The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

HEALTH POLICY
Senator Bean, Chair
Senator Sobel, Vice Chair

MEETING DATE: Tuesday, February 16, 2016
TIME: 1:30—3:30 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Bean, Chair; Senator Sobel, Vice Chair; Senators Braynon, Flores, Gaetz, Galvano, Garcia, Grimsley, and Joyner

TAB	OFFICE and APPOINTMENT (HOME CITY)	FOR TERM ENDING	COMMITTEE ACTION
	Senate Confirmation Hearing: A public hearing will be held for consideration of the below-named executive appointment to the office indicated.		
	State Surgeon General		
1	Armstrong, John H. (Ocala)	Pleasure of Governor	Recommend Confirm Yeas 5 Nays 4

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
2	**CS/SB 706** Regulated Industries / Altman (Similar H 223, CS/CS/H 249)	Culinary Education Programs; Providing for the applicability of Department of Health sanitation rules to a licensed culinary education program; authorizing a culinary education program with a public food service establishment license to obtain an alcoholic beverage license under certain conditions; authorizing the Division of Alcoholic Beverages and Tobacco to adopt rules to administer such licenses, etc. RI 02/09/2016 Fav/CS HP 02/16/2016 Favorable FP	Favorable Yeas 9 Nays 0
3	**CS/SB 974** Fiscal Policy / Sobel (Similar H 1217)	Hair Restoration or Transplant; Defining the term "hair restoration or transplant"; prohibiting a person who is not licensed or is not certified under specified provisions from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant; providing an exception, etc. HP 01/11/2016 Favorable AHS 01/21/2016 AHS 01/26/2016 Favorable FP 02/04/2016 Fav/CS HP 02/16/2016 Fav/CS	Fav/CS Yeas 9 Nays 0

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
4	**SB 1306** Grimsley (Identical H 1063, Compare H 1061, Linked S 1316)	Public Records and Meetings/Nurse Licensure Compact; Providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity, etc. HP 02/09/2016 Temporarily Postponed HP 02/16/2016 Fav/CS GO RC	Fav/CS Yeas 9 Nays 0
5	**SB 1286** Gibson (Similar H 1261)	Diabetes Educator Practice; Creating part XVII of ch. 468, F.S., entitled “Diabetes Educators Practice”; prohibiting a person from engaging in diabetes education or diabetes self-management education or training unless he or she holds a certain license; specifying that the Dietetics and Nutrition Practice Council, under the supervision of the Board of Medicine, is responsible for licensing, monitoring, and disciplining diabetes educators, etc. HP 02/16/2016 Temporarily Postponed AHS AP	Temporarily Postponed
6	**SB 1626** Hutson (Similar H 1277)	Licensure of Foreign-trained Physicians; Establishing licensure requirements for certain foreign-trained physicians; authorizing the Board of Medicine to impose licensure restrictions, limitations, or conditions on certain foreign-trained physicians, etc. HP 02/16/2016 Temporarily Postponed AHS FP	Temporarily Postponed
7	**Workshop** - Discussion and testimony only on the following (no vote to be taken): **Statewide Medicaid Managed Care Pharmacy Networks**		Discussed
	Other Related Meeting Documents		

RICK SCOTT
GOVERNOR

May 4, 2015

Secretary Kenneth W. Detzner
Department of State
State of Florida
R. A. Gray Building, Room 316
500 South Bronough Street
Tallahassee, Florida 32399-0250

Dear Secretary Detzner:

Please be advised I have made the following reappointment under the provisions of Section 20.43, Florida Statutes:

Dr. John H. Armstrong

As State Surgeon General and Secretary of the Department of Health, subject to confirmation by the Senate. This appointment is effective May 4, 2015, for a term ending at the pleasure of the Governor.

Sincerely,

Rick Scott
Governor

RS/vh

THE CAPITOL
TALLAHASSEE, FLORIDA 32399 • (850) 488-2272

OATH OF OFFICE

(Art. II. § 5(b), Fla. Const.)

RECEIVED
DEPARTMENT OF STATE
2015 JUL -9 AM 10:12
DIVISION OF ELECTIONS
TALLAHASSEE, FL

STATE OF FLORIDA

County of Leon

I do solemnly swear (or affirm) that I will support, protect, and defend the Constitution and Government of the United States and of the State of Florida; that I am duly qualified to hold office under the Constitution of the State, and that I will well and faithfully perform the duties of

STATE SURGEON GENERAL & SECRETARY OF HEALTH
(Title of Office)

on which I am now about to enter, so help me God.

[NOTE: If you affirm, you may omit the words "so help me God." *See* § 92.52, Fla. Stat.]

John H. Armstrong MD, FACS
Signature

Sworn to and subscribed before me this 30 *day of* June, 2015.

Margaret H Medina
Signature of Officer Administering Oath or of Notary Public

Margaret Harvard Medina
Print, Type, or Stamp Commissioned Name of Notary Public

MARGARET HARVARD MEDINA
Commission # FF 008844
Expires April 23, 2017
Bonded Thru Troy Fain Insurance 800-385-7019

Personally Known ☑ ***OR*** *Produced Identification* ☐

Type of Identification Produced _____

ACCEPTANCE

I accept the office listed in the above Oath of Office.

Mailing Address: ☑ Home ☐ Office

_____
Street or Post Office Box

_____
City, State, Zip Code

JOHN H. ARMSTRONG, MD, FACS
Print name as you desire commission issued

John H Armstrong MD, FACS
Signature

DS-DE 56 (Rev. 02/10)

CERTIFICATION

STATE OF FLORIDA
COUNTY OF Leon

Before me, the undersigned Notary Public of Florida, personally appeared JOHN H. ARMSTRONG, MD, who, after being duty sworn, say: (1) that he/she has carefully and personally prepared or read the answers to the foregoing questions; (2) that the information contained in said answers is complete and true; and (3) that he/she will, as an appointee, fully support the Constitutions of the United States and of the State of Florida.

John H. Armstrong MD
Signature of Applicant-Affiant

Sworn to and subscribed before me this 29 day of July, 2015.

Margaret H Medina
Signature of Notary Public-State of Florida

MARGARET HARVARD MEDINA
Commission # FF 008844
Expires April 23, 2017
Bonded Thru Troy Fain Insurance 800-385-7019

Margaret Harvard Medina
(Print, Type, or Stamp Commissioned Name of Notary Public)

My commission expires: April 23, 2017

Personally Known ☑ **OR** Produced Identification ☐

Type of Identification Produced _____

(seal)

The Florida Senate

Committee Notice Of Hearing

IN THE FLORIDA SENATE
TALLAHASSEE, FLORIDA

IN RE: Executive Appointment of

John H. Armstrong

State Surgeon General

NOTICE OF HEARING

TO: Dr. John H. Armstrong

YOU ARE HEREBY NOTIFIED that the Committee on Health Policy of the Florida Senate will conduct a hearing on your executive appointment on Tuesday, February 16, 2016, in the Pat Thomas Committee Room, 412 Knott Building, commencing at 1:30 p.m., pursuant to Rule 12.7(1) of the Rules of the Florida Senate.

Please be present at the time of the hearing.
DATED this the 11th day of February, 2016

Committee on Health Policy

Aaron Bean

Senator Aaron Bean
As Chair and by authority of the committee

cc: Members, Committee on Health Policy
Office of the Sergeant at Arms

THE FLORIDA SENATE

COMMITTEE WITNESS OATH

CHAIR:

Please raise your right hand and be sworn in as a witness.

Do you swear or affirm that the evidence you are about to give will be the truth, the whole truth, and nothing but the truth?

WITNESS'S NAME: John Armstrong

ANSWER: I do

Pursuant to §90.605(1), *Florida Statutes*: "The witness's answer shall be noted in the record."

COMMITTEE NAME: Health Policy

DATE: 2/16/2016

The Florida Senate

COMMITTEE RECOMMENDATION ON EXECUTIVE APPOINTMENT

COMMITTEE: Committee on Health Policy
MEETING DATE: Tuesday, February 16, 2016
TIME: 1:30—3:30 p.m.
PLACE: Pat Thomas Committee Room, 412 Knott Building

TO: The Honorable Andy Gardiner, President

FROM: Committee on Health Policy

The committee was referred the following executive appointment subject to confirmation by the Senate:

Office: State Surgeon General

Appointee: Armstrong, John H.

Term: 5/4/2015-Pleasure of Governor

After inquiry and due consideration, the committee recommends that the Senate **confirm** the aforesaid executive appointment made by the Governor.

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic Surgeon Gen. Confirmation

Amendment Barcode (if applicable)

Name Brian Charpiat

Job Title Customer Support specialist

Address 11320 Renne Dr.
Street

Phone 904-553-3014

Jacksonville, FL 32218
City *State* *Zip*

Email bwcharpiat@aol.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☒ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Surgeon General Confirmation

Name Courtney Charpiat

Job Title Child who is deaf

Address 11320 Renne Drive
Street

Phone 904-210-8478

Jacksonville FL 32218
City *State* *Zip*

Email ally44@hotmail.com

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic Surgeon General Confirmation

Amendment Barcode (if applicable)

Name Debbie Charpiat

Job Title Project Specialist

Address 11320 Renne Drive
Street

Phone 904-210-8478

Jacksonville FL 32218
City *State* *Zip*

Email ally44@hotmail.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing Self

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic Surgeon General Confirmation

Amendment Barcode (if applicable)

Name Theresa Bulger

Job Title Lobbyist

Address 2531 Hayden
Street

Tallahassee FL
City *State* *Zip*

Phone 904 880 9065

Email bulger12@yahoo.com

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing (1) Florida Families, (2) FL. Association of Audiologists, (3) Clarke School

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic John H. Armstrong

Amendment Barcode (if applicable)

Name Win Adams, CSA

Job Title

Address 646 Fellowship Dr.
Street

Phone 407-310-1110 (c)

Fern Park FL 32730
City *State* *Zip*

Email ws898@earthlink.net

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Former FL Board of Pharmacy member

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

2-16-2016
1:30
412-K

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the ~~Senator or Senate Professional Staff conducting~~ the meeting)

2-16-2016
Meeting Date

WAIVE IN SUPPORT

Bill Number (if applicable)

Topic CONFORMATION OF JOHN ARMSTRONG, MD

Amendment Barcode (if applicable)

Name STEPHEN R. WINN

Job Title EXECUTIVE DIRECTOR

Address 2544 BLAIRSTONE PINES DRIVE
Street

Phone 878-7364

TALLAHASSEE FL 32301
City *State* *Zip*

Email

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [X] In Support [ ] Against
(The Chair will read this information into the record.)

Representing FLORIDA OSTEOPATHIC MEDICAL ASSOCIATION

Appearing at request of Chair: [ ] Yes [ ] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic Confirmation of Dr. Armstrong

Amendment Barcode (if applicable)

Name Mary Thomas

Job Title Assistant General Counsel

Address 1430 Piedmont Dr E
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850 224 1044 96

Email MThomas@flmedical.org

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Medical Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic Surgeon General Confirmation

Amendment Barcode (if applicable)

Name Chris Nuland

Job Title

Address 1000 Riverside Avenue
Street
Jacksonville, FL 32204
City *State* *Zip*

Phone 904-233-3051

Email nulandlaweaol.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☑ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Public Health Association

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2-16-16 (Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Bill Number (if applicable)

Amendment Barcode (if applicable)

Topic Surgeon General Confirmation

Name David W. Poole

Job Title Director, Legislative Affairs

Address 1825 County Club Dr.
Street

Tallahassee FL 32301
City *State* *Zip*

Phone 850-766-3323

Email david.poole@aidshealth.org

Speaking: [X] For [ ] Against [ ] Information

Waive Speaking: [ ] In Support [ ] Against
(The Chair will read this information into the record.)

Representing AIDS Healthcare Foundation

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [X] Yes [ ] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic SURGEON GENERAL CONFIRMATION

Amendment Barcode (if applicable)

Name LOUIS ST. PETERY

Job Title PEDIATRICIAN

Address 1132 LEE AVE
Street

TALLAHASSEE FL 32303
City *State* *Zip*

Phone 850-294-4309

Email LSPETERY@GMAIL.COM

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing SELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1.16.16
Meeting Date

N/A
Bill Number (if applicable)

Topic SURGEON GENERAL CONFIRMATION

Amendment Barcode (if applicable)

Name CARLOS GUILLERMO SMITH

Job Title GOVERNMENT AFFAIRS MANAGER

Address 2237 STONINGTON AVE
Street

Phone 404.934.4944

ORLANDO FL 32817
City *State* *Zip*

Email

Speaking: ☐ For ☑ Against ☐ Information

Waive Speaking: ☐ In Support ☑ Against
(The Chair will read this information into the record.)

Representing EQUALITY FLORIDA

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

Bill Number (if applicable)

Topic ~~Consideration~~ SG Confirmation Hearing

Amendment Barcode (if applicable)

Name Tazia Staggs

Job Title physician

Address 7905 E Okara Rd
Street

Phone 9134699282

Tampa FL 33612
City *State* *Zip*

Email tazia.staggs@gmail.com

Speaking: ☐ For ☒ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

COMMITTEE VOTE RECORD – EXECUTIVE APPOINTMENT

COMMITTEE: Health Policy
NAME: Armstrong, John H.
BOARD: State Surgeon General
FINAL ACTION: Recommend Confirm
MEETING DATE: Tuesday, February 16, 2016
TIME: 1:30—3:30 p.m.
PLACE: 412 Knott Building

FINAL VOTE			2/16/2016 1 Motion to Recommend Confirm Grimsley		2/16/2016 2 Motion to Vote Time Certain at 3:27 p.m. Galvano			
Yea	**Nay**	**SENATORS**	**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**
	X	Braynon						
	X	Flores						
X		Gaetz						
X		Galvano						
X		Garcia						
X		Grimsley						
	X	Joyner						
	X	Sobel, VICE CHAIR						
X		Bean, CHAIR						
5	4	**TOTALS**	FAV	-	FAV	-		
Yea	**Nay**		**Yea**	**Nay**	**Yea**	**Nay**	**Yea**	**Nay**

CODES: FAV=Favorable
UNF=Unfavorable
-R=Reconsidered
TP=Temporarily Postponed
VA=Vote After Roll Call
VC=Vote Change After Roll Call
WD=Withdrawn
OO=Out of Order
AV=Abstain from Voting

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/SB 706
INTRODUCER:	Regulated Industries Committee and Senator Altman
SUBJECT:	Culinary Education Programs
DATE:	February 12, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Oxamendi	Caldwell	RI	**Fav/CS**
2.	Lloyd	Stovall	HP	**Favorable**
3.			FP	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 706 permits certain culinary education programs to qualify for an alcoholic beverages license for the sale of beer, wine, and distilled spirits (alcoholic beverages). The Department of Business and Professional Regulation (DBPR) regulates public food service establishments through its Division of Hotels and Restaurants and the sale and service of alcoholic beverages through its Division of Alcoholic Beverages and Tobacco (DABT).

The bill subjects culinary education programs licensed or permitted as food service establishments under ch. 509, F.S., to the sanitation rules of the Department of Health (DOH).

The bill defines a culinary education program to mean a program that educates enrolled students in the culinary arts, including preparation, cooking, and presentation of food, or a program that provides education and experience in culinary arts-related businesses. A culinary education program must be inspected by a state agency for compliance with sanitation standards. The culinary education program must be provided by a:

- State university;
- Florida college system institution;
- Career center;
- Charter technical career center;
- Nonprofit independent college or university that is located and chartered in this state, meets certain accreditation requirements, and is eligible to participate in the William L. Boyd, IV, Florida Resident Access Grant Program; or

- Nonpublic postsecondary educational institution.

The bill creates a special alcoholic beverages license for culinary education programs. The bill permits a culinary education program to qualify for a public food service license issued by the Division of Hotels and Restaurants in order for the program to also qualify for an alcoholic beverage license. The program would remain subject to the sanitation rules established by the DOH.

The bill explicitly provides that the special license does not authorize the culinary education program to conduct any activities that would violate alcoholic beverages laws, including certain age restrictions, or local law. A culinary education program with a special license may not sell alcoholic beverages by the package for off-premise consumption.

The bill provides an effective date of July 1, 2016.

II. Present Situation:

Florida's Beverage Law

Florida's Beverage Law regulates alcoholic beverages.[1] The Division of Alcoholic Beverages and Tobacco, within the Department of Business the Professional Regulation, is responsible for the regulation of the manufacture, packaging, distribution, and sale of alcoholic beverages within the state.[2]

The term "alcoholic beverages" is defined in s. 561.01(4)(a), F.S., to mean distilled spirits and all beverages containing one-half of 1 percent or more alcohol by volume and that the percentage of alcohol by volume is determined by comparing the volume of ethyl alcohol with all other ingredients in the beverage.

The terms "intoxicating beverage" and "intoxicating liquor" are defined in s. 561.01(5), F.S., to mean only those alcoholic beverages containing more than 4.007 percent of alcohol by volume.

Liquor and distilled spirits are regulated by ch. 565, F.S. The terms "liquor," "distilled spirits," "spirituous liquors," "spirituous beverages," or "distilled spirituous liquors," are defined by s. 565.01, F.S., to mean that substance known as ethyl alcohol, ethanol, or spirits of wine in any form, including all dilutions and mixtures thereof from whatever source or by whatever process produced.

Section 561.20, F.S., limits the number of alcoholic beverage licenses that permit the sale of beer, wine, and distilled spirits that may be issued per county. The number of licenses is limited to one license per 7,500 residents within the county. These limited alcoholic beverage licenses are known as "quota" licenses. New quota licenses are created and issued when there is an increase in the population of a county. The licenses can also be issued when a county initially changes from a county which does not permit the sale of intoxicating liquors to one that does permit their sale. The quota license is the only type of alcoholic beverage license that is limited

[1] Chapters 561-565 and 567-568, F.S., comprise Florida's Beverage Law
[2] Section 561.02, F.S.

in number. Due to the limitation on the number of quota licenses that may be issued, a prospective applicant must either purchase an existing license or enter a drawing to win the right to apply for a newly authorized quota license.[3]

Section 561.20(2), F.S., provides several exceptions to the number of licenses that permit the sale of beer, wine, and distilled spirits.[4] Quota license exceptions are known as "special licenses."

The annual fee for a quota license for the consumption of alcoholic beverages on the premises will vary based on county population but ranges from $624 to $1,820.[5] However, at the initial issuance of a new license, the licensee must pay a one-time fee of $10,750.[6] For the purchase and transfer of an existing license, a licensee must pay a transfer fee (not to exceed $5,000). The cost of purchasing an existing license is determined by the market condition for quota licenses.[7]

Quota License Exception for Caterers

The limitation on the number of licenses per county does not apply to a caterer licensed by the Division of Hotels and Restaurants under ch. 509, F.S., who derives at least 51 percent of its gross revenue from the sale of food and nonalcoholic beverages, and sells or serves alcoholic beverages only for consumption on the premises of a catered event at which the licensee is also providing prepared food.[8]

A qualified, licensed caterer's annual fee is $1,820 for a license to sell or serve beer, wine and distilled spirits, on the premises of events at which the caterer is also providing prepared food.[9]

Food Safety Programs

Three state agencies operate food safety programs in Florida: the Department of Agriculture and Consumer Services (DACS), the DBPR, and the DOH. The three agencies carry out similar regulatory activities, regulate separate sectors of the food service industry, and are funded at different levels because of statutory fee caps.[10] Each agency issues food establishment licenses or

[3] Florida Dep't of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco, *Frequently Asked Questions, Licensing-related* http://www.myfloridalicense.com/dbpr/abt/documents/abt_frequently_asked_questions_001.pdf (last visited Feb. 11, 2016).
[4] Section 561.20(2), F.S., also provides special licenses for hotels and motels, condominiums licensed under ch. 509, F.S., restaurants that derive at least 51 percent of gross profits from the sale of food and nonalcoholic beverages; and specialty centers built on government-owned land, bowling establishments, and airports.
[5] *See* s. 565.02(1), F.S.
[6] Section 561.19(5), F.S.
[7] Florida Dep't of Business and Professional Regulation, Division of Alcoholic Beverages and Tobacco, *Frequently Asked Questions*, http://www.myfloridalicense.com/dbpr/abt/documents/abt_frequently_asked_questions_001.pdf (last visited Feb. 11, 2016).
[8] Section 561.20(2)(a)5., F.S.
[9] *See* ss. 561.20(2)(a)5 and 565.02(1)(b), F.S.
[10] Office of Program Policy Analysis and Gov't Accountability, *State Food Safety Programs Should Improve Performance and Financial Self-Sufficiency*, Report No. 08-67 (Dec. 2008), http://www.oppaga.state.fl.us/reports/pdf/0867rpt.pdf (last visited Feb. 11, 2016).

permits, conducts food safety and sanitation inspections, and enforces regulations through fines and other disciplinary actions.[11]

Each agency has authority over specific types of food establishments. In general, the DACS regulates grocery stores, supermarkets, bakeries, and convenience stores that offer food service, the DBPR regulates restaurants and caterers, and the DOH regulates facilities that serve high-risk populations such as hospitals, nursing homes, residential care facilities, and schools.[12] While these agencies do not perform duplicate inspections, a single establishment with multiple food operations could be licensed or have food permits from multiple departments.[13]

Public Food Service Establishments

The Division of Hotels and Restaurants is the state entity charged with enforcing the provisions of part I of ch. 509, F.S., and all other applicable laws relating to the inspection and regulation of public food service establishments for the purpose of protecting the public health, safety, and welfare.

The Division of Hotels and Restaurants inspects and licenses public food service establishments, defined in s. 509.013(5)(a), F.S., to mean:

> any building, vehicle, place, or structure, or any room or division in a building, vehicle, place, or structure where food is prepared, served, or sold for immediate consumption on or in the vicinity of the premises; called for or taken out by customers; or prepared prior to being delivered to another location for consumption.[14]

There are several exclusions from the definition of public food service establishment, including:[15]

- Any place maintained and operated by a public or private school, college, or university for the use of students and faculty or temporarily to serve events such as fairs, carnivals, and athletic contests.
- Any eating place maintained and operated by a church or a religious, nonprofit fraternal, or nonprofit civic organization for the use of members and associates or temporarily to serve events such as fairs, carnivals, or athletic contests.
- Any eating place located on an airplane, train, bus, or watercraft which is a common carrier.
- Any eating place maintained by a facility certified or licensed and regulated by the Agency for Health Care Administration (AHCA), the Department of Children and Families (DCF), or other similar place regulated under s. 381.0072, F.S.
- Any place of business issued a permit or inspected by the DACS under s. 500.12, F.S.

---

[11] *Id.*
[12] Office of Program Policy Analysis and Gov't Accountability, *State's Food Safety Programs Have Improved Performance and Financial Self-Sufficiency*, Report No. 10-44 (June 2010), *available at* http://www.oppaga.state.fl.us/MonitorDocs/Reports/pdf/1044rpt.pdf (last visited Feb. 11, 2016).
[13] *Supra* note 10.
[14] Section 509.013(5)(a), F.S.
[15] Section 509.013(5)(b), F.S.

- Any place of business where the food available for consumption is limited to ice, beverages, popcorn, or other prepackaged food.
- Any theater, if the primary use is as a theater and if patron service is limited to food items customarily served to the admittees of theaters.
- Any vending machine that dispenses any food or beverages other than potentially hazardous foods.
- Any research and development test kitchen limited to the use of employees and not open to the general public.

The exemption for places regulated under s. 381.0072, F.S., applies to "food service establishments" licensed and regulated by the DOH. The term "food service establishment" includes various types of facilities, including public or private schools, adult day care centers, short-term residential treatment centers, residential treatment facilities, homes for special services, and intermediate care facilities for persons with developmental disabilities.[16]

Department of Agriculture and Consumer Services - Florida Food Safety Act

Under the Florida Food Safety Act (Food Safety Act),[17] the DACS is charged with administering and enforcing the provisions of the Food Safety Act in order to prevent fraud, harm, adulteration, misbranding, or false advertising in the preparation, manufacture, or sale of articles of food. It is further charged with the regulation of the production, manufacture, transportation, and sale of food, as well as articles entering into, and intended for use as ingredients in the preparation of food.[18]

An individual seeking to operate a food establishment or retail food store must first obtain a food permit from the DACS.[19] Prior to the issuance of a permit, the DACS performs an inspection of the food establishment, its equipment, and the methods of operation for compliance with the Food Safety Act. Section 500.03(1)(p), F.S., defines "food establishment" as a factory, food outlet, or other facility manufacturing, processing, packing, holding, or preparing food or selling food at wholesale or retail. The term does not include business or activity regulated under s. 413.051, F.S., s. 500.80, F.S., ch. 509, F.S., or ch. 601, F.S.[20]

Department of Health Food Service Protections

The DOH has been charged with protecting the public from food borne illness for locations that are not licensed under ch. 500, F.S., by the DACS or ch. 509, F.S., by the Division of Hotels and restaurants.[21] The DOH's authority includes developing and enforcing standards and requirements for the storage, preparation, serving, and display of food in food service establishments as defined in s. 381.0072(2)(c), F.S.

[16] *See* s. 381.0072(1)(b), F.S.
[17] *See* ch. 500, F.S
[18] Section 500.032, F.S.
[19] Section 500.12(1), F.S.
[20] This exemption applies to vending stands operated by eligible blind persons, cottage food operations, lodging and food service establishments, and citrus facilities.
[21] Section 381.0072(1), F.S.

The DOH utilizes a risk-based inspection program to conduct more frequent inspections of facilities posing a greater risk to the public becoming sick from the consumption of their product.[22] The inspections are performed by the environmental health sections of the local county health departments.

Culinary Education Programs

The Commission for Independent Education (commission) monitors the activities of each licensed school, college, and university in Florida. The commission reviews each institution's degree and non-degree granting programs as part of its license granting or annual license renewal process. [23] Curriculum, enrollment, program offerings, and institutional policies are reviewed as part of that process.

Culinary education programs fall within the Hospitality and Tourism Career curriculum under the DOE's Career and Technical Education programs. The curriculum offers students hands-on educational opportunities in a variety of trades and programs throughout the state in school districts, community colleges, and state universities.[24] The DOE divides the cluster into four pathways:

- Restaurant and Food/Beverage Services;
- Lodging;
- Travel and tourism; and
- Recreation, amusement and attractions.[25]

Currently, there are no stand-alone culinary education programs approved in the State University System.[26] In the university system, culinary arts education and experience is provided through hospitality administration/management, restaurant/food services management, and resort management classes. For example, a hospitality major at Florida State University is a limited access major in the university's College of Business with pre-requisite courses in macroeconomics, accounting, and marketing. Students will take courses in law, food and beverage management, leadership and ethics, catering management, resort operations, beverages (alcoholic and non-alcoholic), event, and convention management. Hospitality majors also complete 1,000 hours of work experience in the hospitality industry as part of their credit hours.[27]

---

[22] Florida Dep't of Health, *Food Safety and Sanitation*, http://www.floridahealth.gov/Environmental-Health/food-safety-and-sanitation/index.html (last visited Feb. 1, 2016).
[23] Commission on Independent Education, *2014-15 Annual Report*, http://www.fldoe.org/core/fileparse.php/7748/urlt/CIE-Annual-Report-2014-2015.pdf (last visited Feb. 11, 2016).
[24] Fla. Dept. of Education, *Career & Technical Education - Hospitality & Tourism*, http://www.fldoe.org/academics/career-adult-edu/career-tech-edu/hospitality-tourism.stml (last visited Feb. 11, 2016).
[25] *Id.*
[26] State University System of Florida, Board of Governors, *Senate Bill 706 Analysis*, p. 1 (Nov. 10, 2015) (on file with the Senate Committee on Health Policy).
[27] Fla. State University, Dedman School of Hospitality, *B.S. Degree in Hospitality Mgmt., Requirements for the Hospitality Management Major* (2015-2016) http://business.fsu.edu/docs/default-source/cob/Department-Docs/undergraduate-programs/hospitality2015-2016.pdf?sfvrsn=2 (last visited Feb. 11, 2016).

III. Effect of Proposed Changes:

Department of Health Food Service Protections

The bill amends s. 381.0072(1), F.S., to provide that a food service establishment that is a culinary education program licensed under ch. 509, F.S., is subject to the sanitation rules of the DOH.

Culinary Education Programs

The bill amends. s. 381.0072(2), F.S., to define the term "culinary education program" as a program that educates enrolled students in the culinary arts, including the preparation, cooking, and presentation of food, or provides education and experience in culinary arts-related businesses. A culinary education program must be inspected by a state agency for compliance with sanitation standards. The culinary education program must be provided by a:

- State university as defined in s. 1000.21, F.S.;[28]
- Florida College System institution as defined in s. 1000.21, F.S.;[29]
- Career center, as defined in s. 1001.44, F.S.;[30]
- Charter technical career center, as defined in s. 1002.34, F.S.;[31]
- Nonprofit independent college or university that is located and chartered in this state and accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to grant baccalaureate degrees, that is under the jurisdiction of the Department of Education and that is eligible to participate in the William L. Boyd, IV, Florida Resident Access Grant Program;[32] or
- Nonpublic postsecondary educational institution licensed pursuant to part III of ch. 1005, F.S.[33]

Culinary education programs located in secondary schools are not included in this definition.[34]

---

[28] Pursuant to s. 1000.21(6), F.S., "state university" refers to the 12 state universities and any branch campuses, centers, or other affiliates of the institutions.

[29] Pursuant to s. 1000.21(3), F.S., "Florida College System institution" refers to the 28 state colleges and any branch campuses, centers, or other affiliates of the institutions.

[30] Section 1001.44, F.S., defines a career center as an educational institution offering terminal courses of a technical nature and courses for out-of-school youth and adults, and is subject to the state's education code and the control of the district school board of the school district in which it is located.

[31] Section 1002.34(3)(a), F.S., defines a charter technical career center as a public school or a pubic technical center operated under a charter granted by a district school board or Florida College System institution board of trustees or a consortium, including one or more district school boards and Florida College System institution boards of trustees, that includes the district in which the facility is located, that is nonsectarian in it programs, admission policies, employment practices, and operations, and is managed by a board of directors.

[32] The William L. Boyd, IV, Florida Resident Access Grant Program provides tuition assistance to Florida undergraduate students attending an eligible independent, non-profit college or university located in Florida. *See* s. 1009.89, F.S.

[33] Pursuant to s. 1005.02(11), F.S., a nonpublic postsecondary educational institution means any postsecondary educational institution that operates in this state or makes application to operate in this state, and is not provided, operated, or supported by the State of Florida, is political subdivisions, or the federal government.

[34] The term "secondary school" generally refers to a high school or similar institution providing instruction for students between elementary school and college and usually offering general, technical, vocational, or college-preparatory courses. *See* http://www.merriam-webster.com/dictionary/secondary%20school (last visited Jan. 25, 2016).

The bill amends s. 381.0072(2) (c), F.S., to provide that the term "food service establishment" includes a culinary education program where food is prepared and intended for individual portion service, regardless of the whether there is a charge for the food or whether the program is inspected by another state agency with compliance standards.

Chapter 509, F.S., Public Food Service Establishments

The bill amends s. 509.013(5)(a), F.S., to provide that the term "public food service establishments," which are regulated by the Division of Hotels and Restaurants, includes a culinary education program that offers, prepares, serves, or sells food to the general public, regardless of whether it is inspected by another agency.

Alcoholic Beverage License for Caterers

The bill amends s. 561.20(2)(a)5., F.S., to exempt a licensed culinary education program from the requirement that a caterer licensed to sell alcoholic beverages must derive at least 51 percent of its gross profits from the sale of food and nonalcoholic beverages.

The bill also creates s. 561.20(2)(a)6., F.S., to create a quota license exception for a culinary education program, as defined in s. 381.0072(2), F.S., which is licensed as a public food service establishment by the Division of Hotels and Restaurants.

This special license permits a licensed culinary education program to sell alcoholic beverages for consumption on its licensed premises. The culinary education program must specify designated areas in its facility where alcoholic beverages may be consumed. Alcoholic beverages may not be removed from the designated area and the alcoholic beverages sold for consumption on the premises must be consumed on the licensed premises only.[35]

The bill provides that this special license for a culinary education program does not require the licensee to derive at least 51 percent of its gross revenue from the sale of food and nonalcoholic beverages.

If a culinary education program also provides catering services, the bill provides that the special license will also allow for the sale and consumption of alcoholic beverages on the premises of a catered event at which the licensee is also providing prepared food. The culinary education program must prominently display its license at catered events, and maintain for three years all records required by the department by rule to demonstrate compliance with the requirements of s. 561.20(2)(a)6., F.S.

The bill provides that the culinary education program will be assessed an annual fee of $1,820 annually in compliance with s. 565.02(1)(b), F.S., regardless of the population of the county

[35] Pursuant to s. 561.01(11), F.S., "licensed premises" means not only the rooms where alcoholic beverages are stored or sold by the licensee, but also all other rooms in the building which are so closely connected therewith as to admit of free passage from drink parlor to other rooms over which the licensee has some dominion or control and shall also include all of the area embraced within the sketch, appearing on or attached to the application for the license involved and designated as such on said sketch, in addition to that included or designated by general law.

where the license is issued. The culinary education program must prominently display its beverage license at any catered event at which it will be selling or serving alcoholic beverages.

If a culinary education program also has any other license under the Beverage Law, the special license, provided under the bill's provisions, does not authorize the holder to conduct activities on the premises that are governed by the other license or licenses that would otherwise be prohibited by the terms of that license or the Beverage Law. Nothing in this bill authorizes a licensee to conduct activities that are prohibited by the Beverage Law or local law.

The bill prohibits a licensed culinary education program from selling alcoholic beverages by the package for off-premise consumption. The bill requires a culinary education program to comply with age requirements for vendors as provided under the Beverage Law.[36]

The bill authorizes the Division of Alcoholic Beverages and Tobacco to adopt rules to administer the special license, including rules governing licensure, recordkeeping, and enforcement.

