHSMV) reports there were 7,461 accidents where a child restraint device was not used.²⁹ Further, in 2020, there were 8,595 citations given for no or improper child restraint device and leaving a child unattended in a motor vehicle.³⁰

²⁰ An autocycle is a three-wheeled motorcycle that has two wheels in the front and one wheel in the back; is equipped with a roll cage or roll hoops, a seat belt for each occupant, antilock brakes, a steering wheel, and seating that does not require the operator to straddle or sit astride it; and is manufactured in accordance with the applicable federal motorcycle safety standards by a manufacturer registered with the National Highway Traffic Safety Administration.

²¹ S. 316.614(4), F.S.

²² S. 316.614(6)(d), F.S.

²³ S. 316.613(6), F.S.

²⁴ *Id.*

²⁵ Under s. 318.13, F.S., an "infraction" means a noncriminal violation that may require community service hours under s. 316.027(4), F.S., but is not punishable by incarceration and for which there is no right to a trial by jury or a right to court-appointed counsel.

²⁶ S. 318.14(1), F.S. A person who is not required to appear at a mandatory hearing under s. 318.19, F.S., may elect to pay a civil penalty and delinquent fee, if applicable, either by mail or in person, or enter into a payment plan to pay the civil penalty and delinquent fee, if applicable.

²⁷ Any person cited for an infraction that results in a crash that causes the death of another will be required to appear at a mandatory hearing.

²⁸ Florida Highway Safety and Motor Vehicles, Children Involved in a Crash in Florida by Injury Severity and Type of Restraint System Used, <https://www.flhsmv.gov/safety-center/child-safety/safety-belts-child-restraints/child-restraint-data-dashboard/> (last visited Mar. 15, 2021).

²⁹ *Id.*

³⁰ Florida Highway Safety and Motor Vehicles, 2021 Agency Bill Analysis for HB 837 (Feb. 5, 2021).

DHSMV reports that from 2013-2020, an average of 1,287 minors received an incapacitating injury and an average of 102 child fatalities occurred from motor vehicle accidents each year.³¹ It is unknown how many of these children were not properly restrained.³²

Currently, a CPT may accept referrals related to the lack of proper use of a child restraint or seatbelts. However, the case would not constitute a mandatory referral unless it met one of the criteria outlined in s. 39.303(4), F.S.

Leaving Children Unattended or Unsupervised in a Vehicle

Section 316.6135, F.S., prohibits a caregiver³³ from leaving a child younger than 6 years of age unattended or unsupervised in a motor vehicle longer than 15 minutes, or for any period of time while the motor vehicle is running, the health of the child is in danger, or the child appears to be in distress. Each of these violations has its own penalties.³⁴

If the caregiver leaves a child younger than 6 years of age unattended or unsupervised in a vehicle longer than 15 minutes, or for any period of time while the motor vehicle is running, the child's health is in danger, or the child appears to be in distress, and that action causes great bodily harm, permanent disability, or permanent disfigurement to a child, then the person commits a third degree felony punishable as provided in ss. 775.082, 775.083, or 775.084, F.S.

Any law enforcement officer who observes a child left unattended or unsupervised in a motor vehicle may use whatever means reasonably necessary to protect the child and remove the child from the motor vehicle.³⁵ If the law enforcement officer is unable to locate a caregiver, the child is required to be placed in DCF's custody pursuant to ch. 39, F.S.³⁶

Children experience different types of dangers if left unattended or unsupervised in a motor vehicle, such as heatstroke, setting the car in motion, seatbelt strangulation and leaving the car voluntarily.³⁷ From January 1990 to December 2014, there were 11,759 non-traffic injuries and fatalities in the US to children 0 to 14 years of age, with a median age of the affected children being 3.7 years.³⁸ The incident types include:

- 3,115 children unattended in hot vehicles resulting in 729 deaths.
- 2,251 backovers³⁹ resulting in 1,232 deaths.
- 1,439 frontovers⁴⁰ resulting in 692 deaths.
- 777 vehicles knocked into motion resulting in 227 deaths.
- 415 underage drivers resulting in 203 deaths.
- 173 power window incidents resulting in 61 deaths.
- 134 falls resulting in 54 deaths.
- 79 fires resulting in 41 deaths.
- 3,377 other incidents resulting in 157 deaths.⁴¹

³¹ Florida Department of Health, *2021 Agency Bill Analysis for HB 837* (Mar. 3, 2021).

³² *Id.*

³³ The term "caregiver" encompasses a parent, legal guardian, or other person responsible for a child's welfare.

³⁴ Pursuant to s. 316.6135(2), F.S., a caregiver who leaves a child younger than 6 years of age unattended or unsupervised in a motor vehicle longer than 15 minutes commits a second degree misdemeanor punishable up to 60 days in jail and a \$500 maximum fine. Pursuant s. 316.6135(3), F.S., a caregiver who leaves a child younger than 6 years of age unattended or unsupervised in a motor vehicle for any period of time while the vehicle is running, the health of the child is in danger, or the child appears to be in distress is guilty of noncriminal traffic infraction punishable by a fine not less than \$50 and not more than \$500.

³⁵ S. 316.6135(5), F.S.

³⁶ S. 316.6135(7), F.S.

³⁷ Kids and Cars, *NEVER Leave a Child Alone Inside a Vehicle... Not Even for a Minute!*, <http://www.kidsandcars.org/wp-content/uploads/2019/02/Kids-Alone-in-Cars-FACT-SHEET.pdf> (last visited Mar. 15, 2021).

³⁸ Mark R. Zonfrillo, et al., *Unintentional non-traffic injury and fatal events: Threats to children in and around vehicles*, Traffic Injury Prevention, 19:2, 184-188, <https://docs.house.gov/meetings/IF/IF17/20190523/109548/HHRG-116-IF17-Wstate-FennellJ-20190523-SD004.pdf#page=5&zoom=100,0,66> (last visited Mar. 15, 2021).

³⁹ Backovers are defined as a child being backed over by vehicle traveling in reverse.

⁴⁰ Frontovers are defined as a slow forward-moving vehicle running over a child.

⁴¹ *Supra* note 35.

Since 1998, 882 children have died nationwide due to vehicular heatstroke.⁴² The national average of child heatstroke deaths per year since 1998 is 38. Fifty-five percent of these deaths involve children under the age of one.⁴³ Forty-six of the 432 child vehicular heatstroke deaths from 2010-2020 in the U.S. occurred in Florida.⁴⁴

Currently, a CPT may accept referrals related to children left unattended or unsupervised in motor vehicles. However, the case would not constitute a mandatory referral unless it met a criterion outlined in s. 39.303(4), F.S.⁴⁵

Effect of Proposed Changes

Expanding the Definition of “Harm”

The bill amends s. 39.01(35), F.S., to also consider as “harm” any violations of:

- child restraint requirements in s. 316.613, F.S.;
- seat belt requirements in s. 316.614, F.S.;
- s. 316.6135, F.S., which relates to leaving a child unattended or unsupervised in a motor vehicle if a physician licensed under ch. 458 or 459, F.S., substantiates that the violation caused the child’s injury or death.

By expanding the definition of harm, more situations would meet the statutory criteria for a child protective investigation.

The bill is more comprehensive than DCF’s current agency rule, because the bill encompasses *all* injuries due to violations of child restraint or seat belt requirements or injuries from leaving a child unattended or unsupervised in a vehicle, and not just those that are deemed serious. This could potentially result in an increased number of reports to the hotline and additional child protective investigations. As a result, CBCs and their subcontractors may be required to provide services to these children and families.

Child Protection Teams

The bill amends s. 39.303(4), F.S., to require DCF to refer the following hotline reports to CPTs for an assessment when a physician licensed under ch. 458 or 459, F.S., substantiates an injury or death to a child is exacerbated by not properly being restrained in a motor vehicle with a child restraint or seatbelt pursuant to ss. 316.613, F.S., or 316.614, F.S., or from being left unattended or unsupervised in a vehicle, if the child is younger than 6 years of age.

The bill also requires mandatory referrals to CPTs on cases reported to DCF from emergency room physicians. From July 27 – December 8, 2019,⁴⁶ the hotline received 204 reports from emergency room physicians, 201⁴⁷ of which were accepted for a child protective investigation.⁴⁸

⁴² U.S. Department of Transportation (USDOT), Traffic Safety Marketing, *Child Safety: Heatstroke Prevention*, See Kids and Cars.org, Children Vehicular Heatstroke Deaths by Year, https://www.trafficsafetymarketing.gov/get-materials/child-safety/heatstroke-prevention?_ga=2.56158690.870054613.1615229487-1650636428.1615229487 (last visited Mar. 10, 2021).

⁴³ Kids and Cars.org, Fact Sheet, <https://www.kidsandcars.org/wp-content/uploads/2020/01/Heatstroke-fact-sheet.pdf> (last visited Mar. 10, 2021).

⁴⁴ Email from Prof. Jan Null, Certified Consulting Meteorologist, Department of Meteorology & Climate Services, San Jose State University, RE: Updated spreadsheet on Child Vehicle Heat Stroke Deaths (Mar. 11, 2021). See also Kids and Cars, 2018-2020 Child Hot Car Deaths, <https://www.kidsandcars.org/2018-u-s-child-hot-car-fatalities/>, <https://www.kidsandcars.org/2019-child-hot-car-deaths/>, and <https://www.kidsandcars.org/2020-child-hot-car-deaths/> (last visited Mar. 11, 2021).

⁴⁵ *Supra* note 28.

⁴⁶ The option to track hotline reports from emergency room physicians was added to DCF’s system in July 2019, so the data is new and limited.

⁴⁷ The three calls that were screened-out was due to an error in identifying the occupation of the caller or due to incorrect coding of the call.

Some abuse or neglect cases in the above situation might already meet criteria for a mandatory referral to CPTs.⁴⁹ CPTs may also choose to review other cases that do not meet the criteria for a mandatory referral based on information provided in the hotline report. Therefore, the number of additional reports likely to be received that would not currently be referred to CPTs for an assessment is unknown.⁵⁰

CPTs will need to review the cases and provide services deemed necessary and appropriate.

B. SECTION DIRECTORY:

Section 1: Amending s 39.01, F.S., relating to definitions.

Section 2: Amending s. 39.303, F.S., relating to child protection teams and sexual abuse treatment programs; services; eligible cases.

Section 3: Amending 39.302, F.S., relating to protective investigations of institutional child abuse, abandonment, or neglect.

Section 4: Amending s. 39.521, F.S., relating to disposition hearings; powers of disposition.

Section 5: Amending s. 39.6012, F.S., relating to case plan tasks; services.

Section 6: Providing an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

Expanding the Definition of Harm (DCF)

There is an indeterminate, but likely insignificant, fiscal impact to DCF. By expanding the definition of harm, child protective investigators may experience an increased workload because more situations would meet the statutory required criteria to initiate a child protective investigation. It is unknown how many additional investigations would materialize by expanding the definition of harm, pursuant to the provisions of the bill. Current department policy is guided by Rule that authorizes the Hotline to accept reports of infants and children who are not properly restrained.⁵¹ Furthermore, the broad maltreatment category of “inadequate supervision” for all suspected abuse reports allows DCF to investigate reports that don’t result in injury or death. The department projects additional reports to the Hotline could result in 4,866 child protective investigations per year; however, DCF does not believe that additional resources are needed to process the additional workload as current practice already includes Hotline complaints based on improper child restraint practices.⁵²

Cases Referred to CPTs (DOH)

To the extent that DCF child protective investigators refer certain abuse reports to Child Protection Teams, an increase of abuse allegations to the Hotline may result in a workload increase to CPTs. The fiscal impact is indeterminate as its unknown how may additional referrals may result from the provisions of the bill. Similar to the current DCF policy of accepting Hotline reports from incidents involving improper vehicular child restraint, statute lists nine situations that require a referral from DCF to CPTs, of which four injuries are common to vehicular accidents (e.g., injuries to the head,

⁴⁸ Email from Kimora McConnell, Florida Department of Children and Families, RE: Data request, (Dec. 12, 2019).

⁴⁹ For example, if a child was in a car accident, was not properly restrained, and experienced injuries to the head, the report would meet the criteria for a mandatory referral to CPT for assessment.

⁵⁰ *Supra* note 28.

⁵¹ 65C-29.003(6)(e), Florida Administrative Code

⁵² Florida Department of Children and Families, *2021 Agency Bill Analysis for HB 837* (March 1, 2021).

bruises anywhere on the body, etc.).⁵³ While the increase of referrals that may result from this bill remains indeterminate, it's likely many incidents that arise from improper use of child restraints are investigated under current practice within existing resources. Over the past two fiscal years, the Legislature has appropriated an additional \$3 million in funding for CPTs to address increases in workload and can absorb the additional costs as a result of the bill.

FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

B. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Expanding the Definition of Harm

There is an indeterminate but likely insignificant impact to CBCs. It is unknown how many investigations due to expanding the definition of "harm" would result in case management services being required. Therefore, it is difficult to project the fiscal impact on the CBCs and their subcontractors' caseloads but the impact is likely insignificant.

C. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not applicable. The bill does not appear to require counties or municipalities to spend funds or take action requiring the expenditures of funds; reduce the authority that counties or municipalities have to raise revenues in the aggregate; or reduce the percentage of state tax shared with counties or municipalities.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The agencies impacted by the bill have sufficient rulemaking authority to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2021, the Children, Families, and Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment includes Doctors of Osteopathic

⁵³ Ibid.

Medicine licensed under ch. 459, F.S., to those who may substantiate whether a violation caused a child's injury or death.

The analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

CS/HB 837

2021

1 A bill to be entitled
2 An act relating to harm to children; amending s.
3 39.01, F.S.; expanding the definition of the term
4 "harm" to include violations of certain motor vehicle
5 laws that result in the death of or injury to a child
6 under certain circumstances; amending s. 39.303, F.S.;
7 expanding the types of reports that the Department of
8 Children and Families must refer to Child Protection
9 Teams; amending ss. 39.302, 39.521, and 39.6012, F.S.;
10 conforming cross-references; providing an effective
11 date.

12
13 Be It Enacted by the Legislature of the State of Florida:
14

15 Section 1. Subsections (8) through (38) of section 39.01,
16 Florida Statutes, are renumbered as subsections (7) through
17 (37), respectively, present subsection (7) is renumbered as
18 subsection (38), and present subsection (35) is amended to read:

19 39.01 Definitions.—When used in this chapter, unless the
20 context otherwise requires:

21 (34) ~~(35)~~ "Harm" to a child's health or welfare can occur
22 when a ~~any~~ person:

23 (a) Inflicts or allows to be inflicted upon the child
24 physical, mental, or emotional injury. In determining whether
25 harm has occurred, the following factors must be considered in

26 | evaluating any physical, mental, or emotional injury to a child:
27 | the age of the child; any prior history of injuries to the
28 | child; the location of the injury on the body of the child; the
29 | multiplicity of the injury; and the type of trauma inflicted.

30 | Such injury includes, but is not limited to:

31 | 1. Willful acts that produce the following specific
32 | injuries:

- 33 | a. Sprains, dislocations, or cartilage damage.
- 34 | b. Bone or skull fractures.
- 35 | c. Brain or spinal cord damage.
- 36 | d. Intracranial hemorrhage or injury to other internal
37 | organs.
- 38 | e. Asphyxiation, suffocation, or drowning.
- 39 | f. Injury resulting from the use of a deadly weapon.
- 40 | g. Burns or scalding.
- 41 | h. Cuts, lacerations, punctures, or bites.
- 42 | i. Permanent or temporary disfigurement.
- 43 | j. Permanent or temporary loss or impairment of a body
44 | part or function.

45 |
46 | As used in this subparagraph, the term "willful" refers to the
47 | intent to perform an action, not to the intent to achieve a
48 | result or to cause an injury.

49 | 2. Purposely giving a child poison, alcohol, drugs, or
50 | other substances that substantially affect the child's behavior,

51 motor coordination, or judgment or that result in sickness or
52 internal injury. For the purposes of this subparagraph, the term
53 "drugs" means prescription drugs not prescribed for the child or
54 not administered as prescribed, and controlled substances as
55 outlined in Schedule I or Schedule II of s. 893.03.

56 3. Leaving a child without adult supervision or
57 arrangement appropriate for the child's age or mental or
58 physical condition, so that the child is unable to care for the
59 child's own needs or another's basic needs or is unable to
60 exercise good judgment in responding to any kind of physical or
61 emotional crisis.

62 4. Inappropriate or excessively harsh disciplinary action
63 that is likely to result in physical injury, mental injury as
64 defined in this section, or emotional injury. The significance
65 of any injury must be evaluated in light of the following
66 factors: the age of the child; any prior history of injuries to
67 the child; the location of the injury on the body of the child;
68 the multiplicity of the injury; and the type of trauma
69 inflicted. Corporal discipline may be considered excessive or
70 abusive when it results in any of the following or other similar
71 injuries:

- 72 a. Sprains, dislocations, or cartilage damage.
- 73 b. Bone or skull fractures.
- 74 c. Brain or spinal cord damage.
- 75 d. Intracranial hemorrhage or injury to other internal

76 organs.

77 e. Asphyxiation, suffocation, or drowning.

78 f. Injury resulting from the use of a deadly weapon.

79 g. Burns or scalding.

80 h. Cuts, lacerations, punctures, or bites.

81 i. Permanent or temporary disfigurement.

82 j. Permanent or temporary loss or impairment of a body
83 part or function.

84 k. Significant bruises or welts.

85 (b) Commits, or allows to be committed, sexual battery, as
86 defined in chapter 794, or lewd or lascivious acts, as defined
87 in chapter 800, against the child.

88 (c) Allows, encourages, or forces the sexual exploitation
89 of a child, which includes allowing, encouraging, or forcing a
90 child to:

91 1. Solicit for or engage in prostitution; or

92 2. Engage in a sexual performance, as defined by chapter
93 827.

94 (d) Exploits a child, or allows a child to be exploited,
95 as provided in s. 450.151.

96 (e) Abandons the child. Within the context of the
97 definition of "harm," the term "abandoned the child" or
98 "abandonment of the child" means a situation in which the parent
99 or legal custodian of a child or, in the absence of a parent or
100 legal custodian, the caregiver, while being able, has made no

101 significant contribution to the child's care and maintenance or
102 has failed to establish or maintain a substantial and positive
103 relationship with the child, or both. For purposes of this
104 paragraph, "establish or maintain a substantial and positive
105 relationship" includes, but is not limited to, frequent and
106 regular contact with the child through frequent and regular
107 visitation or frequent and regular communication to or with the
108 child, and the exercise of parental rights and responsibilities.
109 Marginal efforts and incidental or token visits or
110 communications are not sufficient to establish or maintain a
111 substantial and positive relationship with a child. The term
112 "abandoned" does not include a surrendered newborn infant as
113 described in s. 383.50, a child in need of services as defined
114 in chapter 984, or a family in need of services as defined in
115 chapter 984. The incarceration, repeated incarceration, or
116 extended incarceration of a parent, legal custodian, or
117 caregiver responsible for a child's welfare may support a
118 finding of abandonment.

119 (f) Neglects the child. Within the context of the
120 definition of "harm," the term "neglects the child" means that
121 the parent or other person responsible for the child's welfare
122 fails to supply the child with adequate food, clothing, shelter,
123 or health care, although financially able to do so or although
124 offered financial or other means to do so. However, a parent or
125 legal custodian who, by reason of the legitimate practice of

126 religious beliefs, does not provide specified medical treatment
127 for a child may not be considered abusive or neglectful for that
128 reason alone, but such an exception does not:

129 1. Eliminate the requirement that such a case be reported
130 to the department;

131 2. Prevent the department from investigating such a case;
132 or

133 3. Preclude a court from ordering, when the health of the
134 child requires it, the provision of medical services by a
135 physician, as defined in this section, or treatment by a duly
136 accredited practitioner who relies solely on spiritual means for
137 healing in accordance with the tenets and practices of a well-
138 recognized church or religious organization.

139 (g) Exposes a child to a controlled substance or alcohol.
140 Exposure to a controlled substance or alcohol is established by:

141 1. A test, administered at birth, which indicated that the
142 child's blood, urine, or meconium contained any amount of
143 alcohol or a controlled substance or metabolites of such
144 substances, the presence of which was not the result of medical
145 treatment administered to the mother or the newborn infant; or

146 2. Evidence of extensive, abusive, and chronic use of a
147 controlled substance or alcohol by a parent to the extent that
148 the parent's ability to provide supervision and care for the
149 child has been or is likely to be severely compromised.
150

As used in this paragraph, the term "controlled substance" means prescription drugs not prescribed for the parent or not administered as prescribed and controlled substances as outlined in Schedule I or Schedule II of s. 893.03.

