

CHAPTER 383

MATERNITY AND INFANCY HYGIENE

- 383.011 Administration of maternal and child health programs.
- 383.0115 The Commission on Marriage and Family Support Initiatives.
- 383.013 Prenatal care.
- 383.015 Breastfeeding.
- 383.016 Breastfeeding policy for "baby-friendly" facilities providing maternity services and newborn infant care.
- 383.04 Prophylactic required for eyes of infants.
- 383.06 Report of inflammation or discharge in infant's eyes.
- 383.07 Penalty for violation.
- 383.11 Reports.
- 383.13 Use of information by department.
- 383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.
- 383.145 Newborn and infant hearing screening.
- 383.15 Legislative intent; perinatal intensive care services.
- 383.16 Definitions; ss. 383.15-383.21.
- 383.17 Regional perinatal intensive care centers program; authority.
- 383.18 Contracts; conditions.
- 383.19 Standards; funding; ineligibility.
- 383.21 Program review.
- 383.216 Community-based prenatal and infant health care.
- 383.2161 Maternal and child health report.
- 383.30 Birth Center Licensure Act; short title.
- 383.301 Licensure and regulation of birth centers; legislative intent.

383.302 Definitions of terms used in ss. 383.30-383.335.

383.304 Licensure requirement for birth centers.

383.305 Licensure; issuance, renewal, denial, suspension, revocation; fees; background screening.

383.307 Administration of birth center.

383.308 Birth center facility and equipment; requirements.

383.309 Minimum standards for birth centers; rules and enforcement.

383.31 Selection of clients; informed consent.

383.3105 Patients consenting to adoptions; protocols.

383.311 Education and orientation for birth center clients and their families.

383.312 Prenatal care of birth center clients.

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.

383.315 Agreements with consultants for advice or services; maintenance.

383.316 Transfer and transport of clients to hospitals.

383.318 Postpartum care for birth center clients and infants.

383.32 Clinical records.

383.324 Inspections and investigations; inspection fees.

383.325 Inspection reports.

383.327 Birth and death records; reports.

383.33 Administrative penalties; emergency orders; moratorium on admissions.

383.331 Injunctive relief.

383.332 Establishing, managing, or operating a birth center without a license; penalty.

383.335 Partial exemptions.

383.336 Provider hospitals; practice parameters; peer review board.

383.3361 Limitations on civil and administrative liability.

383.3362 Sudden Infant Death Syndrome.

383.33625 Stephanie Saboor Grieving Parents Act; disposition of fetus; notification; forms developed.

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.

383.412 Public records and public meetings exemptions.

383.50 Treatment of abandoned newborn infant.

383.51 Confidentiality; identification of parent leaving newborn infant at hospital, emergency medical services station, or fire station.

383.011 Administration of maternal and child health programs.--

(1) The Department of Health is designated as the state agency for:

(a) Administering or providing for maternal and child health services to provide periodic prenatal care for patients who are at low or medium risk of complications during pregnancy and to provide referrals to higher level medical facilities for those patients who develop medical conditions for which treatment is beyond the scope and capabilities of the county health departments. Maternal and child health services shall include encouragement of breastfeeding.

(b) Administering or providing for periodic medical examinations, nursing appraisals, and nutrition counseling for infant and child patients to assess developmental progress and general health conditions; administering or providing for treatment for health complications when such treatment is within the scope and capabilities of the county health departments or Children's Medical Services. Nutrition counseling for newborn babies shall include encouragement of breastfeeding.

(c) Administering and providing for the expansion of the maternal and child health services to include pediatric primary care programs subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

(d) Administering and providing for prenatal and infant health care delivery services through county health departments or subcontractors for the provision of the following enhanced services for medically and socially high-risk clients, subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216:

1. Case finding or outreach.
2. Assessment of health, social, environmental, and behavioral risk factors.
3. Case management utilizing a service delivery plan.
4. Home visiting to support the delivery of and participation in prenatal and infant primary health care services.
5. Childbirth and parenting education, including encouragement of breastfeeding.

(e) The department shall establish in each county health department a Healthy Start Care Coordination Program in which a care coordinator is responsible for receiving screening reports and risk assessment reports from the Office of Vital Statistics; conducting assessments as part of a multidisciplinary team, where appropriate; providing technical assistance to the district prenatal and infant care coalitions; directing family outreach efforts; and coordinating the provision of services within and outside the department using the plan developed by the coalition. The care coordination process must include, at a minimum, family outreach workers and health paraprofessionals who will assist in providing the following enhanced services to pregnant women, infants, and their families that are determined to be at potential risk by the department's screening instrument: case finding or outreach; assessment of health, social, environmental, and behavioral risk factors; case management utilizing the family support plan; home visiting to support the delivery of and participation in prenatal and infant primary care services; childbirth and parenting education, including encouragement of breastfeeding; counseling; and social services, as appropriate. Family outreach workers may include social work professionals or nurses with public health education and counseling experience.

Paraprofessionals may include resource mothers and fathers, trained health aides, and parent educators. The care coordination program shall be developed in a coordinated, nonduplicative manner with the Developmental Evaluation and Intervention Program of Children's Medical Services, using the local assessment findings and plans of the prenatal and infant care coalitions and the programs and services established in chapter 411, Pub. L. No. 99-457, and this chapter.

1. Families determined to be at potential risk based on the thresholds established in the department's screening instrument must be notified by the department of the determination and recommendations for followup services. All Medicaid-eligible families shall receive Early Periodic Screening, Diagnosis and Treatment (EPSDT) Services of the Florida Medicaid Program to help ensure continuity of care. All other families identified at potential risk shall be directed to seek additional health care followup visits as provided under s. 627.6579. A family identified as a family at potential risk is eligible for enhanced services under the care coordination process within the resources allocated, if it is not already receiving services from the Developmental Evaluation and Intervention Program. The department shall adopt rules regulating the assignment of family outreach workers and paraprofessionals based on the thresholds established in the department's risk assessment tool.

2. As part of the care coordination process, the department must ensure that subsequent screenings are conducted for those families identified as families at potential risk. Procedures for subsequent screenings of all infants and toddlers must be consistent with the established periodicity schedule and the level of risk. Screening programs must be conducted in accessible locations, such as child care centers, local schools, teenage pregnancy programs, community centers, and county health departments. Care coordination must also include initiatives to provide immunizations in accessible locations. Such initiatives must seek ways to ensure that children not currently being served by immunization efforts are reached.

3. The provision of services under this section must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter.

(f) Receiving the federal maternal and child health and preventive health services block grant funds.

(g) Receiving the federal funds for the "Special Supplemental Nutrition Program for Women, Infants, and Children," or WIC, authorized by the Child Nutrition Act of 1966, as amended, and for administering the statewide WIC program.

(h) Designating facilities that provide maternity services or newborn infant care as "baby-friendly" when the facility has established a breastfeeding policy under s. 383.016.

(i) Receiving federal funds for children eligible for assistance through the portion of the federal Child and Adult Care Food Program for children, which is referred to as the Child Care Food Program, and for establishing and administering this program. The purpose of the Child Care Food Program is to provide nutritious meals and snacks for children in nonresidential day care. To ensure the quality and integrity of the program, the department shall develop standards and procedures that govern sponsoring organizations, day care homes, child care centers, and centers that operate outside school hours. Standards and procedures must address the following: participation criteria for sponsoring organizations, which may include administrative budgets, staffing requirements, requirements for experience in operating similar programs, operating hours and availability, bonding requirements, geographic coverage, and a required minimum number of homes or centers; procedures for investigating complaints and allegations of noncompliance; application and renewal requirements; audit requirements; meal pattern requirements; requirements for managing funds; participant eligibility for free and

reduced-price meals; food storage and preparation; food service companies; reimbursements; use of commodities; administrative reviews and monitoring; training requirements; recordkeeping requirements; and criteria pertaining to imposing sanctions and penalties, including the denial, termination, and appeal of program eligibility.

(2) The Department of Health shall follow federal requirements and may adopt any rules necessary for the implementation of the maternal and child health care program, the WIC program, and the Child Care Food Program.

(a) The department may adopt rules that are necessary to administer the maternal and child health care program. The rules may include, but need not be limited to, requirements for client eligibility, program standards, service delivery, system responsibilities of county health departments and system assurance for healthy start coalitions, care coordination, enhanced services, quality assurance, and provider selection. The rules may also include provisions for the identification, screening, and intervention efforts by health care providers prior to and following the birth of a child and responsibilities for the interprogram coordination of prenatal and infant care coalitions.

(b) The department may adopt rules that are necessary to administer the statewide WIC program. The rules may include, but need not be limited to, criteria for grocers' participation, client eligibility, contracts with local agencies for service delivery, and food purchases and penalties for program abuse.

(c) With respect to the Child Care Food Program, the department shall adopt rules that interpret and implement relevant federal regulations, including 7 C.F.R. part 226. The rules may address at least those program requirements and procedures identified in paragraph (1)(i).

History.--s. 1, ch. 88-153; s. 23, ch. 91-282; s. 3, ch. 94-217; s. 54, ch. 97-101; s. 16, ch. 98-151; s. 24, ch. 98-191; s. 56, ch. 99-397; s. 17, ch. 2000-242.

383.0115 The Commission on Marriage and Family Support Initiatives.--

(1) LEGISLATIVE FINDINGS AND INTENT.--The Legislature finds that:

(a) Families in this state deserve respect and support. Children need support and guidance from both mothers and fathers, and families need support and guidance from community systems to help them thrive.

(b) There are many problems facing families.

(c) Florida is a state rich in diversity, and its population and families come from all over the world, representing many cultures, languages, belief systems, and experiences.

(d) While some relationships between mothers and fathers are broken and beyond repair, others can be nurtured and salvaged with the provision of appropriate community supports to fathers as well as mothers. For parents, these supports may include opportunities to obtain or increase educational levels and employment skills, access to the justice system, support from community agencies to help them become free of substance abuse and violent relationships, and easy and affordable access to relationship-skills education. For some unwed parents, it will be possible and desirable to help them move towards marriage; for others, the optimum goal may be to help them coparent, spend time with their child, and pay child support regularly.

(e) Assisting states to end dependence of low-income parents by promoting job preparation, work, and marriage and assisting states in encouraging the formation and maintenance of two-parent families are the two of four stated purposes of federal welfare reform enacted in 1996 which have been largely neglected by states and for which states are now urging Congress to designate 10 percent of all welfare funds, specifically for relationship education and skills development, responsible fatherhood programs, and community support as it seeks to reauthorize the Temporary Assistance for Needy Families Act in 2002.

(f) Public policy should not operate to force people to get married, should not withdraw or diminish benefits to single mothers merely because they are not married, and should not keep people in abusive relationships.

It is therefore the intent of the Legislature to build on the accomplishments of the Commission on Responsible Fatherhood, which has achieved recognition as a national model of a comprehensive statewide strategy to address fatherhood issues; to increase public awareness of the problems of families, including failing marriages, violence, poverty, substance abuse, lack of access to community systems and supports that families need; and to continue to develop sound public policy related to parenting, marriage, and the effects of poverty, violence, and abuse on children and their families through the work of the Commission on Marriage and Family Support Initiatives. The Legislature further intends that, to the extent practicable, the laws of this state should do all that is possible to provide support for children and encourage, promote, and value strong, safe, long-term marriages and family life that includes grandparents, family members, community support, and all that children need to grow up healthy and to thrive.

(2) ESTABLISHMENT OF COMMISSION.--

(a) There is created within the Department of Children and Family Services, for administrative purposes, a commission, as defined in s. 20.03(10), called the Commission on Marriage and Family Support Initiatives. The commission is independent of the head of the department. The commission is authorized to hire an executive director, a researcher, and an administrative assistant. The executive director shall report to, and serve at the pleasure of, the commission.