The bill provides an effective date of July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Private sector culinary education programs with a special alcoholic beverage license will be subject to the safety and sanitation standards of the DOH. The DBPR notes that it is

[36] Sections 562.11(4) and 562.111(2), F.S., allows alcoholic beverages to be served to a student who is at least 18 years of age and the alcoholic beverage is delivered as part of the student's required curriculum at an accredited postsecondary educational institution if the student is enrolled in the college and required to taste alcoholic beverages for instructional purposes only during class under the supervision of authorized personnel. Section 562.13, F.S., prohibits the employment of a person under the age of 18 by vendors licensed under the Beverage Law; however, this prohibition does not apply to employees under the age of 18 for certain types of establishments, such as drug stores, grocery stores, hotels, bowling alleys, etc.

not clear whether there are any significant differences between the inspection standards used by the Division of Hotels and Restaurants and the standards that would be required under CS/SB 706, the DOH sanitation and safety standards.[37] Culinary education programs in the private sector may face an increased burden to the extent that meeting such standards are different than any current standards.

Culinary education programs seeking to be licensed as a caterer by the Division of Hotels and Restaurants within DBPR pay an initial fee of $473 and an annual fee of $273.[38]

All culinary education programs seeking the new special alcoholic beverage license would incur the annual cost of the special license (ranging from $624 to $1820, depending on the county), plus any inspection fees that occur throughout the year. A culinary education program that provides catering services pays a state license tax of $1,820 annually.

C. Government Sector Impact:

The bill authorizes the DBPR to issue a special alcoholic license for culinary education programs licensed as a public food service establishment. The DBPR anticipates an increase in food service licenses, plan reviews, and statutorily required inspections.[39] A new license will need to be created, rules adopted, and updates made to the application and the inspectors' electronic device inspection program.[40] Technology changes can be made within existing resources according to the DBPR.

According to the DBPR, the new license type will generate additional state revenue. Each license fee will generate $1,820 annually regardless of the population of the county where the license is issued.[41]

The number of new licenses is contingent upon the number of entities that meet the license qualifications. The DBPR estimates that 62 entities are currently known to operate culinary education programs in the state which could qualify for the new license. The city and county where each new license is issued will receive 38 percent and 24 percent of the license fees, respectively.

Universities and other public colleges may be required to pay associated fees for licenses and inspection which may affect the availability and cost of culinary education programs.[42]

The Department of Health reports no fiscal impact.

---

[37] Dep't of Business and Professional Regulation, *House Bill 249 Analysis*, p. 7 (Nov. 10, 2015) (on file with the Senate Committee on Health Policy).
[38] *Id at 5.*
[39] *Id at 3*.
[40] *Id.*
[41] *Id.*
[42] *Supra* note 26, at 3.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The DBPR notes that the bill creates a new special alcoholic beverage license which expands privileges for the sale and service of liquor in Florida as an additional exception to Florida's quota beverage license provisions based on county population size. The standards and qualifications for the culinary education programs are beyond the control and jurisdiction of the DBPR, and the determination of who qualifies for this license will be primarily controlled by the manner in which other agencies establish, interpret, modify, or enforce the core qualifications of a culinary education program.[43]

VIII. Statutes Affected:

This bill substantially amends the following sections of the Florida Statutes: 381.0072, 509.013, and 561.20.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Regulated Industries on February 9, 2016:
The committee substitute includes the following places within the definition of a culinary arts education program: a career center, as defined in s. 1001.44, F.S., and a charter technical career center, as defined in s. 1002.34, F.S.

B. Amendments:

None.

[43] *Supra* note 37, at 6.

By the Committee on Regulated Industries; and Senator Altman

580-03280-16 2016706c1

A bill to be entitled

An act relating to culinary education programs; amending s. 381.0072, F.S.; providing for the applicability of Department of Health sanitation rules to a licensed culinary education program; defining the term "culinary education program"; including certain culinary education programs under the term "food service establishment" and providing for the applicability of food service protection requirements thereto; conforming provisions to changes made by the act; amending s. 509.013, F.S.; revising the term "public food service establishment" to include a culinary education program; amending s. 561.20, F.S.; authorizing a culinary education program with a public food service establishment license to obtain an alcoholic beverage license under certain conditions; authorizing the Division of Alcoholic Beverages and Tobacco to adopt rules to administer such licenses; providing an effective date.

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

Section 1. Section 381.0072, Florida Statutes, is amended to read:

381.0072 Food service protection.—

(1) DEPARTMENT OF HEALTH; SANITATION RULES.—

(a) It shall be the duty of the Department of Health to adopt and enforce sanitation rules consistent with law to ensure the protection of the public from food-borne illness. These rules shall provide the standards and requirements for the storage, preparation, serving, or display of food in food service establishments as defined in this section ~~and which are~~

580-03280-16 2016706c1

~~not permitted or licensed under chapter 500 or chapter 509~~.

(b) A food service establishment is subject to the sanitation rules adopted and enforced by the department. This section does not apply to a food service establishment permitted or licensed under chapter 500 or chapter 509 unless the food service establishment is a culinary education program licensed under chapter 509.

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

(a) "Culinary education program" means a program that:

1. Educates enrolled students in the culinary arts, including the preparation, cooking, and presentation of food, or provides education and experience in culinary arts-related businesses;

2. Is provided by:

a. A state university as defined in s. 1000.21;

b. A Florida College System institution as defined in s. 1000.21;

c. A career center as provided for in s. 1001.44;

d. A charter technical career center as defined in s. 1002.34;

e. A nonprofit independent college or university that is located and chartered in this state and accredited by the Commission on Colleges of the Southern Association of Colleges and Schools to grant baccalaureate degrees, that is under the jurisdiction of the Department of Education, and that is eligible to participate in the William L. Boyd, IV, Florida Resident Access Grant Program; or

f. A nonpublic postsecondary educational institution licensed pursuant to part III of chapter 1005; and

3. Is inspected by any state agency or agencies for compliance with sanitation standards.

(b) ~~(a)~~ "Department" means the Department of Health or its representative county health department.

(c) ~~(b)~~ "Food service establishment" means detention facilities, public or private schools, migrant labor camps, assisted living facilities, facilities participating in the United States Department of Agriculture Afterschool Meal Program that are located at a facility or site that is not inspected by another state agency for compliance with sanitation standards, adult family-care homes, adult day care centers, short-term residential treatment centers, residential treatment facilities, homes for special services, transitional living facilities, crisis stabilization units, hospices, prescribed pediatric extended care centers, intermediate care facilities for persons with developmental disabilities, boarding schools, civic or fraternal organizations, bars and lounges, vending machines that dispense potentially hazardous foods at facilities expressly named in this paragraph, and facilities used as temporary food events or mobile food units at any facility expressly named in this paragraph, where food is prepared and intended for individual portion service, including the site at which individual portions are provided, regardless of whether consumption is on or off the premises and regardless of whether there is a charge for the food. The term includes a culinary education program where food is prepared and intended for individual portion service, regardless of whether there is a charge for the food or whether the program is inspected by another state agency for compliance with sanitation standards.

The term does not include any entity not expressly named in this paragraph; nor does the term include a domestic violence center certified by the Department of Children and Families and monitored by the Florida Coalition Against Domestic Violence under part XII of chapter 39 if the center does not prepare and serve food to its residents and does not advertise food or drink for public consumption.

(d) ~~(c)~~ "Operator" means the owner, operator, keeper, proprietor, lessee, manager, assistant manager, agent, or employee of a food service establishment.

(3) ~~(2)~~ DUTIES.—

(a) The department may advise and consult with the Agency for Health Care Administration, the Department of Business and Professional Regulation, the Department of Agriculture and Consumer Services, and the Department of Children and Families concerning procedures related to the storage, preparation, serving, or display of food at any building, structure, or facility not expressly included in this section that is inspected, licensed, or regulated by those agencies.

(b) The department shall adopt rules, including definitions of terms which are consistent with law prescribing minimum sanitation standards and manager certification requirements as prescribed in s. 509.039, and which shall be enforced in food service establishments as defined in this section. The sanitation standards must address the construction, operation, and maintenance of the establishment; lighting, ventilation, laundry rooms, lockers, use and storage of toxic materials and cleaning compounds, and first-aid supplies; plan review; design, construction, installation, location, maintenance, sanitation,

and storage of food equipment and utensils; employee training, health, hygiene, and work practices; food supplies, preparation, storage, transportation, and service, including access to the areas where food is stored or prepared; and sanitary facilities and controls, including water supply and sewage disposal; plumbing and toilet facilities; garbage and refuse collection, storage, and disposal; and vermin control. Public and private schools, if the food service is operated by school employees, bars and lounges, civic organizations, and any other facility that is not regulated under this section are exempt from the rules developed for manager certification. The department shall administer a comprehensive inspection, monitoring, and sampling program to ensure such standards are maintained. With respect to food service establishments permitted or licensed under chapter 500 or chapter 509, the department shall assist the Division of Hotels and Restaurants of the Department of Business and Professional Regulation and the Department of Agriculture and Consumer Services with rulemaking by providing technical information.

(c) The department shall carry out all provisions of this chapter and all other applicable laws and rules relating to the inspection or regulation of food service establishments as defined in this section, for the purpose of safeguarding the public's health, safety, and welfare.

(d) The department shall inspect each food service establishment as often as necessary to ensure compliance with applicable laws and rules. The department shall have the right of entry and access to these food service establishments at any reasonable time. In inspecting food service establishments under

this section, the department shall provide each inspected establishment with the food recovery brochure developed under s. 595.420.

(e) The department or other appropriate regulatory entity may inspect theaters ~~exempted in subsection (1)~~ to ensure compliance with applicable laws and rules pertaining to minimum sanitation standards. A fee for inspection shall be prescribed by rule, but the aggregate amount charged per year per theater establishment shall not exceed $300, regardless of the entity providing the inspection.

(4)~~(3)~~ LICENSES REQUIRED.—

(a) *Licenses; annual renewals.*—Each food service establishment regulated under this section shall obtain a license from the department annually. Food service establishment licenses shall expire annually and are not transferable from one place or individual to another. However, those facilities licensed by the department's Office of Licensure and Certification, the Child Care Services Program Office, or the Agency for Persons with Disabilities are exempt from this subsection. It shall be a misdemeanor of the second degree, punishable as provided in s. 381.0061, s. 775.082, or s. 775.083, for such an establishment to operate without this license. The department may refuse a license, or a renewal thereof, to any establishment that is not constructed or maintained in accordance with law and with the rules of the department. Annual application for renewal is not required.

(b) *Application for license.*—Each person who plans to open a food service establishment regulated under this section and not regulated under chapter 500 or chapter 509 shall apply for

and receive a license prior to the commencement of operation.

(5)~~(4)~~ LICENSE; INSPECTION; FEES.—

(a) The department is authorized to collect fees from establishments licensed under this section and from those facilities exempted from licensure under paragraph (4)(a)~~(3)(a)~~. It is the intent of the Legislature that the total fees assessed under this section be in an amount sufficient to meet the cost of carrying out the provisions of this section.

(b) The fee schedule for food service establishments licensed under this section shall be prescribed by rule, but the aggregate license fee per establishment shall not exceed $300.

(c) The license fees shall be prorated on a quarterly basis. Annual licenses shall be renewed as prescribed by rule.

(6)~~(5)~~ FINES; SUSPENSION OR REVOCATION OF LICENSES; PROCEDURE.—

(a) The department may impose fines against the establishment or operator regulated under this section for violations of sanitary standards, in accordance with s. 381.0061. All amounts collected shall be deposited to the credit of the County Health Department Trust Fund administered by the department.

(b) The department may suspend or revoke the license of any food service establishment licensed under this section that has operated or is operating in violation of any of the provisions of this section or the rules adopted under this section. Such food service establishment shall remain closed when its license is suspended or revoked.

(c) The department may suspend or revoke the license of any food service establishment licensed under this section when such

establishment has been deemed by the department to be an imminent danger to the public's health for failure to meet sanitation standards or other applicable regulatory standards.

(d) No license shall be suspended under this section for a period of more than 12 months. At the end of such period of suspension, the establishment may apply for reinstatement or renewal of the license. A food service establishment which has had its license revoked may not apply for another license for that location prior to the date on which the revoked license would have expired.

(7)~~(6)~~ IMMINENT DANGERS; STOP-SALE ORDERS.—

(a) In the course of epidemiological investigations or for those establishments regulated by the department under this chapter, the department, to protect the public from food that is unwholesome or otherwise unfit for human consumption, may examine, sample, seize, and stop the sale or use of food to determine its condition. The department may stop the sale and supervise the proper destruction of food when the State Health Officer or his or her designee determines that such food represents a threat to the public health.

(b) The department may determine that a food service establishment regulated under this section is an imminent danger to the public health and require its immediate closure when such establishment fails to comply with applicable sanitary and safety standards and, because of such failure, presents an imminent threat to the public's health, safety, and welfare. The department may accept inspection results from state and local building and firesafety officials and other regulatory agencies as justification for such actions. Any facility so deemed and

closed shall remain closed until allowed by the department or by judicial order to reopen.

(8) ~~(7)~~ MISREPRESENTING FOOD OR FOOD PRODUCTS.—No operator of any food service establishment regulated under this section shall knowingly and willfully misrepresent the identity of any food or food product to any of the patrons of such establishment. Food used by food establishments shall be identified, labeled, and advertised in accordance with the provisions of chapter 500.

Section 2. Paragraph (a) of subsection (5) of section 509.013, Florida Statutes, is amended to read:

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

(5)(a) "Public food service establishment" means any building, vehicle, place, or structure, or any room or division in a building, vehicle, place, or structure where food is prepared, served, or sold for immediate consumption on or in the vicinity of the premises; called for or taken out by customers; or prepared prior to being delivered to another location for consumption. The term includes a culinary education program, as defined in s. 381.0072(2), which offers, prepares, serves, or sells food to the general public, regardless of whether it is inspected by another state agency for compliance with sanitation standards.

Section 3. Paragraph (a) of subsection (2) of section 561.20, Florida Statutes, is amended to read:

561.20 Limitation upon number of licenses issued.—

(2)(a) No such limitation of the number of licenses as herein provided shall henceforth prohibit the issuance of a special license to:

1. Any bona fide hotel, motel, or motor court of not fewer than 80 guest rooms in any county having a population of less than 50,000 residents, and of not fewer than 100 guest rooms in any county having a population of 50,000 residents or greater; or any bona fide hotel or motel located in a historic structure, as defined in s. 561.01(21), with fewer than 100 guest rooms which derives at least 51 percent of its gross revenue from the rental of hotel or motel rooms, which is licensed as a public lodging establishment by the Division of Hotels and Restaurants; provided, however, that a bona fide hotel or motel with no fewer than 10 and no more than 25 guest rooms which is a historic structure, as defined in s. 561.01(21), in a municipality that on the effective date of this act has a population, according to the University of Florida's Bureau of Economic and Business Research Estimates of Population for 1998, of no fewer than 25,000 and no more than 35,000 residents and that is within a constitutionally chartered county may be issued a special license. This special license shall allow the sale and consumption of alcoholic beverages only on the licensed premises of the hotel or motel. In addition, the hotel or motel must derive at least 60 percent of its gross revenue from the rental of hotel or motel rooms and the sale of food and nonalcoholic beverages; provided that the provisions of this subparagraph shall supersede local laws requiring a greater number of hotel rooms;

2. Any condominium accommodation of which no fewer than 100 condominium units are wholly rentable to transients and which is licensed under the provisions of chapter 509, except that the license shall be issued only to the person or corporation which

operates the hotel or motel operation and not to the association of condominium owners;

3. Any condominium accommodation of which no fewer than 50 condominium units are wholly rentable to transients, which is licensed under the provisions of chapter 509, and which is located in any county having home rule under s. 10 or s. 11, Art. VIII of the State Constitution of 1885, as amended, and incorporated by reference in s. 6(e), Art. VIII of the State Constitution, except that the license shall be issued only to the person or corporation which operates the hotel or motel operation and not to the association of condominium owners;

4. Any restaurant having 2,500 square feet of service area and equipped to serve 150 persons full course meals at tables at one time, and deriving at least 51 percent of its gross revenue from the sale of food and nonalcoholic beverages; however, no restaurant granted a special license on or after January 1, 1958, pursuant to general or special law shall operate as a package store, nor shall intoxicating beverages be sold under such license after the hours of serving food have elapsed; or

5. Any caterer, deriving at least 51 percent of its gross revenue from the sale of food and nonalcoholic beverages, licensed by the Division of Hotels and Restaurants under chapter 509. This subparagraph does not apply to a culinary education program, as defined in s. 381.0072(2), which is licensed as a public food service establishment by the Division of Hotels and Restaurants and provides catering services. Notwithstanding any other provision of law to the contrary, a licensee under this subparagraph shall sell or serve alcoholic beverages only for consumption on the premises of a catered event at which the

licensee is also providing prepared food, and shall prominently display its license at any catered event at which the caterer is selling or serving alcoholic beverages. A licensee under this subparagraph shall purchase all alcoholic beverages it sells or serves at a catered event from a vendor licensed under s. 563.02(1), s. 564.02(1), or licensed under s. 565.02(1) subject to the limitation imposed in subsection (1), as appropriate. A licensee under this subparagraph may not store any alcoholic beverages to be sold or served at a catered event. Any alcoholic beverages purchased by a licensee under this subparagraph for a catered event that are not used at that event must remain with the customer; provided that if the vendor accepts unopened alcoholic beverages, the licensee may return such alcoholic beverages to the vendor for a credit or reimbursement. Regardless of the county or counties in which the licensee operates, a licensee under this subparagraph shall pay the annual state license tax set forth in s. 565.02(1)(b). A licensee under this subparagraph must maintain for a period of 3 years all records required by the department by rule to demonstrate compliance with the requirements of this subparagraph, including licensed vendor receipts for the purchase of alcoholic beverages and records identifying each customer and the location and date of each catered event. Notwithstanding any provision of law to the contrary, any vendor licensed under s. 565.02(1) subject to the limitation imposed in subsection (1), may, without any additional licensure under this subparagraph, serve or sell alcoholic beverages for consumption on the premises of a catered event at which prepared food is provided by a caterer licensed under chapter 509. If a licensee

under this subparagraph also possesses any other license under the Beverage Law, the license issued under this subparagraph shall not authorize the holder to conduct activities on the premises to which the other license or licenses apply that would otherwise be prohibited by the terms of that license or the Beverage Law. Nothing in this section shall permit the licensee to conduct activities that are otherwise prohibited by the Beverage Law or local law. The Division of Alcoholic Beverages and Tobacco is hereby authorized to adopt rules to administer the license created in this subparagraph, to include rules governing licensure, recordkeeping, and enforcement. The first $300,000 in fees collected by the division each fiscal year pursuant to this subparagraph shall be deposited in the Department of Children and Families' Operations and Maintenance Trust Fund to be used only for alcohol and drug abuse education, treatment, and prevention programs. The remainder of the fees collected shall be deposited into the Hotel and Restaurant Trust Fund created pursuant to s. 509.072.

6. A culinary education program, as defined in s. 381.0072(2), which is licensed as a public food service establishment by the Division of Hotels and Restaurants.

a. This special license shall allow the sale and consumption of alcoholic beverages on the licensed premises of the culinary education program. The culinary education program shall specify designated areas in the facility where the alcoholic beverages may be consumed at the time of application. Alcoholic beverages sold for consumption on the premises may be consumed only in areas designated pursuant to s. 561.01(11) and may not be removed from the designated area. Such license shall

be applicable only in and for designated areas used by the culinary education program.

b. If the culinary education program provides catering services, this special license shall also allow the sale and consumption of alcoholic beverages on the premises of a catered event at which the licensee is also providing prepared food. A culinary education program that provides catering services is not required to derive at least 51 percent of its gross revenue from the sale of food and nonalcoholic beverages. Notwithstanding any other provision of law to the contrary, a licensee that provides catering services under this sub-subparagraph shall prominently display its beverage license at any catered event at which the caterer is selling or serving alcoholic beverages. Regardless of the county or counties in which the licensee operates, a licensee under this sub-subparagraph shall pay the annual state license tax set forth in s. 565.02(1)(b). A licensee under this sub-subparagraph must maintain for a period of 3 years all records required by the department by rule to demonstrate compliance with the requirements of this sub-subparagraph.

c. If a licensee under this subparagraph also possesses any other license under the Beverage Law, the license issued under this subparagraph does not authorize the holder to conduct activities on the premises to which the other license or licenses apply that would otherwise be prohibited by the terms of that license or the Beverage Law. This subparagraph does not permit the licensee to conduct activities that are otherwise prohibited by the Beverage Law or local law. Any culinary education program that holds a license to sell alcoholic

beverages shall comply with the age requirements set forth in ss. 562.11(4), 562.111(2), and 562.13.

d. The Division of Alcoholic Beverages and Tobacco may adopt rules to administer the license created in this subparagraph, to include rules governing licensure, recordkeeping, and enforcement.

e. A license issued pursuant to this subparagraph does not permit the licensee to sell alcoholic beverages by the package for off-premises consumption.

However, any license heretofore issued to any such hotel, motel, motor court, or restaurant or hereafter issued to any such hotel, motel, or motor court, including a condominium accommodation, under the general law shall not be moved to a new location, such license being valid only on the premises of such hotel, motel, motor court, or restaurant. Licenses issued to hotels, motels, motor courts, or restaurants under the general law and held by such hotels, motels, motor courts, or restaurants on May 24, 1947, shall be counted in the quota limitation contained in subsection (1). Any license issued for any hotel, motel, or motor court under the provisions of this law shall be issued only to the owner of the hotel, motel, or motor court or, in the event the hotel, motel, or motor court is leased, to the lessee of the hotel, motel, or motor court; and the license shall remain in the name of the owner or lessee so long as the license is in existence. Any special license now in existence heretofore issued under the provisions of this law cannot be renewed except in the name of the owner of the hotel, motel, motor court, or restaurant or, in the event the hotel,

motel, motor court, or restaurant is leased, in the name of the lessee of the hotel, motel, motor court, or restaurant in which the license is located and must remain in the name of the owner or lessee so long as the license is in existence. Any license issued under this section shall be marked "Special," and nothing herein provided shall limit, restrict, or prevent the issuance of a special license for any restaurant or motel which shall hereafter meet the requirements of the law existing immediately prior to the effective date of this act, if construction of such restaurant has commenced prior to the effective date of this act and is completed within 30 days thereafter, or if an application is on file for such special license at the time this act takes effect; and any such licenses issued under this proviso may be annually renewed as now provided by law. Nothing herein prevents an application for transfer of a license to a bona fide purchaser of any hotel, motel, motor court, or restaurant by the purchaser of such facility or the transfer of such license pursuant to law.

Section 4. This act shall take effect July 1, 2016.

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Military and Veterans Affairs, Space, and Domestic Security, *Chair*
Children, Families, and Elder Affairs, *Vice-Chair*
Appropriations
Appropriations Subcommittee on General Government
Environmental Preservation and Conservation
Finance and Tax

SENATOR THAD ALTMAN
16th District

February 10, 2016

The Honorable Aaron Bean
Senate Committee on Health Policy, Chair
530 Knott Building
404 South Monroe Street
Tallahassee, FL 32399

Dear Chairman Bean:

I respectfully request that SB 706, related to *Culinary Education Programs,* be placed on the committee agenda at your earliest convenience.

Thank you for your consideration, and please do not hesitate to contact me should you have any questions.

Sincerely,

Thad Altman

CC: Sandra Stovall, Staff Director, 530 Knott Building
Celia Georgiades, Committee Administrative Assistant

TA/dw

REPLY TO:
☐ 6767 North Wickham Road, Suite 211, Melbourne, Florida 32940 (321) 752-3138
☐ 314 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5016

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

706
Bill Number (if applicable)

Topic Culinary School

Amendment Barcode (if applicable)

Name Susan Goldstein

Job Title Advocate / Consultant / Parent

Address 3158 Inverness
Street

Phone 954 830-6300

Weston FL 33332
City State Zip

Email skgoldstein@hotmail.com

Speaking: ☐ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing ARC Broward

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Military and Veterans Affairs, Space, and Domestic Security, *Chair*
Children, Families, and Elder Affairs, *Vice-Chair*
Appropriations
Appropriations Subcommittee on General Government
Environmental Preservation and Conservation
Finance and Tax

SENATOR THAD ALTMAN
16th District

February 16, 2016

The Honorable Bean
Senate Committee on Health Policy
530 Knott Building
404 S. Monroe Street
Tallahassee, FL 32399-1100

Dear Chairman Bean:

Senate Bill 706, related to *Culinary Education Programs,* is on the Health Policy committee agenda on February 16, 2016. Due to illness I will be unable to attend.

Please recognize my Legislative Aide Ms. Lindy Smith to present SB 706 on my behalf. Please feel free to contact me if you have any questions.

Sincerely,

Thad Altman

CC: Sandra Stovall, Staff Director, 530 Knott Building
Celia Georgiades, Committee Administrative Assistant

TA/dv

REPLY TO:
❒ 8910 Astronaut Blvd, Cape Canaveral, FL 32920 (321) 868-2132
❒ 314 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5016

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	CS/CS/SB 974
INTRODUCER:	Health Policy Committee; Fiscal Policy Committee; and Senator Sobel and others
SUBJECT:	Hair Restoration or Transplant
DATE:	February 17, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossito-Van Winkle	Stovall	HP	**Favorable**
2.	Brown	Pigott	AHS	**Recommend: Favorable**
3.	Pace	Hrdlicka	FP	**Fav/CS**
4.	Rossitto-Van Winkle	Stovall	HP	**Fav/CS**

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/CS/SB 974 prohibits anyone other than a physician or physician assistant (PA) licensed under the medical practice act or the osteopathic practice act, or an advanced registered nurse practitioner (ARNP) from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant. Hair restoration or transplant is defined as a surgical procedure that extracts or removes hair follicles from one location on a person's body to another location on that person's body.

The bill has no fiscal impact on state government.

II. Present Situation:

Hair Restoration Procedures

There are several techniques a physician can employ to restore hair to bald or balding portions of the human scalp. The most recently developed procedure is the follicular unit transplant. This procedure involves the removal of a strip of tissue from the donor area of a patient's scalp which is then divided into a number of individual follicular units. The physician then grafts the

individual follicular units into tiny holes made in the bald area of the scalp, called recipient sites.[1]

Another type of hair restoration procedure is the bald scalp reduction procedure. As implied by the name, a bald scalp reduction procedure entails the removal of a bald area of the patient's scalp, and hair-producing areas of the scalp are stretched to cover the area removed. A similar procedure, the scalp flap surgery, involves the cutting and grafting of an entire flap of hair-producing scalp onto a bald area of the scalp. Both bald scalp reduction and scalp flap surgeries can have rapid results, but the follicular unit transplant surgery is generally preferred due to the more natural look produced and the risk of scarring or failure inherent with bald scalp reduction and scalp flap surgeries.[2]

Tissue or scalp expansion procedures can also be used to restore bald areas of the scalp. Tissue expansion uses a balloon, called an expander, to stretch the skin in order to create extra skin which can be removed and grafted onto the bald area. Tissue expansion can be used for scalp repair since the stretched skin on the scalp retains normal hair growth.[3]

Regulation of Physician Assistants in Florida

Chapter 458, F.S., provides for the regulation of the practice of medicine by the Board of Medicine. Chapter 459, F.S., similarly provides for the regulation of the practice of osteopathic medicine by the Board of Osteopathic Medicine. Physician assistants (PA) are regulated by both boards. Licensure of PAs is overseen jointly by the boards through the Council on Physician Assistants.[4]

Physician assistants are trained and required by statute to work under the supervision and control of medical physicians or osteopathic physicians.[5] The Board of Medicine and the Board of Osteopathic Medicine have adopted rules that set out the general principles a supervising physician must use in developing the scope of practice of the PA under both direct[6] and indirect[7] supervision.

A supervising physician's decision to permit a PA to perform a task or procedure under direct or indirect supervision must be based on reasonable medical judgment regarding the probability of morbidity and mortality to the patient. The supervising physician must be certain that the PA is

---

[1] Bernstein Medical Center for Hair Restoration, *Follicular Unit Transplant*, available at http://www.bernsteinmedical.com/fut-hair-transplant/ (last visited on Jan. 28, 2016).
[2] Foundation for Hair Restoration, *Bald Scalp Reduction and Scalp Flap Surgery: A Historical Perspective*, available at http://www.foundhair.com/pages/baldScalp.shtml (last visited on Jan. 28, 2016).
[3] University of Pittsburgh Medical Center, Children's Hospital of Pittsburgh, *Tissue Expansion*, available at http://www.chp.edu/our-services/plastic-surgery/patient-procedures/tissue-expansion (last visited on Jan. 28, 2016).
[4] The council on Physician Assistants consists of three physicians who are members of the Board of Medicine; one physician who is a member of the Board of Osteopathic Medicine; and a physician assistant appointed by the State Surgeon General. See ss. 458.347(9) and 459.022(9), F.S.
[5] Sections 458.347(4) and 459.022(4), F.S.
[6] "*Direct supervision*" requires the physician to be on the premises and immediately available. See Rules 64B8-30.001(4) and 64B15-6.001(4), F.A.C.
[7] "*Indirect supervision*" refers to the easy availability of the supervising physician to the PA, which includes the ability to communicate by telecommunications, and requires the physician to be within reasonable physical proximity. See Rules 64B8-30.001(5) and 64B15-6.001(5), F.A.C.

knowledgeable and skilled in performing the tasks and procedures assigned.[8] Each physician or group of physicians supervising a licensed PA must be qualified in the medical areas in which the PA is to perform and must be individually or collectively responsible and liable for the performance and the acts and omissions of the PA.[9]

Regulation of Advanced Registered Nurse Practitioners in Florida

Chapter 464, F.S., governs the licensure and regulation of nurses in Florida. Nurses are licensed by the Department of Health and are regulated by the Board of Nursing (BON).[10] An ARNP is a licensed nurse who is certified in advanced or specialized nursing.[11] Florida recognizes three types of ARNPs: nurse practitioner (NP), certified registered nurse anesthetist (CRNA), and certified nurse midwife (CNM).[12]

To be certified as an ARNP, a nurse must hold a current license as a registered nurse[13] and submit proof to the BON that he or she meets one of the following requirements:[14]

- Satisfactory completion of a formal post-basic educational program of specialized or advanced nursing practice;
- Certification by an appropriate specialty board;[15]or
- Graduation from a master's degree program in a nursing clinical specialty area with preparation in specialized practitioner skills.

Advanced or specialized nursing functions may only be performed under protocol of a supervising physician or dentist. Within the established framework of the protocol, an ARNP may:[16]

- Monitor and alter drug therapies;
- Initiate appropriate therapies for certain conditions; and
- Order diagnostic tests and physical and occupational therapy.

Chapter 464, F.S., further describes additional functions that may be performed within an ARNP's specialty certification (CRNA, CNM, and NP).[17]

An ARNP must meet financial responsibility requirements, as determined by rule of the BON**,** and the practitioner profiling requirements.[18] The BON requires professional liability coverage of

[8] Rules 64B8-30.012(2) and 64B15-6.010(2), F.A.C.
[9] Sections 458.347(3) and 459.022(3), F.S.
[10] The BON is comprised of 13 members appointed by the Governor and confirmed by the Senate who serve 4-year terms. See s. 464.004, F.S.
[11] "Advanced or specialized nursing practice" is defined as the performance of advanced-level nursing acts approved by the BON which, by virtue of post-basic specialized education, training, and experience, are appropriately performed by an advanced registered nurse practitioner. See s. 464.003(2) and (3), F.S.
[12] Section 464.003(3), F.S. Florida certifies clinical nurse specialists as a category distinct from advanced registered nurse practitioners. See ss. 464.003(7) and 464.0115, F.S.
[13] Also referred to as "practice of professional nursing," which is defined in s. 464.003(20), F.S.
[14] Section 464.012(1), F.S.
[15] Specialty boards expressly recognized by the BON are set forth in Rule 64B9-4.002(2), F.A.C.
[16] Section 464.012(3), F.S.
[17] Section 464.012(4), F.S.
[18] Sections 456.0391, 456.041, and 456.048, F.S.

at least $100,000 per claim with a minimum annual aggregate of at least $300,000 or an unexpired irrevocable letter of credit in the same amounts payable to the ARNP.[19]

Regulation of Hair Restoration Procedures in Florida

Currently, there is no provision under chs. 458 or 459, F.S., that defines "hair restoration or transplant" or provides guidelines on who may perform a hair restoration or transplant procedure.

III. Effect of Proposed Changes:

This bill creates new sections of Florida Statutes relating to hair restoration or transplant in the medical practice act, ch. 458, F.S., and the osteopathic medical practice act, ch. 459, F.S. The bill defines hair restoration or transplant to mean a surgical procedure that extracts or removes hair follicles from one location on a person's body for the purpose of redistributing the hair follicles to another location on that body.

The bill prohibits anyone other than a physician or PA licensed under either practice act, or an ARNP from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant. This has the effect of restricting a physician from delegating certain aspects of a hair transplant or hair restoration surgery to anyone other than a licensed PA or an ARNP.

The effective date of the bill is July 1, 2016.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

[19] Rule 64B9-4.002(5), F.A.C.

B. Private Sector Impact:

CS/CS/SB 974 prevents persons other than licensed physicians or PAs under the medical practice act or osteopathic practice act and ARNPs from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. None. Statutes Affected:

This bill creates the following sections of the Florida Statutes: 458.352 and 459.027.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS/CS by Health Policy on February 16, 2016:
The committee substitute removes the authorization for registered nurses to perform hair restoration and transplant services that was added to the bill in Fiscal Policy.

CS by Fiscal Policy on February 4, 2016:
The committee substitute authorizes nurses licensed under ch. 464, F.S., to perform hair restoration and transplant services under the direction of a person licensed under ch. 458 or ch. 459, F.S.

B. Amendments:

None.

162030

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/16/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Sobel) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 458.352, Florida Statutes, is created to read:

458.352 Hair restoration or transplant.—

(1) As used in this section, the term "hair restoration or transplant" means a surgical procedure that extracts or removes hair follicles from one location on an individual living human

162030

body for the purpose of redistributing the hair follicles to another location on that body.

(2) A person who is not licensed under this chapter or chapter 459 or certified under s. 464.012 may not perform a hair restoration or transplant or make incisions for the purpose of performing a hair restoration or transplant.

