



Florida Department of Health, Division of Medical Quality Assurance

2017 MULTI BOARD WORKGROUP MEETING

A multi-disciplinary team approach to health care regulation

ROSEN PLAZA HOTEL 9700 International Drive, Orlando, FL 32819

JUNE 2, 2017

AGENDA

9:00 Welcome and Introductions Lucy C. Gee, MS, Director

10:30-10:45 Remarks Celeste Philip, MD, MPH,
State Surgeon General &
Secretary

Workgroup Moderator Lucy C. Gee, MS, Director

Wrong Site Surgery and Retained Foreign Objects

Break

Telehealth

Lunch

Controlled Substances

Break

Anesthesia

Legislative Summary

Wrap-up





FLORIDA | Board of Medicine

Wrong Site Surgery and Retained Foreign Objects

Florida Department of Health- Division of MQA
Florida Board of Medicine Surgical Care Committee Meeting
Thursday, February 2, 2017



www.floridahealth.gov

Wrong Site Surgery

- The cases analyzed are from 2004, when the Joint Commission implemented the Universal Protocol, to 2015. All cases in this presentation are Final Orders where the physicians have been disciplined for Wrong Site/Procedure/Patient/Implant Surgery, it does not include PCP cases. Information was gathered from the Departments Licensee Database, research articles, and old reports given to the Board.
- Section- 456.072(1)(bb) Florida Statutes Performing or attempting to perform health care services on the wrong patient, a wrong-site procedure, a wrong procedure, or an unauthorized procedure or a procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition. For the purposes of this paragraph, performing or attempting to perform health care services includes the preparation of the patient.

2004	31
2005	32
2006	59
2007	52
2008	57
2009	41
2010	40
2011	20
2012	22
2013	31
2014	29
2015	20

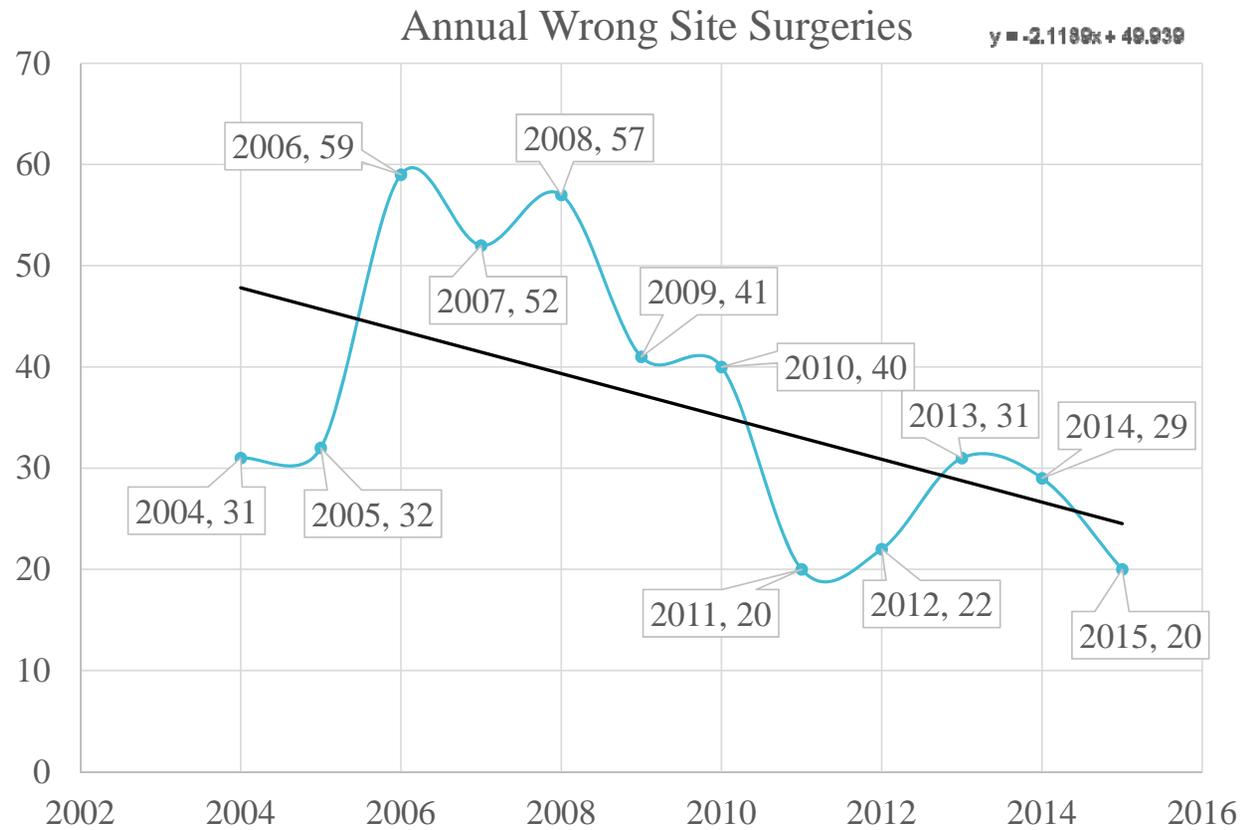


Fig. 1.1 shows the downward trend of WSS over the last 11 years. 2006 was the highest year while 2011 and 2015 are the lowest years yet.

It was asked at the last board meeting to see if the trendline would change if Ophthalmology cases were taken out of the data set.

Slope with Ophthalmology ~ -2.1
Slope w/o Ophthalmology ~ -1.9

It appears that the change in slope is not very significant without Ophthalmology cases.

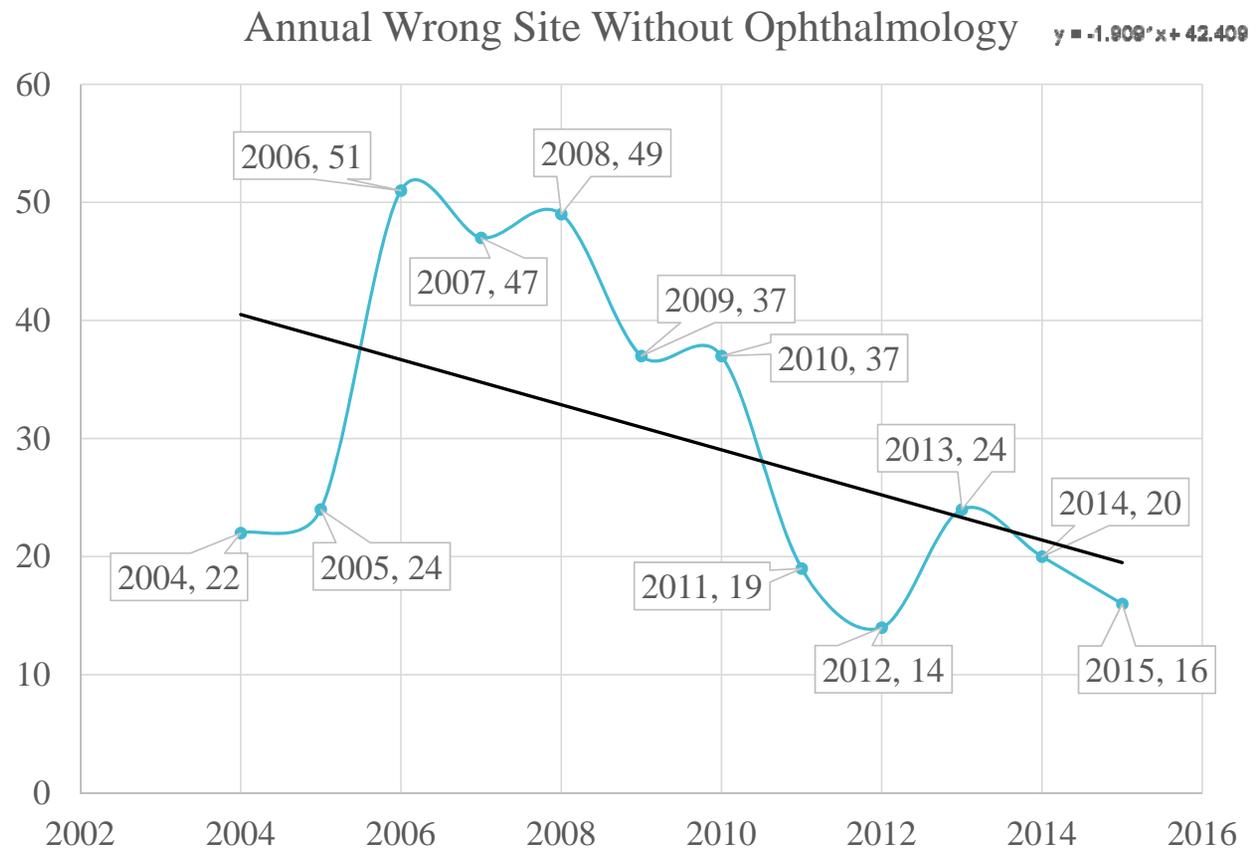


Fig 1.2 Without Ophthalmology cases the slope of the trendline does not change significantly. This indicates that Ophthalmology is not responsible for the decline in WSS over the last 11 years.

2004	11
2005	17
2006	8
2007	6
2008	11
2009	6
2010	10
2011	11
2012	19
2013	10
2014	6
2015	6

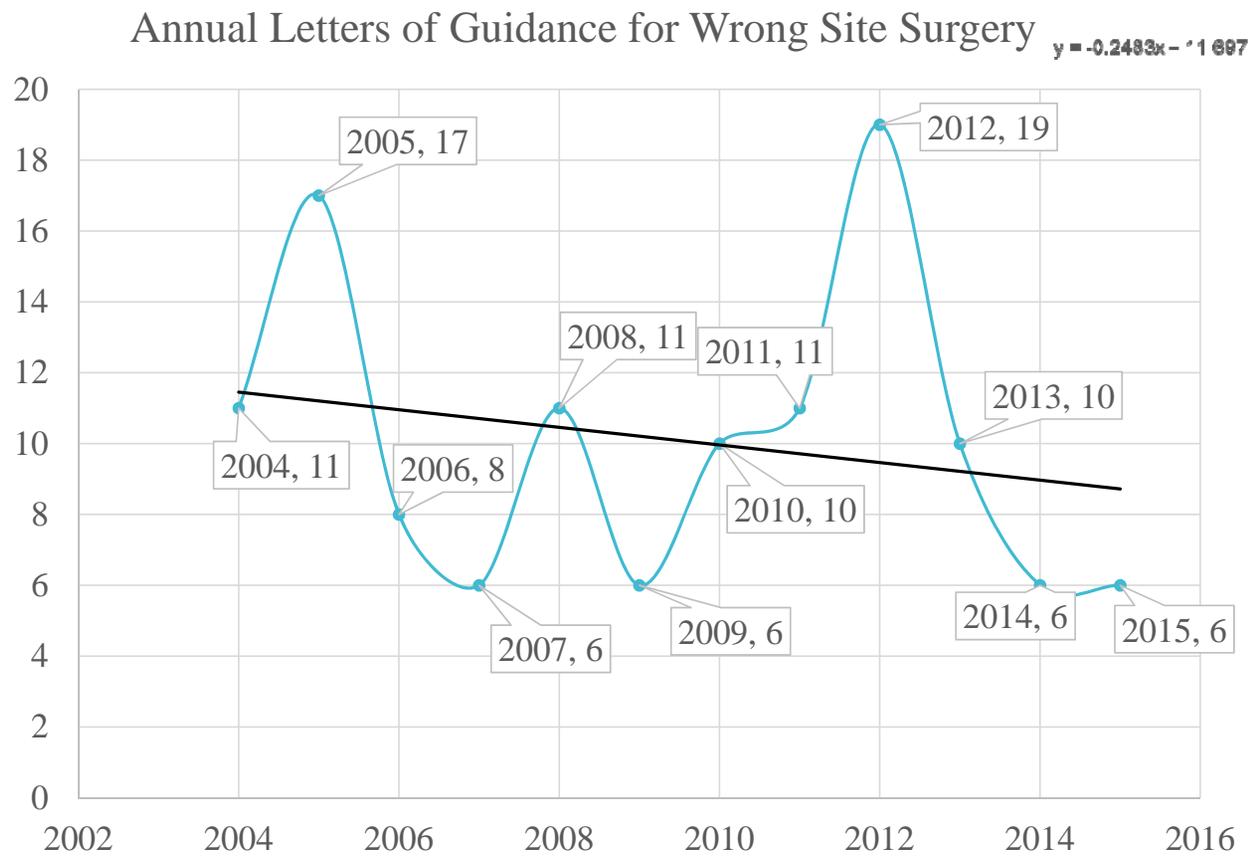


Fig 1.3 shows that the number of Letters of Guidance given in result of a WSS has not changed significantly in the last 11 years.

Unclosed cases range from “under review” to “pending final action.” This graph is meant to help visualize what the trend look like if all unclosed cases were disciplined.

There are 36 unclosed cases from 2012 to 2015 and no unclosed cases from any other years.

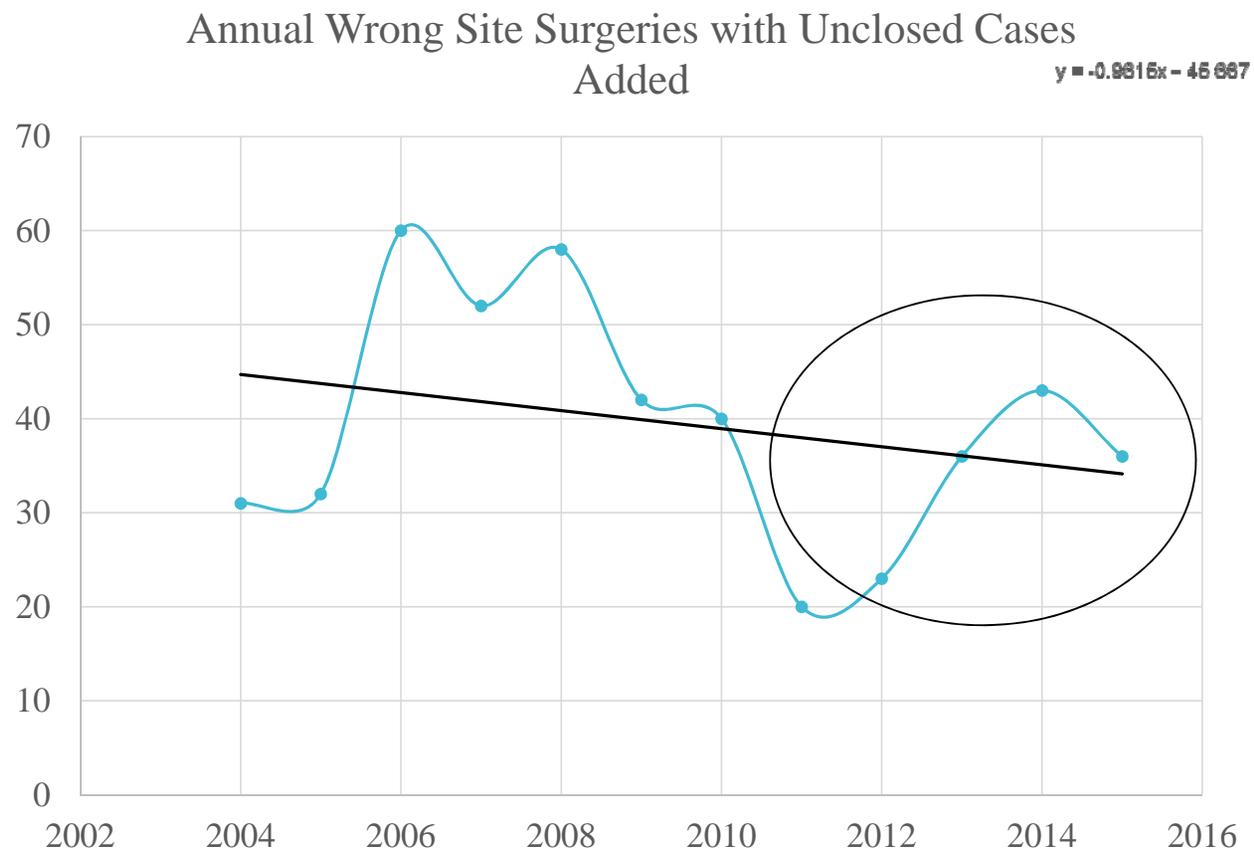


Fig 1.4 shows what the annual WSs graph would look like if all unclosed cases were disciplined. This is a theoretical graph.

Whether or not a pause was done did not seem to have an affect on the occurrence of a wrong site surgery (WSS). This was due to the fact that in most cases at least 1 step of the Universal Protocol was done incorrectly.

Yes, Pause done	243
No Pause done	190
Unknown	2

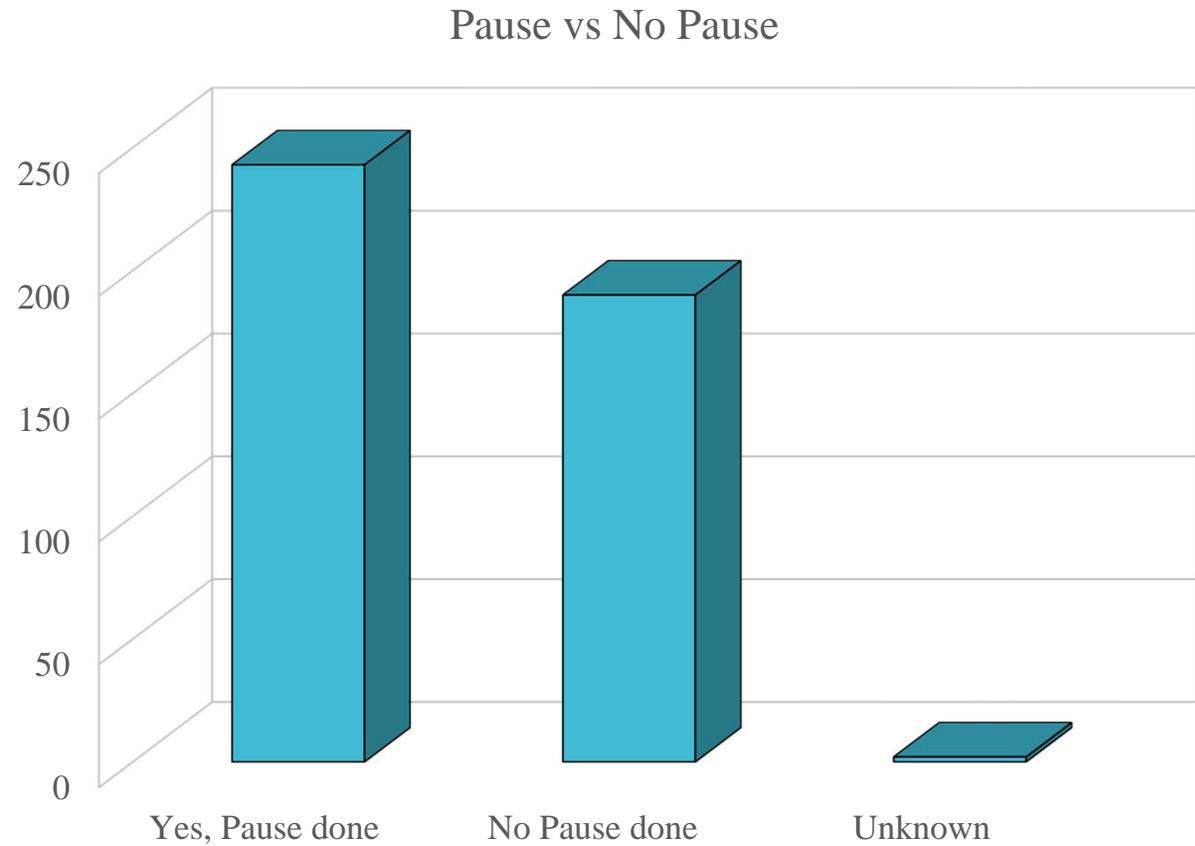


Fig 1.5 is an absolute representation of whether a pause was done or not. I will be breaking this down further in the presentation to give more information about this graph.

This is a breakdown of the “Yes, pause done” column on the previous slide. As you can see, in the majority of cases with a pause, some part of the Universal Protocol was done incorrectly.

Errors include-

- Incorrect Patient Verification
- Incorrect Procedure Verification
- Incorrect/no site marking
- Incorrect Consent
- Incorrect Pause procedure

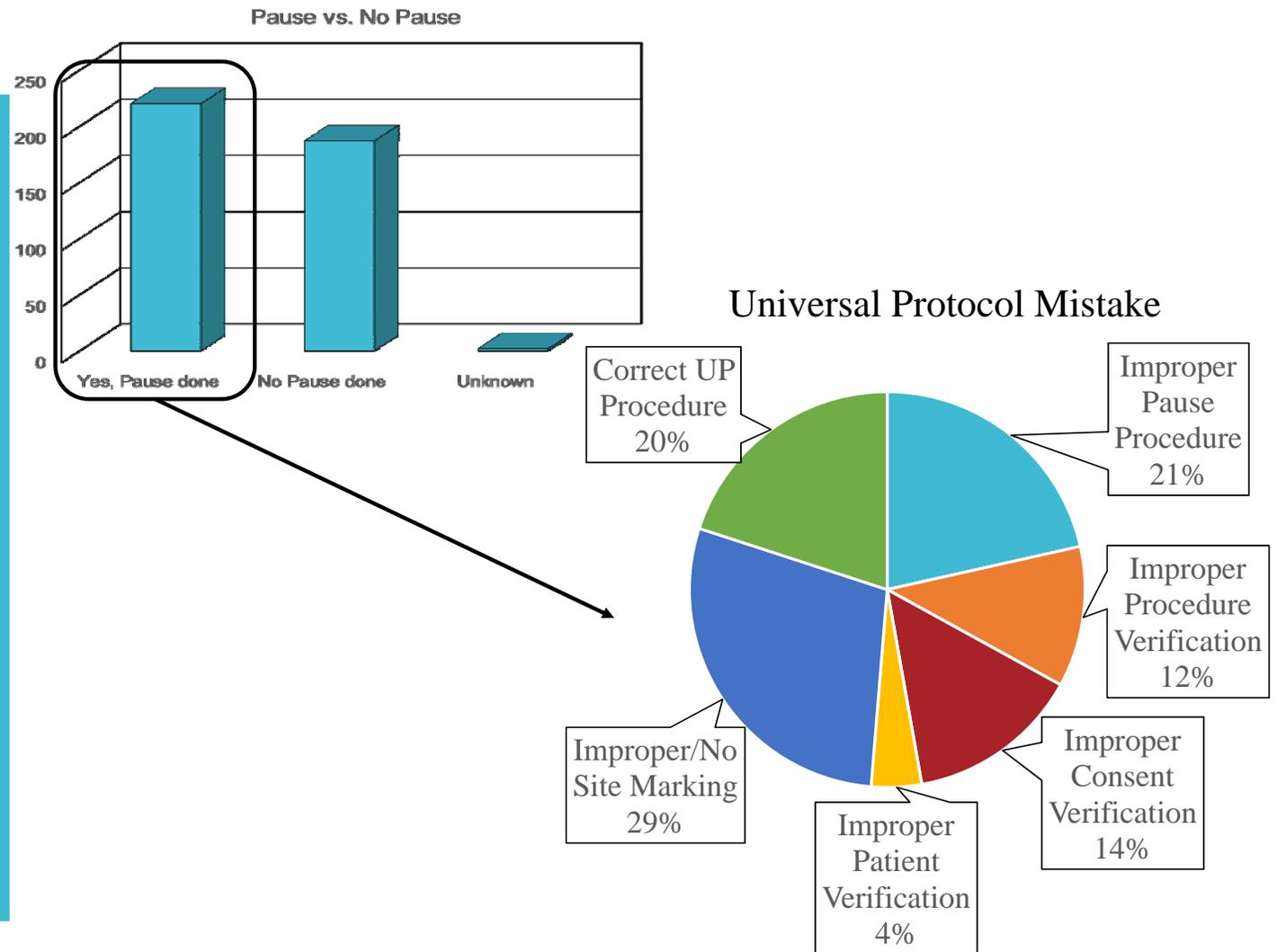


Fig 1.6 shows what caused the WSS when a pause was done.

The Universal Protocol mistakes can be generalized to Proper, Improper, and No Pause categories. Here are those numbers as they relate to Facility type.