(b) The commission shall consist of 18 members. The commission shall consist of members from the public sector and the private sector, including community and faith-based organizations, but at least 50 percent of the commissioners shall be from the private sector. Commissioners should have experience in one or more of the following areas: business; workforce development; education; health care; treatment of substance abuse; child development; and domestic violence prevention. For the initial appointments, the Governor, the President of the Senate, and the Speaker of the House of Representatives shall consider making appointments from the current members of the Commission on Responsible Fatherhood.

(c) The Governor, the President of the Senate, and the Speaker of the House of Representatives shall each appoint six members to the commission. Initial appointments shall be made by August 1, 2003. Each commissioner shall serve a 2-year term, except that for the initial appointments to the commission, the Governor, the President of the Senate and the Speaker of the House of Representatives shall each appoint two members for a term of 3 years, two members for a term of 2 years, and two members for a term of 1 year. A vacancy shall be filled by appointment by the original appointing authority for the unexpired portion of the term.

(d) The first meeting of the commission shall be no later than October 1, 2003. Commissioners shall elect a chair at the first meeting by a majority vote of the members present, a quorum being present. A majority of the membership constitutes a quorum.

(e) A quorum shall be required for the commission to meet and to conduct business. The commission shall meet semiannually and more frequently upon call of the chair. The commission may conduct its meetings through teleconferences or other similar means.

(f) Commissioners are not entitled to compensation for their services as members, but may be reimbursed for per diem and travel expenses as provided in s. 112.061.

(3) SCOPE OF ACTIVITY.--The commission shall:

(a) Develop the following documents by October 1, 2004, and, upon their completion, submit a copy to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the secretary of the department:

1. A report that details comprehensive statewide strategies for Florida to promote safe, violence-free, substance-abuse-free, respectful, nurturing, and responsible parenting, including connection or reconnection of responsible parents, both mothers and fathers, with their families and children;

2. A report that makes recommendations on how to increase the availability of and access to parenting and relationship skills education and training, and to encourage and support the formation and maintenance of two-parent families and family structures that are best for the children. This shall include providing a plan for delivering services and supports to couples and families to help them learn communication and conflict-resolution skills prior to marriage, enable couples to refresh those skills periodically during marriage and, if the marriage fails, provide divorce education, safety planning, and mediation techniques that teach parents how to be safe and to work through their problems and how to minimize the impact of the divorce on their children; and

3. A promising practices manual or tool that highlights successful efforts at promoting marriage and Florida families and family life.

(b) Develop a community awareness campaign to promote community collaboration and coordinated grassroots programs that show how people, advocates, and agencies can work together to promote marriage in Florida families.

(c) Serve as a clearinghouse for collecting and disseminating information related to research findings on poverty, violence, and other social forces and their effects on families and innovative approaches to the delivery of services necessary for the formation and maintenance of strong families.

(d) By December 31 of each year, beginning December 31, 2003, issue an annual report to the Governor, the President of the Senate, the Speaker of the House of Representatives, and the Chief Justice of the Supreme Court on progress it is making on its responsibilities.

(4) COORDINATION.--The commission shall coordinate its work with community-based organizations, including those that are faith-based; with schools, courts, certified local domestic violence centers, adult and juvenile criminal justice systems, and agencies providing social welfare, welfare transition, and child support services; and with any appropriate research and policy development centers, including, but not limited to, those within universities that focus on issues related to families, fatherhood, motherhood, low-income families, marriages, children and poverty, scientific methods to determine paternity for the purpose of addressing support issues, parenting, and relationship skills.

(5) **FUNDING.**--The operation of the Commission on Marriage and Family Support Initiatives shall be funded from general revenue funds currently allocated to the Commission on Responsible Fatherhood, shall maintain the current connection with the Ounce of Prevention Fund, and shall support and continue any community-based programs established by the Commission on Responsible Fatherhood. The Commission on Marriage and Family Support Initiatives may seek and accept grants or funds from any public source, federal, state, or local, to supplement its operation and defray the expenses incurred in the operation and implementation of this section.

(6) Pursuant to the requirements in s. 20.052(2), the department shall advise the Legislature when the commission ceases to be essential to the furtherance of a public purpose.

History.--s. 1, ch. 2003-122; s. 5, ch. 2006-171.

383.013 Prenatal care.--The Department of Health shall:

(1) Provide a statewide prenatal care program for low-income pregnant women, which includes early, regular prenatal care by practitioners trained in prenatal care and delivery.

(2) Provide a risk factor analysis to identify women at risk for a preterm birth, or other high-risk conditions, and provide education regarding maintaining healthy birth conditions.

(3) Monitor the availability and accessibility of prenatal care services and the development of special outreach programs for medically underserved and rural areas.

(4) Establish by rule the eligibility criteria for prenatal care for indigent pregnant women when state funds are used for prenatal care.

(5) Develop guidelines for expediting the provision of prenatal care for eligible women and monitor the implementation of the guidelines to determine the need for further action.

(6) Expand, to the extent possible, training of state and local health providers in programs and practices pertaining to improved pregnancy outcomes.

(7) Provide regional perinatal intensive care satellite clinics to deliver Level III obstetric outpatient services to women diagnosed as being high risk, which includes an interdisciplinary team to deliver specialized high-risk obstetric care. The provision of satellite clinics is subject to the availability of moneys and the limitations established by the General Appropriations Act or chapter 216.

History.--s. 11, ch. 83-379; s. 24, ch. 91-282; s. 55, ch. 97-101.

383.015 Breastfeeding.--The breastfeeding of a baby is an important and basic act of nurture which must be encouraged in the interests of maternal and child health and family values, and in furtherance of this goal:

(1) A mother may breastfeed her baby in any location, public or private, where the mother is otherwise authorized to be, irrespective of whether the nipple of the mother's breast is uncovered during or incidental to the breastfeeding.

(2) A facility lawfully providing maternity services or newborn infant care may use the designation "baby-friendly" if it establishes a breastfeeding policy in accordance with s. 383.016.

History.--s. 1, ch. 93-4; s. 2, ch. 94-217.

383.016 Breastfeeding policy for "baby-friendly" facilities providing maternity services and newborn infant care.--A facility lawfully providing maternity services or newborn infant care may use the designation "baby-friendly" on its promotional materials if the facility has complied with at least 80 percent of the requirements developed by the Department of Health in accordance with UNICEF and World Health Organization baby-friendly hospital initiatives.

History.--s. 1, ch. 94-217; s. 56, ch. 97-101.

383.04 Prophylactic required for eyes of infants.--Every physician, midwife, or other person in attendance at the birth of a child in the state is required to instill or have instilled into the eyes of the baby within 1 hour after birth an effective prophylactic recommended by the Committee on Infectious Diseases of the American Academy of Pediatrics for the prevention of neonatal ophthalmia. This section does not apply to cases where the parents file with the physician, midwife, or other person in attendance at the birth of a child written objections on account of religious beliefs contrary to the use of drugs. In such case the physician, midwife, or other person in attendance shall maintain a record that such measures were or were not employed and attach thereto any written objection.

History.--s. 1, ch. 20690, 1941; ss. 19, 35, ch. 69-106; s. 123, ch. 77-147; s. 27, ch. 87-387; s. 57, ch. 97-101; s. 25, ch. 98-191.

383.06 Report of inflammation or discharge in infant's eyes.--Any person who shall nurse or attend any infant shall report any inflammation or unnatural discharge in the eyes of said child that shall develop within 2 weeks after birth, to the local health officer or licensed physician, which report shall be made within 6 hours.

History.--s. 3, ch. 20690, 1941.

383.07 Penalty for violation.--Any person who fails to comply with the provisions of ss. 383.04-383.06 shall be guilty of a misdemeanor of the second degree, punishable as provided in s. 775.083.

History.--s. 4, ch. 20690, 1941; s. 332, ch. 71-136.

383.11 Reports.--The laboratory report on the serological test shall be made on a form to be provided by the Department of Health. In submitting the sample of blood for the test, the physician shall designate that this is a pregnancy test; and the laboratory report shall state that this was a pregnancy test.

History.--s. 4, ch. 22644, 1945; ss. 19, 35, ch. 69-106; s. 126, ch. 77-147; s. 59, ch. 97-101.

383.13 Use of information by department.--The Department of Health shall be authorized to use the information derived from pregnancy serological tests for such followup procedures as are required by law or deemed necessary by said department for the protection of the public health.

History.--s. 6, ch. 22644, 1945; ss. 19, 35, ch. 69-106; s. 128, ch. 77-147; s. 60, ch. 97-101.

383.14 Screening for metabolic disorders, other hereditary and congenital disorders, and environmental risk factors.--

(1) **SCREENING REQUIREMENTS.**--To help ensure access to the maternal and child health care system, the Department of Health shall promote the screening of all newborns born in Florida for metabolic, hereditary, and congenital disorders known to result in significant impairment of health or intellect, as screening programs accepted by current medical practice become available and practical in the judgment of the department. The department shall also promote the identification and screening of all newborns in this state and their families for environmental risk factors such as low income, poor education, maternal and family stress, emotional instability, substance abuse, and other high-risk conditions associated with increased risk of infant mortality and morbidity to provide early intervention, remediation, and prevention services, including, but not limited to, parent support and training programs, home visitation, and case management. Identification, perinatal screening, and intervention efforts shall begin prior to and immediately following the birth of the child by the attending health care provider. Such efforts shall be conducted in hospitals, perinatal centers, county health departments, school health programs that provide prenatal care, and birthing centers, and reported to the Office of Vital Statistics.

(a) *Prenatal screening.*--The department shall develop a multilevel screening process that includes a risk assessment instrument to identify women at risk for a preterm birth or other high-risk condition. The primary health care provider shall complete the risk assessment instrument and report the results to the Office of Vital Statistics so that the woman may immediately be notified and referred to appropriate health, education, and social services.

(b) *Postnatal screening.*--A risk factor analysis using the department's designated risk assessment instrument shall also be conducted as part of the medical screening process upon the birth of a child and submitted to the department's Office of Vital Statistics for recording and other purposes provided for in this chapter. The department's screening process for risk assessment shall include a scoring mechanism and procedures that establish thresholds for notification, further assessment, referral, and eligibility for services by professionals or paraprofessionals consistent with the level of risk. Procedures for developing and using the screening instrument, notification, referral, and care coordination services, reporting requirements, management information, and maintenance of a computer-driven registry in the Office of Vital Statistics which ensures privacy safeguards must be consistent with the provisions and plans established under chapter 411, Pub. L. No. 99-457, and this chapter. Procedures established for reporting information and maintaining a confidential registry must include a mechanism for a centralized information depository at the state and county levels. The department shall coordinate with existing risk assessment systems and information registries. The department must ensure, to the maximum extent possible, that the screening information registry is integrated with the department's automated data systems, including the Florida On-line Recipient Integrated Data Access (FLORIDA) system. Tests and screenings must be performed by the State Public Health Laboratory, in coordination with Children's Medical Services, at such times and in such manner as is prescribed by the department after consultation with the Genetics and Infant Screening Advisory Council and the State Coordinating Council for School Readiness Programs.

(c) *Release of screening results.*--Notwithstanding any other law to the contrary, the State Public Health Laboratory may release, directly or through the Children's Medical Services program, the results of a newborn's hearing and metabolic tests or screening to the newborn's primary care physician.