(h) Uses mechanical devices, unreasonable restraints, or extended periods of isolation to control a child.

(i) Engages in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child.

(j) Negligently fails to protect a child in his or her care from inflicted physical, mental, or sexual injury caused by the acts of another.

(k) Has allowed a child's sibling to die as a result of abuse, abandonment, or neglect.

(l) Makes the child unavailable for the purpose of impeding or avoiding a protective investigation unless the court determines that the parent, legal custodian, or caregiver was fleeing from a situation involving domestic violence.

(m) Violates s. 316.613 or s. 316.614 and such violation results in the death of the child or injury to the child that requires treatment at a medical facility, if a physician licensed under chapter 458 or chapter 459 substantiates that the violation caused the child's death or injury.

(n) Violates s. 316.6135 and such violation results in the death of the child or injury to the child that requires

176 treatment at a medical facility, if a physician licensed under
177 chapter 458 or chapter 459 substantiates that the violation
178 caused the child's death or injury.

179 Section 2. Paragraphs (j), (k), and (l) are added to
180 subsection (4) of section 39.303, Florida Statutes, to read:

181 39.303 Child Protection Teams and sexual abuse treatment
182 programs; services; eligible cases.—

183 (4) The child abuse, abandonment, and neglect reports that
184 must be referred by the department to Child Protection Teams of
185 the Department of Health for an assessment and other appropriate
186 available support services as set forth in subsection (3) must
187 include cases involving:

188 (j) A child who was not properly restrained in a motor
189 vehicle pursuant to s. 316.613 or s. 316.614 and such action
190 resulted in harm as defined in s. 39.01(34)(m).

191 (k) A child who was left unattended or unsupervised in a
192 motor vehicle pursuant to s. 316.6135 and such action resulted
193 in harm as defined in s. 39.01(34)(n).

194 (l) Reports from emergency room physicians.

195 Section 3. Subsection (1) of section 39.302, Florida
196 Statutes, is amended to read:

197 39.302 Protective investigations of institutional child
198 abuse, abandonment, or neglect.—

199 (1) The department shall conduct a child protective
200 investigation of each report of institutional child abuse,

201 abandonment, or neglect. Upon receipt of a report that alleges
202 that an employee or agent of the department, or any other entity
203 or person covered by s. 39.01(36) ~~s. 39.01(37)~~ or (54), acting
204 in an official capacity, has committed an act of child abuse,
205 abandonment, or neglect, the department shall initiate a child
206 protective investigation within the timeframe established under
207 s. 39.201(5) and notify the appropriate state attorney, law
208 enforcement agency, and licensing agency, which shall
209 immediately conduct a joint investigation, unless independent
210 investigations are more feasible. When conducting investigations
211 or having face-to-face interviews with the child, investigation
212 visits shall be unannounced unless it is determined by the
213 department or its agent that unannounced visits threaten the
214 safety of the child. If a facility is exempt from licensing, the
215 department shall inform the owner or operator of the facility of
216 the report. Each agency conducting a joint investigation is
217 entitled to full access to the information gathered by the
218 department in the course of the investigation. A protective
219 investigation must include an interview with the child's parent
220 or legal guardian. The department shall make a full written
221 report to the state attorney within 3 working days after making
222 the oral report. A criminal investigation shall be coordinated,
223 whenever possible, with the child protective investigation of
224 the department. Any interested person who has information
225 regarding the offenses described in this subsection may forward

226 a statement to the state attorney as to whether prosecution is
227 warranted and appropriate. Within 15 days after the completion
228 of the investigation, the state attorney shall report the
229 findings to the department and shall include in the report a
230 determination of whether or not prosecution is justified and
231 appropriate in view of the circumstances of the specific case.

232 Section 4. Paragraph (c) of subsection (1) of section
233 39.521, Florida Statutes, is amended to read:

234 39.521 Disposition hearings; powers of disposition.—

235 (1) A disposition hearing shall be conducted by the court,
236 if the court finds that the facts alleged in the petition for
237 dependency were proven in the adjudicatory hearing, or if the
238 parents or legal custodians have consented to the finding of
239 dependency or admitted the allegations in the petition, have
240 failed to appear for the arraignment hearing after proper
241 notice, or have not been located despite a diligent search
242 having been conducted.

243 (c) When any child is adjudicated by a court to be
244 dependent, the court having jurisdiction of the child has the
245 power by order to:

246 1. Require the parent and, when appropriate, the legal
247 guardian or the child to participate in treatment and services
248 identified as necessary. The court may require the person who
249 has custody or who is requesting custody of the child to submit
250 to a mental health or substance abuse disorder assessment or

251 evaluation. The order may be made only upon good cause shown and
252 pursuant to notice and procedural requirements provided under
253 the Florida Rules of Juvenile Procedure. The mental health
254 assessment or evaluation must be administered by a qualified
255 professional as defined in s. 39.01, and the substance abuse
256 assessment or evaluation must be administered by a qualified
257 professional as defined in s. 397.311. The court may also
258 require such person to participate in and comply with treatment
259 and services identified as necessary, including, when
260 appropriate and available, participation in and compliance with
261 a mental health court program established under chapter 394 or a
262 treatment-based drug court program established under s. 397.334.
263 Adjudication of a child as dependent based upon evidence of harm
264 as defined in s. 39.01(34)(g) ~~s. 39.01(35)(g)~~ demonstrates good
265 cause, and the court shall require the parent whose actions
266 caused the harm to submit to a substance abuse disorder
267 assessment or evaluation and to participate and comply with
268 treatment and services identified in the assessment or
269 evaluation as being necessary. In addition to supervision by the
270 department, the court, including the mental health court program
271 or the treatment-based drug court program, may oversee the
272 progress and compliance with treatment by a person who has
273 custody or is requesting custody of the child. The court may
274 impose appropriate available sanctions for noncompliance upon a
275 person who has custody or is requesting custody of the child or

276 make a finding of noncompliance for consideration in determining
277 whether an alternative placement of the child is in the child's
278 best interests. Any order entered under this subparagraph may be
279 made only upon good cause shown. This subparagraph does not
280 authorize placement of a child with a person seeking custody of
281 the child, other than the child's parent or legal custodian, who
282 requires mental health or substance abuse disorder treatment.

283 2. Require, if the court deems necessary, the parties to
284 participate in dependency mediation.

285 3. Require placement of the child either under the
286 protective supervision of an authorized agent of the department
287 in the home of one or both of the child's parents or in the home
288 of a relative of the child or another adult approved by the
289 court, or in the custody of the department. Protective
290 supervision continues until the court terminates it or until the
291 child reaches the age of 18, whichever date is first. Protective
292 supervision shall be terminated by the court whenever the court
293 determines that permanency has been achieved for the child,
294 whether with a parent, another relative, or a legal custodian,
295 and that protective supervision is no longer needed. The
296 termination of supervision may be with or without retaining
297 jurisdiction, at the court's discretion, and shall in either
298 case be considered a permanency option for the child. The order
299 terminating supervision by the department must set forth the
300 powers of the custodian of the child and include the powers

ordinarily granted to a guardian of the person of a minor unless otherwise specified. Upon the court's termination of supervision by the department, further judicial reviews are not required if permanency has been established for the child.

4. Determine whether the child has a strong attachment to the prospective permanent guardian and whether such guardian has a strong commitment to permanently caring for the child.

Section 5. Paragraph (c) of subsection (1) of section 39.6012, Florida Statutes, is amended to read:

39.6012 Case plan tasks; services.—

(1) The services to be provided to the parent and the tasks that must be completed are subject to the following:

(c) If there is evidence of harm as defined in s. 39.01(34)(g) ~~s. 39.01(35)(g)~~, the case plan must include as a required task for the parent whose actions caused the harm that the parent submit to a substance abuse disorder assessment or evaluation and participate and comply with treatment and services identified in the assessment or evaluation as being necessary.

Section 6. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1093 Abuse, Neglect, and Abandonment Education
SPONSOR(S): Children, Families & Seniors Subcommittee, Valdés and others
TIED BILLS: **IDEN./SIM. BILLS:** SB 1100

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	17 Y, 0 N, As CS	Woodruff	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Chapter 39, F.S., creates the dependency system charged with protecting child welfare. Florida's child welfare system identifies children and families in need of services through reports to the central abuse hotline and child protective investigations. The Department of Children and Families (DCF) and community-based care lead agencies work with those families to address the problems endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

When the state takes a child into its custody, it accepts responsibility for the child's safety. Courts have found that foster children have a constitutional right to be free from unnecessary pain and a fundamental right to physical safety.

Florida law sets forth goals for the delivery of services to children in shelter or foster care, including that services should be directed by the principle that the health and safety of children should be of paramount concern.

The bill amends current law to require the design and delivery of child welfare services to be directed by the principle that the health and safety of children, including the freedom from abuse, abandonment, or neglect, is of paramount concern. It requires DCF to operate with the understanding that the rights of children in shelter or foster care are critical to their safety, permanency, and well-being. It requires DCF to work with all stakeholders to help children become knowledgeable about their rights.

The bill requires case managers or other staff to provide verbal and written instructions on how to identify and report child abuse, abandonment, or neglect to a child entering shelter or foster care. The case manager or other staff must review this information with a child every six months and upon every placement change until the child leaves shelter or foster care. The case manager must document in court reports and case notes the date the child received the information.

The bill also authorizes and encourages district school boards to establish educational programs for students ages 5 through 18 relating to the process for identifying and reporting abuse, neglect, or abandonment. This program may be provided in conjunction with other programs required by law.

The bill has an insignificant fiscal impact on state government that can be absorb within existing resources. The bill has no fiscal impact on local government.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

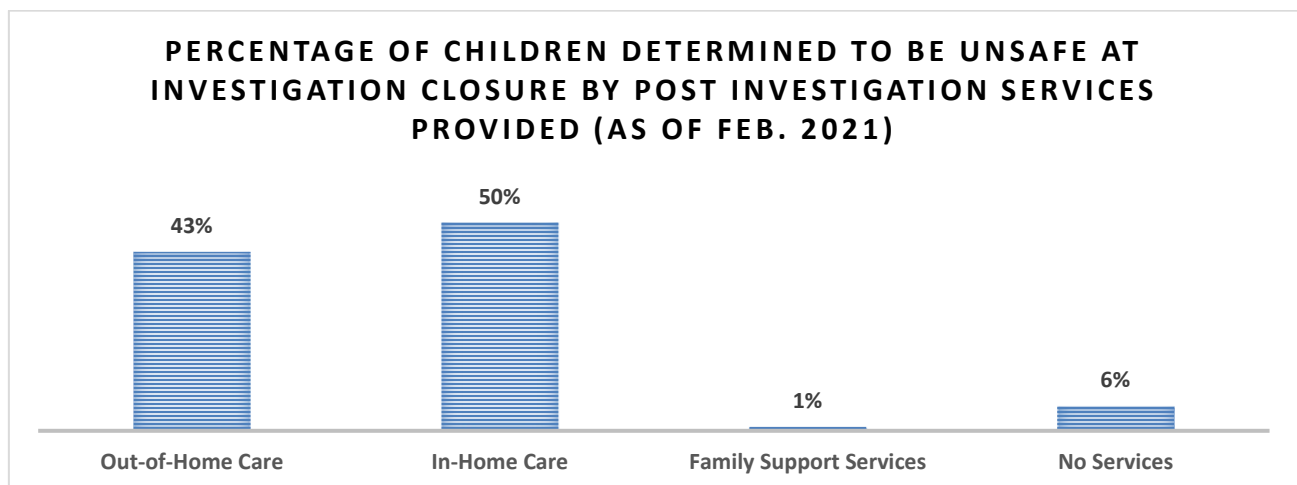
A. EFFECT OF PROPOSED CHANGES:

Background

Florida's Child Welfare System

Chapter 39, F.S., creates the dependency system charged with protecting child welfare. Florida's child welfare system identifies children and families in need of services through reports to the central abuse hotline and child protective investigations. The Department of Children and Families (DCF) and community-based care lead agencies (CBCs) work with those families to address the problems endangering children, if possible. If the problems cannot be addressed, the child welfare system finds safe out-of-home placements for these children.

DCF's practice model is based on the safety of the child within the home by using in-home services, such as parenting coaching and counseling, to maintain and strengthen that child's natural supports in his or her environment. The graph below shows the responses for children determined to be unsafe, depicting the percentage of such children placed in out-of-home placements, receiving services in the home or through family support services, which are offered to families on a voluntary basis, and receiving no services.¹



DCF contracts for case management, out-of-home services, and related services with CBCs. The outsourced provision of child welfare services is intended to increase local community ownership of service delivery and design. CBCs contract with a number of subcontractors for case management and direct care services to children and their families. There are 17 CBCs statewide, which together serve the state's 20 judicial circuits.

DCF remains responsible for a number of child welfare functions, including operating the central abuse hotline, performing child protective investigations, and providing children's legal services.² Ultimately, DCF is responsible for program oversight and the overall performance of the child welfare system.³

¹ Florida Department of Children and Families, Child Welfare Key Indicators Monthly Report, (Feb. 2021), http://centerforchildwelfare.fmhi.usf.edu/ga/cwkeyindicator/KI_Monthly_Report_Feb%202021.pdf (last visited Mar. 21, 2021).

² OPPAGA, report 06-50.

³ *Id.*

Rights of and Goals for Delivery of Services to Children in Foster Care

The U.S. and Florida Constitutions provide rights to individuals, including children in foster care, as do certain federal and state laws. Examples include basic rights and a right to privacy under Article I, §2 and Article I, §23 of the Florida Constitution, the right to high quality education under Article IX of the Florida Constitution, and due process rights under the U.S. Constitution.

When a state takes a child into custody, it accepts responsibility for the child's safety.⁴ Courts have found that foster children have a constitutional right to be free from unnecessary pain and a fundamental right to physical safety.⁵ When a state fails to meet that obligation, it deprives the child of a liberty interest under the Fourteenth Amendment.⁶

Section 39.4085, F.S., sets forth goals⁷ for the delivery of services to children in shelter or foster care, including that services should be directed by the principle that the health and safety of children should be of paramount concern and children in shelter or foster care should:

- Receive a copy of these goals and have the goals fully explained to them when they are placed in the custody of DCF.
- Enjoy individual dignity, liberty, pursuit of happiness, and the protection of their civil and legal rights as a person while in the custody of the state.
- Have their privacy protected, have their personal belongings secure and transported with them, and unless otherwise ordered by the court, have uncensored communication, including receiving and sending unopened communications and having access to a telephone.
- Have personnel providing services who are sufficiently qualified and experienced to assess risk children face prior to removal from their home and to meet the needs of the children once they are in DCF's custody.
- Remain in the custody of their parents or legal custodians unless and until there has been a determination by a qualified person exercising competent professional judgment that removal is necessary to protect their physical, mental, or emotional health or safety.
- Have a full risk, health, educational, medical, and psychological screening, and, if needed, assessment and testing upon adjudication into foster care; and to have their photograph and fingerprints included in their case management file.
- Be referred to and receive services, including necessary medical, emotional, psychological, psychiatric, and educational evaluations and treatment, as soon as practicable after identification of the need for such services by the screening and assessment process.
- Be placed in a home with no more than one other child, unless part of a sibling group.
- Be placed away from other children known to pose a threat of harm to them, either because of their own risk factors or those of the other child.
- Be placed in a home where the shelter or foster caregiver is aware of and understands the child's history, needs, and risk factors.
- Be the subject of a plan developed by the counselor and the shelter or foster caregiver to deal with identified behaviors that may present a risk to the child or others.
- Be involved and incorporated, where appropriate, in the development of the case plan, to have a case plan that will address their specific needs, and to object to any of the provisions in the case plan.
- Receive meaningful case management and planning that will quickly return the child to the family or move the child on to other forms of permanency.
- Receive regular communication with a case manager, at least once a month, which includes meetings with the child alone and conferring with the caregiver.

⁴ *Ray v. Foltz*, 370 F.3d 1079, 1082 (11th Cir. 2004)(citing *Taylor v. Ledbetter*, 818 F.2d 791-95 (11th Cir. 1987).

⁵ *Id.*

⁶ *Id.*

⁷ The provisions in S. 39.4085, F.S., establish goals, not rights. The section does not require the delivery of any particular service or level of service in excess of existing appropriations. A person does not have a cause of action against the state or any of its subdivisions, agencies, contractors, subcontractors, or agents, based upon the adoption of or failure to provide adequate funding for the achievement of these goals by the Legislature. The section does not require the expenditure of funds to meet the goals except funds specifically appropriated for such purpose.

- Enjoy regular visitation, at least once a week, with their siblings unless the court orders otherwise.
- Enjoy regular visitation with parents, at least once a month, unless the court orders otherwise.
- Receive a free and appropriate education, minimal disruption to their education, and retention in their home school, if appropriate; referral to the child study team; all special educational services, including, where appropriate, the appointment of a parent surrogate; the sharing of all necessary information between the school board and DCF, including information on attendance and educational progress.
- Be able to raise grievances with DCF over the care they are receiving from their caregivers, case managers, or other service providers.
- Be heard by the court, if appropriate, at all review hearings.
- Have a guardian ad litem appointed to represent, within reason, their best interests and, where appropriate, an attorney ad litem appointed to represent their legal interests. Their guardian ad litem and attorney ad litem must have immediate and unlimited access to the children they represent.
- Have all their records available for review by their guardian ad litem and attorney ad litem if they deem such review is necessary.
- Organize as a group for purposes of ensuring they receive the services and living conditions to which they are entitled and to provide support for one another while in DCF's custody.
- Be afforded prompt access to all available state and federal programs.

In accordance with s. 39.4091, F.S., caregivers for children in out-of-home care must use the "reasonable and prudent standard". This means that the caregiver must use sensible parental decision-making that maintains the child's health, safety, and best interests while at the same time encourages the child's emotional and developmental growth when determining whether to allow a child in out-of-home care to participate in extracurricular, enrichment, and social activities.⁸

Public Law 113-183, Preventing Sex Trafficking and Strengthening Families Act, requires that, as part of case planning beginning at age 14, children in foster care must be given a document describing their rights with respect to safety, exploitation, education, health, visitation, and court participation. They must also be informed of their rights to be provided certain specific documents such as copies of consumer credit reports. Children are to sign an acknowledgement that they received these documents.⁹

Educational Programs

Child Abuse, Abandonment, and Neglect

Section 39.001(9), F.S., requires the Office of Adoption and Child Protection, within the Governor's Office, to establish a comprehensive statewide approach for, in part, the prevention of child abuse, abandonment, and neglect.¹⁰ The Office of Adoption and Child Protection works in partnership with DCF, the Department of Education (DOE), and the Department of Health (DOH) to develop ways to inform and instruct appropriate district personnel in all school districts in the detection of child abuse, abandonment, and neglect, and the proper action to be taken if there is a suspicion of child abuse, abandonment, or neglect.

The Office of Adoption and Child Protection, DCF, DOE, and DOH must also work together to develop curriculum materials to assist personnel in providing instruction through a multidisciplinary approach on the identification, intervention, and prevention of child abuse, abandonment, and neglect.¹¹ The

⁸ Florida Department of Children and Families, CFOP 170-11, Ch. 6 (Sept. 2020), <https://www.myflfamilies.com/admin/publications/cfops/CFOP%20170-xx%20Child%20Welfare/CFOP%20170-11%20%20Placement/CFOP%20170-11.%20%20%20%20Placement.pdf>

⁹ Florida Department of Children and Families, 2021 Agency Bill Analysis for HB 1093 (March 7, 2021).

¹⁰ S. 39.001(9), F.S.

¹¹ S. 39.001(10)(b)2., F.S.

curriculum materials are geared toward a sequential program of instruction at the four progressional levels (K-3, 4-6, 7-9, and 10-12).¹² All school districts are encouraged to utilize the curriculum.

