FDLE
Florida Department
of Law Enforcement

Medical Examiners Commission Meeting

December 19, 2017

MEDICAL EXAMINERS COMMISSION MEETING

Embassy Suites Orlando, Lake Buena Vista South
4955 Kyngs Heath Road
Kissimmee, Florida
December 19, 2017, 10:00 AM

Opening Remarks

Introduction of Commission Members and Staff

Approval of Meeting Agenda and Minutes from previous Commission Meeting of August 25, 2017

	ISSUE NUMBER	**PRESENTER**
1.	Informational Items:	
	• Status Report: MEC Appointments and Reappointments	Vickie Koenig
	• Status Report: District 14 and 16 Appointment	Vickie Koenig
	• Status Report: Reappointments for Districts 8, 10, 12, and 18-24	Vickie Koenig
	• 2016 Drugs Identified in Deceased Persons Report	Beth McNeil
	• 2016 Annual Workload Report	Beth McNeil
	• 2017 Interim Drugs Identified in Deceased Persons Report	Beth McNeil
	• Coverdell Grant	Beth McNeil
	• 2018 Reappointment/Assessments for Districts 1-7	Vickie Koenig
	• 2018 Legislative Update	Jim Martin
2.	Unidentified Deceased Initiative	Doug Culbertson
3.	2018 Drug Data Changes	Vickie Koenig
4.	Emerging Drugs	Bruce A. Goldberger, Ph.D.
5.	Solicitation for 2018 FAME Educational Conference	Bruce A. Goldberger, Ph.D.
6.	Other Business	
	Department of Health Grant	Joshua Sturms

MEDICAL EXAMINERS COMMISSION MEETING
Renaissance Tampa International Plaza Hotel
4200 Jim Walter Boulevard
Tampa, Florida 33607
August 25, 2017 10:00 AM

Chairman Stephen J. Nelson, M.D. called the meeting of the Medical Examiners Commission to order at **10:00 AM** at the Renaissance Tampa International Plaza Hotel in Tampa, Florida. He advised those in the audience that the meetings of the Medical Examiners Commission are open to the public and that members of the public will be allowed five minutes to speak. He then welcomed everyone to the meeting and asked Commission members, staff, and audience members to introduce themselves.

Commission members present:

Stephen J. Nelson, M.A., M.D., F.C.A.P., District 10 Medical Examiner
Barbara C. Wolf, M.D., District 5 Medical Examiner
Wesley H. Heidt, J.D., Office of the Attorney General
Hon. James S. Purdy, J.D., Public Defender, 7th Judicial Circuit
Robin Giddens Sheppard, L.F.D., Funeral Director
Kenneth T. Jones, State Registrar, Department of Health
Hon. Carol Whitmore, R.N., Manatee County Commissioner

Vacant positions on the Commission:

Sheriff
State Attorney

Commission staff present:

Vickie Koenig
James D. Martin, J.D.
Beth McNeil

District Medical Examiners present:

Jon Thogmartin, M.D. (District 6)
Russell Vega, M.D. (District 12)
Joshua Stephany, M.D. (Districts 9 and 25)
Michael Bell, M.D. (District 15)

Other District personnel present:

Jeff Martin (District 1)
Jennifer Dierksen, M.D. (District 4)
Jennifer Park, D.O. (Districts 9 and 25)
Judy Olson (District 16)
Patricia Wheaton (District 21)
Tim Crutchfield (District 4)
Bill Pellan (District 6)
Gary Utz, M.D. (Districts 9 and 25 / FAME Pres.)
Stephen Robinson, M.D. (District 17)

Guests present:

Bruce A. Goldberger, Ph.D. (UF)
Rebecca Sayer (LifeLink)
Kelsee Hentschel-Fey (USF)
Joshua Sturms (DOH)
Karen Card (DOH)
Stephanie Moody-Geissler (DCF)
Regina Ross, J.D. (St. Johns County)
Linda Pollard (FDLE)
Karen Weaver (FDLE)
Ricardo Camacho (UF)
Ashley Crawford Ramos (KeraLink International)
Chandler Brownlee (LifeNet)
Leah Colston (DOH)
Chris Bufano, J.D. (FDLE)
Lynnetta Oxendine (TransLife)
Heather Hoog (RTI Donor Services)
Andrew Shelton (FDLE)
Valerie DeLeon (UF / CAPHIL)

Janet Finlayson (UF / CAPHIL)
Melissa Pope (USF)
Katie Rubin (UF / CAPHIL)
Jake Martin (St. Augustine Record)

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE AGENDA.

Dr. Nelson noted an error on page 3, first paragraph, fourth line. The word 'been' should be stricken so that the line will read: "requested and were ~~been~~ granted an extension of the deadline for their response. Dr. Nelson stressed that". **A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY FOR THE COMMISSION TO APPROVE THE MINUTES AS AMENDED OF THE MAY 10, 2017, MEDICAL EXAMINERS COMMISSION MEETING.**

ISSUE NUMBER 1: INFORMATIONAL ITEMS

- Status Report: MEC Appointments and Reappointments – Ms. Koenig informed the Commission there is a new contact person in the Governor's Appointments Office, and they have all the necessary paperwork for all the outstanding positions. The District Medical Examiner, the Funeral Home Director, and the County Commissioner positions on the MEC are still pending gubernatorial appointment.

The Sheriff seat, vacated when Clay County Sheriff Rick Beseler retired, has not yet been filled. The nominees are Sheriff Harrell Reid (Hamilton County) and Sheriff Lou Roberts (Jackson County).

Mr. Jim Purdy completed his second full term on June 30, 2017, and he will continue to serve until his replacement is appointed. The Public Defender nominees are Hon. Charles Cofer (4th Judicial Circuit) and Hon. Carey Haughwout (15th Judicial Circuit).

The State Attorney seat, vacated when 4th Judicial Circuit State Attorney Angela Corey lost her bid for reelection, is still pending gubernatorial appointment. The nominee is Hon. Jeffrey Siegmeister (3rd Judicial Circuit).

- Status Report: District 14 Appointment – The recommendation of Jay M. Radtke, M.D. as District Medical Examiner in District 14 (Bay, Calhoun, Gulf, Holmes, Jackson, and Washington counties) is still pending gubernatorial appointment.

- Status Report: Reappointments for Districts 8, 10, 12, and 18-24 – Ms. Koenig informed the Commission the Governor's Appointments Office has not yet reappointed the District Medical Examiners in Districts 8 (Alachua, Baker, Bradford, Gilchrist, Levy, and Union counties), 10 (Hardee, Highlands, and Polk counties), 12 (DeSoto, Manatee, and Sarasota counties), 18 (Brevard county), 19 (Indian River, Martin, Okeechobee, and St. Lucie counties), 20 (Collier county), 21 (Glades, Hendry, and Lee counties), 22 (Charlotte county), 23 (Flagler, Putnam, and St. Johns counties), or 24 (Seminole county). The incumbent District Medical Examiners continue to serve until reappointed or replaced by the Governor, pursuant to Article X, Section 3 of the Florida Constitution.

- 2016 Drugs Identified in Deceased Persons Report – Ms. McNeil reported that the drug data has been received from all the districts. Some of the data is still in the process of quality assurance review.

- 2016 Annual Workload Report – Ms. McNeil stated that the final data from the districts has been received and the Annual Workload report is currently being drafted. A September release date is anticipated.

- 2016 Coverdell Grant – Ms. McNeil announced that she is in contact with the 14 districts awarded funding. Four districts have received approved budget amendments, and 7 districts have submitted reimbursement requests. She will continue to monitor the spending of the remaining districts.

ISSUE NUMBER 2: NOMINATION FOR DISTRICT 16 MEDICAL EXAMINER

Dr. Nelson reported that the Search Committee in District 16 (Monroe County) met July 12, 2017, and chose two finalists. One candidate withdrew from consideration. The Search Committee submitted only Michael R. Steckbauer, M.D. as their finalist for consideration.

A MOTION WAS MADE, SECONDED, AND PASSED UNANIMOUSLY THAT MICHAEL R. STECKBAUER, M.D., BE RECOMMENDED TO THE GOVERNOR FOR APPOINTMENT AS THE DISTRICT 16 MEDICAL EXAMINER.

ISSUE NUMBER 3: DEPARTMENT OF HEALTH GRANT

Representatives from the Department of Health (DOH) addressed the Commission again regarding the status of their grant from the Centers for Disease Control for tracking fatal and nonfatal overdoses of opioids. DOH appeared before the Commission in May 2016 to discuss their interest in applying for the grant, and they were awarded the core grant for a 2-year period beginning September 1, 2017, rather than 3-years as was originally sought. While DOH was approved for 2 years under the core grant, they only have an approved amount of $493,571.00 for the first budget period (Sept 1, 2017-August 31, 2018). DOH expects they would get a similar amount for the second year. DOH also requested a supplemental grant that could assist the district medical examiners with the cost of toxicology testing.

DOH is targeting 14 medical examiner districts covering 29 counties to provide reports for fatal overdoses that are medical examiner cases. DOH would extract 33 of the 175 data points required for the grant (only 3 of those data points – type of drug poisoning, height, and weight – are medical examiners data, the other 30 are from the toxicology analyses) and the grant should not cause additional work for the targeted medical examiner districts. The districts that are being targeted in the grant are District 1, 4, 6, 7, 9, 10, 11, 12, 13, 15, 17, 18, 21, and 24.

There was discussion among the medical examiners in attendance and the Commission. The DOH was asked to work with the doctors in attendance to determine the best manner in obtaining the desired data points from the medical examiners without duplicating efforts that already exist. DOH was also asked to notify Commission staff if the supplemental grant is awarded to assist in developing a distribution plan. *(NOTE: DOH was notified after the August 25th Tampa MEC meeting that the supplemental grant was awarded in the amount of $197,428.00. While the $197,428 is for the first year of the grant, the notice DOH received from the CDC mentioned that future year funding would be based on satisfactory programmatic progress and the availability of funds. It is unknown if the supplemental funds will be available for the second year.)*

ISSUE NUMBER 4: DISTRICT 23 DISCIPLINARY CASES – FREDERICK P. HOBIN, M.D.

Assistant General Counsel Chris Bufano, prosecuting the matter for the Commission, provided documentation that Dr. Hobin retired and is no longer employed as an associate medical examiner in any district. His employment at the District 8 and District 23 offices ended on December 1, 2016, and from the District 19 office on May 3, 2017.

Therefore, the Commission no longer holds jurisdiction to proceed with the proposed disciplinary action against Dr. Hobin. Mr. Bufano recommended that the Commission dismiss the Administrative Complaint in this case without prejudice, with the understanding that if Dr. Hobin is ever appointed as a medical examiner in Florida, the Commission regains jurisdiction to refile the Administrative Complaint. Neither Dr. Hobin nor his counsel were at the meeting.

Dr. Nelson questioned whether all the files were removed from Dr. Hobin's home and are now returned to the possession of the District 23 office. Deputy St. Johns County Attorney Regina Ross said the county retrieved all the documents Dr. Hobin had at his home and that those documents were copies rather than originals.

MS. WHITMORE MADE A MOTION, DR. NELSON SECONDED, AND THE MOTION PASSED UNANIMOUSLY TO DISMISS THE ADMINISTRATIVE COMPLAINT (CASE NUMBER 17-2) AGAINST DR. HOBIN WITHOUT PREJUDICE.

Dr. Barbara Wolf, Mr. Ken Jones, and Mr. Wesley Heidt recused themselves from voting as they were members of the probable cause panel who investigated the complaint.

ISSUE NUMBER 4: DISTRICT 23 DISCIPLINARY CASES – PREDRAG BULIC, M.D.

Mr. Bufano advised the Commission that Dr. Bulic submitted his executed Election of Rights form disputing the findings of fact by the Commission in Administrative Complaint Case Number 17-1, and requested a formal hearing before the Division of Administrative Hearings (DOAH). In preparation for trial, a requirement of DOAH is to determine if a settlement agreement can be reached between the parties. While Dr. Bulic was not present, Ms. Ross was in attendance to answer questions on behalf of Dr. Bulic.

Dr. Nelson stated that the county's recollection of the document's whereabouts and how the whole controversy started were "vastly different". Ms. Ross said this was all prior to Dr. Bulic being appointed to the office, and reiterated that Dr. Hobin and his counsel were not present to speak for themselves and she would rather not speak on his behalf. Dr. Nelson advised that Dr. Bulic is now the superintendent of the records, regardless of what happened before his time with the office.

The proposed Settlement Agreement before the Commission states:

STIPULATION AND SETTLEMENT AGREEMENT

> COMES NOW, the Petitioner, Medical Examiners Commission, by and through the undersigned Assistant General Counsel, and the Respondent, Predrag Bulic, M.D., and enter into the following Stipulation and Settlement Agreement pursuant to Section 120.57(4), Florida Statutes, as the final resolution of this cause, subject to ratification and adoption by the Medical Examiners Commission. The Terms of this agreement are as follows:

1. The Respondent maintains his dispute of the allegations set forth in the Administrative Complaint and does not, by entry into this Stipulation and Settlement Agreement, admit the allegations of misconduct set forth in the Administrative Complaint filed herein, but agrees to the terms contained herein in order to dispose of this case and to improve operations of the District 23 Medical Examiner Office.

2. As a condition of entering into this Stipulation and Settlement Agreement, the Respondent has provided the staff of the Medical Examiners Commission with the attached proof of implementation of clear policies and procedures enacted to: (a) ensure that all original documentation related to a death investigation will be housed and maintained in the medical examiner's office in accordance with applicable laws, regulations, rules and policies; and (b) that autopsy photographs will not be disclosed to anyone who is not legally authorized to view them (See Attachment 1).

3. Following review of the policies and procedures attached hereto and described above, should the Medical Examiners Commission determine that they are insufficient to address the storage and maintenance of documentation related to death investigations and the disclosure of autopsy photographs, Respondent agrees to a one-year period of probation. Such probation shall commence fifteen (15) days following the entry of the Final Order and shall continue for one year thereafter. The staff of Medical Examiners Commission shall monitor the probation and provide input to Respondent in developing acceptable policies and procedures. The Medical Examiners Commission will determine if the revised policies and procedures implemented by the Respondent are sufficient to satisfy the requirements under this Stipulation and Settlement Agreement.

4. Should the probation period commence, the parties agree that probation shall terminate upon the showing by the Respondent of the implementation of such acceptable policies and procedures to Commission staff. During such time, Respondent shall not violate any provision of Chapter 406 Part I, Florida Statutes, or Chapter 11G, Florida Administrative Code. Additionally, Respondent shall advise the Medical Examiners Commission staff, in writing, of any change(s) of address, telephone number and/or employment.

5. The undersigned Assistant General Counsel or assignee agrees to recommend that the Medical Examiners Commission adopt this Stipulation and Settlement Agreement as the final disposition of this matter.

6. Both parties understand that this proposed settlement is not final until the Commission has approved and adopted it as the final disposition of this case. The parties further understand that if the Commission does not approve and adopt this Agreement, the case can then proceed to formal hearing as originally requested by the Respondent, unless the parties agree otherwise.

7. The parties stipulate that upon the signing of this Agreement, neither party may thereafter modify the terms of this Stipulation and Settlement Agreement nor repudiate or withdraw from this Stipulation and Settlement Agreement, except upon written consent of the other party or in the event the Commission should by a majority vote reject the terms of this Stipulation and Settlement Agreement.

Mr. Bufano stated if the Commission found Dr. Bulic's policies and procedures to be lacking the Commission had the option to put Dr. Bulic on probation for up to one year in order for him to work

with staff to correct the policies and procedures. Once the policies and procedures were acceptable, Dr. Bulic's probation would end.

If the Commission rejected the settlement agreement, the Commission could attempt to negotiate another settlement with Ms. Ross during the meeting or remand the case to DOAH for prosecution.

Dr. Wolf and Dr. Nelson expressed concerns over Dr. Bulic's response to the administrative complaint in that he denied and made accusations against the Commission's handling of the complaint. Mr. Purdy advised the Commission that Dr. Bulic essentially entered a "no-contest plea" instead of an admission of guilt. Mr. Bufano indicated the case would be going to a trial if the Commission denied the settlement, so Dr. Bulic didn't have any option but to dispute the claims.

There was discussion among the Commissioners about whether to add a period of probation, if only for monitoring purposes. Ms. Ross pointed out that revised policies were implemented in March 2016, and all District 23 staff received appropriate training on handling public records requests. The two staff members who routinely handle public records requests will receive annual training, which they completed in May 2017 for this calendar year.

MR. PURDY MADE A MOTION, MS. WHITMORE SECONDED, AND THE MOTION PASSED UNANIMOUSLY TO ACCEPT THE SETTLEMENT AGREEMENT PRESENTED FOR CASE NUMBER 17-1 AGAINST DR. BULIC.

Dr. Barbara Wolf, Mr. Ken Jones, and Mr. Wesley Heidt recused themselves from voting as they were members of the probable cause panel who investigated the complaint.

ISSUE NUMBER 5: NEXT-OF-KIN HIERARCHY (§406.135(2) F.S. vs. §497.005(43) F.S.)

Mr. Martin advised the Commission that there is a distinction between next-of-kin hierarchy between two sections of Florida Statutes:

- §406.135, F.S., dealing with the release of autopsy photos and recordings, the hierarchy is spouse, parents, then adult child.
- §497.005(43), F.S., dealing with the disposition of the body, the hierarchy is spouse, adult child, parent, etc.

Mr. Martin presented this as an informational item so that the district medical examiners are aware of the differences.

ISSUE NUMBER 6: OVERVIEW OF CHANGES TO RECORDS RETENTION – GS1 AND GS2

Mr. Martin stated that the Records Retention schedules for Medical Examiners (GS2) and General Records (GS1) were updated by the Department of State effective August 2017. Only a few minor changes were made to the wording of "156 – Burial Transit Permits", "169 – Evidence Records: Stained Sections/Embedded Tissues/Specimens", and "183 – Medical Examiner Records: Autopsy Supporting Documents" in the GS2 for medical examiners and they removed "duplicate copies" from the records retention schedule. In the GS1, there were revisions to the retention schedule for administrative matters such as "104- Equipment/Vehicle Maintenance Records", "42 – Purchasing Records", and "28 – Telephone Call Records". Mr. Martin advised the offices to review the updates.

ISSUE NUMBER 7: UNIDENTIFIED DECEASED INITIATIVE

Mr. Andrew Shelton introduced Inspector Linda Pollard, who is new to the position. He informed the Commission of four success stories in the past eight months.

The first case was from 2005 in District 13. An unidentified male was found dead aboard a "go fast" vessel carrying cocaine, when he took his life as the Coast Guard approached. This individual was unknown to the other three occupants aboard the vessel. The other three occupants were interviewed. Eventually, FDLE worked with the Columbian National Police, and he was identified through fingerprints in May 2017.

In 2006, District 21 had a case of an unidentified individual who was found in a mobile home in Clewiston, and it was determined to be a homicide. The individual was found in advanced stages of decomposition, and the face was unrecognizable. The individual was identified by the Department of Homeland Security's Latent Prints section through fingerprints in May 2017. He was identified as a Mexican national. The U.S. Border Patrol also confirmed his identity through fingerprints.

The next case involved a pedestrian killed in an automobile accident in 1983 in Bay County in District 14. Given the age of this case, all they had were fingerprints and dental. This individual was identified through fingerprints using FDLE's Biometric Support Services in June 2017.

The last success story is from District 1, and the decedent had been unidentified since November 2016. This individual was found unresponsive and taken to the hospital as a possible drug overdose. He was identified through fingerprints run by the U.S. Border Patrol in July 2017.

Mr. Shelton reminded the Commission that FDLE's Enforcement and Investigative Support unit is available to assist in the identification of unidentified medical examiner cases. The unit can provide assistance with DNA status, fingerprint submissions, dental records, FCIC/NCIC queries on active missing persons cases, resource information, forensic artist, and can open cases.

ISSUE NUMBER 8: EMERGING DRUGS

Bruce A. Goldberger, Ph.D. addressed the Commission on emerging drugs that are being seen in the medical examiner's toxicology labs. There has been an influx of fentanyl analogs with the most recent being parafluorofentanyl, para-fluorobutyrylfentanyl, and 4-methoxybutyrylfentanyl. The labs are also seeing 4-ANPP; however, it is a precursor of fentanyl analogs and a metabolite of furanylfentanyl. Florida has not seen any cases of acrylfentanyl yet. Two new designer benzodiazepines have been seen: diclazepam and flubromazepam.

One of the issues the medical examiner toxicology labs face is a lack of street level surveillance, and this is also a problem at the federal level. Dr. Goldberger advised those in attendance that there is a statewide naloxone order that allows the medical examiner offices and toxicology labs to purchase naloxone as a safety precaution.

FDLE Special Agent Supervisor Karen Weaver works with the organized crime intelligence unit. In 2011-2012, her office began to receive a monthly report of new or unusual substances from the FDLE drug chemistry sections. This was initially being used to identify emerging synthetic cannabinoids and cathinones. Beginning in June, the seven local crime labs (Miami-Dade, Broward, Palm Beach, Indian River, Sarasota, Manatee, and Pinellas) also began submitting the report of new or unusual

substances. A review of the last 6 months reports revealed diclazepam, U-51743, and U-49900. She hopes that being able to address the Commission regularly will assist in providing a possible early warning detection aid for the medical examiners.

ISSUE NUMBER 9: 2017 FAME EDUCATIONAL CONFERENCE

Dr. Goldberger reported that the 2017 FAME Educational Conference was an excellent meeting at a great location (Four Seasons Resort, 10100 Dream Tree Blvd., Lake Buena Vista, FL). It was probably one of the best meetings in content that has been held.

ISSUE NUMBER 10: SOLICITATION FOR 2018 FAME EDUCATIONAL CONFERENCE

Dr. Goldberger reported that the 2018 FAME Educational Conference is tentatively scheduled for July 18-20, 2018, at the Mission Inn, Howey-in-the-Hills, Florida, with a $155 per night rate. The District 14 Medical Examiner's Office will host the 2018 conference.

ISSUE NUMBER 11: OTHER BUSINESS

- Ms. Koenig updated the Commission on the results of the surveys by RTI International, under a contract with the Drug Enforcement Agency (DEA). There are only two districts that had not yet responded to the survey and RTI was very pleased with the response from Florida. Dr. Nelson encouraged the outstanding districts to participate so that complete results can be shared.

- Gary Utz, M.D. addressed the Commission as the incoming President of the Florida Association of Medical Examiners (FAME) to seek the support and assistance from the Commission for Florida's medical examiners to access the Prescription Drug Monitoring Program (PDMP) when needed for their cases. The Commission agreed to provide a letter of support for medical examiner access based upon Commission staff's conversations with the Department of Health.

With no further business to come before the Commission, the meeting was adjourned at 12:23 P.M.

FOR IMMEDIATE RELEASE
November 14, 2017

CONTACT: GOVERNOR'S PRESS OFFICE
(850) 717-9282
media@eog.myflorida.com

Gov. Scott Appoints Two to Medical Examiners Commission

TALLAHASSEE, Fla. – Today, Governor Rick Scott announced the appointments of Sheriff James "Harrell" Reid and State Attorney Jeffrey Siegmeister to the Medical Examiners Commission.

Sheriff Reid, 70, of Jasper, currently serves as the Sheriff of Hamilton County. He received his bachelor's degree from the University of Florida. Sheriff Reid is appointed to fill a vacant seat due to the resignation of Sheriff Paul Beseler, for a term beginning November 14, 2017, and ending August 21, 2021.

State Attorney Siegmeister, 49, of Live Oak, currently serves as the State Attorney of the Third Judicial Circuit of Florida. He received his bachelor's and law degrees from the University of Florida. Siegmeister is appointed to fill a vacant seat due to the resignation of Angela Corey, for a term beginning November 14, 2017, and ending July 1, 2019.

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2018 Legislative Bills of Interest

Controlled Substance Prescribing – PDMP (HB 21 Boyd / SB8 Benacquisto)

These bills provide medical examiners with indirect access to the Prescription Drug Monitoring Program. Medical examiners conducting an authorized investigation pursuant to s. 406.11, F.S., may request information from the PDMP through a program manager within the Department of Health. The specific authorizations in each bill are found in HB 21 on pages 48, 63, and 64 and in SB 8 on pages 42 and 55.

Proposed effective date is July 1, 2018.

Deaths Resulting from Overdoses (HB 125 Payne)

This bill amends s. 893.0301, F.S., to require the report prepared by the law enforcement agency investigating a death from an apparent drug overdose to include all controlled substances (Schedules I-IV of s. 893.03,F.S.) found on or near the deceased person or among the deceased possessions. The report must identified who prescribed or delivered the controlled substances if known, and must classify the death as a 'suspicious death" or a "death investigation". The bill further requires the classification of death made by law enforcement to be included in the medical examiner report prepared pursuant to s. 406.11, F.S.

Proposed effective date is July 1, 2018.

Nursing Homes (HB 655 Edwards / SB 896 Farmer)

These bills add deaths in nursing homes on the federal Special Focus Facility list or the Agency for Health Care Administration's Nursing Home Guide Watch list to the enumerated types of deaths that become medical examiner cases in s. 406.11, F.S. The bills further require the medical examiner to notify and forward all documentation to the state attorney in support of a determination that a nursing home resident died as a result of abuse, sexual abuse, or negligence. The state attorney is required to convene a grand jury within 90 days of such notification and investigate whether to file criminal charges. The specific changes impacting medical examiners are found in HB 655 on pages 58-60 and in SB 896 on pages 50-52.

Proposed effective date is July 1, 2018.

Photographs, Video or Audio Recordings Depicting the Killing of a Person (HB 653 Brown / SB 1178 Bracy)

These bills expand the public records exemption in s. 406.136, F.S. to include any photograph, video, or audio recording held by an agency that depicts or records the killing of a person, not just a law enforcement officer acting in his or her official capacity. This essentially restores s. 406.136, F.S. to its wording prior to October 1, 2016.