	Hospital	ASC	Office	Total
Proper	39	11	1	51
Improper	92	89	8	189
No	97	83	15	195

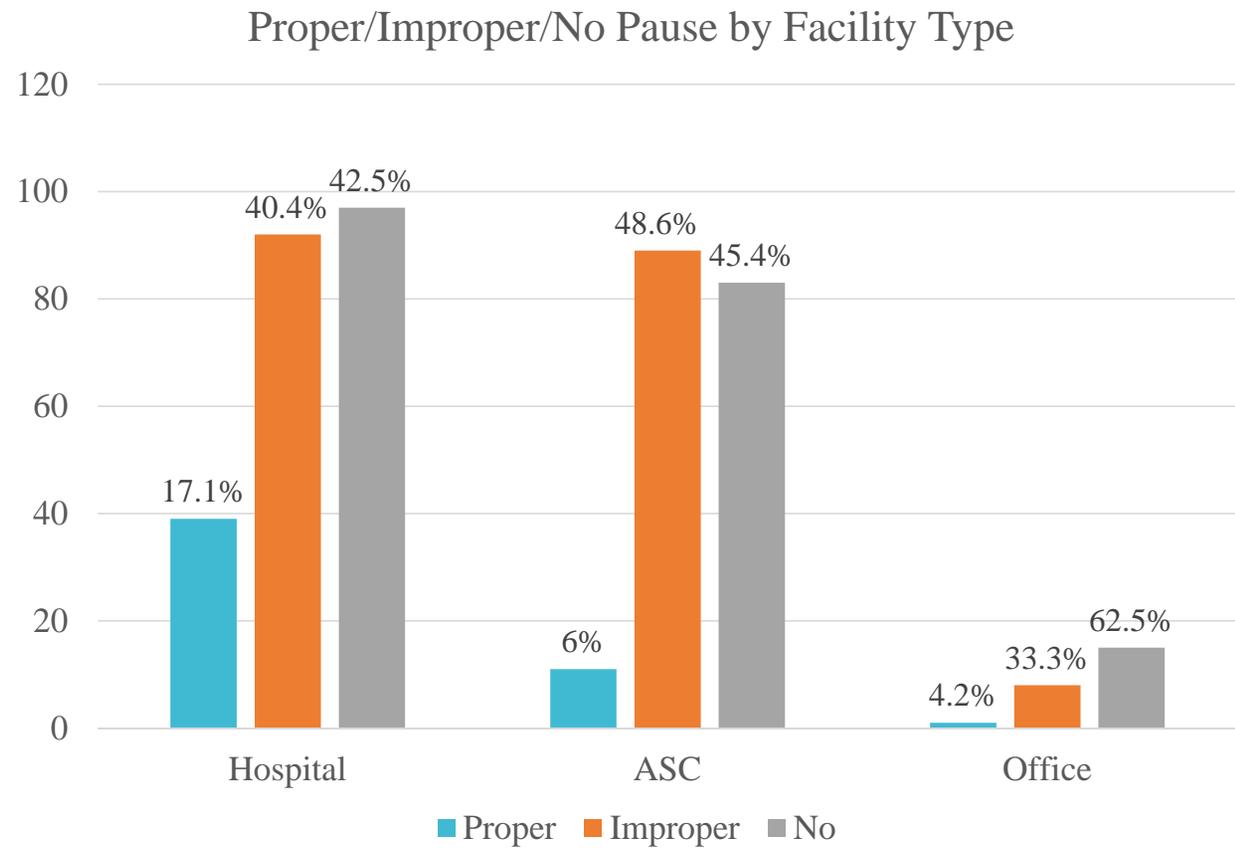


Fig 1.7 shows what percentage of proper/improper/no pause was done within each facility and shows the relative amounts of proper/improper/no pause done between facility types.

The number of estimated annual procedures are generated from an past report to the board coupled with a report from the CDC regarding Ambulatory Surgery.

It appears that a wrong site surgery is most likely to happen at an ambulatory surgery center (ASC) and least likely to happen at a Hospital.

Occurrence of a Wrong Site/Procedure/Patient/Implant Surgery
Organized by Facility Type

<u>Facility Type</u>	<u>Estimated Procedures 2004-2015</u>	<u>% that are WSS</u>
Hospitals	77,573,320	0.000294
ASC	29,236,680	0.000623
Office	7,590,000	0.000316



Fig 1.8 shows the percentage occurrence of WSS at each facility type.

WRONG SITE	317
WRONG IMPLANTATION	37
WRONG PATIENT	31
WRONG PROCEDURE	50



Fig 1.9 shows which types of errors are most common within the description of a WSS.

This chart indicates which specialties committed the most wrong site/procedure/patient/ or implant surgeries. “Other” category contains specialties with fewer than 3 cases.

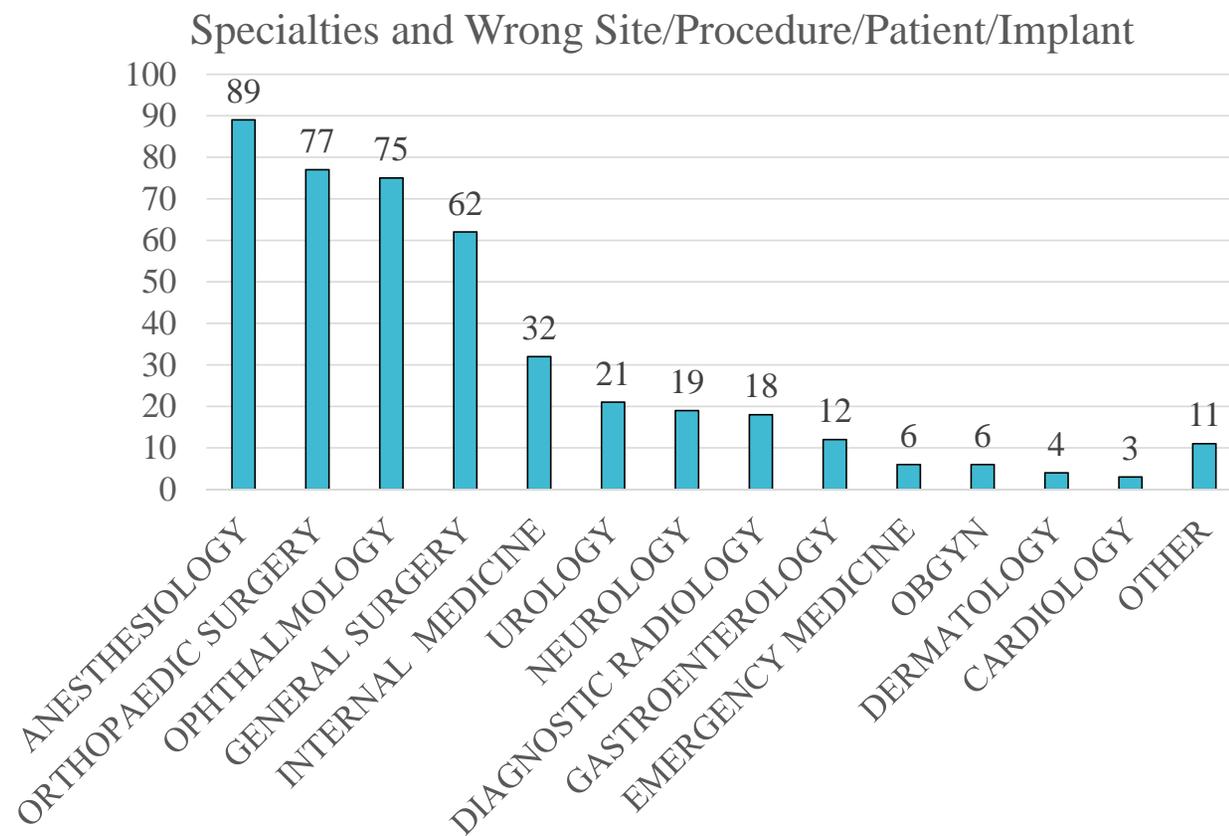


Fig 1.10 shows the top specialties with WSS mistakes in the last 11 years.

There does not appear to be a strong correlation to WSS and a companion case for a nurse. Most cases of WSS had no nurse companion cases.

Companion Case- Nurse	93
No Nurse Companion Case	342

Companion Case-Nurse vs. No Nurse Companion Case

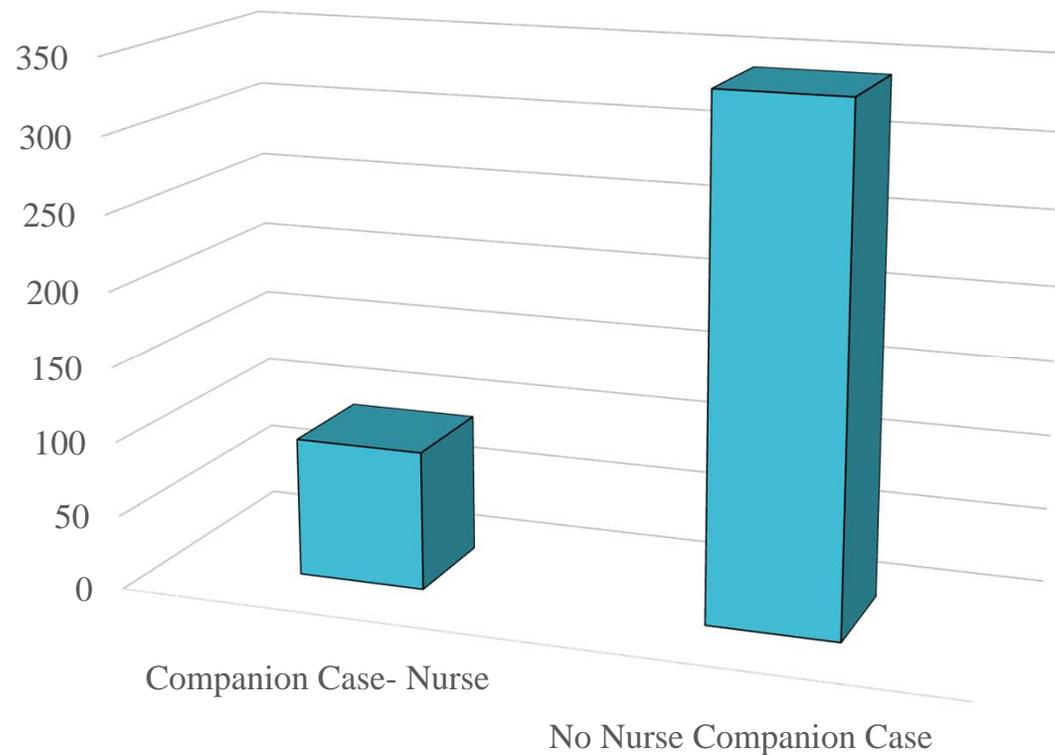


Fig 1.11 shows how many nurse companion cases there are compared to WSS cases without any nurse companion cases. This does not show how many nurses were disciplined for a WSS.

It appears that nurses are not often disciplined in their companion cases for WSS. Only 21.5% of nurse companion cases were given a disciplinary final action.

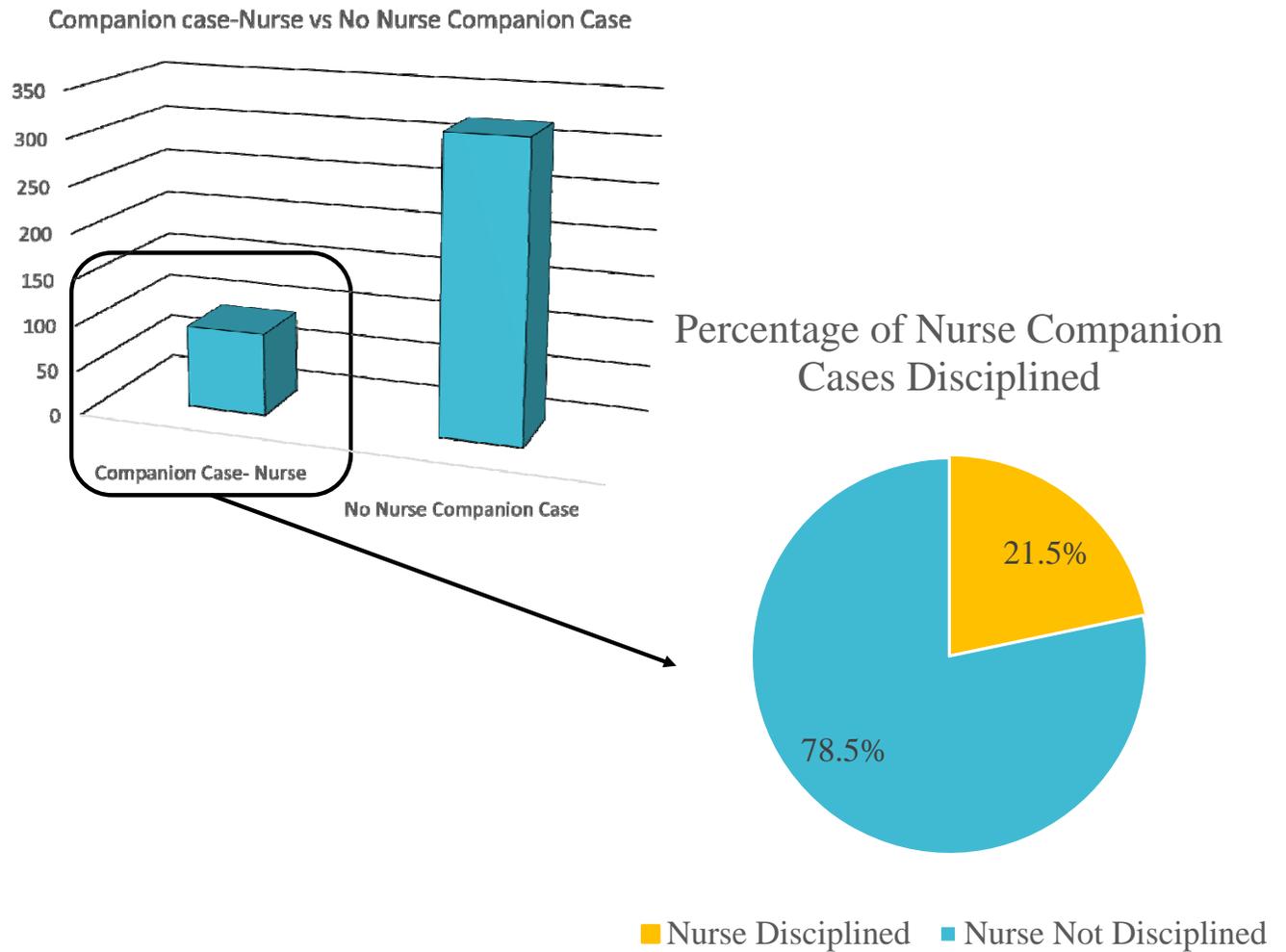


Fig 1.12 show what percentage of nurse companion cases were disciplined for WSS.

Possible Solutions

- Strict Adherence to the entire Universal Protocol including correct marking of the surgical site and mindful and intentional time-outs.
- Active participation is needed. Just “going through the motions” of the steps of the protocol can also lead to wrong site surgeries.

TIME OUT!	
All personnel involved in procedure must agree before starting.	
<input type="checkbox"/> Correct patient	<input type="checkbox"/> Correct images are displayed if needed
<input type="checkbox"/> Correct side and site marked	<input type="checkbox"/> Correct equipment/supplies/implants
<input type="checkbox"/> Agreement on Procedure to be done	<input type="checkbox"/> Antibiotics administered as needed
<input type="checkbox"/> Correct Patient Position	<input type="checkbox"/> Fluids for irrigation
<input type="checkbox"/> Consent Verified	<input type="checkbox"/> Assessed precautions based on medication use or patient history:
<div style="display: flex; justify-content: space-between;"> Signature RN/MD Date/Time </div>	
CL32009	

TIME OUT	
STOP ACTIVITY!	
1.	Correct Patient
2.	Correct Site & Side?
3.	Consent signed?
4.	Agreement on procedure
5.	Allergies?
6.	Antibiotic given?
7.	Special Equipment / Implant present?
8.	Tourniquet tested?
9.	SCD's operational?
 	

CONCLUSION

- According to the information gathered, it seems to indicate that the occurrence of wrong site surgeries is not prevented just by a time out or pause. The whole Universal Protocol must be correctly followed. The Time-Out step must be done with all members of the Surgical Team actively participating.
- While the number of wrong site surgeries has decreased over the last 11 years, this sentinel event is not yet eliminated.

Retained Foreign Object Cases

- There were far fewer Retained Foreign Object (RFO) cases found so conclusions are harder to draw from such a small sample. Cases analyzed are from 2004 to 2015. All cases in this presentation are Final Orders where the physicians have been disciplined for a Retained Foreign Object, PCP cases are not included. Information was gathered from the Departments Licensee Database, research articles, and old reports given to the Board.
- Section- 456.072(1)(cc), Florida Statutes Leaving a foreign body in a patient, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or other diagnostic procedures. For the purposes of this paragraph, it shall be legally presumed that retention of a foreign body is not in the best interest of the patient and is not within the standard of care of the profession, regardless of the intent of the professional.

2004	6
2005	7
2006	3
2007	6
2008	7
2009	6
2010	8
2011	3
2012	7
2013	2
2014	1
2015	3

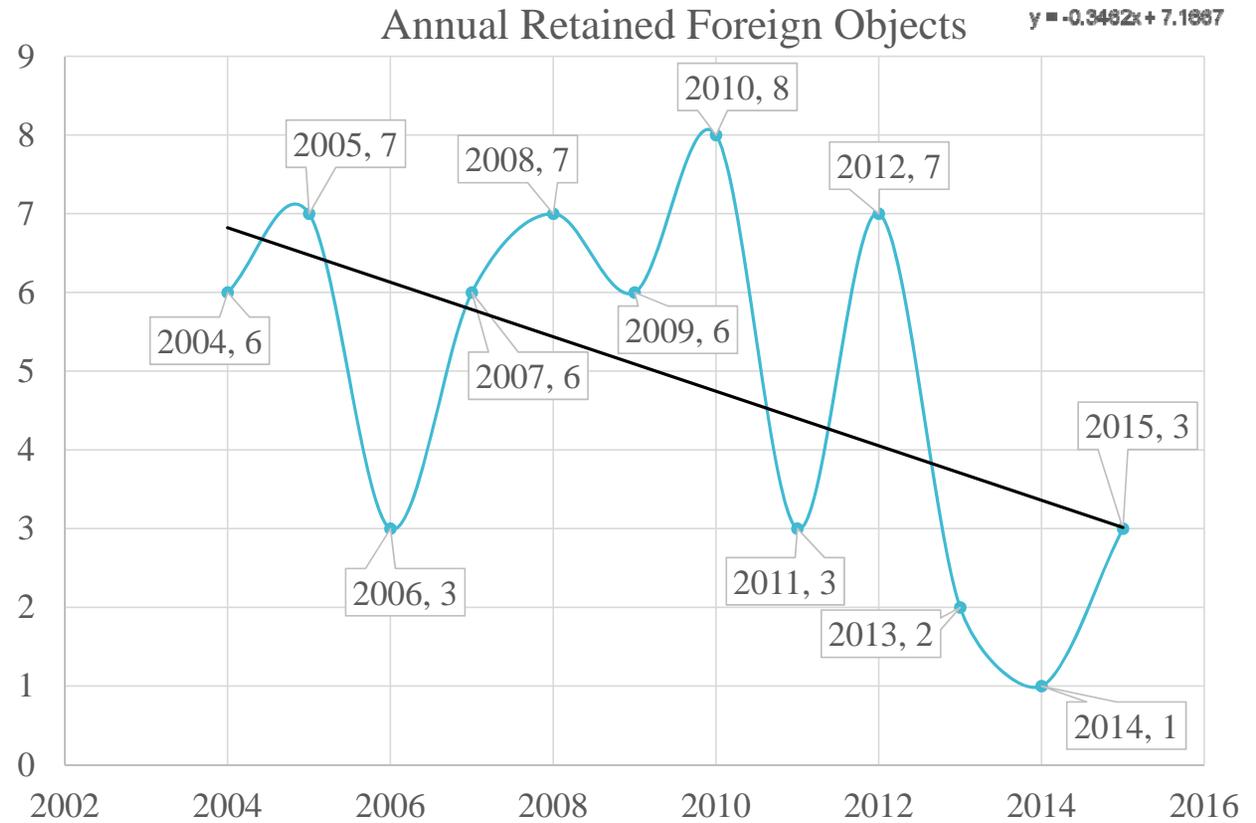


Fig 2.1 shows the downward trend of RFOs over the last 11 years. This result is subject to change as 24 unclosed cases between 2013-2015 get their final orders.

The count was deemed correct in the majority of cases due to counting mistakes, the retained item not being included in the count, or the surgical item breaking off in the patient.

CORRECT COUNT	42
COUNT INCORRECT	3
NO COUNT	14

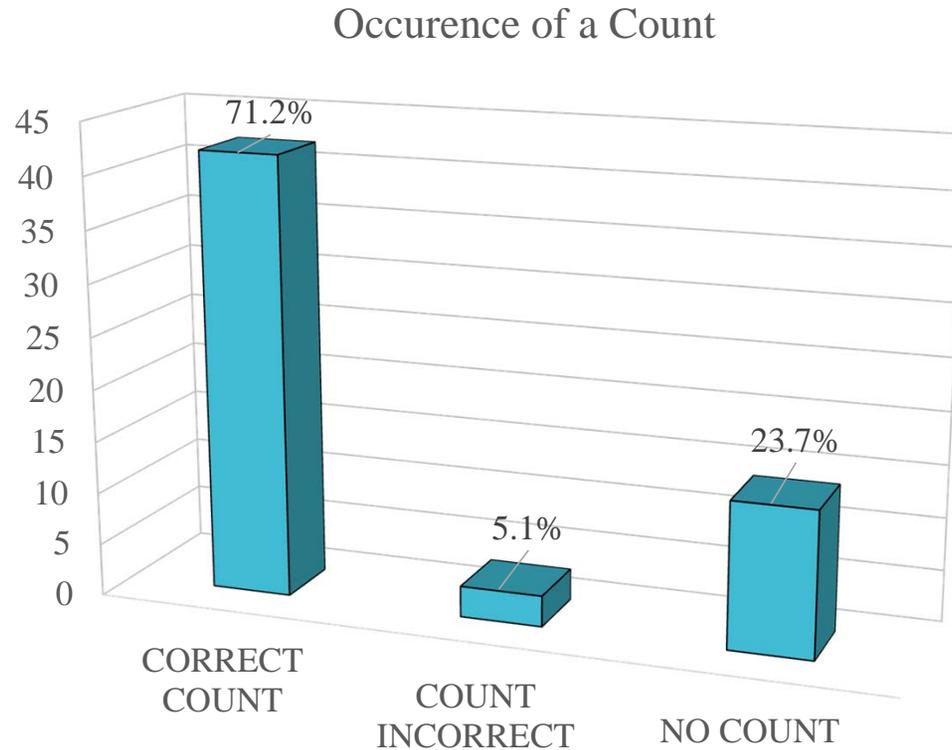


Fig. 2.2 shows whether or not a count was completed before and after a surgery. In most cases the count was completed and deemed correct before the occurrence of a RFO.

- This is a chart of what happened when the count was deemed correct and a RFO occurred. The most common occurrence was a counting mistake tied with a broke item being retained.
- The next most common occurrence was the item not being counted in the first place.

