



Summary of HB 607

HB 607: ADVANCED PRACTICE REGISTERED NURSE AUTONOMOUS PRACTICE

HB 607, as originally filed, would have allowed physician assistants and all advanced practice nurses, including certified registered nurse anesthetists, to practice without physician supervision and with little restrictions on the type of practice they could engage in.

The final product, passed by the Senate, the House and signed by the Governor on the same day (March 11, 2020) is a more restrictive approach, as it only provides for autonomous practice for APRNs and certified nurse midwives. Physician assistants, CRNAs and psychiatric nurses will still have to work under a protocol with a supervising physician.

APRNs will be restricted to autonomous practice only in primary care fields, such as family medicine, general pediatrics and general internal medicine. The Board of Nursing, unfortunately, will be in charge of adopting rules that define exactly what primary care is. In this not yet fully defined field of primary care, autonomous APRNs will be able to perform any function they can perform under a protocol under current law, specifically:

- Prescribe, dispense, administer, or order any drug
- Initiate appropriate therapies for certain conditions
- Perform additional functions as may be determined by rule
- Order diagnostic tests and physical and occupational therapy
- Order any medication for administration to a patient in a facility licensed under chapter 395 or part II of chapter 400

In certain health care facilities (hospitals, skilled nursing facilities, hospice, and intermediate care facilities for the developmentally disabled) autonomous APRNs will be allowed to admit, manage the care of and discharge patients.

Perhaps the most significant expansion is the change that allows autonomous APRNs to sign, certify, stamp, verify or endorse anything that is required by law to be provided by a physician. This would appear to include functions such as signing death certificates and releasing Baker Act patients. This would also appear to apply only in the primary care sphere. The only stated exception is that autonomous APRNs may not certify patients for medical marijuana eligibility.

HB 607 does contain a couple of small limitations – an autonomous APRN may not perform any surgical procedure other than a subcutaneous procedure, and a certified nurse midwife must have a written patient transfer agreement with a hospital and written referral agreement with an MD or DO.

In a meaningless nod to the fact that the Board of Nursing lacks the expertise to promulgate rules governing the practice of individuals providing primary medical care, the bill creates the “Council on Advanced Practice Registered Nurse Autonomous Practice.” This council will be made up of two MDs, two DOs, four autonomous APRNs and the Surgeon General. The council is advisory only, but if the Board of Nursing rejects its recommendations on standards of practice, the BON must at least state with particularity the basis for the rejection.

The qualifications for obtaining autonomous APRN status are not onerous. To register, one must:

- Hold an active, unencumbered Florida license to practice advanced nursing.
- Not been subject to certain disciplinary actions within the last five years.
- Have completed at least 3,000 clinical practice hours within the five years preceding registration. application under the supervision of an MD or DO.
- Have completed within the past five years three graduate-level hours in differential diagnosis and three hours in pharmacology.
- Maintain professional liability coverage in a defined amount.

To renew autonomous practice registration, and APRN must complete at least 10 hours of additional continuing education.

In a lame attempt to inform the public that APRNs are able to practice without any type of physician supervision, the Department is required to “conspicuously” note on the APRNs online practitioner profile that the APRN is registered to practice autonomously, and autonomous APRNs are required to provide new patients with written information about their qualifications and the nature of autonomous practice.

Perhaps the only bright spot of the bill is a half-measure. Health insurance companies are prohibited from requiring an insured to receive services from an autonomous APRN in place of a physician. Insurers, however, are not prohibited from incentivizing treatment from autonomous APRNs in place of physicians. They can’t require you to see an APRN, but they can offer lower copayments if you do.

The final insult in this bill provides up to \$15,000 in loan forgiveness for autonomous APRNs who provide primary care services in a primary care health professional shortage area. The bill appropriates \$5 million in nonrecurring funds for this loan forgiveness program, but only for autonomous APRNs. There is no funding provided for physician loan forgiveness.

This bill goes into effect on July 1, 2020.

1. Modify or discontinue medicinal drugs prescribed by a health care practitioner with whom he or she does not have a collaborative practice agreement.
2. Enter into a collaborative practice agreement while acting as an employee without the written approval of the owner of the pharmacy.
3. Initiate or prescribe a controlled substance under a collaborative practice agreement.

Pharmacists who practice under a collaborative practice agreement must complete an eight-hour CE course every two years approved by the Board of Pharmacy.

It is unclear exactly what a supervising physician can allow a pharmacist to do under a collaborative practice agreement. The bill changes the practice of pharmacy to include the “initiating, modifying, or discontinuing drug therapy for a chronic health condition under a collaborative pharmacy practice agreement,” and appears to allow pharmacists to diagnose or treat any disease, initiate any drug therapy and practice medicine as specifically authorized by the new sections created by HB 389. The section on chronic health conditions specifically authorizes pharmacists to provide “specified patient care services” but never defines what those specified patient care services are.