Mental Health Awareness

Beginning with the 2018-2019 school year, DOE established an evidence-based youth mental health awareness and assistance training program to help school personnel identify and understand the signs of emotional disturbance, mental illness, and substance use disorders, and provide such personnel with the skills to help a person who is developing or experiencing an emotional disturbance, mental health, or substance use problem.¹³

A school safety specialist, who is a certified youth mental health awareness and assistance trainer, ensures that all school personnel within the school district receives youth mental health awareness and assistance training.¹⁴ The training program includes:

- An overview of mental illnesses and substance use disorders and the need to reduce the stigma of mental illness.
- Information on the potential risk factors and warning signs of emotional disturbance, mental illness, or substance use disorders, including, but not limited to, depression, anxiety, psychosis, eating disorders, and self-injury, as well as common treatments for those conditions and how to assess risks.
- Information on how to engage at-risk students with the skills, resources, and knowledge required to assess the situation, and how to identify and encourage the students to use appropriate professional help and other support strategies, including, but not limited to, peer, social, or self-help care.¹⁵

Educational Instruction

The law requires school districts to provide a variety of programs for children in kindergarten through grade 12, including a health education program.¹⁶ The health education program must address concepts of:

- Community health.
- Consumer health.
- Environmental health.
- Family life, including the awareness of the benefits of sexual abstinence as the expected standard and the consequences of teenage pregnancy.
- Mental and emotional health.
- Injury prevention and safety.
- Internet safety.
- Nutrition.
- Personal health.
- Prevention and control of disease.
- Substance use and abuse.

In addition, the health education curriculum for students ages 7 through 12 must include a teen dating violence and abuse component that includes, but is not limited to, the definition of dating violence and abuse, the warning signs of dating violence and abusive behavior, the characteristics of healthy relationships, measures to prevent and stop dating violence and abuse, and community resources available to victims of dating violence and abuse.¹⁷

¹² S. 39.001(10)(b)5., F.S.

¹³ S. 1012.584(1), F.S.

¹⁴ S. 1012.584 (2), F.S.

¹⁵ S. 1012.584(3), F.S.

¹⁶ S. 1003.42(n), F.S.

¹⁷ *Id.*

There is currently no educational program required by law directly addressing the identification and reporting of child abuse, abandonment, or neglect.

Effect of Proposed Changes

CS/HB 1093 requires the design and delivery of child welfare services to be directed by the principle that the health and safety of children, including the freedom from abuse, abandonment, or neglect, is of paramount concern. It requires DCF to operate with the understanding that the rights of children in shelter or foster care are critical to their safety, permanency, and well-being and to work with all stakeholders to help such children become knowledgeable about their rights

It requires case managers or other staff to provide verbal and written instructions to a child entering shelter or foster care in an understandable manner on how to identify and report child abuse, abandonment, or neglect. The case manager or other staff must review this information with a child every six months and upon every placement change until the child leaves shelter or foster care. The case manager must document in court reports and case notes the date the child received the information.

CS/HB 1093 also authorizes and encourages district school boards to establish an educational program for students ages 5 through 18 relating to the process for identifying and reporting abuse, abandonment, or neglect. This program may be provided in conjunction with the youth mental health awareness and assistance training program required under s. 1012.584, F.S., any other mental health education program offered by the school district, or any of the educational instruction programs required under s. 1003.42(2), F.S.

B. SECTION DIRECTORY:

Section 1: Amending s. 39.4085, F.S., relating to legislative findings and declaration of intent for goals for dependent children.

Section 2: Provides an effective date.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has a minimal fiscal impact as technology modifications will be necessary to the Florida Safe Families Network (FSFN). This system serves as the department's repository of information for each child or family that's encountered the state's child welfare program. The bill will require changes to FSFN to document the child's receipt of the enumerated goals. The department estimates these changes to have a nonrecurring cost of up-to \$120,000.¹⁸ A review of DCF's Information Technology budget shows an average, annual reversion of \$174,900 among various categories. It is likely the department can cover the nonrecurring technology costs.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

¹⁸ Department of Children and Families, 2021 *Agency Legislative Bill Analysis for HB 1093*, (March 7, 2021)

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill has an indeterminate, but likely insignificant, fiscal impact on CBCs. CBCs may incur a workload increase to review the required information with children in shelter or foster care.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None

B. RULE-MAKING AUTHORITY:

DCF has sufficient rulemaking authority to implement the bill's provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2021, the Children, Families, and Seniors Subcommittee adopted a strike-all amendment and reported the bill favorably as a committee amendment. The strike-all:

- Aligns the bill's language with current law.
- Specifies the case manager or other staff is the person responsible to inform a child entering shelter or foster care on identifying and reporting child abuse, abandonment, or neglect.
- Removes the authorization and encouragement of district school boards to establish educational programs for instructional personnel about child abuse, abandonment, and neglect.

The bill analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

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1 A bill to be entitled
2 An act relating to abuse, abandonment, or neglect
3 education; amending s. 39.4085, F.S.; revising
4 legislative intent; specifying goals of children in
5 shelter or foster care; providing responsibilities of
6 the Department of Children and Families, case
7 managers, and other staff; authorizing district school
8 boards to establish specified educational programs for
9 certain students and provide such programs in
10 conjunction with other specified programs; providing
11 an effective date.

12
13 Be It Enacted by the Legislature of the State of Florida:

14
15 Section 1. Section 39.4085, Florida Statutes, is amended
16 to read:

17 39.4085 ~~Legislative findings and declaration of intent for~~
18 Goals for dependent children; responsibilities; education.—

19 (1) The Legislature finds ~~and declares~~ that the design and
20 delivery of child welfare services should be directed by the
21 principle that the health and safety of children, including the
22 freedom from abuse, abandonment, or neglect, is ~~should be~~ of
23 paramount concern and, therefore, establishes the following
24 goals for children in shelter or foster care:

25 (a) ~~(1)~~ To receive a copy of this act and have it fully

26 explained to them when they are placed in the custody of the
27 department.

28 (b)~~(2)~~ To enjoy individual dignity, liberty, pursuit of
29 happiness, and the protection of their civil and legal rights as
30 persons in the custody of the state.

31 (c)~~(3)~~ To have their privacy protected, have their
32 personal belongings secure and transported with them, and,
33 unless otherwise ordered by the court, have uncensored
34 communication, including receiving and sending unopened
35 communications and having access to a telephone.

36 (d)~~(4)~~ To have personnel providing services who are
37 sufficiently qualified and experienced to assess the risk
38 children face before ~~prior to~~ removal from their homes and to
39 meet the needs of the children once they are in the custody of
40 the department.

41 (e)~~(5)~~ To remain in the custody of their parents or legal
42 custodians unless and until there has been a determination by a
43 qualified person exercising competent professional judgment that
44 removal is necessary to protect their physical, mental, or
45 emotional health or safety.

46 (f)~~(6)~~ To have a full risk, health, educational, medical,
47 and psychological screening and, if needed, assessment and
48 testing upon adjudication into foster care; and to have their
49 photograph and fingerprints included in their case management
50 file.

51 (g)~~(7)~~ To be referred to and receive services, including
52 necessary medical, emotional, psychological, psychiatric, and
53 educational evaluations and treatment, as soon as practicable
54 after identification of the need for such services by the
55 screening and assessment process.

56 (h)~~(8)~~ To be placed in a home with no more than one other
57 child, unless they are part of a sibling group.

58 (i)~~(9)~~ To be placed away from other children known to pose
59 a threat of harm to them, either because of their own risk
60 factors or those of the other child.

61 (j)~~(10)~~ To be placed in a home where the shelter or foster
62 caregiver is aware of and understands the child's history,
63 needs, and risk factors.

64 (k)~~(11)~~ To be the subject of a plan developed by the
65 counselor and the shelter or foster caregiver to deal with
66 identified behaviors that may present a risk to the child or
67 others.

68 (l)~~(12)~~ To be involved and incorporated, if ~~where~~
69 appropriate, in the development of the case plan, to have a case
70 plan which will address their specific needs, and to object to
71 any of the provisions of the case plan.

72 (m)~~(13)~~ To receive meaningful case management and planning
73 that will quickly return the child to his or her family or move
74 the child on to other forms of permanency.

75 (n)~~(14)~~ To receive regular communication with a case

manager ~~caseworker~~, at least once a month, which shall include meeting with the child alone and conferring with the shelter or foster caregiver.

(o) ~~(15)~~ To enjoy regular visitation, at least once a week, with their siblings unless the court orders otherwise.

(p) ~~(16)~~ To enjoy regular visitation with their parents, at least once a month, unless the court orders otherwise.

(q) ~~(17)~~ To receive a free and appropriate education; minimal disruption to their education and retention in their home school, if appropriate; referral to the child study team; all special educational services, including, if ~~where~~ appropriate, the appointment of a parent surrogate; and the sharing of all necessary information between the school board and the department, including information on attendance and educational progress.

(r) ~~(18)~~ To be able to raise grievances with the department over the care they are receiving from their caregivers, case managers ~~caseworkers~~, or other service providers.

(s) ~~(19)~~ To be heard by the court, if appropriate, at all review hearings.

(t) ~~(20)~~ To have a guardian ad litem appointed to represent, within reason, their best interests and, if ~~where~~ appropriate, an attorney ad litem appointed to represent their legal interests; the guardian ad litem and attorney ad litem shall have immediate and unlimited access to the children they

101 represent.

102 (u)~~(21)~~ To have all their records available for review by
103 their guardian ad litem and attorney ad litem if they deem such
104 review necessary.

105 (v)~~(22)~~ To organize as a group for purposes of ensuring
106 that they receive the services and living conditions to which
107 they are entitled and to provide support for one another while
108 in the custody of the department.

109 (w)~~(23)~~ To be afforded prompt access to all available
110 state and federal programs, including, but not limited to: Early
111 Periodic Screening, Diagnosis, and Testing (EPSDT) services,
112 developmental services programs, Medicare and supplemental
113 security income, Children's Medical Services, and programs for
114 severely emotionally disturbed children.

115
116 ~~The provisions of This subsection establishes section establish~~
117 goals and not rights. ~~Nothing in This subsection does not~~
118 require ~~section shall be interpreted as requiring~~ the delivery
119 of any particular service or level of service in excess of
120 existing appropriations. A No person does not shall have a cause
121 of action against the state or any of its subdivisions,
122 agencies, contractors, subcontractors, or agents, based upon the
123 adoption of or failure to provide adequate funding for the
124 achievement of these goals by the Legislature. This subsection
125 does not ~~Nothing herein shall~~ require the expenditure of funds

126 to meet the goals established in this subsection ~~herein~~ except
127 those funds specifically appropriated for such purpose.

128 (2) The department shall operate with the understanding
129 that the rights of children in shelter or foster care are
130 critical to their safety, permanency, and well-being. The
131 department shall work with all stakeholders to help such
132 children become knowledgeable about their rights.

133 (3) (a) The case manager or other staff shall provide
134 verbal and written instructions to a child entering shelter or
135 foster care to educate the child on identifying and reporting
136 abuse, abandonment, or neglect. The verbal and written
137 instructions must use words and phrasing that each child can
138 understand and must occur in a manner that is most effective for
139 each child. The written instructions are only required if the
140 child is of a sufficient age and understanding to receive such
141 instructions. The case manager or other staff must give each
142 child the opportunity to ask questions about his or her rights
143 and how to identify and report abuse, abandonment, or neglect.
144 The case manager or other staff shall document in court reports
145 and case notes the date the information was provided to the
146 child. The case manager or other staff must review the
147 information with the child every 6 months and upon every
148 placement change until the child leaves shelter or foster care.

149 (b) District school boards are authorized and encouraged
150 to establish educational programs for students ages 5 through 18

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151 relating to identifying and reporting abuse, abandonment, or
152 neglect and the effects of such abuse, abandonment, or neglect
153 on a child. The district school boards may provide such programs
154 in conjunction with the youth mental health awareness and
155 assistance training program required under s. 1012.584, any
156 other mental health education program offered by the school
157 district, or any of the educational instruction required under
158 s. 1003.42(2).

159 Section 2. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1233 Genetic Counseling Patient Protection Act

SPONSOR(S): Professions & Public Health Subcommittee, Silvers

TIED BILLS: HB 1235 **IDEN./SIM. BILLS:** SB 1770

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	14 Y, 0 N, As CS	Morris	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health facilities and more than 40 health care professions. Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory authority and licensure authority for MQA, including the discipline of practitioners.

Genetic counselors provide individuals information about how genetic conditions might affect them or their families. Genetic counselors collect personal and family history and use such information to determine how likely it is that an individual or his or her family member has a genetic condition. Genetic counselors are not licensed or regulated in this state.

CS/HB 1233 creates the "Genetic Counseling Patient Protection Act," requiring DOH to regulate and license genetic counselors. The bill:

- Creates requirements for initial licensure and renewal for genetic counselors;
- Establishes the scope of practice for licensed genetic counselors;
- Authorizes DOH to adopt rules regarding continuing education requirements;
- Subjects genetic counselors to disciplinary action if they commit specified prohibited acts;
- Authorizes DOH to deny an application for licensure or impose penalties on a licensee who commits specified prohibited acts; and
- Exempts active duty commissioned medical officers of the United States Armed Forces or Public Health Service and licensed health care practitioners from the requirements of the genetic counselor practice act.

The bill also makes technical and conforming changes.

The bill has a significant, negative fiscal impact on DOH. The bill has no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Health Care Professional Licensure

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners. MQA works in conjunction with 22 boards and 4 councils to license and regulate 7 types of health care facilities and more than 40 health care professions.¹ Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for MQA. MQA is statutorily responsible for the following boards and professions established within the division:²

- The Board of Acupuncture, created under ch. 457, F.S.;
- The Board of Medicine, created under ch. 458, F.S.;
- The Board of Osteopathic Medicine, created under ch. 459, F.S.;
- The Board of Chiropractic Medicine, created under ch. 460, F.S.;
- The Board of Podiatric Medicine, created under ch. 461, F.S.;
- Naturopathy, as provided under ch. 462, F.S.;
- The Board of Optometry, created under ch. 463, F.S.;
- The Board of Nursing, created under part I of ch. 464, F.S.;
- Nursing assistants, as provided under part II of ch. 464, F.S.;
- The Board of Pharmacy, created under ch. 465, F.S.;
- The Board of Dentistry, created under ch. 466, F.S.;
- Midwifery, as provided under ch. 467, F.S.;
- The Board of Speech-Language Pathology and Audiology, created under part I of ch. 468, F.S.;
- The Board of Nursing Home Administrators, created under part II of ch. 468, F.S.;
- The Board of Occupational Therapy, created under part III of ch. 468, F.S.;
- Respiratory therapy, as provided under part V of ch. 468, F.S.;
- Dietetics and nutrition practice, as provided under part X of ch. 468, F.S.;
- The Board of Athletic Training, created under part XIII of ch. 468, F.S.;
- The Board of Orthotists and Prosthetists, created under part XIV of ch. 468, F.S.;
- Electrolysis, as provided under ch. 478, F.S.;
- The Board of Massage Therapy, created under ch. 480, F.S.;
- The Board of Clinical Laboratory Personnel, created under part III of ch. 483, F.S.;
- Medical physicists, as provided under part IV of ch. 483, F.S.;
- The Board of Opticianry, created under part I of ch. 484, F.S.;
- The Board of Hearing Aid Specialists, created under part II of ch. 484, F.S.;
- The Board of Physical Therapy Practice, created under ch. 486, F.S.;
- The Board of Psychology, created under ch. 490, F.S.;
- School psychologists, as provided under ch. 490, F.S.;
- The Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling, created under ch. 491, F.S.; and
- Emergency medical technicians and paramedics, as provided under part III of ch. 401, F.S.

Genetic Counseling

¹ Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2019-2020*, p. 6, <http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/documents/2019-2020-annual-report.pdf> (last visited on March 26, 2021).

² Id.

Advances in genetic technology and research have increased the amount of information available to individuals and providers and increased the demand for genetic services, including genetic testing, diagnosis and interpretation of test results, and genetic counseling.³ Genetic test results can help diagnose, confirm, or indicate increased risk for developing a particular condition, which genetic counseling can help explain the results and available treatment options.

Genetic counseling gives individuals information about how genetic conditions might affect them or their families. Genetic counselors collect personal and family history and use such information to determine how likely it is that an individual or his or her family member has a genetic condition. Based on such information, a genetic counselor helps an individual determine if a genetic test is suitable. Genetic counseling after genetic testing can help an individual better understand his or her test results and treatment options.⁴

Individuals seek genetic counseling for multiple reasons, including to:⁵

- Address prenatal concerns about factors that might affect a baby during infancy, including genetic conditions and birth defects;
- Address concerns if a child is showing signs and symptoms of a genetic disorder, including abnormal newborn screening results, intellectual or developmental disabilities, or birth defects;
- Determine if an individual is at risk of being affected by a health condition, including hereditary breast and ovarian cancer, muscular dystrophy, Huntington's disease, and sickle cell disease.

Genetic counselors who wish to become certified must pass a certification examination issued by the American Board of Genetic Counseling (ABGC).⁶ The primary qualification to sit for the certification examination is a master's degree in genetic counseling from a program accredited by the Accreditation Council for Genetic Counseling.⁷ States currently issuing a genetic counselor license require individuals to pass the ABGC certification examination.⁸

Genetic counselors primarily practice in hospital settings and can work in all medical specialties or practice in one specialty area, such as pediatrics, oncology, or cardiology.⁹ They assess individuals or families with or at risk for genetic conditions and provide counseling and education on test results. Genetic counselors are not physicians; they typically work in conjunction with medical geneticists to provide genetic services.¹⁰ Medical geneticists will order genetic testing and interpret the results and a genetic counselor will provide further education on the results and how they may affect an individual or their family.¹¹

Twenty-nine states require licensure for genetic counselors.¹² Florida does not require licensure and there are approximately 127 genetic counselors providing services in this state.¹³

Sunrise Act

³ United States Government Accountability Office, Report to Congressional Committees: Genetic Services – Information on Genetic Counselor and Medical Geneticist Workforces (July 2020), <https://www.gao.gov/assets/gao-20-593.pdf> (last visited March 26, 2021).

⁴ Centers for Disease Control and Prevention, *Genetic Counseling*, https://www.cdc.gov/genomics/gtesting/genetic_counseling.htm (last visited March 26, 2021).

⁵ Id.

⁶ American Board of Genetic Counseling, Inc., *Certification Qualifications*, <https://www.abgc.net/becoming-certified/do-i-qualify/> (last visited March 26, 2021). Certification is valid for 5 years, after which time the genetic counselor must seek recertification.

The University of South Florida has the only certified genetic counseling training program in Florida.

⁷ Id.

⁸ Id.

⁹ Id.

¹⁰ Medical geneticists are physicians who specialize in medical genetics and conduct genetic testing and provide diagnoses.

¹¹ *Supra*, note 6.

¹² National Society of Genetic Counselors, *States Issuing Licenses for Genetic Counselors*, <https://www.nsgc.org/Policy-Research-and-Publications/State-Licensure-for-Genetic-Counselors/States-Issuing-Licenses> (last visited March 26, 2021). States requiring licensure of genetic counselors include: Alabama, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kentucky, Louisiana, Massachusetts, Michigan, Minnesota, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Ohio, Oklahoma, Pennsylvania, South Dakota, Tennessee, Utah, Virginia, and Washington.

¹³ Department of Health, Agency Analysis of 2021 House Bill 1233 (March 22, 2021).

Generally, a sunrise review is a formal process where a legislature scrutinizes legislation proposing to regulate an unregulated profession or occupation by requiring a cost-benefit analysis before the legislation is enacted.¹⁴ The Sunrise Act requires the Legislature to consider certain factors before determining whether to regulate an unregulated profession or occupation.¹⁵ Proponents of regulation must file information about the regulation's potential impacts, costs, and benefits upon request.¹⁶

Section 11.62, F.S., is Florida's sunrise review, which is called the Sunrise Act. The Sunrise Act states that regulation should not be adopted unless it is:¹⁷

- Necessary to protect the public health, safety, or welfare from significant and discernible harm or damage;
- Exercised only to the extent necessary to prevent the harm; and
- Limited so as not to unnecessarily restrict entry into the practice of the profession or adversely affect public access to the professional services.

In determining whether to regulate a profession or occupation, the Sunrise Act requires the Legislature to consider the following:

- Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
- Whether the practice of the profession or occupation requires specialized skill or training and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
- Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
- Whether the public is or can be effectively protected by other means; and
- Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.

Genetic Counselor Sunrise Act Questionnaire

A Sunrise Act questionnaire has been completed by The Florida Association of Genetic Counselors (FLAGC).¹⁸ FLAGC is seeking licensure and regulation of genetic counselors to protect the health, safety, and welfare of the public.¹⁹ Florida does not license or regulate genetic counselors.

¹⁴ National Conference of State Legislatures, Improving Occupational Licensing with Sunrise and Sunset Review Acts, <https://www.ncsl.org/research/labor-and-employment/improving-occupational-licensing-with-sunrise-and-sunset-reviews.aspx> (last visited March 26, 2021).

¹⁵ S. 11.62, F.S.

¹⁶ S. 11.62(4), F.S.

¹⁷ S. 11.62(2), F.S.