Section 2. Section 459.027, Florida Statutes, is created to read:

459.027 Hair restoration or transplant.—

(1) As used in this section, the term "hair restoration or transplant" means a surgical procedure that extracts or removes hair follicles from one location on an individual living human body for the purpose of redistributing the hair follicles to another location on that body.

(2) A person who is not licensed under this chapter or chapter 458 or certified under s. 464.012 may not perform a hair restoration or transplant or make incisions for the purpose of performing a hair restoration or transplant.

Section 3. This act shall take effect July 1, 2016.

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

And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to hair restoration or transplant; creating ss. 458.352 and 459.027, F.S.; defining the term "hair restoration or transplant"; prohibiting a person who is not licensed or is not certified under

162030

ch. 458, F.S., ch. 459, F.S., or s. 464.012, F.S., from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant; providing an effective date.

By the Committee on Fiscal Policy; and Senators Sobel and Garcia

594-03050-16 2016974c1

A bill to be entitled

An act relating to hair restoration or transplant; creating ss. 458.352 and 459.027, F.S.; defining the term "hair restoration or transplant"; prohibiting a person who is not licensed or is not certified under ch. 458, F.S., ch. 459, F.S., or s. 464.012, F.S., from performing a hair restoration or transplant or making incisions for the purpose of performing a hair restoration or transplant; providing an exception; providing an effective date.

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

Section 1. Section 458.352, Florida Statutes, is created to read:

458.352 Hair restoration or transplant.—

(1) As used in this section, the term "hair restoration or transplant" means a surgical procedure that extracts or removes hair follicles from one location on an individual living human body for the purpose of redistributing the hair follicles to another location on that body.

(2) A person who is not licensed under this chapter or chapter 459 or certified under s. 464.012 may not perform a hair restoration or transplant or make incisions for the purpose of performing a hair restoration or transplant, except that a registered nurse licensed under chapter 464 may perform hair restoration and transplant services under the direction of a person licensed under this chapter or chapter 459.

Section 2. Section 459.027, Florida Statutes, is created to read:

459.027 Hair restoration or transplant.—

(1) As used in this section, the term "hair restoration or

594-03050-16 2016974c1

transplant" means a surgical procedure that extracts or removes hair follicles from one location on an individual living human body for the purpose of redistributing the hair follicles to another location on that body.

(2) A person who is not licensed under this chapter or chapter 458 or certified under s. 464.012 may not perform a hair restoration or transplant or make incisions for the purpose of performing a hair restoration or transplant, except that a registered nurse licensed under chapter 464 may perform hair restoration and transplant services under the direction of a person licensed under this chapter or chapter 458.

Section 3. This act shall take effect July 1, 2016.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL: CS/SB 1306

INTRODUCER: Health Policy Committee and Senator Grimsley

SUBJECT: Public Records and Meetings/Nurse Licensure Compact

DATE: February 17, 2016 REVISED:

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Lloyd	Stovall	HP	**Fav/CS**
2.			GO	
3.			RC	

Please see Section IX. for Additional Information:

COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 1306 creates an exemption from the public record requirements for a nurse's personal identifying information, other than the nurse's name, licensure status, or licensure number, obtained from the coordinated licensure information system (CLIS) under the Nurse Licensure Compact (NLC or compact), as defined in s. 464.0095, F.S.,[1] and held by the Department of Health (department) or the Board of Nursing (board).

The bill also creates an exemption from the public meeting requirements for a meeting or a portion of the meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under the compact. The exemption applies when matters are specifically exempted from disclosure by state or federal law are discussed. The recordings, minutes, and records generated from those meetings are also exempt from s. 119.071(1), F.S., and s. 24(a), Art. I of the State Constitution.

The bill takes effect on the same date that Senate Bill 1316 or similar legislation takes effect. Senate Bill 1316, the substantive bill for the compact, is effective on December 31, 2018, or upon enactment of the NLC into law by 26 states whichever occurs first.

[1] Section 464.0095, F.S., is created in SB 1316 and establishes the state's participation in the Nurse Licensure Compact and the coordinated licensure information system.

The bill provides for the repeal of the exemption on October 2, 2021, unless reviewed and reenacted by the Legislature. It also provides statements of public necessity for the public records and public meetings exemptions as required by the State Constitution.

Because the bill creates a new public records exemption, a two-thirds vote of the members present and voting in each house of the Legislature is required for final passage.

II. Present Situation:

The Florida Constitution provides that the public has the right to access government records and meetings. The public may inspect or copy any record made or received in connection with the official business of any public body, officer, or employee received in connection with the official business of any public body, officer, or employee of the state, or of persons acting on their behalf.[2] The public also has a right to be afforded notice and access to meetings of any collegial public body of the executive branch of state government or of any local government.[3] The Legislature's meetings must also be open and noticed to the public, unless there is an exception provided for by the Constitution.[4]

In addition to the Florida Constitution, the Florida Statutes specify conditions under which public access must be provided to government records and meetings. Chapter 119, F.S., the "Public Records Act" constitutes the main body of public records laws, and states that:

> It is the policy of this state that all state, county, and municipal records are open for personal inspection and copying by any person. Providing access to public records is the duty of each agency.[5]

According to the Public Records Act, a public record includes virtually any document or recording, regardless of its physical form or how it may be transmitted.[6] A violation of the Public Records Act may result in civil or criminal liability.[7]

---

[2] FLA. CONST. art. 1, s. 24(a).
[3] FLA. CONST. art. 1, s. 24(b).
[4] FLA. CONST. art. 1, s. 24(b).
[5] Chapter 119, F.S.
[6] Section 119.011(12), F.S., defines "public record" to mean "all documents, papers, letters, maps, books, tapes, photographs, films, sound recordings, data processing software, or other material, regardless of their physical form, characteristics, or means of transmission, made or received pursuant to law or ordinance or in connection with the transaction of official business by any agency." Section 119.011(2), F.S., defines "agency" to mean as "any state, county, district, authority, or municipal officer, department, division, board, bureau, commission, or other separate unit of government created or established by law including, for the purpose of this chapter, the Commission on Ethics, the Public Service Commission, and the Office of Public Counsel, and any other public or private agency, person, partnership, corporation, or business entity acting on behalf of any public agency." The Public Records Act does not apply to legislative or judicial records. *Locke v. Hawkes*, 595 So. 2d 32 (Fla. 1992). The Legislature's records are public pursuant to s. 11.0431, F.S.
[7] Section 119.10, F.S. Public records laws are found throughout the Florida Statutes, as are penalties for violations of those laws.

Section 286.011, F.S., the "Sunshine Law,"[8] requires all meetings of any board or commission or local agency or authority at which official acts are to be taken to be noticed and open to the public.[9]

The Legislature may, by two-thirds votes of the House and the Senate[10] create an exemption to public records or open meetings requirements.[11] An exemption must explicitly state the public necessity of the exemption[12] and must be tailored to accomplish the stated purpose of the law.[13] A statutory exemption which does not meet these two criteria may be found unconstitutional, and efforts may not be made by the court to preserve the exemption.[14]

Open Government Sunset Review Act

In addition to the constitutional requirements relating to the enactment of a public records exemption, the Legislature may subject the new or broadened exemption to the Open Government Sunset Review Act (OGSR).

The OGSR prescribes a legislative review process for newly created or substantially amended public records.[15] The OGSR provides that an exemption automatically repeals on October 2nd of the fifth year after creation or substantial amendment; in order to save an exemption from repeal, the Legislature must reenact the exemption.[16] In practice, many exemptions are continued by repealing the sunset date rather than reenacting the exemption.

---

[8] *Board of Public Instruction of Broward County v. Doran*, 224 So. 2d 693, 695 (Fla. 1969).

[9] Section 286.011(1)-(2), F.S. The Sunshine Law does not apply to the Legislature; rather, open meetings requirements for the Legislature are set out in the Florida Constitution. Article III, s. 4(e) of the Florida Constitution provides the legislative committee meetings must be open and noticed to the public. In addition, prearranged gatherings, between more than two members of the Legislature, or between the Governor, the President of the Senate, or the Speaker of the House of Representatives, the purpose of which is to agree upon or to take formal legislative action, must be reasonable open to the public.

[10] FLA. CONST. art. I, s. 24(c).

[11] FLA. CONST. art. I, s. 24(c). There is a difference between records the Legislature designates as exempt from public records requirements and those the Legislature designates as *confidential* and exempt. A record classified as exempt from public disclosure may be disclosed under certain circumstances. *Williams v. City of Minneola*, 575 So.2d 687 (Fla. 5th DCA 1991). If the Legislature designates a record as confidential, such record may not be released to anyone other than the persons or entities specifically designated in the statutory exemption. *WFTV, Inc. v. The School Board of Seminole*, 874 So.2d 48 (Fla. 5th DCA 2004).

[12] FLA. CONST. art. I, s. 24(c).

[13] FLA. CONST. art. I, s. 24(c).

[14] *Halifax Hosp. Medical Center v. News-Journal Corp.*, 724 So.2d 567 (Fla. 1999). In *Halifax Hospital*, the Florida Supreme Court found that a public meetings exemption was unconstitutional because the statement of public necessity did not define important terms and did not justify the breadth of the exemption. In *Baker County Press, Inc. v. Baker County Medical Services, Inc.*, 870 So. 2d 189 (Fla. 1st DCA 2004), the court found that the intent of a statute was to create a public records exemption. The *Baker County Press* court found that since the law did not contain a public necessity statement, it was unconstitutional.

[15] Section 119.15, F.S. According to s. 119.15(4)(b), F.S., a substantially amended exemption is one that is expanded to include more information or to include meetings. The OGSR does not apply to an exemption that is required by federal law or that applies solely to the Legislature or the State Court System pursuant to s. 119.15(2), F.S. The OGSR process is currently being followed; however, the Legislature is not required to continue to do so. The Florida Supreme Court has found that one Legislature cannot bind a future Legislature. *Scott v. Williams*, 107 So. 3d 379 (Fla. 2013).

[16] Section 119.15(3), F.S.

Under the OGSR the purpose and necessity of reenacting the exemption are reviewed. The Legislature must consider the following questions during its review of an exemption:[17]

- What specific records or meetings are affected by the exemption?
- Whom does the exemption uniquely affect, as opposed to the general public?
- What is the identifiable public purpose or goal of the exemption?
- Can the information contained in the records or discussed in the meeting be readily obtained by alternative means? If so, how?
- Is the record or meeting protected by another exemption?
- Are there multiple exemptions for the same type of record or meeting that it would be appropriate to merge?

If the Legislature expands an exemption, then a public necessity statement and a two-thirds vote for passage are required.[18] If the exemption is reenacted without substantive changes or if the exemption is narrowed, then a public necessity statement and a two-thirds vote for passage are not required. If the Legislature allows an exemption to sunset, the previously exempt records will remain exempt unless otherwise provided for by law.[19]

Nurse Licensure Compact

The Nurse Licensure Compact bill, SB 1316, authorizes Florida to enter the revised Nurse Licensure Compact (NLC or compact), a multi-state agreement that establishes a mutual recognition system for the licensure of registered nurses and licensed practical or vocational nurses. A nurse who is issued a multi-state license from a state that is a party to the NLC would be permitted to practice in any state that is also a party to the compact. A nurse with a multistate license privilege must comply with the practice laws of the state in which he or she is practicing or where the patient is located. A party state may continue to issue a single-state license, authorizing practice only in that state.

The NLC permits a state to take adverse action against the multistate licensure privilege of any nurse practicing in that state. The home state has the exclusive authority to take adverse action against the home state license, including revocation and suspension. The NLC requires all participating states to report to the CLIS, all adverse actions taken against a nurse's license or multistate licensure practice privilege, any current significant investigative information, and denials of information.

All party states may access the CLIS to see licensure and disciplinary information for nurses licensed in the party states. The CLIS includes nurse's personal identifying information, licensure classification information and statuses, public emergency and final disciplinary action information, and status information about multistate licensure privileges from all party states. A party state may designate the information it contributes to the CLIS as confidential, prohibiting its disclosure to nonparty states. State licensing boards must report disciplinary information, significant investigative information, and denials of applications to the CLIS promptly.

[17] Section 119.15(6)(a), F.S.
[18] FLA. CONST. art. I, s. 24(c).
[19] Section 119.15(7), F.S.

The NLC establishes the Interstate Commission of Nurse Licensure Compact Administrators (commission) to oversee the operation of the NLC. The head of each state's licensing board of his or her designee must serve as the state's delegate to the commission. The NLC grants the commission authority to promulgate uniform rules relating to the implementation and administration of NLC. The commission may also take action against a party state if a party state fails to meet its obligations under the NLC, including termination of membership after exhausting all other means of compliance.

All commission meetings are open to the public and must be publicly noticed. Both commission meetings and hearings for proposed rules must be noticed at least 60 days prior to each meeting on the commission's website and on the website of each party state's licensing board or published in the publication in which each state would otherwise post proposed rules. The compact also provides for public comment opportunities through both oral and written testimony. Closed meetings are permitted if the commission is discussing:

- A party state's noncompliance with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigating compliance with the NLC; or
- Matters specifically exempted from disclosure by federal or state law.

The commission must keep comprehensive minutes of matters discussed in its meetings and provide a full and accurate summary of actions taken, and the reasons. Minutes of a closed meeting will be sealed; however, such minutes may be released pursuant to a majority vote of the commission or an order of a court of competent jurisdiction.

The compact is effective on December 31, 2018, or upon enactment of the NLC into law by 26 states whichever occurs first.[20]

III. Effect of Proposed Changes:

Section 1 creates section 464.0096, F.S., to make a nurse's personal identifying information, other than the nurse's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as defined in s. 464.0095, F.S., and held by the department or board exempt from public disclosure under s. 119.07(1), F.S. and s. 24(a), Art. I of the State Constitution, unless the state that originally reported the information to the coordinated licensure

[20] Twenty-five states have enacted the original Nurse Licensure Compact.

information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be disclosed to the extent permitted by the reporting state's law.

The bill also creates an exemption from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution for a meeting or any portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators during which any matters specifically exempted from disclosure by federal or state statute are discussed.

Recordings, minutes, and records generated during an exempt meeting are exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution.

The exemption is subject to the Open Government Sunset Review Act and will stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2 provides, as required by the State Constitution, a statement of public necessity which states that protection of the specified information is required under the Nurse Licensure Compact which the state must adopt in order to become a party state to the compact. Without the public records exemption, the state would be unable to effectively and efficiently implement and administer the compact.

Additionally, the bill provides a statement of public necessity, as required by the State Constitution, for protecting any meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators (commission) at which matters specifically exempted from disclosure by federal or state statute are discussed. These meetings or portions of meetings would be exempted from s. 286.011, F.S., and s. 24(b), Art. I. of the Florida Constitution..

Without the public meeting exemption, the state will be prohibited from becoming a party to the compact. Thus, the state will be unable to effectively and efficiently administer the compact.

The bill includes a statement of public necessity by the Legislature that the recordings, minutes, and records generated during an exempt meeting of the commission is exempt pursuant to s. 464.0096, F.S., and exempt from s. 119.07(1), F.S. and s. 24(a), Art. I of the State Constitution. Release of such information would negate the public meeting exemption.

Section 3 provides that the act shall take effect on the same date as Senate Bill 1316 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

Under the compact, the commission meetings must be open to the public and such meetings, including rulemaking hearings, must be publicly noticed 60 days prior to each meeting. Proposed rules must be posted to the commission's website and to the party state's licensing board websites or the publication in which each party state would otherwise publish proposed rules. The public must also be provided a reasonable opportunity for public comment, orally or in writing, for proposed rules.

However, under SB 1316, the compact permits the commission to meet in closed, nonpublic meetings under these circumstances:

- A party state's noncompliance with its obligations under the compact;
- The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the Commission's internal personnel practices and procedure;
- Current, threatened, or reasonably anticipated litigation;
- Contract negotiations for the purchase or sale of goods, services, or real estate;
- Accusing a person of a crime or formally censuring a person;
- Disclosure of trade secrets or commercial or financial information that is privileged or confidential;
- Disclosure of information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;
- Disclosure of investigatory records compiled for law enforcement purposes;
- Disclosure of information related to any reports prepared by or on behalf of the commission for the purpose of investigating compliance with the NLC; or
- Matters specifically exempted from disclosure by federal or state law.

CS/SB 1306 simplifies this list to the last bullet: matters specifically exempted from disclosure by state or federal statute.

The commission is required to keep minutes of these closed sessions that fully describe all matters discussed and provide an accurate summary of actions taken. All minutes and documents of a closed meeting shall remain under seal according to the compact's provisions, subject to release by a majority vote of the commission or order of a court of competent jurisdiction.

Vote Requirement

Article I, Section 24(c) of the State Constitution requires a two-thirds vote of the members present and voting for final passage of a newly created or expanded public records or public meeting exemption. This bill creates a public records exemption for information obtained from the coordinated licensure information system, and held by the Department of Health or the Board of Nursing, thus it requires a two-thirds vote.

Public Necessity Statement

Article I, Section 24(c) of the State Constitution requires a public necessity statement for a newly created or expanded public records or public meeting exemption. This bill

creates a new public records exemption and includes a public necessity statement that supports the exemption. The exemption is no broader than necessary to accomplish the stated purpose.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

None.

C. Government Sector Impact:

The department reports no impact for CS/SB 1306.

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill creates section 464.0096 of the Florida Statutes.

IX. Additional Information:

A. Committee Substitute – Statement of Substantial Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

CS by Health Policy on February 16, 2016
The CS narrows the types of personal identifying information obtained from the coordinated licensure system and held by the department that will be exempt from s. 119.07(1), F.S., and s. 24(a), Art. I of the State Constitution. A nurse's name, licensure status, and licensure number will not be exempt. Additional information may be made public if the state that originally reported the information authorizes the disclosure of such information by law.

The CS provides that a meeting or a portion of a meeting of commission is specifically exempt from s. 286.011, F.S., and s. 24(b), Art. I of the State Constitution at which

matters specifically exempted from disclosure under federal or state statute are discussed. The bill no longer lists specific topics of discussion that are exempt.

The CS modifies both the public records and the meeting exemptions throughout the bill to reflect that such exemptions are only exempt, but not confidential.

A cross reference to the substantive bill, Senate Bill 1316, is added to the effective date.

B. Amendments:

None.

613610

LEGISLATIVE ACTION

Senate	.	House
Comm: RCS	.	
02/16/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment (with title amendment)

Delete everything after the enacting clause and insert:

Section 1. Section 464.0096, Florida Statutes, is created to read:

464.0096 Nurse Licensure Compact; public records and meetings exemptions.—

(1) A nurse's personal identifying information, other than the nurse's name, licensure status, or licensure number,


613610

obtained from the coordinated licensure information system, as defined in s. 464.0095, and held by the department or the board is exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated licensure information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be disclosed to the extent permitted by the reporting state's law.

(2)(a) A meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095 at which matters specifically exempted from disclosure by federal or state statute are discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution.

(b) Recordings, minutes, and records generated during an exempt meeting are exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a nurse's personal identifying information, other than the nurse's name, licensure status, or licensure number, obtained from the coordinated licensure information system, as defined in s. 464.0095, Florida Statutes, and held by the Department of Health or the Board of Nursing be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Nurse Licensure Compact, which the state must adopt in


613610

order to become a party state to the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095, Florida Statutes, at which matters specifically exempted from disclosure by federal or state statute are discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution.

(b) The Nurse Licensure Compact requires any meeting or portion of a meeting in which the substance of paragraph (a) is discussed to be closed to the public. Without the public meeting exemption, this state will be prohibited from becoming a party state to the compact. Thus, this state will be unable to effectively and efficiently administer the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 464.0096, Florida Statutes, be made exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that SB 1316 or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

613610

========== T I T L E A M E N D M E N T ==========
And the title is amended as follows:

Delete everything before the enacting clause and insert:

A bill to be entitled

An act relating to public records and meetings; creating s. 464.0096, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

226384

LEGISLATIVE ACTION

Senate	.	House
Comm: WD	.	
02/09/2016	.	
	.	
	.	
	.	

The Committee on Health Policy (Grimsley) recommended the following:

Senate Amendment

Delete line 140
and insert:
SB 1316 or similar legislation takes effect, if such legislation

By Senator Grimsley

21-01887-16 20161306__

A bill to be entitled

An act relating to public records and meetings; creating s. 464.0096, F.S.; providing an exemption from public records requirements for certain information held by the Department of Health or the Board of Nursing pursuant to the Nurse Licensure Compact; authorizing disclosure of the information under certain circumstances; providing an exemption from public meeting requirements for certain meetings of the Interstate Commission of Nurse Licensure Compact Administrators; providing an exemption from public records requirements for recordings, minutes, and records generated during the closed portion of such a meeting; providing for future legislative review and repeal of the exemptions; providing a statement of public necessity; providing a contingent effective date.

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

Section 1. Section 464.0096, Florida Statutes, is created to read:

464.0096 Nurse Licensure Compact; public records and meetings exemptions.—

(1) A nurse's personal identifying information obtained from the coordinated licensure information system, as defined in s. 464.0095, and held by the department or the board is confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution unless the state that originally reported the information to the coordinated licensure information system authorizes the disclosure of such information by law. Under such circumstances, the information may only be

21-01887-16 20161306__

disclosed to the extent permitted by the reporting state's law.

(2)(a) A meeting or portion of a meeting of the Interstate Commission of Nurse Licensure Compact Administrators established under s. 464.0095 during which any of the following is discussed is exempt from s. 286.011 and s. 24(b), Art. I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002 or commercial or financial information required by the commission's bylaws or rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes. For the purposes of this subparagraph, the term "active" has the same meaning as provided in s. 119.011(3)(d).

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest and the privacy of individuals, and proprietary information.

(b) Recordings, minutes, and records generated during an exempt meeting are confidential and exempt from s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(3) This section is subject to the Open Government Sunset Review Act in accordance with s. 119.15 and shall stand repealed on October 2, 2021, unless reviewed and saved from repeal through reenactment by the Legislature.

Section 2. (1) The Legislature finds that it is a public necessity that a nurse's personal identifying information obtained from the coordinated licensure information system, as defined in s. 464.0095, Florida Statutes, and held by the Department of Health or the Board of Nursing be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Protection of such information is required under the Nurse Licensure Compact, which the state must adopt in order to become a party state to the compact. Without the public records exemption, this state will be unable to effectively and efficiently implement and administer the compact.

(2)(a) The Legislature finds that it is a public necessity that any meeting or portion of a meeting of the Interstate

Commission of Nurse Licensure Compact Administrators established under s. 464.0095, Florida Statutes, at which any of the following is discussed be made exempt from s. 286.011, Florida Statutes, and s. 24(b), Article I of the State Constitution:

1. Failure of a party state to comply with its obligations under the Nurse Licensure Compact.

2. The employment, compensation, discipline, or other personnel matters, practices, or procedures related to specific employees or other matters related to the commission's internal personnel practices and procedures.

3. Current, threatened, or reasonably anticipated litigation.

4. Negotiation of contracts for the purchase or sale of goods, services, or real estate.

5. Accusing any person of a crime or formally censuring any person.

6. Trade secrets as defined in s. 688.002, Florida Statutes, or commercial or financial information required by the commission's bylaws or rules to be kept privileged or confidential.

7. Information of a personal nature which the commission determines by majority vote would constitute a clearly unwarranted invasion of personal privacy if disclosed to the public.

8. Active investigatory records compiled for law enforcement purposes.

9. Information related to any reports prepared by or on behalf of the commission for the purpose of investigation of compliance with the Nurse Licensure Compact.

10. Information made confidential or exempt pursuant to federal law or pursuant to the laws of any party state.

11. Information made exempt pursuant to rules or bylaws of the commission, which would protect the public's interest, the privacy of individuals, and proprietary information.

(b) The Nurse Licensure Compact requires any meeting or portion of a meeting in which the substance of paragraph (a) is discussed to be closed to the public. Without the public meeting exemption, this state will be prohibited from becoming a party state to the compact. Thus, this state will be unable to effectively and efficiently administer the compact.

(3) The Legislature also finds that it is a public necessity that the recordings, minutes, and records generated during a meeting that is exempt pursuant to s. 464.0096, Florida Statutes, be made confidential and exempt from s. 119.07(1), Florida Statutes, and s. 24(a), Article I of the State Constitution. Release of such information would negate the public meeting exemption. As such, the Legislature finds that the public records exemption is a public necessity.

Section 3. This act shall take effect on the same date that SB ____ or similar legislation takes effect, if such legislation is adopted in the same legislative session or an extension thereof and becomes law.

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1286
INTRODUCER:	Senators Gibson and Latvala
SUBJECT:	Diabetes Educator Practice
DATE:	February 15, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			AP	

I. Summary:

SB 1286 creates a new licensed and regulated profession in Florida, the diabetes educator. The bill prohibits persons, and many licensed health care professionals, from engaging in diabetes education or diabetes self-management education or training (DSME/T) unless he or she holds a diabetes educator license. The bill expands the role of the Dietetics and Nutrition Practice Council under the Board of Medicine (BOM); by assigning it responsibility for the licensing, monitoring, and disciplining of diabetes educators. The bill requires the BOM to adopt rules and set fees for all application, licensure, and renewal processes of the profession.

The effective date of the bill is January 1, 2018.

II. Present Situation:

Diabetes is a group of diseases in which the body produces too little insulin,[1] is unable to use insulin efficiently, or both. When diabetes is not controlled, glucose and fats remain in the blood and eventually cause damage to vital organs.

The most common forms of diabetes are:

- **Type 1**: Sometimes known as juvenile diabetes, type 1 is usually first diagnosed in children and adolescents and accounts for about five percent of all diagnosed cases. Type 1 diabetes is an autoimmune disease in which the body's own immune system destroys cells in the pancreas that produce insulin. Type 1 may be caused by genetic, environmental, or other risk factors. At this time, there are no methods to prevent or cure type 1 diabetes, and treatment requires the use of insulin by injection or pump.

[1] Insulin is a hormone that allows glucose (sugar) to enter cells and be converted to energy. Merriam-Webster, available at: http://www.merriam-webster.com/dictionary/insulin, (last visited Feb. 11, 2016).

- **Type 2**: Sometimes known as adult-onset diabetes, type 2 accounts for about 95 percent of diagnosed diabetes in adults and is usually associated with older age, obesity, lack of physical activity, family history, or a personal history of gestational diabetes. Studies have shown that healthy eating, regular physical activity, and weight loss can prevent or delay the onset of type 2 diabetes or eliminate the symptoms and effects post-onset.
- **Gestational diabetes**: This type of diabetes develops and is diagnosed as a result of pregnancy in 2 to 10 percent of pregnant women. Gestational diabetes can cause health problems during pregnancy for both the child and mother. Children whose mothers have gestational diabetes have an increased risk of developing obesity and type 2 diabetes. [2]

Complications of diabetes include: heart disease, stroke, high blood pressure (hypertension), blindness and other eye problems, kidney disease, nervous system disease, vascular disorders, and amputations. Death rates for heart disease and the risk of stroke are about two to four times higher among adults with diabetes than among those without diabetes. Diabetes and its potential health consequences can be managed through physical activity, diet, self-management training, and, when necessary, medication.[3]

People with "pre-diabetes" are at high risk of developing type 2 diabetes, heart disease, and stroke. Their blood glucose levels are higher than normal, but not high enough to be classified as diabetes. Although an estimated 33 percent of adults in the United States have pre-diabetes, less than 10 percent of them report having been told they have the condition. Thus, awareness of the risk is low. People with pre-diabetes who lose five to seven percent of their body weight and get at least 150 minutes per week of moderate physical activity can reduce the risk of developing type 2 diabetes by 58 percent.[4]

Risk factors for diabetes include:[5]
- Being over the age of 45;
- Overweight;
- Having a parent or sibling with diabetes;
- Having a minority family background;
- Developing diabetes while pregnant, gave birth to a baby weighing 9 pounds or more; and
- Being physically active less than three times per week.

Persons with any of the above risk factors are also at risk of developing pre-diabetes. Individuals with pre-diabetes are five to 15 times more likely to develop type 2 diabetes, heart disease, and stroke.[6] The Centers for Disease Control (CDC) estimates that as many as one out of every three

[2] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Report Card*, 1 (2014), p.4, *available at* http://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf, (last visited Feb. 11, 2016).
[3] U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Latest* http://www.cdc.gov/features/diabetesfactsheet/ (last visited Feb. 11, 2016).
[4] *Supra* note 2, at 4.
[5] Florida Department of Health, *Diabetes, Warning Signs and Risk Factors* http://www.floridahealth.gov/diseases-and-conditions/diabetes/warning-signs.html (last visited Feb. 11, 2016).
[6] Florida Department of Health, *Prediabetes, What is Prediabetes?*, http://www.floridahealth.gov/diseases-and-conditions/diabetes/prediabetes.html (last visited Feb. 4, 2015).

American adults has pre-diabetes and half of all Americans aged 65 years and older have pre-diabetes.[7]

In 2013, the American Diabetes Association (ADA)[8] released a report updating its earlier studies (2002, 2007) estimating the economic burden of diagnosed diabetes. In 2012, the total estimated cost of diagnosed diabetes in the United States was $245 billion, including $176 billion in direct medical costs and $69 billion in reduced productivity. This represents a 41 percent increase over the 2007 estimate. The largest components of these costs are hospital inpatient care (43 percent) and medications to treat complications (18 percent). People with diagnosed diabetes incur average medical costs of about $13,700 per year, of which about $7,900 is attributed to diabetes. Care for people with diagnosed diabetes accounts for more than one in five dollars spent on health care in the United States, and more than half of that is directly attributable to diabetes. Overall, average medical expenses for a person with diabetes are 2.3 times higher than they are for a person without diabetes.[9]

Diabetes in Florida

Diabetes was the seventh leading cause of death in 2014 in Florida.[10] The prior year, diabetes had been the sixth leading cause of death. As a percentage of total deaths in the state, diabetes accounted for 2.9 percent of all deaths, and over a three year period (2012 - 2014), diabetes had an age adjusted death rate per 100,000 of 19.7 or 15,597 deaths.[11]

Florida's Diabetes Advisory Council

The Diabetes Advisory Council was reinstated in law in 1980 to guide statewide policy on diabetes prevention, diagnosis, education, care, treatment, impact, and costs.[12] It serves in an advisory capacity to the Department of Health (DOH), other agencies, and the public. The council consists of 26 members appointed by the Governor who have experience related to diabetes. Twenty-one of the members are representatives of a broad range of health and public health-related interests. The remaining five members are representatives of the general public, at least three of whom are affected by diabetes. The council meets annually with the State Surgeon

---

[7] *Id.*

[8] The ADA was founded in 1940 by 26 physicians. It remained an organization for health care professionals during its first 30 years. In 1970, the Association welcomed general members. In the years since, it has grown to include a network of more than 1 million volunteers. See American Diabetes Association, 75 Years of Progress, available at: http://www.diabetes.org/about-us/75th-anniversary/ (last visited Feb. 10, 2016).

[9] American Diabetes Association, *Economic Costs of Diabetes in the U.S. in 2012*, Diabetes Care 36: 1033 – 1046, 2013, *available at*, http://care.diabetesjournals.org/content/36/4/1033.full.pdf+html (last visited Feb. 11, 2016).

[10] Florida Department of Health, *Florida Vital Statistics Annual Report*, p. 18, available at: http://www.flpublichealth.com/VSBOOK/pdf/2014/Deaths.pdf, (last visited Feb. 11, 2016).

[11] Florida Department of Health, *Florida Charts: Diabetes Deaths - Three Year Trends* http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090 (last visited Feb. 11, 2016).

[12] Chapter 1980-62, Laws of Fla. (reinstating the Diabetes Advisory Council into Chapter 381, F.S., pertaining to health.) The council had previously been located under ch. 241, F.S., relating to education and had been repealed by the 1979 Legislature. *See Florida Legislature - 1980 Summary of General Legislation*, p. 145, available at: http://www.law.fsu.edu/library/collection/FlSumGenLeg/FlSumGenLeg1980.pdf (Last visited February 11, 2016).

General to make recommendations regarding the public health aspects of the prevention and control of diabetes.[13]

Diabetes Educators

The American Diabetes Association (ADA) defines a "diabetes educator" as, "a health care professional who teaches people who have diabetes how to manage their diabetes."[14] Diabetes educators are found in hospitals, physician offices, managed care organizations, home health care, and other settings.[15]

The State of Florida does not currently license or regulate diabetes educators. The existing scope of practice in Florida for the following health care professions includes patient or client education, and that education can relate to diabetes:

- Medical Physician
- Osteopathic Physician
- Podiatric Physician
- Chiropractic Physician
- Dentist
- Pharmacist
- Advanced Registered Nurse Practitioner (ARNP, CNS, CRNA)
- Physician Assistant
- Registered Nurse
- Dental Hygienist
- Licensed Practical Nurse
- Paramedic
- Emergency Medical Technician
- Dietitian/Nutritionist
- Orthotist
- Acupuncturist
- Athletic Trainer
- Physical Therapist
- Massage Therapist
- Prosthetist
- Midwifery
- Optician
- Optometrist
- School Psychologist
- Orthotic Fitter

---

[13] Section 385.203, F.S. The Diabetes Advisory Council and the Florida Diabetes Alliance's Florida's Diabetes Strategic Plan 2015 – 2020 contains no recommendations for this new profession of licensed diabetes educators. *See* Florida Department of Health, Diabetes Advisory Council, *Diabetes Strategic Plan 2015 – 2020*, available at: http://www.floridahealth.gov/provider-and-partner-resources/dac/_documents/2015-strategic-plan.pdf, (last visited Feb. 15, 2016).

[14] *See* American Diabetes Association, Diabetes Basics, *Common Terms*, available at: http://www.diabetes.org/diabetes-basics/common-terms/?loc=db-slabnav, (Last visited February 10, 2016).