(2) RULES.--After consultation with the Genetics and Newborn Screening Advisory Council, the department shall adopt and enforce rules requiring that every newborn in this state shall, prior to becoming 1 week of age, be subjected to a test for phenylketonuria and, at the appropriate age, be tested for such other metabolic diseases and hereditary or congenital disorders as the department may deem necessary from time to time. After consultation with the State Coordinating Council for School Readiness Programs, the department shall also adopt and enforce rules requiring every newborn in this state to be screened for environmental risk factors that place children and their families at risk for increased morbidity, mortality, and other negative outcomes. The department shall adopt such additional rules as are found necessary for the administration of this section and s. 383.145, including rules providing definitions of terms, rules relating to the methods used and time or times for testing as accepted medical practice indicates, rules relating to charging and collecting fees for the administration of the newborn screening program authorized by this section, rules for processing requests and releasing test and screening results, and rules requiring mandatory reporting of the results of tests and screenings for these conditions to the department.

(3) DEPARTMENT OF HEALTH; POWERS AND DUTIES.--The department shall administer and provide certain services to implement the provisions of this section and shall:

- (a) Assure the availability and quality of the necessary laboratory tests and materials.
- (b) Furnish all physicians, county health departments, perinatal centers, birthing centers, and hospitals forms on which environmental screening and the results of tests for phenylketonuria and such other disorders for which testing may be required from time to time shall be reported to the department.
- (c) Promote education of the public about the prevention and management of metabolic, hereditary, and congenital disorders and dangers associated with environmental risk factors.
- (d) Maintain a confidential registry of cases, including information of importance for the purpose of followup services to prevent mental retardation, to correct or ameliorate physical handicaps, and for epidemiologic studies, if indicated. Such registry shall be exempt from the provisions of s. 119.07(1).
- (e) Supply the necessary dietary treatment products where practicable for diagnosed cases of phenylketonuria and other metabolic diseases for as long as medically indicated when the products are not otherwise available. Provide nutrition education and supplemental foods to those families eligible for the Special Supplemental Nutrition Program for Women, Infants, and Children as provided in s. 383.011.
- (f) Promote the availability of genetic studies and counseling in order that the parents, siblings, and affected newborns may benefit from available knowledge of the condition.
- (g) Have the authority to charge and collect fees for the administration of the newborn screening program authorized in this section, as follows:
 - 1. A fee not to exceed \$15 will be charged for each live birth, as recorded by the Office of Vital Statistics, occurring in a hospital licensed under part I of chapter 395 or a birth center licensed under s. 383.305 per year. The department shall calculate the annual assessment for each hospital and birth center, and this assessment must be paid in equal amounts quarterly. Quarterly, the department shall generate and mail to each hospital and birth center a statement of the amount due.

2. As part of the department's legislative budget request prepared pursuant to chapter 216, the department shall submit a certification by the department's inspector general, or the director of auditing within the inspector general's office, of the annual costs of the uniform testing and reporting procedures of the newborn screening program. In certifying the annual costs, the department's inspector general or the director of auditing within the inspector general's office shall calculate the direct costs of the uniform testing and reporting procedures, including applicable administrative costs. Administrative costs shall be limited to those department costs which are reasonably and directly associated with the administration of the uniform testing and reporting procedures of the newborn screening program.

(h) Have the authority to bill third-party payors for newborn screening tests.

All provisions of this subsection must be coordinated with the provisions and plans established under this chapter, chapter 411, and Pub. L. No. 99-457.

(4) **OBJECTIONS OF PARENT OR GUARDIAN.**--The provisions of this section shall not apply when the parent or guardian of the child objects thereto. A written statement of such objection shall be presented to the physician or other person whose duty it is to administer and report tests and screenings under this section.

(5) **ADVISORY COUNCIL.**--There is established a Genetics and Newborn Screening Advisory Council made up of 15 members appointed by the Secretary of Health. The council shall be composed of two consumer members, three practicing pediatricians, at least one of whom must be a pediatric hematologist, one representative from each of the four medical schools in the state, the Secretary of Health or his or her designee, one representative from the Department of Health representing Children's Medical Services, one representative from the Florida Hospital Association, one individual with experience in newborn screening programs, one individual representing audiologists, and one representative from the Agency for Persons with Disabilities. All appointments shall be for a term of 4 years. The chairperson of the council shall be elected from the membership of the council and shall serve for a period of 2 years. The council shall meet at least semiannually or upon the call of the chairperson. The council may establish ad hoc or temporary technical advisory groups to assist the council with specific topics which come before the council. Council members shall serve without pay. Pursuant to the provisions of s. 112.061, the council members are entitled to be reimbursed for per diem and travel expenses. It is the purpose of the council to advise the department about:

(a) Conditions for which testing should be included under the screening program and the genetics program.

(b) Procedures for collection and transmission of specimens and recording of results.

(c) Methods whereby screening programs and genetics services for children now provided or proposed to be offered in the state may be more effectively evaluated, coordinated, and consolidated.

History.--s. 1, ch. 65-519; ss. 19, 35, ch. 69-106; s. 1, ch. 71-140; s. 129, ch. 77-147; s. 1, ch. 78-245; s. 2, ch. 79-26; s. 1, ch. 82-46; s. 2, ch. 83-265; s. 8, ch. 86-220; ss. 1, 5, 6, ch. 89-93; s. 2, ch. 90-344; s. 22, ch. 91-282; s. 5, ch. 91-429; s. 672, ch. 95-148; s. 9, ch. 95-394; s. 1, ch. 96-306; s. 194, ch. 96-406; s. 188, ch. 97-101; s. 29, ch. 97-237; s. 23, ch. 99-397; s. 45, ch. 2000-139; s. 18, ch. 2000-242; s. 15, ch. 2000-337; s. 14, ch. 2001-53; s. 62, ch. 2001-277; s. 3, ch. 2004-245; s. 13, ch. 2004-350; s. 7, ch. 2006-227.

383.145 Newborn and infant hearing screening.--

(1) LEGISLATIVE INTENT.--The intent of this section is to provide a statewide comprehensive and coordinated interdisciplinary program of early hearing impairment screening, identification, and followup care for newborns. The goal is to screen all newborns for hearing impairment in order to alleviate the adverse effects of hearing loss on speech and language development, academic performance, and cognitive development. It is further the intent of the Legislature that the provisions of this act only be implemented to the extent that funds are specifically included in the General Appropriations Act for carrying out the purposes of this section.

(2) DEFINITIONS.--

(a) "Agency" means the Agency for Health Care Administration.

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

(c) "Hearing impairment" means a hearing loss of 30 dB HL or greater in the frequency region important for speech recognition and comprehension in one or both ears, approximately 500 through 4,000 hertz.

(d) "Infant" means an age range from 30 days through 12 months.

(e) "Licensed health care provider" means a physician licensed pursuant to chapter 458 or chapter 459, a nurse licensed pursuant to chapter 464, or an audiologist licensed pursuant to chapter 468, rendering services within the scope of his or her license.

(f) "Management" means the habilitation of the hearing-impaired child.

(g) "Newborn" means an age range from birth through 29 days.

(h) "Screening" means a test or battery of tests administered to determine the need for an in-depth hearing diagnostic evaluation.

(3) REQUIREMENTS FOR SCREENING OF NEWBORNS; INSURANCE COVERAGE; REFERRAL FOR ONGOING SERVICES.--

(a) Each licensed hospital or other state-licensed birthing facility that provides maternity and newborn care services shall provide that all newborns are, prior to discharge, screened for the detection of hearing loss, to prevent the consequences of unidentified disorders.

(b) Each licensed birth center that provides maternity and newborn care services shall provide that all newborns are, prior to discharge, referred to a licensed audiologist, a physician licensed under chapter 458 or chapter 459, or a hospital or other newborn hearing screening provider, for screening for the detection of hearing loss, to prevent the consequences of unidentified disorders. The referral for appointment shall be made within 30 days after discharge. Written documentation of the referral must be placed in the newborn's medical chart.

(c) If the parent or legal guardian of the newborn objects to the screening, the screening must not be completed. In such case, the physician, midwife, or other person who is attending the newborn shall maintain a record that the screening has not been performed and attach a written objection that must be signed by the parent or guardian.

(d) For home births, the health care provider in attendance is responsible for coordination and referral to a licensed audiologist, hospital, or other newborn hearing screening provider. The referral for appointment shall be made within 30 days after the birth. In cases in which the home birth is not attended by a primary health care provider, a referral to a licensed audiologist, physician licensed pursuant to chapter 458 or chapter 459, hospital, or other newborn hearing screening provider must be made by the health care provider within the first 3 months after the child's birth.

(e) All newborn and infant hearing screenings shall be conducted by a licensed audiologist, physician licensed under chapter 458 or chapter 459, or appropriately supervised individual who has completed documented training specifically for newborn hearing screening. Every licensed hospital that provides maternity or newborn care services shall obtain the services of a licensed audiologist, physician licensed pursuant to chapter 458 or chapter 459, or other newborn hearing screening provider, through employment or contract or written memorandum of understanding, for the purposes of appropriate staff training, screening program supervision, monitoring the scoring and interpretation of test results, rendering of appropriate recommendations, and coordination of appropriate followup services. Appropriate documentation of the screening completion, results, interpretation, and recommendations must be placed in the medical record within 24 hours after completion of the screening procedure.

(f) The screening of a newborn's hearing should be completed before the newborn is discharged from the hospital. If the screening is not completed before discharge due to scheduling or temporary staffing limitations, the screening must be completed within 30 days after discharge. Screenings completed after discharge or performed because of initial screening failure must be completed by an audiologist licensed in the state, a physician licensed under chapter 458 or chapter 459, or a hospital or other newborn hearing screening provider.

(g) Each hospital shall formally designate a lead physician responsible for programmatic oversight for newborn hearing screening. Each birth center shall designate a licensed health care provider to provide such programmatic oversight and to ensure that the appropriate referrals are being completed.

(h) When ordered by the treating physician, screening of a newborn's hearing must include auditory brainstem responses, or evoked otoacoustic emissions, or appropriate technology as approved by the United States Food and Drug Administration.

(i) By October 1, 2000, newborn hearing screening must be conducted on all newborns in hospitals in this state on birth admission. When a newborn is delivered in a facility other than a hospital, the parents must be instructed on the importance of having the hearing screening performed and must be given information to assist them in having the screening performed within 3 months after the child's birth.

(j) The initial procedure for screening the hearing of the newborn or infant and any medically necessary followup reevaluations leading to diagnosis shall be a covered benefit, reimbursable under Medicaid as an expense compensated supplemental to the per diem rate for Medicaid patients enrolled in MediPass or Medicaid patients covered by a fee for service program. For Medicaid patients enrolled in HMOs, providers shall be reimbursed directly by the Medicaid Program Office at the Medicaid rate. This service may not be considered a covered service for

the purposes of establishing the payment rate for Medicaid HMOs. All health insurance policies and health maintenance organizations as provided under ss. 627.6416, 627.6579, and 641.31(30), except for supplemental policies that only provide coverage for specific diseases, hospital indemnity, or Medicare supplement, or to the supplemental policies, shall compensate providers for the covered benefit at the contracted rate. Nonhospital-based providers shall be eligible to bill Medicaid for the professional and technical component of each procedure code.

(k) Any child who is diagnosed as having a permanent hearing impairment shall be referred to the primary care physician for medical management, treatment, and followup services. Furthermore, in accordance with Pub. L. No. 105-17, The Infants and Toddlers Program, Individuals with Disabilities Education Act, any child from birth to 36 months of age who is diagnosed as having a hearing impairment that requires ongoing special hearing services must be referred to the Children's Medical Services Early Intervention Program serving the geographical area in which the child resides.

(l) Any person who is not covered through insurance and cannot afford the costs for testing shall be given a list of newborn hearing screening providers who provide the necessary testing free of charge.

History.--s. 1, ch. 2000-177.