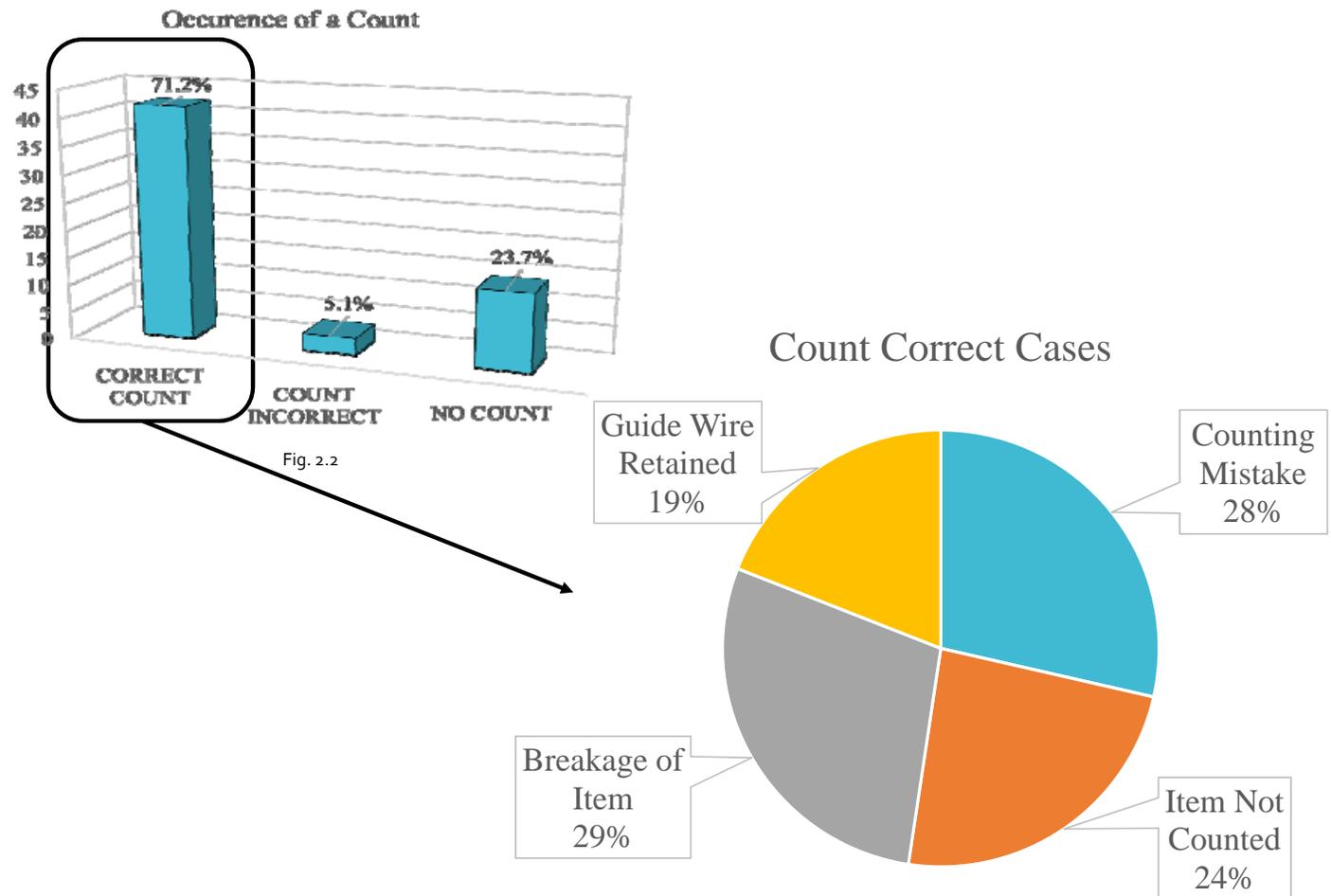


Fig. 2.3 shows what happened that lead to a RFO after the count was deemed correct. The most common instance was a broken item was left inside the patient.

In the majority of retained foreign object cases there were no companion cases for nurses. However, in 42 cases the count was deemed correct and in 14 cases the count was not done at all.

Companion Case- Nurse	9
No Nurse Companion Case	50

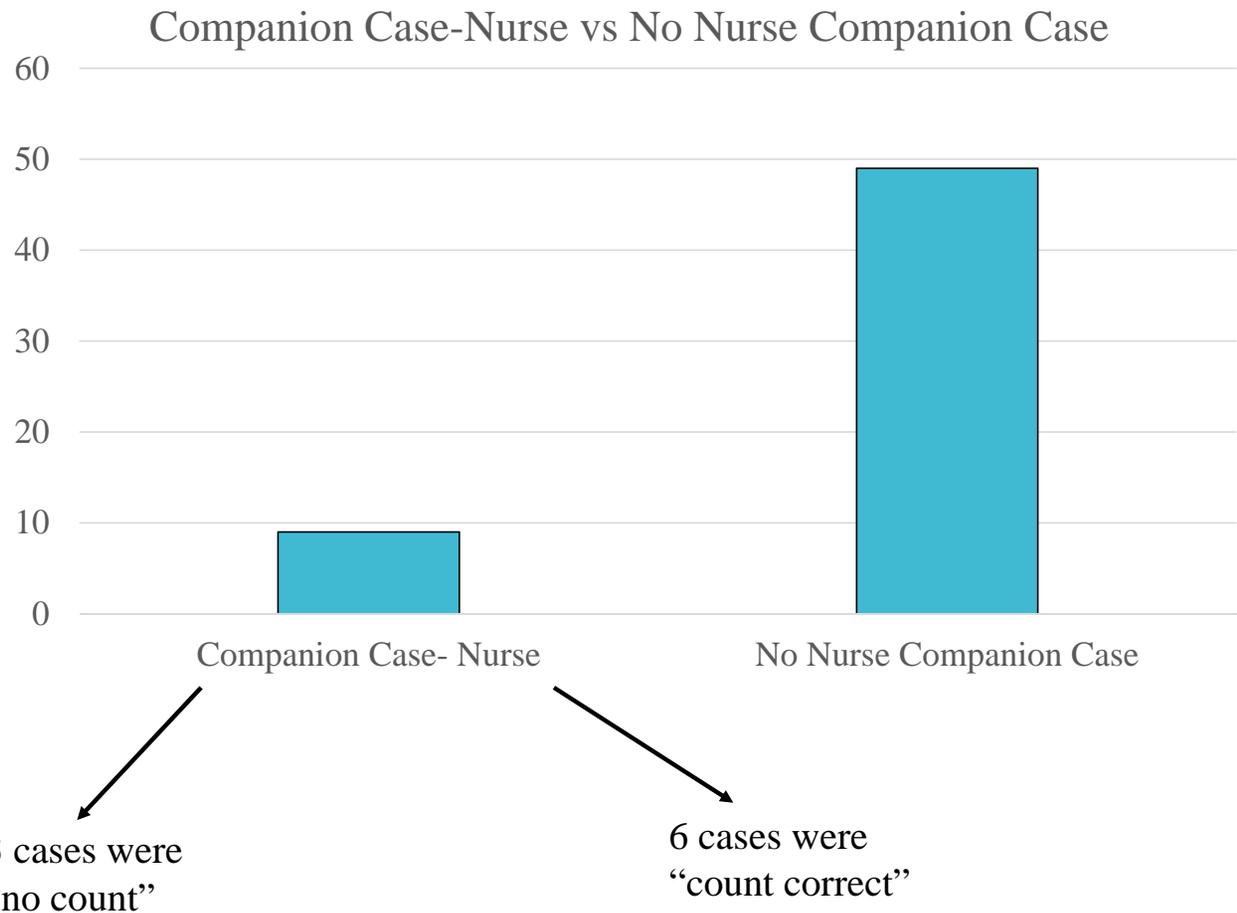


Fig. 2.4 shows how many RFO cases listed a nurse on the companion case. Again this is not a graph for how many nurses were disciplined.

Breakdown of cases with when a Nurse was Disciplined

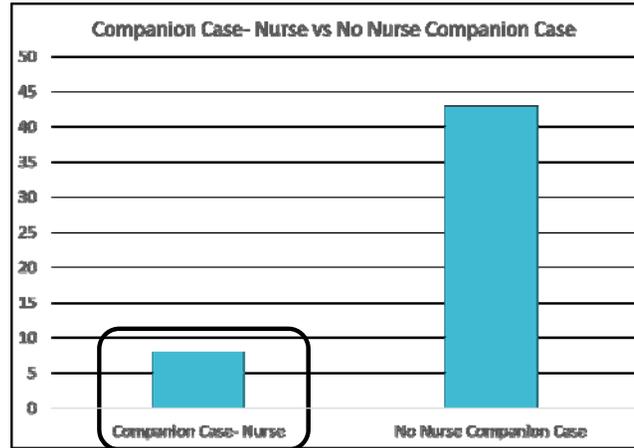
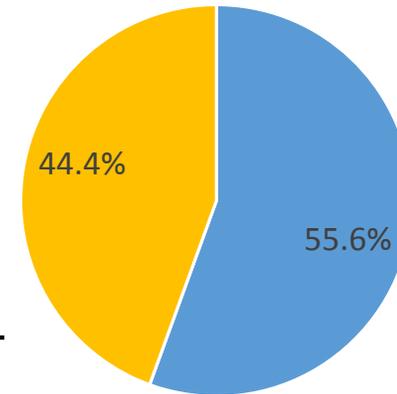


Fig. 2.4

Percentage of Nurse Companion Cases Disciplined



■ Nurse Not Disciplined ■ Nurse Disciplined

- 2 cases were “no count”
- 2 cases were “count correct”

Fig 2.5 shows that 4 nurses were disciplined from their companion case, that is 50%.

89.8% of RFOs after surgery happened in a hospital setting. I could not find any research as to why this might be.

HOSPITAL	53
AMBULATORY SURGICAL CENTER	5
OFFICE	1

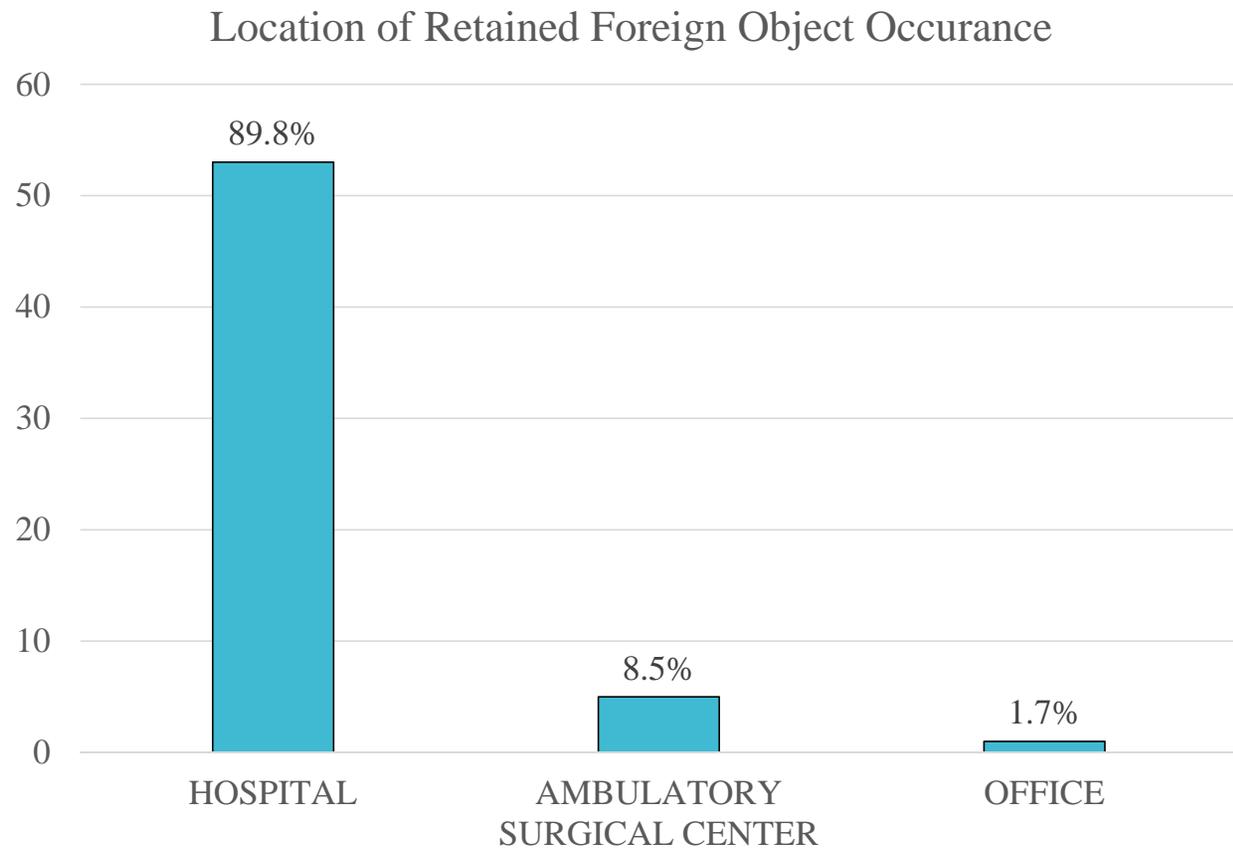


Fig 2.6 shows that the large majority of RFOs happened in a hospital. There was no research found as to why this might be.

As demonstrated by the previous graph, a RFO is most likely to happen at a Hospital and least likely to happen in an Office. This table shows the exact percentages of occurrence.

Occurrence of a Retained Foreign Object Organized by Facility Type

<u>Facility Type</u>	<u>Estimated procedures 2004-2015</u>	<u>% that had a RFO</u>
Hospital	77,573,320	0.000068
ASC	29,236,680	0.000017
Office	7,590,000	0.000013

Fig. 2.7 shows the exact percentages of occurrence of RFO by facility type

Possible Solutions



Radiographic Screening intra and post operation, RFID infused sponges/towels with a smart bin, and barcoded sponges and towels accompanied by app or laptop are all technological ways to take human error out of surgical counts. Improper counts and correct counts can both lead to retained foreign objects, these technologies could prevent that.



Possible Solutions cont.

- Policy regarding the inspection of all equipment, especially guide wires, to look for any breakage that might have occurred. This will initiate an investigation of the surgical site, in the event of a broken off piece, and hopefully lead to its discovery.
- Making sure every item is counted will also help reduce RFOs

CONCLUSION

- Any conclusion is difficult to draw from a sample of 59. However, by looking at the collected data it appears that the count before and after a surgery is not adequate to eliminate retained foreign objects after surgery.
- It also appears the occurrence of these events is declining.

Hospitals and Surgery Centers

- Florida Statutes 395.1065(3), 395.10975(1)(e), 395.1055(1)(a), 395.1055(1)(g), 395.0193(5)(6), and 395.0197(4)(7)(8) are all statutes under which a hospital or surgery center can be cited /fined or that pertain to WSS or RFOs.
- These Statutes state that unless the facility covers up a mistake, takes too long to report a mistake, does not have adequate personnel that lead to the mistake, or something about the facility's structure or equipment caused the mistake they cannot be cited or fined.
- Any surgical policy error can be addressed in the "corrective action taken" section of UCF/Code 15 reports.

CITATIONS

- Butcher, L. (2011, November 1). Wrong-site surgery. Retrieved October 7, 2016, from <http://www.hhnmag.com/articles/4587-wrong-site-surgery>
- S. (2006). Patient Safety Refresher. Retrieved October 7, 2016, from <http://med.stanford.edu/shs/update/archives/DEC2006/boardpass.pdf>
- Safety Advisory, P. P. (2011, June 8). Applying the Universal Protocol to Improve Patient Safety in Radiology Services. Pennsylvania Patient Safety Advisory, 63-69. Retrieved October 7, 2016, from [http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/jun8\(2\)/Pages/63.aspx](http://patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2011/jun8(2)/Pages/63.aspx)
- Stahel, P. F., Mehler, P. S., Clarke, T. J., & Varnell, J. (2009, July 1). The 5th anniversary of the "Universal Protocol": Pitfalls and pearls revisited. *Patient Safety in Surgery*, 3(14). doi:10.1186/1754-9493-3-14
- Mulloy DF, Hughes RG. Wrong-Site Surgery: A Preventable Medical Error. In: Hughes RG, editor. *Patient Safety and Quality: An Evidence-Based Handbook for Nurses*. Rockville (MD): Agency for Healthcare Research and Quality (US); 2008 Apr. Chapter 36. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK2678/>
- Kennedy, J. (2010). Prevention of Retained. Retrieved October 7, 2016, from http://www.wshmma.org/events/2010/Prevention_of_Retained_Foreign_Objects.pdf
- Berger, P. S., & Sanders, G. (2008, May). Objects Retained During Surgery: Human Diligence Meets Systems Solutions. *The Risk Management and Patient Safety Institute*. Retrieved November 7, 2016, from <http://psqh.com/sep0ct08/objects.html>
- Cullen, K. A., Hall, M. J., & Golosinskiy, A. (2009, January 28). Ambulatory Surgery in the United States, 2006. *National Health Statistics Reports*, 11, 1-28. Retrieved November 7, 2016, from <http://www.cdc.gov/nchs/data/nhsr/nhsr011.pdf>
- Cline, R., M.D. (2007, June 20). Reduction of Wrong Site Surgeries in the State of Florida. *Florida Department of Health Board of Medicine*, 1-3.
- Dyches, R. (2006, July 5). Reduction of Wrong Site Surgery in the State of Florida. *Surgical Care Committee and Board of Medicine*, 1-3.
- Advis, P. P. (2009, June 6). Beyond the Count: Preventing the Retention of Foreign Objects. Pennsylvania Patient Safety Advisory, 39-45. Retrieved October 7, 2016, from [http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Jun6\(2\)/Pages/39.as](http://www.patientsafetyauthority.org/ADVISORIES/AdvisoryLibrary/2009/Jun6(2)/Pages/39.as)
- Osman, B. M., & Shapiro, F. E. (2014). Safe Anesthesia in the Office-Based Surgical Setting. *ASM Monitor*, 78, 14-17. Retrieved January 3, 2017, from <http://monitor.pubs.asahq.org/article.aspx?articleid=2432317&resultClick=1>



Florida Report on Telehealth Utilization and Accessibility

December 2016



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Executive Summary

Chapter 2016-240, Laws of Florida, was passed during the state's regular 2016 Legislative Session, and was signed by Governor Rick Scott becoming effective on July 1, 2016. The law directs the state's Agency for Health Care Administration (AHCA), the Department of Health (DOH), and the Office of Insurance Regulation (OIR) to collaboratively survey the Florida licensed health care facilities, professionals, and payers of health care services in an effort to determine and document:

- *The types of health care services provided via telehealth in the state*
- *The extent to which telehealth is used by health care practitioners and health care facilities nationally and in the state*
- *The estimated costs and cost savings to health care entities, health care practitioners, and the state associated with using telehealth to provide health care services*
- *Which health care insurers, health maintenance organizations, and managed care organizations cover health care services provided to patients in Florida via telehealth, whether the coverage is restricted or limited, and how such coverage compares to that insurer's coverage for services provided in person*

The law directs AHCA to compile the survey and research findings and submit a report of such findings to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before December 31, 2016. This report is submitted by the Agency to meet the requirements of Chapter 2016-240; and represents the collaborative efforts across AHCA, DOH, and OIR.

The new telehealth law also creates a Telehealth Advisory Council for the purpose of making recommendations to the Governor and the Legislature. The law designates the Secretary of AHCA as the Council's Chair, and designates the State Surgeon General (or designee) as a member. The Agency's Secretary and the Surgeon General appointed 13 Council members representing specific stakeholder groups. The Council is charged to review the survey and research findings included in this report, and to employ that information to inform recommendations to increase the use and accessibility of services provided via telehealth, including the identification of any barriers to implementing or accessing services provided via telehealth. A report of the Council's recommendations must be submitted to the Governor, the President of the Senate, and the Speaker of the House of Representatives on or before October 31, 2017.

Highlighted findings contained within this initial report include:

- Utilization of telehealth is expanding in Florida and nationally, both in terms of the variety of applications and use cases as well as patient volume and demand.
- Nearly half (44.8%) of Florida hospitals responding to AHCA's telehealth survey indicated that telehealth services are available through their facilities.
- The most frequent use cases of telehealth reported by licensed health care facilities in Florida include: neurology (including stroke care), home health/patient monitoring, primary care, behavioral health, and radiology.
- Nearly half (44%) of home health agencies responding to the Agency's survey indicated using telehealth to assist with remote patient monitoring.
- Benefits reported from health care facilities and professionals offering telehealth services include improved convenience for both patients and providers, improved efficiencies, and improved patient care outcomes.
- Financial barriers are the most frequently reported obstacles among health care facilities and providers during both implementation and ongoing operations of telehealth programs.
- Due to multiple and often conflicting definitions of telehealth at every level (Federal, State, and among private payers and policymakers), there is significant uncertainty across stakeholder groups regarding types of services and activities that may qualify as telehealth for the purposes of coverage and reimbursement.
- Despite great technological advances over time in the field of Health Information Technology, including Electronic Health Records (EHR) systems and Health Information Exchange (HIE) networks, there remain significant challenges with interoperability between providers across the state and nationally, making it difficult for health care professionals to obtain adequate medical history and clinical information at the time they are treating a patient. These gaps in interoperability were cited by survey respondents as a common barrier to the development and implementation of telehealth programs.
- Research and survey findings indicate that few providers have achieved a financial Return on Investment (ROI) attributable to the implementation of telehealth services; although some examples do exist.
- Many providers reported a lack of detailed knowledge about telehealth services, and indicated interest in gaining access to evidence-based best practices, educational resources, or training opportunities associated with telehealth.

This report details these and other findings from survey responses and highlights from a literature review of national telehealth research studies.

Introduction

The United States, including Florida, is experiencing a shortage of health care professionals to serve a growing and aging population. Data referenced in the Florida House of Representatives legislative staff analysis for House Bill 7087 (2016) noted that there were 615 federally designated Health Professional Shortage Areas (HPSAs) within the state for primary care, dental care, and mental health therapists as of June 19, 2014. The U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA) Bureau of Health Workforce data indicates that the number of HPSAs in Florida has grown to 623 by December of 2016. Multiple national proposals and recommendations have been developed in recent years to address these shortages, including:

- Creation of new scholarships and residency programs to train more providers
- Expanding the scope of practice for certain health care professionals
- More efficient utilization of the existing workforce through the expanded use of telehealth¹

Chapter 2016-240, Laws of Florida was enacted by the legislature in 2016 creating a Florida telehealth Advisory Council (Council) charged with reviewing research and survey findings and developing recommendations to support expansion or increased access to health services provided through telehealth in the state. The law requires the Florida Agency for Health Care Administration (AHCA), the Florida Department of Health (DOH), and Florida Office of Insurance Regulation (OIR) to respectively survey licensed health care facilities, licensed health care practitioners, and licensed health care insurers and Health Maintenance Organizations (HMOs), to assess the current Telehealth landscape across the state and to inform the Council's work.

This report presents findings from the surveys as well as research findings compiled from multiple resources representing both Florida and national perspectives. The focus of the surveys and report, as guided by Chapter 2016-240, Laws of Florida, include:

- National and state utilization of telehealth
- Types of healthcare services provided via telehealth
- Costs and cost savings associated with using telehealth to provide health care services
- The extent of insurance coverage for providing health care services via telehealth and how such coverage compares to coverage for in-person services
- Barriers to using or accessing services through telehealth

Survey findings will also be provided to the Telehealth Advisory Council (Council). The Council is, in turn, required to submit a report of recommendations for increasing the use and accessibility of telehealth to the Governor, the President of the Senate, and the Speaker of the House of Representatives by October 31, 2017.

Florida Telehealth Surveys

Survey Methodology – Florida Licensed Health Care Facilities

Florida's Agency for Health Care Administration licenses more than 48,000 health care facilities and businesses in Florida.

Agency staff first identified the facility types most likely to be utilizing telehealth services; then executed a series of direct emails to the facility contact email addresses maintained by the Agency within its facility licensure database for the selected facility types. A personalized email was sent to the executive contact of each facility premise and included brief background information on the authorization and purpose for the survey, instructions on how to complete the survey, the facility's specific AHCA-issued license number and AHCA file number for reference, and information on how to contact Agency staff with questions about the survey. The email then provided a hyperlink to the Agency's electronic health facility survey. The survey link was also published to the Agency's website, on its dedicated Telehealth Advisory Council webpage. The Agency used a variety of approaches to raise awareness of the survey including a press release and electronic provider alerts to subscribed interested parties to notify stakeholders and encourage participation in the survey. The facility survey was launched in August, 2016 and surveys were collected through September 30th. Agency staff monitored response rates by facility type, and sent follow-up emails during the month of September to those facility types with relatively low response rates.

Sixteen facilities types, totaling approximately 11,900 individual facilities, were identified as the most probable users of telehealth. The overall response rate from those facilities was 49%. (Figure 1)

Figure 1. Florida Licensed Facility Telehealth Survey Response Rates

	Number of Surveys	Total Number of Facilities	Response Rate
AMBULATORY SURGICAL CENTER	342	433	79%
ASSISTED LIVING FACILITY	1,237	2,886	43%
BIRTH CENTER	22	33	67%
CLINICAL LABORATORY	1,523	3,815	40%
CRISIS STABILIZATION UNIT	40	57	70%
END-STAGE RENAL DISEASE	331	428	77%
HOME HEALTH AGENCY	867	1,960	44%
HOME MEDICAL EQUIPMENT PROVIDER	574	966	59%
HOSPICE	23	45	51%
HOSPITALS	239	306	78%
INTERMEDIATE CARE FACILITY FOR THE DEVELOPMENTALLY DISABLED	72	100	72%
NURSING HOME	479	669	72%
PRESCRIBED PEDIATRIC EXTENDED CARE CENTER	53	61	87%
RESIDENTIAL TREATMENT CENTER FOR CHILDREN AND ADOLESCENTS	17	31	55%
RESIDENTIAL TREATMENT FACILITY	43	98	44%
TRANSITIONAL LIVING FACILITY	9	12	75%

Office of Insurance Regulation Survey Methodology

The Florida Office of Insurance Regulation is responsible for the regulation, compliance, and enforcement of statutes related to the business of insurance in the state. The Office worked closely with the Agency to develop a survey for the state’s licensed health insurance plans and Health Maintenance Organizations (HMOs) that aligned closely with the questions and focus of the health care facility and licensed health care practitioner surveys. The Office leveraged its existing health information systems to create the payer survey in a secure environment.