[15] *Id.*

- Mental Health Counselor
- Clinical Psychologist
- Clinical Social Worker

Kentucky enacted a diabetes educator law in 2013,[16] and Indiana did so in 2014.[17] Both are under the respective state's board of medicine. Kentucky provides three paths for individuals to become licensed as diabetes educators. An individual must file an application, pay a fee, and demonstrate completion of any one of the following:

- A board-approved course in diabetes education with demonstrable experience in the care of people with diabetes under supervision that meets requirements specified in administrative regulations promulgated by the board;[18] or
- The credentialing program of the American Association of Diabetes Educators (AADE) or the National Certification Board for Diabetes Educators (NCDBE); or
- An equivalent credentialing program as determined by the board.

Indian's law is similar to Kentucky's as a diabetes educator license can be obtained by demonstrating completion of one of the four following:

- The AADE core concepts course[19] with demonstrable experience in the care of individuals with diabetes under supervision that meets requirements specified in rules adopted by the board.
- The credentialing program of the AADE;
- The credentialing program of the NCBDE; or
- An equivalent credentialing program as determined by the board.

The AADE was founded in 1973, as a multi-disciplinary professional membership organization dedicated to improving diabetes care through education. It has more than 14,000 members including nurses, dietitians, pharmacists and others. The AADE offers the Board Certified-Advanced Diabetes Management (BC-ADM) credential.[20]

---

[16] The Kentucky Board of Licensed Diabetes Educators, *Laws and Regulations Relating to Licensed Diabetes Educators*, s. 309.335, K.R.S., p. 7, available at: http://bde.ky.gov/Documents/Laws%20and%20Regulations.pdf, (last visited Feb. 11, 2016).

[17] See IC 25-14.3-3-3, (2015), available at http://www.in.gov/pla/files/2015_Medical_Compilation.pdf, (last visited Feb. 11, 2016).

[18] 201 KAR 45:110 (2015), requires the apprentice diabetes educator to accumulate at least 750 hours of supervised work experience in 5 years with 250 of the hours being obtained in the 12 months preceding licensure application. The apprentice is required to interact with the supervisor at least two hours quarterly, one hour of which must be in person. A supervisor shall not supervise more than four apprentices at a time. The supervision process shall focus on: (a) Identifying strengths, developmental needs, and providing direct feedback to foster the professional development of the apprentice diabetes educator; (b) Identifying and providing resources to facilitate learning and professional growth; (c) Developing awareness of professional and ethical responsibilities in the practice of diabetes education; and (d) Ensuring the safe and effective delivery of diabetes education services and fostering the professional competence and development of the apprentice diabetes educator.

[19] American Association of Diabetes Educators, *CORE Concepts Course On Line*, is available for a cost of between $386 - $586, *available at* https://www.diabeteseducator.org/education-career/online-courses/ccc-online, (last visited Feb. 11, 2016).

[20] The American Association of Diabetes Educators, *About AADE*, available at: https://www.diabeteseducator.org/about-aade, (last visited Feb. 12, 2016).

Healthcare professionals who hold BC-ADM certification, if within their scope of practice, are trained to:

- Adjust medications;
- Treat and monitor complications and other comorbidities;
- Council patents on lifestyle modifications;
- Address psychosocial issues; and
- Participate in research and mentoring.

Certification as a BC-ADM requires a current active licensure/registration as a registered nurse, dietitian, pharmacist, physician or physician assistant, a master's or higher level degree, and 500 clinical practice hours within 48 months prior to taking the certification exam.[21]

The NCBDE was established in 1986 as an independent organization that promotes the interests of diabetes educators and the public by granting certification to qualified health professionals. The NCBDE offers the Certified Diabetes Educator (CDE) credential. Individuals holding the CDE credential educate people affected by diabetes to manage the condition and promote self-management in order to optimize health outcomes.[22]

Certification as a CDE requires active licensure/registration as a psychologist, registered nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, dietitian with a Commission on Dietetic Registration (CDR), or a health professional with a master's degree or higher in social work. Professional practice experience, continuing education and an examination are also required.[23]

The CDC has also established the CDC National Diabetes Recognition Program (NDRP) as part of the National Diabetes Prevention Program (NDPP).[24] The NDPP is a partnership of public and private organizations working to reduce the growing problem of lack of public education on prediabetes and type 2 diabetes.[25] A key part of the NDPP is the lifestyle change program to prevent or delay type 2 diabetes. Hundreds of in-person, and online, lifestyle change programs nationwide teach participants to make CDC approved lasting lifestyle changes, like eating healthier, adding physical activity into a daily routine, and improving coping skills. To ensure high quality, the CDC recognizes lifestyle change programs that meet certain standards and show they can achieve results. These standards include following an approved curriculum, facilitation by a trained lifestyle coach, and submitting data each year to show that the program is having an impact. The NDPP must use a lifestyle coach to deliver the program to participants. Many

[21] Id.
[22] National Certification Board for Diabetes Educators, *History*, http://www.ncbde.org/about/history/ (last visited Feb. 12, 2016).
[23] Id.
[24] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *Diabetes Prevention Recognition Program, Standards and Operating Procedures*, available at: http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf, (last visited Feb. 11, 2016).
[25] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *What Is the National DPP?*, http://www.cdc.gov/diabetes/prevention/about/index.html, (last visited Feb. 11, 2016).

lifestyle coaches are registered dieticians or registered nurses, but no credentials are required;[26] and the CDC has a free lifestyle coach facilitator training guide available on its website.[27]

The AADE also offers NDPP diabetes lifestyle coach training based on the curriculum of the CDC in a 2 day, in person, course for $750 - $850 to acquire all necessary skills to deliver a successful CDC NDRP/NDPP Program.[28]

The Sunrise Act and Sunrise Questionnaire

The Sunrise Act (the act), codified in s. 11.62, F.S., requires the Legislature to consider specific factors in determining whether to regulate a new profession or occupation. The legislative intent in the act provides that:

- No profession or occupation be subject to regulation unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the state's police power be exercised only to the extent necessary for that purpose; and
- No profession or occupation be regulated in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the services to the public.

The Legislature must review all legislation proposing regulation of a previously unregulated profession or occupation and make a determination for regulation based on consideration of the following:

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

The act requires the proponents of legislation for the regulation of a profession or occupation to provide specific information in writing to the state agency that is proposed to have jurisdiction

[26] *Supra* note 20, at 25.
[27] U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *National Diabetes Prevention Program, Life Coach Facilitation Guide* http://www.cdc.gov/diabetes/prevention/pdf/curriculum_intro.pdf (last visited Feb. 11, 2016).
[28] American Association of Diabetes Educators, *AADE Diabetes Prevention Program Lifestyle Coach Training*, https://www.diabeteseducator.org/practice/diabetes-prevention-program/lifestyle-coach-training (last visited Feb. 11, 2016).

over the regulation and to the legislative committees of reference.[29] This required information is traditionally compiled in a "Sunrise Questionnaire."

III. Effect of Proposed Changes:

SB 1286 creates part XVII of ch. 468, F.S., entitled "Diabetes Educator Practice," to establish a new licensed and regulated profession in Florida, the diabetes educator.

The bill enumerates that the previously unregulated profession or occupation of a diabetes educator requires licensing and regulating for the following reasons:

- The practice of diabetes education or diabetes self-management education and training (DSME/T) requires highly skilled and educated professionals to protect the public health and safety;
- It is difficult for the public to make informed choices about diabetes education;
- The consequences of choosing the wrong diabetic education could seriously endanger the public health and safety; and
- A person practicing diabetes education or DSME/T who falls below a minimum level of competent, safe practice presents a danger to the public.

The bill defines the following terms for the diabetes educator practice:

- "Board Certified–Advanced Diabetes Management Professional" means a health care professional who has passed the BC-ADM examination administered by the AADE.
- "Certified diabetes educator" or "CDE" means a health care professional who:
  - Possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention, and DSME/T; and
  - Has passed the NCBDE certification examination for diabetes educators.
- "Council" means the Dietetics and Nutrition Practice Council which will regulate diabetes educators under the supervision of the BOM;
- "Diabetes self-management education and training" or "DSME/T" means educational services provided for diabetes self-management included in the national standards published by the AADE and the ADA.
- "Licensed diabetes educator" or "LDE" means a person who has met all requirements of this part to receive a license;
- "National Certification Board for Diabetes Educators" or "NCBDE" means the board that conducts the national certification program and administers certification.
- "Practice of diabetes education or DSME/T" means the assessment of a person with or at risk for diabetes, the development of a plan of care for that person, the evaluation of the person's response to the implementation of the plan of care, and the recording and evaluation of the person's experience.

The bill requires that a person have a license issued by the DOH in order to engage in diabetes education or DSME/T for remuneration, or hold himself or herself out as a diabetes educator or DSME/T. To qualify for a license a person must submit a written application and provide evidence that the applicant has met one of the following requirements:

[29] See s. 11.62(4)(a)-(m), F.S.

- Passed the NCBDE examination[30] for and received certification as a CDE;
- Passed the BC-ADM examination[31] and received the AADE's BC-ADMdesignation; or
- Completed 250 hours of experience under the supervision of a CDE, with 40 percent of the hours earned in the 12 months immediately before application, and passed a certification examination administered by the NCBDE.

The bill does not prohibit allopathic or osteopathic physicians, physician assistants, podiatrists, dentists, nurses, optometrists, or pharmacists, or their respective supervised employees, or federal employees discharging their official duties, from practicing diabetes education or DSME/T within the scope their license.

The bill limits the scope of practice for the following Florida healthcare practitioners, currently able to engage in diabetes education and DSME/T under their respective practice acts, from practicing diabetes education or DSME/T without obtaining a separate license:

- Chiropractic Physicians
- Naturopathic Physicians
- Paramedics
- Emergency Medical Technicians
- Dietitians
- Nutritionists
- Orthotists
- Acupuncturists
- Athletic Trainers
- Physical Therapists
- Massage Therapists
- Prosthetists
- Midwives
- School Psychologists
- Orthotic Fitters
- Mental Health Counselors

[30] In order to sit for the NCBDE examination a candidate must have a current unrestricted active license or registration as a clinical psychologist, registered nurse, occupational therapist, optometrist, pharmacist, physical therapist, physician, podiatrist, master certified health education specialist, certified clinical exercise physiologist, registered clinical exercise physiologist, registered dietitian, dietitian, nutritionist, or registered physician assistant; or hold a minimum of a master's degree in social work from a U.S. college or university accredited by a nationally recognized regional accrediting body. If the candidate does not have these credentials he or she may investigate the NCBDE's Unique Pathway which requires a degree, two calendar years of practice experience within the last four years since receiving the license, registration or advanced degree; 1000 hours of practice experience in DSME within the last 4 years of which 40 percent (400 hours) must have been accrued in the last year; and 15 hours of continuing education applicable to diabetes within the past 2 years. *See* National Certification Board for Diabetes Educators, *2016 Certification Examination for Diabetes Educators*, Rev. November 20, 2015, available at: http://www.ncbde.org/assets/1/7/Handbook_Current.pdf, (last visited Feb. 12, 2016).

[31] Certification as a BC-ADM requires a current active licensure/registration as a registered nurse, dietitian, pharmacist, physician or physician assistant, a master's or higher level degree, and 500 clinical practice hours within 48 months prior to taking the certification exam. *See* American Association of Diabetes Educators, *Candidate Handbook For the American Association of Diabetes Educators (AADE) Board Certified Advanced Diabetes Management (BC-ADM) Examination*, updated May 26, 2015, available at: https://castleworldwide.com/aade/AppSystem/6/Public/Resource/AADE_Candidate_Handbook.pdf, (last reviewed Feb. 12, 2016).

- Clinical Psychologists
- Clinical Social Workers

Under the bill the above listed healthcare practitioners could be subject to discipline for providing diabetes education to their patients or clients under their respective practice acts for violating s. 456.072(1)(o)., F.S., for practicing or offering to practice beyond the scope of law.

The bill allows licensed diabetes educators from any U.S. state or territory, or foreign country, whose licensure requirements were equal to, or exceed, those of Florida, to engage in the practice of diabetes education or DSME/T without obtaining a Florida license.

The bill expands the role of the Dietetics and Nutrition Practice Council (council)[32]giving it the additional responsibility, under the supervision of the BOM, for licensing, monitoring, and disciplining diabetes educators. The BOM is required to certify, and the council is required to issue licenses by endorsement, to qualified applicants who submit an application, fee and evidence of one of the following:

- A CDE or BC-ADM designation; or
- A valid license to practice diabetes education or DSME/T issued by another U.S. state or territory, if the board determines that the criteria for the issuance of such license are substantially equivalent to those of this state.

The bill requires the BOM to set all application, licensure, endorsement and renewal fees, within limits, and to make rules to implement part XVII of ch. 468, F.S.

The bill creates a first degree misdemeanor criminal offense for practicing DSME/T or engaging in diabetes education for remuneration, or holding oneself out as a diabetes educator, unless licensed as required by the act.

The bill also provides grounds for disciplinary action including grounds for denial of a license.

Section 468.506, F.S., relating to the council, is amended to change the composition of the council. Rather than four persons licensed under the Dietetics and Nutrition Practice Act, membership of these practitioners is reduced to three and one person licensed as a diabetes educator is added to the council.

The bill has an effective date of January 1, 2018.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

None.

[32] The Dietetics and Nutrition Practice Council is currently under the Board of Medicine. It approves applications for licensure for dieticians and nutritionists, but the council does not have authority to discipline licensees. The Board is tasked with all matters relating to the discipline of Dietitian/Nutritionists. *See* s.468.505, F.S.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

SB 1286 establishes maximum fees as follows:

- A nonrefundable application fee - $100;
- An initial licensure fee - $100;
- A biennial renewal fee - $50;
- A fee for licensure by endorsement - $350;
- A fee for a temporary permit - $100; and
- A fee for reactivation of an inactive license - $50.

B. Private Sector Impact:

The bill will require chiropractic physicians, naturopathic physicians, paramedics, emergency medical technicians, dietitians, nutritionists, orthotists, acupuncturists, athletic trainers, physical therapists, massage therapists, prosthetists, midwives, school psychologists, orthotic fitters, mental health counselors, clinical psychologists, and clinical social workers to cease diabetes education in the course of their care of patients with, or at risk of having, diabetes or obtain additional training and another license.

Healthcare practitioners providing diabetes education will now require an additional license. Individuals will be required to pay all fees associated with initial licensure and licensure renewal/reactivation. Individuals will also be responsible for any costs associated with obtaining and maintaining the needed certifications and continuing education.

The bill may limit patient and public access to diabetes education by restricting the persons who could provide that information, including the above noted health care providers who may choose not to be dually licensed. Non-profit diabetes education providers as well as health and wellness service providers may also be adversely impacted.

C. Government Sector Impact:

The Division of Medical Quality Assurance (MQA) will be required to license and regulate a new profession. The CBMT indicates that there are over 14,000 diabetes educators with BC-ADM credentials nationwide, yet it is unknown how many are in Florida; therefore the fiscal impact is indeterminate at this time.

VI. Technical Deficiencies:

- Lines 127 - 131 exempt a person licensed under the laws of another state or territory whose licensure requirements are equal to or exceed Florida's from licensure in this state. This appears to allow a person to practice in Florida without being subject to regulation or disciplinary action in the event of a failure to meet practice requirements or criminal conviction. These lines also appear to be in conflict with lines 204 - 208 which provide for a person so licensed in another state to apply for licensure in this state by endorsement.
- The powers and duties vested in the Council in lines 134 - 139 and 362 - 365 appear to be in conflict with s. 468.506, F.S., which limits powers and duties of the Council to those delegated by the BOM.
- Lines 332 - 336 refers to reissuance of a license and final orders issued by the "board" which appears to be in conflict with lines 134 - 139 which specify that the council will license and discipline diabetes educators.
- The bill makes multiple references to the Council issuing/reissuing and renewing licenses. The DOH is the entity that issues/reissues and renews licenses.
- The bill provides for a temporary permit fee, however, it does not specify the requirements for obtaining a temporary permit. Based upon the requirements specified for permanent licensure it is not clear that a temporary permit process is required.

VII. Related Issues:

The Florida Senate Sunrise Questionnaire to aid the Legislature in determining the need to regulate diabetes educators has been provided to the Senate Health Policy Committee.

The bill will impact the scope of practice for some currently regulated health care providers such as chiropractic physicians, naturopathic physicians; paramedics, emergency medical technicians, dietitians, nutritionists, orthotists, acupuncturists, athletic trainers, physical therapists, massage therapists, prosthetists, midwives, school psychologists, orthotic fitters, mental health counselors, clinical psychologists, and clinical social workers. They will no longer be able to provide diabetes education to their patients or clients without obtaining this additional license.

The number of individuals who will qualify for, or pursue licensure is unknown. The restrictions on the practice of providing diabetes education may affect the public's access to these services.

The effective date of the act is January 1, 2018. Providing an effective date prior to the requirement for licensure may facilitate implementation of the act.

VIII. Statutes Affected:

This bill substantially amends section 468.506 of the Florida Statutes.

This bill creates the following sections of the Florida Statutes: 468.931, 468.944, 468.932, 468.933, 468.934, 468.935, 468.936, 468.937, 468.938, 468.939, 468.940, 468.941, 468.942, and 468.943.

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Gibson

9-01017A-16 20161286__

A bill to be entitled

An act relating to diabetes educator practice; creating part XVII of ch. 468, F.S., entitled "Diabetes Educators Practice"; creating s. 468.931, F.S.; providing legislative findings and intent; creating s. 468.932, F.S.; defining terms; creating s. 468.933, F.S.; prohibiting a person from engaging in diabetes education or diabetes self-management education or training unless he or she holds a certain license; creating s. 468.934, F.S.; providing applicability; creating s. 468.935, F.S.; specifying that the Dietetics and Nutrition Practice Council, under the supervision of the Board of Medicine, is responsible for licensing, monitoring, and disciplining diabetes educators; creating s. 468.936, F.S.; authorizing the board to adopt rules, subject to certain requirements; creating s. 468.937, F.S.; requiring the board to establish licensure and other fees and capping certain fees; creating s. 468.938, F.S.; providing requirements for licensure as a diabetes educator; creating s. 468.939, F.S.; providing for the use of certain titles by a licensed diabetes educator; requiring a person licensed under this part to display and exhibit the license pursuant to board rule; creating s. 468.940, F.S.; providing for licensure by endorsement; providing an exception; creating s. 468.941, F.S.; requiring the council to issue license renewals in certain circumstances; requiring the board to adopt rules that establish a procedure for the biennial renewal of diabetes educator licenses; creating s. 468.942, F.S.; authorizing the reactivation of inactive licenses

9-01017A-16 20161286__

under certain circumstances; requiring the board to adopt rules for inactive licenses and continuing education requirements for the reactivation of licenses; creating s. 468.943, F.S.; providing prohibitions and penalties; creating s. 468.944, F.S.; specifying grounds for denial of licensure or disciplinary action; amending s. 468.506, F.S.; revising the membership and responsibilities of the Dietetics and Nutrition Practice Council; requiring the council to ensure that diabetes educators meet certain requirements; providing an effective date.

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

Section 1. Part XVII of chapter 468, Florida Statutes, consisting of ss. 468.931-468.944, Florida Statutes, is created and entitled "Diabetes Educators Practice."

Section 2. Section 468.931, Florida Statutes, is created to read:

468.931 Legislative findings and intent.—The Legislature finds that the practice of diabetes education or diabetes self-management education and training (DSME/T) requires highly skilled and educated professionals to protect the public health and safety. The Legislature further finds that it is difficult for the public to make informed choices about diabetes education and that the consequences of wrong choices could seriously endanger the public health and safety. The sole legislative purpose in enacting this part is to ensure that every person who practices diabetes education or DSME/T in this state meets

minimum requirements for safe practice. It is the intent of the Legislature that any person practicing diabetes education or DSME/T who falls below minimum competency or who otherwise presents a danger to the public be prohibited from practicing in this state. It is also the intent of the Legislature that the practice of diabetes education or DSME/T be authorized and regulated solely within the limits expressly provided by this part and rules adopted thereunder.

Section 3. Section 468.932, Florida Statutes, is created to read:

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

(1) "Board" means the Board of Medicine.

(2) "Board Certified-Advanced Diabetes Management Professional" means a health care professional who has passed the Board Certified-Advanced Diabetes Management (BC-ADM) examination administered by the American Association of Diabetes Educators.

(3) "Certified diabetes educator" or "CDE" means a health care professional who possesses comprehensive knowledge of and experience in prediabetes, diabetes prevention, and DSME/T, and who has passed the National Certification Board for Diabetes Educators (NCBDE) certification examination for diabetes educators.

(4) "Council" means the Dietetics and Nutrition Practice Council created by s. 468.506 which regulates the licensure of diabetes educators under the direct supervision of the board.

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

(6) "Diabetes self-management education and training" or "DSME/T" means educational services provided for diabetes self-

management included in the national standards published by the American Association of Diabetes Educators and the American Diabetes Association.

(7) "Licensed diabetes educator" or "LDE" means a person who has met all of the requirements of this part to receive a license pursuant to s. 468.938.

(8) "National Certification Board for Diabetes Educators" or "NCBDE" means the board that conducts the national certification program and administers certification in a manner that upholds standards for competent practice in diabetes education and DSME/T.

(9) "Person" means a natural person.

(10) "Practice of diabetes education or DSME/T" means the assessment of a person with or at risk for diabetes, the development of a plan of care for that person, the evaluation of the person's response to the implementation of the plan of care, and the recording and evaluation of the person's experience.

Section 4. Section 468.933, Florida Statutes, is created to read:

468.933 License required.—A person may not engage for remuneration in diabetes education or DSME/T or hold himself or herself out as a practitioner of diabetes education or DSME/T unless he or she is licensed in accordance with this part.

Section 5. Section 468.934, Florida Statutes, is created to read:

468.934 Applicability.—This part does not prohibit:

(1) A person licensed in this state under chapter 458, chapter 459, chapter 461, chapter 463, part I of chapter 464, chapter 465, or chapter 466, when engaging in the profession or

occupation for which he or she is licensed, or any person employed by and performing tasks or activities under the supervision of the licensee, from rendering services within the scope of the profession or occupation of the licensee.

(2) A person who is employed by the Federal Government or any bureau, division, or agency of the Federal Government from discharging his or her official duties.

(3) A person who is a diabetes educator licensed under the laws of another state or territory of the United States or another country whose licensure requirements are equal to or exceed those defined in this part from engaging in diabetes education or DSME/T.

Section 6. Section 468.935, Florida Statutes, is created to read:

468.935 Dietetics and Nutrition Practice Council.—In addition to the powers and duties delegated to the Dietetics and Nutrition Practice Council under s. 468.506, the council is responsible, under the supervision of the board, for licensing, monitoring, and disciplining diabetes educators to ensure that minimum requirements for competency and safe practice are met.

Section 7. Section 468.936, Florida Statutes, is created to read:

468.936 Rulemaking Authority.—The board may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this part and chapter 456. The powers and duties of the board as set forth in this part are supplemental and additional to those conferred upon the board by chapter 458 and do not limit or supersede the powers and duties of the board under that chapter.

Section 8. Section 468.937, Florida Statutes, is created to

read:

468.937 Fees.—The board shall establish by rule the following fees, which must be adequate to administer and implement this part:

(1) A nonrefundable application fee, which may not exceed $100.

(2) An initial licensure fee, which may not exceed $100.

(3) A biennial renewal fee, which may not exceed $50.

(4) A fee for licensure by endorsement, which may not exceed $350.

(5) A fee for a temporary permit, which may not exceed $100.

(6) A fee for reactivation of an inactive license, which may not exceed $50.

(7) Fees for application and certification verification, recordmaking, and recordkeeping, respectively.

Section 9. Section 468.938, Florida Statutes, is created to read:

468.938 Licensure requirements.—To qualify for a license to practice as a diabetes educator, a person must submit a written application on forms provided by the board evidencing and ensuring to the satisfaction of the board that the applicant has met one or more of the following requirements:

(1) Passed the National Certification Board of Diabetes Educator's (NCBDE) examination for and received certification as a certified diabetes educator (CDE).

(2) Passed the Board Certified-Advanced Diabetes Management (BC-ADM) examination and received the American Association of Diabetes Educators' BC-ADM designation.

(3) Completed a minimum of 250 hours of experience under the supervision of an CDE, with at least 40 percent of those hours earned in the 12 months immediately before submitting an application, and passed a certification examination administered by the NCBDE.

Section 10. Section 468.939, Florida Statutes, is created to read:

468.939 License to be displayed.—

(1) A licensed diabetes educator may use the term "licensed diabetes educator" or "LDE" in connection with his or her name or place of business to denote licensure under this part.

(2) Each person who is issued a license under this part shall conspicuously display the license in his or her office, place of business, or place of employment and shall exhibit such license to any member or authorized representative of the board as required by board rule.

Section 11. Section 468.940, Florida Statutes, is created to read:

468.940 Licensure by endorsement.—

(1) The council shall issue a license by endorsement to an applicant whom the board certifies as qualified, upon receipt of a completed application and the fee specified in s. 468.937.

(2) The board shall certify as qualified for licensure by endorsement under this section an applicant who:

(a) Presents evidence satisfactory to the board that he or she is a CDE or has received a BC-ADM designation; or

(b) Holds a valid license to practice diabetes education or DSME/T issued by another state, district, or territory of the United States, if the board determines that the criteria for the

issuance of such a license are substantially equivalent to or more stringent than those of this state.

(3) The council may not issue a license by endorsement under this section to an applicant who is under investigation in any jurisdiction for any act that would constitute a violation of this part or chapter 456 until the investigation is complete and disciplinary proceedings have been terminated.

Section 12. Section 468.941, Florida Statutes, is created to read:

468.941 Renewal of license.—

(1) The council shall renew a license under this part upon receipt of the renewal application and the fee specified in s. 468.937 and the successful completion of 75 hours of continuing education in the preceding 5 years or 15 hours of continuing education in the preceding year. For a biennial renewal, licensees must successfully complete 30 hours of continuing education during the 2-year license period.

(2) The board shall adopt rules establishing a procedure for the biennial renewal of licenses under this part.

Section 13. Section 468.942, Florida Statutes, is created to read:

468.942 Reactivation of license.—

(1) The board shall adopt rules relating to inactive licenses and for the reactivation of such licenses. The board shall also prescribe by rule continuing education requirements for reactivation of a license, which may not exceed 20 hours for each year the license was inactive.

(2) A license issued under this part which has become inactive may be reactivated upon receipt by the council of a

reactivation application, the fee specified in s. 468.937, and proof of the successful completion of continuing education required by the NBCDE and board rule.

Section 14. Section 468.943, Florida Statutes, is created to read:

468.943 Prohibitions; penalties.—

(1) A person may not knowingly do any of the following:

(a) Engage in diabetes education or the practice of DSME/T for remuneration unless the person is licensed under this part.

(b) Use the name or title "LDE," "licensed diabetes educator," "diabetes specialist," "diabetes educator," or any other words, letters, abbreviations, or insignia indicating or implying that he or she is a diabetes educator, or holds himself or herself out as such, unless the person is licensed under this part.

(c) Present as his or her own the license of another.

(d) Give false or forged evidence to the board or a member of the board.

(e) Use or attempt to use a license that has been suspended, revoked, or placed on inactive or delinquent status.

(f) Employ unlicensed persons to engage in diabetes education or DSME/T.

(g) Conceal information relative to any violation of this part.

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

Section 15. Section 468.944, Florida Statutes, is created to read:

468.944 Grounds for disciplinary action.—

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

(a) Violating this part, a board rule adopted pursuant to this part, or a lawful order of the board or council previously entered in a disciplinary hearing held pursuant to this part, or failing to comply with a lawfully issued subpoena of the department, board, or council. This paragraph also applies to an order or a subpoena previously issued by the department during its period of regulatory control over this part.

(b) Being unable to engage in diabetes education or DSME/T with reasonable skill and safety by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material or as a result of any mental or physical condition.

1. A licensee whose license is suspended or revoked pursuant to this paragraph, at reasonable intervals, shall be given an opportunity to demonstrate that he or she can resume the competent practice of diabetes education or DSME/T with reasonable skill and safety to patients.

2. The record of the proceeding or the orders entered by the board in a proceeding under this paragraph may not be used against a licensee in any other proceeding.

(c) Attempting to procure or procuring a license to practice diabetes education or DSME/T by fraud or misrepresentation of material fact.

(d) Having a license to practice diabetes education or DSME/T revoked, suspended, or otherwise acted against, including the denial of licensure by the licensing authority of another state, district, territory, or country.

(e) Being convicted or found guilty of, or entering a plea of nolo contendere to, regardless of adjudication, a crime in any jurisdiction which directly relates to the practice of or the ability to practice diabetes education or DSME/T.

(f) Making or filing a report or record, signed in the licensee's capacity as a licensed diabetes educator, which he or she knows to be false or willfully failing to file a signed report or record required by state or federal law, willfully impeding or obstructing such a filing, or inducing another person to impede or obstruct such a filing.

(g) Advertising goods or services in a manner that is fraudulent, false, deceptive, or misleading in form or content.

(h) Committing an act of fraud or deceit, or of negligence, incompetency, or misconduct in the practice of diabetes education or DSME/T.

(i) Practicing with a license that has been suspended, revoked, or placed on inactive or delinquent status.

(j) Treating or attempting to treat human ailments by means other than by diabetes education or DSME/T.

(k) Failing to maintain acceptable standards of practice as set forth by the board and the council in rules adopted pursuant to this part.

(l) Engaging directly or indirectly in the dividing, transferring, assigning, rebating, or refunding of fees received for professional services, or profiting by means of a credit or other valuable consideration, such as an unearned commission, a discount, or a gratuity, with a person referring a patient or with a relative or business associate of the referring person. This part does not prohibit the members of a regularly and

properly organized business entity that is composed of licensees under this part and recognized under the laws of this state from making any division of their total fees among themselves as they determine necessary.

(m) Advertising, by or on behalf of a licensee under this part, a method of assessment or treatment that is experimental or without generally accepted scientific validation.

(n) Violating this chapter or chapter 456, or any rules adopted thereunder.

(2) The council must reissue the license of a disciplined licensed diabetes educator upon certification by the board that the disciplined diabetes educator has complied with the terms and conditions set forth in the final order of the board disciplining the diabetes educator.

Section 16. Section 468.506, Florida Statutes, is amended to read:

468.506 Dietetics and Nutrition Practice Council.—There is created the Dietetics and Nutrition Practice Council under the supervision of the board. The council shall consist of three ~~four~~ persons licensed under this part, one person licensed under part XVII of this chapter, and one consumer who is 60 years of age or older. Council members shall be appointed by the board. Licensed members shall be appointed based on the proportion of licensees within each of the respective disciplines. Members shall be appointed for 4-year staggered terms. In order to be eligible for appointment, each licensed member must have been a licensee under this part for at least 3 years before ~~prior to~~ his or her appointment. A ~~No~~ council member may not ~~shall~~ serve more than two successive terms. The board may delegate such

powers and duties to the council as it may deem proper to carry out the operations and procedures necessary to implement ~~effectuate the provisions of~~ this part. However, the powers and duties delegated to the council by the board must encompass both dietetics and nutrition practice and nutrition counseling. The council shall also operate under the supervision of the board to ensure that diabetes educators in this state meet at least the minimum requirements for the safe practice of diabetes education or DSME/T. In addition to being responsible for licensing, monitoring, disciplining, and educating dietitians, nutritionists, and nutrition counselors, the council is responsible for licensing, monitoring, and disciplining diabetes educators to ensure patient safety and competency to practice in this state. Any time there is a vacancy on the council, any professional association composed of persons licensed under this part may recommend licensees to fill the vacancy to the board in a number at least twice the number of vacancies to be filled, and the board may appoint from the submitted list~~, in its discretion, any of those persons so recommended~~. Any professional association composed of persons licensed under this part may file an appeal regarding a council appointment with the State Surgeon General, whose decision shall be final. The board shall fix council members' compensation and pay their expenses in the same manner as provided in s. 456.011.

Section 17. This act shall take effect January 1, 2018.

FLORIDA SENATE
SUNRISE QUESTIONNAIRE

INSTRUCTIONS FOR COMPLETING THIS QUESTIONNAIRE:

Regulation of professions is mandated by the Legislature only for the preservation of the health, safety, and welfare of the public. The criteria for regulating a health care profession are set forth in various sections of ch. 456, F.S., which governs all professionals regulated by the Department of Health. If the Legislature authorizes regulation of your profession, you will be subject to the provisions contained in this chapter, as well as your individual practice act. Nothing in your practice act should conflict with ch. 456, F.S. Please familiarize yourself with this chapter prior to submitting proposed Sunrise legislation.

This questionnaire is designed to obtain information that will aid the Legislature in determining the need for regulation of your profession and in analyzing proposed legislation seeking to establish regulation under the Department of Health. Your cooperation in completing this questionnaire is greatly appreciated.

Each part of every question must be addressed. If there is no information available to answer the question, please state this as your response and describe what you did to attempt to find information that would answer the question. If you think the question is not applicable, please state this and explain your response. When supporting information is appropriate, it should be included as an appendix and labeled accordingly. References within the main document to information contained in the appendices should be properly labeled.

Please read the entire questionnaire before answering any questions so that you will understand what information is being requested and how questions relate to each other.

Legislative History

1. What is the history of regulation or attempts at regulation of this group? For example, has this profession ever been regulated and subsequently deregulated? Has legislation requiring regulation been filed in the past? Has legislation requiring regulation passed and been vetoed? Please explain why the regulation was sunset, why bills did not pass or why legislation was vetoed.

Applicant Group Identification

This section of the questionnaire is designed to help identify the group seeking regulation and to determine if the applicant group adequately represents the occupation.

2. What occupational group is seeking regulation? Identify by name, address, phone number, and associational affiliation the individuals who should be contacted when communicating with this group regarding this questionnaire.

3. List all titles currently used by Florida practitioners of this occupation. Estimate the total number of practitioners now in Florida and the number using each title. Document the source of this estimate.

4. Identify each occupational association or similar organization representing current practitioners in Florida and estimate its membership. Please provide membership lists to document the numbers of people in these associations. List the names of any associated national group.

5. Estimate the percentage of practitioners who support this request for regulation. Document the source of this estimate

6. Name the group or individual representing the practitioners in this effort to seek regulation. How was this group or individual selected?

7. Are all practitioner groups listed in response to questions represented in the organization or by the individuals seeking regulation? If not, why?