383.15 Legislative intent; perinatal intensive care services.--The Legislature finds and declares that many perinatal diseases and disabilities have debilitating, costly, and often fatal consequences if left untreated. Many of these debilitating conditions could be prevented or ameliorated if services were available to the public through a regional perinatal intensive care centers program. Perinatal intensive care services are critical to the well-being and development of a healthy society and represent a constructive, cost-beneficial, and essential investment in the future of our state. Therefore, it is the intent of the Legislature to develop a regional perinatal intensive care centers program. The Legislature further intends that development of a regional perinatal intensive care centers program shall not reduce or dilute the current financial commitment of the state, as indicated through appropriation, to the existing regional perinatal intensive care centers. It is the intent of the Legislature that any additional regional perinatal intensive care center authorized under s. 383.19 after July 1, 1993, shall not receive payments authorized under s. 409.9112 unless specific appropriations are provided to expand such payments to additional hospitals.

History.--s. 1, ch. 76-54; s. 1, ch. 77-171; s. 1, ch. 94-140.

383.16 Definitions; ss. 383.15-383.21.--As used in ss. 383.15-383.21, the term:

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

(2) "Regional perinatal intensive care center" or "center" means a unit designated by the department, located within a hospital, and specifically designed to provide a full range of health services to its patients.

(3) "Patient" means a woman who is experiencing a high-risk pregnancy and who has been declared financially and medically eligible or a newborn infant who needs intensive care and who is declared financially and medically eligible.

History.--s. 2, ch. 76-54; s. 1, ch. 77-171; s. 1, ch. 79-351; s. 1, ch. 85-225; s. 2, ch. 94-140; s. 61, ch. 97-101.

383.17 Regional perinatal intensive care centers program; authority.--The department may contract with health care providers in establishing and maintaining centers in accordance with ss. 383.15-383.21. The cost of administering the regional perinatal intensive care centers program shall be paid by the department from funds appropriated for this purpose.

History.--s. 3, ch. 76-54; s. 1, ch. 77-171; s. 1, ch. 82-209; s. 2, ch. 85-225; s. 3, ch. 94-140.

383.18 Contracts; conditions.--Participation in the regional perinatal intensive care centers program under ss. 383.15-383.21 is contingent upon the department entering into a contract with a provider. The contract shall provide that patients will receive services from the center and that parents or guardians of patients who participate in the program and who are in compliance with Medicaid eligibility requirements as determined by the department are not additionally charged for treatment and care which has been contracted for by the department. Financial eligibility for the program is based on the Medicaid income guidelines for pregnant women and for children under 1 year of age. Funding shall be provided in accordance with ss. 383.19 and 409.908.

History.--s. 4, ch. 76-54; s. 1, ch. 77-174; s. 4, ch. 80-177; s. 3, ch. 82-209; s. 4, ch. 85-225; s. 32, ch. 87-225; s. 4, ch. 94-140.

383.19 Standards; funding; ineligibility.--

(1) The department shall adopt rules that specify standards for development and operation of a center which include, but are not limited to:

(a) The need to provide services through a regional perinatal intensive care center and the requirements of the population to be served.

(b) Equipment.

(c) Facilities.

(d) Staffing and qualifications of personnel.

(e) Transportation services.

(f) Data collection.

(g) Definitions of terms.

(2) The department shall designate at least one center to serve a geographic area representing each region of the state in which at least 10,000 live births occur per year, but in no case may there be more than 11 regional perinatal intensive care centers established unless specifically authorized in the appropriations act or in this subsection. Medicaid reimbursement shall be made for services provided to patients who are Medicaid recipients. Medicaid reimbursement for in-center obstetrical physician services shall be based upon the obstetrical care group payment system. Medicaid reimbursement for in-center neonatal physician services shall be based upon the neonatal care group payment system. These prospective payment systems, developed by the department, must place patients into homogeneous groups based on clinical factors, severity of illness, and intensity of care. Outpatient obstetrical services and other related services, such as consultations, shall be reimbursed based on the usual Medicaid method of payment for outpatient medical services.

(3) Failure to comply with the standards established under this section constitutes grounds for terminating the contract.

(4) The department shall give priority to establishing centers in hospitals that demonstrate an interest in perinatal intensive care by meeting program standards.

(5) A private, for-profit hospital that does not accept county, state, or federal funds or indigent patients is not eligible to participate under ss. 383.15-383.21.

(6) Each hospital which contracts with the department to provide services under the terms of ss. 383.15-383.21 shall prepare an annual report that includes, but is not limited to, the number of clients served and the costs of services.

History.--s. 5, ch. 76-54; s. 1, ch. 77-171; s. 1, ch. 77-174; s. 2, ch. 79-351; s. 152, ch. 79-400; s. 5, ch. 80-177; s. 2, ch. 82-209; s. 5, ch. 85-225; s. 5, ch. 94-140; s. 19, ch. 2000-242.

383.21 Program review.--At least annually during the contract period, the department shall evaluate the services rendered by each center. The department shall submit an annual programmatic and financial evaluation report, by center, to the Legislature no later than December 1 of each year.

History.--s. 7, ch. 76-54; s. 1, ch. 77-171; s. 6, ch. 80-177; s. 6, ch. 94-140.

383.216 Community-based prenatal and infant health care.--

(1) The Department of Health shall cooperate with localities which wish to establish prenatal and infant health care coalitions, and shall acknowledge and incorporate, if appropriate, existing community children's services organizations, pursuant to this section within the resources allocated. The purpose of this program is to establish a partnership among the private sector, the public sector, state government, local government, community alliances, and maternal and child health care providers, for the provision of coordinated community-based prenatal and infant health care. The prenatal and infant health care coalitions must work in a coordinated, nonduplicative manner with local health planning councils established pursuant to s. 408.033.

(2) Each prenatal and infant health care coalition shall develop, in coordination with the Department of Health, a plan which shall include at a minimum provision to:

(a) Perform community assessments, using the Planned Approach to Community Health (PATCH) process, to identify the local need for comprehensive preventive and primary prenatal and infant health care. These assessments shall be used to:

1. Determine the priority target groups for receipt of care.
2. Determine outcome performance objectives jointly with the department.
3. Identify potential local providers of services.
4. Determine the type of services required to serve the identified priority target groups.
5. Identify the unmet need for services for the identified priority target groups.

(b) Design a prenatal and infant health care services delivery plan which is consistent with local community objectives and this section.

(c) Solicit and select local service providers based on reliability and availability, and define the role of each in the services delivery plan.

(d) Determine the allocation of available federal, state, and local resources to prenatal and infant health care providers.

(e) Review, monitor, and advise the department concerning the performance of the services delivery system, and make any necessary annual adjustments in the design of the delivery system, the provider composition, the targeting of services, and other factors necessary for achieving projected outcomes.

(f) Build broad-based community support.

(3) Supervision of the prenatal and infant health care coalitions is the responsibility of the department. The department shall:

(a) Assist in the formation and development of the coalitions.

(b) Define the core services package so that it is consistent with the prenatal and infant health care services delivery plan.

(c) Provide data and technical assistance.

(d) Assure implementation of a quality management system within the provider coalition.

(e) Define statewide, uniform eligibility and fee schedules.

(f) Evaluate provider performance based on outcome measures established by the prenatal and infant health care coalition and the department.

(4) In those communities which do not elect to establish a prenatal and infant health care coalition, the Department of Health is responsible for all of the functions delegated to the coalitions in this section.

(5) The membership of each prenatal and infant health care coalition shall represent health care providers, the recipient community, and the community at large; shall represent the racial, ethnic, and gender composition of the community; and shall include at least the following:

(a) Consumers of family planning, primary care, or prenatal care services, at least two of whom are low-income or Medicaid eligible.

(b) Health care providers, including:

1. County health departments.

2. Migrant and community health centers.

3. Hospitals.

4. Local medical societies.

5. Local health planning organizations.

(c) Local health advocacy interest groups and community organizations.

(d) County and municipal governments.

(e) Social service organizations.

(f) Local education communities.

(6) Prenatal and infant health care coalitions may be established for single counties or for services delivery catchment areas. A prenatal and infant health care coalition shall be initiated at the local level on a voluntary basis. Once a coalition has been organized locally and includes the membership specified in subsection (5), the coalition must submit a list of its members to the Secretary of Health to carry out the responsibilities outlined in this section.

(7) Effective January 1, 1992, the Department of Health shall provide up to \$150,000 to each prenatal and infant health care coalition that petitions for recognition, meets the membership criteria, demonstrates the commitment of all the designated members to participate in the coalition, and provides a local cash or in-kind contribution match of 25 percent of the costs of the coalition. An in-kind contribution match may be in the form of staff time, office facilities, or supplies or other materials necessary for the functioning of the coalition.

(8) Local prenatal and infant health care coalitions may hire staff or contract for independent staffing and support to enable them to carry out the objectives of this section. Staff shall have knowledge and expertise in community health and related resources and planning, grant writing, public information and communication techniques, organizational development, and data compilation and analysis.

(9) Local prenatal and infant health care coalitions shall incorporate as not-for-profit corporations for the purpose of seeking and receiving grants from federal, state, and local government and other contributors. However, a coalition need not be designated as a tax-exempt organization under s. 501(c)(3) of the Internal Revenue Code.

(10) The Department of Health shall adopt rules necessary to administer this section, including rules defining acceptable "in-kind" contributions and rules providing definitions of terms, coalition responsibilities, coalition operations and standards, and conditions for establishing and approving a coalition. A coalition may not be a direct provider of prenatal and infant-care services.

History.--s. 26, ch. 91-282; s. 69, ch. 95-143; s. 62, ch. 97-101; s. 20, ch. 2000-242.

383.2161 Maternal and child health report.--The Department of Health annually shall compile and analyze the risk information collected by the Office of Vital Statistics and the district prenatal and infant care coalitions and shall prepare and submit to the Legislature by January 2 a report that includes, but is not limited to:

(1) The number of families identified as families at potential risk;

(2) The number of families that receive family outreach services;

- (3) The increase in demand for services; and
- (4) The unmet need for services for identified target groups.

History.--s. 27, ch. 91-282; s. 63, ch. 97-101; s. 110, ch. 97-237.

383.30 Birth Center Licensure Act; short title.--Sections 383.30-383.335 shall be known and may be cited as the "Birth Center Licensure Act."

History.--ss. 1, 27, ch. 84-283; s. 4, ch. 91-429.

383.301 Licensure and regulation of birth centers; legislative intent.--It is the intent of the Legislature to provide for the protection of public health and safety in the establishment, maintenance, and operation of birth centers by providing for licensure of birth centers and for the development, establishment, and enforcement of minimum standards with respect to birth centers.

History.--ss. 2, 27, ch. 84-283; s. 4, ch. 91-429; s. 18, ch. 2000-141; s. 34, ch. 2001-186; s. 3, ch. 2001-372.

383.302 Definitions of terms used in ss. 383.30-383.335.--As used in ss. 383.30-383.335, the term:

- (1) "Agency" means the Agency for Health Care Administration.
- (2) "Birth center" means any facility, institution, or place, which is not an ambulatory surgical center or a hospital or in a hospital, in which births are planned to occur away from the mother's usual residence following a normal, uncomplicated, low-risk pregnancy.
- (3) "Clinical staff" means individuals employed full time or part time by a birth center who are licensed or certified to provide care at childbirth.
- (4) "Consultant" means a physician licensed pursuant to chapter 458 or chapter 459 who agrees to provide advice and services to a birth center and who either:
 - (a) Is certified or eligible for certification by the American Board of Obstetrics and Gynecology, or
 - (b) Has hospital obstetrical privileges.
- (5) "Governing body" means any individual, group, corporation, or institution which is responsible for the overall operation and maintenance of a birth center.
- (6) "Governmental unit" means the state or any county, municipality, or other political subdivision or any department, division, board, or other agency of any of the foregoing.
- (7) "Licensed facility" means a facility licensed in accordance with s. 383.305.
- (8) "Low-risk pregnancy" means a pregnancy which is expected to result in an uncomplicated birth, as determined through risk criteria developed by rule of the department, and which is accompanied by adequate prenatal care.