The Office conducted a direct email distribution of the survey notification to its constituents, including active follow-up with nonresponsive payers periodically throughout the data collection period. The health plan surveys were disseminated in September, and data was collected through the month of October. The Office collected all survey responses and provided a complete dataset of the responses to the Agency for analysis.

Fifty-Four (54) Health Plans offering at least one of six lines of business were surveyed. 100% of the plans surveyed responded.

Department of Health Survey Methodology

The Department of Health licenses health care practitioners in Florida and is required by Chapter 2016-240, Laws of Florida, to survey practitioners as a condition of licensure renewal. Most health care licensees are required to renew their licenses biennially in order to maintain the right to practice; however, some professions require annual renewal of the license. Due to the condensed time period from the effective date of the law (July 1, 2016) to the required submission date for survey findings to the Governor and the legislature (December 31, 2017), there was a limited number of health care professionals scheduled to renew their licenses during the available data collection period.

DOH added the telehealth practitioner survey to their electronic license renewal application effective July 1, 2016. In an effort to gain as much feedback from the state's licensed health care professionals as possible for this report, a volunteer survey was also offered by AHCA to practitioners. The voluntary electronic survey was posted on the Agency's dedicated telehealth web page. The Department of Health encouraged provider participation through mutual posting of the survey on both its FLHealthSource.gov homepage as well as their dedicated website for clinical laboratories. Despite these efforts, the voluntary survey received relatively limited response. Information provided in this report includes information from practitioners that completed the Department of Health survey for renewal between July 1, 2016 and December 1, 2016. To date the DOH licensure survey has generated a total of 26,579 responses.

Additional information from DOH licensed practitioners will be provided to the Council as it becomes available for consideration in their final recommendations.

Nine types of practitioners renewed or began renewing their DOH license between July 1 and December 1, 2016. (Figure 2) These licensees include nursing home administrators, athletic trainers, a segment of registered nurses, consultant pharmacists, and a segment of medical doctors. (Figure 3)

Figure 2. DOH Licensees with a Renewal Date between July 1 & Dec 31, 2016

	# of Completed Surveys/Renewals	# Eligible to Renew	Response Rate
Consultant Pharmacist	1,470	3,027	49%
Optician	1,881	3,893	48%
Registered Pharmacy Technician	14,727	42,677	35%

Figure 3. DOH Licensees with a Renewal Date after Dec 31, 2016

	# of Completed Surveys/Renewals	# Eligible to Renew	Response Rate
Anesthesiologist Assistants	50	300	17%
Diagnostic Radiological Physicist	37	103	36%
Hearing Aid Specialist	57	1,059	5%
Licensed Clinical Social Worker	5	10,192	0%
Licensed Marriage and Family Therapists	1	2,069	0%
Medical Doctor	10,575	33,058	32%
Medical Health Physicist	12	38	32%
Medical Nuclear Radiological Physicists	25	58	43%
Occupational Therapist	226	8,960	3%
Occupational Therapist Assistant	89	5,446	2%
Optometrist	370	3,408	11%
Pharmacy	44	10,166	0%
Therapeutic Radiological Physicist	144	401	36%

The state’s federally certified Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and the Florida Department of Health’s 67 County Health Departments (CHDs) are also entities which may provide telehealth services. A separate version of the Agency’s electronic health professional survey was created, and a link to the survey was distributed to these entities along with a request for voluntary completion. The Florida Association of Community Health Centers (FACHC) assisted the Agency in distributing the voluntary survey to its’ member FQHCs. The voluntary survey was also published on the Agency’s dedicated telehealth website. Data collection from these provider types is on-going; and any information obtained from these entities will be provided to the Council for consideration in their final recommendations to the Governor and Legislature.

Background

The term Telemedicine is often used as synonymous with telehealth, although some stakeholders consider telehealth to be a more comprehensive term that encompasses not only direct patient care (diagnosis and treatment), but also educational and administrative processes. There is no universally accepted definition of telehealth. The definition used for the survey is from Segen's Medical Dictionary, which provides a fairly broad definition:

*"Telehealth is a generic term for the remote delivery of health care through the use of electronic information and telecommunications technologies."*²

Definitions for telehealth/telemedicine associated with Florida regulations can be found in the Florida Boards of Medicine and Osteopathic Medicine rules 64B8-9.0141, FAC and 64B15-14.0081, FAC respectively.

*"Telemedicine" means the practice of medicine by a licensed Florida physician or physician assistant where patient care, treatment, or services are provided through the use of medical information exchanged from one site to another via electronic communications. Telemedicine shall not include the provision of health care services only through an audio only telephone, email messages, text messages, facsimile transmission, U.S. Mail or other parcel service, or any combination thereof.*³

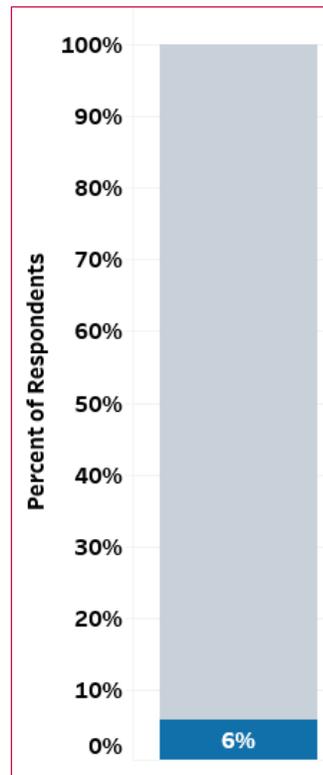
Additionally, the Agency for Health Care Administration defines telehealth for the purpose of fee-for-service reimbursement under the state's Medicaid program, in rule 59G-1.057, FAC.:

*"The practice of health care delivery by a practitioner who is located at a site other than the site where a recipient is located for the purposes of evaluation, diagnosis, or treatment."*⁴

Although telehealth technology in some form has been in use since the 1960s, patient demand for care access has more recently pushed telehealth into the mainstream. National studies show that 74% of consumers use telehealth services; 76% of patients value access to care over the need for human interaction with their health provider; 70% of patients are comfortable talking with their health provider via text, email or video; and 30% of patients are already using computers or mobile devices to check medical or diagnostic information.⁵

A national survey of health care executives published in 2016 reported 63% of health care practitioners use some type of telehealth platform to provide health services.⁶ Only 6% percent of surveyed practitioners in Florida indicate they use telehealth to provide health care services (Figure 4).

Figure 4. Florida Licensed Health Practitioners Who Completed the Survey, Indicating They Offer Telehealth Services



In 2013, 52% of hospitals in the nation utilized telehealth and another 10% were beginning the process.⁷ Of Florida hospitals responding to the AHCA statewide survey, 45% indicate they offer health care through some form of telehealth (Figure 5). A majority of the facilities offering telehealth services in Florida indicate the benefits are patient convenience and better coordination of care (Figure 6). Patient interest combined with health practitioner workforce shortages and advancements in technology make telehealth increasingly vital to the health care delivery system.

Figure 5. Florida Licensed Hospitals That Completed the Survey, Indicating They Offer Telehealth Services

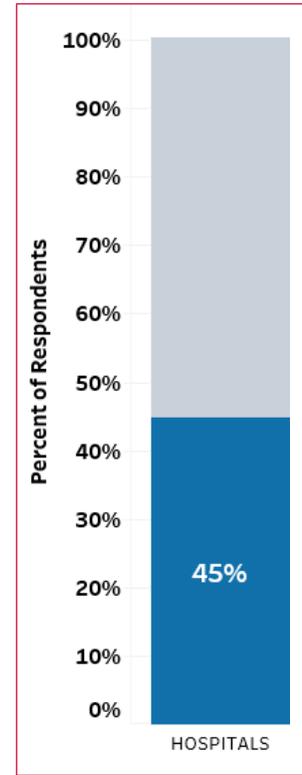
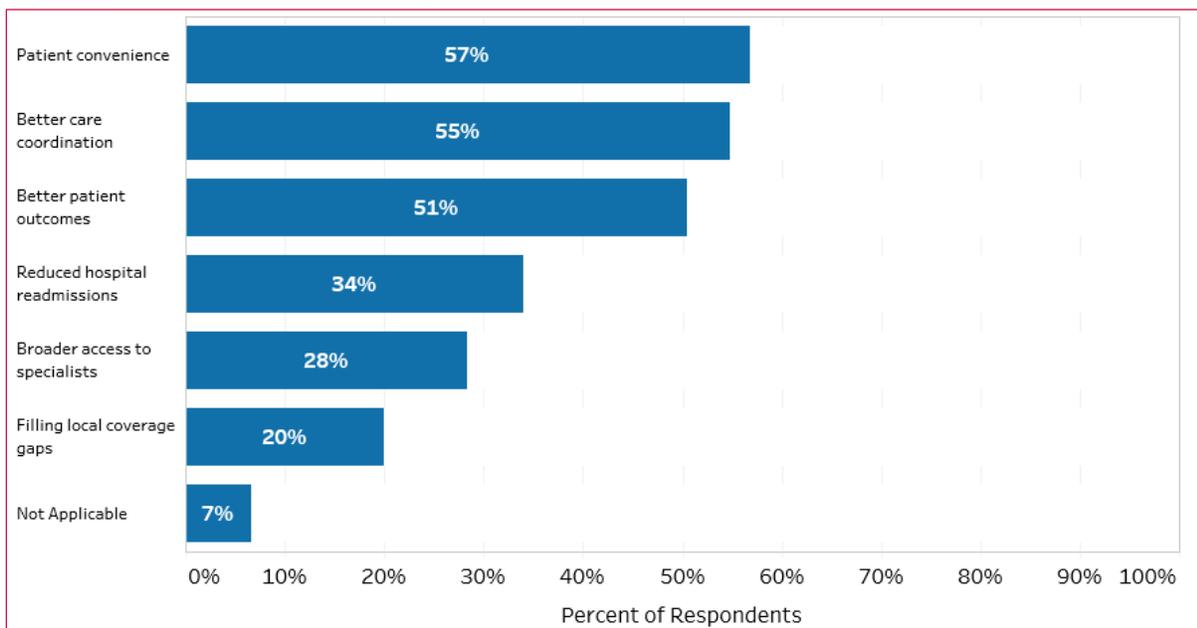


Figure 6. Benefits Reported by Facilities Using Telehealth



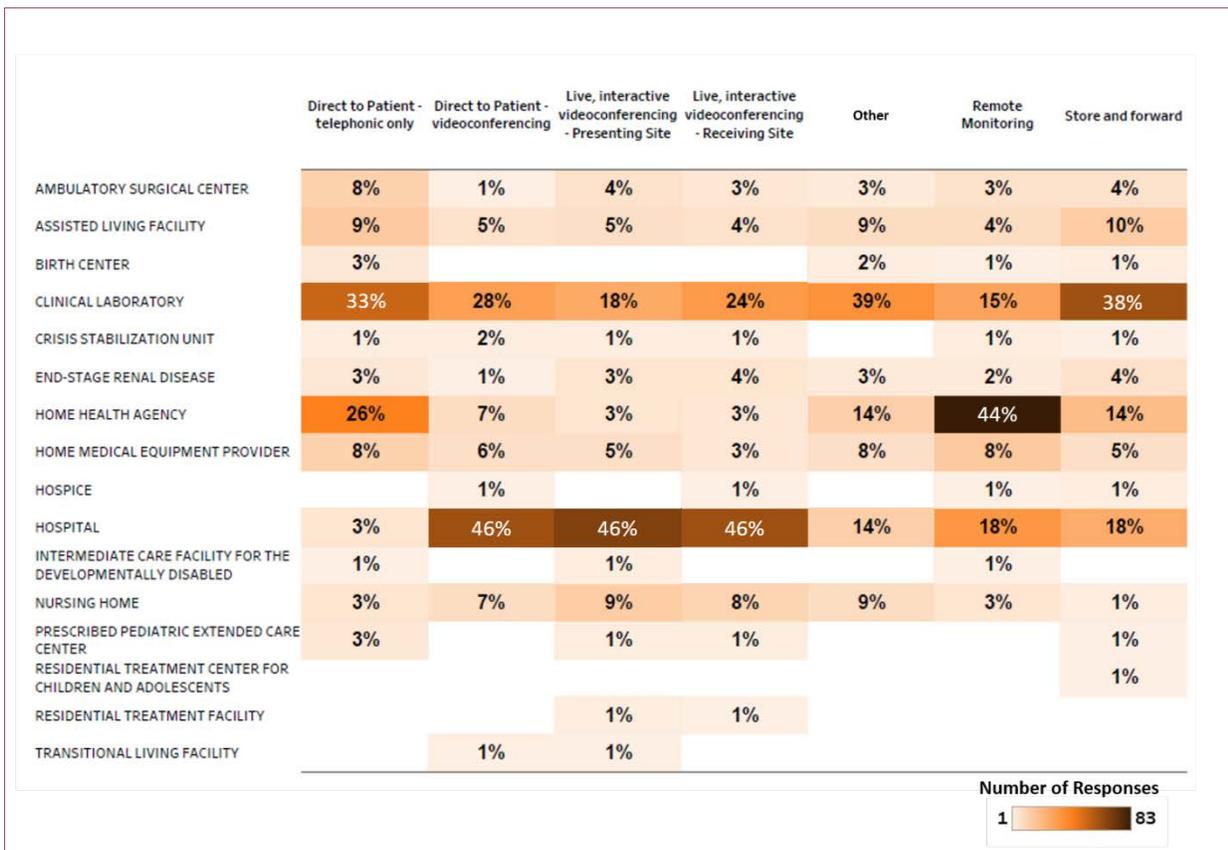
Health Care Services Offered via Telehealth

The United States Department of Health and Human Services notes that telehealth is not a type of health care service; it is a means or method used to deliver health care.⁸ The standard of care for providing health services should not alter based on the mode of delivery.⁹ Telehealth services can enable real-time (synchronous) communication between patients and care providers through video conferencing; facilitate the storage and forwarding (asynchronous) of clinical data to offsite location for evaluation by specialist teams; and support remote monitoring of patient’s chronic conditions via sensors and monitoring equipment. Telehealth technology is evolving into wearable and even implantable devices (mobile health) that detect information such as EKG readings.¹⁰ Under each of the broader categories are various models of use.

Examples of Hospital-Based Telehealth Platforms	
Service Type	Description
Telestroke	Remote evaluations, diagnoses and treatment recommendations are transmitted from neurologists to emergency medicine physicians treating stroke patients at other sites
Teleradiology	Radiology images and associated data are transmitted between locations for the purpose of primary interpretation or consult and clinical review
Tele-ICU	Networks of audiovisual communication and computer systems are linked with critical care physicians and nurses to ICUs in other, often remote hospitals
Telemental Health	Mental health and substance abuse services are provided from a distance using videoconferencing and other advanced communication technologies
Telepathology	The practice of pathology is performed at a remote location by means of video cameras, monitors, and a remote controlled microscope
Remote Clinical Monitoring	Disease management of patients using continuous or frequent periodic remote clinical monitoring via advanced communication technologies (EKG, glucose testing, etc.)
Telepharmacy	Pharmaceutical care for patients (or supervision to technicians) is provided at a distance using advanced telecommunications technology
Cybersurgery	Surgeons use surgical techniques with a telecommunication conduit connected to a robotic instrument to operate on a remote patient

Telehealth is currently used in a broad array of applications. The use of telehealth crosses most health service disciplines including, but not limited to, primary medical care, specialty care, chronic disease management, behavioral counseling, physical therapy, speech therapy, pharmacy, and home health (Figure 7). One of the most prevalent forms of hospital-based telemedicine is radiological services, which use an asynchronous platform which allows radiologists to perform their work in distant locations. Over 5 million patients have had diagnostic radiology tests read by an off-site specialist¹¹, according to the American Telehealth Association. In the late 1990s and early 2000s, there were initiatives by some radiology groups to locate physicians in Europe and Australia in order to leverage the benefits of time zone differences with the United States. For example, a physician working during the daytime hours in Australia could cover the night shift in the United States.¹²

Figure 7. Florida Licensed Facilities Reporting Telehealth Utilization, by Facility Type and Service Type.

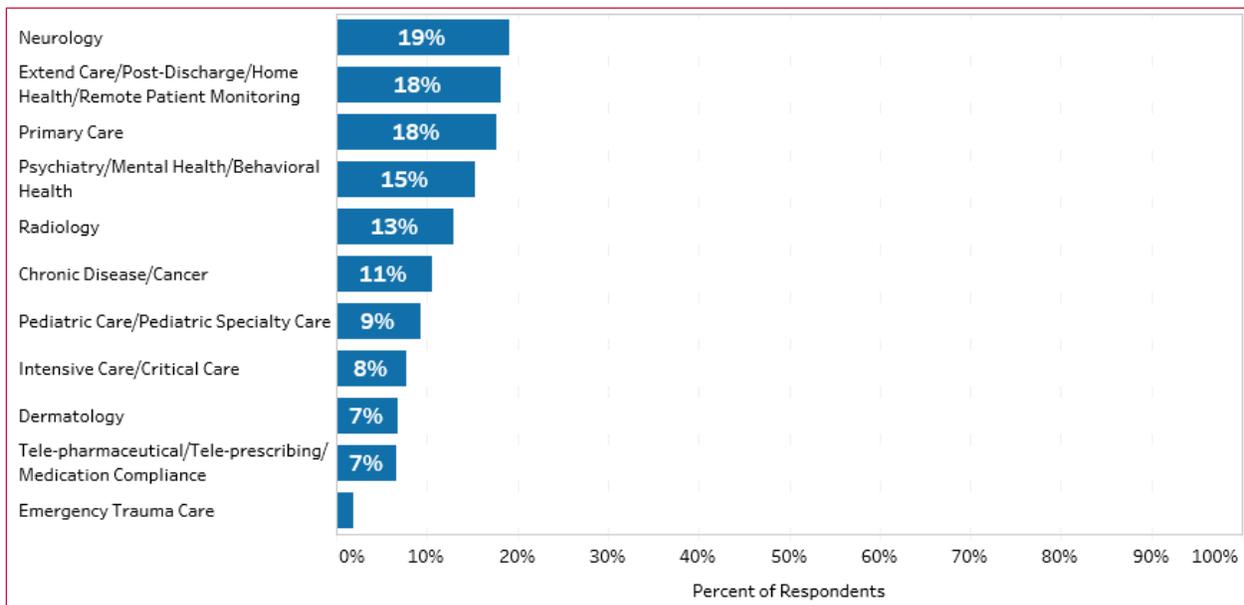


Despite a vast number of potential applications and use cases; current telehealth industry utilization can be categorized into four major classifications of health care services¹³:

- **Patient care**, including the sharing of audio, video, and medical data between the patient and health care practitioner; specialist consultation; and diagnostic image review for the purpose of treatment and diagnosis
- **Remote patient monitoring**, including the collection and transmission of patient health data to monitoring stations (i.e. electrocardiogram, glucose levels, blood pressure readings, etc.)
- **Medical education and mentoring** of health care practitioners on special topics or procedures
- **Consumer medical and health information** which can assist in improving life style changes for improved health

Findings from the Agency’s survey of Florida licensed health care facilities demonstrates varied usage of telehealth modalities across provider types, with the most use and variation occurring among hospitals. Teleneurology is one of the most prevalent services offered from facilities who utilize telehealth in Florida (Figure 8).

Figure 8. Types of Health Care Services Offered by Hospitals Completing the Survey That Currently Use Telehealth



Telehealth Service Examples

Study on Veterans Affairs Use of Tele-rehabilitation

The United States Department of Veterans Affairs (VA) introduced its telehealth program in 1990 and is considered a pioneer in this industry. During calendar year 2012, the VA served more than 485,000 patients and completed approximately 1.4 million telehealth consultations.¹⁴ One study examined the VA's use of telehealth on a group of 26 veterans living in rural areas who received physical therapy via in-home video or tele-rehabilitation. All of the participants in the tele-rehabilitation study showed significant improvement and reported satisfaction with their experience. In addition to positive results, the use of tele-rehabilitation in this case was associated with minimizing time, expense, and inconvenience of receiving in-person care.¹⁵

Study on Impact of Virtual Physician Use in Skilled Nursing Facility

Cobble Hill Health Center, a 360 bed Skilled Nursing Facility in New York, participated in one-year study that looked at the impact of using "virtual physicians" (video conferencing) outside of regular primary care physician hours. According to the study 60%-70% of nursing facility to hospital transfers, when viewed in retrospect, should not occur. Additionally, these transfers often lead this senior population to increased confusion, fall risk, risk of skin ulcers, and exposure to hospital acquired infections. During the one-year study, 91 patients avoided unnecessary hospitalizations. Of those, 63% were long term care residents and 37% were short term patients.¹⁶

Mayo Clinic Tele-Stroke Network Program

Real-time applications of telehealth can allow for instantaneous assistance through a live video conferencing "hub and spoke" model. These real-time applications are often used for specialist consultation. One example is for tele-neurology, when a patient is experiencing a stroke and a neurologist is hours away. The Mayo Clinic has implemented a model to assist smaller and underserved hospitals with less extensive neurology services in providing stroke care. The study notes improved patient functional outcomes – with a higher percentage reporting no significant disability, higher overall self-reported health, and improved neurological status within 24 hours and after 90 days.¹⁷

United Kingdom Department of Health's Whole System Demonstrator Program

The United Kingdom's study on remote patient monitoring is the largest known randomized control trial of telehealth. The study involved 6,191 patients, including 3,030 patients who had one of three conditions: diabetes, chronic heart failure (CHF), or Chronic Obstructive Pulmonary Disease (COPD). The patients were remotely monitored by 238 general practitioners. Study

results published in 2012 indicated a 45% reduction in mortality rates and 20% reduction in emergency department admissions among the study population.¹⁸

The Extent of Telehealth Use by Health Care Practitioner and Facility

The use of telehealth technologies to provide health care services is growing at a significant rate. Among Florida facilities and practitioners that completed the survey and who indicated they use telehealth, a majority have recently begun providing telehealth services. 55% of practitioners and 19% of facilities indicate they began offering telehealth services for the first time within the last year (Figures 9 & 10). Major factors driving the adoption of telehealth include advancing technologies, an aging population, health practitioner shortage, and greater acceptance of innovative treatment by patients. Although telehealth capabilities have been available for many years, recent advancements in technology and greater accessibility to those technologies are catalysts for growth.

Figure 9. Percent of Practitioners Who Reported Using Telehealth for Less Than 1 Year.