It is important to note that, unlike the next section on minor, nonchronic health conditions, any services the pharmacist provides must be for the patients of the collaborating physician only. This will require a pharmacist to enter into multiple collaborative agreements if he or she wants to provide services to patients with different treating physicians. A pharmacist will not be able to provide services to any person who is not already under the care of a physician.

Testing or Screening for and Treatment of Minor, Nonchronic Health Conditions

HB 389 allows pharmacists to test, screen for and treat minor nonchronic health conditions under the framework of an established written protocol with an MD or DO. The bill defines a minor, nonchronic health condition as a short-term condition that is generally managed with minimal treatment or self-care, and includes:

- Influenza
- Streptococcus
- Lice
- Skin conditions, such as ringworm and athlete’s foot
- Minor uncomplicated infections

Unlike for chronic conditions, there is no authority for the Board of Pharmacy to add other conditions by rule. The FMA will argue that pharmacists can only test for and treat the enumerated conditions. Exactly which skin conditions and minor infections a pharmacist can test/treat will have to be worked out via rule and/or litigation.

To test, screen for and treat minor, nonchronic health conditions, a pharmacist must:

- Hold an active and unencumbered license to practice pharmacy in Florida
- Maintain at least \$250,000 of liability coverage
- Report a diagnosis or suspected existence of a disease of public health significance to the department
- Furnish patient records to a health care practitioner designated and requested by the patient
- Maintain records of all patients receiving services for five years
- Hold a certification from the Board of Pharmacy

The requirements for certification must be established by the BOP (in “consultation” with the BOM and the BOOM) and must require a pharmacist to complete a one-time, 20-hour education course approved by the BOP (again in “consultation” with the BOM and BOOM). The course must, at a minimum, address patient assessments, point-of-care testing procedures, safe and effective treatment of minor, nonchronic health conditions, and identification of contraindications.

The BOP shall also adopt a formulary of medicinal drugs a pharmacist may prescribe for the minor nonchronic conditions listed above. The formulary must include drugs approved by the FDA that are indicated for treatment of each minor, nonchronic condition. Controlled substances are specifically excluded.

HB 389 specifically allows any pharmacist who tests/treats under this section to use any test that CMS has determined qualifies for a waiver under the Clinical Laboratory Improvement Amendments of 1988, or any screening procedure that can be safely performed by a pharmacist. This is obviously open to a wide range of interpretation.

The bill requires the written protocol between the pharmacist and the supervising physician to include the particular terms and conditions imposed by the supervising physician appropriate to the pharmacist’s training. At a minimum, the protocol must include:

- The specific categories of patients that the pharmacist is authorized to test and treat.
- The supervising physician’s instructions for obtaining a patient’s medical history to identify disqualifying health conditions, adverse reactions and contraindications to the approved course of treatment.
- The supervising physician’s instructions for how the pharmacist is to treat minor, nonchronic health conditions.
- A process and schedule for how the supervising physician is to review the actions of the pharmacist, and how the pharmacist is to notify the supervising physician of the patient’s condition, the tests the pharmacist has administered, the test results and the course of treatment.
- Any other requirements established by the Board of Pharmacy (in consultation with the BOM and the BOOM).

HB 389 deleted the major safeguards adopted by the Senate in committee but did retain a few minor ones.

The supervising physician is required to review the pharmacist's actions in accordance with the protocol. Absent rules implementing this provision, a physician could presumably conduct the review at his or her discretion, even months after the care has been provided.

The pharmacist may not enter into a protocol while acting as an employee without written approval of the owner of the pharmacy. This will not be a problem, as it most likely will be the pharmacy owner requiring the pharmacist to provide these services.

Pharmacists who enter into a protocol to test/treat minor, nonchronic conditions must complete a BOP-approved three-hour continuing education course every two years.

Any pharmacy that has a pharmacist who tests/treats minor, nonchronic health conditions must prominently display a sign stating that any patient who receives such services is advised to seek follow-up care from his/her primary care physician. The pharmacist providing such testing/treatment must provide patients with written information advising them to seek follow-up care from their primary care provider per guidelines to be adopted by the BOP.

HB 389 provides that requirements for a pharmacist to test/treat minor, nonchronic conditions do not apply when treated with over-the-counter products. Presumably then, a pharmacist can test and treat the flu, strep, etc. without entering into a physician protocol if he or she only treats such conditions with over-the-counter products. The FMA will maintain that a pharmacist without a protocol cannot test for minor, nonchronic conditions.

Unlike for chronic conditions, as explained in the section above, a pharmacist will be able to test/treat for minor, nonchronic conditions by entering into a single protocol agreement with an MD or DO. Pharmacists are not limited to testing/treating only the patients of physicians that they have a protocol agreement with.

It should be noted that autonomous APRNs (as provided for in HB 607) are not authorized to enter into collaborative practice agreements with pharmacists or enter into protocols with pharmacists to test/treat minor, nonchronic conditions.

This act takes effect July 1, 2020.