(9) "Person" means any individual, firm, partnership, corporation, company, association, institution, or joint stock association and means any legal successor of any of the foregoing.

(10) "Premises" means those buildings, beds, and facilities located at the main address of the licensee and all other buildings, beds, and facilities for the provision of maternity care located in such reasonable proximity to the main address of the licensee as to appear to the public to be under the dominion and control of the licensee.

History.--ss. 3, 27, ch. 84-283; s. 4, ch. 91-429; s. 64, ch. 97-101; s. 7, ch. 98-171.

383.304 Licensure requirement for birth centers.--

(1) A person or governmental unit may not establish, conduct, or maintain a birth center in this state without first obtaining a license under s. 383.305.

(2) It is unlawful for any person to use or advertise to the public, in any way or by any medium whatsoever, any facility as a birth center unless such facility has first secured a license under s. 383.305.

History.--ss. 5, 27, ch. 84-283; s. 4, ch. 91-429.

383.305 Licensure; issuance, renewal, denial, suspension, revocation; fees; background screening.--

(1)(a) Upon receipt of an application for a license and the license fee, the agency shall issue a license if the applicant and facility have received all approvals required by law and meet the requirements established under ss. 383.30-383.335 and by rules promulgated hereunder.

(b) A provisional license may be issued to any birth center that is in substantial compliance with ss. 383.30-383.335 and with the rules of the agency. A provisional license may be granted for a period of no more than 1 year from the effective date of rules adopted by the agency, shall expire automatically at the end of its term, and may not be renewed.

(c) A license, unless sooner suspended or revoked, automatically expires 1 year from its date of issuance and is renewable upon application for renewal and payment of the fee prescribed, provided the applicant and the birth center meet the requirements established under ss. 383.30-383.335 and by rules promulgated hereunder. A complete application for renewal of a license shall be made 90 days prior to expiration of the license on forms provided by the agency.

(2) An application for a license, or renewal thereof, shall be made to the agency upon forms provided by it and shall contain such information as the agency reasonably requires, which may include affirmative evidence of ability to comply with applicable laws and rules.

(3)(a) Each application for a birth center license, or renewal thereof, shall be accompanied by a license fee. Fees shall be established by rule of the agency. Such fees are payable to the agency and shall be deposited in a trust fund administered by the agency, to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335.

(b) The fees established pursuant to ss. 383.30-383.335 shall be based on actual costs incurred by the agency in the administration of its duties under such sections.

(4) Each license is valid only for the person or governmental unit to whom or which it is issued; is not subject to sale, assignment, or other transfer, voluntary or involuntary; and is not valid for any premises other than those for which it was originally issued.

(5) Each license shall be posted in a conspicuous place on the licensed premises.

(6) Whenever the agency finds that there has been a substantial failure to comply with the requirements established under ss. 383.30-383.335 or in rules adopted under those sections, it is authorized to deny, suspend, or revoke a license.

(7) Each applicant for licensure must comply with the following requirements:

(a) Upon receipt of a completed, signed, and dated application, the agency shall require background screening, in accordance with the level 2 standards for screening set forth in chapter 435, of the managing employee, or other similarly titled individual who is responsible for the daily operation of the center, and of the financial officer, or other similarly titled individual who is responsible for the financial operation of the center, including billings for patient care and services. The applicant must comply with the procedures for level 2 background screening as set forth in chapter 435 as well as the requirements of s. 435.03(3).

(b) The agency may require background screening of any other individual who is an applicant if the agency has probable cause to believe that he or she has been convicted of a crime or has committed any other offense prohibited under the level 2 standards for screening set forth in chapter 435.

(c) Proof of compliance with the level 2 background screening requirements of chapter 435 which has been submitted within the previous 5 years in compliance with any other health care licensure requirements of this state is acceptable in fulfillment of the requirements of paragraph (a).

(d) A provisional license may be granted to an applicant when each individual required by this section to undergo background screening has met the standards for the Department of Law Enforcement background check, but the agency has not yet received background screening results from the Federal Bureau of Investigation, or a request for a disqualification exemption has been submitted to the agency as set forth in chapter 435 but a response has not yet been issued. A standard license may be granted to the applicant upon the agency's receipt of a report of the results of the Federal Bureau of Investigation background screening for each individual required by this section to undergo background screening which confirms that all standards have been met, or upon the granting of a disqualification exemption by the agency as set forth in chapter 435. Any other person who is required to undergo level 2 background screening may serve in his or her capacity pending the agency's receipt of the report from the Federal Bureau of Investigation. However, the person may not continue to serve if the report indicates any violation of background screening standards and a disqualification exemption has not been requested of and granted by the agency as set forth in chapter 435.

(e) Each applicant must submit to the agency, with its application, a description and explanation of any exclusions, permanent suspensions, or terminations of the applicant from the Medicare or Medicaid programs. Proof of compliance with the requirements for disclosure of ownership and control interests under the Medicaid or Medicare programs shall be accepted in lieu of this submission.

(f) Each applicant must submit to the agency a description and explanation of any conviction of an offense prohibited under the level 2 standards of chapter 435 by a member of the board

of directors of the applicant, its officers, or any individual owning 5 percent or more of the applicant. This requirement does not apply to a director of a not-for-profit corporation or organization if the director serves solely in a voluntary capacity for the corporation or organization, does not regularly take part in the day-to-day operational decisions of the corporation or organization, receives no remuneration for his or her services on the corporation or organization's board of directors, and has no financial interest and has no family members with a financial interest in the corporation or organization, provided that the director and the not-for-profit corporation or organization include in the application a statement affirming that the director's relationship to the corporation satisfies the requirements of this paragraph.

(g) A license may not be granted to an applicant if the applicant or managing employee has been found guilty of, regardless of adjudication, or has entered a plea of nolo contendere or guilty to, any offense prohibited under the level 2 standards for screening set forth in chapter 435, unless an exemption from disqualification has been granted by the agency as set forth in chapter 435.

(h) The agency may deny or revoke licensure if the applicant:

1. Has falsely represented a material fact in the application required by paragraph (e) or paragraph (f), or has omitted any material fact from the application required by paragraph (e) or paragraph (f); or
2. Has had prior action taken against the applicant under the Medicaid or Medicare program as set forth in paragraph (e).

(i) An application for license renewal must contain the information required under paragraphs (e) and (f).

History.--ss. 5, 6, 27, ch. 84-283; s. 4, ch. 91-429; ss. 8, 71, ch. 98-171; s. 60, ch. 2000-349; s. 25, ch. 2001-53; s. 2, ch. 2001-67; s. 148, ch. 2001-277; s. 40, ch. 2004-267.

383.307 Administration of birth center.--

(1) Each birth center shall have a governing body which is responsible for the overall operation and maintenance of the birth center.

(a) The governing body shall develop and display a table of organization which shows the structure of the birth center and identifies the governing body, the birth center director, the clinical director, the clinical staff, and the medical consultant.

(b) The governing body shall develop and make available to staff, clinicians, consultants, and licensing authorities a manual which documents policies, procedures, and protocols, including the roles and responsibilities of all personnel.

(2) There shall be an adequate number of licensed personnel to provide clinical services needed by mothers and newborns and a sufficient number of qualified personnel to provide services for families and to maintain the birth center.

(3) All clinical staff members and consultants shall hold current licenses from this state to practice their respective disciplines.

(4) Clinical staff members and consultants shall adopt bylaws which are subject to the approval of the governing body and which shall include recommendations for clinical staff or

consultation appointments, delineation of clinical privileges, and the organization of the clinical staff.

History.--ss. 3, 7, 27, ch. 84-283; s. 4, ch. 91-429; s. 48, ch. 99-397.

383.308 Birth center facility and equipment; requirements.--

(1) A birth center shall be so designed to assure adequate provision for birthing rooms, bath and toilet facilities, storage areas for supplies and equipment, examination areas, and reception or family areas. Handwashing facilities shall be in, or immediately adjacent to, all examining areas and birthing rooms.

(2)(a) A birth center shall be equipped with those items needed to provide low-risk maternity care and readily available equipment to initiate emergency procedures in life-threatening events to mother and baby, as defined by rule of the agency.

(b) Provision shall be made, on or off the premises, for laundry, sterilization of supplies and equipment, laboratory examinations, and light snacks. If a food service is provided, special requirements shall be met as defined in rules promulgated pursuant to chapter 381.

(3) A birth center shall meet codes for ordinary construction and for water supply and sewage disposal. Solid waste shall be disposed of in accordance with the provisions of chapter 403 and rules promulgated thereunder.

(4)(a) A birth center shall be maintained in a safe, clean, and orderly manner.

(b) The governing body shall ensure that there is compliance with firesafety provisions required by rules promulgated pursuant to chapter 633.

History.--ss. 8, 27, ch. 84-283; s. 4, ch. 91-429; s. 9, ch. 98-171.

383.309 Minimum standards for birth centers; rules and enforcement.--

(1) The agency shall adopt and enforce rules to administer ss. 383.30-383.335, which rules shall include, but are not limited to, reasonable and fair minimum standards for ensuring that:

(a) Sufficient numbers and qualified types of personnel and occupational disciplines are available at all times to provide necessary and adequate patient care and safety.

(b) Infection control, housekeeping, sanitary conditions, disaster plan, and medical record procedures that will adequately protect patient care and provide safety are established and implemented.

(c) Licensed facilities are established, organized, and operated consistent with established programmatic standards.

(2) Any licensed facility that is in operation at the time of adoption of any applicable rule under ss. 383.30-383.335 shall be given a reasonable time under the particular circumstances, not to exceed 1 year after the date of such adoption, within which to comply with such rule.

(3) The agency may not establish any rule governing the design, construction, erection, alteration, modification, repair, or demolition of birth centers. It is the intent of the

Legislature to preempt that function to the Florida Building Commission and the State Fire Marshal through adoption and maintenance of the Florida Building Code and the Florida Fire Prevention Code. However, the agency shall provide technical assistance to the commission and the State Fire Marshal in updating the construction standards of the Florida Building Code and the Florida Fire Prevention Code which govern birth centers. In addition, the agency may enforce the special-occupancy provisions of the Florida Building Code and the Florida Fire Prevention Code which apply to birth centers in conducting any inspection authorized under this chapter.

History.--ss. 23, 27, ch. 84-283; s. 4, ch. 91-429; s. 10, ch. 98-171; s. 19, ch. 2000-141; s. 34, ch. 2001-186; s. 3, ch. 2001-372.

383.31 Selection of clients; informed consent.--

(1)(a) A birth center may accept only those patients who are expected to have normal pregnancies, labors, and deliveries.

(b) The criteria for the selection of clients and the establishment of risk status shall be defined by rule of the agency.

(2)(a) A patient may not be accepted for care until the patient has signed a client informed-consent form.

(b) The agency shall develop a client informed-consent form to be used by the center to inform the client of the benefits and risks related to childbirth outside a hospital.

History.--ss. 9, 10, 27, ch. 84-283; s. 4, ch. 91-429; s. 11, ch. 98-171.

383.3105 Patients consenting to adoptions; protocols.--

(1) Each licensed facility shall adopt a protocol that at a minimum provides for facility staff to be knowledgeable of the waiting periods, revocation and the contents of the consent to adoption as contained in s. 63.082(4), and describes the supportive and unbiased manner in which facility staff will interact with birth parents and prospective adoptive parents regarding the adoption, in particular during the waiting period required in s. 63.082(4)(b) before consenting to an adoption.