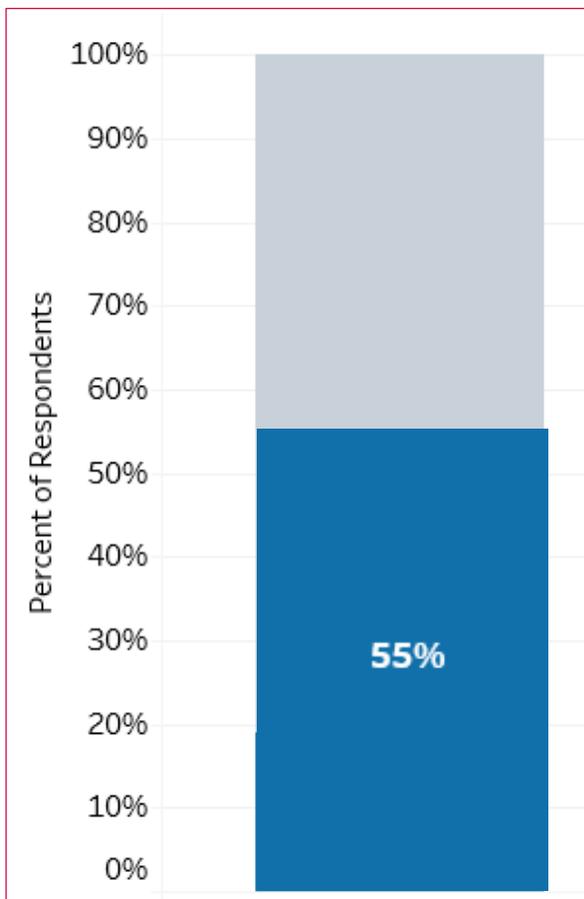
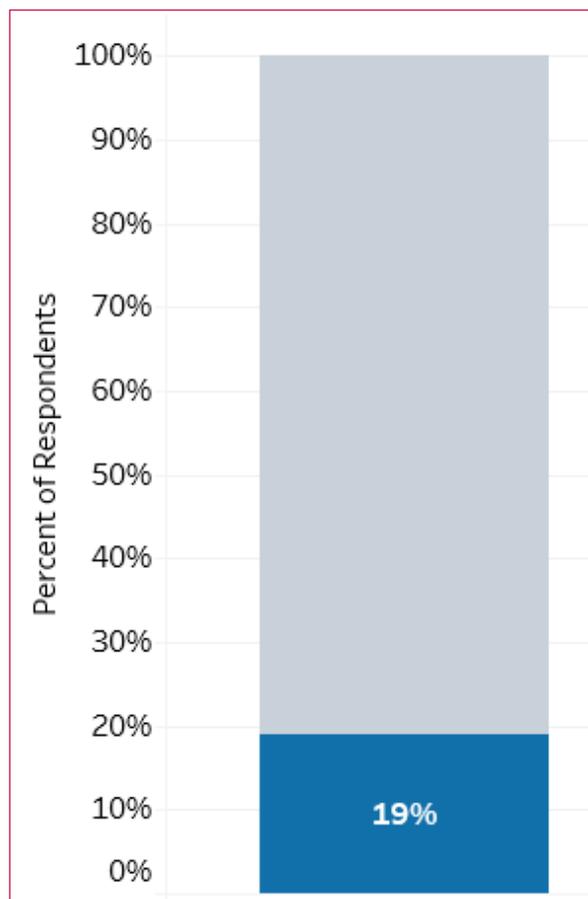
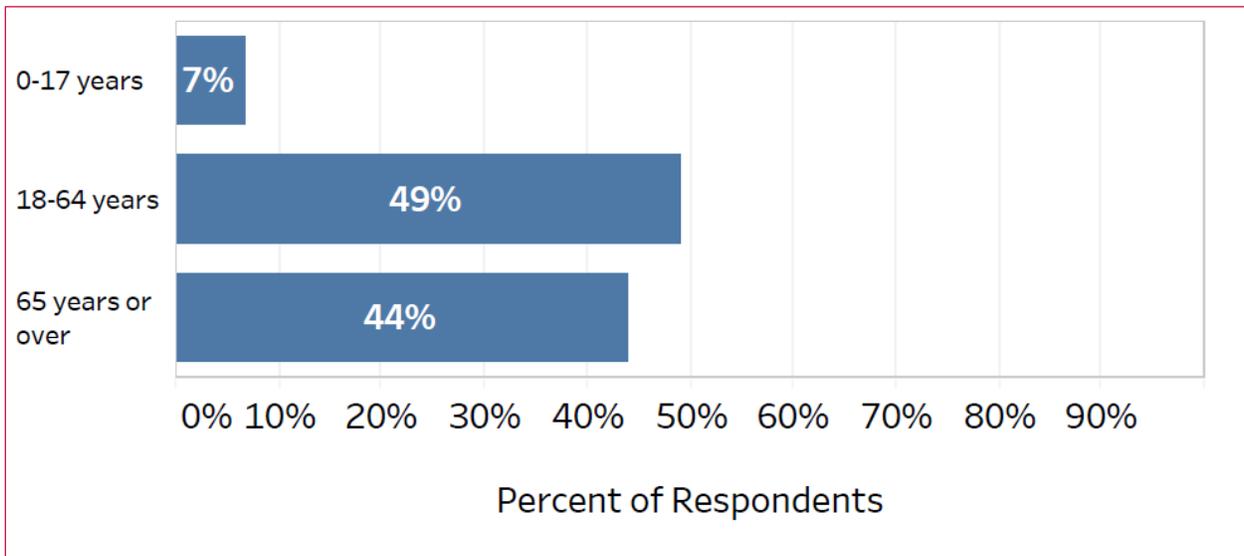


Figure 10. Percent of Facilities That Have Been Using Telehealth for Less Than 1 Year.



Florida is especially impacted by a senior population that is growing faster than the national rate. Persons aged 65 years and older comprised 12.4% of the United States population in 2000, but are expected to grow to be 19% of the population by 2030.¹⁹ As of July 2015, Florida’s seniors made up 19.4% of Florida’s population.²⁰ Our nation’s senior population is known to have higher rates of chronic disease including congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), diabetes, hypertension (high blood pressure), and end stage renal disease than persons under the age of 65. This growing population with complex care needs is largely responsible for rising health care costs nationally and presents an urgent need for innovative care delivery. Furthermore, while the senior population is increasing, the health practitioner population is decreasing. The Association of American Medical Colleges anticipates a shortfall of more than 130,000 physicians nationally by 2025.²¹ Patients are also becoming more proactive in their health care delivery choices - with utilization of telehealth services expected to increase nationally from an estimated 250,000 patients in 2013 to an estimated 3.2 million patients in 2018.²² Based on survey responses, a majority of Florida patients using telehealth services offered through licensed facilities are between the ages of 18-64. Close behind, 44 % of persons receiving health care via telehealth technology are seniors (Figure 11).

Figure 11. Reported Age Categories of Floridians Using Telehealth Services



Costs and Cost Savings

There are a number of different and varying costs associated with the development and operation of telehealth services. Costs vary by delivery model and are a product of project establishment and equipment investments, maintenance fees, communications fees, and staffing expenses.²³ Health care providers typically absorb the cost for implementation of telehealth services.²⁴ Florida facilities and practitioners are not immune to these costs, indicating that equipment and on-going costs needed to provide telehealth services were purchased using general operating funds (Figures 12 & 13).

Figure 12. Sources of Funding for Telehealth Equipment Among Facilities Offering Telehealth Services

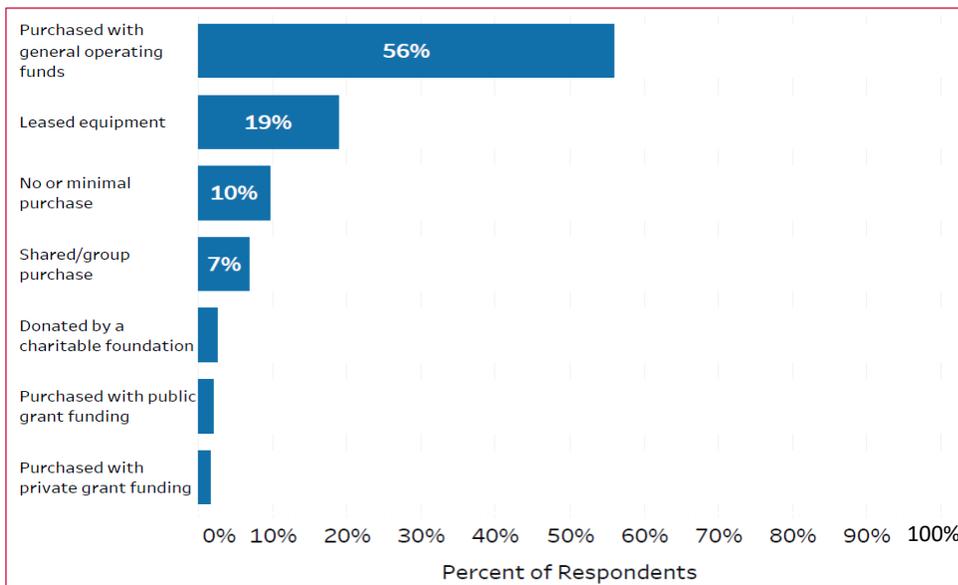
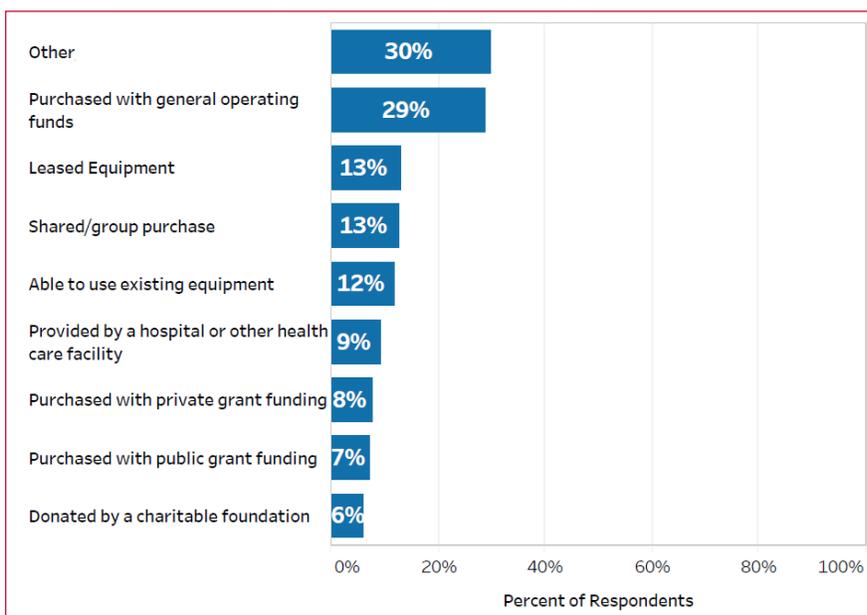


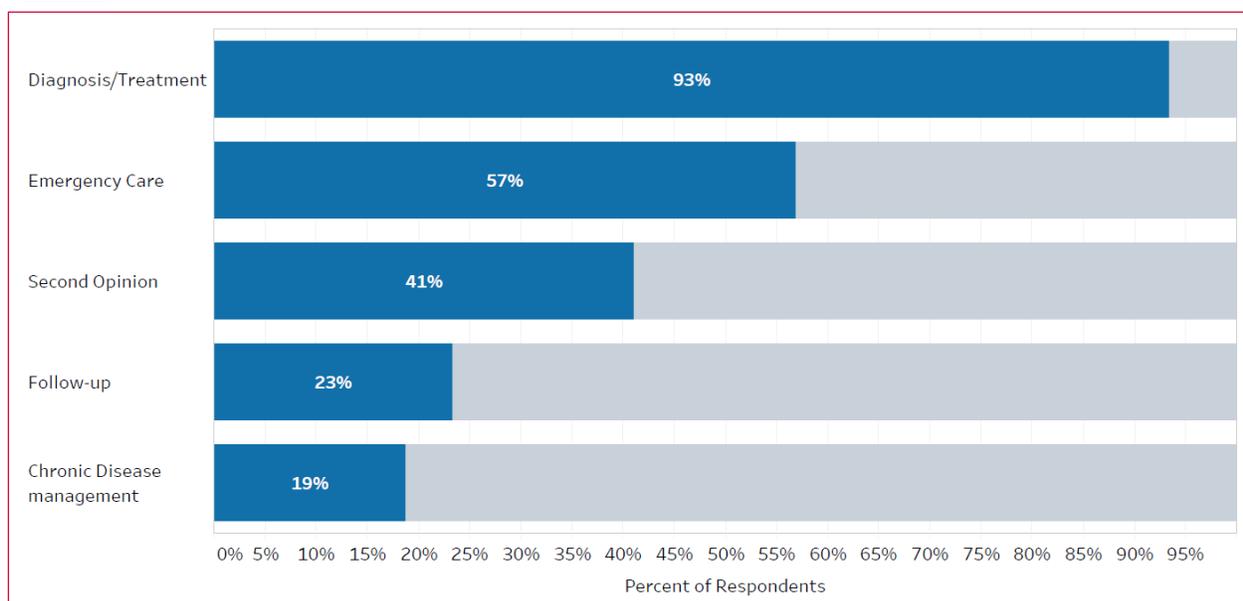
Figure 13. Sources of Funding for Telehealth Equipment Among Health Care Professionals Offering Telehealth Services



Operational cost savings derived from employing telehealth services are typically denoted from a Health System perspective rather than an individual provider perspective. The American Hospital Association notes that direct return on investment for health care providers is limited; particularly when there is limited coverage and reimbursement by health plans for the services offered by telehealth.²⁵ Florida health facilities and practitioners identify costs, reimbursement, and inability to determine a Return on Investment (ROI) as challenges in providing telehealth services (Figures 15, 16, and 17).

From a national perspective, some studies have determined that telehealth can help achieve the Institute for Healthcare Improvement’s (IHI) *Triple Aim* goals of improving the patient experience of care, improving population health, and lowering health care costs by improving access to appropriate, lower-cost services such as timely primary or specialty care, or through lower-cost settings such as clinics, homes or workplaces.²⁶ The U.S. Centers for Medicare and Medicaid Services (CMS) view telehealth as a cost-effective alternative to traditional service delivery.²⁷ Florida health providers corroborate this theory by identifying diagnosis/treatment and emergency care as top uses for telehealth (Figure 14).

Figure 14. Telehealth Use by Facilities



In terms of telehealth cost effectiveness related to clinical outcomes, some stakeholders believe additional research is needed.²⁸ A stakeholder group brought together by the Center for Connected Health Policy found that additional controlled studies need to be done in this area.²⁹ The studies in this field are each limited to different telehealth modalities, settings, diseases or conditions, or patient groups. This diversity makes it difficult to generalize cost effectiveness as a whole.³⁰

Figure 15. Barriers to Implementation Among Facilities Offering Telehealth

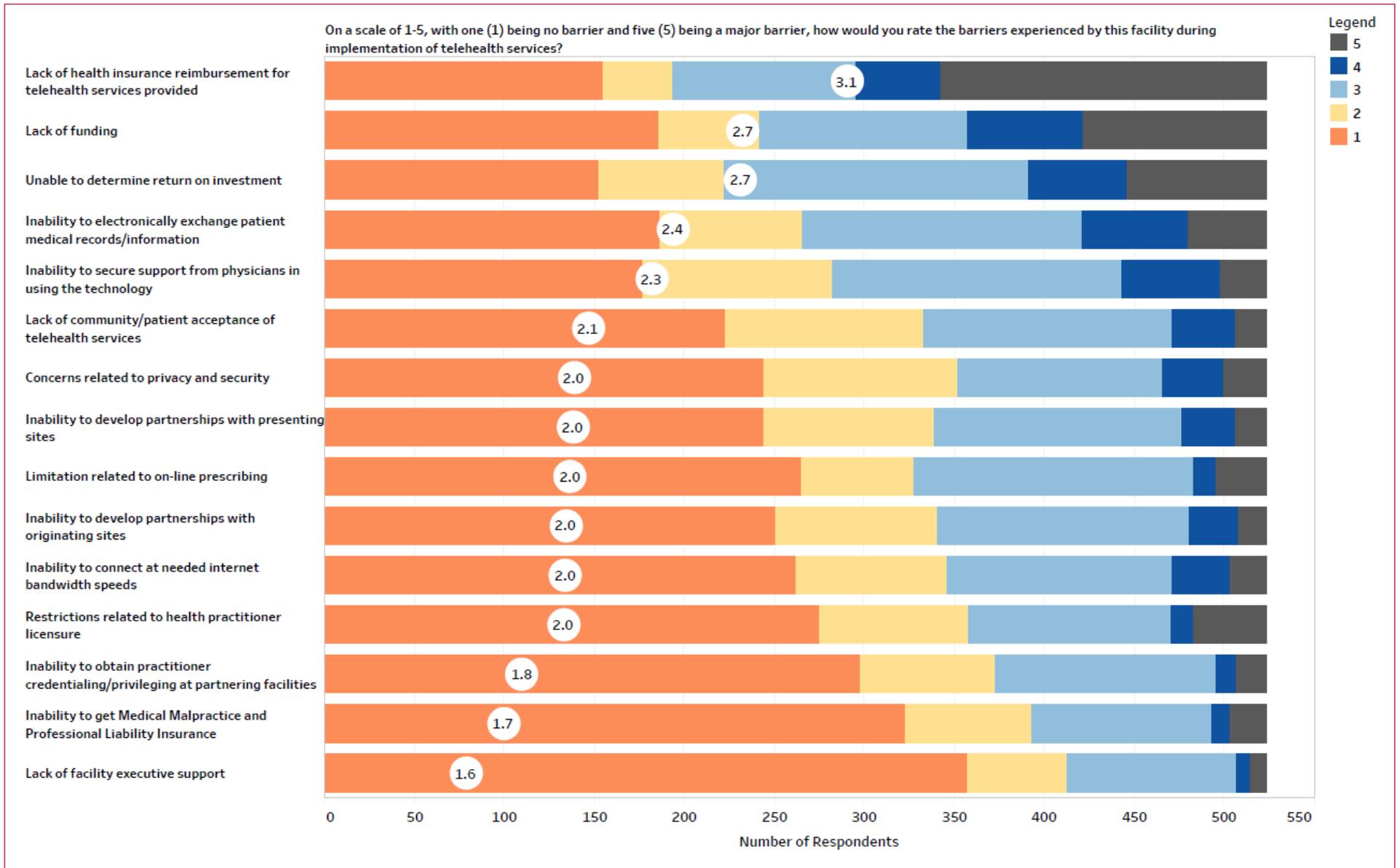


Figure 16. Barriers to Implementation Among Facilities Attempting to Offer Telehealth Services

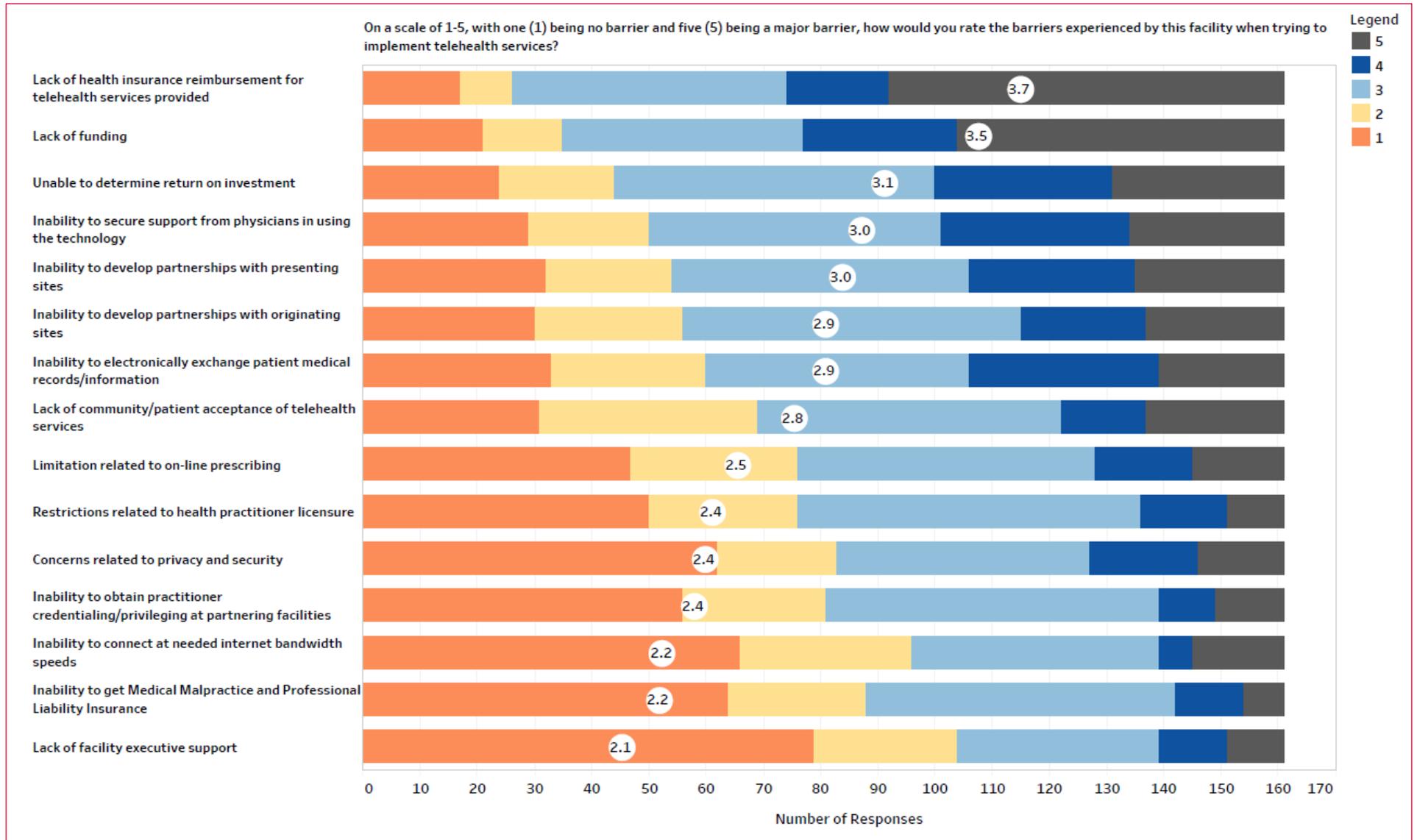
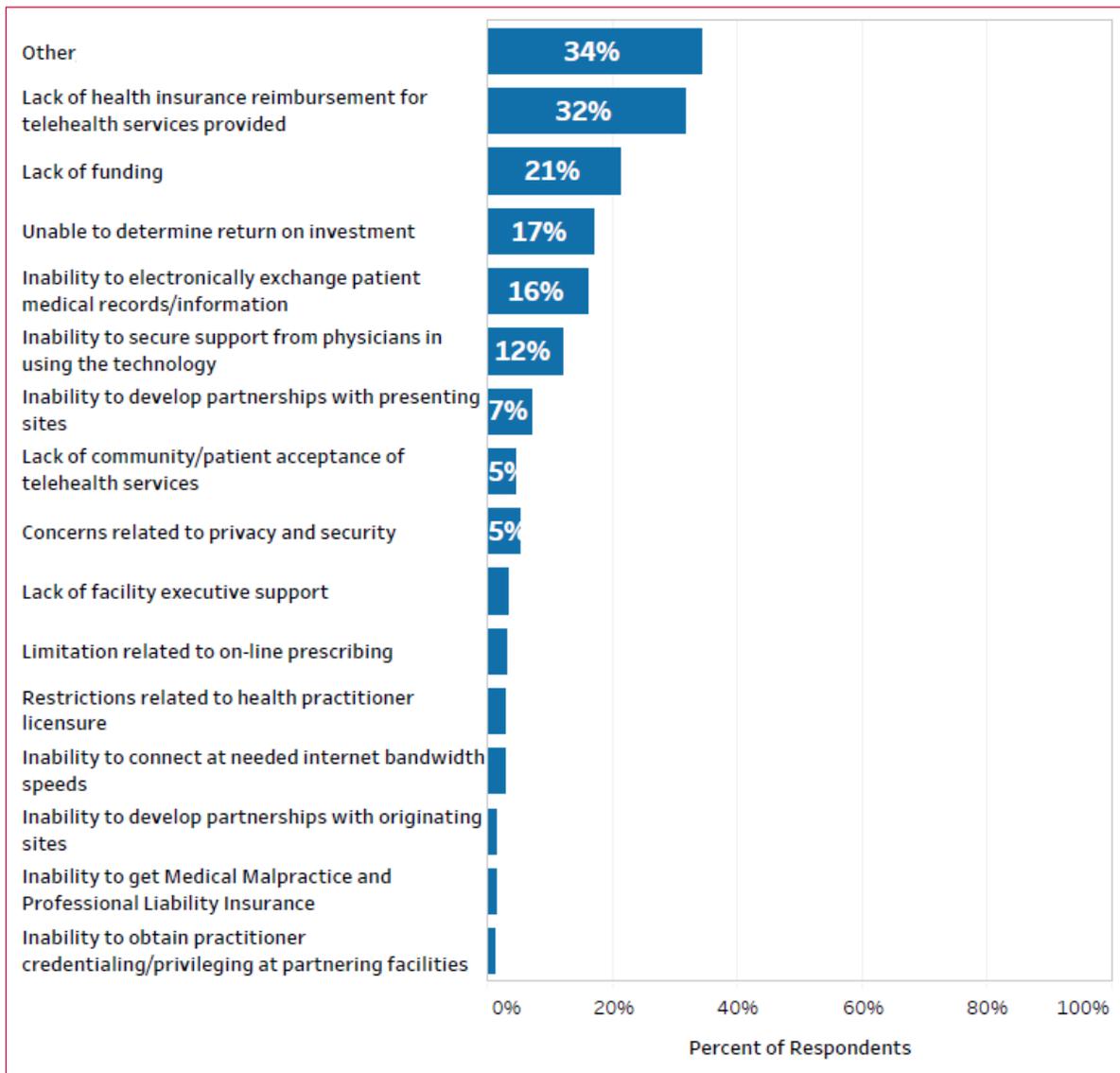