Proposed effective date is October 1, 2018.

Elder Abuse Fatality Review Teams (HB 259 Watson / 422 Gibson)

These bills authorize the establishment of elder abuse fatality review teams to review abuse related deaths. Review teams must be established in each judicial circuit by December 31, 2018, and are composed of volunteers who serve 2-year terms without compensation. A medical examiner is among those listed as possible members of the review team. The review teams are assigned to the Department of Elder Affairs for administrative purposes.

Proposed effective date is July 1, 2018.

Varnadoe Forensic Research Center (HB 2255 Burgess)

This bill accompanies an appropriations project to establish a forensic anthropology research facility.

Proposed effective date is July 1, 2018.

Joint Medical Examiner/Broward Sheriff's Office Crime Lab Facility (HB 3599 Moraitis)

This bill accompanies an appropriation project to construct a state of the art facility for the Broward Medical Examiner's Office and the Broward Sheriff's Office Crime Laboratory.

Proposed effective date of July 1, 2018.

Public Meetings (HB 589 Newton / SB 1092 Radar)

These bills apply to meetings of any board or commission of any state agency or authority, or any county, municipal corporation or political subdivision. They require notices of any such meeting at least 3 days prior to the meeting to include publication of the agenda and any materials distributed at the meeting. Two complete copies of the agenda and related items must be available for public inspection at the meeting. Time must be allotted for public comment as either the firs tor last agenda item. Each member of the public has the right to speak for 3 minutes. Time may be extended by the chair or restricted to 1 minute per person when more than 20 individuals request to address on agenda item. A response is required to any question posed to the board or commission either at the meeting or through written correspondence within 10 days after the meeting. Written responses must be incorporated into the minutes of the meeting.

Proposed effective date is July 1, 2018.

A bill to be entitled

An act relating to controlled substances; creating s. 456.0301, F.S.; authorizing certain boards to require practitioners to complete a specified board-approved continuing education course to obtain authorization to prescribe controlled substances as part of biennial renewal; providing exceptions; providing course requirements; prohibiting the department from renewing a license of a prescriber under specified circumstances; requiring a licensee to submit confirmation of course completion; providing for each licensing board requiring such continuing education course to include hours of completion with the total hours of continuing education required in certain circumstances; authorizing rulemaking; amending s. 456.072, F.S.; authorizing disciplinary action against practitioners for violating specified provisions relating to controlled substances; amending s. 456.44, F.S.; defining the term "acute pain"; providing for the adoption of standards of practice for the treatment of acute pain; providing that failure of a practitioner to follow specified guidelines is grounds for disciplinary action; limiting opioid prescriptions for the treatment of acute pain to a specified period under certain circumstances; authorizing prescriptions

for such opioids for an extended period if specified requirements are met; amending ss. 458.3265 and 459.0137, F.S.; requiring certain pain management clinic owners to register approved exemptions with the department; requiring certain clinics to obtain certificates of exemption; providing requirements for such certificates; authorizing rulemaking relating to specified exemptions; amending ss. 465.0155 and 465.0276, F.S.; providing requirements for pharmacists and practitioners for the dispensing of controlled substances to persons not known to them; defining the term "proper identification"; amending s. 893.03, F.S.; conforming the state controlled substances schedule to the federal controlled substances schedule; amending s. 893.055, F.S.; revising and providing definitions; revising requirements for the prescription drug monitoring program; authorizing rulemaking; requiring the department to maintain an electronic system for certain purposes to meet specified requirements; requiring certain information to be reported to the system by a specified time; specifying direct access to system information; authorizing department to enter into reciprocal agreements or contracts to share prescription drug monitoring information with certain entities;

providing requirements for such agreements; authorizing the department to enter into agreements or contracts for secure connections with practitioner electronic systems; requiring specified persons to consult the system for certain purposes within a specified time; providing exceptions to the duty of specified persons to consult the system under certain circumstances; authorizing the department to issue nondisciplinary citations to specified entities for failing to meet certain requirements; prohibiting the failure to report the dispensing of a controlled substance when required to do so; providing penalties; authorizing the department to enter into agreements or contracts for specified purposes; providing for the release of information obtained by the system; allowing specified persons to have direct access to information for the purpose of reviewing the controlled drug prescription history of a patient; providing prescriber or dispenser immunity from liability for review of patient history when acting in good faith; providing construction; prohibiting the department from specified uses of funds; authorizing the department to conduct or participate in studies for specified purposes; requiring an annual report to be submitted to the Governor and Legislature by a

specified date; providing report requirements; providing exemptions; establishing direct-support organizations for specified purposes; defining the term "direct-support organization"; requiring a direct-support organization to operate under written contract with the department; providing contract requirements; requiring the direct-support organization to obtain written approval from the department for specified purposes; authorizing rulemaking; providing for an independent annual financial audit by the direct-support organization; providing that copies of such audit be provided to specified entities; providing for future repeal of provisions relating to the direct-support organization; amending s. 893.0551, F.S.; revising provisions concerning release of information held by the prescription drug monitoring program; amending ss. 458.331, 459.015, 463.0055, 782.04, 893.13, 893.135, and 921.0022, F.S.; correcting cross-references; conforming provisions to changes made by the act; providing effective dates.

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

Section 1. Section 456.0301, Florida Statutes, is created to read:

456.0301 Requirement for instruction on controlled substance prescribing.-

(1)(a) If not already required by the licensee's practice act, the appropriate board shall require each person registered with the United States Drug Enforcement Administration and authorized to prescribe controlled substances pursuant to 21 U.S.C. s. 822 to complete a board-approved 2-hour continuing education course on prescribing controlled substances as part of biennial renewal. The course must include information on the current standards regarding for prescribing controlled substances, particularly opiates, alternatives to these standards, and information on the risks of opioid addiction following all stages of treatment in the management of acute pain. The course may be offered in a distance learning format and must be included within the number of continuing education hours required by law. The department may not renew the license of any prescriber registered with the United States Drug Enforcement Administration to prescribe controlled substances that has failed to complete the course. When required by this paragraph, the course shall be completed by January 31, 2019, and at each subsequent renewal.

(b) Each such licensee shall submit confirmation of having completed such course when applying for biennial renewal.

(c) Each licensing board that requires a licensee to complete an educational course pursuant to this subsection may include the hours required for completion of the course in the total hours of continuing education required by law for such profession unless the continuing education requirements for such profession consist of fewer than 30 hours biennially.

(2) Each board may adopt rules to administer this section.

Section 2. Paragraph (gg) of subsection (1) of section 456.072, Florida Statutes, is amended to read:

456.072 Grounds for discipline; penalties; enforcement.—

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(gg) Engaging in a pattern of practice when prescribing medicinal drugs or controlled substances which demonstrates a lack of reasonable skill or safety to patients, a violation of any provision of this chapter or ss. 893.055 and 893.0551, a violation of the applicable practice act, or a violation of any rules adopted under this chapter or the applicable practice act of the prescribing practitioner. Notwithstanding s. 456.073(13), the department may initiate an investigation and establish such a pattern from billing records, data, or any other information obtained by the department.

Section 3. Paragraphs (a) through (g) of subsection (1) of section 456.44, Florida Statutes, are redesignated as paragraphs

(b) through (h), respectively, a new paragraph (a) is added to that subsection, subsection (3) is amended, and subsections (4) and (5) are added to that section, to read:

456.44 Controlled substance prescribing.—

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

(a) "Acute pain" means the normal, predicted, physiological, and time-limited response to an adverse chemical, thermal, or mechanical stimulus associated with surgery, trauma, or acute illness.

(3) STANDARDS OF PRACTICE FOR TREATMENT OF CHRONIC NONMALIGNANT PAIN.—The standards of practice in this section do not supersede the level of care, skill, and treatment recognized in general law related to health care licensure.

(a) A complete medical history and a physical examination must be conducted before beginning any treatment and must be documented in the medical record. The exact components of the physical examination shall be left to the judgment of the registrant who is expected to perform a physical examination proportionate to the diagnosis that justifies a treatment. The medical record must, at a minimum, document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, a review of previous medical records, previous diagnostic studies, and history of alcohol and substance abuse. The medical record shall

also document the presence of one or more recognized medical indications for the use of a controlled substance. Each registrant must develop a written plan for assessing each patient's risk of aberrant drug-related behavior, which may include patient drug testing. Registrants must assess each patient's risk for aberrant drug-related behavior and monitor that risk on an ongoing basis in accordance with the plan.

(b) Each registrant must develop a written individualized treatment plan for each patient. The treatment plan shall state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and shall indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the registrant shall adjust drug therapy to the individual medical needs of each patient. Other treatment modalities, including a rehabilitation program, shall be considered depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment. The interdisciplinary nature of the treatment plan shall be documented.

(c) The registrant shall discuss the risks and benefits of the use of controlled substances, including the risks of abuse and addiction, as well as physical dependence and its consequences, with the patient, persons designated by the patient, or the patient's surrogate or guardian if the patient

is incompetent. The registrant shall use a written controlled substance agreement between the registrant and the patient outlining the patient's responsibilities, including, but not limited to:

1. Number and frequency of controlled substance prescriptions and refills.

2. Patient compliance and reasons for which drug therapy may be discontinued, such as a violation of the agreement.

3. An agreement that controlled substances for the treatment of chronic nonmalignant pain shall be prescribed by a single treating registrant unless otherwise authorized by the treating registrant and documented in the medical record.

(d) The patient shall be seen by the registrant at regular intervals, not to exceed 3 months, to assess the efficacy of treatment, ensure that controlled substance therapy remains indicated, evaluate the patient's progress toward treatment objectives, consider adverse drug effects, and review the etiology of the pain. Continuation or modification of therapy shall depend on the registrant's evaluation of the patient's progress. If treatment goals are not being achieved, despite medication adjustments, the registrant shall reevaluate the appropriateness of continued treatment. The registrant shall monitor patient compliance in medication usage, related treatment plans, controlled substance agreements, and indications of substance abuse or diversion at a minimum of 3-

month intervals.

(e) The registrant shall refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention shall be given to those patients who are at risk for misusing their medications and those whose living arrangements pose a risk for medication misuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder requires extra care, monitoring, and documentation and requires consultation with or referral to an addiction medicine specialist or a psychiatrist.

(f) A registrant must maintain accurate, current, and complete records that are accessible and readily available for review and comply with the requirements of this section, the applicable practice act, and applicable board rules. The medical records must include, but are not limited to:

1. The complete medical history and a physical examination, including history of drug abuse or dependence.

2. Diagnostic, therapeutic, and laboratory results.

3. Evaluations and consultations.

4. Treatment objectives.

5. Discussion of risks and benefits.

6. Treatments.

7. Medications, including date, type, dosage, and quantity prescribed.

8. Instructions and agreements.

9. Periodic reviews.

10. Results of any drug testing.

11. A photocopy of the patient's government-issued photo identification.

12. If a written prescription for a controlled substance is given to the patient, a duplicate of the prescription.

13. The registrant's full name presented in a legible manner.

(g) A registrant shall immediately refer patients with signs or symptoms of substance abuse to a board-certified pain management physician, an addiction medicine specialist, or a mental health addiction facility as it pertains to drug abuse or addiction unless the registrant is a physician who is board-certified or board-eligible in pain management. Throughout the period of time before receiving the consultant's report, a prescribing registrant shall clearly and completely document medical justification for continued treatment with controlled substances and those steps taken to ensure medically appropriate use of controlled substances by the patient. Upon receipt of the consultant's written report, the prescribing registrant shall incorporate the consultant's recommendations for continuing, modifying, or discontinuing controlled substance therapy. The resulting changes in treatment shall be specifically documented in the patient's medical record. Evidence or behavioral

indications of diversion shall be followed by discontinuation of controlled substance therapy, and the patient shall be discharged, and all results of testing and actions taken by the registrant shall be documented in the patient's medical record.

This subsection does not apply to a board-eligible or board-certified anesthesiologist, physiatrist, rheumatologist, or neurologist, or to a board-certified physician who has surgical privileges at a hospital or ambulatory surgery center and primarily provides surgical services. This subsection does not apply to a board-eligible or board-certified medical specialist who has also completed a fellowship in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association, or who is board eligible or board certified in pain medicine by the American Board of Pain Medicine, the American Board of Interventional Pain Physicians, the American Association of Physician Specialists, or a board approved by the American Board of Medical Specialties or the American Osteopathic Association and performs interventional pain procedures of the type routinely billed using surgical codes. This subsection does not apply to a registrant who prescribes medically necessary controlled substances for a patient during an inpatient stay in a hospital licensed under chapter 395.

(4) STANDARDS OF PRACTICE FOR TREATMENT OF ACUTE PAIN.—The department shall adopt rules establishing guidelines for prescribing controlled substances for acute pain, including evaluation of the patient, creation of a treatment plan, obtaining informed consent and agreement for treatment, periodic review of the treatment plan, consultation, medical record review, and compliance with controlled substance laws and regulations. Failure of a prescriber to follow such guidelines constitutes grounds for disciplinary action pursuant to s. 456.072(1)(gg), punishable as provided in s. 456.072(2).

(5) PRESCRIPTION SUPPLY.-

(a) Except as provided in paragraph (b), a prescription for a Schedule II opioid, as defined in s. 893.03 or 21 U.S.C. s. 812, for the treatment of acute pain must not exceed a 3-day supply.

(b) An up to 7-day supply of an opioid described in paragraph (a) may be prescribed if:

1. The practitioner, in his or her professional judgment, believes that more than a 3-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition.

2. The practitioner indicates "MEDICALLY NECESSARY" on the prescription.

3. The prescriber adequately documents in the patient's medical records the acute medical condition and lack of

alternative treatment options that justify deviation from the 3-day supply limit established in this subsection.

Section 4. Effective January 1, 2019, subsections (2) through (5) of section 458.3265, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) are amended, and a new subsection (2) is added to that section, to read:

458.3265 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-

management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from

federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors described in subsection (4) ~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1), must apply for a certificate of exemption on a form adopted in rule by the department. The form shall require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) Within 30 days after the receipt of a complete application, the department must approve or deny the application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A certificate of exemption is not movable or transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at

least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must immediately notify the department and register as a pain management clinic under subsection (1).

(3)~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) A physician may not practice medicine in a pain-management clinic, as described in subsection (5)~~(4)~~, if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. A physician who violates this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4)~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the

Board of Medicine adopted pursuant to subsection (5) ~~(4)~~ unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Medicine.

(5) ~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 5. Effective January 1, 2019, subsections (2) through (5) of section 459.0137, Florida Statutes, are renumbered as subsections (3) through (6), respectively, paragraphs (a) and (g) of subsection (1), paragraph (a) of present subsection (2), paragraph (a) of present subsection (3), and paragraph (a) of present subsection (4) are amended, and a new subsection (2) is added to that section, to read:

459.0137 Pain-management clinics.—

(1) REGISTRATION.—

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

a. "Board eligible" means successful completion of an anesthesia, physical medicine and rehabilitation, rheumatology, or neurology residency program approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association for a period of 6 years from successful completion of such residency program.

b. "Chronic nonmalignant pain" means pain unrelated to

cancer which persists beyond the usual course of disease or the injury that is the cause of the pain or more than 90 days after surgery.

c. "Pain-management clinic" or "clinic" means any publicly or privately owned facility:

(I) That advertises in any medium for any type of pain-management services; or

(II) Where in any month a majority of patients are prescribed opioids, benzodiazepines, barbiturates, or carisoprodol for the treatment of chronic nonmalignant pain.

2. Each pain-management clinic must register with the department or hold a valid certificate of exemption pursuant to subsection (2). ~~unless:~~

3. The following clinics are exempt from the registration requirement of paragraphs (c)-(m), and must apply to the department for a certificate of exemption:

a. A ~~That~~ clinic ~~is~~ licensed as a facility pursuant to chapter 395;

b. A clinic in which the majority of the physicians who provide services in the clinic primarily provide surgical services;

c. A ~~The~~ clinic ~~is~~ owned by a publicly held corporation whose shares are traded on a national exchange or on the over-the-counter market and whose total assets at the end of the corporation's most recent fiscal quarter exceeded $50 million;

d. A ~~The~~ clinic ~~is~~ affiliated with an accredited medical school at which training is provided for medical students, residents, or fellows;

e. A ~~The~~ clinic that does not prescribe controlled substances for the treatment of pain;

f. A ~~The~~ clinic ~~is~~ owned by a corporate entity exempt from federal taxation under 26 U.S.C. s. 501(c)(3);

g. A ~~The~~ clinic ~~is~~ wholly owned and operated by one or more board-eligible or board-certified anesthesiologists, physiatrists, rheumatologists, or neurologists; or

h. A ~~The~~ clinic ~~is~~ wholly owned and operated by a physician multispecialty practice where one or more board-eligible or board-certified medical specialists, who have also completed fellowships in pain medicine approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or who are also board-certified in pain medicine by the American Board of Pain Medicine or a board approved by the American Board of Medical Specialties, the American Association of Physician Specialists, or the American Osteopathic Association, perform interventional pain procedures of the type routinely billed using surgical codes.

(g) The department may revoke the clinic's certificate of registration and prohibit all physicians associated with that pain-management clinic from practicing at that clinic location based upon an annual inspection and evaluation of the factors

described in subsection (4) ~~(3)~~.

(2) CERTIFICATE OF EXEMPTION.-

(a) A pain management clinic claiming an exemption from the registration requirements of subsection (1), must apply for a certificate of exemption on a form adopted in rule by the department. The form shall require the applicant to provide:

1. The name or names under which the applicant does business.

2. The address at which the pain management clinic is located.

3. The specific exemption the applicant is claiming with supporting documentation.

4. Any other information deemed necessary by the department.

(b) Within 30 days after the receipt of a complete application, the department must approve or deny the application.

(c) The certificate of exemption must be renewed biennially, except that the department may issue the initial certificates of exemption for up to 3 years in order to stagger renewal dates.

(d) A certificateholder must prominently display the certificate of exemption and make it available to the department or the board upon request.

(e) A certificate of exemption is not movable or

transferable. A certificate of exemption is valid only for the applicant, qualifying owners, licenses, registrations, certifications, and services provided under a specific statutory exemption and is valid only to the specific exemption claimed and granted.

(f) A certificateholder must notify the department at least 60 days before any anticipated relocation or name change of the pain management clinic or a change of ownership.

(g) If a pain management clinic no longer qualifies for a certificate of exemption, the certificateholder must immediately notify the department and register as a pain management clinic under subsection (1).

(3) ~~(2)~~ PHYSICIAN RESPONSIBILITIES.—These responsibilities apply to any osteopathic physician who provides professional services in a pain-management clinic that is required to be registered in subsection (1).

(a) An osteopathic physician may not practice medicine in a pain-management clinic, as described in subsection (5) ~~(4)~~, if the pain-management clinic is not registered with the department as required by this section. Any physician who qualifies to practice medicine in a pain-management clinic pursuant to rules adopted by the Board of Osteopathic Medicine as of July 1, 2012, may continue to practice medicine in a pain-management clinic as long as the physician continues to meet the qualifications set forth in the board rules. An osteopathic physician who violates

this paragraph is subject to disciplinary action by his or her appropriate medical regulatory board.

(4) ~~(3)~~ INSPECTION.—

(a) The department shall inspect the pain-management clinic annually, including a review of the patient records, to ensure that it complies with this section and the rules of the Board of Osteopathic Medicine adopted pursuant to subsection (5) ~~(4)~~ unless the clinic is accredited by a nationally recognized accrediting agency approved by the Board of Osteopathic Medicine.

(5) ~~(4)~~ RULEMAKING.—

(a) The department shall adopt rules necessary to administer the registration, exemption, and inspection of pain-management clinics which establish the specific requirements, procedures, forms, and fees.

Section 6. Section 465.0155, Florida Statutes, is amended to read:

465.0155 Standards of practice.—

(1) Consistent with the provisions of this act, the board shall adopt by rule standards of practice relating to the practice of pharmacy which shall be binding on every state agency and shall be applied by such agencies when enforcing or implementing any authority granted by any applicable statute, rule, or regulation, whether federal or state.

(2)(a) Before dispensing a controlled substance to a

person not known to the pharmacist, the pharmacist must require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the pharmacist may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

(b) This subsection does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

(c) As used in this subsection, the term "proper identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 7. Paragraph (d) is added to subsection (2) of section 465.0276, Florida Statutes, to read:

465.0276 Dispensing practitioner.—

(2) A practitioner who dispenses medicinal drugs for human consumption for fee or remuneration of any kind, whether direct or indirect, must:

(d)1. Before dispensing a controlled substance to a person not known to the dispenser, require the person purchasing, receiving, or otherwise acquiring the controlled substance to present valid photographic identification or other verification of his or her identity. If the person does not have proper identification, the dispenser may verify the validity of the prescription and the identity of the patient with the prescriber or his or her authorized agent. Verification of health plan eligibility through a real-time inquiry or adjudication system is considered to be proper identification.

2. This paragraph does not apply in an institutional setting or to a long-term care facility, including, but not limited to, an assisted living facility or a hospital to which patients are admitted.

3. As used in this paragraph, the term "proper identification" means an identification that is issued by a state or the Federal Government containing the person's photograph, printed name, and signature or a document considered acceptable under 8 C.F.R. s. 274a.2(b)(1)(v)(A) and (B).

Section 8. Subsections (2), (3), (4), and (5) of section 893.03, Florida Statutes, are amended to read:

893.03 Standards and schedules.—The substances enumerated in this section are controlled by this chapter. The controlled substances listed or to be listed in Schedules I, II, III, IV, and V are included by whatever official, common, usual,

chemical, trade name, or class designated. The provisions of this section shall not be construed to include within any of the schedules contained in this section any excluded drugs listed within the purview of 21 C.F.R. s. 1308.22, styled "Excluded Substances"; 21 C.F.R. s. 1308.24, styled "Exempt Chemical Preparations"; 21 C.F.R. s. 1308.32, styled "Exempted Prescription Products"; or 21 C.F.R. s. 1308.34, styled "Exempt Anabolic Steroid Products."

(2) SCHEDULE II.—A substance in Schedule II has a high potential for abuse and has a currently accepted but severely restricted medical use in treatment in the United States, and abuse of the substance may lead to severe psychological or physical dependence. The following substances are controlled in Schedule II:

(a) Unless specifically excepted or unless listed in another schedule, any of the following substances, whether produced directly or indirectly by extraction from substances of vegetable origin or independently by means of chemical synthesis:

1. Opium and any salt, compound, derivative, or preparation of opium, except nalmefene or isoquinoline alkaloids of opium, including, but not limited to the following:

a. Raw opium.

b. Opium extracts.

c. Opium fluid extracts.

d. Powdered opium.

e. Granulated opium.

f. Tincture of opium.

g. Codeine.

h. Dihydroetorphine.

i.~~h.~~ Ethylmorphine.

j.~~i.~~ Etorphine hydrochloride.

k.~~j.~~ Hydrocodone and hydrocodone combination products.

l.~~k.~~ Hydromorphone.

m.~~l.~~ Levo-alphacetylmethadol (also known as levo-alpha-acetylmethadol, levomethadyl acetate, or LAAM).

n.~~m.~~ Metopon (methyldihydromorphinone).

o.~~n.~~ Morphine.

p. Oripavine.

q.~~o.~~ Oxycodone.

r.~~p.~~ Oxymorphone.

s.~~q.~~ Thebaine.

2. Any salt, compound, derivative, or preparation of a substance which is chemically equivalent to or identical with any of the substances referred to in subparagraph 1., except that these substances shall not include the isoquinoline alkaloids of opium.

3. Any part of the plant of the species Papaver somniferum, L.

4. Cocaine or ecgonine, including any of their

stereoisomers, and any salt, compound, derivative, or preparation of cocaine or ecgonine, except that these substances shall not include ioflupane I 123.

(b) Unless specifically excepted or unless listed in another schedule, any of the following substances, including their isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible within the specific chemical designation:

1. Alfentanil.
2. Alphaprodine.
3. Anileridine.
4. Bezitramide.
5. Bulk propoxyphene (nondosage forms).
6. Carfentanil.
7. Dihydrocodeine.
8. Diphenoxylate.
9. Fentanyl.
10. Isomethadone.
11. Levomethorphan.
12. Levorphanol.
13. Metazocine.
14. Methadone.
15. Methadone-Intermediate,4-cyano-2-dimethylamino-4,4-diphenylbutane.

16. Moramide-Intermediate,2-methyl-3-morpholoino-1,1-diphenylpropane-carboxylic acid.

17. Nabilone.

18. Pethidine (meperidine).

19. Pethidine-Intermediate-A,4-cyano-1-methyl-4-phenylpiperidine.

20. Pethidine-Intermediate-B,ethyl-4-phenylpiperidine-4-carboxylate.

21. Pethidine-Intermediate-C,1-methyl-4- phenylpiperidine-4-carboxylic acid.

22. Phenazocine.

23. Phencyclidine.

24. 1-Phenylcyclohexylamine.

25. Piminodine.

26. 1-Piperidinocyclohexanecarbonitrile.

27. Racemethorphan.

28. Racemorphan.

29. Remifentanil.

30.~~29.~~ Sufentanil.

31. Tapentadol.

32. Thiafentanil.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including their salts, isomers, optical isomers,

salts of their isomers, and salts of their optical isomers:

1. Amobarbital.

2. Amphetamine.

3. Glutethimide.

4. Lisdexamfetamine.

5.~~4.~~ Methamphetamine.

6.~~5.~~ Methylphenidate.

7.~~6.~~ Pentobarbital.

8.~~7.~~ Phenmetrazine.

9.~~8.~~ Phenylacetone.

10.~~9.~~ Secobarbital.

(d) Dronabinol (synthetic THC) in oral solution in a drug product approved by the United States Food and Drug Administration.