Consumer Group Identification

This section is designed to identify consumers who typically seek practitioner services and to identify groups, outside of those seeking regulation, with an interest in the proposed regulation.

8. Do practitioners typically deal with a specific consumer population? Are clients generally individuals or organizations? Document.

9. Identify any advocacy groups representing Florida consumers of this service, e.g., AARP. List also the name of any applicable national advocacy groups.

10. Identify the consumer populations not now using practitioner services who will be likely to do so, if regulation is approved.

11. Name any groups who will oppose this proposed regulation or others with an interest in this proposed regulation. If there are none, indicate efforts made to identify them.

Need for Regulation?

A. The unregulated Practice of this occupation will harm or endanger the public health, safety, and welfare.

12. Is there or has there been significant public need and demand for a regulatory standard? Document. If not, what is the basis for seeking regulation?

13. What harm to the public has occurred as a result of the unregulated practice of this profession? What is the nature and severity of the harm? Document the physical, social, intellectual, financial, health, safety, and welfare threats to the consumer if this practice remains unregulated.

14. How likely is it that harm will occur? Cite cases or instances of consumer injury and the estimated number of these injuries. If there are none, how is harm currently avoided?

15. What are the estimated numbers of complaints against professionals practicing this profession? (Some information can be obtained from the Department of Agriculture, Division of Consumer Services, or the State Attorney's Office.)

16. What provisions of the proposed legislation would protect the consumer from injury?

B. Existing protection available to the consumer is insufficient.

17. Is there a national certification or registration available for this profession? If yes, what percentage of practitioners in Florida currently are members?

18. To what extent do consumers currently control their exposure to risk? How do clients locate and select practitioners?

19. Are clients frequently referred to practitioners for services? Give examples of referral patterns.

20. Are clients frequently referred elsewhere by practitioners? Give examples of referral patterns.

21. What sources exist to inform consumers of the risk inherent in incompetent practice and of what practitioner behaviors constitute competent performance?

22. What administrative or legal remedies are currently available to redress consumer injury and abuse in this field?

23. Are the currently available remedies insufficient or ineffective? If so, please explain.

C. No alternatives to regulation will adequately protect the public

24. Explain why marketplace factors will not be as effective as governmental regulation in ensuring public welfare. Document specific instances in which market controls have broken down or proven ineffective in assuring consumer protection.

25. Are there other states in which this occupation is regulated? If so, identify the states and indicate the manner in which consumer protection is ensured in those states. Provide as an appendix copies of the regulatory provisions from these states.

26. What means other than governmental regulation have been employed in Florida to ensure consumer health, safety, and welfare? Show why the following would be inadequate:
    (a) code of ethics
    (b) codes of practice enforced by professional associations
    (c) national certification
    (d) dispute-resolution mechanisms such as mediation or arbitration
    (e) recourse to current applicable law
    (f) regulation of those who employ or supervise practitioners
    (g) caveat emptor, i.e., "let the buyer beware"
    (h) other measures attempted

27. If a "grandfather" clause (in which current practitioners are exempted from compliance with proposed entry standards) will be allowed, how is that clause justified? What safeguards will be provided to consumers regarding this group?

D. Regulation will mitigate existing problems.

28. What specific benefits will the public realize if this occupation is regulated?

29. Which consumers of practitioner services are most in need of protection? Which require least protection? Which consumers will benefit most and least from regulation?

30. Provide evidence of "net" benefit when the following possible effects of regulation are considered:
    (a) restriction of opportunity to practice
    (b) restricted supply of practitioners
    (c) increased cost of services to consumers
    (d) increased governmental intervention in the marketplace

E. Practitioners operate independently, making decisions of consequences.

31. To what degree do individual practitioners make professional judgments of consequence? What are these judgments? How frequently do they occur? What are the consequences? Document.

32. To what extent do practitioners work independently, as opposed to working under the auspices of an organization, an employer, or a supervisor?

33. To what extent do decisions made by the practitioner require a high degree of skill or knowledge to avoid harm?

F. Functions and tasks of the occupation are clearly defined.

34. Does the proposed regulatory scheme define a scope of activity which requires licensure, or merely prevent the use of a designated job title or occupational description without a license? Explain.

35. Describe the important functions, tasks, and duties performed by practitioners. Identify the services and/or products provided.

36. Is there a consensus on what activities constitute competent practice of the occupation? If so, state and document. If not, what is the basis for assessing competence?

37. Is such competent practice measurable by objective standards such as peer review? Give examples.

38. Specify activities or practices that would suggest that a practitioner is incompetent. To what extent is public harm caused by personal factors such as dishonesty? Document.

G. The occupation is clearly distinguishable from other occupations that are already regulated.

39. What similar occupations have been regulated in Florida? Is the practice proposed for regulation part of another licensed profession's scope of practice?

40. Describe functions performed by practitioners proposing this legislation which differ from those performed by occupations listed in the above question.

41. What is the relationship among those groups listed in response to question 38 and practitioners? Can practitioners be considered a branch of a currently regulated occupation?

42. What impact will the requested regulation have upon the authority and scope of practice of currently regulated groups?

43. Are there unregulated occupations performing services similar to those of the group to be regulated? If so, estimate those numbers of unregulated practitioners.

44. Describe the similarities and differences between practitioners and the groups identified in the above question.

45. Will this legislation create confusion in the marketplace regarding who is licensed and who is not?

46. Will this generate scope of practice or unlicensed activity complaints?

H. The occupation requires possession of knowledge, skills, and abilities that are both teachable and testable.

47. Is there a generally accepted core set of knowledge, skills, and abilities without which a practitioner may cause public harm? Describe and document.

48. What methods are currently used to define the requisite knowledge, skills, and abilities? Who is responsible for defining them?

49. Are those skills, abilities, and knowledge testable? Is the work of the group sufficiently defined that competence could be evaluated by some standard (i.e., ratings of education, experience, or exam performance)? Is there a national examination given to test this skill, ability, and knowledge level? What is the name of the test and the name and address of the testing service that has developed and offers this examination?

50. List institutions and program titles offering accredited and nonaccredited preparatory programs in Florida. Estimate the annual number of graduates from each. If there are no such programs in Florida, list programs found elsewhere. Will out-of-state programs be recognized? How?

51. Apart from the above listed programs, indicate various methods of acquiring the required knowledge, skills, and ability such as apprenticeships, internships, on-the-job training, etc.

52. Estimate the percentage of current practitioners trained by each of the routes described in questions 49 and 50.

53. Does any examination or other measure currently exist to test for functional competence in this profession? If so, indicate how and by whom each was constructed and by whom it is currently administered. Include the name, address, and phone number. If not, indicate search efforts to locate such method.

54. Describe the format and content of each examination listed in question 52. Describe the sections of each examination. What competencies is each designed to measure? How do these relate to the knowledge, skills, and abilities listed in question 46?

55. If more than one examination is listed above, which do you intend to support, if any? Why? If none of the above, why not and what do you propose as an alternate?

Economic Impact

56. How many people are exposed annually to this occupation? Will regulation of the occupation affect this figure? If so, in what way?

57. What is the current cost of the service provided? Estimate the amount of money spent annually in Florida for the services of this group. How will regulation affect these costs? Provide documentation for your answers.

58. Outline major governmental activities you believe will be necessary to appropriately regulate practitioners.
    Some examples:
    (a) regulation by a newly created board, regulation by an existing board, or regulation by the department. (if an existing board is applicable, please identify that board);
    (b) credentials and licensure requirements review;
    (c) examination development and administration
    (d) licensure renewal;
    (e) enforcement of the law: complaints; investigations; prosecution; inspections; etc.
    (f) continuing education, approval and school accreditation, etc.

59. How many practitioners are likely to be licensed if regulation is approved? Document.

60. How many practitioners are expected to apply each year if regulation is adopted? Document.

61. If small numbers will apply in answers to 58 and 59, how are costs justified?

62. Does adoption of the requested regulation represent the most cost effective form of regulation? Indicate alternatives considered and costs associated with each.

Proposed Legislation

63. Attach a draft of the legislation proposing new regulation. Please include:
    (a) whether or not a board will be established
    (b) what background, education, and experience will be required by licensees
    (c) if an examination must be successfully completed
    (d) if a grandfather clause will be implemented and what the deadline date will be
    (e) what actions will be prohibited and what disciplinary measures will be allowed

11.62 Legislative review of proposed regulation of unregulated functions.—
(1) This section may be cited as the "Sunrise Act."
(2) It is the intent of the Legislature:
(a) That no profession or occupation be subject to regulation by the state unless the regulation is necessary to protect the public health, safety, or welfare from significant and discernible harm or damage and that the police power of the state be exercised only to the extent necessary for that purpose; and
(b) That no profession or occupation be regulated by the state in a manner that unnecessarily restricts entry into the practice of the profession or occupation or adversely affects the availability of the professional or occupational services to the public.
(3) In determining whether to regulate a profession or occupation, the Legislature shall consider the following factors:
(a) Whether the unregulated practice of the profession or occupation will substantially harm or endanger the public health, safety, or welfare, and whether the potential for harm is recognizable and not remote;
(b) Whether the practice of the profession or occupation requires specialized skill or training, and whether that skill or training is readily measurable or quantifiable so that examination or training requirements would reasonably assure initial and continuing professional or occupational ability;
(c) Whether the regulation will have an unreasonable effect on job creation or job retention in the state or will place unreasonable restrictions on the ability of individuals who seek to practice or who are practicing a given profession or occupation to find employment;
(d) Whether the public is or can be effectively protected by other means; and
(e) Whether the overall cost-effectiveness and economic impact of the proposed regulation, including the indirect costs to consumers, will be favorable.
(4) The proponents of legislation that provides for the regulation of a profession or occupation not already expressly subject to state regulation shall provide, upon request, the following information in writing to the state agency that is proposed to have jurisdiction over the regulation and to the legislative committees to which the legislation is referred:
(a) The number of individuals or businesses that would be subject to the regulation;
(b) The name of each association that represents members of the profession or occupation, together with a copy of its codes of ethics or conduct;
(c) Documentation of the nature and extent of the harm to the public caused by the unregulated practice of the profession or occupation, including a description of any complaints that have been lodged against persons who have practiced the profession or occupation in this state during the preceding 3 years;
(d) A list of states that regulate the profession or occupation, and the dates of enactment of each law providing for such regulation and a copy of each law;
(e) A list and description of state and federal laws that have been enacted to protect the public with respect to the profession or occupation and a statement of the reasons why these laws have not proven adequate to protect the public;
(f) A description of the voluntary efforts made by members of the profession or occupation to protect the public and a statement of the reasons why these efforts are not adequate to protect the public;
(g) A copy of any federal legislation mandating regulation;

(h) An explanation of the reasons why other types of less restrictive regulation would not effectively protect the public;
(i) The cost, availability, and appropriateness of training and examination requirements;
(j) The cost of regulation, including the indirect cost to consumers, and the method proposed to finance the regulation;
(k) The cost imposed on applicants or practitioners or on employers of applicants or practitioners as a result of the regulation;
(l) The details of any previous efforts in this state to implement regulation of the profession or occupation; and
(m) Any other information the agency or the committee considers relevant to the analysis of the proposed legislation.
(5) The agency shall provide the Legislature with information concerning the effect of proposed legislation that provides for new regulation of a profession or occupation regarding:
(a) The departmental resources necessary to implement and enforce the proposed regulation;
(b) The technical sufficiency of the proposal for regulation, including its consistency with the regulation of other professions and occupations under existing law; and
(c) If applicable, any alternatives to the proposed regulation which may result in a less restrictive or more cost-effective regulatory scheme.
(6) When making a recommendation concerning proposed legislation providing for new regulation of a profession or occupation, a legislative committee shall determine:
(a) Whether the regulation is justified based on the criteria specified in subsection (3), the information submitted pursuant to request under subsection (4), and the information provided under subsection (5);
(b) The least restrictive and most cost-effective regulatory scheme that will adequately protect the public; and
(c) The technical sufficiency of the proposed legislation, including its consistency with the regulation of other professions and occupations under existing law.
History.—s. 6, ch. 91-429; s. 1, ch. 94-218; s. 133, ch. 99-251.

LEGISLATIVE HISTORY

1. This is the first attempt at Florida licensure. Currently, the only other state with diabetes educator licensure is Kentucky.

APPLICANT GROUP IDENTIFICATION

2. American Association of Diabetes Educators (AADE). Florida Contact for AADE: Melanie Bostick, Liberty Partners of Tallahassee, PO Box 390, Tallahassee, FL 32302. (850) 841-1726.

3. Currently, there are 686 individuals who are members of the AADE in Florida. Approximately 350 individuals in Florida have earned the Certified Diabetes Educator (CDE) certification from the National Certification Board for Diabetes Educators or have earned the (BC-ADM) certification from the American Association of Diabetes Educators. *https://www.diabeteseducator.org*

4. N/A – Need to contact AADE directly

5. N/A – Need to contact AADE directly

6. Liberty Partners of Tallahassee, LLC

7. Yes

CONSUMER GROUP IDENTIFICATION

8. Individuals - Diabetes educators are healthcare professionals who focus on helping people with and at risk for diabetes and related conditions achieve behavior change goals which, in turn, lead to better clinical outcomes and improved health status.

9. American Association of Diabetes Educators.

10. People with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and related conditions.

11. Unsure

NEED FOR REGULATION

12. Management of diabetes is complex. It is very important that the health care professionals who hold themselves out as Diabetes Educators are well-educated and appropriately credentialed in the delivery of quality Diabetes Education. Licensure of the Diabetes Educator will provide a Scope of Practice and minimum provider qualifications.

Diabetes Educators Licensure is intended for the health care professional who has a defined role as a diabetes educator, not for those who may perform some diabetes related functions as part of or in the course of other routine occupational duties.

Several studies provide additional compelling evidence that diabetes self-management training (DSMT) and diabetes self-management education (DSME) programs, involving a health team approach that includes credentialed diabetes educators, not only significantly reduce overall health costs but also improve health outcomes.

13. Unfortunately, the findings also show that DSMT programs are underutilized by some aspects of the population most in need of such services, and that physician awareness of DSMT is limited.

Over the past 32 years, from 1980 through 2012, the number of adults with diagnosed diabetes in the United States nearly quadrupled, from 5.5 million to 21.3 million. Among adults, about 1.7 million new cases of diabetes are diagnosed each year. If this trend continues, as many as 1 out of every 3 adults in the United States could have diabetes by 2050..

14. Each year, more than 200,000 deaths occur among people with diabetes in the United States. In 2013, diabetes was the country's seventh leading cause of death. More than 29 million people—or 9.3% of the US population—are estimated to have diagnosed or undiagnosed diabetes. *Center for Disease Control*

15. Unknown

16. Chapter 468.943, F.S. and 468.944, F.S.

17. Yes, National Certification Board for Diabetes Educators (NCBDE) *http://www.ncbde.org* and (BC-ADM) certification from the American Association of Diabetes Educators. *https://www.diabeteseducator.org*

18. In addition to those who already have diabetes, CDC estimates that 86 million US adults, more than 1 of 3, have prediabetes, which can increase the risk of developing type 2 diabetes, heart disease, and stroke.

Diabetes educators currently work at physician's office, a facility, community health center and hospitals.

19. Typically, a primary care physician will send a patient to a nurse who practices in diabetes education, to a podiatrist, to a nutrionist or dietician or pharmacist for the correct medication.

20. None that is known.

21. Unknown

22. Unknown

23. This is an additional, voluntary license that allows an individual to specialize in all aspects of diabetes education. This licensure is not intended to impede or restrict any other scope of practice.

24. There have been places like grocery stores, drug stores, massage and spa parlors that offer "diabetes education" and/or wellness programs advertising ways to lower diabetes. These programs are not recognized by the American Diabetes Association and therefore could be harmful to the public welfare. There needs to be more public awareness and licensed individuals available to provide these types of programs if these types of facilities want to offer diabetes education.

25. Kentucky and pending legislation Pennsylvania

26. None

27. They currently hold their Certified Diabetes Educator credential and have passed the national exam.

28. Safe, reliable access to health care. Growing awareness of diabetes, lower costs as more individuals use a licensed diabetes educator to manage their diabetes.

29. Consumers with diabetes and pre-diabetes will benefit from this regulation.

30. (a) No
(b) No
(c) No
(d) No

31. Unknown

32. Unknown – licensed practitioners will work in all types of environments.

33. Most all of the decisions by the practitioner require an advanced knowledge in diabetes self-management training to provide the level of care required for that individual to avoid being harmed by the disease.

34. Requires licensure

35. Diabetes Self-Management training

36. Yes, having earned the required practice hours, have passed the CDE exam already or take the CDE exam, have a primary license or master's degree.

37. N/A

38. Prescribing the wrong diet, medicine or overall plan to treat diabetes.

39. None.

40. Focus only on diabetes self-management education and not any other diseases or illnesses. The licensed diabetes educator scope of practice is narrowed only diabetes self-management training.

41. Unknown

42. None

43. Yes, unknown.

44. The practitioners seeking licensure have passed a national exam and earned numerous practice hours.

45. No

46. No

47. Unknown

48. The American Diabetes Association

49. Yes

50. None

51. None

52. Unknown

53. Yes, by the National Certification Board for Diabetes Educators and the American Association of Diabetes Educators.

54. Information would come these groups. – Do not have the specifics.

55. Both can be used toward licensure in Florida.

56. Unknown, but it is expected that number of individuals will obtain this license will increase as the number of individuals who the disease affects keeps

rising.

57. Unknown – these services are currently billed in several ways under other provider codes.

58. (A) Regulation by an existing board
(B) Licensure requirements
(C) Exam and practice hours required
(D) Licensure renewal and continuing education
(E) Licensure revocation, complaints enforcement

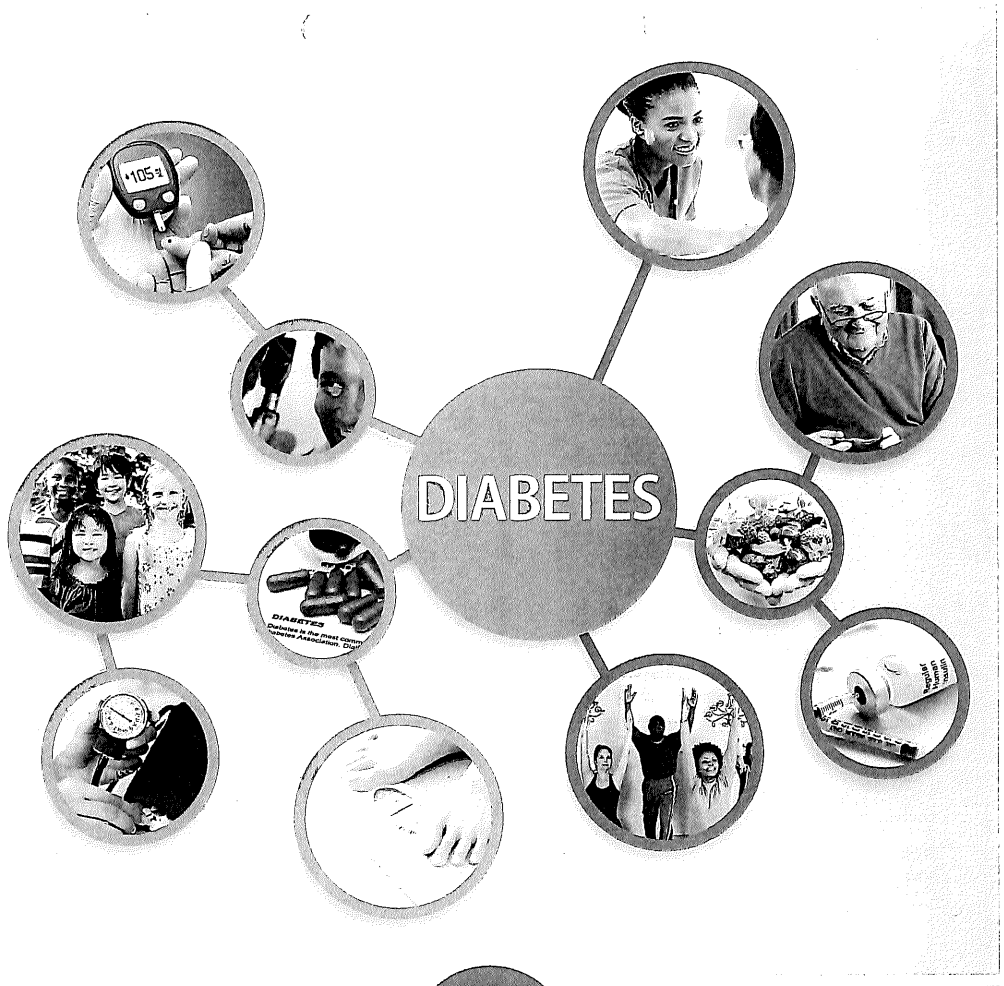
59. At least 500+

60. Unknown

61. Neutral – licensure fee should cover the cost of licensure and renewal fee should cover the cost of renewal.

62. Yes

63. See attached.



Diabetes 2014 Report Card

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion

For More Information
Division of Diabetes Translation
National Center for Chronic Disease Prevention and Health Promotion
Centers for Disease Control and Prevention
4770 Buford Hwy, Mailstop F-75
Atlanta, GA 30341-3717

1-800-CDC-INFO (232-4636); TTY: 1-888-232-6348
Contact CDC-INFO

This publication is available at
www.cdc.gov/diabetes/library/reports/congress.html

Suggested Citation
Centers for Disease Control and Prevention. *Diabetes Report Card 2014*. Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2015.

Background

The *Diabetes Report Card* is published by the Centers for Disease Control and Prevention (CDC) every 2 years to provide current information on the status of diabetes in the United States. It includes the most recent information and data available about diabetes, gestational diabetes, prediabetes, preventive care practices, risk factors, quality of care, diabetes outcomes, and, to the extent possible, national and state trends. Public health professionals, state health departments, and communities can use these data to focus their diabetes prevention and control efforts on areas of greatest need.

CDC plays a unique role in preventing, controlling, and managing diabetes in the United States. We support improvements in health outcomes for people with prediabetes and diagnosed diabetes through a variety of public health programs that are designed to prevent diabetes and control its complications.

CDC is working to reverse the diabetes epidemic in the United States by

- Monitoring and tracking disease trends.
- Identifying, implementing, and evaluating effective interventions.
- Improving medical care for people with diabetes.
- Reducing the number of annual diabetes deaths.

Each year, more than 200,000 deaths occur among people with diabetes in the United States. In 2013, diabetes was the country's seventh leading cause of death. More than 29 million people—or 9.3% of the US population—are estimated to have diagnosed or undiagnosed diabetes.

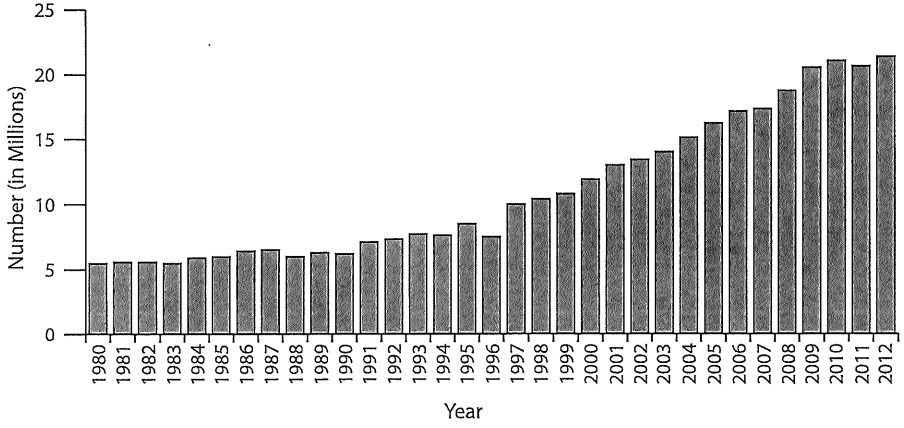
In addition to those who already have diabetes, CDC estimates that 86 million US adults, more than 1 of 3, have prediabetes, which can increase the risk of developing type 2 diabetes, heart disease, and stroke.

The increase in the number of people with diabetes in the United States is due in part to people with the disease living longer because of improvements in self-management practices and health care services.

National and State Diabetes Trends

Over the past 32 years, from 1980 through 2012, the number of adults with diagnosed diabetes in the United States nearly quadrupled, from 5.5 million to 21.3 million (Figure 1). Among adults, about 1.7 million new cases of diabetes are diagnosed each year. If this trend continues, as many as 1 out of every 3 adults in the United States could have diabetes by 2050.

Figure 1. Number of US Adults Aged 18 or Older with Diagnosed Diabetes, 1980-2012



Source: National Diabetes Surveillance System, National Health Interview Survey data.

A recent CDC study suggests that, after decades of continued growth in the prevalence and incidence of diagnosed diabetes, the diabetes epidemic may be beginning to slow. Although the numbers are not growing dramatically each year, they are still alarmingly high.

In addition, although overall rates of diagnosed diabetes seem to be slowing, they are continuing to increase among some groups—such as non-Hispanic blacks, Hispanics, and people with less than a high school education.

Diabetes Cost the United States an Estimated $245 Billion in 2012

- $176 billion in direct medical costs (medical goods and services)
- $69 billion in indirect costs from lost workdays, restricted activity, disability, and early death

Who's at Risk?

About 8.1 million people with diabetes do not know they have the disease. Because prediabetes and type 2 diabetes have few physical symptoms, some people may not realize how serious the disease is. People can help lower their chances of getting diabetes by knowing its risk factors—such as increased age, lack of physical activity, a family history of diabetes, certain socioeconomic conditions, obesity, and race and ethnicity.

Obesity

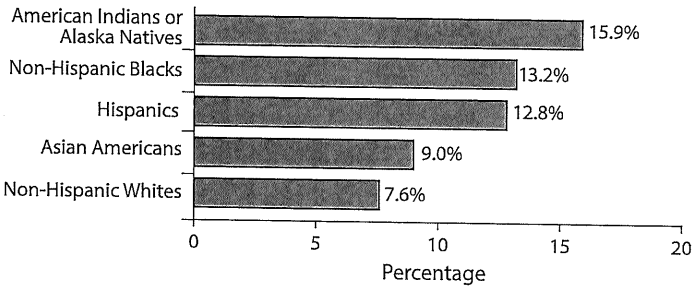
Obesity is one of several risk factors linked to type 2 diabetes. An unhealthy diet, lack of physical activity, and socioeconomic factors contribute to both obesity and type 2 diabetes. Obesity in people with type 2 diabetes is also associated with poor control of blood sugar, blood pressure, and cholesterol levels. Many of the health complications of diabetes become more severe when they are compounded by overweight or obesity.

The diabetes and obesity epidemics, combined with longer life spans, have increased the lifetime risk of developing diabetes to about 40% for US adults. The risk is the same for both men and women.

Race and Ethnicity

Compared with non-Hispanic whites, members of racial and ethnic minority groups are more likely to have diagnosed diabetes (Figure 2). During their lifetime, half of all Hispanic men and women and non-Hispanic black women are predicted to develop the disease.

Figure 2. Percentage of US Adults Aged 20 or Older with Diagnosed Diabetes, by Racial and Ethnic Group, 2010-2012

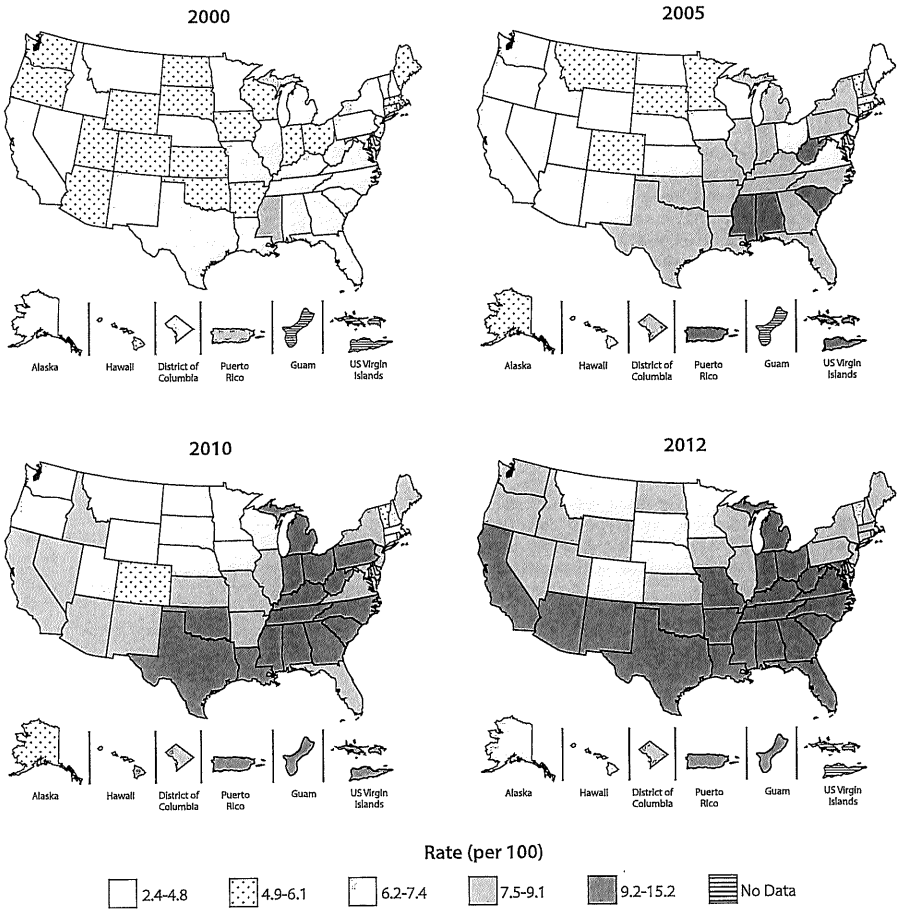


Note: Percentages are age-adjusted to the 2000 US standard population.
Source: National Health Interview Survey, 2010-2012, and the Indian Health Service's National Patient Information Reporting System, 2012.

Diagnosed Diabetes

During 2000-2012, the percentage of US adults with diagnosed diabetes grew across all states and US territories and was particularly high in Southern and Appalachian states (Figure 3). More information about state and county estimates of diabetes in the United States is available online at CDC's Diabetes Data and Statistics website.

Figure 3. Geographic Distribution of Diagnosed Diabetes in the United States, 2000-2012



Note: Rates are age-adjusted to the 2000 US standard population.
Source: National Diabetes Surveillance System.

Diabetes Overview

Diabetes is a group of diseases characterized by high blood sugar. When a person has diabetes, the body either does not make enough insulin or is unable to use its own insulin well. If blood sugar builds up in the body and its levels are not controlled, it can lead to serious health complications, such as heart disease, stroke, kidney disease, blindness, amputations of the legs and feet, and early death. CDC programs and other scientific activities support improvements in health outcomes for people with type 1 diabetes, type 2 diabetes, gestational diabetes, and prediabetes.

Type 1 Diabetes

This form of diabetes develops when the cells in the pancreas that produce insulin, known as beta cells, are destroyed. The destruction of the beta cells limits the making and release of insulin, a hormone that helps lower blood sugar. This disease can occur at any age, but the peak ages for diagnosis are in the middle teen years.

There is no known way to prevent type 1 diabetes. To survive, people with type 1 diabetes must have insulin delivered by injection or pump. Type 1 diabetes accounts for about 5% of all diagnosed cases of diabetes in US adults.

Type 2 Diabetes

This form of diabetes is the most common, accounting for about 90%-95% of diagnosed diabetes in US adults. It usually begins as insulin resistance, a disorder in which cells, primarily within the muscles, liver, and fat tissue, do not use insulin properly. The risk of developing type 2 diabetes is associated with aging, obesity, family history of diabetes, a personal history of gestational diabetes, not being physically active, and race and ethnicity.

Gestational Diabetes

This form of diabetes can develop during the second or third trimester of pregnancy. Gestational diabetes increases blood sugar levels and raises the risk of complications for both mother and baby. The risk factors are similar to those for type 2 diabetes, and treatment may include changes in diet or lifestyle or the use of insulin.

Women with gestational diabetes have a higher risk of developing the disease again during future pregnancies. They also have a higher risk of developing type 2 diabetes in the future.

Other Types of Diabetes

Other types of diabetes include maturity-onset diabetes of the young or latent autoimmune diabetes in adults. These types of diabetes are caused by specific genetic conditions or from surgery, medications, infections, pancreatic disease, or other illnesses. Other types of diabetes account for 1%-5% of all diagnosed cases.

Prediabetes

People with prediabetes have blood sugar levels that are higher than normal, but not high enough to be considered diabetes. Prediabetes can put people at increased risk of developing type 2 diabetes, heart disease, and stroke.

Diabetes in Youth

The increasing frequency of both type 1 and type 2 diabetes in youth has been among the most concerning aspects of the diabetes epidemic. Until recently, reliable data had been lacking on changes in diabetes prevalence in youth over time or even on how many children in the United States had type 1 or type 2 diabetes.

In response to this growing public health concern, CDC and the National Institutes of Health funded the SEARCH for Diabetes in Youth Study to examine type 1 and type 2 diabetes among children and adolescents in the United States.

Since 2000, the SEARCH Study has been helping to identify the types of diabetes and diabetic complications found in children and adolescents and how the disease affects the lives of this population. More than 20,000 participants are helping researchers collect baseline population data on childhood diabetes rates.

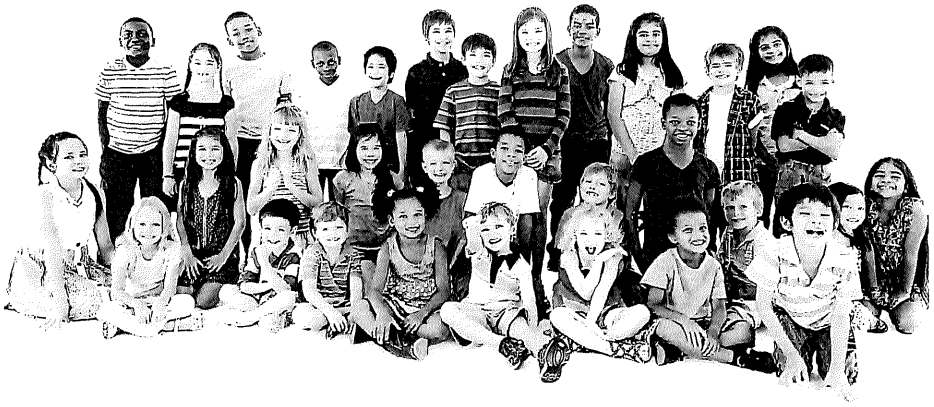
The SEARCH findings point to the need for better treatment strategies and technologies to improve diabetes management and metabolic control in children and adolescents.