¹⁸ The Florida Association of Genetic Counselors, Sunrise Review for Proposed Licensing of Genetic Counselors (on file with the Professions and Public Health Subcommittee staff).

¹⁹ *Id.*

Effect of the Bill

CS/HB 1233 creates the “Genetic Counseling Patient Protection Act,” adding genetic counselors to the list of health care practitioners requiring licensing and regulation by DOH.

The bill establishes the scope of practice for genetic counselors, which is to advise individuals or families affected by or at risk of genetic disorders. Genetic counselors may advise an individual or a family affected by or at risk of genetic disorders, including:

- Evaluating individual and family medical histories to determine risk for genetic or medical conditions and diseases;
- Discussing health factors and risk management for genetic or medical conditions and diseases with patients;
- Ordering genetic laboratory tests and diagnostic studies;
- Evaluating laboratory test results and diagnostic studies against individual and family medical history to assess risk factors for genetic or medical conditions and diseases;
- Explaining clinical implications of genetic laboratory tests and diagnostic studies results to patients;
- Evaluating the individual or family and providing client centered counseling and guidance;
- Using community resources that provide medical, educational, financial, and psychosocial support and advocacy;
- Providing written documentation of medical, genetic, and counseling information for individuals, families, and health care professionals; and
- Referring individuals to a physician for diagnosis and treatment.

The bill creates requirements for licensure as a genetic counselor and requires DOH to issue a license, valid for two years, to an applicant who:

- Submits an application on a form approved by DOH;
- Is of good moral character;
- Has earned a:
 - o Master’s degree from a genetic counseling program or an equivalent program as determined by the ABGC Counseling or its successor or equivalent; or
 - o Doctoral degree from a medical genetics program accredited by the American Board of Genetics and Genomics or the Canadian College of Medical Geneticists.
- Passes the examination for certification as:
 - o A genetic counselor by the ABGC, the American Board of Genetics and Genomics, or the Canadian Association of Genetic Counselors; or
 - o A medical or clinical geneticist by the American Board of Medical Genetics and Genomics or the Canadian College of Medical Geneticists.

The bill authorizes DOH to issue a temporary license for up to two years to applicants who meet all the requirements for licensure, except for the examination requirement if the applicant is eligible to sit for the next available certification examination.

The bill requires DOH to renew the license of a genetic counselor upon receipt of a renewal application. The bill also requires DOH to adopt rules on continuing education requirements consistent with the ABGC.

The bill prohibits a person from:

- Making a false or fraudulent statement in any application, affidavit, or statement presented to DOH;
- Practicing genetic counseling, holding himself or herself out as a genetic counselor, or providing genetic counseling services without obtaining a license from DOH; and

- Using the title “genetic counselor” or any other title, designation, words, letters, or abbreviations which indicate a person is authorized to practice genetic counseling unless such person holds a valid license or is exempt from such licensure.

The bill makes it a second degree misdemeanor to violate any of the above prohibitions, punishable by a fine of up to \$500 and imprisonment of up to 60 days. The bill authorizes DOH to discipline a genetic counselor, or deny an application for licensure as a genetic counselor, if an applicant or licensee:

- Fraudulently attempts to obtain, obtains, or renews a license as a genetic counselor;
- Has a license revoked, suspended, or otherwise acted against, including licensure denial, in another jurisdiction;
- Is convicted, found guilty of, or pleads no contest to a crime in any jurisdiction that directly related to the practice of genetic counseling, including violations of federal law;
- Makes or files a false report that the licensee knows is false;
- Intentionally or negligently fails to file a report required by state or federal law, or willfully impedes, obstructs, or induces another person to impede or obstruct such filing;
- Knowingly advertises genetic counseling services in a fraudulent, false, deceptive, or misleading manner;
- Violates a DOH-issued disciplinary order or fails to comply with a DOH-issued subpoena;
- Practices with a revoked, suspended, or inactive license;
- Commits gross or repeated malpractice, or fails to deliver genetic counseling services at an acceptable level of care;
- Displays unprofessional conduct, including failure to conform to minimum standards set by the practice act and DOH rule, including:
 - o Practicing beyond the scope of practice of a genetic counselor;
 - o Failing to refer a patient to a health care practitioner if the licensed genetic counselor is unwilling or unable to provide services;
 - o Failing to maintain confidentiality; and
 - o Financially exploiting the patient or his or her family.
- Violates the genetic counseling practice act.

The bill exempts active duty commissioned medical officers of the United States Armed Forces or the United States Public Health Service and health care practitioners licensed in this state, other than licensed genetic counselors, from the requirements of the genetic counseling practice act.

The bill makes conforming technical and conforming changes.

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

B. SECTION DIRECTORY:

- Section 1:** Creates Part III of ch. 483, F.S., the “Genetic Counseling Patient Protection Act.”
- Section 2:** Amends s. 456.001, F.S., relating to definitions.
- Section 3:** Amends s. 20.43, F.S., relating to Department of Health.
- Section 4:** Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

HB 1235, linked to CS/HB 1233, authorizes an initial application fee of \$25 and an annual renewal fee of \$25 for genetic counselors seeking licensure. The total annual revenue DOH will receive from such fees is approximately \$3,175 based on there being 127 genetic counselors currently practicing in Florida.

2. Expenditures:

DOH will incur costs associated with rulemaking to implement the bill's provisions, developing the licensure application, and updating the LEIDS licensing system. Current resources are adequate to absorb these costs.²⁰

DOH will incur costs associated with the regulation and licensure of genetic counselors. DOH estimates 3 FTE and 1 OPS position will be required to implement the provisions of the bill.²¹ The below table summarizes the various functions and costs associated with the regulation and licensure of genetic counselors under the bill:

Function	FTE Request and Description	FTE	Salary Rate	Salary & Benefits	OPS Cost	Recurring Expenses/HR Transfer	Nonrecurring Expenses	Total for Function
Application Processing	Two Regulatory Specialist FTE and one OPS to analyze, approve or deny licensure applications, and update practitioner profiles	2.0	63,700	91,091	35,360	18,971	13,287	158,709
Enforcement and Investigations	One Investigation Specialist FTE to review complaints associated with unlicensed activity	1.0	32,708	46,772		16,004	4,429	67,205
Total:		3.0	96,408	137,863	35,360	34,975	17,716	225,914

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Genetic counselors will incur costs associated with obtaining licensure by DOH.

D. FISCAL COMMENTS:

None.

²⁰ Id.

²¹ *Supra*, note 13.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking authority to implement its provisions.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On April 1, 2021, the Professions and Public Health Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

- Established the scope of practice for licensed genetic counselors;
- Authorized genetic counselor licenses to be valid for 2 years;
- Required licensure applicants to graduate from a master's program approved by the Accreditation Council of Genetic Counseling or its successor or equivalent; and
- Authorized DOH to issue a temporary license to applicants who meet certain requirements.

This analysis is drafted to the committee substitute as passed by the Professions and Public Health Subcommittee.

1 A bill to be entitled
2 An act relating to Genetic Counseling Patient
3 Protection Act; creating part III of ch. 483, F.S.,
4 titled "Genetic Counseling"; providing a short title,
5 legislative findings and intent, and definitions;
6 providing licensure and licensure renewal
7 requirements; requiring the Department of Health to
8 adopt by rule continuing education requirements;
9 prohibiting certain acts; providing penalties and
10 grounds for disciplinary action; authorizing the
11 department to enter an order denying licensure or
12 imposing other penalties; providing exemptions;
13 amending s. 456.001, F.S.; revising the definition of
14 the term "health care practitioner" to include
15 licensed genetic counselors; amending s. 20.43, F.S.;
16 correcting a cross-reference relating to the
17 department's responsibilities for health care
18 practitioners; providing an effective date.

19
20 Be It Enacted by the Legislature of the State of Florida:

21
22 Section 1. Part III of chapter 483, Florida Statutes,
23 consisting of sections 483.911, 483.912, 483.913, 483.914,
24 483.915, 483.916, 483.917, and 483.918, is created to read:
25

PART III

GENETIC COUNSELING

483.911 Short title.—This part may be cited as the
"Genetic Counseling Patient Protection Act."

483.912 Legislative findings and intent.—The sole
legislative purpose for enacting this part is to ensure that
every genetic counselor practicing in this state meets minimum
requirements for safe practice. The Legislature finds that the
delivery of genetic counseling services by unskilled and
incompetent persons presents a danger to public health and
safety. Because it is difficult for the public to make informed
choices related to genetic counseling services and since the
consequences of uninformed choices can seriously endanger public
health and safety, it is the intent of the Legislature to
prohibit the delivery of genetic counseling services by persons
who are determined to possess less than minimum competencies or
who otherwise present a danger to the public.

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

(1) "Department" means the Department of Health.

(2) "Genetic counselor" means a person licensed under this
part to practice genetic counseling.

(3) "Scope of practice of genetic counseling" means the
process of advising an individual or a family affected by or at
risk of genetic disorders, including:

(a) Obtaining and evaluating individual and family medical

51 histories to determine risk for genetic or medical conditions
52 and diseases in an individual, his or her offspring, and other
53 family members.

54 (b) Discussing the clinical features, family history,
55 means of diagnosis, genetic and environmental factors, and
56 management of risk for genetic or medical conditions and
57 diseases.

58 (c) Identifying, ordering, and coordinating genetic
59 laboratory tests and other diagnostic studies as appropriate for
60 the genetic assessment.

61 (d) Integrating genetic laboratory test results and other
62 diagnostic studies with individual and family medical histories
63 to assess and communicate risk factors for genetic or medical
64 conditions and diseases.

65 (e) Explaining the clinical implications of genetic
66 laboratory tests and other diagnostic studies and the results.

67 (f) Evaluating the individual's or the family's responses
68 to the condition or risk of recurrence and providing client-
69 centered counseling and anticipatory guidance.

70 (g) Identifying and using community resources that provide
71 medical, educational, financial, and psychosocial support and
72 advocacy.

73 (h) Providing written documentation of medical, genetic,
74 and counseling information for individuals, families, and health
75 care professionals.

76 (i) Referring individuals to a physician for diagnosis and
77 treatment.

78 483.914 Licensure requirements.—

79 (1) A person desiring to be licensed as a genetic
80 counselor under this part must apply to the department on a form
81 approved by the department.

82 (2) The department shall issue a license, valid for a
83 period of 2 years after the date of issuance, to each applicant
84 who:

85 (a) Has completed an application.

86 (b) Is of good moral character.

87 (c) Provides satisfactory documentation of having earned:

88 1. A master's degree from a genetic counseling training
89 program or an equivalent program as determined by the
90 Accreditation Council for Genetic Counseling or its successor or
91 equivalent; or

92 2. A doctoral degree from a medical genetics training
93 program accredited by the American Board of Medical Genetics and
94 Genomics or the Canadian College of Medical Geneticists.

95 (d) Has passed the examination for certification as:

96 1. A genetic counselor by the American Board of Genetic
97 Counseling, Inc., the American Board of Medical Genetics and
98 Genomics, or the Canadian Association of Genetic Counsellors; or

99 2. A medical or clinical geneticist by the American Board
100 of Medical Genetics and Genomics or the Canadian College of

101 Medical Geneticists.

102 (3) The department may issue a temporary license for up to
103 2 years to an applicant who meets all of the requirements for
104 licensure except for the examination requirement in this section
105 and is eligible to sit for the next available certification
106 examination.

107 483.915 Licensure renewal and continuing education
108 requirements.—

109 (1) The department shall renew a license upon receipt of a
110 renewal application.

111 (2) The department shall adopt by rule continuing
112 education requirements consistent with nationally accepted
113 standards of the American Board of Genetic Counseling, Inc.

114 483.916 Prohibitions; penalties.—

115 (1) A person may not:

116 (a) Make a false or fraudulent statement in any
117 application, affidavit, or statement presented to the
118 department.

119 (b) Practice genetic counseling or hold himself or herself
120 out as a genetic counselor or as being able to practice genetic
121 counseling or to render genetic counseling services without a
122 license issued under this part, unless exempt from licensure
123 under this part.

124 (c) Use the title "genetic counselor" or any other titles,
125 designations, words, letters, abbreviations, or devices tending

126 to indicate that the person is authorized to practice genetic
127 counseling, unless that person holds a current license as a
128 genetic counselor issued under this part or is exempt from
129 licensure under this part.

130 (2) A person who violates this section commits a
131 misdemeanor of the second degree, punishable as provided in s.
132 775.082 or s. 775.083.

133 483.917 Grounds for disciplinary action; penalties.—

134 (1) The following acts constitute grounds for denial of a
135 license or disciplinary action, as specified in s. 456.072(2):

136 (a) Attempting to obtain, obtaining, or renewing a license
137 under this part by fraudulent misrepresentation.

138 (b) Having a license revoked, suspended, or otherwise
139 acted against, including the denial of licensure in another
140 jurisdiction.

141 (c) Being convicted or found guilty of, or entered a plea
142 of nolo contendere to, regardless of adjudication, a crime in
143 any jurisdiction that directly relates to the practice of
144 genetic counseling, including a violation of any federal law or
145 regulation regarding genetic counseling.

146 (d) Making or filing a report or record that the licensee
147 knows is false, intentionally or negligently failing to file a
148 report or record required by state or federal law, willfully
149 impeding or obstructing such filing, or inducing another person
150 to impede or obstruct such filing. Such reports or records

151 include only reports or records that are signed by a person who
152 is licensed under this part.

153 (e) Knowingly advertising services related to genetic
154 counseling in a fraudulent, false, deceptive, or misleading
155 manner.

156 (f) Violating a previous order of the department entered
157 in a disciplinary hearing or failing to comply with a subpoena
158 issued by the department.

159 (g) Practicing with a revoked, suspended, or inactive
160 license.

161 (h) Gross or repeated malpractice or the failure to
162 deliver genetic counseling services with that level of care and
163 skill which is recognized by a reasonably prudent licensed
164 genetic counselor as being acceptable under similar conditions
165 and circumstances.

166 (i) Unprofessional conduct, including any departure from
167 or failure to conform to the minimal prevailing standards of
168 acceptable practice under this part and department rule such as:

169 1. Practicing or offering to practice beyond the scope
170 permitted by law or accepting and performing genetic counseling
171 services the licensee knows, or has reason to know, the licensee
172 is not competent to perform.

173 2. Failing to refer a patient to a health care
174 practitioner as defined in s. 456.001 if the licensee is unable
175 or unwilling to provide genetic counseling services to the

176 patient.

177 3. Failing to maintain the confidentiality of any
178 information received under this part or failing to maintain the
179 confidentiality of patient records pursuant to s. 456.057,
180 unless such information or records are released by the patient
181 or otherwise authorized or required by law to be released.

182 4. Exercising influence on the patient or family in such a
183 manner as to exploit the patient or family for financial gain of
184 the licensee.

185 (j) Violating this part or chapter 456, or any rules
186 adopted pursuant thereto.

187 (2) The department may enter an order denying licensure or
188 imposing penalties against an applicant for licensure or a
189 licensee who is found guilty of violating subsection (1) or s.
190 483.916.

191 483.918 Exemptions.—This part does not apply to:

192 (1) A commissioned medical officer of the United States
193 Armed Forces or the United States Public Health Service while on
194 active duty or while acting within the scope of his or her
195 military or public health responsibilities.

196 (2) A health care practitioner as defined in s. 456.001,
197 other than a genetic counselor licensed under this part, who is
198 practicing within the scope of his or her training, education,
199 and licensure, and who is doing work of a nature consistent with
200 such training, education, and licensure.

201 Section 2. Subsection (4) of section 456.001, Florida
202 Statutes, is amended to read:

203 456.001 Definitions.—As used in this chapter, the term:

204 (4) "Health care practitioner" means any person licensed
205 under chapter 457; chapter 458; chapter 459; chapter 460;
206 chapter 461; chapter 462; chapter 463; chapter 464; chapter 465;
207 chapter 466; chapter 467; part I, part II, part III, part V,
208 part X, part XIII, or part XIV of chapter 468; chapter 478;
209 chapter 480; part I, ~~or~~ part II, or part III, of chapter 483;
210 chapter 484; chapter 486; chapter 490; or chapter 491.

211 Section 3. Subsection (8) of section 20.43, Florida
212 Statutes, is amended to read:

213 20.43 Department of Health.—There is created a Department
214 of Health.

215 (8) The department may hold copyrights, trademarks, and
216 service marks and enforce its rights with respect thereto,
217 except such authority does not extend to any public records
218 relating to the department's responsibilities for health care
219 practitioners regulated under ~~part II of~~ chapter 456 ~~455~~.

220 Section 4. This act shall take effect July 1, 2021.

COMMITTEE/SUBCOMMITTEE AMENDMENT

Bill No. CS/HB 1233 (2021)

Amendment No.

COMMITTEE/SUBCOMMITTEE ACTION

ADOPTED ☐ (Y/N)

ADOPTED AS AMENDED ☐ (Y/N)

ADOPTED W/O OBJECTION ☐ (Y/N)

FAILED TO ADOPT ☐ (Y/N)

WITHDRAWN ☐ (Y/N)

OTHER ☐

Committee/Subcommittee hearing bill: Health Care Appropriations Subcommittee

Representative Silvers offered the following:

Amendment (with title amendment)

Between lines 219 and 220, insert:

Section 4. For the 2021-2022 fiscal year, the sums of \$41,535 in recurring funds and \$4,429 in nonrecurring funds from the Medical Quality Assurance Trust Fund are appropriated to the Department of Health for the purpose of implementing this act.

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

Remove line 18 and insert:

practitioners; providing an appropriation; providing an effective date.

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Published On: 4/8/2021 12:11:13 PM

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1235 Fees
SPONSOR(S): Silvers
TIED BILLS: HB 1233 **IDEN./SIM. BILLS:** SB 1772

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	14 Y, 0 N	Morris	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

Genetic counselors provide individuals information about how genetic conditions might affect them or their families. Genetic counselors collect personal and family history and use such information to determine how likely it is that an individual or his or her family member has a genetic condition. Genetic counselors are not licensed or regulated in this state.

CS/HB 1233 creates the “Genetic Counseling Patient Protection Act,” requiring the Department of Health (DOH) to regulate and license genetic counselors.

HB 1235, which is linked to HB 1233, requires DOH to adopt rules relating to the issuance and annual renewal of genetic counselor licenses. The bill authorizes DOH to charge an application fee of \$25 for a genetic counselor license. The bill also authorizes an annual renewal fee not to exceed \$25. The bill allows DOH to waive the fee by rule. Proceeds from the collected fees must be deposited into the DOH Administrative Trust Fund and used for the administration of genetic counselor licensure.

The bill will have a positive fiscal impact on DOH.

The bill will be effective on the same date that CS/HB 1233 or similar legislation takes effect.

This bill authorizes a new state fee, requiring a two-thirds vote of the membership of the House. See Section III.A.2. of the analysis.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Current Situation

Legislation Imposing or Raising State Fees or Taxes

The Florida Constitution provides that no state tax or fee may be imposed, authorized, or raised by the Legislature except through legislation approved by two-thirds of the membership of each house of the Legislature.¹ For purposes of this requirement, a “fee” is any charge or payment required by law, including any fee or charge for services and fees or costs for licenses and to “raise” a fee or tax means to:²

- Increase or authorize an increase in the rate of a state tax or fee imposed on a percentage or per mill basis;
- Increase or authorize an increase in the amount of a state tax or fee imposed on a flat or fixed amount basis; or
- Decrease or eliminate a state tax or fee exemption or credit.

A bill that imposes, authorizes, or raises any state fee or tax may only contain the fee or tax provision(s) and may not contain any other subject.³

The constitutional provision does not authorize any state tax or fee to be imposed if it is otherwise prohibited by the constitution and does not apply to any tax or fee authorized or imposed by a county, municipality, school board, or special district.⁴

Health Practitioner Licensure Fees

The Division of Medical Quality Assurance (MQA), within the Department of Health (DOH), has general regulatory authority over health care practitioners.⁵ The MQA works in conjunction with 22 boards and four councils to license and regulate seven types of health care facilities and more than 40 health care professions.⁶ Each profession is regulated by an individual practice act and by ch. 456, F.S., which provides general regulatory and licensure authority for the MQA.

Under current law, the costs of regulation of health care practitioners must be borne by the licensees and licensure applicants.⁷ Regulatory boards, in consultation with DOH, must set renewal fees by rule that must be:⁸

- Based on revenue projections prepared using generally accepted accounting practices;
- Adequate to cover all expenses relating to that board;
- Reasonable, fair, and not serve as a barrier to licensure;
- Be based on potential earnings from working under the scope of the license;

¹ Fla. Const. art. VII, s. 19(a)-(b). The amendment appeared on the 2018 ballot as Amendment 5.