(3) SCHEDULE III.—A substance in Schedule III has a potential for abuse less than the substances contained in Schedules I and II and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to moderate or low physical dependence or high psychological dependence or, in the case of anabolic steroids, may lead to physical damage. The following substances are controlled in Schedule III:

(a) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following

substances having a depressant or stimulant effect on the nervous system:

1. Any substance which contains any quantity of a derivative of barbituric acid, including thiobarbituric acid, or any salt of a derivative of barbituric acid or thiobarbituric acid, including, but not limited to, butabarbital and butalbital.

2. Benzphetamine.

3. Buprenorphine.

4.~~3.~~ Chlorhexadol.

5.~~4.~~ Chlorphentermine.

6.~~5.~~ Clortermine.

7. Embutramide.

8.~~6.~~ Lysergic acid.

9.~~7.~~ Lysergic acid amide.

10.~~8.~~ Methyprylon.

11. Perampanel.

12.~~9.~~ Phendimetrazine.

13.~~10.~~ Sulfondiethylmethane.

14.~~11.~~ Sulfonethylmethane.

15.~~12.~~ Sulfonmethane.

16.~~13.~~ Tiletamine and zolazepam or any salt thereof.

(b) Nalorphine.

(c) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or

preparation containing limited quantities of any of the following controlled substances or any salts thereof:

1. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with an equal or greater quantity of an isoquinoline alkaloid of opium.

2. Not more than 1.8 grams of codeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

3. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with a fourfold or greater quantity of an isoquinoline alkaloid of opium.

4. Not more than 300 milligrams of hydrocodone per 100 milliliters or not more than 15 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients that are not controlled substances.

5. Not more than 1.8 grams of dihydrocodeine per 100 milliliters or not more than 90 milligrams per dosage unit, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

6. Not more than 300 milligrams of ethylmorphine per 100 milliliters or not more than 15 milligrams per dosage unit, with one or more active, nonnarcotic ingredients in recognized therapeutic amounts.

7. Not more than 50 milligrams of morphine per 100 milliliters or per 100 grams, with recognized therapeutic amounts of one or more active ingredients which are not controlled substances.

For purposes of charging a person with a violation of s. 893.135 involving any controlled substance described in subparagraph 3. or subparagraph 4., the controlled substance is a Schedule III controlled substance pursuant to this paragraph but the weight of the controlled substance per milliliters or per dosage unit is not relevant to the charging of a violation of s. 893.135. The weight of the controlled substance shall be determined pursuant to s. 893.135(6).

(d) Anabolic steroids.

1. The term "anabolic steroid" means any drug or hormonal substance, chemically and pharmacologically related to testosterone, other than estrogens, progestins, and corticosteroids, that promotes muscle growth and includes:

a. Androsterone.

b. Androsterone acetate.

c. Boldenone.

d. Boldenone acetate.

e. Boldenone benzoate.

f. Boldenone undecylenate.

g. Chlorotestosterone (Clostebol).

h. Dehydrochlormethyltestosterone.
i. Dihydrotestosterone (Stanolone).
j. Drostanolone.
k. Ethylestrenol.
l. Fluoxymesterone.
m. Formebulone (Formebolone).
n. Mesterolone.
o. Methandrostenolone (Methandienone).
p. Methandranone.
q. Methandriol.
r. Methenolone.
s. Methyltestosterone.
t. Mibolerone.
u. Nortestosterone (Nandrolone).
v. Norethandrolone.
w. Nortestosterone decanoate.
x. Nortestosterone phenylpropionate.
y. Nortestosterone propionate.
z. Oxandrolone.
aa. Oxymesterone.
bb. Oxymetholone.
cc. Stanozolol.
dd. Testolactone.
ee. Testosterone.
ff. Testosterone acetate.

gg. Testosterone benzoate.
hh. Testosterone cypionate.
ii. Testosterone decanoate.
jj. Testosterone enanthate.
kk. Testosterone isocaproate.
ll. Testosterone oleate.
mm. Testosterone phenylpropionate.
nn. Testosterone propionate.
oo. Testosterone undecanoate.
pp. Trenbolone.
qq. Trenbolone acetate.
rr. Any salt, ester, or isomer of a drug or substance described or listed in this subparagraph if that salt, ester, or isomer promotes muscle growth.

2. The term does not include an anabolic steroid that is expressly intended for administration through implants to cattle or other nonhuman species and that has been approved by the United States Secretary of Health and Human Services for such administration. However, any person who prescribes, dispenses, or distributes such a steroid for human use is considered to have prescribed, dispensed, or distributed an anabolic steroid within the meaning of this paragraph.

(e) Ketamine, including any isomers, esters, ethers, salts, and salts of isomers, esters, and ethers, whenever the existence of such isomers, esters, ethers, and salts is possible

within the specific chemical designation.

(f) Dronabinol (synthetic THC) in sesame oil and encapsulated in a soft gelatin capsule in a drug product approved by the United States Food and Drug Administration.

(g) Any drug product containing gamma-hydroxybutyric acid, including its salts, isomers, and salts of isomers, for which an application is approved under s. 505 of the Federal Food, Drug, and Cosmetic Act.

(4)(a) SCHEDULE IV.—A substance in Schedule IV has a low potential for abuse relative to the substances in Schedule III and has a currently accepted medical use in treatment in the United States, and abuse of the substance may lead to limited physical or psychological dependence relative to the substances in Schedule III.

(b) Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances, including its salts, isomers, and salts of isomers whenever the existence of such salts, isomers, and salts of isomers is possible within the specific chemical designation, are controlled in Schedule IV:

1. Alfaxalone.

2.~~(a)~~ Alprazolam.

3.~~(b)~~ Barbital.

4.~~(c)~~ Bromazepam.

5.~~(iii)~~ Butorphanol tartrate.

6.~~(d)~~ Camazepam.

7.~~(jjj)~~ Carisoprodol.

8.~~(e)~~ Cathine.

9.~~(f)~~ Chloral betaine.

10.~~(g)~~ Chloral hydrate.

11.~~(h)~~ Chlordiazepoxide.

12.~~(i)~~ Clobazam.

13.~~(j)~~ Clonazepam.

14.~~(k)~~ Clorazepate.

15.~~(l)~~ Clotiazepam.

16.~~(m)~~ Cloxazolam.

17. Dexfenfluramine.

18.~~(n)~~ Delorazepam.

19. Dichloralphenazone.

20.~~(p)~~ Diazepam.

21.~~(q)~~ Diethylpropion.

22. Eluxadoline.

23.~~(r)~~ Estazolam.

24. Eszopiclone.

25.~~(s)~~ Ethchlorvynol.

26.~~(t)~~ Ethinamate.

27.~~(u)~~ Ethyl loflazepate.

28.~~(v)~~ Fencamfamin.

29.~~(w)~~ Fenfluramine.

30.~~(x)~~ Fenproporex.

31.~~(y)~~ Fludiazepam.

32.~~(z)~~ Flurazepam.

33. Fospropofol.

34.~~(aa)~~ Halazepam.

35.~~(bb)~~ Haloxazolam.

36.~~(cc)~~ Ketazolam.

37.~~(dd)~~ Loprazolam.

38.~~(ee)~~ Lorazepam.

39. Lorcaserin.

40.~~(ff)~~ Lormetazepam.

41.~~(gg)~~ Mazindol.

42.~~(hh)~~ Mebutamate.

43.~~(ii)~~ Medazepam.

44.~~(jj)~~ Mefenorex.

45.~~(kk)~~ Meprobamate.

46.~~(ll)~~ Methohexital.

47.~~(mm)~~ Methylphenobarbital.

48.~~(nn)~~ Midazolam.

49. Modafinil.

50.~~(oo)~~ Nimetazepam.

51.~~(pp)~~ Nitrazepam.

52.~~(qq)~~ Nordiazepam.

53.~~(rr)~~ Oxazepam.

54.~~(ss)~~ Oxazolam.

55.~~(tt)~~ Paraldehyde.

56.~~(uu)~~ Pemoline.

57.~~(vv)~~ Pentazocine.

58. Petrichloral.

59.~~(ww)~~ Phenobarbital.

60.~~(xx)~~ Phentermine.

61.~~(yy)~~ Pinazepam.

62.~~(zz)~~ Pipradrol.

63.~~(aaa)~~ Prazepam.

64.~~(o)~~ Propoxyphene (dosage forms).

65.~~(bbb)~~ Propylhexedrine, excluding any patent or proprietary preparation containing propylhexedrine, unless otherwise provided by federal law.

66.~~(ccc)~~ Quazepam.

67. Sibutramine.

68.~~(ccc)~~ SPA[(-)-1 dimethylamino-1, 2 diphenylethane].

69. Suvorexant.

70.~~(fff)~~ Temazepam.

71.~~(ddd)~~ Tetrazepam.

72. Tramadol.

73.~~(ggg)~~ Triazolam.

74. Zaleplon.

75. Zolpidem.

76. Zopiclone.

77.~~(hhh)~~ Not more than 1 milligram of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

(5) SCHEDULE V.—A substance, compound, mixture, or preparation of a substance in Schedule V has a low potential for abuse relative to the substances in Schedule IV and has a currently accepted medical use in treatment in the United States, and abuse of such compound, mixture, or preparation may lead to limited physical or psychological dependence relative to the substances in Schedule IV.

(a) Substances controlled in Schedule V include any compound, mixture, or preparation containing any of the following limited quantities of controlled substances, which shall include one or more active medicinal ingredients which are not controlled substances in sufficient proportion to confer upon the compound, mixture, or preparation valuable medicinal qualities other than those possessed by the controlled substance alone:

1. Not more than 200 milligrams of codeine per 100 milliliters or per 100 grams.

2. Not more than 100 milligrams of dihydrocodeine per 100 milliliters or per 100 grams.

3. Not more than 100 milligrams of ethylmorphine per 100 milliliters or per 100 grams.

4. Not more than 2.5 milligrams of diphenoxylate and not less than 25 micrograms of atropine sulfate per dosage unit.

5. Not more than 100 milligrams of opium per 100 milliliters or per 100 grams.

6. Not more than 0.5 milligrams of difenoxin and not less than 25 micrograms of atropine sulfate per dosage unit.

7. Brivaracetam.

8. Ezogabine.

9. Lacosamide.

10. Pregabalin.

~~(b) Narcotic drugs. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation containing any of the following narcotic drugs and their salts: Buprenorphine.~~

(b) ~~(c)~~ Stimulants. Unless specifically excepted or unless listed in another schedule, any material, compound, mixture, or preparation which contains any quantity of the following substances having a stimulant effect on the central nervous system, including its salts, isomers, and salts of isomers: Pyrovalerone.

Section 9. Section 893.055, Florida Statutes, is amended to read:

(Substantial rewording of section. See s. 893.055, F.S., for present text.)

893.055 Prescription drug monitoring program.—

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

(a) "Administration" means the obtaining and giving of a

single dose of medicinal drugs by a legally authorized person to a patient for her or his consumption.

(b) "Active investigation" means an investigation that is being conducted with a reasonable, good faith belief that it could lead to the filing of administrative, civil, or criminal proceedings, or that is ongoing and continuing and for which there is a reasonable, good faith anticipation of securing an arrest or prosecution in the foreseeable future.

(c) "Controlled substance" means a controlled substance listed in Schedule II, Schedule III, Schedule IV, or Schedule V of s. 893.03 or 21 U.S.C. s. 812.

(d) "Dispense" means the transfer of possession of one or more doses of a medicinal drug by a health care practitioner to the ultimate consumer or to his or her agent.

(e) "Dispenser" means a dispensing health care practitioner or pharmacist licensed to dispense medicinal drugs in this state.

(f) "Health care practitioner" or "practitioner" means any practitioner licensed under chapter 458, chapter 459, chapter 461, chapter 463, chapter 464, chapter 465, or chapter 466.

(g) "Health care regulatory board" means any board or commission as defined in s. 456.001(1).

(h) "Law enforcement agency" means the Department of Law Enforcement, a sheriff's office in this state, a police department in this state, or a law enforcement agency of the

Federal Government which enforces the laws of this state or the United States relating to controlled substances, and which its agents and officers are empowered by law to conduct criminal investigations and make arrests.

(i) "Pharmacy" includes a community pharmacy, an institutional pharmacy, a nuclear pharmacy, a special pharmacy, or an Internet pharmacy that is licensed by the department under chapter 465 and that dispenses or delivers medicinal drugs, including controlled substances to an individual or address in this state.

(j) "Prescriber" means a prescribing physician, prescribing practitioner, or other prescribing health care practitioner authorized by the laws of this state to order medicinal drugs.

(k) "Program manager" means an employee of or a person contracted by the department who is designated to ensure the integrity of the prescription drug monitoring program in accordance with the requirements established in this section.

(2)(a) The department shall maintain an electronic system to collect and store controlled substance dispensing information and shall release the information as authorized in s. 893.0551. The electronic system must:

1. Not infringe upon the legitimate prescribing or dispensing of a controlled substance by a prescriber or dispenser acting in good faith and in the course of professional

practice.

2. Be consistent with standards of the American Society for Automation in Pharmacy (ASAP).

3. Comply with the Health Insurance Portability and Accountability Act (HIPAA) as it pertains to protected health information (PHI), electronic protected health information (EPHI), and all other relevant state and federal privacy and security laws and regulations.

(b) The department may collaborate with professional health care regulatory boards, appropriate organizations, and other state agencies to identify indicators of controlled substance abuse.

(c) The department shall adopt rules necessary to implement this subsection.

(3) For each controlled substance dispensed to a patient in the state, the following information must be reported by the dispenser to the system as soon thereafter as possible but no later than the close of the next business day after the day the controlled substance is dispensed unless an extension or exemption is approved by the department:

(a) The name of the prescribing practitioner, the practitioner's federal Drug Enforcement Administration registration number, the practitioner's National Provider Identification (NPI) or other appropriate identifier, and the date of the prescription.

(b) The date the prescription was filled and the method of payment, such as cash by an individual, insurance coverage through a third party, or Medicaid payment. This paragraph does not authorize the department to include individual credit card numbers or other account numbers in the system.

(c) The full name, address, telephone number, and date of birth of the person for whom the prescription was written.

(d) The name, national drug code, quantity, and strength of the controlled substance dispensed.

(e) The full name, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued pharmacy permit number, and address of the pharmacy or other location from which the controlled substance was dispensed. If the controlled substance was dispensed by a practitioner other than a pharmacist, the practitioner's full name, address, federal Drug Enforcement Administration registration number, State of Florida Department of Health issued license number, and National Provider Identification (NPI).

(f) Whether the drug was dispensed as an initial prescription or a refill, and the number of refills ordered.

(g) The name of the individual picking up the controlled substance prescription and type and issuer of the identification provided.

(h) Other appropriate identifying information as

determined by department rule.

(i) All acts of administration of controlled substances are exempt from the reporting requirements of this section.

(4) The following shall have direct access to information in the system:

(a) An authorized prescriber or dispenser or his or her designee.

(b) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of employment.

(c) The program manager or designated program and support staff may have access to administer the system.

1. The program manager or designated program and support staff must complete a level II background screening.

2. In order to calculate performance measures pursuant to subsection (14), the program manager or program and support staff members who have been directed by the program manager to calculate performance measures may have direct access to information that contains no identifying information of any patient, physician, health care practitioner, prescriber, or dispenser.

3. The program manager or designated program and support

staff must provide the department, upon request, data that does not contain patient, physician, health care practitioner, prescriber, or dispenser identifying information for public health care and safety initiatives purposes.

4. The program manager, upon determining a pattern consistent with the department's rules established under paragraph (2)(b) may provide relevant information to the prescriber and dispenser.

5. The program manager, upon determining a pattern consistent with the rules established under paragraph (2)(b) and having cause to believe a violation of s. 893.13(7)(a)8., (8)(a), or (8)(b) has occurred, may provide relevant information to the applicable law enforcement agency.

(5) The following entities may not directly access information in the system, but may request information from the program manager or designated program and support staff:

(a) The department for investigations involving licensees authorized to prescribe or dispense controlled substances.

(b) The Attorney General for Medicaid fraud cases involving prescribed controlled substances.

(c) A law enforcement agency during active investigations of potential criminal activity, fraud, or theft regarding prescribed controlled substances.

(d) A medical examiner when conducting an authorized investigation under s. 406.11, to determine the cause of death

of an individual.

(e) An impaired practitioner consultant who is retained by the department under s. 456.076 to review the system information of an impaired practitioner program participant or a referral who has agreed to be evaluated or monitored through the program and who has separately agreed in writing to the consultant's access to and review of such information.

(f) A patient or the legal guardian or designated health care surrogate of an incapacitated patient who submits a written and notarized request that includes the patient's full name, address, phone number, date of birth, and a copy of a government-issued photo identification. A legal guardian or health care surrogate must provide the same information if he or she submits the request.

(6) The department may enter into a reciprocal agreement or contract to share prescription drug monitoring information with another state, district, or territory if the prescription drug monitoring programs of other states, districts, or territories are compatible with the Florida program.

(a) In determining compatibility, the department shall consider:

1. The safeguards for privacy of patient records and the success of the program in protecting patient privacy.

2. The persons authorized to view the data collected by the program. Comparable entities and licensed health care

practitioners in other states, districts, or territories of the United States, law enforcement agencies, the Attorney General's Medicaid Fraud Control Unit, medical regulatory boards, and, as needed, management staff that have similar duties as management staff who work with the prescription drug monitoring program as authorized in s. 893.0551 are authorized access upon approval by the department.

3. The schedules of the controlled substances that are monitored by the program.

4. The data reported to or included in the program's system.

5. Any implementing criteria deemed essential for a thorough comparison.

6. The costs and benefits to the state of sharing prescription information.

(b) The department must assess the prescription drug monitoring program's continued compatibility with the other state's, district's, or territory's program periodically.

(c) Any agreement or contract for sharing of prescription drug monitoring information between the department and another state, district, or territory shall contain the same restrictions and requirements as this section or s. 893.0551, and the information must be provided according to the department's determination of compatibility.

(7) The department may enter into agreements or contracts

to establish secure connections between the system and a prescribing or dispensing health care practitioner's electronic health recordkeeping system. The electronic health recordkeeping system owner or license holder will be responsible for ensuring that only authorized individuals have access to prescription drug monitoring program information.

(8) A prescriber or dispenser or a designee of a prescriber or dispenser must consult the system to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance.

(a) The duty to consult the system does not apply to a prescriber or dispenser or designee of a prescriber or dispenser if the system is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure.

(b) A prescriber or dispenser or designee of a prescriber or dispenser who does not consult the system under this subsection shall document the reason he or she did not consult the system in the patient's medical record or prescription record, and shall not prescribe or dispense greater than a 3-day supply of a controlled substance to the patient.

(c) The department shall issue a nondisciplinary citation to any prescriber or dispenser who fails to consult the system as required by this subsection.

(9) A person who willfully and knowingly fails to report the dispensing of a controlled substance as required by this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(10) Information in the prescription drug monitoring program's system may be released only as provided in this subsection and s. 893.0551. The content of the system is intended to be informational only and imposes no obligations of any nature or any legal duty on a prescriber, dispenser, pharmacy, or patient. Information in the system shall be provided in accordance with s. 893.13(7)(a)8. and is not subject to discovery or introduction into evidence in any civil or administrative action against a prescriber, dispenser, pharmacy, or patient arising out of matters that are the subject of information in the system. The program manager and authorized persons who participate in preparing, reviewing, issuing, or any other activity related to management of the system may not be permitted or required to testify in any such civil or administrative action as to any findings, recommendations, evaluations, opinions, or other actions taken in connection with management of the system.

(11) A prescriber or dispenser, or his or her designee, may have access to the information under this section which relates to a patient of that prescriber or dispenser as needed for the purpose of reviewing the patient's controlled drug

prescription history. A prescriber or dispenser acting in good faith is immune from any civil, criminal, or administrative liability that might otherwise be incurred or imposed for receiving or using information from the prescription drug monitoring program. This subsection does not create a private cause of action, and a person may not recover damages against a prescriber or dispenser authorized to access information under this subsection for accessing or failing to access such information.

(12)(a) All costs incurred by the department in administering the prescription drug monitoring program shall be funded through federal grants, private funding applied for or received by the state, or state funds appropriated in the General Appropriations Act. The department may not:

1. Commit funds for the monitoring program without ensuring funding is available; or

2. Use funds provided, directly or indirectly by prescription drug manufacturers to implement the program.

(b) The department shall cooperate with the direct-support organization established under subsection (15) in seeking federal grant funds, other nonstate grant funds, gifts, donations, or other private moneys for the department if the costs of doing so are immaterial. Immaterial costs include, but are not limited to, the costs of mailing and personnel assigned to research or apply for a grant. The department may

competitively procure and contract pursuant to s. 287.057 for any goods and services required be this section.

(13) The department shall conduct or participate in studies to examine the feasibility of enhancing the prescription drug monitoring program for the purposes of public health initiatives and statistical reporting. Such studies shall respect the privacy of the patient, the prescriber, and the dispenser. Such studies may be conducted by the department or a contracted vendor in order to:

(a) Improve the quality of health care services and safety by improving the prescribing and dispensing practices for prescription drugs;

(b) Take advantage of advances in technology;

(c) Reduce duplicative prescriptions and the overprescribing of prescription drugs; and

(d) Reduce drug abuse.

(14) The department shall annually report on performance measures to the Governor, the President of the Senate, and the Speaker of the House of Representatives by the department each December 1. Performance measures may include, but are not limited to, the following outcomes:

(a) Reduction of the rate of inappropriate use of prescription drugs through department education and safety efforts.

(b) Reduction of the quantity of pharmaceutical controlled

substances obtained by individuals attempting to engage in fraud and deceit.

(c) Increased coordination among partners participating in the prescription drug monitoring program.

(d) Involvement of stakeholders in achieving improved patient health care and safety and reduction of prescription drug abuse and prescription drug diversion.

(15) The department may establish a direct-support organization to provide assistance, funding, and promotional support for the activities authorized for the prescription drug monitoring program.

(a) As used in this subsection, the term "direct-support organization" means an organization that is:

1. A Florida corporation not for profit incorporated under chapter 617, exempted from filing fees, and approved by the Department of State.

2. Organized and operated to conduct programs and activities; raise funds; request and receive grants, gifts, and bequests of money; acquire, receive, hold, and invest, in its own name, securities, funds, objects of value, or other property, either real or personal; and make expenditures or provide funding to or for the direct or indirect benefit of the department in the furtherance of the prescription drug monitoring program.

(b) The State Surgeon General shall appoint a board of

directors for the direct-support organization.

1. The board of directors shall consist of no fewer than five members who shall serve at the pleasure of the State Surgeon General.

2. The State Surgeon General shall provide guidance to members of the board to ensure that moneys received by the direct-support organization are not received from inappropriate sources. Inappropriate sources include, but are not limited to, donors, grantors, persons, or organizations that may monetarily or substantively benefit from the purchase of goods or services by the department in furtherance of the prescription drug monitoring program.

(c) The direct-support organization shall operate under written contract with the department. The contract must, at a minimum, provide for:

1. Approval of the articles of incorporation and bylaws of the direct-support organization by the department.

2. Submission of an annual budget for the approval of the department.

3. The reversion, without penalty, to the department's grants and donations trust fund for the administration of the prescription drug monitoring program of all moneys and property held in trust by the direct-support organization for the benefit of the prescription drug monitoring program if the direct-support organization ceases to exist or if the contract is

terminated.

4. The fiscal year of the direct-support organization, which must begin July 1 of each year and end June 30 of the following year.

5. The disclosure of the material provisions of the contract to donors of gifts, contributions, or bequests, including such disclosure on all promotional and fundraising publications, and an explanation to such donors of the distinction between the department and the direct-support organization.

6. The direct-support organization's collecting, expending, and providing of funds to the department for the development, implementation, and operation of the prescription drug monitoring program as described in this section. The direct-support organization may collect and expend funds to be used for the functions of the direct-support organization's board of directors, as necessary and approved by the department. In addition, the direct-support organization may collect and provide funding to the department in furtherance of the prescription drug monitoring program by:

a. Establishing and administering the prescription drug monitoring program's electronic system, including hardware and software.

b. Conducting studies on the efficiency and effectiveness of the program to include feasibility studies as described in

subsection (13).

c. Providing funds for future enhancements of the program within the intent of this section.

d. Providing user training of the prescription drug monitoring program, including distribution of materials to promote public awareness and education and conducting workshops or other meetings, for health care practitioners, pharmacists, and others as appropriate.

e. Providing funds for travel expenses.

f. Providing funds for administrative costs, including personnel, audits, facilities, and equipment.

g. Fulfilling all other requirements necessary to implement and operate the program as outlined in this section.

7. Certification by the department that the direct-support organization is complying with the terms of the contract in a manner consistent with and in furtherance of the goals and purposes of the prescription drug monitoring program and in the best interests of the state. Such certification must be made annually and reported in the official minutes of a meeting of the direct-support organization.

(d) The activities of the direct-support organization must be consistent with the goals and mission of the department, as determined by the department, and in the best interests of the state. The direct-support organization must obtain written approval from the department for any activities in support of

the prescription drug monitoring program before undertaking those activities.

(e) The direct-support organization shall provide for an independent annual financial audit in accordance with s. 215.981. Copies of the audit shall be provided to the department and the Office of Policy and Budget in the Executive Office of the Governor.

(f) The direct-support organization may not exercise any power under s. 617.0302(12) or (16).

(g) The direct-support organization is not considered a lobbying firm within the meaning of s.11.045.

(h) The department may permit, without charge, appropriate use of administrative services, property, and facilities of the department by the direct-support organization, subject to this section. The use must be directly in keeping with the approved purposes of the direct-support organization and may not be made at times or places that would unreasonably interfere with opportunities for the public to use such facilities for established purposes. Any moneys received from rentals of facilities and properties managed by the department may be held in a separate depository account in the name of the direct-support organization and subject to the provisions of the letter of agreement with the department. The letter of agreement must provide that any funds held in the separate depository account in the name of the direct-support organization must revert to

the department if the direct-support organization is no longer approved by the department to operate in the best interests of the state.