Figure 17. Barriers for Implementing Telehealth Among Practitioners' Private Offices or Group Practices



Studies Related to Telehealth Costs and Savings

Some studies related to cost effectiveness in telehealth have found comparable costs or cost savings compared to traditional care delivery. In a legislatively mandated report, Maryland's Department of Health and Hygiene found that Medicaid expenditures using a live video conferencing model could increase costs to the state by increasing services provided.³¹ The report also noted that the costs could potentially be off-set by reductions in emergency department visits and transportation expenses. A separate study by Dale Yamamoto found potential savings of \$126 per acute care visit for private payers. This study also estimates Medicare could save approximately \$45 per telehealth visit when compared to the average estimated cost of \$156 for in-person care.³²

United States is the Department of Veteran Affairs

One of the largest users of telehealth in the United States is the Department of Veteran Affairs (VA). The VA has reported that home telehealth services reduced bed days associated with inpatient hospital care by 59% and overall hospital admissions by 35% in 2013. Additionally, clinical video telehealth services reduced bed days of care for mental health care patients by 38%. The VA identified cost savings of approximately \$2,000 per person per year for home telehealth; \$34.45 per consult for clinical video telehealth, and \$38.81 in travel costs per consult for store-and-forward telehealth.³³

United States Department of Justice

A report from the US Department of Justice in 1999 identified potential for cost savings in the prison system. The initial demonstration included installing a telemedicine network and interoperable health data exchange capabilities. The report demonstrated that telehealth could play an important role in delivering quality health care in correctional systems at a cost savings to most institutions. Based on the data from the study, the cost-benefit analysis concluded a telehealth consultation would cost an average of \$71, compared with \$173 for an in-person consultation. A follow up report in 2002 provided guidance to correctional institutions on conducting a cost benefit analysis for determining the most appropriate technologies and implementations.³⁴

Study on Impact of Virtual Physician Use in Skilled Nursing Facility

The Cobble Hill study, which used virtual physicians during “off” hours to supplement in-person care, was able to identify a project “net system savings” of over \$1.1 million. However, the study noted a projected increase in spending of over 137,000 for the New York Medicaid program.³⁵

Mayo Clinic Telestroke Network Program

A telestroke network program implemented by Mayo Clinic reported a net savings to hospitals for Medicare patients. This savings takes into consideration initial hospitalization recurrent stroke, nursing home and rehabilitation costs. Additionally, Mayo identifies that Medicare expenditures decrease overall when considering inpatient, recurrent stroke and rehabilitation reimbursements. This is determined by the offset expenditures from decreasing recurrent stroke and rehabilitation care.³⁶

Coverage and Reimbursement for Telehealth Services

Reimbursement levels and allowances for telehealth services vary from state to state and from entity to entity. Some public and private payers limit reimbursement for health services offered through telehealth technology by the type of telehealth service offered and/or by the locations where care is provided and received. 43% of Florida health insurers indicate that they cover some form of telehealth services (Figure 18). Companies who offer Medicare Advantage plans were shown as having the largest percentage of plans offering reimbursement to health care providers for service provided through telehealth technologies (Figure 19). Coverage typically is limited to certain delivery types and requires special coding (Figure 20). A majority of health insurers indicate very limited coverage. Florida health care provider and practitioner survey responses (Figures 15 & 16) concur with health insurer responses by citing a lack of reimbursement as a barrier to implementation

Figure 18. Percentage of Health Plans That Reimburse for Telehealth

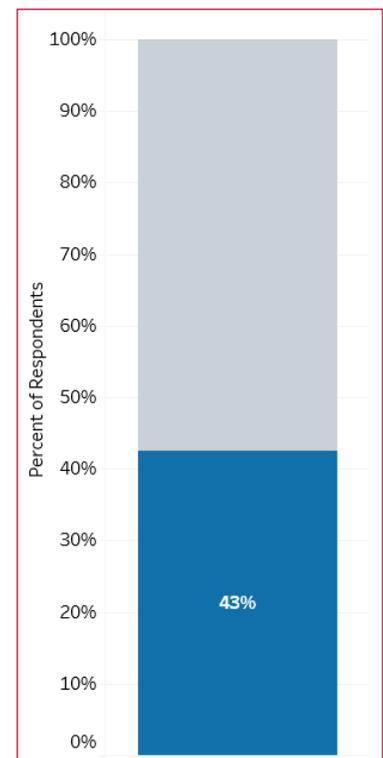


Figure 19. Percentage of Health Plans That Reimburse for Telehealth by Coverage Type

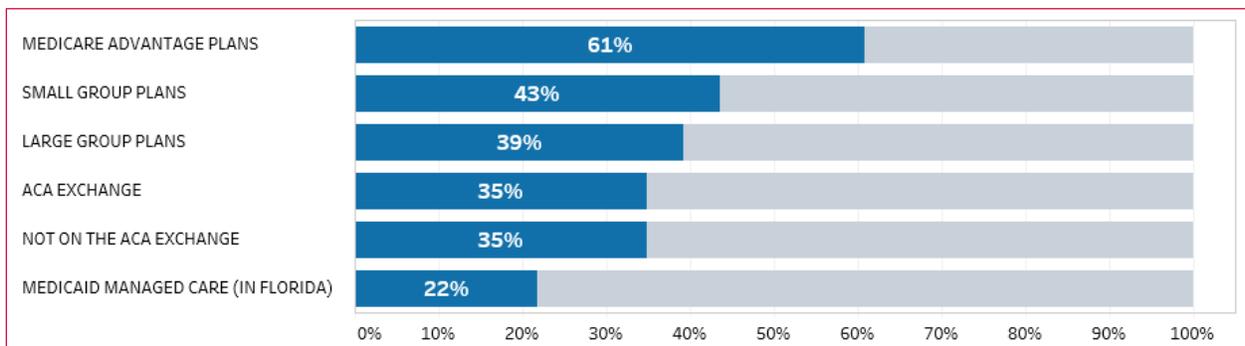
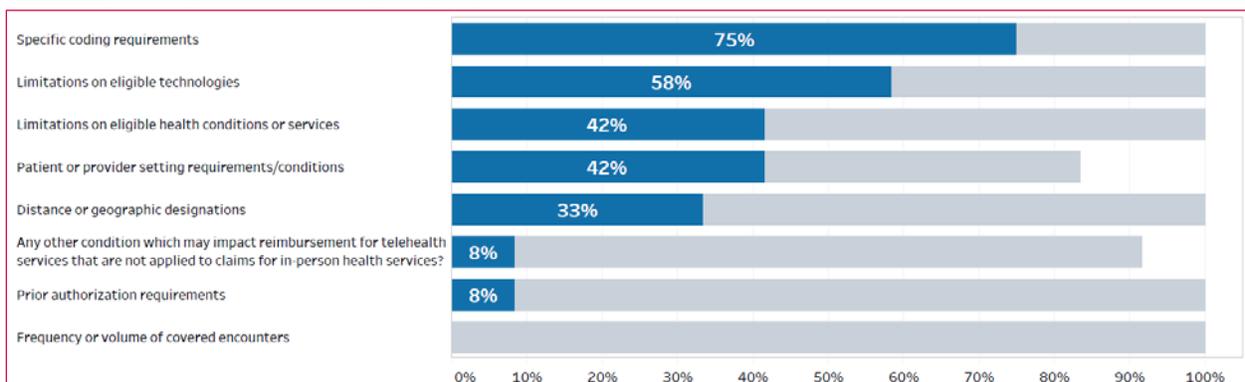


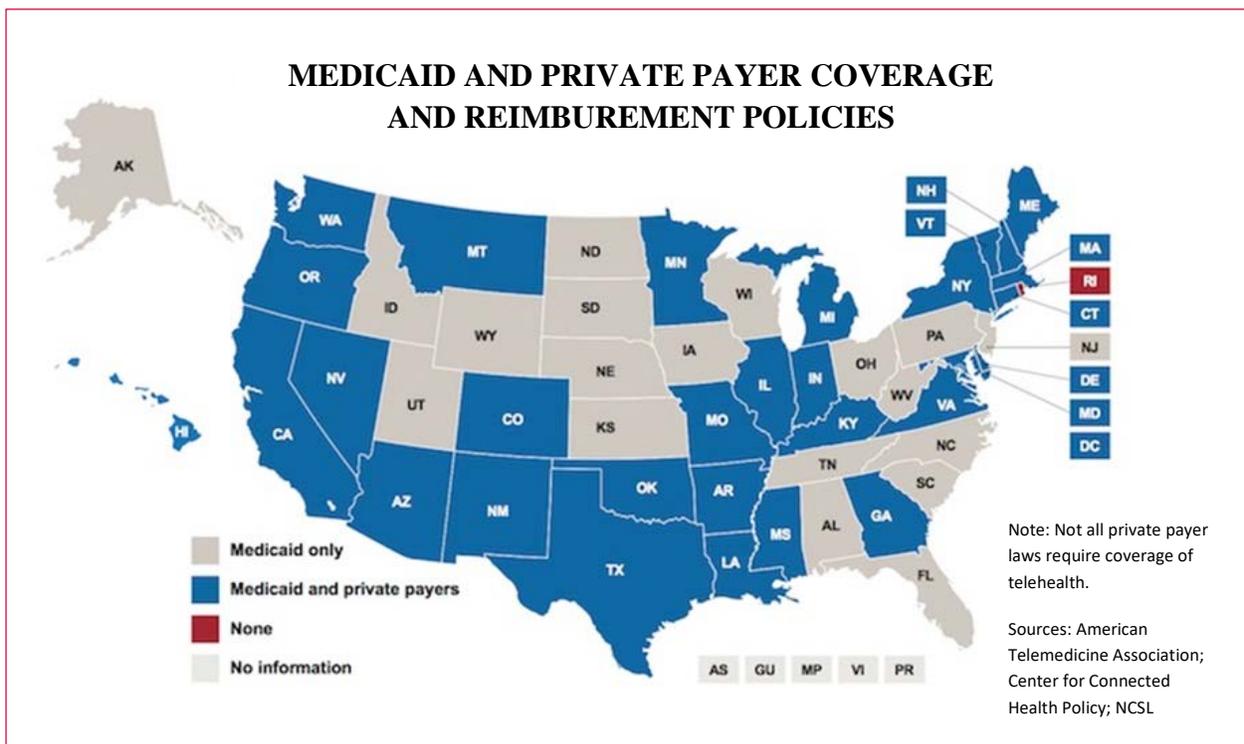
Figure 20. Percentage of Health Plans Reporting Required Conditions for Reimbursement



Private and Commercial Insurance Coverage and Reimbursement

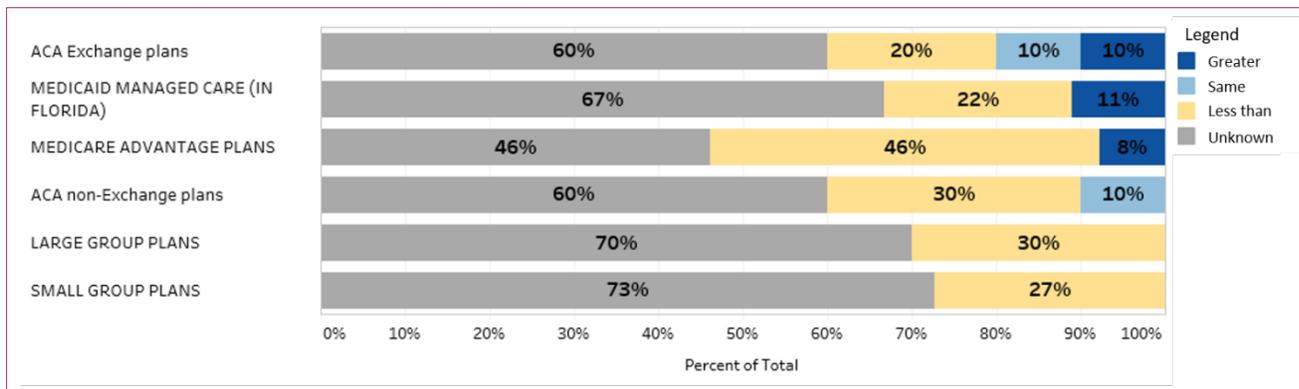
As of December 2016, 29 states, including the District of Columbia, have active parity laws which require private payer coverage and payment for telehealth services to be equitable with coverage and reimbursements for face-to-face health services. Additional states have passed similar parity laws that will become effective in 2017. Of this latter group, Massachusetts is the only state that has regulations exclusively requiring private insurance companies to reimburse for services provided through telehealth.³⁷ The definition of telehealth in each of these states varies, and some state definitions may include limitations on the telehealth modalities encompassed in required coverage and payment models. (Figure 21)

Figure 21. States with Specific Telehealth Coverage and Reimbursement Regulations



Notable differences in the state regulations include whether telehealth services must be reimbursed at the same rate as in-person services; or whether the state only requires that the same services be covered but allow for variable rates of reimbursement.³⁸ Florida does not currently have any statutory requirements related to private payer parity for telehealth services. Some private payers in the state have voluntarily opted to provide coverage and reimbursement for telehealth services (Figure 22).

Figure 22. Percentage of Health Plans Providing Coverage and Reimbursement for Telehealth

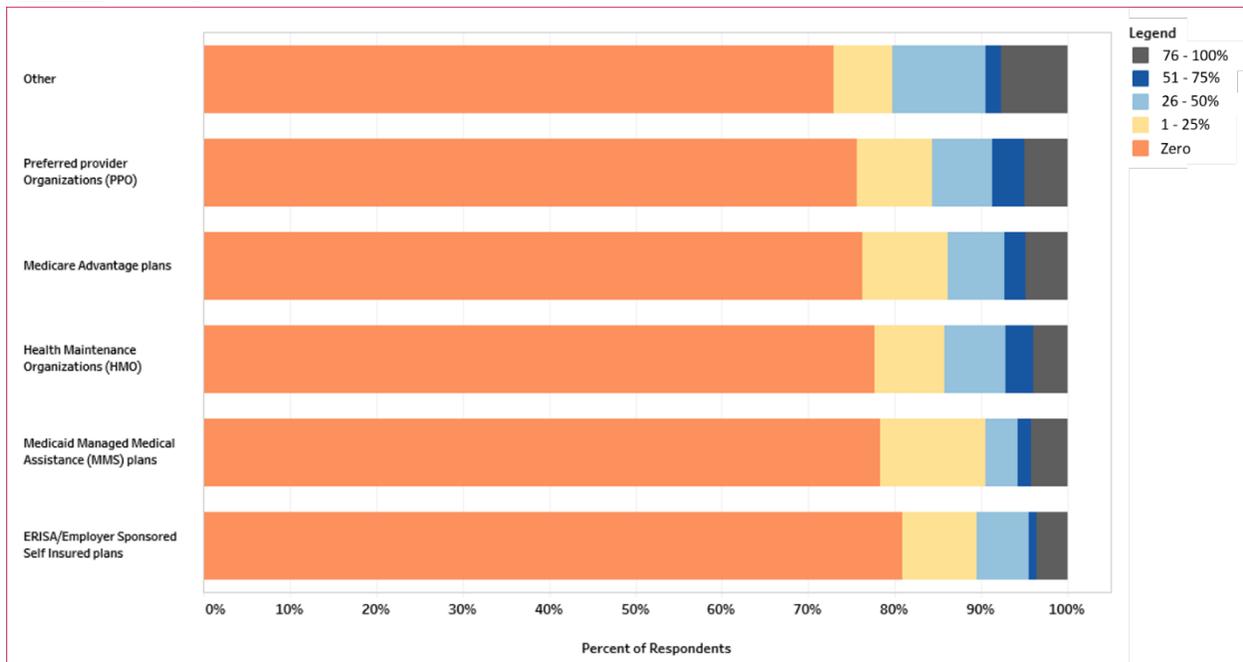


Medicare and Medicaid Coverage and Reimbursement

Medicare offers coverage for specific telehealth services delivered at designated sites covered under Medicare. The U.S. Centers for Medicare and Medicaid Services (CMS) requires both a distant site and a separate originating site (hub and spoke model) within its definition of allowable telehealth services. Asynchronous (store and forward) activities are only reimbursed by Medicare in federal demonstration projects in Hawaii and Alaska. To qualify for Medicare reimbursement, the originating site must be located in a federally defined rural county, designated rural, or identified as a participant in a federal telemedicine demonstration project as of December 21, 2000.³⁹ Additionally, the originating site is limited to specific designated locations including a practitioner’s office, a Critical Access Hospital (CAH) or other hospital, a federally certified Rural Health Clinic (RHC); a Federally Qualified Health Center (FQHC), renal dialysis centers associated with a hospital or CAH, skilled nursing facility, or community mental health center.

In addition to the 28 states that require parity coverage for telehealth services, there are currently 18 states that provide Medicaid coverage and reimbursement for telehealth services. At least 17 states have some reimbursement for remote patient monitoring; and nine states reimburse for store and forward services under their Medicaid program.⁴⁰ Within each of these reimbursement models, there are variances in the types of services, specialties, providers, and locations that are covered.

Figure 23. Percentage of Reimbursement to Health Facilities by Health Plan

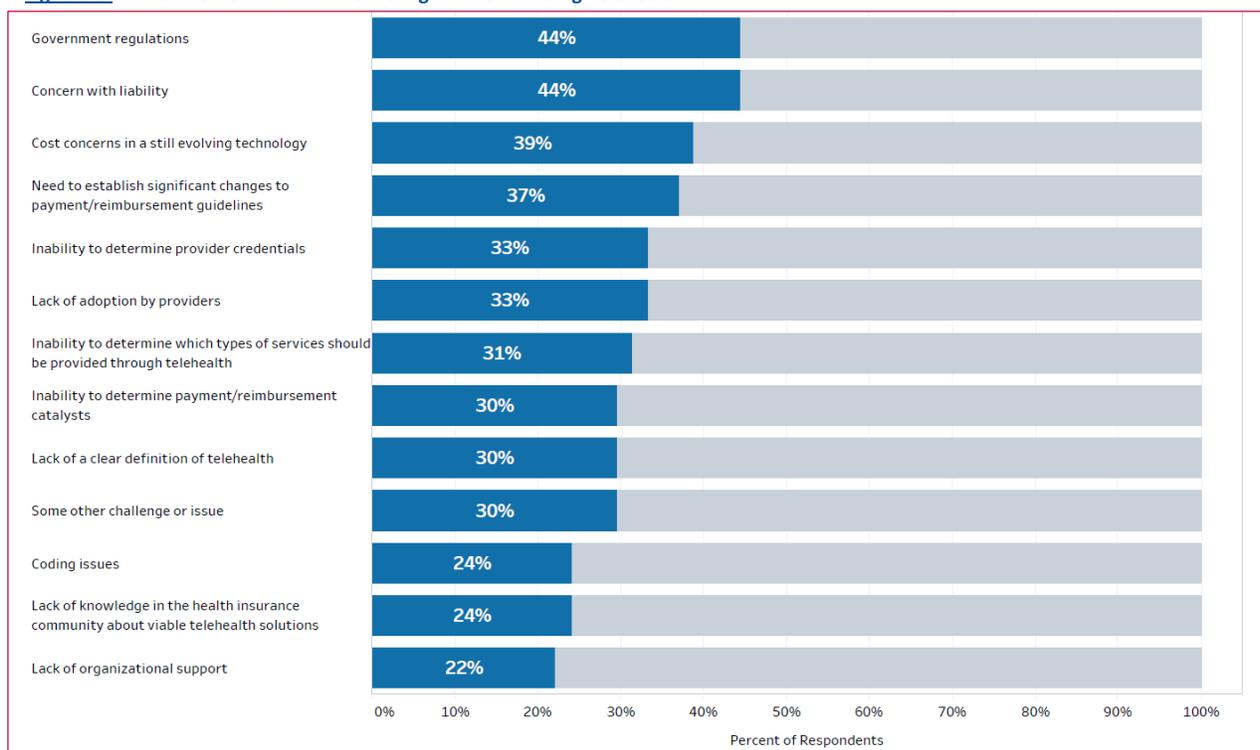


The Florida Medicaid fee-for-service rules were updated in June, 2016 to expand telehealth payments to a broader array of practitioners. Similar to Medicare, Medicaid coverage in Florida is limited to live video conferencing, and pays the practitioner that provides the diagnosis only.⁴¹ With the vast majority of Florida Medicaid beneficiaries enrolled in managed care, Florida’s Medicaid Managed Care plans are authorized to cover telehealth services with greater flexibility; however, there is no mandate for coverage. Based on survey responses by Florida health plans, coverage for telehealth is greatest for Medicaid Managed Care and Affordable Care Act Exchange Plans (Figure 22). Florida health care providers indicate very little reimbursement for telehealth services no matter the plan type (Figure 23).

Barriers to Telehealth

Although telehealth adoption and expansion are on the rise, stakeholders consistently acknowledge there are challenges. The primary issues related to telehealth often cited are financial, interoperability, and licensure.⁴² Florida providers and practitioners noted financial issues and lack of interoperability as top barriers and challenges for implementing and continuing to offer telehealth services. (Figures 15 & 17) Health plans indicate regulations and liability concerns as barrier to providing coverage and reimbursement. (Figure 24)

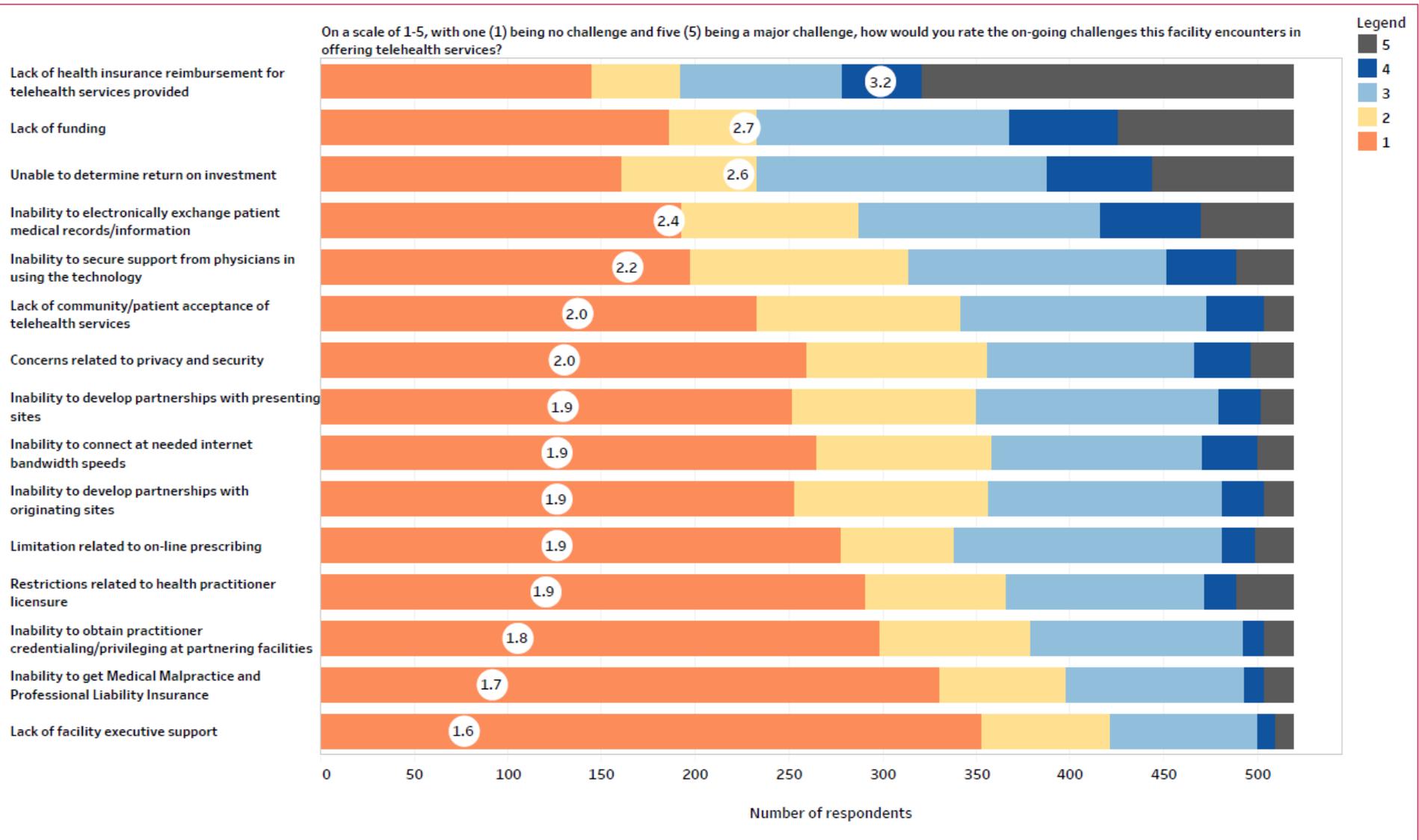
Figure 24. Barriers to Health Plans in Covering and Reimbursing Telehealth



Financial

Florida facility and practitioner licensees who responded to the survey indicated the top three barriers to implementing telehealth involve finances: inadequate reimbursement from payers, insufficient funding capital, and the inability to determine return on investment. These were also ongoing challenges for facilities in maintaining their programs. The same top three barriers were identified by organizations that had tried to implement telehealth in the past, but had discontinued their telehealth programs prior to responding to the survey. (Figures 15, 16, 17) Although not the most frequently reported concern from payers, costs were identified among the top three on-going challenges related to reimbursement for telehealth services.