(2) The protocol shall be in writing and be provided upon request to any birth parent or prospective adoptive parent of a child born in the facility.

History.--s. 40, ch. 2001-3.

383.311 Education and orientation for birth center clients and their families.--

(1) The clients and their families shall be fully informed of the policies and procedures of the birth center, including, but not limited to, policies and procedures on:

(a) The selection of clients.

(b) The expectation of self-help and family/client relationships.

(c) The qualifications of the clinical staff.

- (d) The transfer to secondary or tertiary care.
- (e) The philosophy of childbirth care and the scope of services.
- (f) The customary length of stay after delivery.
- (2) The clients shall be prepared for childbirth and childbearing by education in:
 - (a) The course of pregnancy and normal changes occurring during pregnancy.
 - (b) The need for prenatal care.
 - (c) Nutrition, including encouragement of breastfeeding.
 - (d) The effects of smoking and substance abuse.
 - (e) Labor and delivery.
 - (f) The care of the newborn.

History.--ss. 11, 27, ch. 84-283; s. 4, ch. 91-429; s. 4, ch. 94-217.

383.312 Prenatal care of birth center clients.--

- (1) A birth center shall ensure that its clients have adequate prenatal care, as defined by the agency, and shall ensure that serological tests are administered as required by this chapter.
- (2) Records of prenatal care shall be maintained for each client and shall be available during labor and delivery.

History.--ss. 12, 27, ch. 84-283; s. 4, ch. 91-429; s. 12, ch. 98-171.

383.313 Performance of laboratory and surgical services; use of anesthetic and chemical agents.--

- (1) **LABORATORY SERVICES.**--A birth center may collect specimens for those tests that are requested under protocol. A birth center may perform simple laboratory tests, as defined by rule of the agency, and is exempt from the requirements of chapter 483, provided no more than five physicians are employed by the birth center and testing is conducted exclusively in connection with the diagnosis and treatment of clients of the birth center.
- (2) **SURGICAL SERVICES.**--Surgical procedures shall be limited to those normally performed during uncomplicated childbirths, such as episiotomies and repairs and shall not include operative obstetrics or caesarean sections.
- (3) **ADMINISTRATION OF ANALGESIA AND ANESTHESIA.**--General and conduction anesthesia may not be administered at a birth center. Systemic analgesia may be administered, and local anesthesia for pudendal block and episiotomy repair may be performed if procedures are outlined by the clinical staff and performed by personnel with statutory authority to do so.

(4) INTRAPARTAL USE OF CHEMICAL AGENTS.--Labor may not be inhibited, stimulated, or augmented with chemical agents during the first or second stage of labor unless prescribed by personnel with statutory authority to do so and unless in connection with and prior to emergency transport.

History.--ss. 13, 14, 15, 16, 27, ch. 84-283; s. 4, ch. 91-429; s. 13, ch. 98-171.

383.315 Agreements with consultants for advice or services; maintenance.--

(1) A birth center shall maintain in writing a consultation agreement, signed within the current license year, with each consultant who has agreed to provide advice and services to the birth center as requested.

(2) Consultation may be provided onsite or by telephone, as required by clinical and geographic conditions.

History.--ss. 18, 27, ch. 84-283; s. 4, ch. 91-429.

383.316 Transfer and transport of clients to hospitals.--

(1) If unforeseen complications arise during labor, the client shall be transferred to a hospital.

(2) Each licensed facility shall make arrangements with a local ambulance service licensed under chapter 401 for the transport of emergency patients to a hospital. Such arrangements shall be documented in the policy and procedures manual of the facility if the birth center does not own or operate a licensed ambulance. The policy and procedures manual shall also contain specific protocols for the transfer of any patient to a licensed hospital.

(3) A licensed facility shall identify neonatal-specific transportation services, including ground and air ambulances; list their particular qualifications; and have the telephone numbers for access to these services clearly listed and immediately available.

(4) Annual assessments of the transportation services and transfer protocols shall be made and documented.

History.--ss. 9, 19, 27, ch. 84-283; s. 4, ch. 91-429.

383.318 Postpartum care for birth center clients and infants.--

(1) A mother and her infant shall be dismissed from the birth center within 24 hours after the birth of the infant, except in unusual circumstances as defined by rule of the agency. If a mother or infant is retained at the birth center for more than 24 hours after the birth, a report shall be filed with the agency within 48 hours of the birth describing the circumstances and the reasons for the decision.

(2) A prophylactic shall be instilled in the eyes of each newborn in accordance with s. 383.04.

(3) Postpartum evaluation and followup care shall be provided, which shall include:

(a) Physical examination of the infant.

(b) Metabolic screening tests required by s. 383.14.

- (c) Referral to sources for pediatric care.
- (d) Maternal postpartum assessment.
- (e) Instruction in child care, including immunization and breastfeeding.
- (f) Family planning services.
- (g) Referral to secondary or tertiary care, as indicated.

History.--ss. 17, 27, ch. 84-283; s. 4, ch. 91-429; s. 5, ch. 94-217; s. 14, ch. 98-171.

383.32 Clinical records.--

(1) Clinical records shall contain information prescribed by rule, including, but not limited to:

- (a) Identifying information.
- (b) Risk assessments.
- (c) Information relating to prenatal visits.
- (d) Information relating to the course of labor and intrapartum care.
- (e) Information relating to consultation, referral, and transport to a hospital.
- (f) Newborn assessment, APGAR score, treatments as required, and followup.
- (g) Postpartum followup.

(2) Clinical records shall be immediately available at the birth center:

- (a) At the time of admission.
- (b) When transfer of care is necessary.
- (c) For audit by licensure personnel.

(3) Clinical records shall be kept confidential in accordance with s. 456.057 and exempt from the provisions of s. 119.07(1). A client's clinical records shall be open to inspection only under the following conditions:

- (a) A consent to release information has been signed by the client; or
- (b) The review is made by the agency for a licensure survey or complaint investigation.

(4)(a) Clinical records shall be audited periodically, but no less frequently than every 3 months, to evaluate the process and outcome of care.

(b) Statistics on maternal and perinatal morbidity and mortality, maternal risk, consultant referrals, and transfers of care shall be analyzed at least semiannually.

(c) The governing body shall examine the results of the record audits and statistical analyses and shall make such reports available for inspection by the public and licensing authorities.

History.--ss. 12, 21, 22, 27, ch. 84-283; s. 33, ch. 87-225; s. 1, ch. 90-3; s. 4, ch. 91-429; s. 195, ch. 96-406; s. 20, ch. 98-166; s. 15, ch. 98-171; s. 10, ch. 2000-160.

383.324 Inspections and investigations; inspection fees.--

(1) The agency shall make or cause to be made such inspections and investigations as it deems necessary.

(2) Each facility licensed under s. 383.305 shall pay to the agency, at the time of inspection, an inspection fee established by rule of the agency.

(3) The agency shall coordinate all periodic inspections for licensure made by the agency to ensure that the cost to the facility of such inspections and the disruption of services by such inspections is minimized.

History.--ss. 24, 27, ch. 84-283; s. 4, ch. 91-429; s. 16, ch. 98-171.

383.325 Inspection reports.--

(1) Each licensed facility shall maintain as public information, available upon request, records of all inspection reports pertaining to that facility which have been filed with, or issued by, any governmental agency. Copies of such reports shall be retained in the records of the facility for no less than 5 years from the date the reports are filed and issued.

(2) Any record, report, or document which, by state or federal law or regulation, is deemed confidential shall be exempt from the provisions of s. 119.07(1) and shall not be distributed or made available for purposes of compliance with this section unless or until such confidential status expires, except as described in s. 383.32(2)(c).

(3) A licensed facility shall, upon the request of any person who has completed a written application with intent to be admitted to such facility or any person who is a patient of such facility, or any relative, spouse, or guardian of any such person, furnish to the requester a copy of the last inspection report issued by the agency or an accrediting organization, whichever is most recent, pertaining to the licensed facility, as provided in subsection (1), provided the person requesting such report agrees to pay a reasonable charge to cover copying costs.

History.--ss. 25, 27, ch. 84-283; s. 34, ch. 87-225; s. 1, ch. 90-5; s. 4, ch. 91-429; s. 196, ch. 96-406; s. 17, ch. 98-171.

383.327 Birth and death records; reports.--

(1) A completed certificate of birth shall be filed with the local registrar within 5 days of each birth in accordance with chapter 382.

(2) Each maternal death, newborn death, and stillbirth shall be reported immediately to the medical examiner.

(3) The licensee shall comply with all requirements of this chapter and rules promulgated hereunder.

(4) A report shall be submitted annually to the agency. The contents of the report shall be prescribed by rule of the agency.

History.--ss. 20, 27, ch. 84-283; s. 30, ch. 87-387; s. 4, ch. 91-429; s. 18, ch. 98-171.

383.33 Administrative penalties; emergency orders; moratorium on admissions.--

(1)(a) The agency may deny, revoke, or suspend a license, or impose an administrative fine not to exceed \$500 per violation per day, for the violation of any provision of ss. 383.30-383.335 or any rule adopted under ss. 383.30-383.335. Each day of violation constitutes a separate violation and is subject to a separate fine.

(b) In determining the amount of the fine to be levied for a violation, as provided in paragraph (a), the following factors shall be considered:

1. The severity of the violation, including the probability that death or serious harm to the health or safety of any person will result or has resulted; the severity of the actual or potential harm; and the extent to which the provisions of ss. 383.30-383.335 were violated.
2. Actions taken by the licensee to correct the violations or to remedy complaints.
3. Any previous violations by the licensee.

(c) All amounts collected pursuant to this section shall be deposited into a trust fund administered by the agency to be used for the sole purpose of carrying out the provisions of ss. 383.30-383.335.

(2) The agency may issue an emergency order immediately suspending or revoking a license when it determines that any condition in the licensed facility presents a clear and present danger to the public health and safety.

(3) The agency may impose an immediate moratorium on elective admissions to any licensed facility, building or portion thereof, or service when the agency determines that any condition in the facility presents a threat to the public health or safety.

History.--ss. 26, 27, ch. 84-283; s. 4, ch. 91-429; s. 19, ch. 98-171.

383.331 Injunctive relief.--Notwithstanding the existence or pursuit of any other remedy, the agency may maintain an action in the name of the state for injunction or other process to enforce the provisions of ss. 383.30-383.335 and the rules adopted under such sections.

History.--ss. 26, 27, ch. 84-283; s. 4, ch. 91-429; s. 20, ch. 98-171.

383.332 Establishing, managing, or operating a birth center without a license; penalty.-- Any person who establishes, conducts, manages, or operates any birth center facility without a license under s. 383.305 is guilty of a misdemeanor and, upon conviction, shall be fined not more than \$100 for the first offense and not more than \$500 for each subsequent offense; and each day of continuing violation after conviction shall be considered a separate offense.

History.--ss. 26, 27, ch. 84-283; s. 4, ch. 91-429.

383.335 Partial exemptions.--

(1) Any facility which was providing obstetrical and gynecological surgical services and was owned and operated by a board-certified obstetrician on June 15, 1984, and which is otherwise subject to licensure under ss. 383.30-383.335 as a birth center, is exempt from the provisions of ss. 383.30-383.335 which restrict the provision of surgical services and outlet forceps delivery and the administration of anesthesia at birth centers. The agency shall adopt rules specifically related to the performance of such services and the administration of anesthesia at such facilities.

(2) Any facility which, as of June 15, 1984, had an agreement with a consultant who is licensed pursuant to chapter 458 or chapter 459 but who is not practicing obstetrics, is exempt from the provisions of this act which define the term "consultant."