(i) The department may adopt rules under s. 120.54 to govern the use of administrative services, property, or facilities of the department or office by the direct-support organization.

(j) The department may not permit the use of any administrative services, property, or facilities of the state by a direct-support organization if that organization does not provide equal membership and employment opportunities to all persons regardless of race, color, religion, gender, age, or national origin.

(k) This subsection is repealed October 1, 2027, unless reviewed and saved from repeal by the Legislature.

Section 10. Section 893.0551, Florida Statutes, is amended to read:

893.0551 Public records exemption for the prescription drug monitoring program.—

(1) For purposes of this section, the terms used in this section have the same meanings as provided in s. 893.055.

(2) The following information of a patient or patient's agent, a health care practitioner, a dispenser, an employee of the practitioner who is acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy that is

contained in records held by the department under s. 893.055 is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution:

(a) Name.

(b) Address.

(c) Telephone number.

(d) Insurance plan number.

(e) Government-issued identification number.

(f) Provider number.

(g) Drug Enforcement Administration number.

(h) Any other unique identifying information or number.

(3) The department shall disclose such ~~confidential and exempt~~ information to the following persons or entities upon request and after using a verification process to ensure the legitimacy of the request as provided in s. 893.055:

(a) A health care practitioner, or his or her designee, who certifies that the information is necessary to provide medical treatment to a current patient in accordance with ss. 893.05 and 893.055.

(b) An employee of the United States Department of Veterans Affairs, United States Department of Defense, or the Indian Health Service who provides health care services pursuant to such employment and who has the authority to prescribe controlled substances shall have access to the information in the program's system upon verification of such employment.

(c) The program manager and designated support staff for administration of the program, and to provide relevant information to the prescriber, dispenser, and appropriate law enforcement agencies, in accordance with s. 893.055.

(d) The department for investigations involving licensees authorized to prescribe or dispense controlled substances. The department may request information from the program but may not have direct access to its system. The department may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.

(e) ~~(a)~~ The Attorney General or his or her designee when working on Medicaid fraud cases involving prescribed controlled substances ~~prescription drugs~~ or when the Attorney General has initiated a review of specific identifiers of Medicaid fraud or specific identifiers that warrant a Medicaid investigation regarding prescribed controlled substances ~~prescription drugs~~. The Attorney General's Medicaid fraud investigators may not have direct access to the department's system ~~database~~. The Attorney General or his or her designee may disclose to a criminal justice agency, as defined in s. 119.011, only the ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for the information.

~~(b) The department's relevant health care regulatory boards responsible for the licensure, regulation, or discipline of a practitioner, pharmacist, or other person who is authorized to prescribe, administer, or dispense controlled substances and who is involved in a specific controlled substances investigation for prescription drugs involving a designated person. The health care regulatory boards may request information from the department but may not have direct access to its database. The health care regulatory boards may provide to a law enforcement agency pursuant to ss. 456.066 and 456.073 only information that is relevant to the specific controlled substances investigation that prompted the request for the information.~~

(f) ~~(c)~~ A law enforcement agency that has initiated an active investigation involving a specific violation of law regarding prescription drug abuse or diversion of prescribed controlled substances and that has entered into a user agreement with the department. A law enforcement agency may request information from the department but may not have direct access to its system ~~database~~. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that prompted the request for such information.

(g) A medical examiner or associate medical examiner, as

defined in s 406.06, pursuant to his or her official duties, as required by s. 406.11, to determine the cause of death of an individual. A medical examiner may request information from the department but may not have direct access to the system.

~~(f) A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(7)(c)4.~~

(h) An impaired practitioner consultant who has been authorized in writing by a participant in, or by a referral to, the impaired practitioner program to access and review information as provided in s. 893.055(6)(e) ~~893.055(7)(c)5.~~

(i) ~~(f)~~ A patient or the legal guardian or designated health care surrogate for an incapacitated patient, if applicable, making a request as provided in s. 893.055(6)(f) ~~893.055(7)(c)4~~.

(4) If the department determines consistent with its rules that a pattern of controlled substance abuse exists, the department may disclose such confidential and exempt information to the applicable law enforcement agency in accordance with s. 893.055. The law enforcement agency may disclose to a criminal justice agency, as defined in s. 119.011, only ~~confidential and exempt~~ information received from the department that is relevant to an identified active investigation that is specific to a violation of s. 893.13(7)(a)8., s. 893.13(8)(a), or s. 893.13(8)(b).

(5) Before disclosing ~~confidential and exempt~~ information to a criminal justice agency or a law enforcement agency pursuant to this section, the disclosing person or entity must take steps to ensure the continued confidentiality of all ~~confidential and exempt~~ information. At a minimum, these steps must include redacting any nonrelevant information.

(6) An agency or person who obtains any ~~confidential and exempt~~ information pursuant to this section must maintain the confidential and exempt status of that information and may not disclose such information unless authorized by law. Information shared with a state attorney pursuant to paragraph (3)(e) ~~(3)(a)~~ or paragraph (3)(f) ~~(3)(c)~~ may be released only in response to a discovery demand if such information is directly related to the criminal case for which the information was requested. Unrelated information may be released only upon an order of a court of competent jurisdiction.

(7) A person who willfully and knowingly violates this section commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Section 11. Paragraphs (pp) and (qq) of subsection (1) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.—

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

(pp) Applicable to a licensee who serves as the designated physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or

of the United States which relates to the practice of, or the ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 458.3265(3) ~~458.3265(2)~~.

(qq) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 458.3265(3) ~~458.3265(2)~~.

Section 12. Paragraphs (rr) and (ss) of subsection (1) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.—

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

(rr) Applicable to a licensee who serves as the designated

physician of a pain-management clinic as defined in s. 458.3265 or s. 459.0137:

1. Registering a pain-management clinic through misrepresentation or fraud;

2. Procuring, or attempting to procure, the registration of a pain-management clinic for any other person by making or causing to be made, any false representation;

3. Failing to comply with any requirement of chapter 499, the Florida Drug and Cosmetic Act; 21 U.S.C. ss. 301-392, the Federal Food, Drug, and Cosmetic Act; 21 U.S.C. ss. 821 et seq., the Drug Abuse Prevention and Control Act; or chapter 893, the Florida Comprehensive Drug Abuse Prevention and Control Act;

4. Being convicted or found guilty of, regardless of adjudication to, a felony or any other crime involving moral turpitude, fraud, dishonesty, or deceit in any jurisdiction of the courts of this state, of any other state, or of the United States;

5. Being convicted of, or disciplined by a regulatory agency of the Federal Government or a regulatory agency of another state for, any offense that would constitute a violation of this chapter;

6. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to the practice of, or the

ability to practice, a licensed health care profession;

7. Being convicted of, or entering a plea of guilty or nolo contendere to, regardless of adjudication, a crime in any jurisdiction of the courts of this state, of any other state, or of the United States which relates to health care fraud;

8. Dispensing any medicinal drug based upon a communication that purports to be a prescription as defined in s. 465.003(14) or s. 893.02 if the dispensing practitioner knows or has reason to believe that the purported prescription is not based upon a valid practitioner-patient relationship; or

9. Failing to timely notify the board of the date of his or her termination from a pain-management clinic as required by s. 459.0137(3) ~~459.0137(2)~~.

(ss) Failing to timely notify the department of the theft of prescription blanks from a pain-management clinic or a breach of other methods for prescribing within 24 hours as required by s. 459.0137(3) ~~459.0137(2)~~.

Section 13. Paragraph (b) of subsection (4) of section 463.0055, Florida Statutes, is amended to read:

463.0055 Administration and prescription of ocular pharmaceutical agents.—

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

certified optometrist may not administer or prescribe:

(b) A controlled substance for the treatment of chronic nonmalignant pain as defined in s. 456.44(1)(f) ~~456.44(1)(e)~~.

Section 14. Paragraph (a) of subsection (1) of section 782.04, Florida Statutes, is amended to read:

782.04 Murder.—

(1)(a) The unlawful killing of a human being:

1. When perpetrated from a premeditated design to effect the death of the person killed or any human being;

2. When committed by a person engaged in the perpetration of, or in the attempt to perpetrate, any:

a. Trafficking offense prohibited by s. 893.135(1),

b. Arson,

c. Sexual battery,

d. Robbery,

e. Burglary,

f. Kidnapping,

g. Escape,

h. Aggravated child abuse,

i. Aggravated abuse of an elderly person or disabled adult,

j. Aircraft piracy,

k. Unlawful throwing, placing, or discharging of a destructive device or bomb,

l. Carjacking,

m. Home-invasion robbery,

n. Aggravated stalking,

o. Murder of another human being,

p. Resisting an officer with violence to his or her person,

q. Aggravated fleeing or eluding with serious bodily injury or death,

r. Felony that is an act of terrorism or is in furtherance of an act of terrorism, including a felony under s. 775.30, s. 775.32, s. 775.33, s. 775.34, or s. 775.35, or

s. Human trafficking; or

3. Which resulted from the unlawful distribution by a person 18 years of age or older of any of the following substances, or mixture containing any of the following substances, when such substance or mixture is proven to be the proximate cause of the death of the user:

a. A substance controlled under s. 893.03(1);

b. Cocaine, as described in s. 893.03(2)(a)4.;

c. Opium or any synthetic or natural salt, compound, derivative, or preparation of opium;

d. Methadone;

e. Alfentanil, as described in s. 893.03(2)(b)1.;

f. Carfentanil, as described in s. 893.03(2)(b)6.;

g. Fentanyl, as described in s. 893.03(2)(b)9.;

h. Sufentanil, as described in s. 893.03(2)(b)30.

~~893.03(2)(b)29.~~; or

i. A controlled substance analog, as described in s. 893.0356, of any substance specified in sub-subparagraphs a.-h.,

is murder in the first degree and constitutes a capital felony, punishable as provided in s. 775.082.

Section 15. Paragraphs (a), (c), (d), (e), (f), and (h) of subsection (1), subsection (2), paragraphs (a) and (b) of subsection (4), and subsection (5) of section 893.13, Florida Statutes, are amended to read:

893.13 Prohibited acts; penalties.—

(1)(a) Except as authorized by this chapter and chapter 499, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s.

893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(c) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302 or a public or private elementary, middle, or secondary school between the hours of 6 a.m. and 12 midnight, or at any time in, on, or within 1,000 feet of real property comprising a state, county, or municipal park, a community center, or a publicly owned recreational facility. As used in this paragraph, the term "community center" means a facility operated by a nonprofit community-based organization for the provision of recreational, social, or educational services to the public. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084. The defendant must be sentenced to a minimum term of imprisonment of 3 calendar years unless the offense was committed within 1,000 feet of the real property comprising a child care facility as defined in s. 402.302.

2. A controlled substance named or described in s.

893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

This paragraph does not apply to a child care facility unless the owner or operator of the facility posts a sign that is not less than 2 square feet in size with a word legend identifying the facility as a licensed child care facility and that is posted on the property of the child care facility in a conspicuous place where the sign is reasonably visible to the public.

(d) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public or private college, university, or other postsecondary educational institution. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5.

~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(e) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance not authorized by law in, on, or within 1,000 feet of a physical place for worship at which a church or religious organization regularly conducts religious services or within 1,000 feet of a convenience business as defined in s. 812.171. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,

(2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(f) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising a public housing facility at any time. As used in this section, the term "real property comprising a public housing facility" means real property, as defined in s. 421.03(12), of a public corporation created as a housing authority pursuant to part I of chapter 421. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(h) Except as authorized by this chapter, a person may not sell, manufacture, or deliver, or possess with intent to sell, manufacture, or deliver, a controlled substance in, on, or within 1,000 feet of the real property comprising an assisted living facility, as that term is used in chapter 429. A person who violates this paragraph with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. Any other controlled substance, except as lawfully sold, manufactured, or delivered, must be sentenced to pay a $500 fine and to serve 100 hours of public service in addition to any other penalty prescribed by law.

(2)(a) Except as authorized by this chapter and chapter 499, a person may not purchase, or possess with intent to

purchase, a controlled substance. A person who violates this provision with respect to:

1. A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

2. A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

3. A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(b) Except as provided in this chapter, a person may not purchase more than 10 grams of any substance named or described in s. 893.03(1)(a) or (1)(b), or any combination thereof, or any mixture containing any such substance. A person who violates this paragraph commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(4) Except as authorized by this chapter, a person 18 years of age or older may not deliver any controlled substance to a person younger than 18 years of age, use or hire a person younger than 18 years of age as an agent or employee in the sale or delivery of such a substance, or use such person to assist in

avoiding detection or apprehension for a violation of this chapter. A person who violates this subsection with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

Imposition of sentence may not be suspended or deferred, and the person so convicted may not be placed on probation.

(5) A person may not bring into this state any controlled substance unless the possession of such controlled substance is authorized by this chapter or unless such person is licensed to do so by the appropriate federal agency. A person who violates this provision with respect to:

(a) A controlled substance named or described in s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ commits a felony of the second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(b) A controlled substance named or described in s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6.,

(2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) commits a felony of the third degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(c) A controlled substance named or described in s. 893.03(5) commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

Section 16. Paragraphs (c) and (f) of subsection (1) of section 893.135, Florida Statutes, are amended to read:

893.135 Trafficking; mandatory sentences; suspension or reduction of sentences; conspiracy to engage in trafficking.—

(1) Except as authorized in this chapter or in chapter 499 and notwithstanding the provisions of s. 893.13:

(c)1. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of any morphine, opium, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 4 grams or more of any mixture containing any such substance, but less than 30 kilograms of such substance or mixture, commits a felony of the first degree, which felony shall be known as "trafficking in illegal drugs," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 4 grams or more, but less than 14 grams, such person

shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $100,000.

c. Is 28 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $500,000.

2. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of hydrocodone, as described in s. 893.03(2)(a)1.k. ~~893.03(2)(a)1.j.~~, codeine, as described in s. 893.03(2)(a)1.g., or any salt thereof, or 14 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in hydrocodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 50 grams, such

person shall be sentenced to a mandatory minimum term of imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 50 grams or more, but less than 200 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 200 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

3. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 7 grams or more of oxycodone, as described in s. 893.03(2)(a)1.q. ~~893.03(2)(a)1.o.~~, or any salt thereof, or 7 grams or more of any mixture containing any such substance, commits a felony of the first degree, which felony shall be known as "trafficking in oxycodone," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 7 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years and shall be ordered to pay a fine of $50,000.

b. Is 14 grams or more, but less than 25 grams, such person shall be sentenced to a mandatory minimum term of

imprisonment of 7 years and shall be ordered to pay a fine of $100,000.

c. Is 25 grams or more, but less than 100 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years and shall be ordered to pay a fine of $500,000.

d. Is 100 grams or more, but less than 30 kilograms, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years and shall be ordered to pay a fine of $750,000.

4.a. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 4 grams or more of:

(I) Alfentanil, as described in s. 893.03(2)(b)1.;

(II) Carfentanil, as described in s. 893.03(2)(b)6.;

(III) Fentanyl, as described in s. 893.03(2)(b)9.;

(IV) Sufentanil, as described in s. 893.03(2)(b)30. ~~893.03(2)(b)29.~~;

(V) A fentanyl derivative, as described in s. 893.03(1)(a)62.;

(VI) A controlled substance analog, as described in s. 893.0356, of any substance described in sub-sub-subparagraphs (I)-(V); or

(VII) A mixture containing any substance described in sub-

sub-subparagraphs (I)-(VI),

commits a felony of the first degree, which felony shall be known as "trafficking in fentanyl," punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

b. If the quantity involved under sub-subparagraph a.:

(I) Is 4 grams or more, but less than 14 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and shall be ordered to pay a fine of $50,000.

(II) Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 years, and shall be ordered to pay a fine of $100,000.

(III) Is 28 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 25 years, and shall be ordered to pay a fine of $500,000.

5. A person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 30 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or 30 kilograms or more of any mixture containing any such substance, commits the

first degree felony of trafficking in illegal drugs. A person who has been convicted of the first degree felony of trafficking in illegal drugs under this subparagraph shall be punished by life imprisonment and is ineligible for any form of discretionary early release except pardon or executive clemency or conditional medical release under s. 947.149. However, if the court determines that, in addition to committing any act specified in this paragraph:

a. The person intentionally killed an individual or counseled, commanded, induced, procured, or caused the intentional killing of an individual and such killing was the result; or

b. The person's conduct in committing that act led to a natural, though not inevitable, lethal result,

such person commits the capital felony of trafficking in illegal drugs, punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

6. A person who knowingly brings into this state 60 kilograms or more of any morphine, opium, oxycodone, hydrocodone, codeine, hydromorphone, or any salt, derivative, isomer, or salt of an isomer thereof, including heroin, as described in s. 893.03(1)(b), (2)(a), (3)(c)3., or (3)(c)4., or

60 kilograms or more of any mixture containing any such substance, and who knows that the probable result of such importation would be the death of a person, commits capital importation of illegal drugs, a capital felony punishable as provided in ss. 775.082 and 921.142. A person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

(f)1. Any person who knowingly sells, purchases, manufactures, delivers, or brings into this state, or who is knowingly in actual or constructive possession of, 14 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment utilized in the manufacture of amphetamine or methamphetamine, commits a felony of the first degree, which felony shall be known as "trafficking in amphetamine," punishable as provided in s. 775.082, s. 775.083, or s. 775.084. If the quantity involved:

a. Is 14 grams or more, but less than 28 grams, such person shall be sentenced to a mandatory minimum term of imprisonment of 3 years, and the defendant shall be ordered to pay a fine of $50,000.

b. Is 28 grams or more, but less than 200 grams, such

person shall be sentenced to a mandatory minimum term of imprisonment of 7 years, and the defendant shall be ordered to pay a fine of $100,000.

c. Is 200 grams or more, such person shall be sentenced to a mandatory minimum term of imprisonment of 15 calendar years and pay a fine of $250,000.

2. Any person who knowingly manufactures or brings into this state 400 grams or more of amphetamine, as described in s. 893.03(2)(c)2., or methamphetamine, as described in s. 893.03(2)(c)5. ~~893.03(2)(c)4.~~, or of any mixture containing amphetamine or methamphetamine, or phenylacetone, phenylacetic acid, pseudoephedrine, or ephedrine in conjunction with other chemicals and equipment used in the manufacture of amphetamine or methamphetamine, and who knows that the probable result of such manufacture or importation would be the death of any person commits capital manufacture or importation of amphetamine, a capital felony punishable as provided in ss. 775.082 and 921.142. Any person sentenced for a capital felony under this paragraph shall also be sentenced to pay the maximum fine provided under subparagraph 1.

Section 17. Paragraphs (b), (c), and (e) of subsection (3) of section 921.0022, Florida Statutes, are amended to read:

921.0022 Criminal Punishment Code; offense severity ranking chart.—

(3) OFFENSE SEVERITY RANKING CHART

(b) LEVEL 2

Florida Statute	Felony Degree	Description
379.2431 (1)(e)3.	3rd	Possession of 11 or fewer marine turtle eggs in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)4.	3rd	Possession of more than 11 marine turtle eggs in violation of the Marine Turtle Protection Act.
403.413(6)(c)	3rd	Dumps waste litter exceeding 500 lbs. in weight or 100 cubic feet in volume or any quantity for commercial purposes, or hazardous waste.
517.07(2)	3rd	Failure to furnish a prospectus meeting requirements.
590.28(1)	3rd	Intentional burning of lands.

784.05(3)	3rd	Storing or leaving a loaded firearm within reach of minor who uses it to inflict injury or death.
787.04(1)	3rd	In violation of court order, take, entice, etc., minor beyond state limits.
806.13(1)(b)3.	3rd	Criminal mischief; damage $1,000 or more to public communication or any other public service.
810.061(2)	3rd	Impairing or impeding telephone or power to a dwelling; facilitating or furthering burglary.
810.09(2)(e)	3rd	Trespassing on posted commercial horticulture property.
812.014(2)(c)1.	3rd	Grand theft, 3rd degree; $300

			or more but less than $5,000.
2187			
	812.014(2)(d)	3rd	Grand theft, 3rd degree; $100 or more but less than $300, taken from unenclosed curtilage of dwelling.
2188			
	812.015(7)	3rd	Possession, use, or attempted use of an antishoplifting or inventory control device countermeasure.
2189			
	817.234(1)(a)2.	3rd	False statement in support of insurance claim.
2190			
	817.481(3)(a)	3rd	Obtain credit or purchase with false, expired, counterfeit, etc., credit card, value over $300.
2191			
	817.52(3)	3rd	Failure to redeliver hired vehicle.
2192			
	817.54	3rd	With intent to defraud, obtain mortgage note, etc., by false

		representation.
817.60(5)	3rd	Dealing in credit cards of another.
817.60(6)(a)	3rd	Forgery; purchase goods, services with false card.
817.61	3rd	Fraudulent use of credit cards over $100 or more within 6 months.
826.04	3rd	Knowingly marries or has sexual intercourse with person to whom related.
831.01	3rd	Forgery.
831.02	3rd	Uttering forged instrument; utters or publishes alteration with intent to defraud.
831.07	3rd	Forging bank bills, checks, drafts, or promissory notes.

831.08	3rd	Possessing 10 or more forged notes, bills, checks, or drafts.
831.09	3rd	Uttering forged notes, bills, checks, drafts, or promissory notes.
831.11	3rd	Bringing into the state forged bank bills, checks, drafts, or notes.
832.05(3)(a)	3rd	Cashing or depositing item with intent to defraud.
843.08	3rd	False personation.
893.13(2)(a)2.	3rd	Purchase of any s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs other than cannabis.
893.147(2)	3rd	Manufacture or delivery of drug

paraphernalia.

(c) LEVEL 3

Florida Statute	Felony Degree	Description
119.10(2)(b)	3rd	Unlawful use of confidential information from police reports.
316.066 (3)(b)-(d)	3rd	Unlawfully obtaining or using confidential crash reports.
316.193(2)(b)	3rd	Felony DUI, 3rd conviction.
316.1935(2)	3rd	Fleeing or attempting to elude law enforcement officer in patrol vehicle with siren and lights activated.
319.30(4)	3rd	Possession by junkyard of motor vehicle with identification number plate removed.

319.33(1)(a)	3rd	Alter or forge any certificate of title to a motor vehicle or mobile home.
319.33(1)(c)	3rd	Procure or pass title on stolen vehicle.
319.33(4)	3rd	With intent to defraud, possess, sell, etc., a blank, forged, or unlawfully obtained title or registration.
327.35(2)(b)	3rd	Felony BUI.
328.05(2)	3rd	Possess, sell, or counterfeit fictitious, stolen, or fraudulent titles or bills of sale of vessels.
328.07(4)	3rd	Manufacture, exchange, or possess vessel with counterfeit or wrong ID number.
376.302(5)	3rd	Fraud related to reimbursement for cleanup expenses under the

			Inland Protection Trust Fund.
379.2431 (1)(e)5.		3rd	Taking, disturbing, mutilating, destroying, causing to be destroyed, transferring, selling, offering to sell, molesting, or harassing marine turtles, marine turtle eggs, or marine turtle nests in violation of the Marine Turtle Protection Act.
379.2431 (1)(e)6.		3rd	Possessing any marine turtle species or hatchling, or parts thereof, or the nest of any marine turtle species described in the Marine Turtle Protection Act.
379.2431 (1)(e)7.		3rd	Soliciting to commit or conspiring to commit a violation of the Marine Turtle Protection Act.
400.9935(4)(a)		3rd	Operating a clinic, or offering

or (b)		services requiring licensure, without a license.
400.9935(4)(e)	3rd	Filing a false license application or other required information or failing to report information.
440.1051(3)	3rd	False report of workers' compensation fraud or retaliation for making such a report.
501.001(2)(b)	2nd	Tampers with a consumer product or the container using materially false/misleading information.
624.401(4)(a)	3rd	Transacting insurance without a certificate of authority.
624.401(4)(b)1.	3rd	Transacting insurance without a certificate of authority; premium collected less than $20,000.

626.902(1)(a) & (b)	3rd	Representing an unauthorized insurer.
697.08	3rd	Equity skimming.
790.15(3)	3rd	Person directs another to discharge firearm from a vehicle.
806.10(1)	3rd	Maliciously injure, destroy, or interfere with vehicles or equipment used in firefighting.
806.10(2)	3rd	Interferes with or assaults firefighter in performance of duty.
810.09(2)(c)	3rd	Trespass on property other than structure or conveyance armed with firearm or dangerous weapon.
812.014(2)(c)2.	3rd	Grand theft; $5,000 or more but less than $10,000.

812.0145(2)(c)	3rd	Theft from person 65 years of age or older; $300 or more but less than $10,000.
815.04(5)(b)	2nd	Computer offense devised to defraud or obtain property.
817.034(4)(a)3.	3rd	Engages in scheme to defraud (Florida Communications Fraud Act), property valued at less than $20,000.
817.233	3rd	Burning to defraud insurer.
817.234 (8)(b) & (c)	3rd	Unlawful solicitation of persons involved in motor vehicle accidents.
817.234(11)(a)	3rd	Insurance fraud; property value less than $20,000.
817.236	3rd	Filing a false motor vehicle insurance application.