² Fla. Const. art. VII, s. 19(d).

³ Fla. Const. art. VII, s. 19(e).

⁴ Fla. Const. art. VII s. 19(c).

⁵ Pursuant to s. 456.001(4), F.S., health care practitioners are defined to include acupuncturists, physicians, physician assistants, chiropractors, podiatrists, naturopaths, dentists, dental hygienists, optometrists, nurses, nursing assistants, pharmacists, midwives, speech language pathologists, nursing home administrators, occupational therapists, respiratory therapists, dietitians, athletic trainers, orthotists, prosthetists, electrologists, massage therapists, clinical laboratory personnel, medical physicists, dispensers of optical devices or hearing aids, physical therapists, psychologists, social workers, counselors, and psychotherapists, among others.

⁶ Florida Department of Health, Division of Medical Quality Assurance, *Annual Report and Long-Range Plan, Fiscal Year 2019-2020*, http://www.floridahealth.gov/licensing-and-regulation/reports-and-publications/_documents/2019-2020-annual-report.pdf (last visited March 26, 2021).

⁷ Section 456.025(1), F.S.

⁸ Id.

- Similar to fees imposed on similar licensure types; and
- No more than 10 percent greater than the actual cost to regulate that profession for the previous biennium.

Genetic Counselors

Genetic counselors provide individuals information about how genetic conditions might affect them or their families. Genetic counselors collect personal and family history and use such information to determine how likely it is that an individual or his or her family member has a genetic condition. Based on such information, a genetic counselor helps an individual determine if a genetic test is suitable. Genetic counseling after genetic testing can help an individual better understand his or her test results and treatment options.⁹

Currently, genetic counselors are not licensed or regulated in this state and no fees are assessed for initial licensure or renewal.

Effect of the Bill

HB 1235, which is linked to CS/HB 1233, authorizes DOH to adopt rules relating to the procedures for issuance and annual renewal of genetic counselor licenses, including an application and renewal fee not to exceed \$25. The bill authorizes DOH to waive such fees by rule. Proceeds from collected fees must be deposited in the Administrative Trust Fund within DOH and used for the regulation of genetic counselors.

The bill becomes effective on the same date as HB 1233 or similar legislation.

B. SECTION DIRECTORY:

Section 1: Creates s. 483.919, F.S., relating to licensure of genetic counselors.

Section 2: Provides an effective date of the same date that HB 1233 or similar legislation takes effect.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

The bill authorizes an initial application fee of \$25 and an annual renewal fee of \$25 for genetic counselors seeking licensure. The total annual revenue DOH will receive from such fees is approximately \$3,175 based on there being 127 genetic counselors currently practicing in Florida.

2. Expenditures:

DOH will incur costs associated with the regulation and licensure of genetic counselors, which will be partially offset by application and renewal fees.

⁹ Centers for Disease Control and Prevention, *Genetic Counseling*, https://www.cdc.gov/genomics/gtesting/genetic_counseling.htm (last visited March 26, 2021).

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Genetic counselor license applicants will have to pay an application fee and annual renewal fee. The bill authorizes DOH to set the application and annual renewal fees, but neither fee may exceed \$25.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

Not Applicable. This bill does not appear to affect county or municipal governments.

2. Other:

Article VII, s. 19 of the Florida Constitution requires the imposition, authorization, or raising of a state tax or fee be contained in a separate bill that contains no other subject and be approved by two-thirds of the membership of each house of the Legislature. As such, the bill appears to implicate Art. VII, s. 19 of the Florida Constitution because the bill authorizes a state fee.

B. RULE-MAKING AUTHORITY:

The bill provides sufficient rulemaking needed for implementation.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

HB 1235

2021

1 A bill to be entitled
2 An act relating to fees; creating s. 483.919, F.S.;
3 requiring the Department of Health to adopt by rule
4 procedures for the issuance and annual renewal of
5 genetic counselor licenses, including a specified
6 application fee; authorizing the department to waive
7 payment of the fee by rule; providing for the deposit
8 and use of fee proceeds; providing a contingent
9 effective date.

10
11 Be It Enacted by the Legislature of the State of Florida:

12
13 Section 1. Section 483.919, Florida Statutes, is created
14 to read:

15 483.919 Licensure of genetic counselors.—The department
16 shall adopt by rule procedures for the issuance and annual
17 renewal of a genetic counselor license, including an application
18 fee not to exceed \$25 for such issuance and annual renewal. The
19 department may waive payment of the fee by rule. Proceeds from
20 fees collected pursuant to this section shall be deposited in
21 the Administrative Trust Fund within the Department of Health
22 and used for the administration of genetic counselor licensure.

23 Section 2. This act shall take effect on the same date
24 that HB 1233 or similar legislation takes effect if such
25 legislation is adopted in the same legislative session or an

HB 1235

2021

26 | extension thereof and becomes a law.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1373 Rare Disease Advisory Council

SPONSOR(S): Professions & Public Health Subcommittee, DuBose and others

TIED BILLS: **IDEN./SIM. BILLS:** CS/CS/SB/272

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Professions & Public Health Subcommittee	18 Y, 0 N, As CS	Rahming	McElroy
2) Health Care Appropriations Subcommittee		Mielke	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

In the United States (U.S), a rare disease is any condition that nationally affects fewer than 200,000 people. There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families. This estimate has been used by the rare disease community for several decades to highlight that while individual diseases may be rare, the total number of people with a rare disease is large.

The National Organization for Rare Disorders, a non-profit patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them, is working to establish a Rare Disease Advisory Council (RDAC) in every state. Currently, 16 states have successfully established RDACs, but Florida is not one of them.

CS/HB 1373 creates the Rare Disease Advisory Council (Council) adjunct to the Department of Health (DOH). The bill establishes the membership of the Council as well as the length of the members' terms. The Council is required to:

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in this state.
- Develop recommended strategies for academic research institutions in this state to facilitate continued research on rare diseases.
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients.
- Provide written input and feedback to the DOH, the Medicaid program, and other state agencies on specified matters.

CS/HB 1373 requires the Council to first meet by October 1, 2021, and provide its recommendations to the Governor and the State Surgeon General by July 1 of each year, beginning in 2022.

The bill has a significant, negative fiscal impact on the DOH, which current resources are adequate to absorb, and no fiscal impact on local governments.

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

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Rare Disease

In the United States (U.S), a rare disease is any condition that nationally affects fewer than 200,000 people.¹ There may be as many as 7,000 rare diseases impacting the lives of 25-30 million Americans and their families.² This estimate has been used by the rare disease community for several decades to highlight that while individual diseases may be rare, the total number of people with a rare disease is large.³

Nationally, only a few types of rare diseases are tracked when a person is diagnosed.⁴ These include certain infectious diseases, birth defects, and cancers. It also includes the diseases on state newborn screening tests.⁵ Because most rare diseases are not tracked, it is difficult to determine the exact number of rare diseases or how many people are affected. Researchers have made progress in learning how to diagnose, treat, and even prevent a variety of rare diseases, however, most rare diseases have no treatments.⁶

The National Institutes of Health (NIH) supports research to improve the health of people with rare diseases.⁷ Many of the 27 Institutes and Centers at the NIH fund medical research for rare diseases, such as the National Center for Advancing Translational Sciences (NCATS), which focuses on getting new cures and treatments to all patients more quickly.⁸ NCATS supports research through collaborative projects to study common themes and causes of related diseases.⁹ This approach aims to speed the development of treatments that will eventually serve both rare and common diseases.¹⁰

Efforts to improve and bring to market treatments for rare diseases are coordinated by the Food and Drug Administration.¹¹ The Office of Orphan Products Development (OOPD) provides incentives for drug companies to develop treatments for rare diseases.¹² Between 1973 and 1983, fewer than 10 treatments for rare diseases were approved.¹³ Since 1983, the OOPD program has helped develop and bring to market more than 400 drugs and biologic products for rare diseases.¹⁴

Rare Disease Advisory Council

The National Organization for Rare Disorders (NORD), a non-profit patient advocacy organization dedicated to individuals with rare diseases and the organizations that serve them, is working to establish a Rare Disease Advisory Council (RDAC) in every state. An RDAC is an advisory body providing a platform for the rare disease community to have a stronger voice in state government.¹⁵

¹ U.S. Department of Health & Human Services, National Institutes of Health (NIH), *FAQs About Rare Diseases*, <https://rarediseases.info.nih.gov/diseases/pages/31/faqs-about-rare-diseases#:~:text=In%20the%20United%20States%2C%20only,on%20state%20newborn%20screening%20tests>. (last visited Mar. 18, 2021).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ National Organization for Rare Diseases (NORD), *Rare Disease Advisory Councils (RDACs): Project RDAC*, <https://rarediseases.org/rdac-overview/> (last visited Mar. 18, 2021).

⁸ *Id.*

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ *Id.*

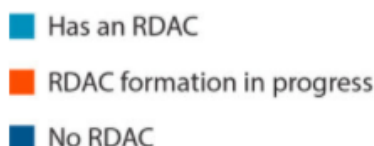
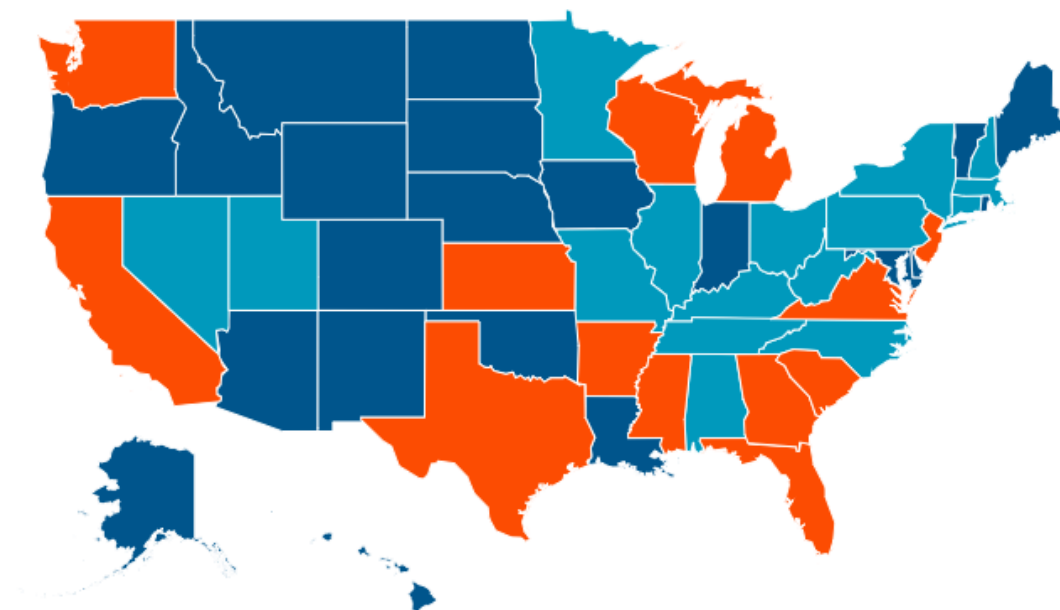
¹⁴ *Id.*

¹⁵ National Organization for Rare Diseases (NORD), *Rare Disease Advisory Councils (RDACs): Project RDAC*, <https://rarediseases.org/rdac-overview/> (last visited Mar. 18, 2021).

RDACs address the needs of affected patients and families by giving stakeholders an opportunity to make recommendations to state leaders on critical issues including the need for increased awareness, diagnostic tools, and access to affordable treatments and cures.¹⁶ These councils are housed by a variety of organizations including departments of health, outside nonprofits, universities, or grantees from departments of health. The types of RDACs include councils, task forces, advisory commissions, or, work groups.

Through the support of the NORD, alongside patient organizations and the other members of the rare disease community, momentum around RDACs is growing. In 2015, the first RDAC was created in North Carolina by patients, caregivers, families, and providers.¹⁷ Currently, there are 16 states with RDACs and 13 states with RDAC formation in progress.¹⁸

RDACs by State



Advisory Councils in Florida

In Florida, a statutorily created advisory council is appointed to function on a continuing basis for the study of the problems arising in a specified functional or program area of state government and to provide recommendations and policy alternatives¹⁹. An advisory council specifically created as an adjunct to an executive agency is created only after being found to be necessary and beneficial to the furtherance of a public purpose and must be terminated by the Legislature when it is no longer necessary.²⁰

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ NORD, *RDACs by State*, <https://rarediseases.org/rdac-overview/rdacs-by-state/> (last visited Mar. 18, 2021).

¹⁹ S. 20.03(7), F.S.

²⁰ S. 20.052, F.S.

Under current law, an advisory body may not be created unless:²¹

- It meets a statutorily defined purpose;
- Its powers and responsibilities conform with the definitions for specified governmental units;
- Its members, unless expressly provided otherwise in the State Constitution, are appointed for four-year staggered terms; and
- Its members, unless expressly provided otherwise by specific statutory enactment, serve without additional compensation or honorarium, and are authorized to receive only per diem and reimbursement for travel expenses as provided in s. 112.061, F.S.

Private citizen members of an advisory body that is adjunct to an executive agency must be appointed by the Governor, the head of the department, the executive director of the department, or a Cabinet officer.²² Unless exempt under law, all advisory council meetings are open to the public under s. 286.011, F.S., and minutes, including a record of all votes cast, must be maintained for all meetings.²³

If an advisory council adjunct to an executive agency is abolished, its records must be appropriately stored, within 30 days after the effective date of its abolition, by the executive agency to which it was adjunct, and any property assigned to it must be reclaimed by the executive agency.²⁴ An advisory council is prohibited from performing any activities after the effective date of its abolition.²⁵

Florida currently does not have an RDAC. However, the Department of Health (DOH) supports existing councils to promote engagement with stakeholders regarding disabilities and developmental delays:²⁶

- The Genetics and Newborn Screening Advisory Council.
 - This council includes a large array of expertise ranging from pediatricians, audiologists, representatives from each of the four medical schools in this state, pediatric hematologist, the Florida Hospital Association, as well as executive representation from the DOH.
- The Florida Interagency Coordinating Council for Infants and Toddlers.
 - This council advises and assists the Early Steps program with its implementation of the Individuals with Disabilities Education Act, Part C, and includes representation from public and private providers, the Agency for Health Care Administration, the Department of Education, and parents.
- The Information Clearinghouse on Developmental Disabilities Advisory Council.
 - This council provides resources to parents with children with developmental disabilities via the Bright Expectations website.

Effect of Proposed Changes

CS/HB 1373 creates s. 381.99, F.S., to establish the Rare Disease Advisory Council (Council). The Council is created adjunct to the DOH for the purpose of providing recommendations on ways to improve health outcomes for individuals with rare diseases, conditions that affect fewer than 200,000 people in the United States.

The bill requires the Governor to appoint members to the Council as follows:

- A representative of the Department of Health.
- A representative of the Agency for Health Care Administration.
- A representative of the Office of Insurance Regulation.
- A representative of the Department of Education.
- One geneticist practicing in this state.

²¹ S. 20.052(4), F.S.

²² S. 20.052(5)(a), F.S.

²³ S. 20.052(5)(c), F.S.

²⁴ S. 20.052(5)(d), F.S.

²⁵ *Id.*

²⁶ Florida Department of Health (DOH), 2021 Agency Legislative Bill Analysis for House Bill 1373, p. 2 (Mar. 1, 2021).

- One registered nurse or advanced practice registered nurse who is licensed and practicing in this state with experience treating rare diseases.
- One hospital administrator from a hospital in this state which provides care to individuals diagnosed with rare diseases.
- A pharmacist who is licensed and practicing in this state who has experience with drugs that are used to treat rare diseases.
- A representative of the biotechnology industry.
- A representative of health insurance companies.

The bill requires the President of the Senate to appoint the following members to the Council:

- A representative from an academic research institution in this state which receives any grant funding for research regarding rare diseases.
- A physician who is licensed under ch. 458 or ch. 459, practices in Florida, and has experience treating rare diseases.
- An individual who is 18 years of age or older who have a rare disease.
- An individual who is a caregiver of an individual with a rare disease.
- A representative of an organization operating in this state which provides care or other support for individuals with rare diseases.

The bill requires the Speaker of the House of Representatives to appoint the following members to the Council:

- A representative from an academic research institution in this state which receives any grant funding for research regarding rare diseases.
- A physician who is licensed under ch. 458 or ch. 459, practices in Florida, and has experience treating rare diseases.
- An individual who is 18 years of age or older who have a rare disease.
- An individual who is a caregiver of an individual with a rare disease.
- A representative of an organization operating in this state which provides care or other support for individuals with rare diseases.

Members of the Council must be appointed by September 1, 2021, and are appointed for four-year terms except that specified members are initially appointed to two-year terms to stagger the appointments. The Council is required to hold its initial meeting by October 1, 2021, and may meet upon the call of the chair or upon the request of the majority of its members thereafter. The Council is authorized to meet electronically.

The bill requires the Council to:

- Consult with experts on rare diseases and solicit public comment to assist in developing recommendations on improving the treatment of rare diseases in this state.
- Develop recommended strategies for academic research institutions in this state to facilitate continued research on rare diseases.
- Develop recommended strategies for health care providers to be informed on how to more efficiently recognize and diagnose rare diseases in order to effectively treat patients. The advisory council shall provide such strategies to the DOH for publication on the department's website.
- Provide written input and feedback to the DOH, the Medicaid program, and other state agencies on specified matters.

The DOH must provide staff and administrative support to the Council. The Council is required to submit a report to the DOH and the State Surgeon General by July 1 of each year, beginning in 2022, which describes the activities of the Council in the most recent year and its findings and recommendations regarding rare disease research and care.

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

B. SECTION DIRECTORY:

Section 1: Creates s. 381.99, F.S., relating to the Rare Disease Advisory Council.

Section 2: Provides an effective date of July 1, 2021.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The DOH will incur costs associated with staffing and supporting the Rare Disease Advisory Council. The DOH estimates one FTE will be required and requests \$75,569 in recurring funds and \$4,429 in nonrecurring funds for Fiscal Year 2021-2022. Additionally, the DOH requests \$47,120 in recurring funds to support travel expenses for Council members to attend an estimated four meetings per year.²⁷ However, the department has sufficient vacancies which can be filled to support the Council.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Not applicable. The bill does not require rulemaking.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

²⁷ DOH, *supra* note 26, at 5.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2021, the Professions & Public Health Subcommittee adopted an amendment to HB 1373 and reported the bill favorably as a committee substitute. The amendment:

- Revised who appoints specified Council members; and
- Required the Council to have two physicians who are licensed under ch. 458 or ch. 459, practice in Florida, and have with experience treating rare diseases.

The analysis is drafted to the committee substitute as passed by the Professions & Public Health Subcommittee.

1 A bill to be entitled
2 An act relating to the Rare Disease Advisory Council;
3 creating s. 381.99, F.S.; creating the advisory
4 council adjunct to the Department of Health;
5 specifying the purpose of the advisory council;
6 providing for staff and administrative support;
7 defining the term "rare disease"; specifying
8 application of state law governing the establishment
9 of advisory councils; prescribing the composition of
10 the advisory council; providing for initial
11 appointments to the advisory council by a specified
12 date; providing organizational and other meeting
13 requirements for the advisory council; prescribing
14 duties and responsibilities of the advisory council;
15 providing an effective date.

16
17 Be It Enacted by the Legislature of the State of Florida:

18
19 Section 1. Section 381.99, Florida Statutes, is created to
20 read:

21 381.99 Rare Disease Advisory Council.—

22 (1) The Rare Disease Advisory Council, an advisory council
23 as defined in s. 20.03(7), is created adjunct to the Department
24 of Health for the purpose of providing recommendations on ways
25 to improve health outcomes for individuals residing in the state

26 who have a rare disease. The department shall provide staff and
27 administrative support for the advisory council in the carrying
28 out of its duties and responsibilities. For purposes of this
29 section, the term "rare disease" means a condition that affects
30 fewer than 200,000 people in the United States. Except as
31 otherwise provided in this section, the advisory council shall
32 operate in a manner consistent with s. 20.052.

33 (2) The advisory council is composed of the following
34 members:

35 (a) As appointed by the Governor:

36 1. A representative of the Department of Health.

37 2. A representative of the Agency for Health Care
38 Administration.

39 3. A representative of the Office of Insurance Regulation.

40 4. A representative of the Department of Education.

41 5. One geneticist practicing in the state.

42 6. One registered nurse or advanced practice registered
43 nurse who is licensed and practicing in the state with
44 experience in treating rare diseases.