Figure 25. On-Going Challenges for Facilities Offering Telehealth



Interoperability

Florida facility and practitioner licensees offering telehealth point to the lack of interoperability between providers as a significant barrier to implementing telehealth. (Figures 15, 16, and 17).

Survey respondents for Florida facilities point to the lack of interoperability between providers as a significant barrier to implementing telehealth. A bipartisan focus group brought together by Health Affairs and the Bipartisan Policy Center also identified the lack of interoperability between electronic health record systems and medical devices as a barrier to telehealth expansion. They noted that the lack of interoperability is both a technical and human issue. In some instances, the technical capability in place limits sharing of data; however, in some cases technology vendors, individual practitioners, or health facilities express an unwillingness to share information with other health care providers.⁴³

In addition to interoperability between health care provider data systems, there is also a lack of interoperability between telehealth technology and electronic health record (EHR) platforms. Recently, Cerner (EHR vendor) and American Well began a partnership to merge their capabilities.⁴⁴ Allscripts (EHR vendor) began working with the University of South Florida Health (USF Health) on a telehealth - EHR integration project in 2012.⁴⁵ USF Health partnered with The Villages Health system to provide telehealth services to the United States' largest over-55 community.⁴⁶

Regulation and Liability

44% of health plans surveyed noted government regulations and liability as barriers for covering telehealth services. The issue of interstate practice and reimbursement is among the legal issues health plans must consider. Licensure of health care practitioner is the responsibility of each state. Practitioners must be licensed in the state where the patient resides. Health plans must ensure they are reimbursing health providers that are appropriately licensed in the jurisdiction where they are treating patients.⁴⁷

Knowledge

All facilities who completed the survey were provided an opportunity to express their opinion on "what would assist [them] in implementing, sustaining, or expanding telehealth services". The responses varied greatly, however, there was a noted interest in additional information about telehealth in general and specific research data. The types of services and activities that fall under the auspice of telehealth were also an area of interest. Other respondents added the need for resources to assist them in determining using if telehealth would be appropriate for their facility.

References

- ¹ "U.S. Department of Health and Human Services Strategic Plan. Goal 1: Strengthen the Nation's Health and Human Service Infrastructure and Workforce " N.p., 15 Mar. 2016. Web. Dec. 2016.
- ² Segen's Medical Dictionary. "Telehealth". 2012 Farlex, Inc. Web. Dec. 2016.
- ³ § 64B8-9.0141, Florida Administrative Code, Board of Medicine. March 2016 and §64B15-14.0081, Florida Administrative Code, Board of Osteopathic Medicine. June 2016.
- ⁴ 59G-1.057, Florida Administrative Code. Agency for Health Care Administration. Medicaid. Telemedicine. June 2016.
- ⁵ "Trends in Telehealth White Paper | Health Care | Patient." *Scribd*. Scribd, 2014. Web. 15 Dec. 2016
- ⁶ Brehm, William. "Telehealth Research Report: Closing the Telehealth Gap - Avizia." *Avizia*. N.p., 2016. Web. 15 Dec. 2016.
- ⁷ "The Promise of Telehealth For Hospitals, Health Systems ..." American Hospital Association, Jan. 2015. Web. 15 Dec. 2016.
- ^{vii} "Telehealth Programs." *Telehealth Programs*. U.S. Department of Health and Human Services, n.d. Web. 15 Dec. 2016.
- ⁹ "State Medical Boards Adopt Policy Guidelines for Safe ..." Federation of State Medical Boards, 2014. Web. 15 Dec. 2016.
- ¹⁰ "Trends in Telehealth Making Healthcare More Collaborative, Affordable, and Effective " NTT Data, 2014. Web. 15 Dec. 2016.
- ¹¹ "Telemedicine: Patient Demand, Cost Containment Drive Growth." *Medical Economics*. Advanstar Communications Inc, n.d. Web. 14 Dec. 2016.
- ¹² Vaughn, D. What is Teleradiology? A History of Teleradiology. Keiser University. Web. Dec 2016.
- ¹³ NTT Data "Trends in Telehealth Making Healthcare More Collaborative, Affordable, and Effective " NTT Data, 2014. Web. 15 Dec. 2016.
- ¹⁴ "Telehealth: Helping Hospitals Deliver Cost-Effective Care." American Hospital Association, n.d. Web. 15 Dec. 2016.
- ¹⁵ Levy, Charles E., MD; Silverman, Erin, PhD; Jia, Huanguang, PhD; Geiss, Meghan, MS; Omura, David, DPT, MHA. "Journal of Rehabilitation Research & Development (JRRD Volume 52. Number 3, 2015. Pages 361-370)." *Effects of Physical Therapy Delivery via Home Video Telerehabilitation on Functional and Health-related Quality of Life Outcomes*. N.p., n.d. Web. 15 Dec. 2016.
- ¹⁶ Whitman, John, MBA, NHA; Donny Tuchman, NHA. "Reducing Avoidable SNF to Hospital Admissions and Readmissions by Implement a Virtual Physician Service, Enabled through Technology" The TRECS Institute Presentation. July 2016.
- ¹⁷ Switzer, JA; Demaerschalk, B; Xie, J; Fan, L; Villa, KF; Su, E.. "Cost-effectiveness of Hub-and-spoke Telestroke Networks for the Management of Acute Ischemic Stroke from the Hospitals' Perspectives." *Circulation. Cardiovascular Quality and Outcomes*. U.S. National Library of Medicine, n.d. Web. 15 Dec. 2016.
- ¹⁸ "Effect of Telehealth on Use of Secondary Care and Mortality: Findings from the Whole System Demonstrator Cluster Randomised Trial." *Effect of Telehealth on Use of Secondary Care and Mortality: Findings from the Whole System Demonstrator Cluster Randomised Trial | The BMJ*. British Medical Journal, 2012.
- ¹⁹ NTT Data NTT Data "Trends in Telehealth Making Healthcare More Collaborative, Affordable, and Effective " NTT Data, 2014. Web. 15 Dec. 2016.
- ²⁰ "Population Estimates, July 1, 2015, (V2015)." *Florida QuickFacts from the US Census Bureau*. N.p., n.d. Web. 15 Dec. 2016.
- ²¹ "GME Funding: How to Fix the Doctor Shortage." *AAMCNews*. Association of American Colleges, n.d. Web. 15 Dec. 2016.
- ²² "The Promise of Telehealth for Hospitals, Health Systems ..." American Hospital Association, Jan. 2015. Web. 15 Dec. 2016.
- ²³ Crowe, BL. "Cost-effectiveness Analysis of Telemedicine." *Journal of Telemedicine and Telecare*. Vol. 4 Number 1 pp14-17 U.S. National Library of Medicine, 1998. Web. 15 Dec. 2016.

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- ²⁴ "Telehealth." *Telehealth | AHRQ National Resource Center; Health Information Technology: Best Practices Transforming Quality, Safety, and Efficiency*. N.p., n.d. Web. 15 Dec. 2016.
- ²⁵ "The Promise of Telehealth For Hospitals, Health Systems ..." American Hospital Association, Jan. 2015. Web. 15 Dec. 2016.
- ²⁶ "National Conference of State Legislatures (NCSL) Report." NCSL Partnership Project on Telehealth, 2015. Web. 15 Dec. 2016.
- ²⁷ "Telemedicine." *Medicaid.gov*. N.p., n.d. Web. 15 Dec. 2016.
- ²⁸ National Conference of State Legislatures (NCSL) Report." NCSL Partnership Project on Telehealth, 2015. Web. 15 Dec. 2016.
- ²⁹ Center for Connected Health Policy, Recommendations for the CCHP Telehealth and the Triple Aim Project: Advancing Telehealth Knowledge and Practice. 2014. Web Dec. 2016.
- ³⁰ Wootton, R. "Twenty Years of Telemedicine in Chronic Disease Management--an Evidence Synthesis." *Journal of Telemedicine and Telecare*. U.S. National Library of Medicine, No. 4 pp 211–220. 2012 Web. 15 Dec. 2016.
- ³¹ National Conference of State Legislatures (NCSL) Report." NCSL Partnership Project on Telehealth, 2015. Web. 15 Dec. 2016.
- ³² Yamamoto, Dale "Assessment of the Feasibility and Cost of Replacing In ..." N.p., 2014. Web. 15 Dec. 2016.
- ³³ "VA Reports Big Wins through Telehealth." *Healthcare IT News*. N.p., 2014. Web. 15 Dec. 2016.
- ³⁴ US Department of Justice-US Department of Defense Joint Steering Group Report. "Implementing Telehealth In Correctional Facilities". National Institute of Justice, 2002. Web. 15 Dec. 2016.
- ³⁵ Whitman, John, MBA, NHA; Tuchman, Donny NHA. "Reducing Avoidable SNF to Hospital Admissions and Readmissions by Implement a Virtual Physician Service, Enabled through Technology" The TRECS Institute Presentation. July 2016.
- ³⁶ Switzer, JA; Demaerschalk,B; Xie, J; Fan, L; Villa, KF; Su, E. "Cost-effectiveness of Hub-and-spoke Telestroke Networks for the Management of Acute Ischemic Stroke from the Hospitals' Perspectives." *Circulation. Cardiovascular Quality and Outcomes*. U.S. National Library of Medicine, n.d. Web. 15 Dec. 2016
- ³⁷ Robin, Lisa, MBA. "Telemedicine Policies, Board by Board Overview." Federation of State Medical Boards. Presentation Nov.2016.
- ³⁸ National Conference of State Legislatures (NCSL) Report." NCSL Partnership Project on Telehealth, 2015. Web. 15 Dec. 2016.
- ³⁹ § 42USC Section 1395(m)(m)(4)(C)(i). Print.
- ⁴⁰ Robin, Lisa, MBA. "Telemedicine Policies, Board by Board Overview." Federation of State Medical Boards. Presentation Nov.2016.
- ⁴¹ § 59G-1.057, Florida Administrative Code. Print.
- ⁴² National Conference of State Legislatures (NCSL) Report." NCSL Partnership Project on Telehealth, 2015. Web. 15 Dec. 2016.
- ⁴³ Marchibroda, J. "A Policy Dialogue On Connected Health." *Health Affairs*. N.p., 2013. Web. 15 Dec. 2016..
- ⁴⁴ "Cerner and American Well to Embed Telehealth Capabilities into Cerner EHR: Cerner.com." *Cerner and American Well to Embed Telehealth Capabilities into Cerner EHR: Cerner.com*. Cerner - Cerner.com, n.d. Web. 15 Dec. 2016.
- ⁴⁵ McCann, Erin. "Telehealth and Allscripts EHR, New Dynamic Duo ..." *Healthcare IT News*, 2012. Web. 15 Dec. 2016.
- ⁴⁶ "USF Health and American Well to Bring Telehealth to Seniors Living at The Villages - USF Health News." *USF Health News*. University of South Florida, 2012. Web. 15 Dec. 2016.
- ⁴⁷ Telehealth Legal and Regulatory Module - Telehealth Resource Center." *Telehealth Resource Center*. The Center for Connected Health Policy, n.d. Web. 15 Dec. 2016.

STATE OF FLORIDA

OFFICE OF THE GOVERNOR EXECUTIVE ORDER NUMBER 17-146 (Opioid Epidemic)

WHEREAS, the Centers for Disease Control and Prevention has declared a national opioid epidemic which poses a severe threat to the State of Florida and requires that measures are taken to protect the communities and the general welfare of this State; and

WHEREAS, in 2015, opioids were responsible for over 33,000 deaths nationwide; and nearly 3,900 deaths in Florida; and

WHEREAS, opioid abuse has required additional resources from local first responders such as law enforcement, firefighters, and emergency medical services; and

WHEREAS, on April 21, 2017, the United States Department of Health and Human Services awarded a grant to the Florida Department of Children and Families in the amount of \$27,150,403 per year for two years to provide prevention, treatment, and recovery support services to address this epidemic; and

WHEREAS, it is necessary to immediately draw down these federal grant funds to provide services to Florida communities instead of waiting until the start of the next fiscal year, July 1, 2017; and

WHEREAS, on April 11, 2017, I directed DCF, DOH and FDLE to meet with communities and hold workshops to identify additional strategies to fight the rising opioid usage cases in Florida.

NOW, THEREFORE, I, RICK SCOTT, as Governor of Florida, by virtue of the authority vested in me by Article IV, Section 1 (a) of the Florida Constitution and by the Public Health Act, and all other applicable laws, promulgate the following Executive Order, to take immediate effect:

Section 1. Because of the foregoing conditions, I declare that the opioid epidemic threatens the State of Florida with an emergency, and that as a consequence of this danger a state of emergency exists in the State of Florida.

Section 2. I give the Florida Department of Children and Families and the Florida Department of Law Enforcement the authority to suspend the effect of any statute, rule, ordinance, or order, to the extent necessary to procure any and all necessary supplies, commodities, services, temporary premises, and other resources, including, but not limited to, any and all statutes, rules, ordinances, or orders which affect leasing, printing, purchasing, travel, and the condition of employment and the compensation of employees, but any statute, rule, ordinance, or order shall be suspended only to the extent necessary to ensure the timely performance of disaster response functions. Any waiver of statutes, rules, ordinances, or orders which affect leasing, printing, purchasing, travel, and the condition of employment and the compensation of employees shall be by emergency rule or order in accordance with sections 120.54(4) and 252.46, Florida Statutes and in no event shall remain in effect beyond the date of expiration of this Order, as extended, or ninety days from the issuance of this Order.

Section 3. Pursuant to section 252.36(1)(a), Florida Statutes, the Executive Office of the Governor may waive all statutes and rules affecting budgeting to the extent necessary to provide budget

authority for state agencies to cope with this emergency. The requirements of sections 252.46 and 120.54(4), Florida Statutes, do not apply to any such waiver issued by the Executive Office of the Governor.

Section 4. I find that the demands placed upon the funds appropriated to the agencies of the State of Florida and to local agencies are unreasonably great and may be inadequate to pay the costs of coping with this severe circumstance. In accordance with section 252.37(2), Florida Statutes, I direct that sufficient funds be made available, as needed, by transferring and expending moneys appropriated for other purposes, moneys from unappropriated surplus funds, or from the Budget Stabilization Fund.

Section 5. I direct the State Health Officer and Surgeon General, Celeste Philip, M.D., MPH, to declare a statewide public health emergency, pursuant to its authority in section 381.00315, Florida Statutes.

Section 6. In accordance with section 381.0011(7), Florida Statutes, I direct the State Health Officer to take any action necessary to protect the public health. Further, I direct the State Health Officer to immediately issue a standing order for approved opioid antagonists to ensure emergency responders have access to this lifesaving medication.

Section 7. This Executive Order shall expire sixty days from this date unless extended.

IN TESTIMONY WHEREOF, I have hereunto set my hand and caused the Great Seal of the State of Florida to be affixed, at Tallahassee, this 3rd day of May, 2017.



GOVERNOR

ATTEST:

SECRETARY OF STATE

FILED
2017 MAY -3 AM 10:30
TALLAHASSEE FLORIDA

Mission:

To protect, promote & improve the health of all people in Florida through integrated state, county & community efforts.



Rick Scott
Governor

Celeste Philip, MD, MPH
Surgeon General and Secretary

Vision: To be the **Healthiest State** in the Nation

**STATE OF FLORIDA
SECOND AMENDED
DEPARTMENT OF HEALTH
DECLARATION OF PUBLIC HEALTH EMERGENCY
AND STATEWIDE STANDING ORDER FOR NALOXONE**

WHEREAS, on May 19, 2017, Governor Rick Scott declared that the opioid epidemic threatens the State of Florida with an emergency, and that as a consequence of this danger a state of emergency exists in the State of Florida; and

WHEREAS, the Centers for Disease Control and Prevention has declared a national opioid epidemic which poses a severe threat to the State of Florida and requires that measures are taken to protect the communities and the general welfare of this State; and

WHEREAS, in 2015, opioids were responsible for nearly 3,900 deaths in Florida; and

WHEREAS, opioid abuse has required additional resources from local first responders such as law enforcement, firefighters, and emergency medical services; and

WHEREAS, in 2016, Florida enacted the “Emergency Treatment and Recovery Act” which authorized health care practitioners to prescribe and dispense opioid antagonists to patients, caregivers and first responders pursuant to a non-patient-specific standing order for the emergency treatment of known or suspected opioid overdoses occurring when a health care practitioner is not available; and

WHEREAS, pharmacists are authorized to dispense an appropriately labeled opioid antagonist based on a non-patient-specific standing order for an autoinjection delivery system or intranasal application delivery system, which must be appropriately labeled with instructions for use; and

WHEREAS, the Act authorizes emergency responders, including but not limited to, law enforcement officers, paramedics and emergency medical technicians, to possess, store and administer emergency opioid antagonists as clinically indicated; and

WHEREAS, immunity from civil liability is provided under section 768.13, Florida Statutes, the Good Samaritan Act, to any person, including health care practitioners and emergency responders, who possess, administer or store an approved opioid antagonist in accordance with the Act. A health care practitioner acting in good faith and exercising reasonable care is not subject to discipline under the applicable professional licensure statute and is also immune from civil or criminal liability for prescribing or dispensing an opioid antagonist in accordance with the Act.

NOW, THEREFORE, I, Celeste Philip, MD, MPH, Surgeon General of Florida and State Health Officer, by virtue of Executive Order Number 17-146 issued by Governor Rick Scott and the authority vested in me by section 381.00315, Florida Statutes, do hereby declare the following:

Section 1: A Public Health Emergency is declared statewide.

Section 2: As directed by Executive Order Number 17-146, the following Florida standing order for Naloxone is issued.

Naloxone Standing Order

This order authorizes pharmacists who maintain a current active license practicing in a pharmacy located in Florida that maintains a current active pharmacy permit to dispense one of the following naloxone formulations to emergency responders for administration to persons exhibiting signs of opioid overdose. Emergency responders include law enforcement officers, firefighters, paramedics and emergency medical technicians.

The pharmacy must maintain a copy of the naloxone Standing Order if dispensing naloxone pursuant to the order.

Incorporated in this Naloxone Standing Order is the expectation that the SAMHSA Opioid Overdose Prevention Toolkit Five Essential Steps for First Responders be followed.

Approved Options for Intranasal or Auto-Injector Administration:

Intranasal	Auto-Injector	Intranasal
<p>Naloxone 2mg/2ml prefilled syringe, # 2 syringes SIG: Spray one-half of the syringe into each nostril upon signs of opioid overdose. Call 911. May repeat x 1. Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration. Kit must contain 2 prefilled syringes and 2 atomizers and instructions for administration.</p>	<p>Naloxone 0.4 mg or 2mg #1 twin pack SIG: Inject one auto-injector into the outer thigh (through clothing if necessary) upon signs of opioid overdose Call 911 May repeat x 1 in 2 to 3 minutes No kit is required. Product is commercially available</p>	<p>Narcan Nasal Spray 4mg, #2 SIG: Administer a single spray intranasally into one nostril. Call 911. Administer additional doses using a new nasal spray with each dose, if patient does not respond or responds and then relapses into respiratory depression. Additional doses may be given every 2 to 3 minutes until emergency medical assistance arrives. No kit is required. Product is commercially available.</p>

Executed this 19th day of May, 2017, in Department of Health Offices, Tallahassee, Leon County, Florida.



Celeste Philip, MD, MPH
 Surgeon General and Secretary

CONTROLLED SUBSTANCES

Presented by:

C. Erica White, MBA, JD

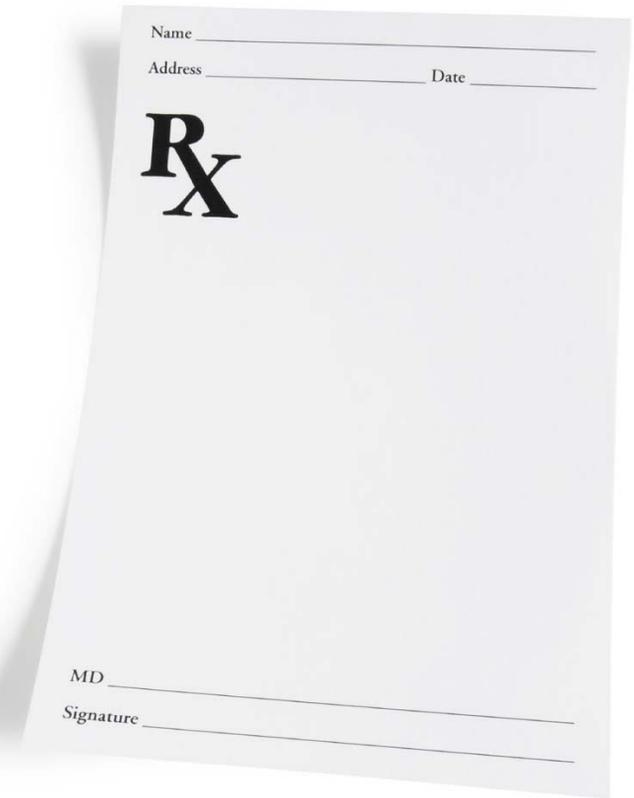
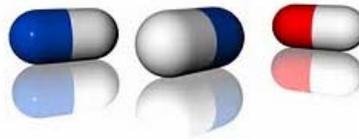
Executive Director

Florida Board of Pharmacy

June 2, 2017

OVERVIEW:

- There is a need for the use of controlled substances, through the use of properly prescribed medications, in order to provide the most effective patient care within various health care professions regulated by the Department.



GOALS:

- To ensure that all health care professions are compliant with Florida Statutes relating to the uses and distributions of controlled substances.



GOALS:

- To prevent fraudulent use or misuse of prescription drugs within regulated health care professions, by monitoring inventories and use of controlled substances by prescribing practitioners.



CONTROLLED SUBSTANCES



- Chapter 893, F.S., sets forth the Florida Comprehensive Drug Abuse Prevention and Control Act (Act).



CONTROLLED SUBSTANCES

- The Act also provides requirements for the prescribing and administering of controlled substances by health care practitioners and proper dispensing by pharmacists and health care practitioners.



DRUG ENFORCEMENT ADMINISTRATION



- Any health care professional wishing to prescribe controlled substances must apply for a registration number from the Drug Enforcement Administration (DEA), housed within the U.S.

Department of Justice.



DRUG ENFORCEMENT ADMINISTRATION



- Registration numbers are linked to state licenses and may be suspended or revoked upon any disciplinary action taken against a licensee.



PRESCRIBING PRACTITIONERS



PRESCRIBING PRACTITIONERS

A Pharmacist, in good faith and in the course of professional practice only, may dispense controlled substances upon a written or oral prescription of a practitioner.



Section 893.04(1), F.S.

PRESCRIBING PRACTITIONERS

A Physician licensed under Chapter 458, 459, 461, or 466, a PA licensed under Chapter 458 or 459, or an ARNP certified under Chapter 464 - Part I who prescribes any controlled substance, listed in Schedule II, III, or IV as defined, in Section 893.03, F.S.,....



Section 456.44(2), F.S.

PRESCRIBING PRACTITIONER

...Must designate himself or herself as a controlled substance prescribing practitioner on his or her practitioner profile, for the treatment of chronic nonmalignant pain.



Section 456.44(2), F.S.

PRESCRIBING PRACTITIONERS



- A Dentist shall have the right to prescribe drugs or medicine, subject to limitations imposed by law.
- Pharmacists licensed pursuant to Chapter 465, F.S., may fill prescriptions from licensed dentists in this state for any drugs necessary for the practice of Dentistry.



Section 466.017(1) -(2), F.S.