817.2361	3rd	Creating, marketing, or presenting a false or fraudulent motor vehicle insurance card.
817.413(2)	3rd	Sale of used goods as new.
828.12(2)	3rd	Tortures any animal with intent to inflict intense pain, serious physical injury, or death.
831.28(2)(a)	3rd	Counterfeiting a payment instrument with intent to defraud or possessing a counterfeit payment instrument.
831.29	2nd	Possession of instruments for counterfeiting driver licenses or identification cards.
838.021(3)(b)	3rd	Threatens unlawful harm to public servant.
843.19	3rd	Injure, disable, or kill police

			dog or horse.
2252			
	860.15(3)	3rd	Overcharging for repairs and parts.
2253			
	870.01(2)	3rd	Riot; inciting or encouraging.
2254			
	893.13(1)(a)2.	3rd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs).
2255			
	893.13(1)(d)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of university.
2256			
	893.13(1)(f)2.	2nd	Sell, manufacture, or deliver s. 893.03(1)(c), (2)(c)1.,

			(2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs within 1,000 feet of public housing facility.
2257			
	893.13(4)(c)	3rd	Use or hire of minor; deliver to minor other controlled substances.
2258			
	893.13(6)(a)	3rd	Possession of any controlled substance other than felony possession of cannabis.
2259			
	893.13(7)(a)8.	3rd	Withhold information from practitioner regarding previous receipt of or prescription for a controlled substance.
2260			
	893.13(7)(a)9.	3rd	Obtain or attempt to obtain controlled substance by fraud, forgery, misrepresentation, etc.
2261			
	893.13(7)(a)10.	3rd	Affix false or forged label to

			package of controlled substance.
2262			
	893.13(7)(a)11.	3rd	Furnish false or fraudulent material information on any document or record required by chapter 893.
2263			
	893.13(8)(a)1.	3rd	Knowingly assist a patient, other person, or owner of an animal in obtaining a controlled substance through deceptive, untrue, or fraudulent representations in or related to the practitioner's practice.
2264			
	893.13(8)(a)2.	3rd	Employ a trick or scheme in the practitioner's practice to assist a patient, other person, or owner of an animal in obtaining a controlled substance.
2265			
	893.13(8)(a)3.	3rd	Knowingly write a prescription

		for a controlled substance for a fictitious person.
893.13(8)(a)4.	3rd	Write a prescription for a controlled substance for a patient, other person, or an animal if the sole purpose of writing the prescription is a monetary benefit for the practitioner.
918.13(1)(a)	3rd	Alter, destroy, or conceal investigation evidence.
944.47 (1)(a)1. & 2.	3rd	Introduce contraband to correctional facility.
944.47(1)(c)	2nd	Possess contraband while upon the grounds of a correctional institution.
985.721	3rd	Escapes from a juvenile facility (secure detention or residential commitment facility).

(e) LEVEL 5

Florida Statute	Felony Degree	Description
316.027(2)(a)	3rd	Accidents involving personal injuries other than serious bodily injury, failure to stop; leaving scene.
316.1935(4)(a)	2nd	Aggravated fleeing or eluding.
316.80(2)	2nd	Unlawful conveyance of fuel; obtaining fuel fraudulently.
322.34(6)	3rd	Careless operation of motor vehicle with suspended license, resulting in death or serious bodily injury.
327.30(5)	3rd	Vessel accidents involving personal injury; leaving scene.
379.365(2)(c)1.	3rd	Violation of rules relating to:

			willful molestation of stone crab traps, lines, or buoys; illegal bartering, trading, or sale, conspiring or aiding in such barter, trade, or sale, or supplying, agreeing to supply, aiding in supplying, or giving away stone crab trap tags or certificates; making, altering, forging, counterfeiting, or reproducing stone crab trap tags; possession of forged, counterfeit, or imitation stone crab trap tags; and engaging in the commercial harvest of stone crabs while license is suspended or revoked.
2280			
	379.367(4)	3rd	Willful molestation of a commercial harvester's spiny lobster trap, line, or buoy.
2281			
	379.407(5)(b)3.	3rd	Possession of 100 or more undersized spiny lobsters.
2282			

381.0041(11)(b)	3rd	Donate blood, plasma, or organs knowing HIV positive.
440.10(1)(g)	2nd	Failure to obtain workers' compensation coverage.
440.105(5)	2nd	Unlawful solicitation for the purpose of making workers' compensation claims.
440.381(2)	2nd	Submission of false, misleading, or incomplete information with the purpose of avoiding or reducing workers' compensation premiums.
624.401(4)(b)2.	2nd	Transacting insurance without a certificate or authority; premium collected $20,000 or more but less than $100,000.
626.902(1)(c)	2nd	Representing an unauthorized insurer; repeat offender.
790.01(2)	3rd	Carrying a concealed firearm.

790.162	2nd	Threat to throw or discharge destructive device.
790.163(1)	2nd	False report of bomb, explosive, weapon of mass destruction, or use of firearms in violent manner.
790.221(1)	2nd	Possession of short-barreled shotgun or machine gun.
790.23	2nd	Felons in possession of firearms, ammunition, or electronic weapons or devices.
796.05(1)	2nd	Live on earnings of a prostitute; 1st offense.
800.04(6)(c)	3rd	Lewd or lascivious conduct; offender less than 18 years of age.
800.04(7)(b)	2nd	Lewd or lascivious exhibition; offender 18 years of age or

			older.
2296			
	806.111(1)	3rd	Possess, manufacture, or dispense fire bomb with intent to damage any structure or property.
2297			
	812.0145(2)(b)	2nd	Theft from person 65 years of age or older; $10,000 or more but less than $50,000.
2298			
	812.015(8)	3rd	Retail theft; property stolen is valued at $300 or more and one or more specified acts.
2299			
	812.019(1)	2nd	Stolen property; dealing in or trafficking in.
2300			
	812.131(2)(b)	3rd	Robbery by sudden snatching.
2301			
	812.16(2)	3rd	Owning, operating, or conducting a chop shop.
2302			
	817.034(4)(a)2.	2nd	Communications fraud, value $20,000 to $50,000.

817.234(11)(b)	2nd	Insurance fraud; property value $20,000 or more but less than $100,000.
817.2341(1), (2)(a) & (3)(a)	3rd	Filing false financial statements, making false entries of material fact or false statements regarding property values relating to the solvency of an insuring entity.
817.568(2)(b)	2nd	Fraudulent use of personal identification information; value of benefit, services received, payment avoided, or amount of injury or fraud, $5,000 or more or use of personal identification information of 10 or more persons.
817.611(2)(a)	2nd	Traffic in or possess 5 to 14 counterfeit credit cards or related documents.

817.625(2)(b)	2nd	Second or subsequent fraudulent use of scanning device, skimming device, or reencoder.
825.1025(4)	3rd	Lewd or lascivious exhibition in the presence of an elderly person or disabled adult.
827.071(4)	2nd	Possess with intent to promote any photographic material, motion picture, etc., which includes sexual conduct by a child.
827.071(5)	3rd	Possess, control, or intentionally view any photographic material, motion picture, etc., which includes sexual conduct by a child.
839.13(2)(b)	2nd	Falsifying records of an individual in the care and custody of a state agency involving great bodily harm or

			death.
2312			
	843.01	3rd	Resist officer with violence to person; resist arrest with violence.
2313			
	847.0135(5)(b)	2nd	Lewd or lascivious exhibition using computer; offender 18 years or older.
2314			
	847.0137 (2) & (3)	3rd	Transmission of pornography by electronic device or equipment.
2315			
	847.0138 (2) & (3)	3rd	Transmission of material harmful to minors to a minor by electronic device or equipment.
2316			
	874.05(1)(b)	2nd	Encouraging or recruiting another to join a criminal gang; second or subsequent offense.
2317			
	874.05(2)(a)	2nd	Encouraging or recruiting person under 13 years of age to join a criminal gang.

893.13(1)(a)1.	2nd	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs).
893.13(1)(c)2.	2nd	Sell, manufacture, or deliver cannabis (or other s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) drugs) within 1,000 feet of a child care facility, school, or state, county, or municipal park or publicly owned recreational facility or community center.
893.13(1)(d)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000

		feet of university.
893.13(1)(e)2.	2nd	Sell, manufacture, or deliver cannabis or other drug prohibited under s. 893.03(1)(c), (2)(c)1., (2)(c)2., (2)(c)3., ~~(2)(c)5.,~~ (2)(c)6., (2)(c)7., (2)(c)8., (2)(c)9., (2)(c)10., (3), or (4) within 1,000 feet of property used for religious services or a specified business site.
893.13(1)(f)1.	1st	Sell, manufacture, or deliver cocaine (or other s. 893.03(1)(a), (1)(b), (1)(d), or (2)(a), (2)(b), or (2)(c)5. ~~(2)(c)4.~~ drugs) within 1,000 feet of public housing facility.
893.13(4)(b)	2nd	Use or hire of minor; deliver to minor other controlled substance.

893.1351(1)	3rd	Ownership, lease, or rental for trafficking in or manufacturing of controlled substance.

Section 18. Except as otherwise provided in this act, this act shall take effect July 1, 2018.

A bill to be entitled

An act relating to deaths resulting from apparent drug overdoses; providing a short title; amending s. 893.0301, F.S.; providing additional requirements for reports of deaths resulting from apparent drug overdoses; providing an effective date.

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

Section 1. This act may be cited as "Devin's Law."

Section 2. Section 893.0301, Florida Statutes, is amended to read:

893.0301 Death resulting from apparent drug overdose; reporting requirements.—If a person dies of an apparent drug overdose:

(1) A law enforcement agency shall prepare a report identifying each ~~prescribed~~ controlled substance listed in Schedule I, Schedule II, Schedule III, or Schedule IV of s. 893.03 which is found on or near the deceased or among the deceased's possessions. The report must identify the person who prescribed or delivered the controlled substance, if known or ascertainable. Thereafter, the law enforcement agency shall classify the death as a "suspicious death" or a "death investigation," absent any mitigating circumstances, and submit a copy of the report to the medical examiner. Mitigating

circumstances shall be considered if the decedent is found to have lawfully obtained the controlled substance or substances that contributed to the death.

(2) A medical examiner who is preparing a report pursuant to s. 406.11 shall include in the report information identifying each ~~prescribed~~ controlled substance listed in Schedule I, Schedule II, Schedule III, or Schedule IV of s. 893.03 that was found in, on, or near the deceased or among the deceased's possessions, as well as the classification of death found by the reporting law enforcement agency.

Section 3. This act shall take effect July 1, 2018.

A bill to be entitled

An act relating to nursing homes and related health care facilities; creating s. 366.042, F.S.; requiring the Florida Public Service Commission to ensure that public utilities effectively prioritize the restoration of services to certain health care facilities in the event of emergencies; amending s. 366.15, F.S.; deleting a provision specifying that noncompliance with certain provisions related to medically essential electric public utility service does not form the basis for a cause of action against a public utility; deleting a provision specifying that a public utility's failure to comply with certain obligations does not constitute negligence; amending s. 400.0060, F.S.; defining the term "autonomy"; amending s. 400.0063, F.S.; establishing an Office of the State Long-Term Care Ombudsman within the Department of Elderly Affairs to administer the State Long-Term Care Ombudsman Program; requiring the office to contract with or make a grant to a private nonprofit organization to manage the day-to-day operations of the program; providing that the office is not responsible for the licensing or certification of long-term care facilities and prohibiting the office from having a relationship with such

facilities; revising the appointment and removal processes for the state ombudsman; requiring the state ombudsman and the office's legal advocate to register as lobbyists; expanding the duties of the legal advocate to include assisting the state ombudsman with certain tasks related to the autonomy of the program; amending s. 400.0065, F.S.; providing that a purpose of the State Long-Term Care Ombudsman Program is to support, rather than to administer, the state and local councils; revising requirements for the annual report required to be prepared by the State Long-Term Care Ombudsman; amending s. 400.0067, F.S.; revising the membership of the State Long-Term Care Ombudsman Council; revising the number of consecutive terms that may be served by the chair of the state council; amending s. 400.0069, F.S.; requiring each state long-term care ombudsman district to convene a public meeting at least monthly, rather than quarterly; requiring representatives of the program, upon an affirmative vote of the state council, to comment on certain existing and proposed rules, regulations, and policies; amending s. 400.0073, F.S.; authorizing state and local councils to hold public hearings related to certain investigations; requiring the legal advocate to pursue legal remedies under certain

circumstances; amending s. 400.0074, F.S.; requiring that onsite administrative assessments include the review of the facility's emergency management plan; authorizing the office's legal advocate to pursue legal remedies for certain violations; requiring, rather than authorizing, the department to adopt rules implementing procedures for conducting onsite administrative assessments of long-term care facilities; amending s. 400.0077, F.S.; specifying that the public discussion of administrative assessments before the council is open to the public and subject to ch. 119 and s. 286.011, F.S.; amending s. 400.0078, F.S.; requiring the State Long-Term Care Ombudsman Program to create and make available a poster that contains certain information; requiring each long-term care facility to display the State Long-Term Care Ombudsman Program poster; creating s. 400.008, F.S.; providing legislative intent; requiring the Office of the State Long-Term Care Ombudsman to conduct unannounced quality-of-care evaluations of certain health and long-term care facilities; providing civil immunity from liability for certain personnel of the office who participate in evaluations; amending s. 400.0081, F.S.; requiring long-term care facilities to timely provide to the

program, upon request, copies of records, policies, or documents needed to complete an investigation or assessment; requiring, rather than authorizing, the department, to adopt rules to establish procedures to ensure access to facilities, residents, and records; amending s. 400.0083, F.S.; revising a penalty; requiring the Office of the State Long-Term Care Ombudsman to investigate certain alleged violations; requiring the office to report to the Agency for Health Care Administration if it is determined that a violation occurred; requiring the agency to impose a fine for certain instances of interference with or retaliation against the State Long-Term Care Ombudsman program; requiring the agency to collect and transfer fines into the Quality of Long-Term Care Facility Improvement Trust Fund; requiring that the Division of Administrative Hearings conduct a hearing if a determination of a violation is contested; requiring the division to adopt rules; requiring the administrative law judge to render a decision within 90 days after a hearing; requiring the Chief Inspector General to investigate any willful agency interference with the State Long-Term Care Ombudsman Program; amending s. 400.0087, F.S.; requiring the nonprofit organization responsible for the day-to-day operations

of the State Long-Term Care Ombudsman Program to consult with the state ombudsman in developing and submitting a budget to the department; limiting to a specified percentage the amount that the department may divert from the federal ombudsman appropriation to cover administrative costs associated with the State Long-Term Care Ombudsman Program; amending s. 400.0089, F.S.; specifying the information that must be included in quarterly reports required to be made by the State Long-Term Care Ombudsman Program; requiring the State Long-Term Care Ombudsman Program to include an analysis of such information in an annual report; amending s. 400.0091, F.S.; revising the subject areas that must be addressed in the curriculum for initial and continuing education training provided to representatives of the State Long-Term Care Ombudsman Program; creating s. 400.0223, F.S.; defining the term "electronic monitoring device"; requiring nursing homes to allow residents, and certain individuals on their behalf, to monitor the residents' rooms through the use of electronic monitoring devices; requiring nursing homes to require persons who conduct such monitoring to post a specific notice on the door to the residents' rooms; providing that such monitoring is voluntary and may be

conducted only at the request and expense of residents or certain individuals on their behalf; prohibiting nursing homes from making certain inquiries of prospective residents or of the representatives of prospective residents; prohibiting nursing homes from rejecting applications for residency or removing residents because of intent to use or use of electronic monitoring devices; requiring nursing homes to inform residents and specified individuals of the resident's right to conduct electronic monitoring; requiring nursing homes to make reasonable physical accommodations for electronic monitoring and to provide a place for mounting and access to a power source; authorizing nursing homes to require that electronic monitoring be conducted in plain view; authorizing nursing homes to require that a request to conduct electronic monitoring be made in writing; providing that audio or video recordings created through the use of electronic monitoring may be admitted into evidence in court or administrative proceedings; providing criminal penalties for nursing home administrators who violate specified provisions relating to electronic monitoring; requiring prior written consent from a resident or certain individuals acting on the resident's behalf before a nursing home

employee, officer, or agent may interfere with an electronic monitoring device; providing a criminal penalty for such interference without prior written consent; imposing a civil penalty on nursing homes that violate provisions related to electronic monitoring; requiring the agency to transfer certain funds into the Quality of Long-Term Care Facility Improvement Trust Fund; repealing s. 400.0238, F.S., relating to limitations on punitive damages; amending s. 400.0239, F.S.; conforming a cross-reference; creating s. 400.1185, F.S.; requiring licensed facilities to create internal resident safety and quality-of-care coordinator programs; specifying required components for the programs, including development and implementation of a reporting system for adverse incidents; requiring that the reporting system require employees and agents to report adverse incidents to the facility's quality-of-care coordinator within a specified timeframe; assigning responsibility for the programs to facility governing boards; requiring facilities to hire a risk manager to serve as the quality-of-care coordinator; limiting the number of internal resident safety and quality-of care programs that coordinators may be responsible for; encouraging the adoption of other approaches to

reducing adverse incidents and violations of residents' rights; requiring the agency to adopt rules to administer the programs; requiring that programs file all incident reports with a designated employee of the facility, who must meet certain requirements; providing immunity from civil liability for individuals who file incident reports; defining the term "adverse incident"; requiring facilities to submit annual reports to the agency by a specified date which must include specified information; requiring the agency to review the information submitted to determine whether disciplinary action is warranted; requiring facilities to submit an incident report to the agency within a certain timeframe after they receive the report; requiring the agency to determine within a certain timeframe whether certain adverse incidents have occurred; specifying information that must be included in the notification; requiring the agency to require a written plan of correction from facilities that violate the reporting requirements; authorizing the agency to impose specified civil penalties and administrative fines for certain violations; requiring facilities to provide the agency with access to certain facility records; requiring the agency to review quality-of-care

programs as part of its licensure inspection process; providing that, in the absence of intentional fraud, quality-of-care coordinators may not be held financially liable for actions taken within the scope of their authority in connection with the administration of this section; requiring the agency to report to the appropriate regulatory board its reasonable belief that the conduct of an agent or employee of a licensed facility constitutes grounds for disciplinary action; requiring the agency to publish on its website an annual report card containing specific information for licensed facilities beginning on a specified date; requiring the report card to include a specified statement; amending s. 400.141, F.S.; requiring a licensed nursing home to satisfy certain financial requirements; providing that the required funds may not be used for litigation costs or attorney fees in certain circumstances; creating s. 400.1411, F.S.; requiring nursing home facilities, as a condition of licensure, to demonstrate to the satisfaction of the agency and the Office of Insurance Regulation of the Financial Services Commission the financial ability to pay claims and costs arising out of the rendering of, or the failure to render, care or services; providing

proper means of documentation; requiring insurers, self-insurers, and risk retention groups to promptly notify the agency and the office of cancellation or nonrenewal of insurance; requiring a licensee to pay the entire amount of a judgment, award, or settlement and all accrued interest if a court issues a final judgment against the licensee, under certain circumstances; providing that certain deceptive, untrue, or fraudulent representation by any individual or entity on behalf of a facility may result in disciplinary action or a civil penalty with no aggregate limit; requiring the agency to issue a conditional license and authorizing the agency to immediately suspend a license if a facility shows a continuous pattern of violation of this section; amending s. 400.19, F.S.; requiring the agency to determine compliance with standards for electricity and emergency power sources during routine unannounced inspections of licensed nursing home facilities; amending s. 400.191, F.S.; requiring facilities that are on the Nursing Home Guide Watch List to conspicuously post a sign that meets certain requirements on each entrance to the facility for a certain period of time; requiring the agency to cite for a class I violation, place a facility on a 6-month

inspection cycle, and, under certain circumstances, extend the duration of a facility's inclusion on the watch list for a specified additional period of time; creating s. 400.226, F.S.; requiring licensed nursing homes to comply with certain federal rules and regulations; providing that a violation of such federal regulations is considered negligence per se; amending s. 400.23, F.S.; requiring the agency, in consultation with the Department of Health and the Department of Elderly Affairs, to adopt and enforce rules requiring a licensed nursing home facility to have adequate electrical equipment, an emergency power source, and a supply of fuel which meet specified criteria; requiring a comprehensive emergency plan to provide for the evacuation of all residents of a facility if the facility experiences a power outage and is unable to sustain adequate emergency power; requiring the agency to immediately impose a fine in a specified amount on a facility if it determines that a resident of the facility died as the result of abuse or neglect; amending s. 406.11, F.S.; requiring medical examiners to determine the cause of death when a person dies in their district in a nursing home on the federal Special Focus Facility list or on the Nursing Home Guide Watch List; amending s. 406.13,

F.S.; requiring a medical examiner to forward documentation to the state attorney if he or she determines that a nursing home resident died as a result of abuse, sexual abuse, or negligence; requiring the state attorney to seat a grand jury within 90 days and investigate whether criminal charges are warranted; repealing s. 429.298, F.S., relating to limitations on punitive damages; amending s. 429.34, F.S.; requiring the agency to determine compliance with certain standards during the routine inspection of a licensed assisted living facility, including those related to construction and emergency power sources; amending s. 429.41, F.S.; requiring the Department of Elderly Affairs, in consultation with the agency, the Department of Children and Families, and the Department of Health, to adopt and enforce rules relating to electricity and requiring a licensed assisted living facility to maintain equipment sufficient to provide an emergency power source and a supply of fuel that meet specified criteria; requiring that a comprehensive emergency plan provide for the evacuation of all residents of a facility if the facility experiences a power outage and is unable to sustain emergency power as required; providing an effective date.

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

Section 1. Section 366.042, Florida Statutes, is created to read:

366.042 Power restoration priority.— The commission shall ensure that public utilities have effectively prioritized, in the event of an emergency, the restoration of services to critical medical facilities, including nursing homes licensed under part II of chapter 400 and assisted living facilities licensed under part I of chapter 429..

Section 2. Subsection (11) of section 366.15, Florida Statutes, is amended, and subsections (1) through (10) of that section are republished, to read:

366.15 Medically essential electric public utility service.—

(1) As used in this section, the term "medically essential" means the medical dependence on electric-powered equipment that must be operated continuously or as circumstances require as specified by a physician to avoid the loss of life or immediate hospitalization of the customer or another permanent resident at the residential service address.

(2) Each public utility shall designate employees who are authorized to direct an ordered continuation or restoration of medically essential electric service. A public utility shall not

impose upon any customer any additional deposit to continue or restore medically essential electric service.

(3)(a) Each public utility shall annually provide a written explanation of the certification process for medically essential electric service to each utility customer. Certification of a customer's electricity needs as medically essential requires the customer to complete forms supplied by the public utility and to submit a form completed by a physician licensed in this state pursuant to chapter 458 or chapter 459 which states in medical and nonmedical terms why the electric service is medically essential. False certification of medically essential service by a physician is a violation of s. 458.331(1)(h) or s. 459.015(1)(i).

(b) Medically essential service shall be recertified once every 12 months. The public utility shall send the certified customer by regular mail a package of recertification materials, including recertification forms, at least 30 days prior to the expiration of the customer's certification. The materials shall advise the certified customer that he or she must complete and submit the recertification forms within 30 days after the expiration of customer's existing certification. If the recertification forms are not received within this 30-day period, the public utility may terminate the customer's certification.

(4) Each public utility shall certify a customer's

electric service as medically essential if the customer completes the requirements of subsection (3).

(5) Notwithstanding any other provision of this section, a public utility may disconnect service to a residence whenever an emergency may threaten the health or safety of a person, the surrounding area, or the public utility's distribution system. The public utility shall act promptly to restore service as soon as feasible.

(6) No later than 24 hours before any scheduled disconnection of service for nonpayment of bills to a customer who requires medically essential service, a public utility shall attempt to contact the customer by telephone in order to provide notice of the scheduled disconnection. If the customer does not have a telephone number listed on the account or if the public utility cannot reach the customer or other adult resident of the premises by telephone by the specified time, the public utility shall send a representative to the customer's residence to attempt to contact the customer, no later than 4 p.m. of the day before scheduled disconnection. If contact is not made, however, the public utility may leave written notification at the residence advising the customer of the scheduled disconnection. Thereafter, the public utility may disconnect service on the specified date.

(7) Each public utility customer who requires medically essential service is responsible for making satisfactory

arrangements with the public utility to ensure payment for such service, and such arrangements must be consistent with the requirements of the utility's tariff.

(8) Each public utility customer who requires medically essential service is solely responsible for any backup equipment or power supply and a planned course of action in the event of a power outage or interruption of service.

(9) Each public utility that provides electric service to any customer who requires medically essential service shall call, contact, or otherwise advise such customer of scheduled service interruptions.

(10)(a) Each public utility shall provide information on sources of state or local agency funding which may provide financial assistance to the public utility's customers who require medically essential service and who notify the public utility of their need for financial assistance.

(b)1. Each public utility that operates a program to receive voluntary financial contributions from the public utility's customers to provide assistance to persons who are unable to pay for the public utility's services shall maintain a list of all agencies to which the public utility distributes such funds for such purposes and shall make the list available to any such person who requests the list.

2. Each public utility that operates such a program shall:

a. Maintain a system of accounting for the specific

amounts distributed to each such agency, and the public utility and such agencies shall maintain a system of accounting for the specific amounts distributed to persons under such respective programs.

b. Train its customer service representatives to assist any person who possesses a medically essential certification as provided in this section in identifying such agencies and programs.

~~(11) Nothing in this act shall form the basis for any cause of action against a public utility. Failure to comply with any obligation created by this act does not constitute evidence of negligence on the part of the public utility.~~

Section 3. Present subsections (3) through (14) of section 400.0060, Florida Statutes, are redesignated as subsections (4) through (15), respectively, and a new subsection (3) is added to that section, to read:

400.0060 Definitions.—When used in this part, unless the context clearly dictates otherwise, the term:

(3) "Autonomy" means the freedom of residents from threats of interference, coercion, retaliation, or intimidation as they reside and receive care in a long-term care facility and as advocated for by the Office of the State Long-Term Care Ombudsman.