45 7. One hospital administrator from a hospital in the state
46 which provides care to individuals diagnosed with rare diseases.

47 8. A pharmacist who is licensed and practicing in the
48 state who has experience with drugs that are used in the
49 treatment of rare diseases.

50 9. A representative of the biotechnology industry.

51 10. A representative of health insurance companies.

52 (b) As appointed by the President of the Senate:

53 1. A representative from an academic research institution
54 in the state which receives grant funding for research regarding
55 rare diseases.

56 2. A physician who is licensed under chapter 458 or
57 chapter 459 and practicing in the state with experience in
58 treating rare diseases.

59 3. An individual who is 18 years of age or older who has a
60 rare disease.

61 4. An individual who is a caregiver of an individual with
62 a rare disease.

63 5. A representative of an organization operating in the
64 state which provides care or other support to individuals with
65 rare diseases.

66 (c) As appointed by the Speaker of the House of
67 Representatives:

68 1. A representative from an academic research institution
69 in the state which receives grant funding for research regarding
70 rare diseases.

71 2. A physician who is licensed under chapter 458 or
72 chapter 459 and practicing in the state with experience in
73 treating rare diseases.

74 3. An individual who is 18 years of age or older who has a
75 rare disease.

76 4. An individual who is a caregiver of an individual with
77 a rare disease.

78 5. A representative of organizations in the state which
79 provide care or other support to individuals with rare diseases.

80
81 Any vacancy on the advisory council must be filled in the same
82 manner as the original appointment.

83 (3) The initial members of the advisory council must be
84 appointed by September 1, 2021. Each member must be appointed to
85 a 4-year term of office. However, in order to achieve staggered
86 terms, each of the initial members appointed pursuant to
87 paragraph (2)(a) must be appointed to a 2-year term. The
88 Governor shall designate a chair and vice chair of the advisory
89 council from among its membership. The advisory council shall
90 meet for its initial meeting by October 1, 2021. Thereafter, the
91 advisory council may meet upon the call of the chair or upon the
92 request of a majority of its members. The advisory council may
93 meet via teleconferencing or other electronic means. Notices for
94 any scheduled meetings of the advisory council must be published
95 in advance on the department's website.

96 (4) The advisory council shall:

97 (a) Consult with experts on rare diseases and solicit
98 public comment to assist in developing recommendations on
99 improving the treatment of rare diseases in the state.

100 (b) Develop recommended strategies for academic research

101 institutions in the state to facilitate continued research on
102 rare diseases.

103 (c) Develop recommended strategies for health care
104 providers to be informed on how to more efficiently recognize
105 and diagnose rare diseases in order to effectively treat
106 patients. The advisory council shall provide such strategies to
107 the Department of Health for publication on the department's
108 website.

109 (d) Provide input and feedback in writing to the
110 department, the Medicaid program, and other state agencies on
111 matters that affect people who have been diagnosed with rare
112 diseases, including, but not limited to, pandemic or natural
113 disaster preparedness and response.

114 (e) By July 1 of each year, beginning in 2022, submit a
115 report to the Governor and the State Surgeon General which
116 describes the activities of the advisory council in the past
117 year and its findings and recommendations regarding rare disease
118 research and care. Additionally, the report must be made
119 available on the department's website.

120 Section 2. This act shall take effect July 1, 2021.

HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/HB 1447 Commission on Mental Health and Substance Abuse

SPONSOR(S): Children, Families & Seniors Subcommittee, Hunschofsky

TIED BILLS: **IDEN./SIM. BILLS:** SB 1888

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Children, Families & Seniors Subcommittee	15 Y, 0 N, As CS	Morris	Brazzell
2) Health Care Appropriations Subcommittee		Fontaine	Clark
3) Health & Human Services Committee			

SUMMARY ANALYSIS

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. It serves children and adults who are otherwise unable to obtain these services (such as individuals who are not covered under Medicaid or private insurance and do not have the financial ability to pay for the services themselves). Individuals may also receive behavioral health services in Florida through other systems, such as Medicaid, schools, and the corrections system.

In 2018, the Legislature enacted the “Marjory Stoneman Douglas High School Public Safety Act” (the Act) to address school safety and security and establish the Marjory Stoneman Douglas High School Public Safety Commission. The Act’s provisions addressed school safety and security by creating the Office of Safe Schools within the Florida Department of Education and requiring increased coordination among state and local agencies serving students with or at-risk of mental illness, among other provisions. In 2019, the Florida Supreme Court convened a Grand Jury to study systemic school safety failures. The Grand Jury was tasked with investigating whether specific public entities failed to act or committed fraud that undermined the school safety activities which the Act and subsequent legislation required. To address such problems, the Grand Jury recommended the Legislature appoint a commission to specifically examine the provision of mental health services in the state.

CS/HB 1447 creates a 19-member Commission on Mental Health and Substance Abuse (Commission), adjunct to DCF, to examine the current methods of providing mental health and substance abuse services in the state. The bill requires DCF to provide administrative staff and support services for the commission. Commission members are appointed by the Governor, President of the Senate, and Speaker of the House of Representatives and must convene by September 1, 2021. The bill requires state departments and agencies to provide assistance in a timely manner if requested by the Commission.

The Commission must submit an initial report by September 1, 2022, and a final report by September 1, 2023, to the Governor, President of the Senate, and Speaker of the House of Representatives on its findings and recommendations on how to best provide and facilitate mental health and substance abuse services in this state. The Commission is repealed on September 1, 2023, unless it is reenacted by the Legislature.

The bill has a significant, negative fiscal impact on DCF that can be absorbed within existing resources. The bill has no fiscal impact to local governments.

The bill is effective upon becoming a law.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Background

Mental Illness

Mental health is a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to contribute to his or her community.¹ The primary indicators used to evaluate an individual's mental health are:²

- **Emotional well-being-** Perceived life satisfaction, happiness, cheerfulness, peacefulness;
- **Psychological well-being-** Self-acceptance, personal growth including openness to new experiences, optimism, hopefulness, purpose in life, control of one's environment, spirituality, self-direction, and positive relationships; and
- **Social well-being-** Social acceptance, beliefs in the potential of people and society as a whole, personal self-worth and usefulness to society, sense of community.

Mental illness is collectively all diagnosable mental disorders or health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning.³ Thus, mental health refers to an individual's mental state of well-being whereas mental illness signifies an alteration of that well-being.

Mental illness affects millions of people in the United States each year. Nearly one in five adults (51.5 million people) live with a mental illness.⁴ An estimated 13.1 million adults aged 18 or older have a serious mental illness.⁵ Many people are diagnosed with more than one mental illness. For example, people who suffer from a depressive illness (major depression, bipolar disorder, or dysthymia) tend to co-occur with substance abuse and anxiety disorders.⁶

According to a 2019 assessment by the U.S. Department of Housing and Urban Development, 567,715 people were homeless on a given nights in the United States.⁷ At a minimum, 116,179, or 20% percent, of these people were severely mentally ill.

Mental Health Services in Florida

The Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment and recovery for children and adults who are otherwise unable to obtain these services. SAMH programs include a range of prevention, acute interventions (e.g. crisis stabilization), residential treatment, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations.

Behavioral Health Managing Entities

¹ World Health Organization, *Mental Health: Strengthening Our Response*, <https://www.who.int/news-room/fact-sheets/detail/mental-health-strengthening-our-response> (last visited March 20, 2021).

² Centers for Disease Control and Prevention, *Learn About Mental Health*, <http://www.cdc.gov/mentalhealth/basics.htm> (last visited March 20, 2021).

³ *Id.*

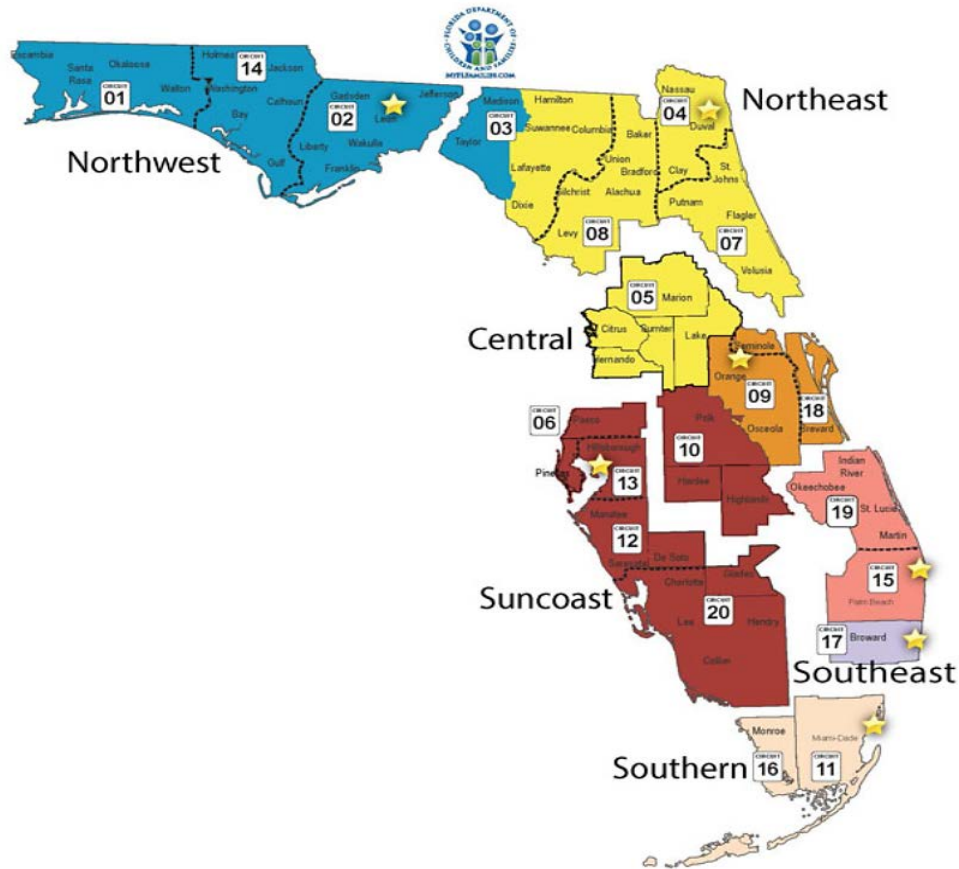
⁴ National Institute on Mental Health, *Mental Illness*, <https://www.nimh.nih.gov/health/statistics/mental-illness.shtml>, (last visited March 20, 2021).

⁵ *Id.*

⁶ John Hopkins Medicine, *Mental Health Disorder Statistics*, <https://www.hopkinsmedicine.org/health/wellness-and-prevention/mental-health-disorder-statistics> (last visited March 20, 2021).

⁷ U.S. Department of Housing and Urban Development, *2019 CoC Homeless Populations and Subpopulations Report – All States, Territories, Puerto Rico, and DC*, <https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/> (last visited March 20, 2021).

In 2001, the Legislature authorized DCF to implement behavioral health managing entities (ME) as the management structure for the delivery of local mental health and substance abuse services.⁸ The implementation of the ME system initially began on a pilot basis and, in 2008, the Legislature authorized DCF to implement MEs statewide.⁹ Full implementation of the statewide managing entity system occurred in April 2013; all geographic regions are now served by a managing entity.¹⁰ DCF contracts with seven MEs – NWF Health Network (blue), Lutheran Services Florida (yellow), Central Florida Cares Health System (orange), Central Florida Behavioral Health Network, Inc. (red), Southeast Florida Behavioral Health (pink), Broward Behavioral Health Network, Inc. (purple), and South Florida Behavioral Health Network, Inc. (beige) that in turn contract with local service providers¹¹ for the delivery of mental health and substance abuse services:¹²



In FY 2019-2020, the network service providers under contract with the MEs served 274,560 individuals.¹³

Coordinated System of Care

⁸ Ch. 2001-191, Laws of Fla.

⁹ Ch. 2008-243, Laws of Fla.

¹⁰ *The Department of Children and Families Performance and Accountability System for Behavioral Health Managing Entities*, Office of Program Policy Analysis and Government Accountability, July 18, 2014.

¹¹ Managing entities create and manage provider networks by contracting with service providers for the delivery of substance abuse and mental health services.

¹² Department of Children and Families, *Managing Entities*, <https://www.myflfamilies.com/service-programs/samh/managing-entities/> (last visited March 20, 2020).

¹³ Department of Children and Families, *Substance Abuse and Mental Health Triennial Plan Update for Fiscal Year*, (December 31, 2020) <https://www.myflfamilies.com/service-programs/samh/publications/docs/2019-2020%20Triennial%20Plan%20Update.pdf> (last visited March 20, 2020).

Managing entities are required to promote the development and implementation of a coordinated system of care.¹⁴ A coordinated system of care means a full array of behavioral and related services in a region or community offered by all service providers, participating either under contract with a managing entity or by another method of community partnership or mutual agreement.¹⁵ A community or region provides a coordinated system of care for those suffering from mental illness or substance abuse disorder through a no-wrong-door model, to the extent allowed by available resources. If funding is provided by the Legislature, DCF may award system improvement grants to managing entities.¹⁶ MEs must submit detailed plans to enhance crisis services based on the no-wrong-door model or to meet specific needs identified in DCF's assessment of behavioral health services in this state.¹⁷ DCF must use performance-based contracts to award grants.¹⁸

There are several essential elements which make up a coordinated system of care, including:¹⁹

- Community interventions;
- Case management;
- Care coordination;
- Outpatient services;
- Residential services;
- Hospital inpatient care;
- Aftercare and post-discharge services;
- Medication assisted treatment and medication management; and
- Recovery support.

A coordinated system of care must include, but is not limited to, the following array of services:²⁰

- Prevention services;
- Home-based services;
- School-based services;
- Family therapy;
- Family support;
- Respite services;
- Outpatient treatment;
- Crisis stabilization;
- Therapeutic foster care;
- Residential treatment;
- Inpatient hospitalization;
- Case management;
- Services for victims of sex offenses;
- Transitional services; and
- Trauma-informed services for children who have suffered sexual exploitation.

Current law requires DCF to define the priority populations which would benefit from receiving care coordination, including considerations when defining such population.²¹ Considerations include the number and duration of involuntary admissions, the degree of involvement with the criminal justice system, the risk to public safety posed by the individual, the utilization of a treatment facility by the individual, the degree of utilization of behavioral health services, and whether the individual is a parent or caregiver who is involved with the child welfare system.

¹⁴ S. 394.9082(5)(d), F.S.

¹⁵ S. 394.4573(1)(c), F.S.

¹⁶ S. 394.4573(3), F.S. The Legislature has not funded system improvement grants.

¹⁷ Id.

¹⁸ Id.

¹⁹ S. 394.4573(2), F.S.

²⁰ S. 394.495(4), F.S.

²¹ S. 394.9082(3)(c), F.S.

MEs are required to conduct a community behavioral health care needs assessment once every three years in the geographic area served by the managing entity, which identifies needs by sub-region.²² The assessments must be submitted to DCF for inclusion in the state and district substance abuse and mental health plan.²³

The Baker Act

In 1971, the Legislature adopted the Florida Mental Health Act, also known as the Baker Act.²⁴ The Baker Act authorizes treatment programs for mental, emotional, and behavioral health which are designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional, and behavioral disorders.²⁵ These treatment programs include, but are not limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short-term and continued treatment to encourage them to assume responsibility for their treatment and recovery.²⁶ The Baker Act provides legal procedures, protections, and rights to individuals examined or treated for mental illness and addresses legal procedures for examination and treatment including: voluntary admission;²⁷ involuntary admission;²⁸ involuntary inpatient treatment;²⁹ and involuntary outpatient treatment.³⁰

The Baker Act requires each county to designate a single law enforcement agency to transfer a person in need of services.³¹ If a person is in custody based on noncriminal or minor criminal behavior, law enforcement transports the person to the nearest receiving facility.³² If, however, the person is arrested for a felony, the person must first be processed in the same manner as any other criminal suspect. Law enforcement must then transport the person to the nearest facility, unless the facility is unable to provide adequate security, in which case the person must be examined and treated wherever he or she is held.³³

Receiving Facilities

A person experiencing severe emotional or behavioral problems often requires emergency treatment to stabilize his or her situation before referral for outpatient services or inpatient services can occur. Emergency mental health stabilization services may be provided to a person on a voluntary or involuntary basis. Receiving facilities, often referred to as Baker Act facilities, are public or private facilities designated by DCF for the purpose of receiving and holding or referring, 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.³⁴ A public receiving facility is a facility that provides mental health services to all persons, regardless of their ability to pay, and receives state funds for such purpose.³⁵ Facilities may only use appropriated funds to provide 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.³⁶

Crisis Stabilization Units (CSUs) are public receiving facilities that receive state funding and provide a less intensive and less costly alternative to inpatient psychiatric hospitalization for individuals presenting as acutely mentally ill. CSUs screen, assess, and admit individuals under the Baker Act, as well as those individuals who voluntarily present themselves, for short-term services.³⁷ CSUs provide

²² S. 394.9082(5)(b), F.S.

²³ S. 394.75(3), F.S.

²⁴ Ch. 71-131, Laws of Fla.; ch. 394, part I, F.S.

²⁵ S. 394.453(1)(a), F.S.

²⁶ S. 394.453(1)(b), F.S.

²⁷ S. 394.4625, F.S.

²⁸ Ss. 397.6772, 397.679, 397.6798, and 397.6811, F.S.

²⁹ S. 394.467, F.S.

³⁰ S. 394.4655, F.S.

³¹ S. 394.462(1)(a), F.S.

³² S. 394.462(1)(g), F.S.

³³ S. 394.462(1)(f) and (g), F.S.

³⁴ S. 394.455(39), F.S. This term does not include a county jail.

³⁵ S. 394.455(37), F.S.

³⁶ Rule 65E-5.400(2), F.A.C.

³⁷ S. 394.875, F.S.

services 24 hours a day, seven days a week, through a team of mental health professionals. The purpose of the CSU is to examine, stabilize, and redirect people to the most appropriate and least restrictive treatment settings, consistent with their mental health needs.

As of March 2021, there were 131 Baker Act receiving facilities in Florida, including 66 public receiving facilities and 65 private receiving facilities.³⁸ Of the 53 public receiving facilities, 47 also contract to provide CSU services.³⁹

Involuntary Admission

A person receiving services on an involuntary basis must be taken to a designated “receiving facility.”⁴⁰ He or she cannot be involuntarily held in a receiving facility for examination for longer than 72 hours.⁴¹ Generally, within the 72-hour examination period, one of the following must occur:⁴²

- The patient must be released, unless he or she is charged with a crime, in which case law enforcement resumes custody;
- The patient must be released into voluntary outpatient treatment;
- The patient must be asked to give consent to be placed as a voluntary patient if placement is recommended; or
- A petition for involuntary placement must be filed in circuit court for outpatient or inpatient treatment

Under the Baker Act, a court must hold a hearing on involuntary inpatient or outpatient placement within five working days after a petition for involuntary placement is filed.⁴³ The petitioner must show, by clear and convincing evidence, that all available less restrictive treatment alternatives are inappropriate and the person is:⁴⁴

- Mentally ill and, because of the illness, has refused voluntary placement for treatment or is unable to determine the need for placement; and
- Manifestly incapable of surviving alone or with the help of family and friends, and without treatment is likely to suffer from neglect to such an extent that it poses a real and present threat of substantial harm to his or her well-being, or substantial likelihood exists that in the near future he or she will inflict serious bodily harm on himself or herself or another person.

Courts, law enforcement officers, and certain health care practitioners are authorized to initiate involuntary examinations.⁴⁵ A circuit court may enter an *ex parte* order finding that a person meets the criteria for involuntary examination.⁴⁶ A law enforcement officer⁴⁷ may take a person into custody who appears to meet the criteria for involuntary examination and transport them to a receiving facility for examination.⁴⁸ A health care practitioner may initiate an involuntary examination by executing an official form adopted by DCF rule called a *Certificate of Professional Initiating an Involuntary Examination*.⁴⁹

³⁸ Department of Children and Families, *Designated Baker Act Receiving Facilities*, (Feb. 2, 2021), <http://www.dcf.state.fl.us/service-programs/samh/crisis-services/docs/baker/Baker%20Act%20Receiving%20Facilities.pdf> (last visited March 20, 2021).

³⁹ *Id.*

⁴⁰ S. 394.455(26), F.S.

⁴¹ S. 394.463(2)(f), F.S.

⁴² S. 394.463(2)(i)4., F.S.

⁴³ Ss. 394.4655(6) and 394.467(6), F.S.

⁴⁴ S. 394.467(1), F.S.