History.--ss. 4, 27, ch. 84-283; s. 4, ch. 91-429; s. 76, ch. 99-8.

383.336 Provider hospitals; practice parameters; peer review board.--

(1) As used in this section, the term "provider hospital" means a hospital in which there annually occur 30 or more births that are paid for partly or fully by state funds or federal funds administered by the state.

(2) The Office of the Secretary of Health, in consultation with the Board of Medicine and the Florida Obstetric and Gynecologic Society, is directed to establish practice parameters to be followed by physicians in provider hospitals in performance of a caesarean section delivery when the delivery will be paid partly or fully by state funds or federal funds administered by the state. These parameters shall be directed to reduce the number of unnecessary caesarean section deliveries. These practice parameters shall address, at a minimum, the following: feasibility of attempting a vaginal delivery for each patient with a prior caesarean section; dystocia, including arrested dilation and prolonged deceleration phase; fetal distress; and fetal malposition. The Department of Health shall adopt rules to implement the provisions of this subsection.

(3) Each provider hospital shall establish a peer review board consisting of obstetric physicians and other persons having credentials within that hospital to perform deliveries by caesarean section. This board shall review, at least monthly, every caesarean section performed since the previous review and paid for by state funds or federal funds administered by the state. The board shall conduct its review pursuant to the parameters specified in the rule adopted by the Department of Health pursuant to this act and shall pay particular attention to electronic fetal monitoring records, umbilical cord gas results, and Apgar scores in determining if the caesarean section delivery was appropriate. The results of this periodic review must be shared with the attending physician. These reviews and the resultant reports must be considered a part of the hospital's quality assurance monitoring and peer review process established pursuant to s. 395.0193.

History.--s. 1, ch. 91-126; s. 89, ch. 92-33; s. 68, ch. 92-289; s. 77, ch. 99-8.

383.3361 Limitations on civil and administrative liability.--Nothing in this act shall serve as the basis for any civil or administrative action, nor as evidence of a standard of care or compliance with a standard of care in any civil or administrative action.

History.--s. 2, ch. 91-126.

383.3362 Sudden Infant Death Syndrome.--

(1) FINDINGS AND INTENT.--The Legislature recognizes that Sudden Infant Death Syndrome, or SIDS, is a leading cause of death among children under the age of 1 year, both nationally and in this state. The Legislature further recognizes that first responders to emergency calls relating to such a death need access to special training to better enable them to distinguish SIDS from death caused by criminal acts and to appropriately interact with the deceased infant's parents or caretakers. At the same time, the Legislature, recognizing that the primary focus of first responders is to carry out their assigned duties, intends to increase the awareness of SIDS by first responders, but in no way expand or take away from their duties. Further, the Legislature recognizes the importance of a standard protocol for review of SIDS deaths by medical examiners and the importance of appropriate followup in cases of certified or suspected SIDS deaths. Finally, the Legislature finds that it is desirable to analyze existing data, and to conduct further research on, the possible causes of SIDS and how to lower the number of sudden infant deaths.

(2) DEFINITION.--As used in this section, the term "Sudden Infant Death Syndrome," or "SIDS," means the sudden unexpected death of an infant under 1 year of age which remains unexplained after a complete autopsy, death-scene investigation, and review of the case history. The term includes only those deaths for which, currently, there is no known cause or cure.

(3) TRAINING.--

(a) The Legislature finds that an emergency medical technician, a paramedic, a firefighter, or a law enforcement officer is likely to be the first responder to a request for assistance which is made immediately after the sudden unexpected death of an infant. The Legislature further finds that these first responders should be trained in appropriate responses to sudden infant death.

(b) After January 1, 1995, the basic training programs required for certification as an emergency medical technician, a paramedic, a firefighter, or a law enforcement officer as defined in s. 943.10, other than a correctional officer or a correctional probation officer, must include curriculum that contains instruction on Sudden Infant Death Syndrome.

(c) The Department of Health, in consultation with the Emergency Medical Services Advisory Council, the Firefighters Employment, Standards, and Training Council, and the Criminal Justice Standards and Training Commission, shall develop and adopt, by rule, curriculum that, at a minimum, includes training in the nature of SIDS, standard procedures to be followed by law enforcement agencies in investigating cases involving sudden deaths of infants, and training in responding appropriately to the parents or caretakers who have requested assistance.

(4) AUTOPSIES.--

(a) The medical examiner must perform an autopsy upon any infant under the age of 1 year who is suspected to have died of Sudden Infant Death Syndrome. The autopsy must be performed within 24 hours after the death, or as soon thereafter as is feasible. When the medical examiner's findings are consistent with the definition of sudden infant death syndrome in subsection (2), the medical examiner must state on the death certificate that sudden infant death syndrome was the cause of death.

(b) The Medical Examiners Commission shall develop and implement a protocol for dealing with suspected sudden infant death syndrome. The protocol must be followed by all medical examiners when conducting the autopsies required under this subsection. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, criteria for any specific tissue sampling, and any other requirements that the commission considers necessary.

(c) A medical examiner is not liable for damages in a civil action for any act or omission done in compliance with this subsection.

(d) An autopsy must be performed under the authority of a medical examiner under s. 406.11.

(5) DEPARTMENT DUTIES RELATING TO SUDDEN INFANT DEATH SYNDROME (SIDS).--The Department of Health shall:

(a) Collaborate with other agencies in the development and presentation of the Sudden Infant Death Syndrome (SIDS) training programs for first responders, including those for emergency medical technicians and paramedics, firefighters, and law enforcement officers.

(b) Maintain a database of statistics on reported SIDS deaths, and analyze the data as funds allow.

(c) Serve as liaison and closely coordinate activities with the Florida SIDS Alliance, including the services related to the SIDS hotline.

(d) Maintain a library reference list and materials about SIDS for public dissemination.

(e) Provide professional support to field staff.

(f) Coordinate the activities of and promote a link between the fetal and infant mortality review committees of the local healthy start coalitions, the local SIDS alliance, and other related support groups.

History.--s. 1, ch. 93-182; s. 673, ch. 95-148; s. 65, ch. 97-101; s. 30, ch. 97-237; s. 18, ch. 2002-404.

383.33625 Stephanie Saboor Grieving Parents Act; disposition of fetus; notification; forms developed.--

(1) This section shall be known by the popular name the "Stephanie Saboor Grieving Parents Act."

(2) A health care practitioner licensed pursuant to chapter 458, chapter 459, chapter 464, or chapter 467 having custody of fetal remains following a spontaneous fetal demise occurring after a gestation period of less than 20 completed weeks must notify the mother of her option to arrange for the burial or cremation of the fetal remains, as well as the procedures provided by general law. Notification may also include other options such as, but not limited to, a ceremony, a certificate, or common burial of the fetal remains.

(3) The Department of Health shall adopt rules to develop forms to be used for notifications and elections by the health care practitioner, and the health care practitioner shall provide the forms to the mother.

(4) A facility licensed pursuant to chapter 383 or chapter 395 having custody of fetal remains following a spontaneous fetal demise occurring after a gestation period of less than 20 completed weeks must notify the mother of her option to arrange for the burial or cremation of the fetal remains, as well as the procedures provided by general law. Notification may also include other options such as, but not limited to, a ceremony, a certificate, or common burial of the fetal remains.

(5) If the mother chooses the option of using the procedures provided by general law, the facility or health care practitioner in custody of fetal remains shall follow the procedures set forth in general law.

(6) The Agency for Health Care Administration shall adopt rules to develop forms to be used for notifications and elections by the facility, and the hospital shall provide the forms to the mother.

History.--s. 1, ch. 2003-52.

383.402 Child abuse death review; State Child Abuse Death Review Committee; local child abuse death review committees.--

(1) It is the intent of the Legislature to establish a statewide multidisciplinary, multiagency child abuse death assessment and prevention system that consists of state and local review committees. The state and local review committees shall review the facts and circumstances of all deaths of children from birth through age 18 which occur in this state as the result of verified child abuse or neglect. The purpose of the review shall be to:

(a) Achieve a greater understanding of the causes and contributing factors of deaths resulting from child abuse.

(b) Whenever possible, develop a communitywide approach to address such cases and contributing factors.

(c) Identify any gaps, deficiencies, or problems in the delivery of services to children and their families by public and private agencies which may be related to deaths that are the result of child abuse.

(d) Make and implement recommendations for changes in law, rules, and policies, as well as develop practice standards that support the safe and healthy development of children and reduce preventable child abuse deaths.

(2)(a) The State Child Abuse Death Review Committee is established within the Department of Health and shall consist of a representative of the Department of Health, appointed by the Secretary of Health, who shall serve as the state committee coordinator. The head of each of the following agencies or organizations shall also appoint a representative to the state committee:

1. The Department of Legal Affairs.
2. The Department of Children and Family Services.
3. The Department of Law Enforcement.

4. The Department of Education.
5. The Florida Prosecuting Attorneys Association, Inc.
6. The Florida Medical Examiners Commission, whose representative must be a forensic pathologist.

(b) In addition, the Secretary of Health shall appoint the following members to the state committee, based on recommendations from the Department of Health and the agencies listed in paragraph (a), and ensuring that the committee represents the regional, gender, and ethnic diversity of the state to the greatest extent possible:

1. A board-certified pediatrician.
2. A public health nurse.
3. A mental health professional who treats children or adolescents.
4. An employee of the Department of Children and Family Services who supervises family services counselors and who has at least 5 years of experience in child protective investigations.
5. The medical director of a child protection team.
6. A member of a child advocacy organization.
7. A social worker who has experience in working with victims and perpetrators of child abuse.
8. A person trained as a paraprofessional in patient resources who is employed in a child abuse prevention program.
9. A law enforcement officer who has at least 5 years of experience in children's issues.
10. A representative of the Florida Coalition Against Domestic Violence.
11. A representative from a private provider of programs on preventing child abuse and neglect.

(3) The State Child Abuse Death Review Committee shall:

(a) Develop a system for collecting data on deaths that are the result of child abuse. The system must include a protocol for the uniform collection of data statewide, which uses existing data-collection systems to the greatest extent possible.

(b) Provide training to cooperating agencies, individuals, and local child abuse death review committees on the use of the child abuse death data system.

(c) Prepare an annual statistical report on the incidence and causes of death resulting from child abuse in the state during the prior calendar year. The state committee shall submit a copy of the report by December 31 of each year to the Governor, the President of the Senate, and the Speaker of the House of Representatives. The report must include recommendations

for state and local action, including specific policy, procedural, regulatory, or statutory changes, and any other recommended preventive action.

- (d) Encourage and assist in developing the local child abuse death review committees.
 - (e) Develop guidelines, standards, and protocols, including a protocol for data collection, for local child abuse death review committees, and provide training and technical assistance to local committees.
 - (f) Develop guidelines for reviewing deaths that are the result of child abuse, including guidelines to be used by law enforcement agencies, prosecutors, medical examiners, health care practitioners, health care facilities, and social service agencies.
 - (g) Study the adequacy of laws, rules, training, and services to determine what changes are needed to decrease the incidence of child abuse deaths and develop strategies and recruit partners to implement these changes.
 - (h) Provide consultation on individual cases to local committees upon request.
 - (i) Educate the public regarding the provisions of chapter 99-168, Laws of Florida, the incidence and causes of child abuse death, and ways by which such deaths may be prevented.
 - (j) Promote continuing education for professionals who investigate, treat, and prevent child abuse or neglect.
 - (k) Recommend, when appropriate, the review of the death certificate of a child who died as a result of abuse or neglect.
- (4) The members of the state committee shall be appointed to staggered terms of office which may not exceed 2 years, as determined by the Secretary of Health. Members are eligible for reappointment. The state committee shall elect a chairperson from among its members to serve for a 2-year term, and the chairperson may appoint ad hoc committees as necessary to carry out the duties of the committee.
- (5) Members of the state committee shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
- (6) At the direction of the Secretary of Health, the director of each county health department, or the directors of two or more county health departments by agreement, may convene and support a county or multicounty child abuse death review committee in accordance with the protocols established by the State Child Abuse Death Review Committee. Each local committee must include a local state attorney, or his or her designee, and any other members that are determined by guidelines developed by the State Child Abuse Death Review Committee. The members of a local committee shall be appointed to 2-year terms and may be reappointed. The local committee shall elect a chairperson from among its members. Members shall serve without compensation but are entitled to reimbursement for per diem and travel expenses incurred in the performance of their duties as provided in s. 112.061 and to the extent that funds are available.
- (7) Each local child abuse death review committee shall:

(a) Assist the state committee in collecting data on deaths that are the result of child abuse, in accordance with the protocol established by the state committee.