Type 1 Diabetes Among Youth

- Nearly 167,000 US youth younger than age 20 had type 1 diabetes in 2009.
- More than 18,000 new cases of type 1 diabetes are estimated to be diagnosed among US youth younger than age 20 each year.
- Non-Hispanic white children and adolescents have the highest rates of new cases of type 1 diabetes.

Type 2 Diabetes Among Youth

- More than 20,000 US youth younger than age 20 had type 2 diabetes in 2009.
- More than 5,000 new cases of type 2 diabetes are estimated to be diagnosed among US youth younger than age 20 each year.
- Rates of new cases are higher among youth aged 10-19 than among younger children.
- Rates of type 2 diabetes are higher among youth aged 10-19 in some racial and ethnic minority groups than among non-Hispanic whites.



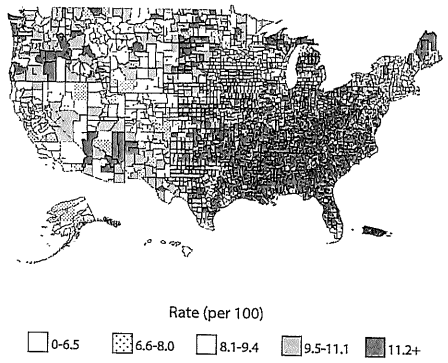
Diabetes in Adults

Diabetes was the seventh leading cause of death in the United States in 2013. CDC is actively working with state health departments, medical providers, caregivers, and community organizations to ensure that we are able to identify and respond effectively to people with diabetes to improve their health outcomes.

Table 1 shows the percentage of US adults, by state, who reported that they have ever been told by a health care provider that they have diabetes. Data for people with undiagnosed diabetes are not included. Estimates range from 6.2% in Montana to 11.7% in Mississippi.

Figure 4 shows the geographic distribution of the rates of diagnosed diabetes in adults across US counties in 2012, with percentages generally higher in the Southeast. CDC used the county data to define a geographic area called the "Diabetes Belt," within which the prevalence of diagnosed diabetes is especially high. This area includes 644 counties in 15 states in the southeastern part of the country.

Figure 4. County-Level Distribution of Diagnosed Diabetes Rates in US Adults, 2012



Note: Rates are age-adjusted to the 2000 US standard population.
Source: Diabetes Data and Statistics, County Data website.

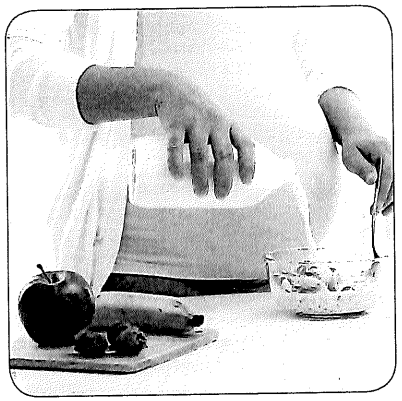
Table 1. Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes, by State, 2012

State	Percentage (%)
All States (Median)	**9.0**
Alabama	11.1
Alaska	7.2
Arizona	10.1
Arkansas	10.3
California	9.6
Colorado	7.2
Connecticut	8.2
Delaware	8.7
District of Columbia	9.0
Florida	9.9
Georgia	9.6
Hawaii	7.0
Idaho	7.8
Illinois	8.9
Indiana	10.1
Iowa	8.6
Kansas	8.8
Kentucky	9.8
Louisiana	11.5
Maine	8.2
Maryland	9.4
Massachusetts	7.7
Michigan	9.4
Minnesota	6.8
Mississippi	11.7
Missouri	9.6
Montana	6.2
Nebraska	7.4
Nevada	8.5
New Hampshire	7.8
New Jersey	8.4
New Mexico	9.4
New York	9.0
North Carolina	9.7
North Dakota	7.8
Ohio	10.5
Oklahoma	10.6
Oregon	9.1
Pennsylvania	8.9
Rhode Island	8.9
South Carolina	10.6
South Dakota	7.0
Tennessee	10.9
Texas	10.6
Utah	7.9
Vermont	6.4
Virginia	9.8
Washington	8.2
West Virginia	11.1
Wisconsin	7.5
Wyoming	8.4

Note: Percentages are age-adjusted to the 2000 US standard population.
Source: Behavioral Risk Factor Surveillance System.

Gestational Diabetes

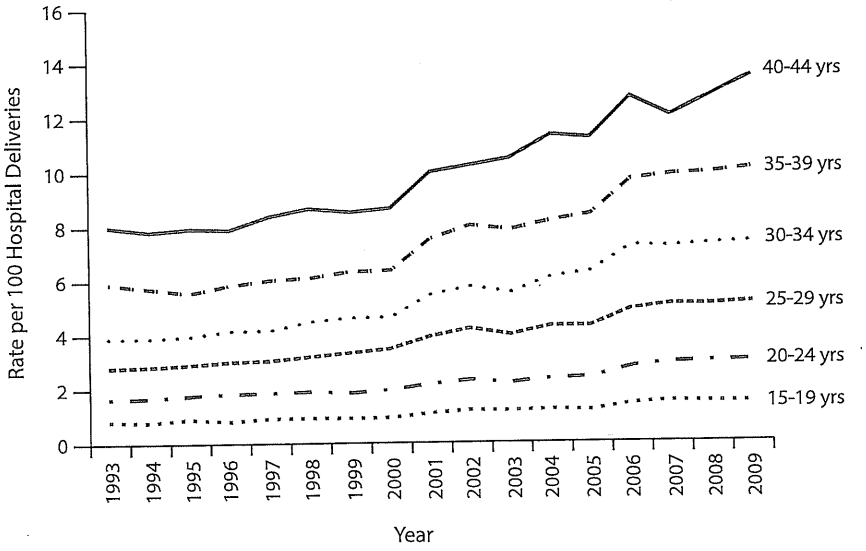
Gestational diabetes develops or is first recognized during pregnancy. Most women are screened for gestational diabetes at 24-28 weeks of pregnancy during prenatal care. If a woman is diagnosed with this type of diabetes, she will need to learn how to maintain normal blood sugar levels to avoid health problems for herself and her baby.



Complications from gestational diabetes include preeclampsia, high birth weight, birth-related trauma, jaundice, low blood sugar (hypoglycemia), and birth defects. Women who have had gestational diabetes are at higher risk of developing type 2 diabetes later in life.

Figure 5 shows trends in the national prevalence of gestational diabetes during 1993-2009 for women aged 15-44 years who delivered babies in hospitals. In 2009, the prevalence of gestational diabetes among all pregnant women who delivered in a hospital was 5.6% per 100 deliveries.

Figure 5. Prevalence of Gestational Diabetes Among US Women Aged 15-44 Who Delivered in a Hospital, 1993-2009



Note: Rates are age-adjusted to the 2000 US standard population.
Source: Nationwide Inpatient Sample, Healthcare Cost and Utilization Project.

Prediabetes

Keeping type 2 diabetes from occurring in the first place is critical to reducing the problems associated with this disease. CDC estimates that 86 million US adults—more than 1 of 3—had prediabetes in 2012. Prediabetes is a serious health condition that increases the risk of developing type 2 diabetes, heart disease, and stroke. Although 37% of US adults have prediabetes, only 11% of those with prediabetes are aware that they have it.

Table 2 shows the percentage of US adults, by state, who reported that they have ever been told by a health care professional that they have prediabetes. Estimates ranged from 4.7% in Vermont and Wyoming to 10.6% in Hawaii. These findings are consistent with analyses of national data that suggest that awareness of prediabetes in the US population is low. As CDC continues to work to prevent type 2 diabetes among people with prediabetes, the percentage of people who are aware that they have prediabetes is expected to rise.

NATIONAL Diabetes PREVENTION PROGRAM

The CDC-led National Diabetes Prevention Program (National DPP) is an evidence-based lifestyle change program for preventing type 2 diabetes. The program stresses education, dietary changes, coping skills, and group activities to help participants lose a moderate amount of weight and get at least 150 minutes a week of physical activity. Trained lifestyle coaches give participants guidance and support.

The program encourages collaboration between federal agencies, community organizations, employers, insurers, health care professionals, academia, and other stakeholders. For more information, including if a program is offered in your community, visit the National Diabetes Prevention Program website.

Table 2. Percentage of US Adults Who Have Ever Been Told by a Health Care Professional that They Have Prediabetes, by State, 2012[a]

State	Percentage (%)
All States (Median)	5.9
Alabama	7.2
Alaska	6.9
Arizona[b]	6.8
Arkansas	5.4
California	NA[c]
Colorado	NA
Connecticut	5.9
Delaware	6.7
District of Columbia[b]	5.0
Florida	7.4
Georgia	6.4
Hawaii	10.6
Idaho[b]	5.9
Illinois	NA
Indiana	5.4
Iowa	5.1
Kansas	5.4
Kentucky	6.9
Louisiana	8.3
Maine	6.2
Maryland	NA
Massachusetts	5.1
Michigan	5.9
Minnesota	5.2
Mississippi	5.4
Missouri	NA
Montana[b]	4.8
Nebraska[b]	5.4
Nevada[b]	7.4
New Hampshire[b]	5.1
New Jersey	5.8
New Mexico	7.0
New York	6.3
North Carolina	6.5
North Dakota	4.9
Ohio	5.2
Oklahoma	5.7
Oregon	6.0
Pennsylvania	5.4
Rhode Island	5.3
South Carolina[b]	5.4
South Dakota	5.5
Tennessee	7.5
Texas	5.9
Utah	5.1
Vermont	4.7
Virginia	6.0
Washington	6.3
West Virginia	6.7
Wisconsin	5.5
Wyoming[b]	4.7

[a] Percentages are age-adjusted to the 2000 US standard population.
[b] Data are from 2011 because 2012 data are not available.
[c] NA = Data not available for 2011 or 2012.
Source: Behavioral Risk Factor Surveillance System.

Preventive Care Practices

Diabetes complications are debilitating, costly, and sometimes deadly. Diabetes is a major cause of health complications, such as heart disease, stroke, kidney damage (chronic kidney disease and kidney failure), blindness, amputations of the legs and feet, and gum disease (periodontitis). Diabetes complications tend to be more common and more severe among people whose diabetes is poorly controlled. People with diabetes can better manage their condition by following clinical care recommendations known as preventive care practices. Preventive care practices are essential to better health outcomes for people with diabetes.

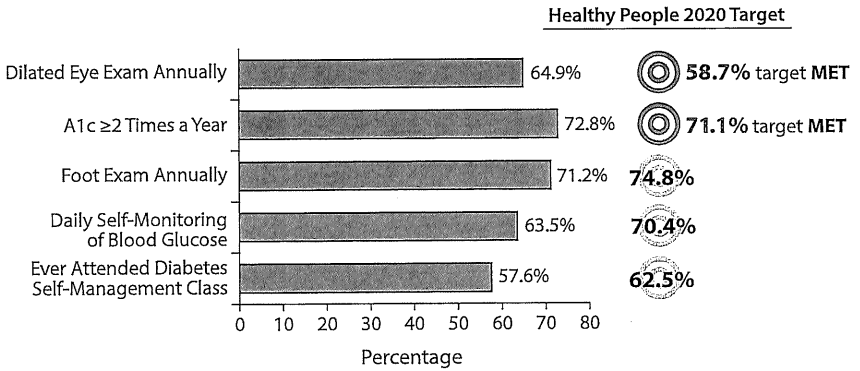
One example of a preventive care practice is diabetes self-management education, which can teach people how to manage the disease with certain self-care behaviors. These behaviors include eating a healthy diet, being physically active, self-monitoring blood sugar levels, and taking medications appropriately. Diabetes self-management education also connects people with diabetes educators who can teach them the problem-solving and coping skills they need to successfully self-manage diabetes and its complications.

Healthy People 2020

Healthy People 2020 is the nation's health agenda for improving the health of all Americans. It tracks progress toward meeting several diabetes-related objectives during this decade. The overall goal is to reduce diabetes and its economic costs and to improve the quality of life for all people who have or are at risk of diabetes. CDC is actively addressing several of the objectives in Healthy People 2020. For more information about these objectives, visit the Healthy People 2020 Diabetes website.

Figure 6 shows the percentage of US adults with diagnosed diabetes who reported receiving recommended preventive care practices during the 2012 Behavioral Risk Factor Surveillance System study period. Examples include annual eye exams and foot exams by a health care provider and daily (or more frequent) self-monitoring of blood sugar (glucose) levels. Five of the 16 Healthy People 2020 objectives for diabetes call for increasing the percentage of people with diabetes who follow these recommendations. Progress has been made in meeting two of the objectives, but more work is needed to meet the other three.

Figure 6. Healthy People 2020 Targets[a] and Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes Who Reported Receiving Recommended Preventive Care Practices,[b] 2012



[a] Available on the Healthy People 2020 Diabetes website.
[b] Percentages are age-adjusted to the 2000 US standard population.
Source: National Diabetes Surveillance System, Behavioral Risk Factor Surveillance System data.

Table 3 presents estimates of the percentage of US adults aged 18 or older who reported receiving recommended preventive care practices, by state. Trend data are on CDC's Diabetes Data and Statistics website. On the State Data site, the box under the "What?" link can be changed to specific topics, including preventive care practices.

Table 3. Percentage of US Adults Aged 18 or Older with Diagnosed Diabetes Who Reported Receiving Recommended Preventive Care Practices, by State, 2012[a]

State	Foot Exam Annually	Dilated Eye Exam Annually	A1c Checked ≥2 Times a Year	Daily Self-Monitoring of Blood Glucose	Ever Attended Diabetes Self-Management Class
All States (Median)	**71.2**	**64.9**	**72.8**	**63.5**	**57.6**
Healthy People 2020 Target	**74.8**	**58.7**	**71.1**	**70.4**	**62.5**
Alabama	67.8	59.3	73.3	66.6	55.7
Alaska	74.9	64.9	73.4	65.0	73.4
Arizona[b]	72.5	63.8	67.3	65.2	53.2
Arkansas	61.7	50.2	66.0	67.7	52.3
California[b]	66.3	66.5	78.2	56.0	60.3
Colorado	NA[c]	NA	NA	NA	NA
Connecticut	76.3	70.9	75.0	63.9	52.6
Delaware	71.0	77.7	74.7	66.3	54.0
District of Columbia[b]	76.9	73.0	76.2	72.2	54.9
Florida[b]	65.1	62.2	68.3	64.6	51.2
Georgia	73.9	69.1	71.6	68.0	58.0
Hawaii	69.8	70.4	80.9	56.6	47.7
Idaho	68.8	53.4	57.3	56.8	62.9
Illinois	NA	NA	NA	NA	NA
Indiana[b]	67.5	62.7	65.9	63.0	59.5
Iowa[b]	77.8	73.9	78.4	61.2	63.9
Kansas	73.9	72.9	73.1	63.1	61.3
Kentucky	67.6	58.7	73.4	64.1	50.8
Louisiana[b]	69.4	65.7	70.5	69.3	57.3
Maine	81.7	65.3	74.9	56.3	61.9
Maryland	NA	NA	NA	NA	NA
Massachusetts[b]	79.2	76.8	75.2	67.6	50.3
Michigan	76.4	60.3	74.9	71.5	62.6
Minnesota	81.7	68.7	73.7	62.1	72.7
Mississippi	66.8	58.2	71.1	71.4	48.6
Missouri[b]	69.1	65.6	70.8	62.1	56.7
Montana[b]	76.8	62.9	68.0	56.7	59.7
Nebraska	71.2	60.7	70.3	59.0	63.7
Nevada	57.0	53.5	68.1	56.1	53.8
New Hampshire[b]	82.0	71.9	75.7	58.3	57.7
New Jersey	65.8	72.3	68.4	59.1	51.2
New Mexico	73.7	63.0	70.2	65.7	60.7
New York	NA	NA	NA	NA	NA
North Carolina	75.1	66.6	73.7	65.8	57.6
North Dakota[b]	81.2	64.7	75.7	63.6	65.7
Ohio	72.6	65.2	71.6	66.0	58.9
Oklahoma	67.0	56.6	76.2	66.6	57.8
Oregon	76.7	61.7	72.7	58.8	67.9
Pennsylvania	76.7	68.9	76.5	63.8	55.6
Rhode Island[b]	76.9	67.5	70.8	64.6	45.8
South Carolina	71.1	58.9	73.7	64.6	51.7
South Dakota	77.9	72.8	70.6	62.4	59.3
Tennessee	76.3	69.0	76.1	66.7	51.0
Texas	70.3	67.1	69.5	61.5	52.3
Utah	70.2	52.8	63.2	62.4	59.0
Vermont	77.9	67.9	75.5	61.2	53.7
Virginia	75.8	66.5	71.5	59.8	59.4
Washington	NA	NA	NA	NA	NA
West Virginia	64.5	65.4	72.8	64.0	50.5
Wisconsin	74.7	62.2	76.4	63.5	66.9
Wyoming	68.1	59.4	64.0	54.0	61.4

[a] Percentages are age-adjusted to the 2000 US standard population.
[b] Data are from 2011 because 2012 data are not available.
[c] NA = Data not available for 2011 or 2012.

Diabetes Complications

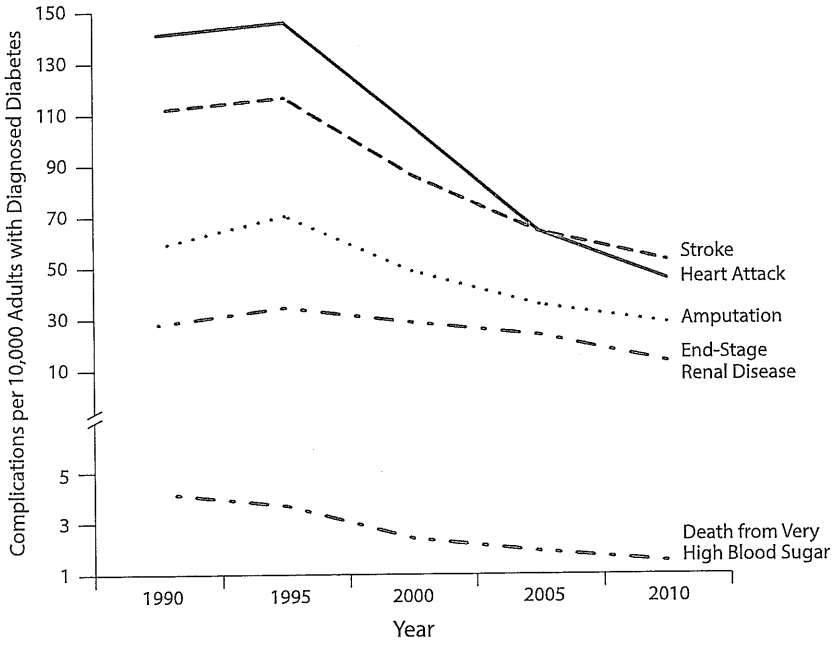
Over the past 20 years, preventive care for adults with diabetes and for the risk factors that cause complications has improved significantly in the United States. The rates of five major complications—heart attack, stroke, amputations of the legs and feet, end-stage renal disease, and deaths due to high blood sugar (hyperglycemic) crisis—all declined in adults with diagnosed diabetes during 1990-2010.

Although the declines in diabetes complications are good news, the number of people who suffer from these complications is still high and will remain high unless we can make significant progress in preventing type 2 diabetes. In addition, people with diabetes are living longer with the disease and its complications.

Recent studies have shown a need for health services to detect and manage diabetes. The continued demand for health services will increase disease management costs and place a burden on the US health care system.

Figure 7 shows that rates of heart attacks and deaths due to high blood sugar crisis among adults diagnosed with diabetes decreased by more than 60% during 1990-2010. Rates of strokes and amputations of the legs and feet fell by about 50%, and rates of kidney failure fell by about 30%. Declines in diabetes complications can be attributed to advances in clinical care, increased availability of preventive health care, control of risk factors, and increased awareness of the potential complications of diabetes.

Figure 7. Trends in Rates of Diabetes Complications Among US Adults with Diagnosed Diabetes, 1990-2010



Adapted from: Gregg EW, Li Y, Wang J, et al. Changes in diabetes-related complications in the United States, 1990-2010. *N Engl J Med.* 2014;370:1514-1523.

Diabetes Prevention and Control Recommendations

Community Preventive Services Task Force: Diabetes Prevention Programs

In July 2014, the Community Preventive Services Task Force recommended "combined diet and physical activity promotion programs for people at increased risk of type 2 diabetes and newly diagnosed diabetes" as an effective intervention for diabetes prevention and control. This recommendation is part of The Guide to Community Preventive Services, which provides systematic reviews and recommendations for community health policies and programs.

These types of programs actively encourage people to improve their diet and increase their physical activity. They commonly include the following:

- A weight loss goal.
- Individual or group sessions (or both) about diet and exercise.
- Meetings with a trained diet or exercise counselor (or both).
- Individually tailored diet or exercise plans.

Higher-intensity programs lead to more weight loss and a larger reduction in new cases of diabetes. For more information about these findings, see the Task Force Finding and Rationale Statement.

US Preventive Services Task Force: Diabetes Screening Measures

In 2008, the US Preventive Services Task Force (USPSTF) approved a "B" recommendation for screening for type 2 diabetes for adults with high blood pressure.[a] This recommendation takes into account the potential benefits of blood pressure measurement as an important predictor of heart disease and its related complications in people with type 2 diabetes. The USPSTF also supported a review of evidence that lifestyle change or medication therapy can delay the onset of type 2 diabetes in people with prediabetes, but it did not provide a rating.

- *The USPSTF recommends screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) higher than 135/80 mm Hg.*

  Grade B: Recommendation

In October 2014, the USPSTF revisited the evidence for screening for type 2 diabetes and approved a draft version of a "B" recommendation for adults in primary care settings with known risk factors for impaired fasting glucose, impaired glucose tolerance, or diabetes.

Risk factors include being age 45 or older, being overweight or obese, or having a first-degree relative with diabetes. Women with a history of gestational diabetes or polycystic ovarian syndrome are also at increased risk. Certain racial and ethnic minority groups, including African Americans, American Indians or Alaska Natives, Asians, Hispanics, and Native Hawaiians or Other Pacific Islanders, are at higher risk than non-Hispanic whites.

- *The USPSTF recommends screening for abnormal blood glucose and type 2 diabetes mellitus in adults who are at increased risk for diabetes.*

  Draft Grade B: Recommendation

In August 2014, the USPSTF updated and refined the "B" recommendation for healthy diet and physical activity counseling to prevent heart disease in adults with cardiovascular risk factors. This recommendation now applies to adults aged 18 or older in primary care settings who are overweight or obese and who have known cardiovascular risk factors, such as high blood pressure, high cholesterol, or diabetes.

- *The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.*

  Grade B: Recommendation

In January 2014, the USPSTF approved a "B" recommendation for gestational diabetes screening for asymptomatic pregnant women after 24 weeks of gestation. The USPSTF determined that this screening is likely to provide substantial health benefits for pregnant women and their unborn children.

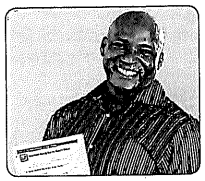
- *The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation.*

  Grade B: Recommendation

[a] The USPSTF grades the strength of the evidence it reviews as "A" (strongly recommends), "B" (recommends), "C" (no recommendation for or against), "D" (recommends against), or "I" (insufficient evidence to recommend for or against).

Stories from the Field

National DPP Lifestyle Coach Dedicated to Helping Others



RICKEY SEWELL
National DPP Lifestyle Coach

Rickey Sewell has been committed to helping people and promoting healthy behavior for decades. In addition to being a trained lifestyle coach with the National Diabetes Prevention Program (National DPP), he is a firefighter and paramedic. He is studying to become a certified diabetes educator and registered nurse.

Because he has several family members who are affected by type 2 diabetes, Rickey is especially passionate about teaching people to prevent and manage the disease. He loves his work as a lifestyle coach and the teachable moments the National DPP offers to participants. He is also a huge fan of its evidence-based approach and loves to dispel myths about what can and cannot prevent diabetes.

"It's the gold standard for lifestyle change to prevent type 2 diabetes, and it's great to be a part of that," Rickey says. "It's wonderful to see how the National DPP inspires people to live a healthier life!" Rickey enjoys reaching out to and connecting with other people, and he has a particular knack for relating to other African American men who might be reluctant to join the National DPP.

"They might be in denial about their risks or feel like [diabetes] can't be prevented," Rickey says. "But when I talk to them about the impact having a chronic disease could have on their family or intimate relationships, as well as the benefits of lifestyle change not just to prevent diabetes, but to be healthier overall, it's easier to get through to them."

Kentucky Coalition Improves Access to Health Care

CDC helps communities develop and set up diabetes projects in areas that are economically distressed or have significant numbers of people with low socioeconomic status. The goal is to get rid of health disparities related to diabetes.

An example of this type of project is the Kentuckiana Regional Planning and Development Agency (KIPDA). The agency supports the KIPDA Rural Diabetes Coalition (KRDC) to improve access to good medical care; affordable, healthy foods; and safe exercise opportunities for people with type 2 diabetes in three Kentucky counties. The KRDC also works to increase awareness about healthy behaviors.

Because of the work of the KRDC and the Kentucky Diabetes Network, state officials pledged $2.6 million a year for 2014-2016 to support diabetes services through local and district health departments. This support will improve access to diabetes education and resources throughout the state.

Participant Learns How Small Changes Can Improve Her Life

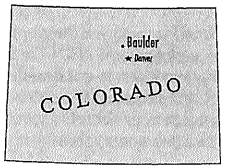
ESTELA URZUA
National DPP Participant

Because her family has a long history of diabetes, Estela Urzua knew that she would have to make changes in her life to avoid developing type 2 diabetes. She joined the National DPP to learn more about healthy eating and exercise. Estela enjoys working with other program participants and has learned from their diverse perspectives and suggestions. She also has learned a lot from her lifestyle coach about portion control and hidden sugar in food.

Throughout the program, Estela has slowly changed her eating habits and added a little exercise to her daily routine. She feels happier and more in control of her life. Estela wants others to know that, with a little work, they can also make a positive difference in their lives.

"I have always had passions in life, and this program has helped me take control of my eating and exercise habits so that I could fully embrace my life passions," Estela says.

Colorado Offers National DPP to State Employees

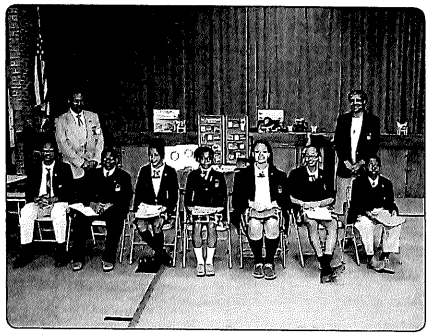


The Colorado Department of Public Health and Environment (CDPHE) has worked with internal and external program champions in Colorado to include the National DPP as a covered health benefit for state government employees. Partners include the state's wellness coordinator, major health plans that operate in the state, the Colorado Prevention Alliance, the Colorado Business Group on Health, and the Colorado Department of Personnel and Administration.

Initially, the partners worked together to pilot test the National DPP for CDPHE employees. This pilot test helped decision makers in Colorado better understand the value of the program. In September 2013, the National DPP became a covered benefit for 34,321 state employees who had either UnitedHealthcare or Kaiser Permanente health plans. Because the National DPP has been proven to prevent or delay the onset of type 2 diabetes, its use in Colorado will result in lower health care costs and a healthier, more productive state workforce.

Students in Alabama Work to Raise Diabetes Awareness

In March 2014, Resurrection Catholic School in Montgomery, Alabama, launched the Diabetes Ambassador Program in partnership with the Alabama Department of Public Health. This program teaches children how to reduce their risk of type 2 diabetes and make healthy lifestyle choices. Seven student ambassadors also used CDC and National Institutes of Health materials from the National Diabetes Education Program to educate their peers, teachers, school staff members, and parents about diabetes prevention.



Students in the Diabetes Ambassador Program at Resurrection Catholic School

The students wore pins from the International Diabetes Federation that had blue circles on them. The blue circle is the global symbol for diabetes. The school's principal also allowed students to wear blue clothing on Diabetes Alert Day (March 25) instead of their normal uniforms to raise awareness about diabetes.

Collaborative Helps Reach Pregnant Women at Risk of Diabetes

To better understand and reduce the problem of gestational diabetes in the United States, CDC and the National Association of Chronic Disease Directors supported the creation of a Gestational Diabetes Collaborative (GDC) in 10 states and four tribal organizations. The GDC is working to improve the monitoring and tracking of gestational diabetes. It also provides outreach and patient education to reduce women's risk of developing type 2 diabetes after delivery.

Preliminary data show that two tribal organizations in Oklahoma have reported significant increases in visits to tribal health care centers by postpartum women. During these visits, women are offered type 2 diabetes screening, healthy lifestyle counseling and, if needed, referrals to diabetes prevention services. Since June 2014, the percentage of women who received these services increased from 16% to 63% in the Chickasaw Nation and from 5% to 69% in the Choctaw Nation.

Technical Notes

The estimates in this report were calculated by CDC staff and are available in more detail in CDC's *National Diabetes Statistics Report, 2014* and from the National Diabetes Surveillance System website. Diabetes data are from the US Census Bureau, the Indian Health Service's National Patient Information Reporting System, and various surveys and data collection systems. These systems include the Behavioral Risk Factor Surveillance System (BRFSS), the National Health Interview Survey, the National Hospital Discharge Survey, and the National Vital Statistics System.

To make meaningful comparisons between states and over time, we used the 2000 US standard population to age adjust our estimated rates. Age adjustment is a statistical process applied to rates of diseases, injuries, and health outcomes. It allows comparisons between communities with different age structures because it proportions rates to a standard age structure. State estimates in this report are based on BRFSS data. Because of the limitations of self-reported data in surveys, these estimates may underreport the rates of diagnosed diabetes and prediabetes in the US population.

References

Ali MK, Bullard KM, Saaddine JB, Cowie CC, Imperatore G, Gregg EW. Achievement of goals in U.S. diabetes care, 1999–2010. *N Engl J Med.* 2013;368:1613-1624.

American Diabetes Association. Economic costs of diabetes in the U.S. in 2012. *Diabetes Care.* 2013;36(4):1033-1046.

Barker LE, Kirtland KA, Gregg EW, Geiss LS, Thompson TJ. Geographic distribution of diagnosed diabetes in the U.S.: a diabetes belt. *Am J Prev Med.* 2011;40(4):434-439.

Boyle JP, Thompson TJ, Gregg EW, Barker LE, Williamson DF. Projection of the year 2050 burden of diabetes in the US adult population: dynamic modeling of incidence, mortality, and prediabetes prevalence. *Popul Health Metrics.* 2010;8:29.

Centers for Disease Control and Prevention. *Gestational Diabetes.* Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

Centers for Disease Control and Prevention. *National Diabetes Statistics Report, 2014.* Atlanta, GA: Centers for Disease Control and Prevention, US Dept of Health and Human Services; 2014.

Centers for Disease Control and Prevention. Diabetes Data and Statistics, County Data website. http://www.cdc.gov/diabetes/atlas/countydata/atlas.html. Accessed February 26, 2015.

Centers for Disease Control and Prevention. National Diabetes Surveillance System website. http://gis.cdc.gov/grasp/diabetes/DiabetesAtlas.html. Accessed February 26, 2015.

Correa A, Bardenheier B, Elixhauser A, Geiss LS, Gregg EW. Trends in prevalence of diabetes among delivery hospitalizations, United States, 1993-2009 [published online ahead of print July 5, 4014]. *Matern Child Health J.* 2015;19(3)635-642. doi: 10.1007/s10995-014-1553-5.

Dabelea D, Mayer-Davis EJ, Saydah S, et al. Prevalence of type 1 and type 2 diabetes among children and adolescents from 2001 to 2009. *JAMA.* 2014;311(17):1778-1786.

Geiss LS, Cowie CC. Type 2 diabetes and persons at high risk of diabetes. In: Venkat Narayan KM, Williams D, Gregg EW, Cowie CC, eds. *Diabetes Public Health: From Data to Policy.* New York, NY: Oxford University Press; 2011:15-32.

Geiss LS, James C, Gregg EW, Albright AL, Williamson DF, Cowie CC. Diabetes risk reduction behaviors among U.S. adults with prediabetes. *Am J Prev Med.* 2010:38(4);403-409.

Geiss LS, Wang J, Cheng YJ. et al. Prevalence and incidence trends for diagnosed diabetes among adults aged 20 to 79 years, United States, 1980-2012. *JAMA.* 2014;312(12):1218-1226.

Gregg EW, Li Y, Wang J, et al. Changes in diabetes-related complications in the United States, 1990–2010. *N Engl J Med.* 2014;370:1514-1523.

Gregg EW, Zhou X, Cheng YJ, Albright AL, Narayan KMV, Thompson TJ. Trends in lifetime risk and years of life lost due to diabetes in the USA, 1985–2011: a modelling study. *Lancet Diabetes Endocrinol.* 2014;2(11):867-874.

Gregg EW, Kirtland KA, Cadwell BL, et al. Estimated county-level prevalence estimates of diabetes and obesity — 2007. *MMWR Morb Mortal Wkly Rep.* 2009;58(45):1259-1263.

Li Y, Geiss LS, Burrows NR, Rolka DB, Albright A. Awareness of prediabetes — United States, 2005–2010. *MMWR Morb Mortal Wkly Rep.* 2013;62(11):209-212.

Xu J, Kochanek KD, Murphy SL, Arias E. Mortality in the United States, 2013. *NCHS Data Brief.* 2014;168:1-8.