Section 4. Section 400.0063, Florida Statutes, is amended to read:

400.0063 Establishment of the State Long-Term Care Ombudsman Program; designation of ombudsman and legal advocate.—

(1) The Office of ~~There is created~~ the State Long-Term Care Ombudsman is established within ~~Program in~~ the Department of Elderly Affairs to administer the State Long-Term Care Ombudsman Program. The office shall enter into a contract with, or make a grant to, a private nonprofit organization to oversee the day-to-day operations of the program. The office does not have any responsibility with regard to the licensing or certification of long-term care facilities and may not have a relationship with any long-term care facilities.

(2)(a) The State Long-Term Care Ombudsman Program shall be headed by the State Long-Term Care Ombudsman, who shall serve on a full-time basis and shall personally, or through representatives of the program, carry out the ~~its~~ purposes and functions of the program in accordance with state and federal law.

(b) A five-member selection panel appointed by the Secretary of Elderly Affairs shall appoint the state ombudsman, who must have ~~shall be appointed by and shall serve at the pleasure of the Secretary of Elderly Affairs. The secretary shall appoint a person who has~~ expertise in the operation of a nonprofit organization and at least 5 years of experience in area ~~the fields of~~ long-term care resident ~~and~~ advocacy. The state ombudsman may be removed from office only by a two-thirds

vote of the state council with the consent of the secretary and the private nonprofit organization that oversees the operations of the program. The ~~to serve as~~ state ombudsman shall register as a lobbyist pursuant to s. 11.045.

(3)(a) The state ombudsman shall select a person who is a member in good standing of The Florida Bar to serve in the position of ~~There is created in the office the position of~~ legal advocate, which is created within the office. The legal advocate, who shall ~~be selected by and~~ serve at the pleasure of the state ombudsman, shall register as a lobbyist ~~and shall be a member in good standing of The Florida Bar~~.

(b) The duties of the legal advocate ~~shall~~ include, but are not ~~be~~ limited to:

1. Assisting the state ombudsman in carrying out the duties of the office with respect to the abuse, neglect, exploitation, or violation of rights of residents of long-term care facilities.

2. Assisting the representatives of the State Long-Term Care Ombudsman Program in carrying out their responsibilities under this part.

3. Pursuing administrative, legal, and other appropriate remedies on behalf of residents.

4. Serving as legal counsel to the representatives of the State Long-Term Care Ombudsman Program in any suit or other legal action that is initiated in connection with the

performance of the official duties of the representatives of the State Long-Term Care Ombudsman Program.

5. Assisting the state ombudsman in ensuring that the program is operated autonomously; without conflict of interest; and without interference, coercion, or retaliation against those associated with the operation of the program.

Section 5. Paragraph (f) of subsection (1) and paragraph (h) of subsection (2) of section 400.0065, Florida Statutes, are amended to read:

400.0065 State Long-Term Care Ombudsman Program; duties and responsibilities.—

(1) The purpose of the State Long-Term Care Ombudsman Program is to:

(f) Support ~~Administer~~ the state and local councils.

(2) The State Long-Term Care Ombudsman has the duty and authority to:

(h) Prepare an annual report describing the activities carried out by the office, the state council, the districts, and the local councils in the year for which the report is prepared. The state ombudsman shall submit the report to the secretary, the United States Assistant Secretary for Aging, the Governor, the President of the Senate, the Speaker of the House of Representatives, the Secretary of Children and Families, and the Secretary of the Agency for Health Care Administration at least 30 days before the convening of the regular session of the

Legislature. The report must, at a minimum:

1. Contain and analyze data collected concerning complaints about and conditions in long-term care facilities and the disposition of such complaints.

2. Evaluate the problems experienced by residents.

3. Analyze the successes of the State Long-Term Care Ombudsman Program during the preceding year, including an assessment of how successfully the program has carried out its responsibilities under the Older Americans Act and the laws of this state.

4. Provide recommendations for policy, regulatory, and statutory changes designed to solve identified problems; resolve residents' complaints; improve residents' lives and quality of care; protect residents' rights, health, safety, and welfare; and remove any barriers to the optimal operation of the State Long-Term Care Ombudsman Program.

5. Contain recommendations from the State Long-Term Care Ombudsman Council, local councils, resident and family councils, and consumer advocacy groups regarding program functions and activities and recommendations for policy, regulatory, and statutory changes designed to protect residents' rights, health, safety, and welfare.

6. Contain any relevant recommendations from the representatives of the State Long-Term Care Ombudsman Program regarding program functions and activities.

Section 6. Subsection (3) and paragraph (c) of subsection (4) of section 400.0067, Florida Statutes, are amended to read:

400.0067 State Long-Term Care Ombudsman Council; duties; membership.—

(3) The State Long-Term Care Ombudsman Council consists of one active certified ombudsman from each local council in each ~~a~~ district and one resident, one family member of a resident, and one consumer advocate, each appointed by the state ombudsman ~~plus three at-large members~~.

~~(a) Each local council in a district must select a representative of its choice to serve on the state council.~~

~~(b)1. The state ombudsman shall submit to the secretary a list of individuals recommended for appointment to the at-large positions on the state council. The list may not include the name of any individual who is currently serving in a district.~~

~~2. The secretary shall appoint three at-large members chosen from the list.~~

(4)

(c)1. The state council shall elect a chair to serve for a term of 1 year. A chair may not serve more than three ~~two~~ consecutive terms.

2. The chair shall select a vice chair from among the members. The vice chair shall preside over the state council in the absence of the chair.

3. The chair may create additional executive positions as

necessary to carry out the duties of the state council. Any person appointed to an executive position shall serve at the pleasure of the chair, and his or her term shall expire on the same day as the term of the chair.

4. A chair may be immediately removed from office before the expiration of his or her term by a vote of two-thirds of all state council members present at any meeting at which a quorum is present. If a chair is removed from office before the expiration of his or her term, a replacement chair shall be chosen during the same meeting in the same manner as described in this paragraph, and the term of the replacement chair shall begin immediately. The replacement chair shall serve for the remainder of the term and is eligible to serve two subsequent consecutive terms.

Section 7. Paragraphs (b) and (c) of subsection (1) and paragraph (d) of subsection (2) of section 400.0069, Florida Statutes, are amended to read:

400.0069 Long-term care ombudsman districts; local long-term care ombudsman councils; duties; appointment.—

(1)(b) The state ombudsman shall ensure that there is at least one employee of the department certified as a long-term care ombudsman and a least one local council operating in each district. The state ombudsman may create additional local councils as necessary to ensure that residents throughout the state have meaningful ~~adequate~~ access to State Long-Term Care

Ombudsman Program services.

(c) Each district shall convene a public meeting at least monthly ~~quarterly~~.

(2) The duties of the representatives of the State Long-Term Care Ombudsman Program are to:

(d) Review and, upon an affirmative vote of the state council ~~if necessary~~, comment on all existing or proposed rules, regulations, and other governmental policies and actions relating to long-term care facilities which ~~that~~ may potentially have an effect on the health, safety, welfare, and rights of residents.

Section 8. Section 400.0073, Florida Statutes, is amended to read:

400.0073 State and local ombudsman council investigations.—

(1) A representative of the State Long-Term Care Ombudsman Program shall identify and investigate, within a reasonable time after a complaint is made~~,~~ by or on behalf of a resident relating to actions or omissions by providers or representatives of providers of long-term care services, other public agencies, guardians, or representative payees which may adversely affect the health, safety, welfare, or rights of residents.

(2) Subsequent to an appeal from a local council, the state council may investigate any complaint received by the local council involving a long-term care facility or a resident.

(3) The state council or a local council may hold a public hearing to assist the State Long-Term Care Ombudsman Program in its investigation of a complaint.

(4)~~(3)~~ If a representative of the State Long-Term Care Ombudsman Program is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the State Long-Term Care Ombudsman Program in the performance of official duties as described in s. 400.0083(1) and to have violated this part. The representative of the State Long-Term Care Ombudsman Program shall report a facility's refusal to allow entry to the state ombudsman or his or her designee, who shall report the incident to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 429.14, s. 429.19, s. 429.69, or s. 429.71. The legal advocate shall pursue legal remedies against a person, a long-term care facility, or another entity that violates s. 400.0083(1).

Section 9. Subsections (1), (4), and (5) of section 400.0074, Florida Statutes, are amended to read:

400.0074 Local ombudsman council onsite administrative assessments.—

(1) A representative of the State Long-Term Care Ombudsman Program shall conduct, at least annually, an onsite administrative assessment of each nursing home, assisted living

facility, and adult family-care home. This administrative assessment must be comprehensive in nature, must be resident-centered, must include a review of the facility's emergency management plan, and must focus on factors affecting residents' rights, health, safety, and welfare. Each local council is encouraged to conduct a similar onsite administrative assessment of each new ~~additional~~ long-term care facility within its jurisdiction.

(4) An onsite administrative assessment may not be accomplished by forcible entry. However, if a representative of the State Long-Term Care Ombudsman Program is not allowed to enter a long-term care facility, the administrator of the facility shall be considered to have interfered with a representative of the State Long-Term Care Ombudsman Program in the performance of official duties as described in s. 400.0083(1) and to have committed a violation of this part. The representative of the State Long-Term Care Ombudsman Program shall report the refusal by a facility to allow entry to the state ombudsman or his or her designee, who shall report the incident to the agency, and the agency shall record the report and take it into consideration when determining actions allowable under s. 400.102, s. 400.121, s. 429.14, s. 429.19, s. 429.69, or s. 429.71. The legal advocate may pursue legal remedies for any violation of s. 400.0083.

(5) The department, in consultation with the state

ombudsman, shall ~~may~~ adopt rules implementing procedures for conducting onsite administrative assessments of long-term care facilities.

Section 10. Subsection (3) of section 400.0077, Florida Statutes, is amended to read:

400.0077 Confidentiality.—

(3) All other matters before the council, including the public discussion of administrative assessments, shall be open to the public and subject to chapter 119 and s. 286.011.

Section 11. Subsection (3) is added to section 400.0078, Florida Statutes, and subsections (1) and (2) are republished, to read:

400.0078 Citizen access to State Long-Term Care Ombudsman Program services.—

(1) The office shall establish a statewide toll-free telephone number and e-mail address for receiving complaints concerning matters adversely affecting the health, safety, welfare, or rights of residents.

(2) Upon admission to a long-term care facility, each resident or representative of a resident must receive information regarding:

(a) The purpose of the State Long-Term Care Ombudsman Program.

(b) The statewide toll-free telephone number and e-mail address for receiving complaints.

(c) Information that retaliatory action cannot be taken against a resident for presenting grievances or for exercising any other resident right.

(d) Other relevant information regarding how to contact representatives of the State Long-Term Care Ombudsman Program.

Each resident or his or her representative must be furnished additional copies of this information upon request.

(3) The State Long-Term Care Ombudsman program shall create and make available a poster that includes the statewide toll-free telephone number as described in subsection (1) and other relevant contact information for receiving complaints or a summary of residents' rights. Each long-term care facility shall display a State Long-Term Care Ombudsman Program poster in multiple, conspicuous places.

Section 12. Section 400.008, Florida Statutes, is created to read:

400.008 Unannounced quality-of-care evaluations.—

(1) It is the intent of the Legislature that the environment in long-term care facilities be conducive to the dignity and autonomy of residents and that investigations by the Office of the State Long-Term Care Ombudsman will safeguard the health, safety, and welfare of residents.

(2) The Office of the State Long-Term Care Ombudsman shall conduct unannounced quality-of-care evaluations of health and

long-term care facilities that provide services to the elderly. The office may use undercover personnel to act as patients or employees of the facility. The purpose of the evaluations is to:

(a) Identify and track abuse and neglect issues and potential abuse and neglect issues in facilities;

(b) Evaluate positive and negative aspects of facility care based on state and federal laws and regulations; and

(c) Observe facilities' actions to correct and resolve complaints, allegations of abuse, neglect, or exploitation.

(3) Any employee or contractor of the Office of the State Long-Term Care Ombudsman who participates in an evaluation is immune from liability in any civil action related to the evaluation, provided that he or she acted in good faith during the course of the evaluation.

Section 13. Section 400.0081, Florida Statutes, is amended to read:

400.0081 Access to facilities, residents, and records.—

(1) A long-term care facility shall provide representatives of the State Long-Term Care Ombudsman Program with access to:

(a) The long-term care facility and its residents.

(b) When ~~Where~~ appropriate, medical and social records of a resident for review if:

1. The representative of the State Long-Term Care Ombudsman Program has the permission of the resident or the

legal representative of the resident; or

2. The resident is unable to consent to the review and does not have a legal representative.

(c) Medical and social records of a resident as necessary to investigate a complaint, if:

1. A legal representative or guardian of the resident refuses to give permission;

2. The representative of the State Long-Term Care Ombudsman Program has reasonable cause to believe that the legal representative or guardian is not acting in the best interests of the resident; and

3. The representative of the State Long-Term Care Ombudsman Program obtains the approval of the state ombudsman.

(d) Administrative records, policies, and documents to which residents or the general public have access.

(e) Upon request, copies of all licensing and certification records maintained by the state with respect to a long-term care facility.

(2) Copies of records, policies, or documents needed to complete an investigation or assessment must be timely provided by the facility upon request and at no expense to the program.

(3) ~~(2)~~ The department, in consultation with the state ombudsman, shall ~~may~~ adopt rules to establish procedures to ensure access to facilities, residents, and records as described in this section.

Section 14. Section 400.0083, Florida Statutes, is amended to read:

400.0083 Interference~~;~~ by a person, facility, or entity; retaliation prohibited; criminal penalties; administrative fines; interference by agency.—

(1) A person, long-term care facility, or other entity may not willfully interfere with a representative of the State Long-Term Care Ombudsman Program in the performance of his or her official duties.

(2) A person, long-term care facility, or other entity may not knowingly or willfully take action or retaliate against any resident, employee, or other person for filing a complaint with, providing information to, or otherwise cooperating with any representative of the State Long-Term Care Ombudsman Program.

(3) A person, long-term care facility, or other entity that violates this section:

(a) Is liable for damages and equitable relief as determined by law.

(b) Commits a misdemeanor of the first ~~second~~ degree, punishable as provided in s. 775.083.

(4) The Office of the State Long-Term Care Ombudsman shall investigate each alleged violation of subsections (1) and (2) to determine if a violation occurred. If the office determines that a violation occurred, it must report the determination to the agency. The agency shall impose a civil penalty of up to $5,000

per occurrence on a person, long-term care facility, or other entity that the office finds in violation of subsection (1) and a civil penalty of up to $10,000 per occurrence on a person, long-term care facility, or other entity that the office finds in violation of subsection (2). The agency shall transfer funds collected pursuant to this subsection into the Quality of Long-Term Care Facility Improvement Trust Fund established under s. 400.0239. The Division of Administrative Hearings shall conduct a hearing if a determination of a violation is contested. The division shall establish by rule procedures for hearing requests. A decision must be rendered by the administrative law judge within 90 days after the hearing.

(5) The Chief Inspector General shall investigate any willful agency interference with the activities of the State Long-Term Care Ombudsman Program in the performance of its official duties.

Section 15. Subsections (1), (3), and (4) of section 400.0087, Florida Statutes, are amended to read:

400.0087 Department oversight; funding.—

(1) The department shall perform its duties ~~meet the costs~~ associated with the State Long-Term Care Ombudsman Program from funds appropriated for that purpose ~~to it~~.

(a) The nonprofit organization responsible for the day-to-day operations of the program, in consultation with the state ombudsman, shall develop and submit a budget to the department

which must ~~shall~~ include the costs associated with administrative support of the State Long-Term Care Ombudsman Program ~~when developing its budget requests for consideration by the Governor and submittal to the Legislature~~.

(b) The department may divert from the federal ombudsman appropriation an amount equal to the department's administrative cost ratio, which may not exceed 5 percent, to cover the costs associated with administering the State Long-Term Care Ombudsman Program. The remaining allotment from the Older Americans Act program shall be expended on direct ombudsman activities.

(3) The department is responsible for ensuring that the State Long-Term Care Ombudsman Program:

(a) Has the objectivity and autonomy ~~independence~~ required to qualify it for funding under the federal Older Americans Act.

(b) Provides information to public and private agencies, legislators, and others.

(c) Provides appropriate training to representatives of the State Long-Term Care Ombudsman Program.

(d) Coordinates ombudsman services with Disability Rights Florida, the Advocacy Center for Persons with Disabilities and with providers of legal services to residents of long-term care facilities in compliance with state and federal laws.

(4) The department shall also:

(a) Receive and disburse state and federal funds for purposes that the state ombudsman has formulated in accordance

with the Older Americans Act.

(b) Whenever the state ombudsman deems necessary, act as liaison between agencies and branches of the federal and state governments and the State Long-Term Care Ombudsman Program.

Section 16. Section 400.0089, Florida Statutes, is amended to read:

400.0089 Complaint data reports.—

(1) The State Long-Term Care Ombudsman Program shall maintain a statewide uniform reporting system to collect and analyze data relating to complaints and conditions in long-term care facilities and to residents for the purpose of identifying and resolving complaints.

(2) Information pertaining to the number and types of complaints received by the State Long-Term Care Ombudsman Program must ~~shall~~ be published quarterly and made readily available and must ~~shall~~ include all of the following:

(a) The license number, name, address, and county of each facility that is the subject of a complaint.

(b) The case number and dates that each investigation was opened and closed.

(c) The identified complaint codes for each case.

(d) The National Ombudsman Reporting System description for each case.

(e) The disposition of each case, specified by complaint code.

(3) The State Long-Term Care Ombudsman Program shall include an analysis of such information in the annual report required under s. 400.0065.

Section 17. Subsection (2) of section 400.0091, Florida Statutes, is amended to read:

400.0091 Training.—The state ombudsman shall ensure that appropriate training is provided to all representatives of the State Long-Term Care Ombudsman Program.

(2) The state ombudsman shall approve the curriculum for the initial and continuing education training, which must, at a minimum, address:

(a) Resident confidentiality.

(b) Guardianships and powers of attorney.

(c) Medication administration.

(d) Care and medication of residents with dementia and Alzheimer's disease.

(e) Accounting for residents' funds.

(f) Discharge rights and responsibilities.

(g) Cultural sensitivity.

(h) Person-centered care initiatives.

(i) Abuse and neglect of residents.

(j) ~~(h)~~ Any other topic related to residency in a long-term care facility.

Section 18. Section 400.0223, Florida Statutes, is created to read:

400.0223 Resident use of electronic monitoring devices in nursing homes.—

(1) As used in this section, the term "electronic monitoring device" includes both of the following:

(a) Video surveillance cameras installed in the room of a resident.

(b) Audio devices installed in the room of a resident designed to acquire communications or other sounds occurring in the room.

(2) A nursing home shall allow a resident; the resident's surrogate; the resident's guardian; or, at the resident's request, the resident's personal representative to monitor the resident's room through the use of electronic monitoring devices.

(3) The nursing home shall require the person who conducts electronic monitoring to post a notice on the door to the resident's room stating that the room is being monitored by an electronic monitoring device.

(4) Electronic monitoring conducted under this section is voluntary and may be conducted only at the request and expense of the resident, the resident's surrogate, the resident's guardian, or the resident's personal representative. To the extent possible, such monitoring must protect the privacy rights of other residents and visitors to the nursing home.

(5)(a) A nursing home may not inquire of a prospective

resident or the representative of a prospective resident who is applying to reside at the facility regarding the resident's intentions to use an electronic monitoring and may not refuse an application for residency or remove a resident from the nursing home on the basis of intent to use or use of an electronic monitoring device.

(b) A nursing home shall inform a resident, the resident's surrogate, the resident's guardian, or the personal representative of the resident of the resident's right to conduct electronic monitoring.

(6) A nursing home shall make reasonable physical accommodations to facilitate electronic monitoring and shall provide a reasonably secure place to mount a video surveillance camera or other electronic monitoring device and access to a power source for the camera or device.

(7) If electronic monitoring is conducted on behalf of a resident, the nursing home may require the resident, the resident's surrogate, the resident's guardian, or the resident's personal representative to conduct the electronic monitoring in plain view.

(8) A nursing home may require that a request to conduct electronic monitoring be made in writing.

(9) Subject to applicable rules of evidence and procedure, an audio or video recording created through the use of electronic monitoring conducted under this section may be

admitted into evidence in any court or administrative proceeding.

(10) An administrator of a nursing home who knowingly refuses to allow a resident; the resident's surrogate; the resident's guardian; or, at the request of the resident, the resident's personal representative to monitor the room of the resident in accordance with this section through the use of an electronic monitoring device commits a misdemeanor of the second degree, punishable under s. 775.082 or s. 775.083.

(11) An administrator of a nursing home who knowingly refuses to admit a person to residency or knowingly allows the removal of a resident from the nursing home because of a request to conduct electronic monitoring under this section commits a misdemeanor of the second degree, punishable under s. 775.082 or s. 775.083.

(12)(a) An employee, officer, or other agent of a nursing home may not intentionally hamper, obstruct, tamper with, or destroy an electronic monitoring device installed in a resident's room in accordance with this section, or a tape or recording made by such a device, unless he or she first obtains the written consent of the resident, the resident's surrogate, the resident's guardian, or the resident's personal representative on a form provided by the agency. Such consent form must be signed by the resident or the person representing the resident who made the request and one other witness.

(b) In the absence of such written consent, an employee, officer, or other agent of a nursing home who intentionally hampers, obstructs, tampers with, or destroys an electronic monitoring device installed in a resident's room in accordance with this section, or a tape or recording made by such a device, commits a misdemeanor of the first degree, punishable under s. 775.082 or s. 775.083.

(13) The agency shall impose a civil penalty not to exceed $500 per violation per day on a licensee who operates a nursing home found to be in violation of this section. The agency shall transfer funds collected pursuant to this subsection into the Quality of Long-Term Care Facility Improvement Trust Fund established under s. 400.0239.

Section 19. Section 400.0238, Florida Statutes, is repealed.

Section 20. Subsection (1) of section 400.0239, Florida Statutes, is amended to read:

400.0239 Quality of Long-Term Care Facility Improvement Trust Fund.—

(1) There is created within the Agency for Health Care Administration a Quality of Long-Term Care Facility Improvement Trust Fund to support activities and programs directly related to improvement of the care of nursing home and assisted living facility residents. The trust fund shall be funded through proceeds generated pursuant to ss. 400.0083 and 400.0223 ~~ss.~~

~~400.0238 and 429.298~~, through funds specifically appropriated by the Legislature, through gifts, endowments, and other charitable contributions allowed under federal and state law, and through federal nursing home civil monetary penalties collected by the Centers for Medicare and Medicaid Services and returned to the state. These funds must be utilized in accordance with federal requirements.

Section 21. Section 400.1185, Florida Statutes, is created to read:

400.1185 Internal resident safety and quality-of-care coordinator program.—

(1) Each licensed facility shall establish an internal resident safety and quality-of-care coordinator program that includes all of the following:

(a) An analysis of the frequency and causes of violations of residents' rights and adverse incidents.

(b) An analysis of resident and family member grievances that relate to resident safety and quality of care.

(c) The development and implementation of measures to promote autonomy within the facility, to enhance the quality of life and the safety of residents, and to decrease the frequency of violations of residents' rights and of adverse incidents.

(d) Safety and risk prevention education and the training of all nonphysician personnel who provide resident care, which must be included as part of the initial orientation of such

personnel. Such personnel shall complete at least 5 additional hours of education and training annually.

(e) The development and implementation of a reporting system that requires all employees and agents of the licensed facility to report adverse incidents to the quality-of-care coordinator, as described in subsection (2), or to his or her designee, within 3 business days after the adverse incident occurs.

(2) The internal resident safety and quality-of-care coordinator programs are the responsibility of the governing board of each facility. Each facility shall hire a risk manager who shall act as the quality-of-care coordinator and be responsible for implementation and oversight of the facility's internal resident safety and quality-of-care coordinator program. The risk manager may not be made responsible for internal resident safety and quality-of-care coordinator programs in more than four facilities licensed under this chapter.

(3) In addition to the programs created under this section, the development of other innovative approaches is encouraged to reduce the frequency and severity of adverse incidents and of violations of residents' rights.

(4) The agency shall adopt rules to administer the internal resident safety and quality-of-care coordinator programs. Each program must file any collected incident reports

with an employee designated by the facility, who must be proficient in resident safety techniques and must have access to all resident care and safety records of the facility, including internal and state-required incident reports. An individual who files an incident report is not subject to civil suit by virtue of filing the incident report. For purposes of this section, the term "adverse incident" means a situation that facility personnel were in control of and that appropriate safety measures could have prevented which results in any of the following:

(a) Death.

(b) Brain or spinal damage.

(c) Permanent disfigurement.

(d) A fracture or dislocation of bones or joints.

(e) A resulting limitation of neurological, physical, or sensory function.

(f) Sexual abuse of a resident.

(g) Assault or battery of a resident.

(h) Any condition resulting from an adverse incident which requires the transfer of a resident to a unit, within or outside of the facility, to provide a more acute level of care.

(5)(a) By January 31 of each year, each licensed facility shall submit a report to the agency summarizing incident reports filed during the previous calendar year. The report must include:

1. The total number of adverse incidents.

2. A listing, by category, of the causes of each injury or death, and the number of incidents occurring within each category.

3. A code number using the facility staff's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to residents, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

4. A description of all claims filed against the licensed facility for a violation of the residents' rights, as specified in s. 400.022, including the total number of pending and closed claims, the names of the individuals involved in each claim, and the nature of the incident that led to each claim, and the status and disposition of each claim. Each report must provide an updated status for any claims identified as being unresolved or pending in the prior year report.

5. The number and nature of disciplinary actions taken against agents or employees of the facility related to patient care and safety.

(b) The agency shall review the information submitted pursuant to paragraph (a) and determine if any reported

incidents may subject a facility or an employee or agent of a facility to disciplinary action.

(c) The report submitted to the agency must also provide the name and license number of the quality-of-care coordinator of the licensed facility, a copy of the facility's policies and procedures that govern the actions taken by the facility and its quality-of-care coordinator to reduce the risk of injuries and deaths and violations of residents' rights, and the results of such actions.