(b) Submit written reports at the direction of the state committee. The reports must include nonidentifying information on individual cases and the steps taken by the local committee and private and public agencies to implement necessary changes and improve the coordination of services and reviews.

(c) Submit all records requested by the state committee at the conclusion of its review of a death resulting from child abuse.

(d) Abide by the standards and protocols developed by the state committee.

(e) On a case-by-case basis, request that the state committee review the data of a particular case.

(8) Notwithstanding any other law, the chairperson of the State Child Abuse Death Review Committee, or the chairperson of a local committee, shall be provided with access to any information or records that pertain to a child whose death is being reviewed by the committee and that are necessary for the committee to carry out its duties, including information or records that pertain to the child's family, as follows:

(a) Patient records in the possession of a public or private provider of medical, dental, or mental health care, including, but not limited to, a facility licensed under chapter 393, chapter 394, or chapter 395, or a health care practitioner as defined in s. 456.001. Providers may charge a fee for copies not to exceed 50 cents per page for paper records and \$1 per fiche for microfiche records.

(b) Information or records of any state agency or political subdivision which might assist a committee in reviewing a child's death, including, but not limited to, information or records of the Department of Children and Family Services, the Department of Health, the Department of Education, or the Department of Juvenile Justice.

(9) The State Child Abuse Death Review Committee or a local committee shall have access to all information of a law enforcement agency which is not the subject of an active investigation and which pertains to the review of the death of a child. A committee may not disclose any information that is not subject to public disclosure by the law enforcement agency, and active criminal intelligence information or criminal investigative information, as defined in s. 119.011(3), may not be made available for review or access under this section.

(10) The state committee and any local committee may share any relevant information that pertains to the review of the death of a child.

(11) A member of the state committee or a local committee may not contact, interview, or obtain information by request or subpoena directly from a member of a deceased child's family as part of a committee's review of a child abuse death, except that if a committee member is also a public officer or state employee, that member may contact, interview, or obtain information from a member of the deceased child's family, if necessary, as part of the committee's review. A member of the deceased child's family may voluntarily provide records or information to the state committee or a local committee.

(12) The chairperson of the State Child Abuse Death Review Committee may require the production of records by requesting a subpoena, through the Department of Legal Affairs, in

any county of the state. Such subpoena is effective throughout the state and may be served by any sheriff. Failure to obey the subpoena is punishable as provided by law.

(13) This section does not authorize the members of the state committee or any local committee to have access to any grand jury proceedings.

(14) A person who has attended a meeting of the state committee or a local committee or who has otherwise participated in activities authorized by this section may not be permitted or required to testify in any civil, criminal, or administrative proceeding as to any records or information produced or presented to a committee during meetings or other activities authorized by this section. However, this subsection does not prevent any person who testifies before the committee or who is a member of the committee from testifying as to matters otherwise within his or her knowledge. An organization, institution, committee member, or other person who furnishes information, data, reports, or records to the state committee or a local committee is not liable for damages to any person and is not subject to any other civil, criminal, or administrative recourse. This subsection does not apply to any person who admits to committing a crime.

(15) The Department of Health shall administer the funds appropriated to operate the review committees and may apply for grants and accept donations.

(16) To the extent that funds are available, the Department of Health may hire staff or consultants to assist a review committee in performing its duties. Funds may also be used to reimburse reasonable expenses of the staff and consultants for the state committee and the local committees.

(17) For the purpose of carrying out the responsibilities assigned to the State Child Abuse Death Review Committee and the local review committees, the Secretary of Health may substitute an existing entity whose function and organization include the function and organization of the committees established by this section.

(18) Each district administrator of the Department of Children and Family Services must appoint a child abuse death review coordinator for the district. The coordinator must have knowledge and expertise in the area of child abuse and neglect. The coordinator's general responsibilities include:

(a) Coordinating with the local child abuse death review committee.

(b) Ensuring the appropriate implementation of the child abuse death review process and all district activities related to the review of child abuse deaths.

(c) Working with the committee to ensure that the reviews are thorough and that all issues are appropriately addressed.

(d) Maintaining a system of logging child abuse deaths covered by this procedure and tracking cases during the child abuse death review process.

(e) Conducting or arranging for a Florida Abuse Hotline Information System (FAHIS) record check on all child abuse deaths covered by this procedure to determine whether there were any prior reports concerning the child or concerning any siblings, other children, or adults in the home.

(f) Coordinating child abuse death review activities, as needed, with individuals in the community and the Department of Health.

(g) Notifying the district administrator, the Secretary of Children and Family Services, the Deputy Secretary for Children's Medical Services, and the Department of Health Child Abuse Death Review Coordinator of all child abuse deaths meeting criteria for review as specified in this section within 1 working day after verifying the child's death was due to abuse, neglect, or abandonment.

(h) Ensuring that all critical issues identified by the local child abuse death review committee are brought to the attention of the district administrator and the Secretary of Children and Family Services.

(i) Providing technical assistance to the local child abuse death review committee during the review of any child abuse death.

History.--s. 13, ch. 99-168; s. 11, ch. 2000-160; s. 8, ch. 2000-217; s. 13, ch. 2001-53; s. 14, ch. 2004-350.

383.412 Public records and public meetings exemptions.--

(1)(a) Any information that reveals the identity of the surviving siblings, family members, or others living in the home of a deceased child who is the subject of review by, and which information is held by, the State Child Abuse Death Review Committee or local committee, or a panel or committee assembled by the state committee or a local committee pursuant to s. 383.402, is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(b) Information made confidential or exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution that is obtained by the State Child Abuse Death Review Committee or a local committee, or a panel or committee assembled by the state committee or a local committee pursuant to s. 383.402, shall retain its confidential or exempt status.

(2) Portions of meetings of the State Child Abuse Death Review Committee or local committee, or a panel or committee assembled by the state committee or a local committee pursuant to s. 383.402, at which information made confidential and exempt pursuant to subsection (1) is discussed are exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(3) The State Child Abuse Death Review Committee and local committees may share with each other any relevant information regarding case reviews involving child death, which information is made confidential and exempt by this section.

(4) Any person who knowingly or willfully makes public or discloses to any unauthorized person any information made confidential and exempt under this section commits a misdemeanor of the first degree, punishable as provided in s. 775.082 or s. 775.083.

(5) This section is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2010, unless reviewed and saved from repeal through reenactment by the Legislature.

History.--s. 1, ch. 2005-190.

383.50 Treatment of abandoned newborn infant.--

(1) As used in this section, the term "newborn infant" means a child that a licensed physician reasonably believes to be approximately 3 days old or younger at the time the child is left at a hospital, emergency medical services station, or fire station.

(2) There is a presumption that the parent who leaves the newborn infant in accordance with this section intended to leave the newborn infant and consented to termination of parental rights.

(3) Each emergency medical services station or fire station staffed with full-time firefighters, emergency medical technicians, or paramedics shall accept any newborn infant left with a firefighter, emergency medical technician, or paramedic. The firefighter, emergency medical technician, or paramedic shall consider these actions as implied consent to and shall:

(a) Provide emergency medical services to the newborn infant to the extent he or she is trained to provide those services, and

(b) Arrange for the immediate transportation of the newborn infant to the nearest hospital having emergency services.

A licensee as defined in s. 401.23, a fire department, or an employee or agent of a licensee or fire department may treat and transport a newborn infant pursuant to this section. If a newborn infant is placed in the physical custody of an employee or agent of a licensee or fire department, such placement shall be considered implied consent for treatment and transport. A licensee, a fire department, or an employee or agent of a licensee or fire department is immune from criminal or civil liability for acting in good faith pursuant to this section. Nothing in this subsection limits liability for negligence.

(4) Each hospital of this state subject to s. 395.1041 shall, and any other hospital may, admit and provide all necessary emergency services and care, as defined in s. 395.002(10), to any newborn infant left with the hospital in accordance with this section. The hospital or any of its licensed health care professionals shall consider these actions as implied consent for treatment, and a hospital accepting physical custody of a newborn infant has implied consent to perform all necessary emergency services and care. The hospital or any of its licensed health care professionals is immune from criminal or civil liability for acting in good faith in accordance with this section. Nothing in this subsection limits liability for negligence.

(5) Except where there is actual or suspected child abuse or neglect, any parent who leaves a newborn infant with a firefighter, emergency medical technician, or paramedic at a fire station or emergency medical services station, or brings a newborn infant to an emergency room of a hospital and expresses an intent to leave the newborn infant and not return, has the absolute right to remain anonymous and to leave at any time and may not be pursued or followed unless the parent seeks to reclaim the newborn infant.

(6) A parent of a newborn infant left at a hospital, emergency medical services station, or fire station under this section may claim his or her newborn infant up until the court enters a judgment terminating his or her parental rights. A claim to the newborn infant must be made to the entity having physical or legal custody of the newborn infant or to the circuit court before whom proceedings involving the newborn infant are pending.

(7) Upon admitting a newborn infant under this section, the hospital shall immediately contact a local licensed child-placing agency or alternatively contact the statewide central abuse

hotline for the name of a licensed child-placing agency for purposes of transferring physical custody of the newborn infant. The hospital shall notify the licensed child-placing agency that a newborn infant has been left with the hospital and approximately when the licensed child-placing agency can take physical custody of the child. In cases where there is actual or suspected child abuse or neglect, the hospital or any of its licensed health care professionals shall report the actual or suspected child abuse or neglect in accordance with ss. 39.201 and 395.1023 in lieu of contacting a licensed child-placing agency.

(8) Any newborn infant admitted to a hospital in accordance with this section is presumed eligible for coverage under Medicaid, subject to federal rules.

(9) A newborn infant left at a hospital, emergency medical services station, or fire station in accordance with this section shall not be deemed abandoned and subject to reporting and investigation requirements under s. 39.201 unless there is actual or suspected child abuse or until the department takes physical custody of the child.

(10) A criminal investigation shall not be initiated solely because a newborn infant is left at a hospital under this section unless there is actual or suspected child abuse or neglect.

History.--s. 1, ch. 2000-188; s. 15, ch. 2001-53; s. 23, ch. 2001-62.

383.51 Confidentiality; identification of parent leaving newborn infant at hospital, emergency medical services station, or fire station.--The identity of a parent who leaves a newborn infant at a hospital, emergency medical services station, or fire station in accordance with s. 383.50 is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution. The identity of a parent leaving a child shall be disclosed to a person claiming to be a parent of the newborn infant. This section is subject to the Open Government Sunset Review Act of 1995 in accordance with s. 119.15, and shall stand repealed on October 2, 2007, unless reviewed and saved from repeal through reenactment by the Legislature.

History.--s. 1, ch. 2000-213; s. 1, ch. 2002-30.