National Association of Chronic Disease Directors. Gestational Diabetes website. http://www.chronicdisease.org/?page=00GDMHomePage. Accessed April 30, 2015.

Patient Protection and Affordable Care Act of 2009. Pub. L No. 111-148, Title X, Sec 10407, 42 USC 247b-9a.

Pettitt DJ, Talton J, Dabelea D, et al. Prevalence of diabetes in U.S. youth in 2009: the SEARCH for Diabetes in Youth Study. *Diabetes Care.* 2014;37(2):402-408.

The Guide to Community Preventive Services website. Diabetes Prevention and Control: Combined Diet and Physical Activity Promotion Programs to Prevent Type 2 Diabetes Among People at Increased Risk. http://www.thecommunityguide.org/diabetes/combineddietandpa.html. Accessed April 30, 2015.

US Department of Health and Human Services, Office of Minority Health. Diabetes and American Indians/Alaska Natives website. http://minorityhealth.hhs.gov/omh/browse.aspx?lvl=4&lvlID=33. Accessed February 26, 2015.

US Department of Health and Human Services, Office of Minority Health. Obesity and American Indians/Alaska Natives website. http://minorityhealth.hhs.gov/omh/content.aspx?lvl=3&lvlID=62&ID=6457. Accessed February 26, 2015.

US Preventive Services Task Force. Recommendations for Primary Care Practice website. http://www.uspreventiveservicestaskforce.org/Page/Name/recommendations. Accessed February 26, 2015.

DIABETES EDUCATOR LICENSURE SUMMARY

Background

Diabetes education, also known as diabetes self-management training (DSMT) or diabetes self-management education (DSME), is defined as a collaborative process through which people with or at risk for diabetes gain the knowledge and skills needed to modify behavior and successfully self-manage the disease and its related conditions. DSMT/DSME is an interactive, ongoing process involving the person with diabetes (or the caregiver or family) and a diabetes educator(s). The intervention aims to achieve optimal health status, better quality of life and reduce the need for costly health care.

Diabetes educators are healthcare professionals who focus on helping people with and at risk for diabetes and related conditions achieve behavior change goals which, in turn, lead to better clinical outcomes and improved health status. Diabetes educators apply in-depth knowledge and skills in the biological and social sciences, communication, counseling, and education to provide self-management education/self management training.

Scope

Diabetes educators are highly skilled professionals integral to the multidisciplinary diabetes care team.

- The role of the diabetes educator can be assumed by professionals from a variety of health disciplines, including, but not limited to: Registered nurses, registered dietitians, pharmacists, physicians, mental health professionals, podiatrists, optometrists, and exercise physiologists. Some services, such as nutrition counseling, medication counseling and psychological support services, however, may be provided in collaboration with a licensed dietitian, registered pharmacist, a licensed psychologist or social worker, or a psychiatric and mental health clinical nurse specialist or nurse practitioner.
- Mastery of the knowledge and skills to be a diabetes educator is obtained through professional practice experience, continuing education, individual study, and mentorship.
    - Many diabetes educators have earned the Certified Diabetes Educator (CDE) credential and/or some have become Board Certified in Advanced Diabetes Management (BC-ADM).

Purpose

Professional licensure has numerous purposes: consumer protection, professional recognition and setting quality guidelines for the profession.

Management of diabetes is complex. It is very important that the health care professionals who set themselves out as Diabetes Educators be well educated and appropriately credentialed in the delivery of quality Diabetes Education. Licensure of the Diabetes Educator will provide a Scope of Practice and minimum provider qualifications.

Diabetes Educators Licensure is intended for the health care professional who has a defined role as a diabetes educator, not for those who may perform some diabetes related functions as part of or in the course of other routine occupational duties.

All health care providers need sufficient diabetes knowledge to provide safe, competent care to persons with or at risk for diabetes. Licensure of the Diabetes Educator will provide minimum standards for patient safety and for recognition of the professional. This will address the current workforce shortage of qualified professionals who can deliver diabetes education.

- The fully burdened cost to treat a patient with diabetes is versus patients without diabetes
- Nearly 50% of the fully burdened annualized cost to treat a patient with diabetes is for emergency room and hospitalizations
- Patients who self-manage their condition have better clinical outcomes and lower annualized costs
- Patients with diabetes manage their condition by themselves based on the coaching from their health care professional
- Patients who lower their HBA1c by one point actuarially reduced the next year costs by 4-6%

Studies Support DSMT Value and Cost Effectiveness

Summary
Several studies provide additional compelling evidence that diabetes self-management training (DSMT) programs, involving a health team approach that includes credentialed diabetes educators, not only significantly reduce overall health costs but also improve health outcomes. Unfortunately, the findings also show that DSMT programs are underutilized by some aspects of the population most in need of such services, and that physician awareness of DSMT is limited.

Licensure of Diabetes Educators Needed
These findings support the critical need for _____ to enact of HB or SB to license diabetes educators. Qualified and licensed diabetes educators will enhance access to DSMT care that directly impacts diabetes health outcomes and saves money.

Findings

- A 3-year retroactive claims analysis of 4 million covered lives, including 250,000 Medicare beneficiaries, presented at an NIH conference in December 2008, showed an average Medicare cost savings per month/per patient of $135 for those beneficiaries who complete DSMT.[4]

- Cost savings for inpatient hospital costs, according to the study above, is even more profound, showing savings of $160 per month/per patient.[5]

- Pharmacy costs for patients in the study above showed a modest increase, as a result of patient adherence to prescribed physician medication regimens. This increase was more than offset by reduced hospitalization and lower overall health expenditures.[5]

- A systematic review of existing literature on DSMT programs found that 70% of all relevant studies showed DSMT resulted in decreased health care costs.[4]

- Patients who undergo a DSMT program have, at a minimum, a 10% higher adherence and compliance rate with clinically appropriate, evidence based medical treatments to improve their health outcomes .[4,5,6] It also includes improvements in risk reduction behaviors, such as blood glucose monitoring and cholesterol monitoring.

- Analysis of commercial and Medicare payer-derived claims data of people with diabetes who receive multiple episodes of DSMT are more likely to obtain care in accordance with recommended guidelines and to comply with diabetes-related prescription regimens, resulting in lower costs and utilization trends.[1]

- A study of the accessibility, availability, and quality of diabetes self-management education (DSME) for uninsured adults or those utilizing Medicaid in a community with a high poverty rate revealed that due to limited availability and inadequate access to quality DSME places vulnerable adults at increased risk for devastating and costly complications despite the known benefits.[2]

- A retrospective analysis was performed with adults diagnosed with type 2 diabetes who received DSME training showed a strong association with a substantial improvement in patients meeting all five elements of a diabetes bundle and a decline in HbA1c beyond usual care.[3]

- In a study of over 32,500 high risk pregnant women with gestational diabetes, DSMT reduced overall pregnancy related health costs by an average of $13 thousand per pregnancy.[4]

- Physician understanding of the role of diabetes education in the treatment of patients with diabetes varies greatly. [ii] This finding supports the ongoing need for Congressional support to help educate physicians about DSMT and the need to include credentialed diabetes educators as providers, to allow them to work more effectively with physician offices to improve patient quality of care.

- Insured patients who are most likely to undergo a DSMT program are younger, female and reside in more affluent areas.[5] Unfortunately, this means that older, poorer, and -- most likely -- sicker Medicare beneficiaries do not have access to the type of cost effective, lifesaving benefits afforded by DSMT.

- The Centers for Disease Control and Prevention analyzed data from the Marketscan Commercial Claims and Encounters database to estimate the claim-based proportion of privately insured adults (aged 18-64 years) with newly diagnosed diabetes who participated in DSMT during the first year after diagnosis. During 2011-2012 an estimated 6.8% of privately insured, newly diagnosed adults participated in DSMT. The data suggests that there is a large gap between the recommended guidelines and current practice, and that there is both an opportunity and a need to enhance rates of DSMT participation among persons newly diagnosed with diabetes.[7]

References:

1. Duncan I, Ahmed T, Li QE, Stetson B, Ruggiero L, Burton K, Rosenthal D, Fitzner K. Assessing the value of the diabetes educator. *Diabetes Educ.* 2011 Sep-Oct;37(5):638-57.
2. Shaw K, Killeen M, Sullivan E, Bowman P. Disparities in diabetes self-management education for uninsured and underinsured adults. *Diabetes Educ.* 2011 Nov-Dec;37(6):813-9.
3. Brunisholz KD, Briot P, Hamilton S, Joy EA, Lomax M, Barton N, Cunningham R, Savitz LA, Cannon W. Diabetes self-management education improves quality of care and clinical outcomes determined by a diabetes bundle measure. *J Multidiscip Healthc.* 2014 Nov 21;7:533-42.
4. Fitzner K, Greenwood D, Payne H, Thomson J, Vukovljak L, McCulloch A, Specker JE. An assessment of patient education and self-management in diabetes disease management--two case studies. *Popul Health Manag.* 2008 Dec;11(6):329-40.

5. Assessing the Value of Diabetes Educators and Diabetes Self-management Education/Training, Ian Duncan FSA FIA FCIA MAAA; Solucia Inc.; Christian Birkmeyer, MA, Solucia Inc; Suzanne Austin Boren, PhD, University of Missouri; Karen Fitzner, PhD, American Association of Diabetes Educators. Poster NIH Disparities Conference, Dec 16-20, 2008, Washington D.C.
6. Boren SA, Fitzner KA, Panhalkar PS, Specker JE. Costs and Benefits Associated with Diabetes Education. *Diabetes Educ.* 2009 Jan-Feb;35(1):72-96.
7. Li R, Shrestha SS, Lipman R, Burrows NR, Kolb LE, Rutledge S. Diabetes self-management education and training among privately insured persons with newly diagnosed diabetes--United States, 2011-2012. *MMWR Morb Mortal Wkly Rep.* 2014 Nov 21;63(46):1045-9.

State of Florida - Florida Medicaid

Diabetes Financial Risk Model Results

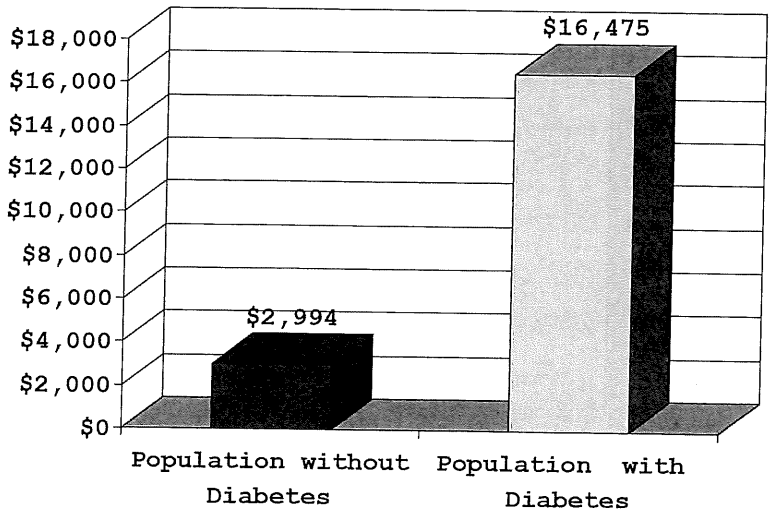
Roche

- State population (2011-2012): 19,045,000
- State medical cost of diabetes (2012): $18.90 billion
- State diabetes incidence (2013): 8.7%, 1,657,000 total lives
- Medicaid population: Disabled Non-Dual and TANF
- Medicaid enrollment: 3,523,843
- Demographic distribution: Estimated
- Medicaid population incidence of diabetes: 4.9%, 172,344 total lives
- Medicaid medical cost of diabetes (adults only in 2011): $2,079 million
- Medicaid diabetes prevention & control program funding (FY 2013): $694,394

[redacted]

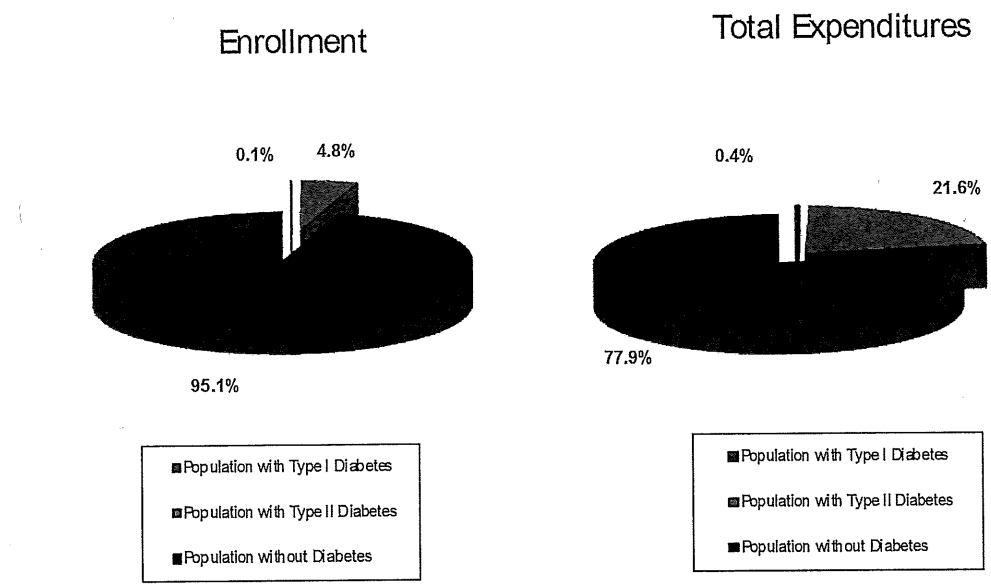
- Patients with diabetes incur total annual costs 450% greater than patients without diabetes
- Values include:
  - Prescription drug costs
  - Hospital inpatient costs
  - Hospital outpatient costs
  - Physician and other services costs

[redacted]



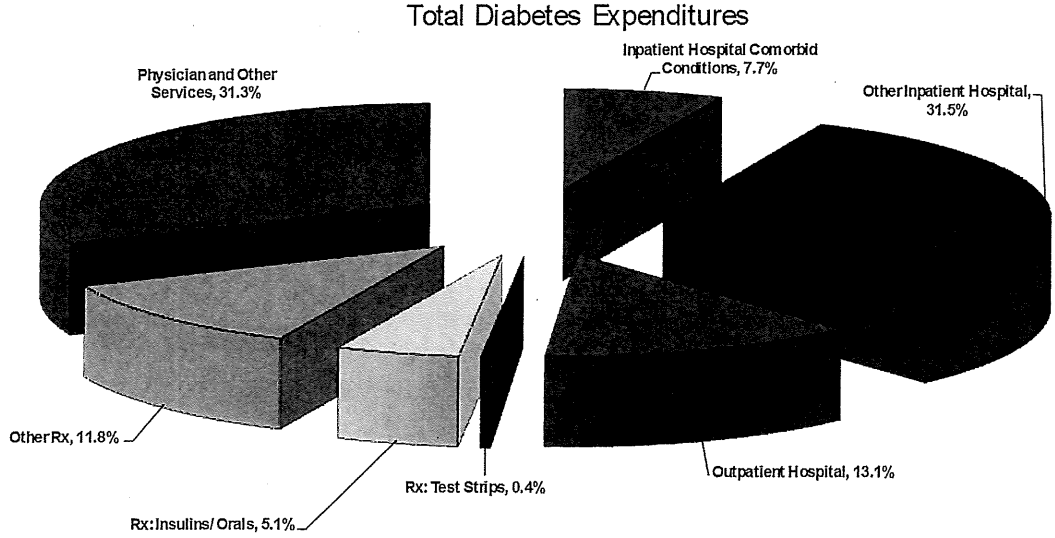
The values shown in the above chart do not reflect state specific experience. The projections were based on public and proprietary third-party vendor data.

[redacted]



The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

[redacted]

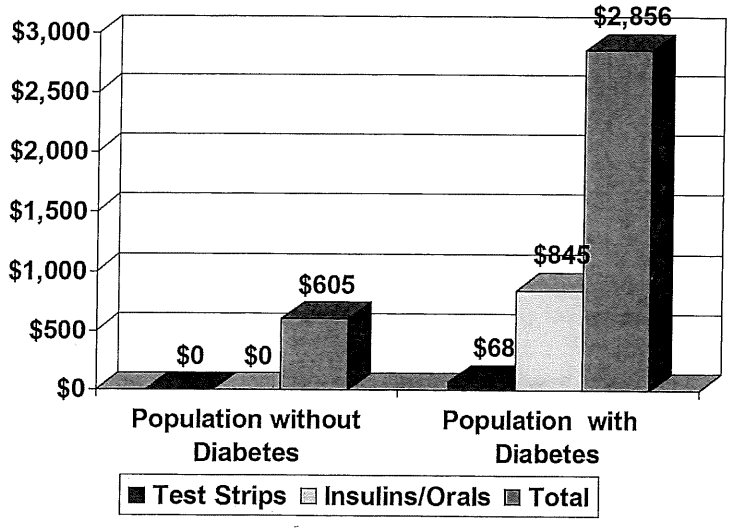


The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

[redacted]

- Patients with diabetes incur annual prescription drug costs 372% greater than patients without diabetes
- Represent costs for drugs dispensed on an outpatient basis through retail pharmacy

[redacted]

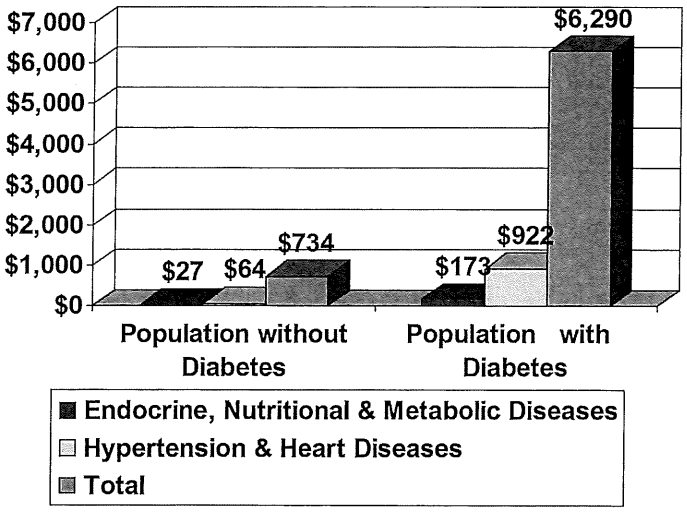


The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

[redacted]

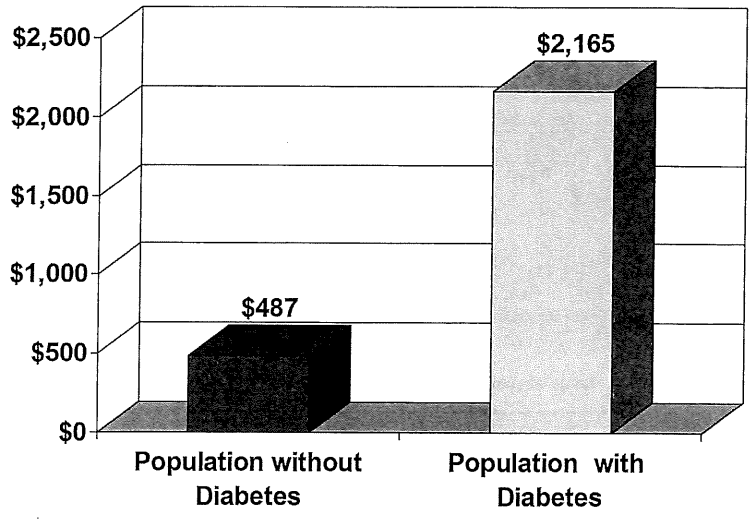
- Patients with diabetes incur annual hospital inpatient costs 757% greater than patients without diabetes
- Represent costs for the hospital facility

[redacted]



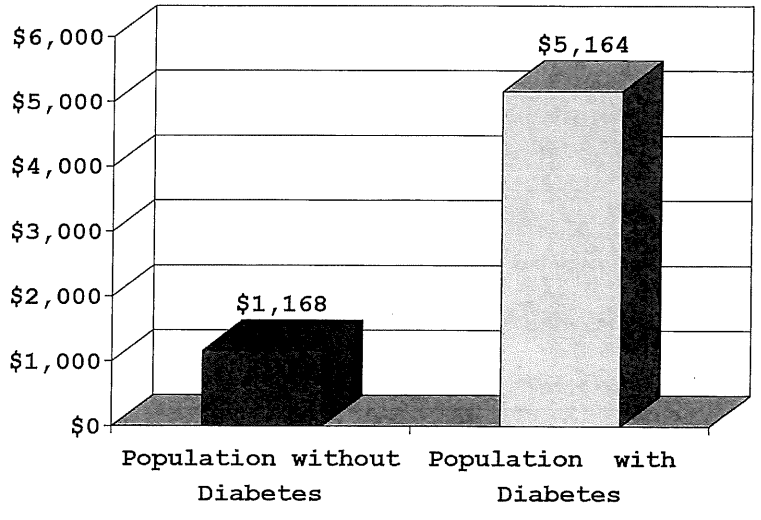
The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

- Patients with diabetes incur annual hospital outpatient costs 344% greater than patients without diabetes
- Represent the costs for the outpatient hospital facility



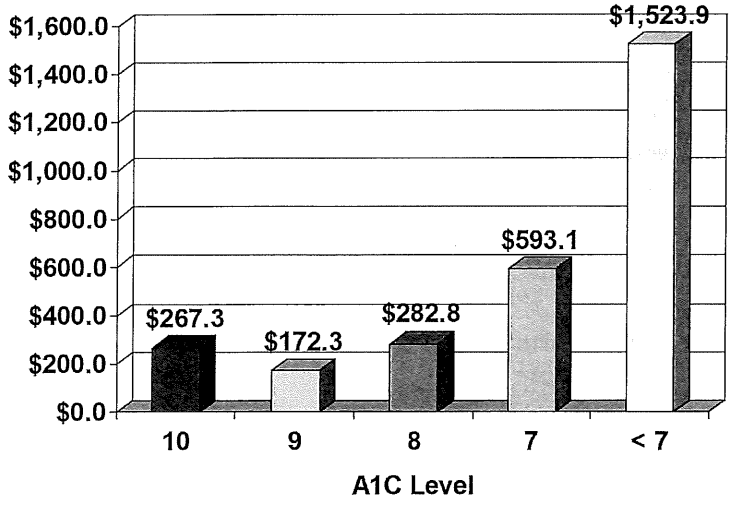
The values shown in the above chart do not reflect state specific experience. The projections were based on public and proprietary third-party vendor data.

- Patients with diabetes incur annual physician and other services costs 342% greater than patients without diabetes
- Represent costs for the inpatient and outpatient physician procedures and other services



The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

- Represents the total direct medical costs based estimated from the proprietary database
- The projection was based on the information presented in the following articles:
  - "A Diabetes Report Card for the United States: Quality of Care in the 1990s" by J.B. Saaddine et al.
  - "Association between glycemic control and short-term healthcare costs" by Mark Aagren and Wenli Luo



The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

[redacted]

- Represents the medical expenditure differential for patients with diabetes by A1C level.

[redacted]

Type : Medicaid - Disabled Non-Dual and TANF
Size : 3,523,843
Prevalence: TANF Prevalence: 1.86% and Disabled Prevalence: 23.35%
Population with Diabetes: 172,344

	A1C Level					
Costs Per Member with Diabetes	**10**	**9**	**8**	**7**	**< 7**	**Tot**
Prescription Drug	$ 3,257	$ 3,126	$ 2,995	$ 2,868	$ 2,747	$
Hospital Inpatient	7,171	6,885	6,595	6,317	6,050	
Hospital Outpatient	2,469	2,370	2,270	2,174	2,082	
Physician and Other Services	5,887	5,652	5,414	5,185	4,967	
Total Costs Per Member with Diabetes	$ 18,785	$ 18,034	$ 17,273	$ 16,544	$ 15,846	$
Population with Diabetes	14,230	9,553	16,373	35,848	96,168	
Total Direct Costs for Population with Diabetes	$ 267,303,000	$ 172,285,000	$ 282,805,000	$ 593,074,000	$ 1,523,919,000	$ 2,839,3

Sources: a) "A Diabetes Report Card for the United States: Quality of Care in the 1990s" by J.B. Saaddine et al.
b) "Association between glycemic control and short-term healthcare costs" by Mark Aagren and Wenli Luo

The values shown in the above chart do not reflect state specific experience.
The projections were based on public and proprietary third-party vendor data.

- The cost projections illustrated in this presentation were developed using:
  - Third-party vendor proprietary databases
  - Other internal databases
  - CDC "National Diabetes Fact Sheets"
  - CMS Medicaid enrollment statistics
  - Agency of Healthcare Research and Quality, Diabetes Care Quality Improvement: "A Resource Guide for State Action"
  - National Healthcare Quality Report
  - "A Diabetes Report Card for the United States: Quality of Care in the 1990's" by J.B. Saaddine et al.
  - "Association between glycemic control and short-term healthcare costs" by Mark Aagren and Wenli Luo
  - Statehealthfacts. May 22, 2014, http://www.kff.org.
- Values shown are estimated and may vary from health plan experience

ROSSITTO-VANWINKLE.TARI

From: HAMID.FARISHA
Sent: Monday, February 15, 2016 9:06 AM
To: ROSSITTO-VANWINKLE.TARI
Cc: GIBSON.AUDREY
Subject: FW: Sunrise Questionnaire for SB 1286
Attachments: Diabetes educators - Sunrise Questionnaire.docx; Cost Bullet Points.docx; diabetesreportcard2014.pdf; DSMT Cost Study State edit.docx; AADE Licensure Reasoning Summary.docx; Florida%20Medicaid.ppt

Good morning Tari,
Attached is the Sunrise Questionnaire and supporting documentation needed for SB 1286: Diabetes Educator Practice.

Farisha Hamid
Legislative Assistant
Office of **Senator Audrey Gibson - District 9**
Phone: (850) 487-5009

From: Melanie Bostick [mailto:Melanie@libertypartnersfl.com]
Sent: Sunday, February 14, 2016 9:25 PM
To: HAMID.FARISHA <HAMID.FARISHA@flsenate.gov>
Cc: Liberty Office <office@libertypartnersfl.com>
Subject: Sunrise Questionnaire for SB 1286

Farisha,

As requested, please find attached the Sunrise Questionnaire for SB 1286. I have also attached all background information that committee staff may use in drafting the staff analysis. Please let us know if you have any questions.

Thank you!

Melanie Shanks Bostick
Vice President
Liberty Partners of Tallahassee, LLC
113 E. College Avenue, Suite 300
P. O. Box 390
Tallahassee, FL 32302
(850) 841-1726 – office
(850) 688-3183 – mobile
(850) 841-7097 – fax
www.libertypartnersfl.com

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR AUDREY GIBSON
9th District

COMMITTEES:
Criminal Justice, *Vice Chair*
Military and Veterans Affairs, Space, and Domestic Security, *Vice Chair*
Appropriations Subcommittee on Transportation, Tourism, and Economic Development
Communications, Energy, and Public Utilities
Rules
Joint Legislative Auditing Committee

January 12, 2016

Senator Aaron Bean, Chair
Committee on Health Policy
302 Senate Office Building
404 South Monroe Street
Tallahassee, Florida 32399-1100

Chair Bean:

I respectfully request that SB 1286, relating to Diabetes Educators Practice, be placed on the next committee agenda.

SB 1286, ensures that individuals who hold themselves out as a diabetes educator and practices in diabetes education meets the minimum requirements for safe practice and any person who falls below a minimum competency or otherwise presents a danger to the public has a path to become competent in the field.

Thank you for your time and consideration.

Sincerely,

Audrey Gibson
State Senator
District 9

REPLY TO:
☐ 101 E. Union Street, Suite 104, Jacksonville, Florida 32202 (904)359-2553 FAX: (904) 359-2532
☐ 205 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5009

Senate's Website: *www.flsenate.gov*

ANDY GARDINER
President of the Senate

GARRETT RICHTER
President Pro Tempore

(1)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

SB 1286
Bill Number (if applicable)

Topic DIABETES EDUCATION - LICENSURE

Amendment Barcode (if applicable)

Name KURT ANDERSON

Job Title DIR. FED. & STATE ADVOCACY

Address _____ Phone 312/420-0920
Street

_____ Email _____
City *State* *Zip*

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing AMERICAN ASSOCIATION OF DIABETES EDUCATORS

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

(2)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

SB 1286
Bill Number (if applicable)

Topic DIABETES EDUCATION LICENSURE

Amendment Barcode (if applicable)

Name CURTIS FORD

Job Title NEIGHBORHOOD MEDICAL CENTER

Address _____ Phone 850 | 300 - 3680
Street

_____ Email _____
City *State* *Zip*

Speaking: [X] For [ ] Against [ ] Information

~~Waive Speaking:~~ [X] ~~In Support~~ [ ] Against
(The Chair will read this information into the record.)

Representing AADE & MYSELF | PATIENT

Appearing at request of Chair: [ ] Yes [X] No

Lobbyist registered with Legislature: [ ] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

(5)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/2016	1286
Meeting Date	*Bill Number (if applicable)*

Topic Diabetes Educator Licensure

Amendment Barcode (if applicable)

Name Dr. Otis Kirksey

Job Title FAMU College of Pharmacy

Address 438 West Brevard St. *(Street)*

Phone (850) 513-3261

Tallahassee *(City)* FL *(State)* 32301 *(Zip)*

Email

Speaking: ☒ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Self and member of American Assoc. of Diabetes

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

2/16/16
Meeting Date

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

1286
Bill Number (if applicable)

Topic SB 1286, Diabetes Educator

Amendment Barcode (if applicable)

Name Jean Vansmith

Job Title Senior Manager, Govt. Relations

Address _____
Street

_____
City *State* *Zip*

Phone 813-482-6393

Email jean.vansmith@flhosp.org

Speaking: ☑ For ☐ Against ☐ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Hospital

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/16/16
Meeting Date

1286
Bill Number (if applicable)

Topic Diabetes Educator

Amendment Barcode (if applicable)

Name Alisa LaPolt

Job Title Lobbyist

Address _____
Street

Phone 443-1319

Tallahassee FL
City *State* *Zip*

Email _____

Speaking: ☐ For ☐ Against ☒ Information

Waive Speaking: ☐ In Support ☐ Against
(The Chair will read this information into the record.)

Representing Florida Nurses Association

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☒ Yes ☐ No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/14/14)

The Florida Senate

BILL ANALYSIS AND FISCAL IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

Prepared By: The Professional Staff of the Committee on Health Policy

BILL:	SB 1626
INTRODUCER:	Senator Hutson
SUBJECT:	Licensure of Foreign-trained Physicians
DATE:	February 15, 2016
REVISED:	

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	**Pre-meeting**
2.			AHS	
3.			FP	

I. Summary:

SB 1626 establishes a fourth pathway for foreign-trained physicians to meet the educational and training requirements to obtain a Florida medical license. The additional pathway allows a foreign-trained physician to obtain a license if he or she:

- Graduated from a foreign medical school, not approved by the Board of Medicine (BOM), but listed in the World Directory of Medical Schools (WDMS), and accredited by the government in the country of location;
- Can demonstrate competency in English;
- Has completed a board-approved residency or fellowship of at least one year in a specialty which counts towards board certification; and
- Has held an active physician's license, and actively practiced for the preceding 10 years.

All other requirements for a Florida allopathic medical license must be met.

II. Present Situation:

Section 458.311, F.S, provides that any person desiring to be licensed as an allopathic physician in Florida, who does not hold a valid medical license in another U.S. state, must apply to the Department of Health (DOH) and pay a nonrefundable application fee. The DOH must license any applicant that the BOM certifies meets the following criteria:

- Is at least 21 years of age;
- Is of good moral character;
- Has not committed any act or offense anywhere which would constitute grounds for discipline under s. 458.331, F.S.;
- Has passed:

- The U.S. Medical Licensing Examination (USMLE),[1,2] or
- A combination of the USMLE and the U.S. Federation of Medical Boards Examination (FLEX),[3] or
- The National Board of Medical Examiners (NBME) Examination4 up through the year 2000, or
- The U.S. Special Purpose Examination (SPEX)5 of the Federation of Medical Boards, if the applicant has passed a state board examination, is currently licensed in another state or Canada;

- Has completed the equivalent of two academic years of pre-professional, postsecondary education which must include courses in anatomy, biology, and chemistry prior to entering medical school; and
- Meets one of the following medical education and postgraduate training requirements:
  - Is a graduate of an allopathic medical school or college within the U.S., or its territories, recognized and approved of by an accrediting agency recognized by the U.S. Office of Education,[6] or the accrediting agency of the U.S. territory; the medical school or college courses were taught in English, or the applicant has demonstrated competency in English by obtaining a satisfactory grade on the Test of Spoken English (TSE)[7] or a similar test approved by BOM rule; and has completed an approved residency of at least 1 year.

[1] The USMLE is a three-step examination for medical licensure in the U.S. and is sponsored by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME). The USMLE assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care. See United States Medical Licensing Examination, *What is USMLE?*, Available at: http://www.usmle.org/, (Last visited February 9, 2016).

[2] As of 1994, the USMLE has become the sole examination pathway to licensure for physicians. The National Board of Medical Examiners (NBME) part examinations and the federation licensing examinations (FLEX) have been phased out. See University of Buffalo, Office of Medical Education, *USMLE Registration*, available at: http://www.smbs.buffalo.edu/ome/ome_resources_usmle.htm, (Last visited February 9, 2016).

[3] *Supra* note 2.

[4] *Supra* note 2.

[5] The SPEX is one of two programs available through the Post-Licensure Assessment System (PLAS), a collaborative initiative established in 1998 by the Federation of State Medical Boards (FSMB) and the National Board of Medical Examiners (NBME) to provide services for use by medical licensing authorities in assessing a licensed or previously licensed physician's aspects of competency to practice medicine. The SPEX is used by state medical boards to re-examine a licensed or previously licensed physician's ongoing level of basic medical knowledge. Situations in which a medical licensing board may require a physician to take SPEX include endorsement of licensure, reinstatement or reactivation of a license after a period of inactivity (due to illness, disciplinary action, etc.). In instances where the state medical board has or is aware of concerns and/or questions about a physician's fitness to practice, the results of the SPEX exam should be evaluated in conjunction with other available evidence to determine a physician's competence and fitness to practice. *See* Joint Program of the Federation of State Medical Boards of the United States, Inc., and the National Board of Medical Examiners, *Special Purpose Examination*, available at: https://www.fsmb.org/Media/Default/PDF/USMLE/SPEX_Bulletin.pdf, (Last visited February 9, 2016).