PAIN MANAGEMENT CLINICS

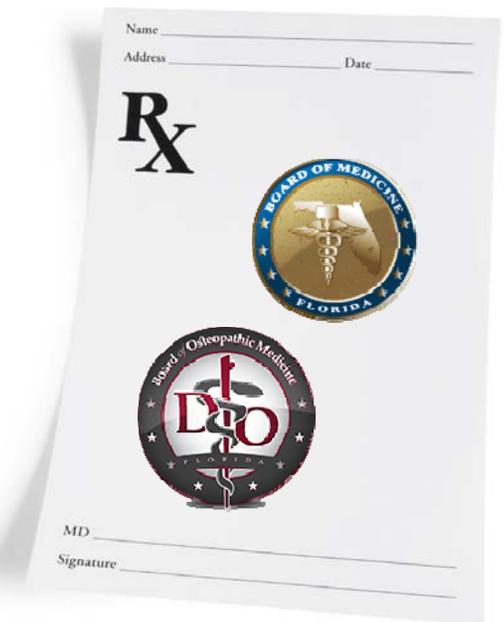




PAIN MANAGEMENT CLINICS



Only a Physician, licensed under Chapter 458 or 459, F.S. may dispense medication or prescribe controlled substances, regulated under Chapter 893, F.S., on the premises of a registered pain-management clinic.



Section 458.3265(2)(b), F.S.



PAIN MANAGEMENT CLINICS



PAs and ARNPs are not allowed to prescribe Controlled Substances, regulated under Chapter 893, F.S., in pain-management clinics.





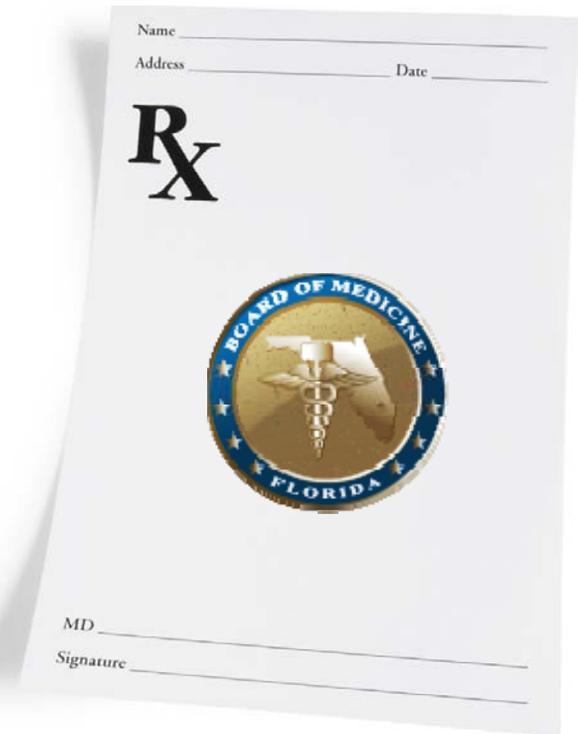
PHYSICIAN ASSISTANTS



PHYSICIAN ASSISTANTS (PA)



Effective January 1, 2017, PAs are authorized to prescribe controlled substances.



PHYSICIAN ASSISTANTS - SUPERVISION



A supervising physician may delegate to a fully licensed PA, the authority to prescribe or dispense any medication used in the supervising physician's practice unless such medication is listed a formulary established in Section 458.347(4)(f), F.S.

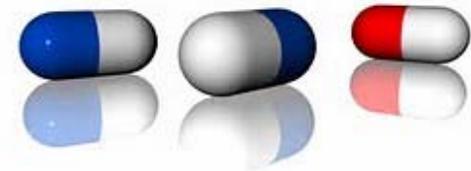




PA FORMULARY



The Council of Physician Assistants shall establish a formulary of medicinal drugs that a fully licensed PA having prescribing authority under Section 458.347, F.S., or Section 459.022, F.S., may not prescribe.





PA FORMULARY



- The formulary must include general anesthetics and radiographic contrast materials.
- The formulary must also limit the prescription of Schedule II controlled as listed in Section 893.03, F.S., to a 7- day supply.





PA FORMULARY



- The bill also requires that the formulary must restrict the prescribing of psychiatric mental health controlled substances for children younger than 18 years of age.

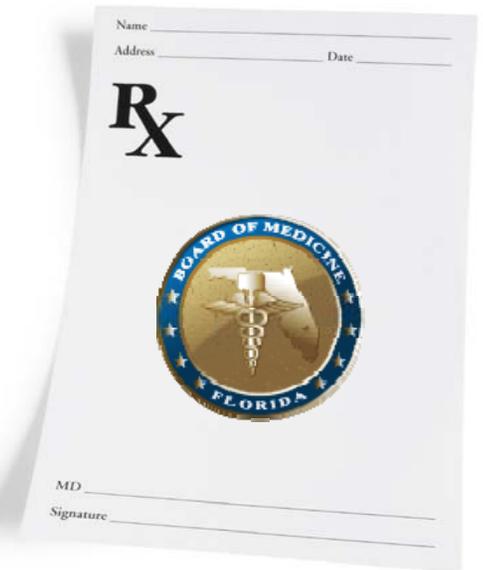


PHYSICIAN ASSISTANTS - SUPERVISION



A fully licensed PA may only prescribe or dispense such medication under the following circumstances:

- A PA must clearly identify to the patient that he or she is a PA.
- The PA must inform the patient that he or she has the right to see a physician prior to any prescription being prescribed or dispensed by the PA.



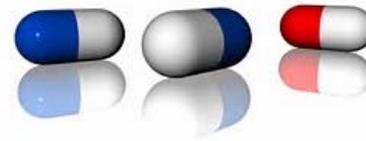
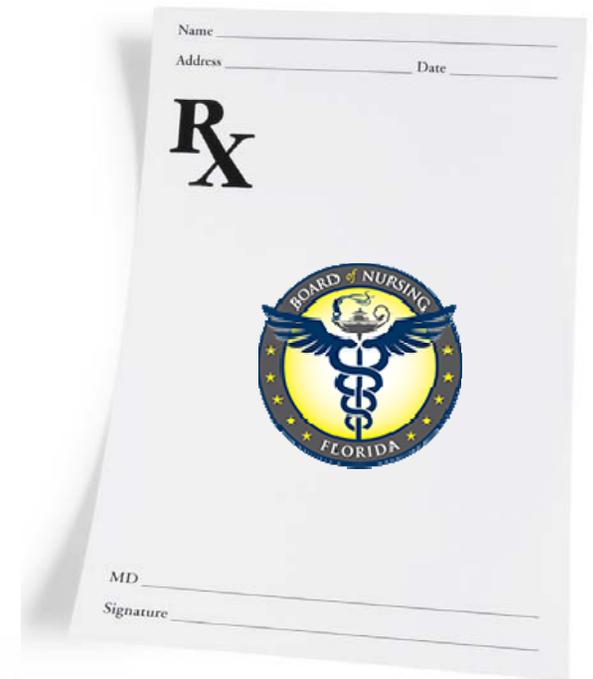
Section 458.347(4)(e), F.S.

ADVANCED REGISTERED NURSE PRACTITIONERS



ARNP PRESCRIBING

Effective January 1, 2017, ARNPs are authorized to prescribe, dispense, administer, or order any drug within an established supervisory protocol.





ARNP PRESCRIBING



An [ARNP](#) may prescribe or dispense a controlled substance, as defined in (s) 893.03, F.S. only he or she has graduated from a program leading to a Master's or Doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills.





ARNP – FORMULARY



The Board of Nursing shall establish a committee to recommend a formulary of controlled substances that an ARNP may not prescribe or may prescribe only for specific uses or in limited quantities.



Section 464.012(6)(a), F.S.

CONTROLLED SUBSTANCE FORMULARY



- Rule 64B9-4.016, F.A.C., became effective on October 16, 2016.
- The Rule provides:
 - ✓ ARNPs may only prescribe controlled substances pursuant to the individual's education, training, experience and protocol.





ARNP – FORMULARY



- ✓ ARNPs must restrict prescriptions of Schedule II controlled substances, listed in Section 893.03, F.S., to a 7-day supply.
- ✓ This does not apply to prescription of psychiatric medications prescribed by a psychiatric nurse as defined in Section 394.455, F.S.



Section 464.012(6)(a), F.S.

Rule 64B9-4.016, F.A.C.,



ARNP – FORMULARY



- ✓ Only ARNPs who meet the definition of a psychiatric nurse, as defined in Section 394.455, F.S., may prescribe psychiatric mental health controlled substances to children younger than 18 years of age.



Section 464.012(6)(a), F.S.

Rule 64B9-4.016, F.A.C.,



ARNP – FORMULARY



The formulary must also limit the prescribing of Schedule II controlled substances as listed in (s) 893.03, F.S., to a 7-day supply, except that such restriction does not apply to controlled substances that are psychiatric medications prescribed by psychiatric nurses as defined in s. 394.455, F.S.





FLORIDA PRESCRIPTION DRUG MONITORING PROGRAM



FLORIDA PDMP / E-FORCSE®



The Florida Prescription Drug Monitoring Program, known as E-FORCSE® (Electronic-Florida Online Reporting of Controlled Substance Evaluation Program), was created by the 2009 Florida Legislature as an initiative to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within Florida.



FLORIDA PDMP / E-FORCSE®

The purpose of the PDMP is to provide the information that is collected in the database to health care practitioners to guide their decisions in prescribing and dispensing these highly abused prescription drugs.



FLORIDA PDMP / E-FORCSE®

Section 893.055, Florida Statutes, requires health care practitioners to report to the PDMP each time a controlled substance is dispensed to an individual. The information is reported through the system as soon as possible but not more than 7 days after dispensing.



FLORIDA PDMP / E-FORCSE®



In addition to practitioners and [Pharmacists](#), a law enforcement agency may request confidential controlled substance dispensing information in the database during active investigations regarding potential criminal activity, fraud, or theft regarding prescribed controlled substances.



FLORIDA PDMP / E-FORCSE®



Also the Department of Health Investigative Services Unit and Medicaid Fraud Unit investigators may request information in the database to aide in the investigation of cases involving controlled substances.



FLORIDA PDMP / E-FORCSE®



On February 14, 2017, a designee of a prescriber or dispenser may have direct access to the controlled substance dispensing information in the E-FORCSE® database by registering on the E-FORCSE® secure web portal.



FLORIDA PDMP / E-FORCSE®



In 2016, Florida Legislature passed SB 964 authorizing direct access to controlled substance dispensing information within the E-FORCSE® database to a designee of a prescriber or dispenser.

Rule 64K-1.003(3), F. A.C. sets forth the requirements for access.



FLORIDA PDMP / E-FORCSE®



The information collected in the system will be used by the PDMP to encourage safer prescribing of controlled substances and to reduce drug abuse and diversion within the State of Florida.



GUIDELINE FOR PRESCRIBING OPIOIDS FOR CHRONIC PAIN

IMPROVING PRACTICE THROUGH RECOMMENDATIONS

CDC's *Guideline for Prescribing Opioids for Chronic Pain* is intended to improve communication between providers and patients about the risks and benefits of opioid therapy for chronic pain, improve the safety and effectiveness of pain treatment, and reduce the risks associated with long-term opioid therapy, including opioid use disorder and overdose. The Guideline is not intended for patients who are in active cancer treatment, palliative care, or end-of-life care.

DETERMINING WHEN TO INITIATE OR CONTINUE OPIOIDS FOR CHRONIC PAIN

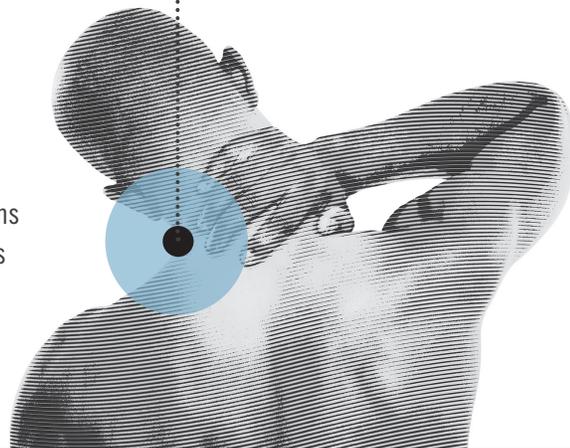
1 Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate.

2 Before starting opioid therapy for chronic pain, clinicians should establish treatment goals with all patients, including realistic goals for pain and function, and should consider how opioid therapy will be discontinued if benefits do not outweigh risks. Clinicians should continue opioid therapy only if there is clinically meaningful improvement in pain and function that outweighs risks to patient safety.

3 Before starting and periodically during opioid therapy, clinicians should discuss with patients known risks and realistic benefits of opioid therapy and patient and clinician responsibilities for managing therapy.

CLINICAL REMINDERS

- Opioids are not first-line or routine therapy for chronic pain
- Establish and measure goals for pain and function
- Discuss benefits and risks and availability of nonopioid therapies with patient



U.S. Department of
Health and Human Services
Centers for Disease
Control and Prevention

LEARN MORE | www.cdc.gov/drugoverdose/prescribing/guideline.html

OPIOID SELECTION, DOSAGE, DURATION, FOLLOW-UP, AND DISCONTINUATION

CLINICAL REMINDERS

- **Use immediate-release opioids when starting**
- **Start low and go slow**
- **When opioids are needed for acute pain, prescribe no more than needed**
- **Do not prescribe ER/LA opioids for acute pain**
- **Follow-up and re-evaluate risk of harm; reduce dose or taper and discontinue if needed**

4

When starting opioid therapy for chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release/long-acting (ER/LA) opioids.

5

When opioids are started, clinicians should prescribe the lowest effective dosage. Clinicians should use caution when prescribing opioids at any dosage, should carefully reassess evidence of individual benefits and risks when considering increasing dosage to ≥ 50 morphine milligram equivalents (MME)/day, and should avoid increasing dosage to ≥ 90 MME/day or carefully justify a decision to titrate dosage to ≥ 90 MME/day.

6

Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids and should prescribe no greater quantity than needed for the expected duration of pain severe enough to require opioids. Three days or less will often be sufficient; more than seven days will rarely be needed.

7

Clinicians should evaluate benefits and harms with patients within 1 to 4 weeks of starting opioid therapy for chronic pain or of dose escalation. Clinicians should evaluate benefits and harms of continued therapy with patients every 3 months or more frequently. If benefits do not outweigh harms of continued opioid therapy, clinicians should optimize other therapies and work with patients to taper opioids to lower dosages or to taper and discontinue opioids.



ASSESSING RISK AND ADDRESSING HARMS OF OPIOID USE

8 Before starting and periodically during continuation of opioid therapy, clinicians should evaluate risk factors for opioid-related harms. Clinicians should incorporate into the management plan strategies to mitigate risk, including considering offering naloxone when factors that increase risk for opioid overdose, such as history of overdose, history of substance use disorder, higher opioid dosages (≥ 50 MME/day), or concurrent benzodiazepine use, are present.

9 Clinicians should review the patient's history of controlled substance prescriptions using state prescription drug monitoring program (PDMP) data to determine whether the patient is receiving opioid dosages or dangerous combinations that put him or her at high risk for overdose. Clinicians should review PDMP data when starting opioid therapy for chronic pain and periodically during opioid therapy for chronic pain, ranging from every prescription to every 3 months.

10 When prescribing opioids for chronic pain, clinicians should use urine drug testing before starting opioid therapy and consider urine drug testing at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs.

11 Clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

12 Clinicians should offer or arrange evidence-based treatment (usually medication-assisted treatment with buprenorphine or methadone in combination with behavioral therapies) for patients with opioid use disorder.

CLINICAL REMINDERS

- **Evaluate risk factors for opioid-related harms**
- **Check PDMP for high dosages and prescriptions from other providers**
- **Use urine drug testing to identify prescribed substances and undisclosed use**
- **Avoid concurrent benzodiazepine and opioid prescribing**
- **Arrange treatment for opioid use disorder if needed**

WHEN THE PRESCRIPTION BECOMES THE PROBLEM



Your prescribed pain medication is only for you.

Health care providers prescribe pain medications based on a person's specific symptoms and medical history. That's why these medicines must not be shared with friends or family. Take your medication as prescribed, and follow your health care provider's instructions on using pain medication with other prescriptions and non-prescription drugs.

When pain medication is misused or abused, it does more harm than good.

Common signs of pain medication misuse or abuse are:

- Failing to take your medicine as prescribed by your health care provider.
- Sharing or selling your medication.
- Taking your medicine for reasons other than prescribed.
- Missing work or school, neglecting family and friends, or endangering yourself.
- Not being honest with your health care provider, family and friends about your medication use.

Know the difference between drug tolerance and drug addiction.

TOLERANCE: When the body becomes used to a drug, it has built a tolerance that makes the drug less effective at a given dose. This is a common occurrence for people with chronic pain who use opioid-based medication such as hydrocodone, oxycodone and morphine.

ADDICTION: A person is addicted when they use a drug compulsively despite the harmful consequences. Addiction is far more than a craving and can be characterized as a disease.

Pain medications should be safely stored and properly disposed.

STORAGE: Store pain medication safely and securely—away from people and pets. Avoid using common storage areas such as bathroom medicine chests, kitchen cabinets or bedroom night stands.

DISPOSAL: Always read and follow the disposal instructions on the drug label or patient information sheet that accompanies your medication. Never flush prescription drugs down the toilet. Get rid of expired, unwanted or unused pain medication as soon as possible to reduce the chance of others accidentally or intentionally taking your medicine.

Community drug take-back programs are your best option for drug disposal. These programs allow you to bring unused drugs to a central location for safe disposal. Call your pharmacist, local law enforcement department or your local government's household trash and recycling service to see if a take-back program is available in your community.

If your community does not offer a drug take-back program, follow these steps:*

1. Mix medicines with a substance that can't be eaten such as dirt, kitty litter or used coffee grounds—don't crush tablets or capsules.
2. Place the mixture in a plastic container or bag, and tightly seal.
3. Throw the container in your household trash.
4. Scratch out and make unreadable all personal information on the prescription label of your empty pill bottle or medicine packaging, and throw these items in your household trash.

Ask your provider about other options to treat your chronic pain.

Be involved, keep your health care team updated on how your treatment is going.

If you are struggling with addiction, help is available in your area.

BIG BEND COMMUNITY BASED CARE (BBCBC): 850-410-1020

CENTRAL FLORIDA BEHAVIORAL HEALTH NETWORK (CFBHN): 813-740-4811

CENTRAL FLORIDA CARES: 407-985-3560

LUTHERAN SERVICES OF FLORIDA: Access to Care Line, 1-877-229-9098

SOUTHEAST FLORIDA BEHAVIORAL HEALTH NETWORK, INC.: 561-203-2485

BROWARD BEHAVIORAL HEALTH COALITION: 877-698-7794

SOUTH FLORIDA BEHAVIORAL HEALTH NETWORK: 888-248-3111

DEPARTMENT OF CHILDREN AND FAMILIES: www.myffamilies.com/service-programs/substance-abuse/get-help

*<https://archive.epa.gov/region02/capp/web/pdf/ppcpflyer.pdf>

2017 MQA LEGISLATIVE SUMMARY

	BILL #	TITLE	BRIEF SUMMARY	COMMENTS	DATE SIGNED BY GOVERNOR	LEAD
	ER HB 209  ER HB 209.pdf	Medical Faculty Certification & Medical Assistant Certification	<p>Summary from MQA Bill Analysis: ER HB 209 creates s. 458.3145(1)(i)9, F.S., to add John Hopkins All Children’s Hospital in St. Petersburg, FL to the list of institutions where the holder of a medical faculty certificate may practice. The bill extends the authorization to practice to a specialty-licensed children’s hospital licensed under chapter 395 that is affiliated with an accredited medical school and its affiliated clinics. The bill amends s. 458.3145, F.S., to extend the required annual review of certificate recipients to out-of-state medical schools and allows provision of medical care or treatment to physicians providing both in-state and out-of-state education. The bill also amends s. 456.013, F.S., and allows the department to process an application using unique personal identification number when a physician is applying for temporary certificate to obtain medical privileges for instructional purposes and does not have a social security number. The bill also provides a requirement to earn a certified medical assistant credential and revises qualifications for being employed as a medical assistant.</p> <p>Effective Date: July 1, 2017</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	
	ER HB 229  ER HB 229.pdf	Health Care Practitioner Licensure	<p>Summary from MQA Bill Analysis: This bill amends various provisions related to the Department of Health impaired practitioner programs. The bill provides a new exception for initial licensure applicants who were arrested or charged with a felony specified in the provision. In addition, the bill provides for an exception to discipline for a licensee who makes an impaired practitioner report to a consultant.</p> <p>Effective Date: Upon Becoming Law</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	
	ER HB 543  ER HB 543.pdf	Regulation of Health Care Practitioners	<p>Summary from MQA Bill Analysis: This bill removes an obsolete advanced registered nurse practitioner (ARNP) certification requirement and the requirement for ARNPs to submit protocols for review. It authorizes the Board of Nursing to conduct on-site nursing education program evaluations, removes a limiting criterion impacting program graduate passage rates, and clarifies requirements of a program's disclosure for the use of simulation technologies, accreditation, probation, and probation termination. It modifies agency assignment specific to reporting implementation of program approval and accountability processes. It further adds administering long-acting antipsychotic medications by pharmacists, modifies prevention of medical errors continuing education for the Orthotics & Prosthetics</p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	

BILL #	TITLE	BRIEF SUMMARY	COMMENTS	DATE SIGNED BY GOVERNOR	LEAD
		<p>profession, and amends the eligibility requirements for licensure of Physical Therapy Assistants.</p> <p>Effective Date: On becoming law</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>			
<p>ER HB 557</p>  <p>ER HB 557.pdf</p>	<p>Controlled Substance Prescribing</p>	<p>Summary from MOA Bill Analysis: This bill requires a dispenser to upload controlled substance dispensing information no later than close of business the day following the dispensing of a controlled substance to the Prescription Drug Monitoring System (PDMS) via the Internet. The bill also modifies the exemptions from reporting to the PDMS when dispensing controlled substances in certain practice locations. Additionally, the bill expands access to the PDMS to employees of the Department of Veterans Affairs (VA) to review a patients' controlled substance dispensing history. The effective date to report dispensing information to the Department no later than close of business the day after a controlled substance is dispensed is January 1, 2018. The effective date modification to the exemptions and expanded access in July 1, 2017.</p> <p>Effective Date: July 1, 2017</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	
<p>ER SB 852</p>  <p>ER SB 852.pdf</p>	<p>Relating to Human Trafficking</p>	<p>Summary from MOA Bill Analysis: The bill directs the Board of Nursing to require two (2) hours of continuing education on human trafficking (Section 6).</p> <p>Effective Date: October 1, 2017</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p>5/9/17</p> <p><i>Must be signed by</i></p> <p>5/24/17</p> <p>Signed by Governor</p>	
<p>ER HB 1307</p>  <p>ER HB 1307.pdf</p>	<p>Physician Assistants</p>	<p>Summary from MOA Bill Analysis: The enrolled bill requires the department to develop and conduct a physician assistant survey to be administered in the same manner as the physician survey and must contain the same information. The department will report the data to the Boards of Medicine and Osteopathic Medicine every two years starting July 1, 2018.</p> <p>Effective Date: Upon Becoming Law</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	

	BILL #	TITLE	BRIEF SUMMARY	COMMENTS	DATE SIGNED BY GOVERNOR	LEAD
	ER HB 5203  ER HB 5203.pdf	Prescription Drug Monitoring Program	<p>Summary from MOA Bill Analysis: The bill authorizes the use of state funds for administration of the Prescription Drug Monitoring Program (PDMP).</p> <p>Effective Date: July 1, 2017</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	
	ER HB 7073  ER HB 7073.pdf	Relating to Ratification of Rule of the Department of Elder Affairs	<p>Summary from Online Sunshine ER Bill: Ratification of a Department of 2 Elder Affairs rule and a Department of Health rule; 3 ratifying a specific rule relating to the practice for 4 professional guardians; ratifying a specific rule 5 adopted by the Board of Medicine relating to the 6 standard of care for office surgery for the sole and 7 exclusive purpose of satisfying any condition on 8 effectiveness pursuant to s. 120.541(3), F.S., which requires ratification of any rule exceeding the specified thresholds for likely adverse impact or increase in regulatory costs; providing applicability.</p> <p>Effective Date: Upon Becoming Law</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>		<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	
	ER HB 7097  ER HB 7097.pdf	Direct Support Organization of the Prescription Drug Monitoring Program	<p>Summary from Online Sunshine: Direct Support Organization of the Prescription Drug Monitoring Program; Provides for future repeal of provisions relating to organization.</p> <p>Effective Date: July 1, 2017</p> <p>Chapter No. 2017- <i>Laws of Florida</i></p>	No Impact for MQA	<p><i>Presented to Governor</i></p> <p><i>Must be signed by</i></p> <p>Signed by Governor</p>	