(6)(a) The licensed facility shall submit an adverse incident report to the agency no later than 1 business day after the quality-of-care coordinator or his or her designee has received the report through the system implemented pursuant to paragraph (1)(e). The report may be submitted to the agency through e-mail, facsimile, or overnight mail delivery. The facility must submit the following information with the report:

1. The identity of the affected resident;

2. The type of adverse incident;

3. Information on any investigation into the incident conducted by the facility; and

4. An assessment as to whether the events causing or resulting in the adverse incident represent a potential risk to other residents.

(b) After receiving the report, the agency must determine by the end of the next business day if any of the following

adverse incidents has occurred, whether arising from events that occurred in the licensed facility or from events that occurred before the resident's admission in the licensed facility:

1. The death of a resident;

2. Brain or spinal damage to a resident;

3. Sexual abuse of a resident; or

4. The assault or battery of a resident.

(7) The agency shall require a written plan of correction from a facility that violates this section. For a single incident or a series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first demand that the facility take corrective action. If the facility does not demonstrate completion of the corrective action within the timeframe allowed by the agency or demonstrates a pattern of nonwillful violations of this section, the agency may impose a civil penalty not to exceed $5,000 for each violation of the reporting requirements of this section. The civil penalty for repeated nonwillful violations may not exceed $10,000 for each violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation per day.

(8) The agency must be given access to facility records needed in the administration of this section.

(9) The agency shall review, as part of its licensure inspection process, the internal resident safety and quality-of-

care coordinator program at each licensed facility subject to this section to determine whether it complies with this section, is being conducted in a manner designed to reduce adverse incidents and violations of residents' rights, and is appropriately reporting incidents under subsections (4) through (6).

(10) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any quality-of-care coordinator for the implementation and oversight of an internal resident safety and quality-of-care coordinator program for any act or proceeding undertaken or performed within the scope of the functions of the program so long as the quality-of-care coordinator acts without intentional fraud.

(11) If the agency, through its receipt of the annual reports required in subsection (5) or through any investigation, has a reasonable belief that the conduct of an agent or employee of a licensed facility constitutes grounds for disciplinary action by the appropriate regulatory board, the agency must report its findings to that board.

(12) Beginning on July 1, 2019, and by each July 1 thereafter, the agency shall publish on its website a report card summarizing the information contained in the annual reports submitted by licensed facilities pursuant to subsection (5) and disciplinary actions reported to the agency. The report card must be organized by county and, for each licensed facility in

the state, must include an itemized list that provides the following information:

(a) The name and address of the facility.

(b) If the facility is structured as a private for-profit, not-for-profit, or public company.

(c) The total number of beds in the facility.

(d) A description of the categories of services provided by the facility.

(e) The percentage of adverse incidents per total number of residents in the facility, by category of reported incident.

(f) The number of claims filed for violations of the resident's rights under s. 400.022, by category of violation.

(g) A listing, by category, of the actions or inactions giving rise to the adverse incidents and claims filed for a violation of the resident's rights and the number in each category.

(h) Disciplinary actions taken against a facility or agents or employees of that facility.

(i) The following statement:

"This report card is just one measure of the quality of a facility. You may want to obtain and consider other information to determine whether this facility is right for you or your loved ones. This report card is not adjusted to reflect the size of the facility or

the severity or complexity of the custodial and health care needs of the residents it serves, and, therefore, some facilities may appear to have more frequent adverse incidents and claims involving violations of residents' rights than others."

The first report card issued pursuant to this subsection may be based on a partial year of data, if necessary.

Section 22. Paragraph (q) of subsection (1) of section 400.141, Florida Statutes, is amended to read:

400.141 Administration and management of nursing home facilities.—

(1) Every licensed facility shall comply with all applicable standards and rules of the agency and shall:

(q) Satisfy the financial requirements in s. 400.1411, which may not be used for litigation costs or attorney fees for the defense of any claim against a nursing home facility pursuant to common law or s. 400.023 or s. 400.0233 ~~Maintain general and professional liability insurance coverage that is in force at all times~~. In lieu of satisfying the financial requirements in s. 400.1411 ~~such coverage~~, a state-designated teaching nursing home and its affiliated assisted living facilities created under s. 430.80 may demonstrate proof of financial responsibility as provided in s. 430.80(3)(g).

Section 23. Section 400.1411, Florida Statutes, is created

to read:

400.1411 Financial requirements.—

(1) As a condition of licensure, a nursing home facility must at all times demonstrate to the satisfaction of the agency and the Office of Insurance Regulation of the Financial Services Commission the financial ability to pay claims, and costs ancillary thereto, arising out of the rendering of, or the failure to render, care or services, by doing one of the following:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b).

(b) Obtaining and maintaining general and professional liability coverage in an amount not less than $1 million per claim, with a minimum annual aggregate of not less than $3 million, from an authorized insurer as defined in s. 624.09, from an eligible surplus lines insurer as defined in s. 626.914(2), or from a Florida-domiciled risk retention group as defined in s. 627.942(9).

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $1 million per claim, with a minimum aggregate availability of credit not less than $3 million. The letter of credit must be payable to the nursing home facility as

beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the nursing home facility or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, care and services. The letter of credit must be nonassignable and nontransferable. The letter of credit must be issued by any bank or savings association organized and existing under the laws of this state or under the laws of the United States which has its principal place of business in this state or has a branch office authorized under the laws of this state or of the United States to receive deposits in this state.

(2) Each insurer, self-insurer, or risk retention group must promptly notify the agency and the office of cancellation or nonrenewal of insurance required by this section.

(3) Upon the entry by a Florida court of an adverse final judgment against a licensee as defined in s. 400.023(2) which arises from an award pursuant to s. 400.023, including an arbitration award, for a claim of negligence or a violation of residents' rights, in contract or tort, or from noncompliance with the terms of a settlement agreement as determined by a court or arbitration panel which arises from a claim pursuant to s. 400.023, the licensee shall pay the plaintiff the entire amount of the judgment, award, or settlement and all accrued

interest pursuant to s. 400.024.

(4) Any deceptive, untrue, or fraudulent representation or violation of this section by any individual or entity on behalf of the facility may result in disciplinary action pursuant to s. 400.121 with no aggregate limit. If a nursing home shows a continuous pattern of violation of this section, the agency must issue a conditional license and may immediately suspend the license.

Section 24. Subsection (3) of section 400.19, Florida Statutes, is amended to read:

400.19 Right of entry and inspection.—

(3) Every 15 months, the agency shall ~~every 15 months~~ conduct at least one unannounced inspection to determine compliance by the licensee with the laws of this state and administrative rules that govern ~~statutes, and with rules promulgated under the provisions of those statutes, governing~~ minimum standards of construction, electricity, and emergency power sources; quality and adequacy of care;~~,~~ and rights of residents. ~~The survey shall be conducted every 6 months for the next 2-year period~~ If a ~~the~~ facility has been cited for a class I deficiency or~~, has been cited~~ for two or more class II deficiencies arising from separate surveys or investigations within a 60-day period~~,~~ or has had three or more substantiated complaints within a 6-month period, each resulting in at least one class I or class II deficiency, the agency shall conduct

unannounced inspections at six-month intervals over the course of the next 2-year period. In addition to any other fees or fines in this part, the agency shall assess a fine for each facility that is subject to the 6-month survey cycle. The fine for the 2-year period is ~~shall be~~ $6,000, one-half to be paid at the completion of each survey. The agency may adjust this fine by the change in the Consumer Price Index, based on the 12 months immediately preceding the increase, to cover the cost of the additional surveys. The agency shall verify through subsequent inspection that any deficiency identified during inspection is corrected. However, the agency may verify the correction of a class III or class IV deficiency unrelated to resident rights or resident care without reinspecting the facility if adequate written documentation has been received from the facility~~,~~ which provides assurance that the deficiency has been corrected. The giving or causing to be given of advance notice of such unannounced inspections by an employee of the agency to any unauthorized person constitutes grounds ~~shall constitute cause~~ for the suspension of such person, pursuant to chapter 110, for not fewer than 5 working days ~~according to the provisions of chapter 110~~.

Section 25. Subsection (3) of section 400.191, Florida Statutes, is amended, to read:

400.191 Availability, distribution, and posting of reports and records.—

(3) Each nursing home facility licensee shall maintain as public information, available upon request, records of all cost and inspection reports pertaining to that facility which ~~that~~ have been filed with, or issued by, any governmental agency. Copies of the reports shall be retained in the records for not less than 5 years following the date the reports are filed or issued.

(a) The agency shall publish in the Nursing Home Guide a "Nursing Home Guide Watch List" to assist consumers in evaluating the quality of nursing home care in Florida. The watch list must identify each facility that met the criteria for a conditional licensure status and each facility that is operating under bankruptcy protection. The watch list must include, but need ~~is~~ not be limited to, the facility's name, address, and ownership; the county in which the facility operates; the license expiration date; the number of licensed beds; a description of the deficiency causing the facility to be placed on the list; any corrective action taken; and the cumulative number of days and percentage of days the facility had a conditional license in the past 30 months. The watch list must include a brief description regarding how to choose a nursing home, the categories of licensure, the agency's inspection process, an explanation of terms used in the watch list, and the addresses and phone numbers of the agency's health quality assurance field offices.

(b) Upon publication of each Nursing Home Guide, the agency shall ~~must~~ post a copy of the guide on its website by the 15th calendar day of the second month following the end of the calendar quarter. Each nursing home licensee must retrieve the most recent version of the Nursing Home Guide from the agency's website.

(c)1. A facility on the watch list must conspicuously post a sign on each entrance to the facility. The lettering must be red, in at least 48-point type, and printed on white card stock. The sign must read as follows:

"NOTICE: THIS FACILITY IS ON FLORIDA'S NURSING HOME GUIDE WATCH LIST."

2. Signs must remain posted for the duration of the 30-month watch list period. If the agency determines that a facility is in violation of this section, the agency must cite the facility for a class I violation, place the facility on a 6-month inspection cycle, and extend the duration of a facility's inclusion on the watch list for an additional 30 months.

Section 26. Section 400.226, Florida Statutes, is created to read:

400.226 Mandatory compliance with federal requirements.—Licensed nursing homes shall comply with the requirements of 42 C.F.R. 483, which are incorporated herein by reference. A

violation of the residents' rights established under this section is considered negligence per se.

Section 27. Paragraphs (d) and (g) of subsection (2) and paragraph (a) of subsection (8) of section 400.23, Florida Statutes, are amended to read:

400.23 Rules; evaluation and deficiencies; licensure status.—

(2) Pursuant to the intention of the Legislature, the agency, in consultation with the Department of Health and the Department of Elderly Affairs, shall adopt and enforce rules to implement this part and part II of chapter 408, which shall include reasonable and fair criteria in relation to:

(d) The equipment essential to the health and welfare of the residents, including equipment sufficient to provide adequate day-to-day electricity, a fully operational emergency power source, and a supply of fuel sufficient to sustain the emergency power source for at least 96 hours during a power outage. The emergency power source must provide enough electricity to consistently maintain an air temperature between 71 and 81° F in the facility.

(g) The preparation and annual update of a comprehensive emergency management plan. The agency shall adopt rules establishing minimum criteria for the plan after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency

evacuation transportation; adequate sheltering arrangements; postdisaster activities, including emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; and responding to family inquiries. The plan must provide for the evacuation of all residents in the event that the facility experiences a power outage and is unable to sustain adequate emergency power as required in paragraph (d). The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

(8) The agency shall adopt rules pursuant to this part and part II of chapter 408 to provide that, when the criteria established under subsection (2) are not met, such deficiencies shall be classified according to the nature and the scope of the deficiency. The scope shall be cited as isolated, patterned, or widespread. An isolated deficiency is a deficiency affecting one

or a very limited number of residents, or involving one or a very limited number of staff, or a situation that occurred only occasionally or in a very limited number of locations. A patterned deficiency is a deficiency where more than a very limited number of residents are affected, or more than a very limited number of staff are involved, or the situation has occurred in several locations, or the same resident or residents have been affected by repeated occurrences of the same deficient practice but the effect of the deficient practice is not found to be pervasive throughout the facility. A widespread deficiency is a deficiency in which the problems causing the deficiency are pervasive in the facility or represent systemic failure that has affected or has the potential to affect a large portion of the facility's residents. The agency shall indicate the classification on the face of the notice of deficiencies as follows:

(a) A class I deficiency is a deficiency that the agency determines presents a situation in which immediate corrective action is necessary because the facility's noncompliance has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident receiving care in a facility. The condition or practice constituting a class I violation shall be abated or eliminated immediately, unless a fixed period of time, as determined by the agency, is required for correction. A class I deficiency is subject to a civil penalty of $10,000 for an

isolated deficiency, $12,500 for a patterned deficiency, and $15,000 for a widespread deficiency. If the agency determines that a resident died as the result of abuse or neglect, it shall immediately impose a $1 million civil penalty on the facility for the deficiency. The fine amount shall be doubled for each deficiency if the facility was previously cited for one or more class I or class II deficiencies during the last licensure inspection or any inspection or complaint investigation since the last licensure inspection. A fine must be levied notwithstanding the correction of the deficiency.

Section 28. Paragraph (a) of subsection (1) of section 406.11, Florida Statutes, is amended to read:

406.11 Examinations, investigations, and autopsies.—

(1) In any of the following circumstances involving the death of a human being, the medical examiner of the district in which the death occurred or the body was found shall determine the cause of death and shall, for that purpose, make or have performed such examinations, investigations, and autopsies as he or she shall deem necessary or as shall be requested by the state attorney:

(a) When any person dies in the state:

1. Of criminal violence.

2. By accident.

3. By suicide.

4. Suddenly, when in apparent good health.

5. Unattended by a practicing physician or other recognized practitioner.

6. In any prison or penal institution.

7. In any nursing home on the federal Special Focus Facility list or on the Nursing Home Guide Watch List as described in s. 400.191(3)(a).

8.~~7.~~ In police custody.

9.~~8.~~ In any suspicious or unusual circumstance.

10.~~9.~~ By criminal abortion.

11.~~10.~~ By poison.

12.~~11.~~ By disease constituting a threat to public health.

13.~~12.~~ By disease, injury, or toxic agent resulting from employment.

Section 29. Section 406.13, Florida Statutes, is amended to read:

406.13 Examiner's report; maintenance of records.—Upon receipt of such notification pursuant to s. 406.12, the district medical examiner or her or his associate shall examine or otherwise take charge of the dead body and shall notify the appropriate law enforcement agency pursuant to s. 406.145. When the cause of death has been established within reasonable medical certainty by the district medical examiner or her or his associate, she or he shall so report or make available to the state attorney, in writing, her or his determination as to the cause of said death. If it is determined that a nursing home

resident died as the result of abuse, sexual abuse, or negligence, the medical examiner must notify and forward all documentation in support of the determination to the state attorney. Upon receipt of such notification, the state attorney shall seat a grand jury within 90 days and investigate whether the filing of criminal charges is warranted. Duplicate copies of records and the detailed findings of autopsy and laboratory investigations shall be maintained by the district medical examiner. Any evidence or specimen coming into the possession of said medical examiner in connection with any investigation or autopsy may be retained by the medical examiner or be delivered to one of the law enforcement officers assigned to the investigation of the death.

Section 30. Section 429.298, Florida Statutes, is repealed.

Section 31. Subsection (2) of section 429.34, Florida Statutes, is amended to read:

429.34 Right of entry and inspection.—

(2) The agency shall inspect each licensed assisted living facility at least once every 24 months to determine compliance by the licensee with this chapter and related rules governing minimum standards of construction, electricity, and emergency power sources; quality and adequacy of care; and resident rights. If an assisted living facility is cited for a class I violation or three or more class II violations arising from

separate surveys within a 60-day period or due to unrelated circumstances during the same survey, the agency must conduct an additional licensure inspection within 6 months.

Section 32. Paragraphs (a) and (b) of subsection (1) of section 429.41, Florida Statutes, are amended to read:

429.41 Rules establishing standards.—

(1) It is the intent of the Legislature that rules published and enforced pursuant to this section shall include criteria by which a reasonable and consistent quality of resident care and quality of life may be ensured and the results of such resident care may be demonstrated. Such rules shall also ensure a safe and sanitary environment that is residential and noninstitutional in design or nature. It is further intended that reasonable efforts be made to accommodate the needs and preferences of residents to enhance the quality of life in a facility. Uniform firesafety standards for assisted living facilities shall be established by the State Fire Marshal pursuant to s. 633.206. The agency, in consultation with the department, may adopt rules to administer the requirements of part II of chapter 408. In order to provide safe and sanitary facilities and the highest quality of resident care accommodating the needs and preferences of residents, the department, in consultation with the agency, the Department of Children and Families, and the Department of Health, shall adopt rules, policies, and procedures to administer this part, which

must include reasonable and fair minimum standards in relation to:

(a) The requirements for and maintenance of facilities, not in conflict with chapter 553, relating to electricity, plumbing, heating, cooling, lighting, ventilation, living space, and other housing conditions, which will ensure the health, safety, and comfort of residents suitable to the size of the structure.

1. Firesafety evacuation capability determination.—An evacuation capability evaluation for initial licensure shall be conducted within 6 months after the date of licensure.

2. Firesafety requirements.—

a. The National Fire Protection Association, Life Safety Code, NFPA 101 and 101A, current editions, shall be used in determining the uniform firesafety code adopted by the State Fire Marshal for assisted living facilities, pursuant to s. 633.206.

b. A local government or a utility may charge fees only in an amount not to exceed the actual expenses incurred by the local government or the utility relating to the installation and maintenance of an automatic fire sprinkler system in a licensed assisted living facility structure.

c. All licensed facilities must have an annual fire inspection conducted by the local fire marshal or authority having jurisdiction.

d. An assisted living facility that is issued a building permit or certificate of occupancy before July 1, 2016, may at its option and after notifying the authority having jurisdiction, remain under the provisions of the 1994 and 1995 editions of the National Fire Protection Association, Life Safety Code, NFPA 101, and NFPA 101A. The facility opting to remain under such provisions may make repairs, modernizations, renovations, or additions to, or rehabilitate, the facility in compliance with NFPA 101, 1994 edition, and may utilize the alternative approaches to life safety in compliance with NFPA 101A, 1995 edition. However, a facility for which a building permit or certificate of occupancy is issued before July 1, 2016, that undergoes Level III building alteration or rehabilitation, as defined in the Florida Building Code, or seeks to utilize features not authorized under the 1994 or 1995 editions of the Life Safety Code must thereafter comply with all aspects of the uniform firesafety standards established under s. 633.206, and the Florida Fire Prevention Code, in effect for assisted living facilities as adopted by the State Fire Marshal.

3. Resident elopement requirements.—Facilities are required to conduct a minimum of two resident elopement prevention and response drills per year. All administrators and direct care staff must participate in the drills which shall include a review of procedures to address resident elopement. Facilities must document the implementation of the drills and

ensure that the drills are conducted in a manner consistent with the facility's resident elopement policies and procedures.

4. Emergency power sources for use during power outages.—Facilities are required maintain a fully operational emergency power source and a supply of fuel sufficient to sustain the emergency power source for at least 96 hours during a power outage. The emergency power source must provide enough electricity to consistently maintain an air temperature between 71 and 81° F in the facility.

(b) The preparation and annual update of a comprehensive emergency management plan. Such standards must be included in the rules adopted by the department after consultation with the Division of Emergency Management. At a minimum, the rules must provide for plan components that address emergency evacuation transportation; adequate sheltering arrangements; postdisaster activities, including provision of emergency power, food, and water; postdisaster transportation; supplies; staffing; emergency equipment; individual identification of residents and transfer of records; communication with families; and responses to family inquiries. The comprehensive emergency management plan must provide for the evacuation of all residents of a facility if the facility experiences a power outage and is unable to sustain emergency power, as required in subparagraph (a)4. The comprehensive emergency management plan is subject to review and approval by the local emergency management agency. During its

review, the local emergency management agency shall ensure that the following agencies, at a minimum, are given the opportunity to review the plan: the Department of Elderly Affairs, the Department of Health, the Agency for Health Care Administration, and the Division of Emergency Management. Also, appropriate volunteer organizations must be given the opportunity to review the plan. The local emergency management agency shall complete its review within 60 days and either approve the plan or advise the facility of necessary revisions.

Section 33. This act shall take effect July 1, 2018.

Florida Enhanced State Opioid Overdose Surveillance (FL-ESOOS) Program

MEDICAL EXAMINER CALL TO ACTION

Please provide: **1)** a signed Letter of Support (LOS) to establish a formal, collaborative partnership with the Department for the purposes of executing and fulfilling the grant requirements; **2)** a Point of Contact (POC) for the FL-ESOOS program staff; and **3)** a response as to your District Medical Examiner office's need for available supplement funding.

Letter of Support

The LOSs are a requirement of both the core grant, and associated supplement, which will serve to illustrate commitment – as a State -- to the ESOOS program and combatting the opioid epidemic. The Department has previously received four LOSs from the Florida Medical Examiners' Commission, the Florida Police Chiefs' Association, the Florida Sheriffs' Association, and the Volusia-Flagler Substance Abuse Task Force.

To ensure compliance with the CDC requirements, signed LOSs must be received no later than **December 22, 2017**. The Department has developed a LOS template (**Appendix A**) with proposed language that you may customize as desired for your convenience. Please utilize your respective District Medical Examiner's office letterhead for your LOS. Once printed and signed, there are two options for returning the LOS to the Department:

1. Scan the signed LOS and e-mail it to the FL-ESOOS Program Principal Investigator: Dr. Karen Card (FLESOOS@flhealth.gov)
2. Mail the signed LOS to the FL-ESOOS Program Principal Investigator: Florida Department of Health, c/o Dr. Karen Card, 4052 Bald Cypress Way, BIN A-22, Tallahassee, FL 32399-1722

Designated Point-of-Contact

The POC will serve as the primary interface with the Department for the purposes of program implementation. Please complete the "Point of Contact Information" form (**Appendix B**) to provide this information.

Supplemental Funding Need

Please refer to the included "**Medical Examiner Information Package"** for details and complete the "Supplemental Funding Need" form (**Appendix C**) to provide this information.

Proposed Next Steps / Follow-Up

The Department will work with your office's designated POC to accomplish the following: **1)** schedule and facilitate an initial, on-boarding site visit by FL-ESOOS program staff to your office; **2)** fully document what reports are available from your respective office, based on the data elements required by the CDC, as well as how your office will be able to provide the reports (e.g. via a MOU/MOA, public records request, etc.) to the Department; and **3)** execute the required contractual mechanism for disbursement/receipt of allocated supplement funds (as applicable, based in indicated need).

APPENDIX A – SAMPLE LETTER OF SUPPORT

December 8, 2017

Karen Card, DrPH, MPH

FL-ESOOS Program Principal Investigator
Bureau of Emergency Medical Oversight
Division of Emergency Preparedness & Community Support
Florida Department of Health
4052 Bald Cypress Way, BIN A-22
Tallahassee, FL 32399-1722

Subject: Florida Enhanced State Opioid Overdose Surveillance (FL-ESOOS) Program

Dear Dr. Card:

On behalf of the Florida District <#TBD> Medical Examiner's office, please accept this formal letter of support for the Florida Department of Health (Department), Bureau of Emergency Medical Oversight's FL-ESOOS program.

The Department recognizes the increasing rate of opioid-involved drug overdose deaths as a growing public health issue. Through the FL-ESOOS program, it seeks to build a system and infrastructure that will allow a collaborative and targeted response to address the growing challenge presented by opioid-involved drug overdoses through the timely dissemination of surveillance data to state and local stakeholders who are working to develop and implement strategic response and prevention initiatives.

The Florida District <#TBD> Medical Examiner's office is pleased to offer its partnership to the Department in support of the FL-ESOOS program by providing available reports (data) associated with suspected opioid-involved overdose deaths occurring in the counties served by our office. Additionally, our office will assess its needs, and work with the Department (as applicable) to take advantage of available supplement funding for comprehensive and specialized toxicology testing for suspected opioid-involved overdose deaths, or submit a proposal for an alternative way to use the supplemental funding to enhance the timeliness and quality of our medical examiner investigations of suspected opioid-involved overdose deaths.

The forthcoming surveillance findings, analyses, and reports from the FL-ESOOS program will serve as an important informational resource not only to our office, but also to those local prevention and response organizations located within the counties we serve.

Sincerely,

<Name>
<Title>

Florida Enhanced State Opioid Overdose Surveillance (FL-ESOOS) Program

APPENDIX B – POINT OF CONTACT INFORMATION FORM

General Information

- District Medical Examiner Office Name: Click or tap here to enter text.
- District Medical Examiner Office Address: Click or tap here to enter text.
- Name of Chief Medical Examiner: Click or tap here to enter text.

Designated Point of Contact (POC)

Please provide the name and contact information for your District Medical Examiner office's POC:

- Name: Click or tap here to enter text.
- Title: Click or tap here to enter text.
- Phone Number: Click or tap here to enter text.
- E-Mail Address: Click or tap here to enter text.

Please complete the information above and return the completed form to the Department no later than **December 22, 2017**. There are two options for returning the completed form to the Department:

1. Send an electronic copy (.DOC or .PDF) via e-mail it to the FL-ESOOS Program Principal Investigator: Dr. Karen Card (FLESOOS@flhealth.gov)
2. Mail a printed copy to the FL-ESOOS Program Principal Investigator: Florida Department of Health, c/o Dr. Karen Card, 4052 Bald Cypress Way, BIN A-22, Tallahassee, FL 32399-1722

APPENDIX C – SUPPLEMENTAL FUNDING NEED

The Department is seeking to provide supplemental financial resources to target District Medical Examiner offices to support them in conducting comprehensive toxicology testing for **ALL** suspected opioid-involved overdose deaths, and / or conduct specialized toxicology testing to identify specific fentanyl analogs and other specific synthetic opioids (when needed) in suspected opioid-involved overdose deaths.