⁴⁵ S. 394.463(2)(a), F.S.

⁴⁶ *Id.*

⁴⁷ “Law enforcement officer” means any person who is elected, appointed, or employed full time by any municipality or the state or any political subdivision thereof; who is vested with authority to bear arms and make arrests; and whose primary responsibility is the prevention and detection of crime or the enforcement of the penal, criminal, traffic, or highway laws of the state. This definition includes all certified supervisory and command personnel whose duties include, in whole or in part, the supervision, training, guidance, and management responsibilities of full-time law enforcement officers, part-time law enforcement officers, or auxiliary law enforcement officers but does not include support personnel employed by the employing agency. S. 943.10(1), F.S.

⁴⁸ 394.463(2)(a)2., F.S.

⁴⁹ The *Certificate of Professional Initiating an Involuntary Examination*, created by DCF, must be executed by health care practitioners initiating an involuntary examination under The Baker Act. The form contains information related to the person’s diagnosis and the

The health care practitioner must have examined the person within the preceding 48 hours and state that the person meets the criteria for involuntary examination.⁵⁰ The Baker Act currently authorizes the following health care practitioners to initiate an involuntary examination by certificate:⁵¹

- A physician licensed under ch. 458 or 459, F.S., who has experience in the diagnosis and treatment of mental and nervous disorders, or a physician employed by the United States Department of Veterans Affairs or Department of Defense.⁵²
- A clinical psychologist, as defined in s. 490.003(7), F.S., with three years of postdoctoral experience in the practice of clinical psychology, inclusive of the experience required for licensure, or a psychologist employed by a facility operated by the United States Department of Veterans Affairs that qualifies as a receiving or treatment facility.⁵³
- A psychiatric nurse who is certified as an advanced registered nurse practitioner under s. 464.012, F.S., who has a master's degree or a doctorate in psychiatric nursing, holds a national advanced practice certification as a psychiatric mental health advance practice nurse, and has two years of post-master's clinical experience under the supervision of a physician.⁵⁴
- A mental health counselor licensed under ch. 491, F.S.
- A marriage and family therapist licensed under ch. 491, F.S.
- A clinical social worker licensed under ch. 491, F.S.

During FY 2018-19, there were 210,992 involuntary examinations in Florida. Law enforcement initiated more than half (51.34 percent), followed closely by those initiated by mental health professionals (46.45 percent), and the remaining 2.22 percent were initiated by a judge's *ex parte* order.⁵⁵

Voluntary Admission

A receiving facility may provide observation, diagnosis, or treatment to any person 18 years or older or any person under 18 if entry is sought by his or her guardian. A person may voluntarily enter a receiving facility only if he or she is willing and competent to consent to admission and treatment. A person under 18 may be admitted only after a hearing to verify the voluntariness of the consent. If a person is incompetent to consent to treatment,⁵⁶ he or she cannot be held under the voluntary provisions of the Baker Act.

A person on voluntary status is presumed to be able to exercise all of his or her rights under the law, including consenting or refusing consent to admission or treatment. If a person is competent, he or she may voluntarily enter any facility he or she chooses. Within 24 hours after voluntary admission, the admitting physician must document in the patient's clinical record that he or she is able to give express and informed consent for admission. If a person is not able to give express and informed consent for admission, he or she must be discharged or transferred to involuntary status.⁵⁷

Substance Abuse

health care practitioner's personal observations of statements and behaviors that support the involuntary examination of such person. See rule reference in Rule 65E-5.280, F.A.C. The form is also online. See, *Certificate of Professional Initiating an Involuntary Examination*, Department of Children and Families, <https://eds.myflfamilies.com/DCFFormsInternet/Search/OpenDCFForm.aspx?FormId=1063> (last visited March 20, 2021).

⁵⁰ S. 394.463(2)(a)3., F.S.

⁵¹ *Id.*

⁵² S. 394.455(32), F.S.

⁵³ S. 394.455(5), F.S.

⁵⁴ S. 394.455(35), F.S.

⁵⁵ Christy, A., et al., *Fiscal Year 2018-2019 Annual Report*, Baker Act Reporting Center, Louis de la Parte Florida Mental Health Institute, Department of Mental Health Law & Policy, University of South Florida, Nov. 2020, https://www.usf.edu/cbcs/baker-act/documents/ba_usf_annual_report_2018_2019.pdf (last visited March 20, 2021).

⁵⁶ "Incompetent to consent to treatment" means that a person's judgment is so affected by his or her mental illness that he or she lacks the capacity to make a well-reasoned, willful, and knowing decision concerning his or her medical or mental health treatment. S. 394.455(15), F.S.

⁵⁷ S. 394.4625(1)(f), F.S.

Substance abuse refers to the harmful or hazardous use of psychoactive substances, including alcohol and illicit drugs.⁵⁸ Substance use disorders occur when the chronic use of alcohol or drugs causes significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home.⁵⁹ Repeated drug use leads to changes in the brain's structure and function that can make a person more susceptible to developing a substance use disorder.⁶⁰ Brain imaging studies of persons with substance use disorders show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control.⁶¹

According to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.⁶² The most common substance use disorders in the United States are from the use of alcohol, tobacco, cannabis, stimulants, hallucinogens, and opioids.⁶³

Substance Abuse Treatment in Florida

In 1970, the Legislature enacted ch. 397, F.S., governing the treatment and rehabilitation of drug dependents.⁶⁴ The following year, the Legislature enacted ch. 396, F.S., titled the "Myers Act" as the state's comprehensive alcoholism prevention, control, and treatment act, modeled after the federal Hughes Act.⁶⁵ In 1993, legislation combined ch. 396 and ch. 397, F.S., into a single law, the Hal S. Marchman Alcohol and Other Drug Services Act ("the Marchman Act").⁶⁶ The Marchman Act supports substance abuse prevention and remediation through a system of prevention, detoxification, and treatment services to assist individuals at risk for or affected by substance abuse.

Additionally, the Department of Children and Families (DCF) administers a statewide system of safety-net services for substance abuse and mental health (SAMH) prevention, treatment, and recovery. SAMH programs include a range of prevention, acute interventions (such as crisis stabilization or detoxification), residential, transitional housing, outpatient treatment, and recovery support services. Services are provided based upon state and federally-established priority populations and delivered through community-based providers.⁶⁷

DCF provides treatment for substance abuse through a community-based provider system that offers detoxification, treatment and recovery support for adolescents and adults affected by substance misuse, abuse or dependence.⁶⁸

- **Detoxification Services:** Detoxification services use medical and clinical procedures to assist individuals and adults as they withdraw from the physiological and psychological effects of substance abuse.⁶⁹
- **Treatment Services:** Treatment services⁷⁰ include a wide array of assessment, counseling, case management, and support that are designed to help individuals who have lost their

⁵⁸ World Health Organization, *Substance Abuse*, http://www.who.int/topics/substance_abuse/en/ (last visited March 20, 2021).

⁵⁹ Substance Abuse and Mental Health Services Administration, *Substance Use Disorders*, <http://www.samhsa.gov/disorders/substance-use> (last visited March 20, 2021).

⁶⁰ National Institute on Drug Abuse, *Drugs, Brains, and Behavior: The Science of Addiction*, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/drug-abuse-addiction> (last visited March 20, 2021).

⁶¹ *Id.*

⁶² *Supra*, note 59.

⁶³ *Id.*

⁶⁴ Department of Children and Families, *Marchman Act User Reference Guide 2003*, <https://www.myflfamilies.com/service-programs/samh/crisis-services/docs/marchman/marchmanacthand03p.pdf>, (last visited March 20, 2021).

⁶⁵ *Id.*

⁶⁶ Ch. 93-39, s. 2, Laws of Fla., codified in ch. 397, F.S.

⁶⁷ These priority populations include, among others, persons diagnosed with co-occurring substance abuse and mental health disorders, persons who are experiencing an acute mental or emotional crisis, children who have or are at risk of having an emotional disturbance, and children at risk for initiating drug use.

⁶⁸ Department of Children and Families, *Treatment for Substance Abuse*, available at <https://www.myflfamilies.com/service-programs/samh/substance-abuse.shtml>, (last visited March 20, 2021).

⁶⁹ *Id.*

⁷⁰ *Id.* Research indicates that persons who successfully complete substance abuse treatment have better post-treatment outcomes related to future abstinence, reduced use, less involvement in the criminal justice system, reduced involvement in the child-protective system, employment, increased earnings, and better health.

abilities to control their substance use on their own and require formal, structured intervention and support. Some of these services may also be offered to the family members of the individual in treatment.⁷¹

- **Recovery Support:** Recovery support services, including transitional housing, life skills training, parenting skills, and peer-based individual and group counseling, are offered during and following treatment to further assist individuals in their development of the knowledge and skills necessary to maintain their recovery.⁷²

DCF regulates substance abuse treatment by licensing individual treatment components under ch. 397, F.S., and rule 65D-30, F.A.C. Licensed service components include a continuum of substance abuse prevention,⁷³ intervention,⁷⁴ and clinical treatment services.⁷⁵

Clinical treatment is a professionally directed, deliberate, and planned regimen of services and interventions that are designed to reduce or eliminate the misuse of drugs and alcohol and promote a healthy, drug-free lifestyle.⁷⁶ “Clinical treatment services” include, but are not limited to, the following licensable service components:⁷⁷

- Addictions receiving facility.
- Day or night treatment.
- Day or night treatment with community housing.
- Detoxification.
- Intensive inpatient treatment.
- Intensive outpatient treatment.
- Medication-assisted treatment for opiate addiction.
- Outpatient treatment.
- Residential treatment.

Behavioral Health Services Provided through Other Systems

Behavioral health services are provided by systems other than DCF’s safety net services. Some examples are the Medicaid system, the criminal justice system, and the education system. Each system serves a different population, is funded in its own way, and has different criteria for qualifying to receive services, different goals for the provision of services, and different means for individuals to receive services.

Medicaid

Medicaid is the health care safety net for low-income Floridians. Medicaid is a partnership of the federal and state governments established to provide coverage for health services for eligible persons. The program is administered by the Agency for Health Care Administration (AHCA) and financed by federal and state funds. AHCA delegates certain functions to other state agencies, including the Department of Children and Families (DCF), which makes eligibility determinations.

⁷¹ *Supra*, note 68.

⁷² *Id.*

⁷³ Section 397.311(26)(c), F.S. Prevention is a process involving strategies that are aimed at the individual, family, community, or substance and that preclude, forestall, or impede the development of substance use problems and promote responsible lifestyles. See also, Department of Children and Families, *Substance Abuse: Prevention*, <https://www.myflfamilies.com/service-programs/samh/prevention/index.shtml>, (last visited March 20, 2021). Substance abuse prevention is best accomplished through the use of ongoing strategies such as increasing public awareness and education, community-based processes and evidence-based practices. These prevention programs are focused primarily on youth, and, in recent years, have shifted to the local level, giving individual communities the opportunity to identify their own unique prevention needs and develop action plans in response. This community focus allows prevention strategies to have a greater impact on behavioral change by shifting social, cultural and community environments.

⁷⁴ Section 397.311(26)(b), F.S. Intervention is structured services directed toward individuals or groups at risk of substance abuse and focused on reducing or impeding those factors associated with the onset or the early stages of substance abuse and related problems.

⁷⁵ Section 397.311(25), F.S.

⁷⁶ *Supra*, note 75.

⁷⁷ Section 397.311(25)(a), F.S.

The structure of each state's Medicaid program varies, but what states must pay for is largely determined by the federal government, as a condition of receiving federal funds.⁷⁸ Federal law sets the amount, scope, and duration of services offered in the program, among other requirements. These federal requirements create an entitlement that comes with constitutional due process protections. The entitlement means that two parts of the Medicaid cost equation – people and utilization – are largely predetermined for the states. The federal government sets the minimum mandatory populations to be included in every state Medicaid program. The federal government also sets the minimum mandatory benefits to be covered in every state Medicaid program. These benefits include community mental health and substance abuse services such as:⁷⁹

- Psychiatric services;
- Individual, family, and group therapy;
- Behavior management; and
- Therapeutic support.

Criminal Justice System

The state forensic system is a network of facilities and community services for criminal defendants needing mental health services.⁸⁰ Only an adult, or a juvenile being prosecuted as an adult, who is charged with a felony offense,⁸¹ and adjudicated incompetent to proceed⁸² or not guilty by reason of insanity,⁸³ may be involuntarily committed to a state civil⁸⁴ or forensic⁸⁵ treatment facility or placed on conditional release⁸⁶ by the court.⁸⁷ Florida does not provide forensic services for defendants charged with misdemeanor offenses.

Pretrial Intervention/Diversion Programs

The Department of Corrections supervises pretrial intervention programs (PTIs) for defendants with pending criminal charges. Section 948.08, F.S., governs PTIs, also referred to as diversion programs, which are available to any first time offender, or any person not convicted of more than one nonviolent misdemeanor, who is charged with a misdemeanor or third degree felony.⁸⁸ The goal of PTI is to offer eligible defendants a sentencing alternative in the form of counseling, education, supervision, or medical and psychological treatment, as appropriate.⁸⁹ Individuals may be eligible for pretrial intervention programs addressing their mental illness or substance use.

While a defendant is in a PTI, his or her criminal charges remain pending. If a defendant successfully completes a PTI, his or her charges may be dismissed.⁹⁰ If the defendant fails to successfully complete the PTI, the program administrator may recommend further supervision or the state attorney may resume prosecution for the offense. The court may not appoint a public defender to represent an

⁷⁸ 42 U.S.C. §§ 1396-1396w-5; 42 C.F.R. Part 430-456 (§§ 430.0-456.725) (2016).

⁷⁹ Section 409.906(8), F.S. See also Agency for Health Care Administration, *Florida's Medicaid Covered Services and HCBS Waivers*, https://ahca.myflorida.com/medicaid/Policy_and_Quality/Policy/behavioral_health_coverage/bhfu/Community_Behavioral_Health.shtml (last visited March 20, 2021).

⁸⁰ See ch. 916, F.S.

⁸¹ Section 916.106(6), F.S.

⁸² Section 916.106(11), F.S.

⁸³ Fla. R. Crim. P. 3.217.

⁸⁴ A "civil facility" is a mental health facility run by or under contract with DCF to serve individuals committed under ch. 394, F.S., and defendants committed under ch. 916, F.S., who do not require the security of a forensic facility; or an intermediate care facility for the developmentally disabled, a foster care facility, a group home facility, or a supported living setting. Section 916.106(4), F.S.

⁸⁵ A "forensic facility" is a separate and secure facility established within DCF or the Agency for Persons with Disabilities to serve forensic clients. A separate and secure facility means a security-grade building for the purpose of separately housing persons who have mental illness from persons who have intellectual disabilities or autism and separately housing persons who have been involuntarily committed under ch. 916, F.S., from nonforensic residents. Section 916.106(10), F.S.

⁸⁶ Section 916.304, F.S.

⁸⁷ See legislative intent in s. 916.105(1)–(4), F.S.

⁸⁸ Section 948.08(1), F.S.

⁸⁹ Section 948.08(1), F.S.

⁹⁰ Section 948.08(5), F.S. If a case is dismissed without prejudice, the case may be refiled at a later time.

indigent defendant who is released to a PTI unless the offender's release is revoked and he or she is subject to imprisonment if convicted.⁹¹

Mental Health Courts

Mental health courts (MHCs) are problem-solving courts that combine judicial supervision with mental health treatment and other support services with the goal of improving public safety by:⁹²

- Reducing criminal recidivism;
- Improving the quality of life of defendants with mental illnesses and increasing their participation in effective treatment; and
- Reducing court-and corrections-related costs, often by providing an alternative to incarceration.

Florida has 31 operating MHCs authorized under s. 394.47892, F.S.⁹³ Due to the lack of specific statutory framework for MHCs, eligibility criteria, program requirements, and other processes differ amongst circuits.

Student Mental Health

Mental Health Assistance Allocation

The Marjory Stoneman Douglas High School Public Safety Act (Act), discussed below, created the Mental Health Assistance Allocation within the Florida Education Finance Program.⁹⁴ The allocation is intended to provide funding to assist school districts in establishing or expanding school-based mental health care, train educators and other school staff in detecting and responding to mental health issues, and connecting children, youth, and families who may experience behavior health issues with appropriate services.⁹⁵ For the 2020-2021 school year, \$100 million was appropriated for the allocation,⁹⁶ with each school district receiving a minimum of \$100,000 with the remaining balance of funds allocated based on each district's proportionate share of the state's total unweighted full-time equivalent student enrollment.⁹⁷ Eligible charter schools are entitled to a proportionate share of the school district's allocation.⁹⁸

School districts are prohibited from using the funds allocated under this section to supplant funds from other operating funds used for the provision of mental health services. These funds may not be used for salary increases or bonuses.⁹⁹

In order to receive allocation funds, a school district must develop and submit to the district school board for approval a detailed plan outlining its local program and planned expenditures.¹⁰⁰ A school district's plan must include all district schools, including charter schools, unless a charter school elects to submit a plan independently from the school district.¹⁰¹ Each approved plan must be submitted to the Commissioner of Education by August 1 each year.

The plan must be focused on a multitiered system of supports to deliver evidence-based mental health care assessment, diagnosis, intervention, treatment, and recovery services. Supports and services under the allocation are provided to students with one or more mental health or co-occurring substance

⁹¹ Section 948.08(3) and (4), F.S.

⁹² Florida Courts, *Mental Health Courts*, <https://www.flcourts.org/Resources-Services/Court-Improvement/Problem-Solving-Courts/Mental-Health-Courts> (last visited Feb. 18, 2021).

⁹³ Section 394.47892, F.S., authorizes each county to fund a mental health court program and addresses the funding of the programs.

⁹⁴ Section 1011.62(16), F.S.

⁹⁵ *Id.*

⁹⁶ Specific Appropriation 8 and 92, s. 2, ch. 2020-111, L.O.F.

⁹⁷ Section 1011.62(16), F.S.; See also Florida Department of Education, Office of Safe Schools, *2020-2021 FEFP – Revised Final Conference Calculations as funded in Chapter 2020-111 (Mental Health Assistance Allocation)*, <http://www.fldoe.org/core/fileparse.php/18612/urlt/2021DistrictMHAssisAllocation.pdf> (last visited March 20, 2021).

⁹⁸ Section 1011.62(16), F.S.

⁹⁹ *Id.*

¹⁰⁰ Section 1011.62(16)(a)1.-2., F.S.

¹⁰¹ *Id.*

abuse diagnoses and to students at high risk of such diagnoses. The provision of these services must be coordinated with a student's primary mental health care provider and with other mental health providers involved in the student's care.¹⁰²

Plans must include elements such as:¹⁰³

- direct employment of school-based mental health service providers to expand and enhance school-based student services and reduce the ratio of students to staff to align with nationally recommended ratio models;
- contracts or interagency agreements with one or more local community behavioral health providers or providers of Community Action Team services to provide behavioral health staff presence and services at district schools; and
- policies and procedures which ensure students who are referred to a school-based or community-based mental health service provider for mental health screening are assessed within 15 days of referral, and that school-based mental health services are initiated within 15 days after identification and assessment and community-based mental health services are initiated within 30 days after school or district referral.¹⁰⁴

School districts are also required to report program outcomes and expenditures annually for the previous fiscal year by September 30. The report must, at a minimum, provide the number of each of the following:¹⁰⁵

- Students who receive screenings or assessments.
- Students who are referred to either school-based or community-based providers for services.
- Students who receive either school-based or community based interventions.
- School-based or community-based mental health providers that were paid out of the mental health assistance allocation.
- Contract-based collaboration efforts or partnerships with community mental health programs.

The Marjory Stoneman Douglas High School Public Safety Commission

In response to the shooting at Marjory Stoneman Douglas High School on February 14, 2018, the Florida Legislature passed SB 7026, the Marjory Stoneman Douglas High School Public Safety Act (Act).¹⁰⁶ The Act's provisions addressed school safety and security by creating the Office of Safe Schools (OSS) within the Florida Department of Education (DOE) and requiring increased coordination among state and local agencies serving students with or at-risk of mental illness, among other provisions.

The Act created the Marjory Stoneman Douglas High School Public Safety Commission (MSD Commission), composed of 16 members, to investigate system failures in the Marjory Stoneman Douglas High School shooting and prior mass violence incidents and develop recommendations for system-wide improvements. The MSD Commission submitted its initial report on January 2, 2019, which contained numerous school safety and security recommendations¹⁰⁷ that the Legislature addressed in SB 7030 (2019), Implementation of Legislative Recommendations of the Marjory Stoneman Douglas High School Public Safety Commission.¹⁰⁸ The MSD Commission's second report, submitted on November 1, 2019, provided recommendations related to safe-school officers, threat

¹⁰² Section 1011.61(16)(b), F.S.

¹⁰³ Id.

¹⁰⁴ Section 1011.62(16)(b)1.-3., F.S.

¹⁰⁵ Section 1011.62(16)(c)-(d), F.S.

¹⁰⁶ Chapter 2018-3, L.O.F.

¹⁰⁷ Marjory Stoneman Douglas High School Public Safety Commission, *Initial Report* (Jan. 2, 2019), <http://www.fdle.state.fl.us/MSDHS/CommissionReport.pdf> (last visited March 20, 2021).

¹⁰⁸ Chapter 2019-22, L.O.F.

assessments, juvenile diversion programs, and mental health, among other recommendations.¹⁰⁹ The MSD Commission is authorized to issue annual reports and is scheduled to sunset on July 1, 2023.¹¹⁰

In February 2019, Governor Ron DeSantis requested, and the Florida Supreme Court convened, a grand jury to study systemic school safety failures. The grand jury was tasked with investigating whether specific public entities failed to act or committed fraud that undermined the school safety activities that the Act and subsequent legislation required.¹¹¹ The Grand Jury's third and most recent report, issued in December 2020, included an analysis of the state's mental health infrastructure and found systemic problems are impacting mental health:¹¹²

- The current mental health system is underfunded leading to an inability to diagnose and properly treat mental health problems;
- The system is too decentralized with national, state, and local entities providing parallel and duplicative resources with little to no coordination;
- Many of the entities involved work for different agencies with different goals; and
- DCF is not currently equipped or empowered to exercise the degree of leadership and control necessary to correct problems in the system.

To address such problems, the Grand Jury recommended the Legislature appoint a commission to specifically examine the provision of mental health services in the state.¹¹³ The Legislature should ensure that relevant stakeholders have an opportunity to participate in and provide knowledge to the commission. The commission should consider how to best provide and facilitate services in dual diagnosis¹¹⁴ cases. Additionally, the commission should be charged with structuring and staffing a permanent, agency-level entity to manage mental health, behavioral health, and substance abuse and addiction services throughout the state.¹¹⁵ Lastly, a cabinet-level agency should be created and funded to administer disparate sources of funding and services relating to the state's mental health system.¹¹⁶

Previous Commissions on Mental Health and Substance Abuse

2001

In 1999, the Legislature created the Florida Commission on Mental Health and Substance Abuse (Commission) to review and evaluate the state's mental health and substance abuse system and make recommendations for change.¹¹⁷ The Commission was made up of 23 professionals from throughout the state, including university professors, service providers, law enforcement, health care professionals, legislators, and state employees. The Commission found that the state's mental health and substance abuse service system is complex and diffuse, that diagnosis and treatment of disorders have improved substantially, and no one governmental entity is responsible for leading the overall system. The Commission recommended:¹¹⁸

¹⁰⁹ Marjory Stoneman Douglas High School Public Safety Commission, *Second Report* (Nov. 1, 2020), <http://www.fdle.state.fl.us/MSDHS/MSD-Report-2-Public-Version.pdf> (last visited March 20, 2021).

¹¹⁰ Section 943.687(9), F.S.

¹¹¹ Ron DeSantis, Governor of Florida, *Petition for Order to Impanel a Statewide Grand Jury*, (Feb. 13, 2019), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_petition_72393_e83.pdf (last visited March 20, 2021); *In re Statewide Grand Jury #20*, No. SC19-240, 2019 WL 908518 (Fla. Feb. 25, 2019), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_disposition_145442_d04i.pdf (last visited March 12, 2021).

¹¹² *Statewide Grand Jury # 20, Third Interim Report of the Twentieth Statewide Grand Jury*, (Dec. 10, 2020), https://efactssc-public.flcourts.org/casedocuments/2019/240/2019-240_miscdoc_365089_e20.pdf (last visited March 20, 2021).

¹¹³ *Id.* at p. 21.

¹¹⁴ The Grand Jury describes "dual diagnosis" cases as cases that lie at the nexus of mental health, substance abuse, and law enforcement interests.

¹¹⁵ *Supra*, note 112 at p. 23.

¹¹⁶ *Id.* at p. 24.

¹¹⁷ Florida Commission on Mental Health and Substance Abuse, *Final Report* (January 2001), (on file with the Children, Families, and Seniors Subcommittee staff).

¹¹⁸ *Id.*

- Establishing a statewide Coordinating Council for Mental Health and Substance Abuse (Council) in the Executive Office of the Governor that will coordinate with the Governor's Office of Drug Control to lead an overall system for mental health and substance abuse services;
- That the Council, in an effort to reduce stigma, should provide and coordinate a range of prevention and education activities to inform the public of the signs and symptoms of mental health and substance abuse disorders and the availability of effective treatment;
- Adequate emergency response capacity should be uniformly available across the state to assure services are available and accessible;
- That DCF should develop criteria for identifying individuals with ongoing need for mental health and substance abuse services and implement a process to enroll such individuals in continuing care services;
- The Council should initiate special studies to better understand the needs of individuals who are inadequately served by the mental health and substance abuse system and develop solutions to meet those needs;
- The Council should place emphasis on individuals served in the law enforcement, corrections, and court systems and divert such individuals from incarceration into treatment whenever possible;
- DCF and the Council should focus on access and choice in mental health and substance abuse services; and
- The Council should promote the development of post-secondary educational programs to provide state-of-the-art knowledge for the state's professional and para-professional service providers that is responsive to the environments in which they will practice.

2006

In 2006, DCF's Assistant Secretary for Substance Abuse and Mental Health appointed a workgroup to address the plans and business models for substance abuse and mental health services in the state. The group included members from DCF service districts, substance abuse and mental health providers, consultants, and professional associations. The workgroup developed several recommendations to improve the substance abuse and mental health system in this state:¹¹⁹

- Define DCF's substance abuse and mental health covered populations by establishing program eligibility criteria;
- Support an effective and orderly transition to Medicaid reform;
- Support several approaches to service management and managing entities depending on the characteristics of service districts;
- Align statutes and state policy in the areas of eligibility, enrollment, case rates, and authorizations of the managing entities; and
- Improve the data management and payment systems so they can support flexible, prospective-payment systems such as case rates and provide the more refined utilization data needed by service districts and managed entities.

As a result, in 2008, the Legislature authorized DCF to contract with managing entities to manage the day-to-day operational delivery of behavioral health services through an organized system of care.¹²⁰

Effect of the Bill

Commission on Mental Health and Substance Abuse

The bill creates the Commission on Mental Health and Substance Abuse (Commission) adjunct to DCF. DCF is required to provide administrative staff and support services for the Commission.

The purpose of the Commission is to:

¹¹⁹ Department of Children and Families, *Managing Substance Abuse and Mental Health Services Workgroup* (October 2006), (on file with the Children, Families, and Seniors Subcommittee staff).

¹²⁰ Ch. 2008-243, Laws of Fla.

- Examine the current methods of providing mental health and substance abuse services in the state;
- Improve the effectiveness of current practices, procedures, programs, and initiatives in providing such services;
- Identify any barriers or deficiencies in the delivery of such services; and
- Recommend changes to existing laws, rules, and policies necessary to implement the Commission's recommendations.

The bill requires the Commission to have 19 members:

- Seven members appointed by the Governor, including a:
 - o Psychologist licensed under ch. 490, F.S., practicing within the mental health delivery system;
 - o Mental health professional licensed under ch. 491, F.S.;
 - o Representative of mental health courts;
 - o Emergency room physician;
 - o Representative from the field of law enforcement;
 - o Representative from the criminal justice system; and
 - o Representative of a child welfare agency involved in the delivery of behavioral health services.
- Five members appointed by the President of the Senate, including a:
 - o Member of the Senate;
 - o Person living with a mental health disorder;
 - o Family member of a consumer of publicly funded mental health services;
 - o Representative of the Louis de la Parte Mental Health Institute within the University of South Florida; and
 - o Representative of a county school district.
- Five members appointed by the Speaker of the House of Representatives, including a:
 - o Member of the House of Representatives;
 - o Representative of a treatment facility;
 - o Representative of a managing entity;
 - o Representative of a community substance abuse provider; and
 - o Psychiatrist licensed under chs. 458 or 459, F.S., practicing within the mental health delivery system.
- The Secretary of DCF; and
- The Secretary of AHCA

The Governor appoints the commission chair from among its members. Appointments must be made by August 1, 2021, and members serve at the pleasure of the officer who appointed the member. A vacancy on the Commission is required to be filled in the same manner as the original appointment.

The Commission is required to convene no later than September 1, 2021, and must meet monthly or upon the call of the chair. Meetings are authorized to be held via teleconference or other electronic means.

The duties of the Commission include:

- Conducting a review and evaluation of the management and functioning of existing publicly supported mental health and substance abuse systems in DCF, AHCA, and all other relevant state departments;
 - o At a minimum, such review must include a review of current goals and objectives, current planning, service strategies, coordination management, purchasing, contracting, financing, local government funding responsibility, and accountability mechanisms.
- Considering the unique needs of people who are dually diagnosed;
- Addressing access to, financing of, and scope of responsibility in the delivery of emergency behavioral health care services;

- Addressing the quality and effectiveness of current service delivery systems and professional staffing and clinical structure of services, roles, and responsibilities of public and private providers;
- Addressing priority population groups for publicly funded services, identifying the comprehensive delivery systems, needs assessment and planning activities, and local government responsibilities for funding services;
- Reviewing the implementation of ch. 2020-107, Laws of Fla., which required the implementation of a coordinated system of mental health care for children and the expansion of mobile response teams across the state;
- Identifying gaps in the provision of mental health and substance abuse services;
- Providing recommendations on how managing entities may promote service continuity;
- Making recommendations about the mission and objectives of state-supported mental health and substance abuse services and the planning, management, staffing, financing, contracting, coordination, and accountability of mechanisms best suited for the recommended mission and objectives; and
- Evaluating and making recommendations regarding the establishment of a permanent, agency-level entity to manage mental health, behavioral health, substance abuse, and related services statewide, including the:
 - o Duties and organizational structure;
 - o Resource needs and possible sources of funding;
 - o Impact on access to and the quality of services;
 - o Impact on individuals with behavioral health needs, and their families, who are currently receiving services and those who are in need of services; and
 - o Relation to and integration with service providers, managing entities, communities, state agencies, and provider systems.

The bill requires state departments and agencies to provide assistance in a timely manner if requested by the Commission.

The Commission is required to submit an initial report by September 1, 2022, and a final report by September 1, 2023, to the Governor, President of the Senate, and Speaker of the House of Representatives on its findings and recommendations on how to best provide and facilitate mental health and substance abuse services.

The bill requires the repeal of the statute authorizing the Commission on September 1, 2023, unless saved from repeal through reenactment by the Legislature.

The bill takes effect upon becoming a law.

B. SECTION DIRECTORY:

- | | |
|------------------|---|
| Section 1 | Provides legislative intent. |
| Section 2 | Creates s. 394.9086, F.S., relating to Commission on Mental Health and Substance Abuse. |
| Section 3 | Provides the act shall take effect upon becoming a law. |

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

None.

2. Expenditures:

The bill has a significant, negative fiscal impact on DCF as the bill requires the department to provide administrative staff and support services for the commission. DCF estimates that implementing the bill requires two staff members with a cost of \$171,296 (a \$166,918 recurring need.)¹²¹ A review of the department's vacant positions shows there are sufficient existing vacancies from which resources can be redirected to fund new positions, many of which have been vacant for over 200 days.

Furthermore, the Commission's final work product is due on September 1, 2023, meaning the fiscal impact is nonrecurring. On average, DCF reverts \$626,700 of budget authority from the Other Personnel Services (OPS) category. This category is to fund personnel resources that are temporary in nature. The department has the ability to internally reorganize positions as needed.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

None.

2. Expenditures:

None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

None.

D. FISCAL COMMENTS:

None.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

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

2. Other:

None.

B. RULE-MAKING AUTHORITY:

Rulemaking authority is not needed to implement the bill.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

On March 23, 2021, the Children, Families, and Seniors Subcommittee adopted an amendment and reported the bill favorably as a committee substitute. The amendment:

¹²¹ Department of Children and Families, Agency Analysis of 2021 House Bill 1447 (March 19, 2021).

- Removed the Surgeon General and adds a person living with a mental disorder and a representative of mental health courts to the commission;
- Replaces the appointees from a small rural county school district and a large county school district with one appointee representing a school district;
- Expanded the duties of the commission to include:
 - o Reviewing the implementation of ch. 2020-107, Laws of Fla.;
 - o Identifying any gaps in providing mental health and substance use disorder services; and
 - o Providing recommendations on how managing entities may promote service continuity.
- Required the commission to make more detailed recommendations on the establishment of an agency-level entity ; and
- Required the commission to meet virtually and submit an initial report by September 2022, and a final report by September 2023 to the Governor, Senate President, and Speaker of the House.

This analysis is drafted to the committee substitute as passed by the Children, Families, and Seniors Subcommittee.

1 A bill to be entitled
2 An act relating to the Commission on Mental Health and
3 Substance Abuse; providing legislative intent;
4 creating s. 394.9086, F.S.; creating the Commission on
5 Mental Health and Substance Abuse adjunct to the
6 Department of Children and Families; requiring the
7 department to provide administrative and staff support
8 services to the commission; providing purposes;
9 providing for membership, term limits, meetings, and
10 duties of the commission; requiring the commission to
11 submit reports of its findings and recommendations to
12 the Legislature and Governor by a specified date;
13 providing for future repeal unless saved by the
14 Legislature through reenactment; providing an
15 effective date.

16
17 Be It Enacted by the Legislature of the State of Florida:

18
19 Section 1. Based on recommendations in the Third Interim
20 Report of the 20th Statewide Grand Jury, submitted December 10,
21 2020, regarding the state's mental health system, it is the
22 intent of the Legislature to establish a commission to examine
23 the state's current policies and procedures for providing mental
24 health and substance abuse services and to make recommendations
25 to improve and facilitate the delivery of mental health and

26 substance abuse services throughout the state.

27 Section 2. Section 394.9086, Florida Statutes, is created
28 to read:

29 394.9086 Commission on Mental Health and Substance Abuse.—

30 (1) CREATION.—The Commission on Mental Health and
31 Substance Abuse, a commission as defined in s. 20.03(10), is
32 created adjunct to the Department of Children and Families. The
33 department shall provide administrative and staff support
34 services relating to the functions of the commission.

35 (2) PURPOSES.—The purposes of the commission are to
36 examine the current methods of providing mental health and
37 substance abuse services in the state and to improve the
38 effectiveness of current practices, procedures, programs, and
39 initiatives in providing such services; identify any barriers or
40 deficiencies in the delivery of such services; and recommend
41 changes to existing laws, rules, and policies necessary to
42 implement the commission's recommendations.

43 (3) MEMBERSHIP; TERM LIMITS; MEETINGS.—

44 (a) The commission shall be composed of 19 members as
45 follows:

46 1. A member of the Senate, appointed by the President of
47 the Senate.

48 2. A member of the House of Representatives, appointed by
49 the Speaker of the House of Representatives.

50 3. The Secretary of Children and Families or his or her
51 designee.

52 4. The Secretary of the Agency for Health Care
53 Administration or his or her designee.

54 5. A person living with a mental health disorder appointed
55 by the President of the Senate.

56 6. A family member of a consumer of publicly funded mental
57 health, appointed by the President of the Senate.

58 7. A representative of the Louis de la Parte Florida
59 Mental Health Institute within the University of South Florida,
60 appointed by the President of the Senate.

61 8. A representative of a county school district, appointed
62 by the President of the Senate.

63 9. A representative of mental health courts, appointed by
64 the Governor.

65 10. A representative of a treatment facility, as defined
66 in s. 394.455, appointed by the Speaker of the House of
67 Representatives.

68 11. A representative of a managing entity as defined in s.
69 394.9082(2), appointed by the Speaker of the House of
70 Representatives.

71 12. A representative of a community substance abuse
72 provider, appointed by the Speaker of the House of
73 Representatives.

74 13. A psychiatrist licensed under chapter 458 or chapter
75 459 practicing within the mental health delivery system,
76 appointed by the Speaker of the House of Representatives.

77 14. A psychologist licensed under chapter 490 practicing
78 within the mental health delivery system, appointed by the
79 Governor.

80 15. A mental health professional licensed under chapter
81 491, appointed by the Governor.

82 16. An emergency room physician, appointed by the
83 Governor.

84 17. A representative from the field of law enforcement,
85 appointed by the Governor.

86 18. A representative from the criminal justice system,
87 appointed by the Governor.

88 19. A representative of a child welfare agency involved in
89 the delivery of behavioral health services, appointed by the
90 Governor.

91 (b) The Governor shall appoint the chair from the members
92 of the commission. Appointments to the commission must be made
93 by August 1, 2021. Members shall be appointed to serve at the
94 pleasure of the officer who appointed the member. A vacancy on
95 the commission shall be filled in the same manner as the
96 original appointment.

97 (c) The commission shall convene no later than September
98 1, 2021. The commission shall meet quarterly or upon the call of

99 the chair. The commission shall hold its meetings via
100 teleconference or other electronic means.

101 (4) DUTIES.—

102 (a) The duties of the Commission on Mental Health and
103 Substance Abuse include the following:

104 1. Conducting a review and evaluation of the management
105 and functioning of the existing publicly supported mental health
106 and substance abuse systems and services in the Department of
107 Children and Families, the Agency for Health Care
108 Administration, and all other departments which administer
109 mental health and substance abuse services. Such review shall
110 include, at a minimum, a review of current goals and objectives,
111 current planning, services strategies, coordination management,
112 purchasing, contracting, financing, local government funding
113 responsibility, and accountability mechanisms.

114 2. Considering the unique needs of persons who are dually
115 diagnosed.

116 3. Addressing access to, and financing of, and scope of
117 responsibility in the delivery of emergency behavioral health
118 care services.

119 4. Addressing the quality and effectiveness of current
120 mental health and substance abuse services delivery systems, and
121 professional staffing and clinical structure of services, roles,
122 and responsibilities of public and private providers, such as
123 community mental health centers, community substance abuse

124 agencies, hospitals, including emergency services departments,
125 law enforcement agencies, and the judicial system.

126 5. Addressing priority population groups for publicly
127 funded mental health and substance abuse services, identifying
128 the comprehensive mental health and substance abuse services
129 delivery systems, mental health and substance abuse needs
130 assessment and planning activities, and local government funding
131 responsibilities for mental health and substance abuse services.

132 6. Reviewing the implementation of chapter 2020-107, Laws
133 of Florida.

134 7. Identifying any gaps in the provision of mental health
135 and substance use disorder services.

136 8. Providing recommendations on how behavioral health
137 managing entities may fulfill their purpose of promoting service
138 continuity.

139 9. Making recommendations regarding the mission and
140 objectives of state-supported mental health and substance abuse
141 services and the planning, management, staffing, financing,
142 contracting, coordination, and accountability mechanisms which
143 will best foster the recommended mission and objectives.

144 10. Evaluating and making recommendations regarding the
145 establishment of a permanent, agency-level entity to manage
146 mental health, substance abuse, and related services statewide.

147 At a minimum, the evaluation must consider and describe the:

148 a. Specific duties and organizational structure proposed
149 for the entity;

150 b. Resource needs of the entity and possible sources of
151 funding;

152 c. Estimated impact on access to and quality of services;

153 d. Impact on individuals with behavioral health needs and
154 their families, both those currently served through the affected
155 systems providing behavioral health services and those in need
156 of services; and

157 e. Relation to, integration with, and impact on providers,
158 managing entities, communities, state agencies, and systems
159 which provide mental health and substance abuse services in this
160 state. Such recommendations must ensure that the ability of such
161 other agencies and systems to carry out their missions and
162 responsibilities is not impaired.

163 (b) The commission may call upon appropriate departments
164 and agencies of state government for such professional
165 assistance as may be needed in the discharge of its duties, and
166 such departments and agencies shall provide such assistance in a
167 timely manner.

168 (5) REPORTS.—By September 1, 2022, the commission shall
169 submit an interim report to the President of the Senate, the
170 Speaker of the House of Representatives, and the Governor
171 containing its findings and recommendations on how to best
172 provide and facilitate mental health and substance abuse

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173 services in the state. The commission shall submit its final
174 report by September 1, 2023.

175 (6) This section is repealed September 1, 2023, unless
176 saved from repeal through reenactment by the Legislature.

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