Please check the response option below that applies to your respective District Medical Examiner office:

☐ **Option 1**	My office has a need for supplemental funding.
☐ **Option 2**	My office has an adequate level of local funding; however, my office will submit a proposal for an alternative way to use the supplement funding to enhance the timeliness and quality of Medical Examiner investigations of suspected opioid-involved overdose deaths (to be submitted to the CDC for review and approval/denial).
☐ **Option 3**	My office has an adequate level of local funding and will not submit a proposal for an alternative way to use the supplement funding.

Florida Enhanced State Opioid Overdose Surveillance (FL-ESOOS) Program

MEDICAL EXAMINER INFORMATION PACKAGE

National Program

In 2016, the Centers for Disease Control and Prevention (CDC) established the Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality program (aka ESOOS), which seeks to enable states to develop and adapt surveillance systems to address the rising rate of overdoses attributable to opioids, including a specific focus on heroin and synthetic opioids such as illicitly manufactured fentanyl, by providing more timely and comprehensive data on fatal and non-fatal opioid overdoses and risk factors associated with fatal overdoses. Twelve states were funded in the program's first round of implementation in 2016.[1] In 2017, the CDC funded an additional 20 states, plus the District of Columbia (D.C.).[2] This is an important and timely effort, which will directly support President Trump's recent declaration of a Nationwide Public Health Emergency to address the opioids crisis.

The Opioid Epidemic in Florida

Data from the Florida Department of Health's (Department) Bureau of Vital Statistics indicates Florida had 2,175 unintentional and undetermined drug overdose (UUDO) deaths in 2014, 2,805 UUDOs in 2015 (a 29% increase), and 4,672 UUDOs in 2016 (a 67% increase). Florida's Statewide Drug Policy Advisory Council (DPAC) 2016 Annual Report states that "Since 2000, the rate of deaths from drug overdoses has increased 137 percent, including a 200 percent increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin). The observed progress in some prescription drug-related outcomes is a positive development in Florida, but new challenges have emerged. There has been a substantial increase in deaths associated with fentanyl and heroin-related drug use." [3]

Florida has passed two laws considered important policy tools in the fight against opioid abuse and misuse; the Prescription Drug Monitoring Program (PDMP), section 893.055, Florida Statutes (F.S.), and the Pill Mill Law on Opioid Prescribing and Utilization, section 458.3265, F.S. However, despite the success of the PDMP and increased regulation of opioid prescriptions, the Department recognizes the increasing rate of opioid-involved drug overdose deaths as a growing public health issue. In Spring 2017, Florida's Governor issued an executive order regarding, and the State Surgeon General issued a declaration of, a statewide public health emergency for the opioid epidemic. Additionally, the Florida Legislature passed House Bill 249 (required controlled substance overdose reporting) during its 2017 session.

Core Grant Overview

In Florida, data relevant to opioid-involved overdoses is available, but not collected in a manner or system that allows for proactive and impactful public health response. The Department's Bureau of Emergency Medical Oversight seeks to build a system and infrastructure that will allow a collaborative and targeted

[1] Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, West Virginia, and Wisconsin.

[2] Alaska, California, Connecticut, Delaware, District of Columbia, Florida, Georgia, Illinois, Indiana, Louisiana, Maryland, Michigan, Minnesota, Nevada, New Jersey, North Carolina, Tennessee, Utah, Vermont, Virginia, and Washington.

[3] Florida Department of Health (2016, December 1). *Statewide Drug Policy Advisory Council 2016 Annual Report*. Retrieved from Florida Health: http://www.floridahealth.gov/provider-and-partner-resources/dpac/DPAC-Annual-Report-2016-FINAL.pdf.

response to address the growing challenge presented by opiate-based drugs through the timely dissemination of surveillance data to stakeholders who develop and implement strategic initiatives that will positively impact the community at risk.

The FL-ESOOS program will execute the core grant's three strategies:

- **Strategy 1 → Increase the timeliness of aggregate non-fatal opioid overdose reporting**
  - Utilizing Florida's Emergency Medical Services Tracking and Reporting System (EMSTARS)[4], produce state and county quarterly reports on emergency medical services (EMS) responses to suspected overdoses involving any-drug and any-opioid within three (3) months of the overdose.
  - EMSTARS receives records from 194 licensed EMS agencies, which is 70% of Florida's total, and contained just over 3.23 million incident-patient records in 2016, representing ~90% of the total number of pre-hospital EMS runs in Florida.
  - The dates of non-fatal opioid-involved overdoses to be included in reporting will range from October 1, 2017 through May 31, 2019; the Department will submit its first quarterly report to the CDC by April 2018.

- **Strategy 2 → Increase the timeliness of aggregate fatal opioid overdose and associated risk factor reporting**
  - Abstract standardized case-level data from the death certificate (DC)[5] and medical examiner/coroner (ME/C) reports on fatal opioid-involved overdoses within eight (8) months of death using the CDC's National Violent Death Reporting System (NVDRS) platform – State Unintentional Drug Overdose Reporting System (SUDORS) module.
  - Data will be extracted on a subset of counties whose residents account for a minimum of 75% of unintentional and undetermined overdose (UUDO) deaths in the state (required CDC minimum).
  - The Department is targeting 14 Medical Examiner (ME) districts covering 29 counties that account for approximately 82% of all 2015 UUDO's, based on 2015 death data from the CDC's WONDER database. (**Appendix A**)
  - The dates of fatal opioid-involved overdoses to be included in reporting will range from July 1, 2017 through December 31, 2018; the Department will submit its first semi-annual report to the CDC by December 2018.

- **Strategy 3 → Disseminate surveillance findings to key stakeholders working to prevent or respond to opioid overdoses (inclusive of sharing data with the CDC to support improved multi-state surveillance of, and response to, opioid-involved overdoses)**

Supplemental Grant Overview

Many of Florida's MEs have carved out budget dollars to help facilitate their ability to request comprehensive and specialized toxicology testing. As such, the Department seeks to assist the MEs, by providing them with access to supplemental financial resources (should they not have an adequate level

[4] An existing Department system to which incident-level, pre-hospital EMS data is reported monthly.

[5] The Bureau of Emergency Medical Oversight has an existing relationship – developed through previous projects – and a data use agreement in place with the Bureau of Vital Statistics for DC data.

of local funding), to 1) increase the frequency of comprehensive toxicology testing performed for **ALL** suspected opioid-involved overdose deaths, and / or 2) increase the frequency of specialized toxicology testing to identify specific fentanyl analogs and other specific synthetic opioids (when needed) in suspected opioid-involved overdose deaths.

Should a given ME district have an adequate level of local funding for conducting comprehensive toxicology testing for all suspected opioid-involved overdose deaths, and for conducting specialized toxicology testing to identify specific fentanyl analogs and other specific synthetic opioids (when needed) in suspected opioid-involved overdose deaths, the Department will accept concept proposals from the ME district for an alternative way to use the funding to enhance the timeliness and quality of ME investigations of suspected opioid-involved overdose deaths. All concept proposals will be submitted to the CDC for review and approval/denial.

Funding

For the core ESOOS program, Florida was awarded $493,571 for the budget period of September 1, 2017 – August 31, 2018. For the ESOOS program supplement, Florida was awarded $197,428 for the budget period of September 1, 2017 – August 31, 2018.

FL-ESOOS Program Contacts

Bureau of Emergency Medical Oversight (BEMO)			
Leah Colston	Bureau Chief	FLESOOS@flhealth.gov	(850) 245-4693
Joshua Sturms	Administrator – Health Information and Policy Analysis Section (HIPAS)	FLESOOS@flhealth.gov	(850) 558-9549
Dr. Karen Card (Principal Investigator)	Epidemiologist, Reporting & Analysis Unit Manager	FLESOOS@flhealth.gov	(850) 558-9506
Connie Clark (Program Manager)	IT Business Consultant – HIPAS	FLESOOS@flhealth.gov	(850) 558-9509

Medical Examiner District Partnerships

To execute Strategy 2 of the core grant, the Department is seeking to establish formal, collaborative partnerships with each of the targeted 14 ME Districts, which cover the state's 29 counties that account for approximately 82% of all 2015 UUDO's. The Department will seek to formally add additional counties (and associated ME Districts) to the program during Grant Year 2; however, any county (and associated ME district) outside of the target area that is interested in participating ahead of this timeframe will be incorporated into the program.

Request to Targeted ME Districts – Core Grant

- The Department will use its Vital Statistics' DC data for identifying – monthly – a list of decedents that meet the CDC's case definition (**Appendix B**) for suspected opioid-involved overdose deaths, within the targeted subset of counties (and associated target ME districts).
- The Department will use this list to generate specific requests –monthly – to the in-scope ME districts.

- The ME districts will be asked to provide **COPIES** – for all suspected opioid-involved deaths – of associated ME reports (e.g. autopsy, toxicology, investigator, etc.) that are available and able to be distributed from the respective ME district office.
  - It is understood that each ME district will differ in terms of what reports it can provide to the Department.
  - It is understood that not all ME Districts have ME Investigators, and as such not all ME districts will have those associated reports.
  - It is understood that any case that is under an active / open investigation with Law Enforcement will not be available to the Department until it is closed.
  - It is understood that some ME districts may require the utilization of a public records request to provide the requested report copies to the Department.
  - The Department will work with each ME district to fully document what reports are available from each ME district, based on the data elements required by the CDC, as well as how each ME district will be able to provide the reports (e.g. via a MOU/MOA, public records request, etc.) – the goal is to limit the need for any unnecessary follow-ups with the ME district by the Department when the monthly requests are made, which is understood to be highly preferable to due ME district workloads and competing priorities.
- The Department has developed multiple alternatives for ME districts to provide report copies.
  - **Electronic Copy [Preferred Method]**
    - The in-scope ME offices will be provided with access to a Secure FTP site for uploading report copies to the Department.
  - **Hard Copy**
    - The in-scope ME offices will be provided with pre-addressed, postage-paid envelopes to enable them to quickly drop the report copies in the mail to the Department, with no cost to the respective ME office.
    - To cover the cost of paper and ink, as well as labor, for making copies of the required reports for the Department, ME offices will be provided financial compensation (reimbursement) of $0.50 per page.
  - **On-Site Abstraction**
    - The Department has budgeted travel costs to enable its Abstractors to travel (as needed / desired) to the ME district offices and perform on-site record abstraction.

- The Department will hire two (2) full-time, qualified, Other Professional Services (OPS) positions to perform **ALL** data abstraction from both the DC and ME reports -- for the available risk factor, toxicology, and other CDC-requested data elements -- and perform entry into the NVDRS SUDORS module.
  - The Abstractors will look for trends in these source documents to help improve data collection.
  - Feedback will be provided to help improve standardization and quality of the source documents.
- The ME districts will be provided with access to all surveillance findings, analyses, reports, dashboards, etc. that are produced by the Department.
- Please reference the included **"Fatal Opioid-Involved Overdose Process Flow"** diagram for a visual depiction of the Department's request to the ME districts.

Request to Targeted ME Districts – Supplement Grant

- ❖ The Department is proposing a direct distribution of all supplement funds -- via a contractual mechanism -- to be made to the individual, targeted ME districts that are in need.
- ❖ The Department will execute contractual agreements with those targeted ME districts who are in need, as the mechanism for distribution of all supplemental funds.
  - ➢ The total amount will be divided based on the proportional number of suspected opioid-involved overdose cases that each of the target ME districts has, relative to the total number of suspected opioid-involved overdose cases (**Appendix C**).
- ME districts will be requested – as a contract provision and deliverable – to provide information to the Department regarding:
  - The ME data system and a list of variables / data elements collected.
  - Name and other specifics of the toxicology testing laboratory used.
  - Initial (to create a baseline) and semi-annual (to track progress) data on the percentage of suspected opioid-involved overdoses that receive a comprehensive toxicology test and/or that receive a specialized toxicology test.
- ME Districts will be requested to submit to the Department:
  - An annual statement / letter of attestation that supplemental grant monies provided have been used only for conducting comprehensive and specialized toxicology testing for suspected opioid-involved overdoses.
  - A summary of dollars spent on comprehensive and specialized toxicology tests for suspected opioid-involved overdoses (in comparison to total grant dollars made available).

APPENDIX A – TARGET MEDICAL EXAMINER DISTRICTS

In-Scope ME Districts	District ME	Counties Covered	Covered By (ME District)?	Also Covers (ME District)?	Additional Counties Covered?
1	Andrea N. Minyard, M.D.	Escambia Okaloosa Santa Rosa Walton	N/A	N/A	N/A
4	Valerie J. Rao, M.D.	Clay Duval Nassau	N/A	3	Columbia Hamilton
6	Jon R. Thogmartin, M.D.	Pasco Pinellas	N/A	N/A	N/A
7	Marie A. Herrmann, M.D.	Volusia	N/A	24	N/A
9	Joshua D. Stephany, M.D.	Orange	N/A	25	Osceola
10	Stephen J. Nelson, M.A., M.D., F.C.A.P.	Hardee Highlands Polk	N/A	N/A	N/A
11	Emma O. Lew, M.D.	Miami-Dade	N/A	N/A	N/A
12	Russell S. Vega, M.D.	DeSoto Manatee Sarasota	N/A	N/A	N/A
13	Mary K. Mainland, M.D.	Hillsborough	N/A	N/A	N/A
15	Michael D. Bell, M.D.	Palm Beach	N/A	N/A	N/A
17	Craig Mallak, M.D.	Broward	N/A	N/A	N/A
18	Sajid S. Qaiser, M.D.	Brevard	N/A	N/A	N/A
21	Rebecca A. Hamilton, M.D.	Glades Hendry Lee	N/A	N/A	N/A
24	Marie A. Herrmann, M.D.	Seminole	7	N/A	N/A

Florida Enhanced State Opioid Overdose Surveillance (FL-ESOOS) Program

The 16 counties that comprise just over 75% (76.70%) of the core grant required UUDO's, are part of 14 different ME districts. Given that the targeted ME districts often cover more than one county, this then provides an additional 13 counties for which data would be collected, bringing the total count to 29 and comprising just over 82% (82.10%) of the UUDO's.

2015 UUDO Data - CDC WONDER Database

	#	County	Deaths	Population	Crude Rate	% of Total Deaths (UUDOs)	ME District	Covered By
In-Scope ME Districts & Core Counties	1	Palm Beach County, FL	265	1,422,789	18.6	9.50%	15	
	2	Broward County, FL	253	1,896,425	13.3	9.10%	17	
	3	Orange County, FL	173	1,288,126	13.4	6.20%	9	
	4	Miami-Dade County, FL	170	2,693,117	6.3	6.10%	11	
	5	Pinellas County, FL	161	949,827	17	5.80%	6	
	6	Hillsborough County, FL	156	1,349,050	11.6	5.60%	13	
	7	Duval County, FL	146	913,010	16	5.30%	4	
	8	Manatee County, FL	137	363,369	37.7	4.90%	12	
	9	Brevard County, FL	132	568,088	23.2	4.70%	18	
	10	Pasco County, FL	95	497,909	19.1	3.40%	6	
	11	Lee County, FL	90	701,982	12.8	3.20%	21	
	12	Polk County, FL	86	650,092	13.2	3.10%	10	
	13	Volusia County, FL	84	517,887	16.2	3.00%	7	
	14	Sarasota County, FL	83	405,549	20.5	3.00%	12	
	15	Seminole County, FL	54	449,144	12	1.90%	24	7
	16	Escambia County, FL	52	311,003	16.7	1.90%	1	
	#	County	Deaths	Population	Crude Rate	% of Total Deaths (UUDOs)	ME District	Covered By
Extra Counties Covered by In-Scope ME Districts	17	Clay County, FL	41	203,967	20.1	1.50%	4	
	18	Okaloosa County, FL	39	198,664	19.6	1.40%	1	
	19	Osceola County, FL	37	323,993	11.4	1.30%	25	**9**
	20	Santa Rosa County, FL	23	167,040	13.8	0.80%	1	
	21	Columbia County, FL	10	68,348	Unreliable	0.40%	3	**4**
	22	Walton County, FL	Suppressed	63,508	Suppressed	Suppressed	1	
	23	Hamilton County, FL	Suppressed	14,295	Suppressed	Suppressed	3	**4**
	24	Nassau County, FL	Suppressed	78,444	Suppressed	Suppressed	4	
	25	Hardee County, FL	Suppressed	27,502	Suppressed	Suppressed	10	
	26	Highlands County, FL	Suppressed	99,491	Suppressed	Suppressed	10	
	27	DeSoto County, FL	Suppressed	35,458	Suppressed	Suppressed	12	
	28	Glades County, FL	Suppressed	13,670	Suppressed	Suppressed	21	
	29	Hendry County, FL	Suppressed	39,119	Suppressed	Suppressed	21	

BOLD = In-Scope ME District

APPENDIX B - CDC CASE DEFINITION FOR OPIOID-INVOLVED DEATHS

- Opioid-involved deaths are drug poisoning deaths where the ME/C report indicates that an opioid contributed to the death. Opioids are any drug contributing to death that would be captured by the following *International Classification of Disease, Tenth Revision* (ICD-10) classification coding scheme:
  - ICD-10 underlying cause-of-death codes on the death certificate are X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the ICD-10 codes T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6 are indicated in the multiple cause-of-death codes.

- Because awardees are collecting data from DC and ME/C reports, examples of drug overdoses considered opioid-involved and not opioid-involved are provided below.

  - Meets fatal opioid-involved overdose case definition
    - The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death, but the DC multiple cause-of-death code does not list any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, in the multiple cause-of-death codes.
    - The ME/C report does not indicate that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death, but the ICD-10 underlying cause of death code on the DC is one of the following, X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, are indicated in the DC multiple cause-of-death codes.
    - The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin contributed to the death AND the ICD-10 underlying cause of death code on the DC is one of the following, X40–44 (unintentional) or Y10–Y14 (undetermined intent) AND any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, are indicated in the DC multiple cause-of-death codes.

  - Does not meet the fatal opioid-involved overdose case definition
    - The ME/C report indicates that a pharmaceutical opioid (e.g., oxycodone) or heroin was detected by toxicology but did not contribute to the death AND the DC multiple cause-of-death code does not list any of the following ICD-10 codes, T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6, in the multiple cause-of-death codes.

It is understood that the CDC case definition may not match (exactly) how Florida defines an opioid-involved death.

APPENDIX C – TARGET MEDICAL EXAMINER DISTRICT SUPPLEMENT FUNDING

2016 Opioid-Involved Deaths (OIDs)* - Target ME Districts (MEDs)
(*Source* : Bureau of Vital Statistics - Death Certificates)

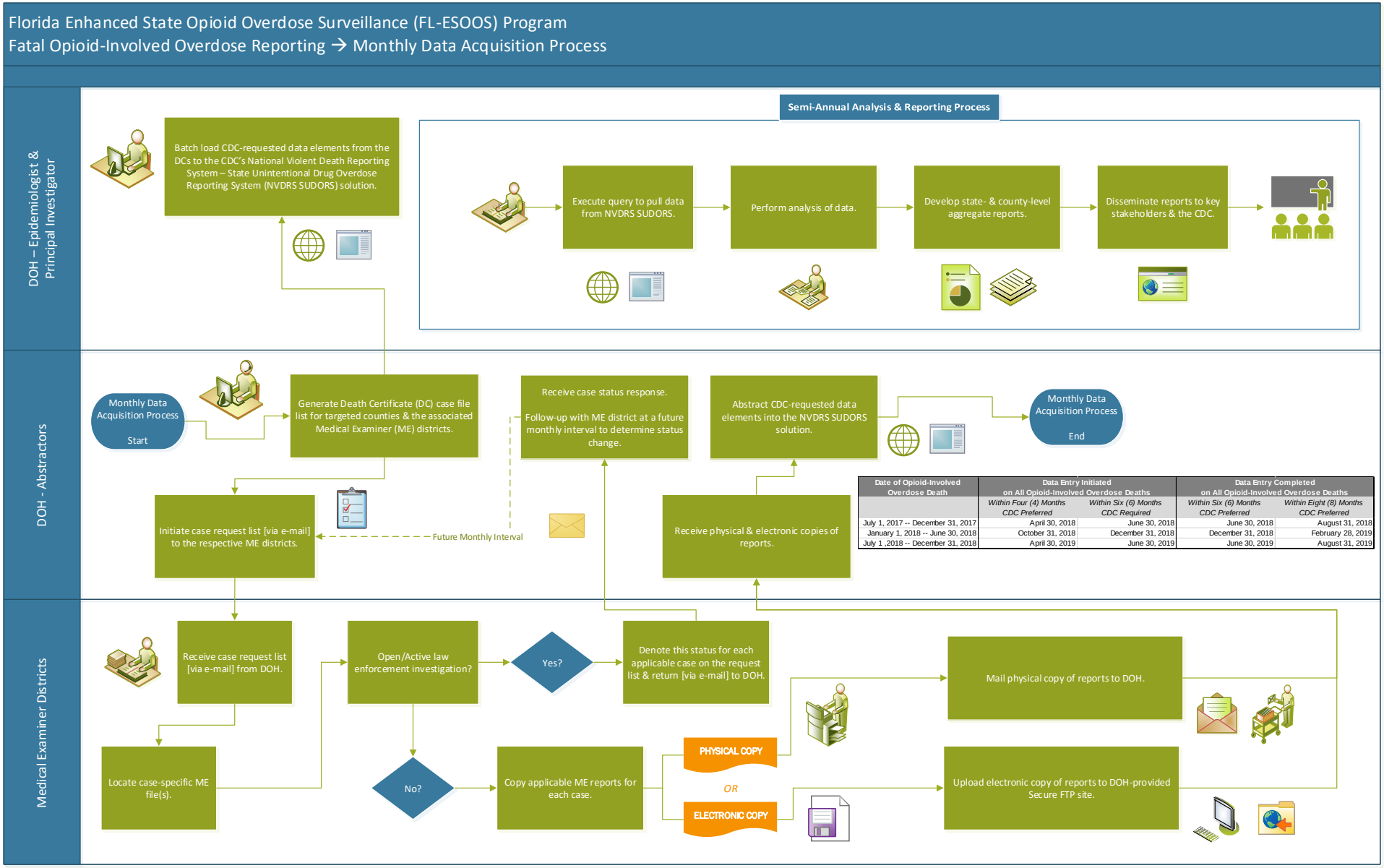
In-Scope MEDs	District ME	Counties Covered	Covered By (MED)?	Also Covers (MED)?	Additional Counties Covered?	MED OID Count	% of MED OID Count Total	Available Supplement Funding	Estimated Monthly OID Case Average
1	Andrea N. Minyard, M.D.	Escambia Okaloosa Santa Rosa Walton	N/A	N/A	N/A	85	3.44%	$ 6,791.33	7
4	Valerie J. Rao, M.D.	Clay Duval Nassau	N/A	3	Columbia Hamilton	402	16.27%	$ 32,119.00	34
6	Jon R. Thogmartin, M.D.	Pasco Pinellas	N/A	N/A	N/A	140	5.67%	$ 11,185.72	12
7**	Marie A. Herrmann, M.D.	Volusia	N/A	24	N/A	75	3.04%	$ 5,992.35	6
9	Joshua D. Stephany, M.D.	Orange	N/A	25	Osceola	234	9.47%	$ 18,696.14	20
10	Stephen J. Nelson, M.A., M.D., F.C.A.P.	Hardee Highlands Polk	N/A	N/A	N/A	27	1.09%	$ 2,157.25	2
11	Emma O. Lew, M.D.	Miami-Dade	N/A	N/A	N/A	305	12.34%	$ 24,368.90	25
12	Russell S. Vega, M.D.	DeSoto Manatee Sarasota	N/A	N/A	N/A	212	8.58%	$ 16,938.38	18
13	Mary K. Mainland, M.D.	Hillsborough	N/A	N/A	N/A	150	6.07%	$ 11,984.70	13
15	Michael D. Bell, M.D.	Palm Beach	N/A	N/A	N/A	367	14.85%	$ 29,322.57	31
17	Craig Mallak, M.D.	Broward	N/A	N/A	N/A	266	10.76%	$ 21,252.87	22
18	Sajid S. Qaiser, M.D.	Brevard	N/A	N/A	N/A	46	1.86%	$ 3,675.31	4
21	Rebecca A. Hamilton, M.D.	Glades Hendry Lee	N/A	N/A	N/A	110	4.45%	$ 8,788.78	9
24**	Marie A. Herrmann, M.D.	Seminole	7	N/A	N/A	52	2.10%	$ 4,154.70	4
						2,471	**100.00%**	**$197,428.00**	**206**

*Where death occurred in Florida and the Medical Examiner/Coroner was called to determine cause of death.

**MEDs 7 & 24 have a combined 2016 OID count of 127 (or 5.14% of the MED OID Count Total), making them eligible for a combined $10,147.50 in Supplement funding. Together, they have an estimated monthly OID Case Average of 10.

NOTE: The 29 counties comprised within these 14 MEDs account for 89.11% of **ALL** opioid-involved overdoses in the state of Florida (total 2016 count of opioid -involved overdoses for Florida is 2,773)

LETTER SIZE - COLOR PRINTER



Date of Opioid-Involved Overdose Death	Data Entry Initiated on All Opioid-Involved Overdose Deaths		Data Entry Completed on All Opioid-Involved Overdose Deaths	
	Within Four (4) Months CDC Preferred	*Within Six (6) Months CDC Required*	*Within Six (6) Months CDC Preferred*	*Within Eight (8) Months CDC Preferred*
July 1, 2017 -- December 31, 2017	April 30, 2018	June 30, 2018	June 30, 2018	August 31, 2018
January 1, 2018 -- June 30, 2018	October 31, 2018	December 31, 2018	December 31, 2018	February 28, 2019
July 1 ,2018 -- December 31, 2018	April 30, 2019	June 30, 2019	June 30, 2019	August 31, 2019