[6] The Liaison Committee on Medical Education (LCME) is recognized by the U.S. Department of Education as the reliable authority for the accreditation of medical education programs leading to the MD degree. See LCME, available at: http://www.lcme.org/about.htm (Last visited February 3, 2016).

[7] The ETS is an examination developed by the Educational Testing Service and administered worldwide to students or professionals who speaks English as a second language. It is designed to assess and measure their ability to communicate effectively in English. The test is commonly used for employment, graduate assistantships, licensure and certification purposes. *See* ETS, *Who We Are*, available at: https://www.ets.org/about/who/, (Last visited February 2, 2016).

- Is a graduate of an allopathic foreign medical school registered with the World Health Organization (WHO) and certified pursuant to s. 458.314, F.S.,[8] as meeting the standards required for accreditation of U.S. medical schools; the foreign medical school courses were taught in English, or the applicant has demonstrated competency in English by obtaining a satisfactory grade on the TSE or BOM approved similar test; and has completed an approved residency of at least 1 year.
- Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314, F.S., but the applicant has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG),[9] holds an active, valid certificate issued by that commission, and has passed the examination given by the commission,[10] and has completed an approved residency or fellowship of at least two years in one specialty area recognized for certification by the American Board of Medical Specialties.

World Directory of Medical Schools

The WHO's World Directory of Medical Schools is no longer incorporated in the Avicenna Directory, but has been transferred to the new WDMS.[11]

The new WDMS is a joint venture of the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER). The WDMS was created by merging FAIMER's International Medical Education Directory (IMED) and WFME's Avicenna Directory. Contained in the directory are institutional details such as historical school names and affiliations and program details such as admission requirements and curriculum duration. The Mission of the WDMS is to list all the Medical schools in the world, with accurate, up-to-date, and comprehensive information on each school.

The listing of a medical school in the WDMS does not denote recognition, accreditation or endorsement by the WDMS, the WHO, or by the partner organizations leading to this venture, the WFME and the FAIMER.[12]

---

[8] Any foreign medical school wishing to be certified by the Florida BOM must apply to the DOH, and demonstrate that their educational program is reasonably comparable to that of similar accredited institutions in the U.S.; and adequately prepares students for the practice of medicine. The curriculum, faculty qualifications, student attendance, plant and facilities, and other relevant factors are reviewed and evaluated by the BOM in conjunction with the DOH. *See* s. 458.314(4), F.S. and ch. 64B8-14 F.A.C.

[9] Certification by ECFMG is the standard for evaluating the qualifications of international medical graduates (IMGs) before these physicians enter U.S. graduate medical education (GME), where they provide supervised patient care. ECFMG certification also is a requirement for IMGs to take Step 3 of the three-step United States Medical Licensing Examination (USMLE) and to obtain an unrestricted license to practice medicine in the United States. ECFMG is a private, nonprofit organization whose members are: American Board of Medical Specialties; American Medical Association; Association of American Medical Colleges; Association for Hospital Medical Education; Federation of State Medical Boards of the United States, Inc.; and National Medical Association. *See* ECFMG, available at: http://www.ecfmg.org/about/index.html, (last visited Feb. 2, 2016).

[10] The ECFMG commission currently partners with the NBME in administering the Step 2 Clinical Skills component of USMLE, a requirement for IMGs. Through this collaboration, ECFMG uses its experience in assessment to ensure that all physicians entering U.S. GME can demonstrate the fundamental clinical skills essential to providing safe and effective patient care under supervision. *See* Educational Council for Foreign Medical Graduates, *Overview*, available at: http://www.ecfmg.org/about/index.html, (last visited Feb. 12, 2016).

[11] *See* World Health Organization, *Health Workforce*, http://www.who.int/hrh/wdms/en/, (last visited Feb. 2, 2016).

[12] *Id.*

On June 30, 2015, the ECFMG began to use the WDMS to determine eligibility of students for certification of foreign medical graduates.[13] If a foreign medical school, meets the ECFMG requirements, then the school's profile in the WDMS contains a notation of such and its graduates are eligible to apply for ECFMG certification and the USMLE.

The ECFMG does not accredit medical schools. A foreign medical school graduate, from a medical school not certified under s. 458.315, F.S., with an ECFMG certification who passes the USMLE is currently eligible for licensure under s. 458.311(1)(f) F.S., if he or she satisfies the residency or fellowship requirements of s. 458.311(1)(f)3.c., F.S.

However, if the medical school is not listed in the world directory or it is listed but its profile does not have the ECFMG notation, its students are ineligible to apply for ECFMG certification or the USMLE.

Licensing of Foreign-trained Physicians in California

The California Division of Licensing has formally published a list of approved and disapproved foreign medical schools. The education and diplomas from the following disapproved foreign medical schools will not be accepted toward meeting the requirements for training or licensure in California[14]:

- CETEC University, Santo Domingo, Dominican. Republic (closed);
- CIFAS University, Santo Domingo, Dominican. Republic (closed);
- UTESA University, Santo Domingo, Dominican. Republic;
- World University, Santo Domingo, Dominican. Republic (closed);
- Spartan Health Sciences University, St. Lucia;
- University of Health Sciences Antigua, St. John's, Antigua;
- Universidad Eugenio Maria de Hostos (UNIREMHOS), Dominican. Republic;
- Universidad Federico Henriquez y Carvajal, Dominican. Republic; and
- St. Matthew's University, Grand Cayman, Cayman Islands.[15]

All of the above California disapproved foreign medical schools are listed in the WDMS, and all are recognized by the ECFMG.[16] The above schools would meet the first prong of the fourth pathway to licensure under SB 1626 for foreign-trained physicians. The schools are accredited by an accrediting agency recognized by their country's governments and they are not certified by the BOM pursuant to s. 458.314, F.S.

---

[13] Educational Commission for Foreign Medical Graduates, *Update: World Directory of Medical Schools Replaces International Medical Education Directory for Purposes of Determining Eligibility for ECFMG Certification and USMLE,* (June 30, 2015) *available at* http://www.ecfmg.org/news/2015/06/30/update-world-directory-of-medical-schools-replaces-international-medical-education-directory-for-purposes-of-determining-eligibility-for-ecfmg-certification-and-usmle/ (last visited Feb. 12, 2016).

[14] As of January 1, 2013, California Business and Professional Code s. 2135.7, made it possible for graduates of unrecognized and even disapproved foreign medical schools to acquire a California Medical License. A graduate of an unrecognized school who holds an unrestricted license in another state for 10 years, and is a board-certified, can now apply for a California medical license. Graduates of disapproved schools were given the same treatment after 12 years. California remains one of the more difficult states in which to obtain a medical license.

[15] http://www.credentialwatch.org/non/california_medical.shtml, (Last visited Feb. 10, 2016).

[16] https://search.wdoms.org/, (last visited Feb. 10, 2016).

A comparison of California's list of approved foreign medical schools and the WDMS shows that Afghanistan, the first country listed in the WDMS, lists 11 state accredited medical schools in the WDMS, but only two are California approved; and both of these are also ECFMG recognized along with six other medical schools. Only three of the 11 listed Afghan medical schools are not ECFMG recognized.

The WMSD also lists 48 state accredited medical schools in Columbia; only 23 of those are on the California approved list; and 46 are eligible for their graduates to apply for ECFMG certification.

III. Effect of Proposed Changes:

SB 1626 amends s. 458.311, F.S., to establish another pathway for foreign-trained physicians to obtain an allopathic physician licensure in Florida. The additional pathway allows the BOM to certify a foreign-trained physician for licensure if, in addition to the requirements of s. 358.311(1)(a) through (e), and (g) through (h), F.S., he or she can provide evidence of the following medical education and postgraduate training:

- Graduation from a foreign allopathic medical school listed in the WDMS, accredited by an accrediting agency[17] recognized by the governmental body of the foreign jurisdiction, but which is not certified pursuant to s. 458.314, F.S.;
- Competency in English by achieving a satisfactory grade on the Test of English as a Foreign Language (TOEFL)[18] of the ETS or a similar test approved by the BOM, if the language of instruction in the foreign medical school was not English;
- Completion of a board-approved residency or fellowship of at least 1 year in a specialty which will count toward a certification by a board certified by the American Board of Medical Specialties; and
- An active physician license in a foreign jurisdiction, and at least ten years of active practice. in that foreign jurisdiction immediately preceding the application.

The bill also authorizes the BOM to certify an applicant who has met the medical education and post graduate training requirements under s. 458.311(1)(f)4., F.S., for licensure through this route and impose a probationary period, scope of practice limitation or supervision requirement that the DOH will impose on the license for the duration specified.

The effective date of the bill is July 1, 2016.

[17] ECFMG certification is not an accreditation. If a foreign medical school meets ECFMG requirements it means that students from that school are eligible to apply to EFCM for EFCM certification, and for examination, if all other eligibility requirements are met. *See* World Medical School Directory, Detail of ECFMG approval notation, available at: https://search.wdoms.org/home/SchoolDetail/F0001899, (last visited Feb. 12, 2016).

[18] TOEFL is a written test given by ETS designed to measure the English proficiency of non-English speaking people and is divided into three sections. It is designed to measure a candidate's ability to use and understand English at the university level. It tests four language skills — listening, reading, speaking and writing; and is administered via the Internet. Test fees vary by country and range from a low of $170.00 in Haiti to a high of $270.00 in Switzerland. EST, *About the TOEFL iBT Test*, available at: http://www.ets.org/toefl/ibt/about?WT.ac=toeflhome_ibtabout2_121127, (last visited Feb. 10, 2016).

IV. Constitutional Issues: Dominican. Republic

A. Municipality/County Mandates Restrictions:

None.

B. Public Records/Open Meetings Issues:

None.

C. Trust Funds Restrictions:

None.

V. Fiscal Impact Statement:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill may aid foreign-trained physicians, intending to become licensed in Florida, and may result in cost savings associated with no longer having to take the USMLE or FLEX to become licensed if the foreign trained physician meets the new licensure criteria provided in the bill. The bill may increase the number of physicians in Florida and help reduce the physician shortages.

C. Government Sector Impact:

The bill may have an indeterminate, positive fiscal impact on the DOH. The DOH may collect application, licensure, and renewal fees from additional individuals that may be eligible to apply for licensure. The DOH may also experience a recurring workload increase as additional individuals may be eligible to apply for licensure. The DOH will incur an insignificant nonrecurring cost associated with rulemaking which current resources are adequate to absorb.[19]

VI. Technical Deficiencies:

None.

VII. Related Issues:

None.

VIII. Statutes Affected:

This bill substantially amends section 458.311 of the Florida Statutes.

[19] Department of Health, *House Bill 1277 Analysis* (January 11, 2015) (on file with the Senate Committee on Health Policy).

IX. Additional Information:

A. Committee Substitute – Statement of Changes:
(Summarizing differences between the Committee Substitute and the prior version of the bill.)

None.

B. Amendments:

None.

By Senator Hutson

6-01677A-16 20161626__

A bill to be entitled

An act relating to licensure of foreign-trained physicians; amending s. 458.311, F.S.; establishing licensure requirements for certain foreign-trained physicians; authorizing the Board of Medicine to impose licensure restrictions, limitations, or conditions on certain foreign-trained physicians; providing an effective date.

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

Section 1. Paragraphs (f) and (h) of subsection (1) and subsection (7) of section 458.311, Florida Statutes, are amended to read:

458.311 Licensure by examination; requirements; fees.—

(1) Any person desiring to be licensed as a physician, who does not hold a valid license in any state, shall apply to the department on forms furnished by the department. The department shall license each applicant who the board certifies:

(f) Meets one of the following medical education and postgraduate training requirements:

1.a. Is a graduate of an allopathic medical school or allopathic college recognized and approved by an accrediting agency recognized by the United States Office of Education or is a graduate of an allopathic medical school or allopathic college within a territorial jurisdiction of the United States recognized by the accrediting agency of the governmental body of that jurisdiction;

b. If the language of instruction of the medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of English as a Foreign Language ~~Test of Spoken English~~ of the

6-01677A-16 20161626__

Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

2.a. Is a graduate of an allopathic foreign medical school registered with the World Health Organization and certified pursuant to s. 458.314 as having met the standards required to accredit medical schools in the United States or reasonably comparable standards;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of the Educational Commission for Foreign Medical Graduates English proficiency certificate or by a satisfactory grade on the Test of English as a Foreign Language ~~Test of Spoken English~~ of the Educational Testing Service or a similar test approved by rule of the board; and

c. Has completed an approved residency of at least 1 year.

3.a. Is a graduate of an allopathic foreign medical school which has not been certified pursuant to s. 458.314;

b. Has had his or her medical credentials evaluated by the Educational Commission for Foreign Medical Graduates, holds an active, valid certificate issued by that commission, and has passed the examination utilized by that commission; and

c. Has completed an approved residency of at least 1 year; however, after October 1, 1992, the applicant shall have completed an approved residency or fellowship of at least 2 years in one specialty area. However, to be acceptable, the fellowship experience and training must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties.

4.a. Is a graduate of an allopathic foreign medical school listed in the World Directory of Medical Schools and accredited by an accrediting agency recognized by the governmental body of the foreign jurisdiction, but which is not certified pursuant to s. 458.314;

b. If the language of instruction of the foreign medical school is other than English, has demonstrated competency in English through presentation of a satisfactory grade on the Test of English as a Foreign Language of the Educational Testing Service or a similar test approved by rule of the board;

c. Has completed a board-approved residency or fellowship of at least 1 year in one specialty area, which must be counted toward regular or subspecialty certification by a board recognized and certified by the American Board of Medical Specialties; and

d. Has held an active physician license and practiced medicine in a foreign jurisdiction for at least the 10 years immediately preceding the application for licensure under this section.

(h) Has obtained a passing score, as established by rule of the board, on the licensure examination of the United States Medical Licensing Examination (USMLE); or a combination of the United States Medical Licensing Examination (USMLE), the examination of the Federation of State Medical Boards of the United States, Inc. (FLEX), or the examination of the National Board of Medical Examiners up to the year 2000; or for the purpose of examination of any applicant who was licensed on the basis of a state board examination and who is currently licensed in at least one other jurisdiction of the United States or

Canada, and who has practiced pursuant to such licensure for a period of at least 10 years, use of the Special Purpose Examination of the Federation of State Medical Boards of the United States (SPEX) upon receipt of a passing score as established by rule of the board. An applicant meeting the medical education and postgraduate training requirements in subparagraph (f)4. may meet the examination requirement of this paragraph by obtaining a passing score on an examination determined by the board to be substantially equivalent to, or more stringent than, the United States Medical Licensing Examination (USMLE). However, for the purpose of examination of any applicant who was licensed on the basis of a state board examination prior to 1974, who is currently licensed in at least three other jurisdictions of the United States or Canada, and who has practiced pursuant to such licensure for a period of at least 20 years, this paragraph does not apply.

(7) Upon certification by the board, the department shall impose conditions, limitations, or restrictions on a license if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter. The board may certify an applicant for licensure who has met the medical education and postgraduate training requirements under subparagraph (1)(f)4. and all other licensure requirements with a condition, limitation, or restriction, including, but not limited to, a probationary period of practice, a scope of practice limitation, or a supervision requirement, which shall be imposed by the department for a duration specified by the board.

Section 2. This act shall take effect July 1, 2016.

The Florida Senate

Committee Agenda Request

To: Senator Aaron Bean, Chair
Committee on Health Policy

Subject: Committee Agenda Request

Date: January 21, 2016

I respectfully request that **Senate Bill #1626**, relating to Licensure of Foreign-Trained Physicians, be placed on the:

☐ committee agenda at your earliest possible convenience.

☒ next committee agenda.

Senator Travis Hutson
Florida Senate, District 6

File signed original with committee office

S-020 (03/2004)

Florida Medicaid: Statewide Medicaid Managed Care Pharmacy Networks

Justin M. Senior

Florida Medicaid Director

Agency for Health Care Administration

Senate Health Policy

February 16, 2016

Statewide Medicaid Managed Care Program

- Most Florida Medicaid recipients are enrolled in one or both components of the Statewide Medicaid Managed Care (SMMC) program, Long-term Care program and Managed Medical Assistance program
- The MMA program provides primary care, acute care and behavioral health care services to recipients eligible for enrollment.

Statewide Medicaid Managed Care Program

- Plans are required to cover prescription benefits at the Medicaid state plan level.
- Plans are also required to develop prior authorization criteria and protocols, which cannot be more restrictive than that used by the Agency.

Statewide Medicaid Managed Care Program

- Throughout implementation and operation of the SMMC program, the Agency has focused on key critical areas to define program success:
- These key areas include (but are not limited to):
  - sufficient provider networks
  - continuity of care

MMA Provider Networks: Contractual Standards

- Robust provider network related contractual standards:
  - Provider network standards
  - Provider Network File (PNF) submitted weekly
  - On-line provider directories updated weekly

MMA Provider Networks: Contractual Standards

- Plans are required to provide each new enrollee:
  - Provider Directory (in print or electronically) and an updated directory every six months
  - Rights and procedures for enrollment and disenrollment
  - How to receive services from non-participating providers.
  - Description of covered services
  - Notification of change in provider network every 6 months
    - Notification within 60 days if recipient is in an active relationship with an impacted provider.

MMA Provider Networks: Enforcement Tools

- If plans fail to meet contract requirements, the Agency has strong compliance and enforcement tools:
  - Liquidated damages
  - Sanctions
  - Enrollment freezes
  - Corrective Action Plans
  - Secret Shopper program

MMA Provider Networks: Pharmacy Providers

- Network adequacy for pharmacy providers is based on:
  - Time and distance standards
  - Regional provider ratios

Required Providers	Urban County		Rural County		Regional Provider Ratios
	Max Time (minutes)	Max Distance (miles)	Max Time (minutes)	Max Distance (miles)	
Pharmacy	30	20	60	45	1:2,500 enrollees
24-hour Pharmacy	60	45	60	45	n/a

Pharmacy Time and Distance

Region	Regional Average Time (minutes)	Regional Average Distance (miles)
Region 1	3.7	3.3
Region 2	6.4	5.9
Region 3	5.1	4.7
Region 4	3.1	2.8
Region 5	1.6	1.2
Region 6	2.5	2.2
Region 7	1.9	1.4
Region 8	3.7	3.3
Region 9	2.5	2.1
Region 10	1.5	0.8
Region 11	2.6	2.0

MMA Provider Networks: Pharmacy Providers

- Recipients must choose an in network pharmacy after 60 day continuity of care period has ended.
- Mail-order pharmacy can be provided as an option for enrollees.
  - Cannot count towards plan's pharmacy network access standards.
- Plans can assign enrollees to a specialty pharmacy for specialty medications.
  - Plans Must ensure members have a choice of available providers.
  - Recipient must be notified and provided with information on how to "opt out" of the assignment.

MMA Provider Networks: Change in Network Providers

- Health plans have flexibility to determine who they contract with.
- When a plan makes a change to their provider network the plan must:
  - notify impacted providers and enrollees in active care sixty days before suspension or termination.
  - allow enrollees to continue receiving medically necessary services for a minimum of sixty days. (continuity of care period)
    - Plans will have to select an in network provider for their services after the 60 day continuity of care period ends
  - process provider claims for services provided for a minimum of sixty days.
- Recipients impacted can change plans through a “good cause” plan change.

Report an Issue or Complaint

- The Agency encourages any individual with a complaint or issue relating to the SMMC program to notify us by calling 1-877-254-1055 or completing our online form http://apps.ahca.myflorida.com/smmc_cirts/.
- Complaints are reviewed and tracked throughout the day by Agency staff.
- The Agency closely monitors all issues and complaints from recipients, providers, and other stakeholders and will hold plans accountable to the statute, contract and guidance.

Questions?

Florida PHARMACY ASSOCIATION

United to Advance Health Care and Pharmacy Practice

February 16, 2016

Florida Senate Committee on Health Policy
404 S. Monroe Street
Tallahassee, Florida 32399-1100

The Florida Pharmacy Association is pleased to submit these comments to the Health Policy Committee regarding discussion and testimony on Statewide Medicaid Managed Care Pharmacy Networks. The Florida Pharmacy Association is the professional society representing Florida pharmacists, united to improve public health and patient care.

Over the years the Florida legislature has been working to find ways to craft a balanced budget. Like each of us we have a check book with both an income and an expense ledger. The challenge is to find a way to get the spending and the income to be in balance and also set aside reserves to deal with unexpected events. The state's checkbook however has an unbelievably large number of entries. I bring your attention to the ones related to health care.

We have in this state a program through Medicaid to help the poor, the indigent and disabled. These are our state's most vulnerable citizens who are caught in a space none of us want to be. They are not the only ones affected by decisions here in Tallahassee.

There is a trend in health care to control rising costs by limiting access to some pharmacies. The theory is that by restricting access and making smaller the number of pharmacies that a patient can choose as their service provider that there would be a possibility of savings. If this is the case then are the costs of Medicaid going down or staying the same?

Current Florida policy for Medicaid says in Florida Statutes 409.975 that the managed care plans can limit the providers in their networks based upon credentials, quality indicators and price. Much of what we have seen in this debate about the pharmacy networks and contracts have been related to

costs. We have not seen anything that suggests quality indicators are included in the determination on who can serve in the pharmacy networks and who cannot. Reports showing high dispensing and refill rates of prescription medications are only part of the story on quality. That message must include information on whether patients who received their medications actually took them and got better from their therapy and whether or not they were being monitored or received pharmacist medication management services.

The Medicaid program also has as policy that a pharmacy has to be within an hour's drive for patients in rural areas. That is a 2 hour round trip for patients that are already challenged with lack of reliable transportation. This could mean that a Medicaid patient may have to drive past a number of pharmacies before they get to one that is covered under their health plan.

Each county has only a certain number of available Medicaid managed care plans. When patients want to stay with the pharmacy/pharmacist they have been using for years, even though they are permitted to switch to another plan, there are not a lot of options. In some counties there is only one option. What we see is patients who wish to transition to a different plan then what we end up with is a managed Medicaid plan that can't handle the influx of new patients and enrollment is suspended. Ultimately, the patient is forced to switch to another pharmacy when that was not their preference in the first place.

Studies show that patients who know their pharmacists and pharmacists who know their patients get better results from their health care and understand how their medications are supposed to help them. When that relationship is disrupted patients have to now form a new relationship in another pharmacy that may be unfamiliar with their health history or their unique needs. Sometimes that works but sometimes it doesn't work for the benefit of the patient.

Just imagine this same scenario happening with your day to day purchases of consumer goods and services. You make your selections or have your services done and then prepare to pay. Upon swiping your debit or credit card provided by your banking institution you see a message that your card will not work in that establishment and that you must go somewhere else to

make your purchases. This is not how the free market system is supposed to work.

Of course we all know that Medicaid is a tax funded health care program administered by the government but did you know that some of these taxes that support Medicaid are coming from the very pharmacy businesses that are being denied the ability to care for the indigent in their communities? Why are their tax dollars and fees that these businesses and pharmacists pay for the privilege of being a local health care provider in Florida ok to fund Medicaid but their high quality value added professional services that they are offering are not acceptable? What is truly ironic is that if a pharmacist chooses to end his or her practice at a pharmacy that is within the Medicaid managed care network they could begin a new practice career in a pharmacy that is NOT part of the managed care plan's network. This pharmacist has the same skills and abilities and yet their clinical services are rejected simply because of the building that they are seeing patients in.

Then there is the question of limiting competition to control costs. Perhaps the theory of economics has changed over the years but it has always been perceived that competition in an open market was healthy especially when a consumer has choices. We are seeing a lot of consolidation within the pharmacy industry driven by health plans that believe limiting the size of their pharmacy networks lower costs. Most of what we are seeing in the literature is that prescription drug costs are rising not falling. Maybe limiting competition in the pharmacy marketplace is not such a good idea after all.

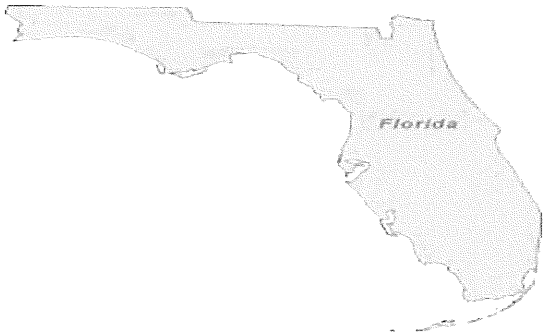
We appreciate your consideration of our submitted comments and will be available to answer any questions.

With kindest regards,

Michael A. Jackson

Michael A. Jackson, BPharm, CPh
Executive Vice President and CEO

Florida



2014

Number of Independent Community Pharmacies:	1304
Total Sales:	$ 4,722,897,616
Pharmacy sales:	$ 4,354,511,602
Front end sales:	$ 368,386,014
Number of full time employees:	12,910
Total prescriptions filled:	80,284,672
Part D prescriptions fillied:	25,691,095
Medicaid prescriptions filled:	13,648,394
Additional economic activity generated by Independent Community Pharmacy in state of Florida:	
Sales:	$4,250,607,854
Employment:	5,164

For more information please contact NCPA Government Affairs

100 Daingerfield Road
Alexandria, VA 22314-2888
(703) 683-8200 PHONE
(703) 683-3619 FAX

PHARMACISTS PROVIDE CARE

PharmacistsProvideCare.com

Improving Patient Care

Improving Patient Outcomes, Quality, and Costs with Pharmacists' Services

The Current State

Patients benefit when medications are used appropriately. Improper medication use adversely impacts patient outcomes, costs, and the health care system as a whole and puts patients at risk.

The Facts

- The United States spends almost $300 billion annually on medication problems including medication non-adherence.
- Chronic diseases account for $1.7 trillion in health care expenditures and 91 percent of all prescriptions filled.
- Almost 50 percent of people prescribed medications for chronic diseases do not take their medications correctly.
- Nearly 70 percent of Americans are on at least one prescription drug and over 50 percent of Americans are on at least two prescription drugs.
- The number of Americans ages 65 years and older is projected to increase 36 percent by 2020.
- On average, two-thirds of Americans aged 65 and older take 5-9 medications.

Patients across the United States are receiving better care and achieving better outcomes from pharmacists' patient care services. Examples of pharmacists' services include: coordination of medications during care transitions, comprehensive medication reviews and monitoring, chronic disease prevention and management, wellness services, and patient education.

A Solution

Pharmacists, with their medication expertise, are uniquely positioned to combat issues plaguing our health care system. Because patients and health care providers need to be able to access pharmacists' services, the American Pharmacists Association seeks provider status for pharmacists – an effort that includes requesting:

- Payers and policy makers to recognize pharmacists as health care providers who improve access, quality, and value of health care.
- Patients to have improved access to pharmacists' services.

The Outcome

By including pharmacists as part of the patient's health care team:

- Patients benefit – enhanced satisfaction, care, and outcomes
- Communities benefit – healthier population, increased access to immunizations
- The health care system benefits – quality, access, and costs are improved

Provider status for pharmacists will result in a team-based, patient-centered health care system providing improved care and value. For more information, visit **PharmacistsProvideCare.com**

CourtSmart Tag Report

Room: KN 412 **Case No.:** **Type:**
Caption: Senate Committee on Health Policy **Judge:**

Started: 2/16/2016 1:35:37 PM
Ends: 2/16/2016 3:30:35 PM **Length: 01:54:59**

1:35:38 PM	Meeting Called to order
1:36:49 PM	Roll Call
1:37:06 PM	Quorum Present
1:37:13 PM	Tab 4 SB 1306 Nurse Licensure Sen Grimsley
1:37:27 PM	Sen Grimsley explains the strike all
1:38:11 PM	A 613610
1:38:23 PM	Public Appearances
1:38:28 PM	Call for question
1:38:32 PM	Sen Joyner question
1:39:04 PM	Sen Grimsley responds
1:39:35 PM	BC 613610 adopted
1:39:46 PM	Martha Deastor, waives in support
1:39:54 PM	Jean waives in support
1:40:12 PM	Sen Joyner question and comment
1:40:53 PM	Roll Call
1:41:00 PM	CS SB 1306 passes favorably
1:41:43 PM	Sen Sobel Hair Restoration
1:41:52 PM	Late file A 162030
1:42:01 PM	Sen Sobel explains
1:42:05 PM	Call for questions and debate or objections
1:42:23 PM	Chris Nuland, Fl society waives in support
1:42:35 PM	Alicia waives in support
1:42:53 PM	Vice Chair Sobel waives close
1:43:02 PM	Roll call on Tab 3 SB 974
1:43:11 PM	SB 974 passes favorably
1:43:29 PM	Tab 2 CS SB 706
1:43:35 PM	Aisst Lindy explains SB 706
1:44:18 PM	Susan Goldste, advocate, waives in support
1:44:42 PM	Roll call
1:44:45 PM	SB CS/SB 706 passes favorably
1:45:08 PM	Tab 5 SB 1286
1:45:27 PM	Sen Gibson explains
1:47:21 PM	Kirk Anderson, Director American Association of Diabetes Ed, of speaks in support
1:50:43 PM	Curtis Ford, patient, speaks in support
1:53:13 PM	Dr. Otis Kirksey, FAMU College of Pharmacy , speaks in support
1:56:58 PM	Alisa Lapolt, Florida Nurses Assocation, provides information
1:57:57 PM	Jean Vansmith, Florida Hospital, speaks in support
1:58:37 PM	Sen Bean poses a question on diabetes education
1:59:30 PM	Sen Gibson responds
2:01:52 PM	Sen Galvano moves to TP the bill
2:02:52 PM	Tab 6 SB 1626 TP
2:03:42 PM	Managed Care Presentation
2:04:37 PM	Justin Senior Florida Medicaid presentations
2:05:35 PM	Sen Galvano motion to show a favorable vote
2:06:01 PM	Sen Bean posses a question
2:06:09 PM	Justin explains and informs the pharmacutical services and managed care plans
2:10:33 PM	Audrey Brown, Pres, Fl Assoc. of Health Plans, speaks
2:18:34 PM	Michael A. Jackson, CEO, Florida Pharmacy Association, speaks to inform
2:19:35 PM	Win Adams, Former Fl Board of Pharmacy member speaks to inform
2:21:39 PM	Charles Daniel Jackson, Stewarts Pharmacy, speaks to inform
2:22:07 PM	Ron Pickens, EPIC, speaks to inform Ind. Pharmacy network
2:23:18 PM	Manjit Matharu, Discount Pharmacy, speaks to inform

2:24:55 PM Richard Bradfford, Eastwood Pharmacy, speaks to inform
2:26:25 PM Lois Adams, Independent Pharmacist, speaks to inform
2:27:44 PM Jim Koivisto speaks to informGregory Baldin, Smart Pharmacy, speaks to inform
2:29:54 PM Bill Scroggins, Smart Pharmacy, speaks to inform
2:31:10 PM Bill Mincy, Independent Pharmacy Owners, speaks to inform
2:32:49 PM Laura Gould, Pharmacist, speaking to inform
2:33:41 PM Scott Hopes, USF College of Pharmacy speaks to inform
2:34:19 PM Sen Joyner question
2:36:13 PM Senior responds
2:36:24 PM Sen Joyner follow up question
2:36:31 PM Senior responds
2:37:44 PM Sen Bean speaks
2:38:08 PM Confirmation of Dr. John Armstrong as Surgeon General
2:42:07 PM Sen Bean question on Zeka
2:43:09 PM Dr. Armstrong informs
2:46:42 PM Vice Chair Sobel question
2:47:34 PM Surgeon General Armstrong responds
2:49:46 PM Vice Chair Sobel follow up question
2:50:05 PM Dr. Armstrong responds
2:52:07 PM Vice Chair Sobel follow up question
2:53:05 PM Vice Chair Sobel follow up question
2:53:06 PM Gen Armstrong responds
2:55:21 PM Pres Gaetz question and comment
2:56:40 PM Pres Gaetz question and comment
2:56:41 PM Gen Armstrong answers
2:58:15 PM Gen Armstrong answers
2:58:16 PM Pres Gaetz follow up questions
2:59:39 PM Gen Armstrong answers
3:01:07 PM Pres Gaetz further follow up question
3:02:47 PM Gen Armstrong answers
3:03:02 PM Sen Grimsley question and comment
3:04:25 PM Gen Armstrong answers
3:04:36 PM Sen Grimsley follow up question
3:05:02 PM Gen Armstrong answers
3:05:50 PM Sen Grimsley comment
3:07:31 PM Sen Grimsley moves to confirm Gen Armstrong
3:07:44 PM Sen Galvano motions to limit debate to vote by 3:27
3:08:10 PM Sen Flores question
3:08:56 PM Gen Armstrong answers
3:09:04 PM Sen Flores question
3:09:20 PM Sen Flores follow up question
3:09:28 PM Gen Armstrong answers
3:09:42 PM Sen Flores follow up
3:10:18 PM Gen Armstrong answers
3:10:32 PM Sen Flores final question
3:11:11 PM Gen Armstrong answers
3:12:12 PM Sen Garcia question
3:13:33 PM Gen Armstrong answers
3:13:42 PM Sen Garcia follow up question
3:14:08 PM Gen Armstrong answers
3:15:25 PM Sen Garcia follow up question
3:15:52 PM Gen Armstrong answers
3:17:38 PM Sen Garcia follow up question
3:19:22 PM Gen Armstrong answers
3:21:38 PM Win Adams waives in support
3:21:47 PM Steven Win waives in support
3:21:54 PM Mary Thomas waive in support
3:22:10 PM Sen Joyner question
3:22:37 PM Gen Armstrong answers
3:22:46 PM Sen Joyner follow up question
3:23:07 PM Gen Armstrong answers
3:23:17 PM Sen Joyner follow up question

3:23:22 PM Gen Armstrong answers
3:24:14 PM Dr. Tanzia Staff waives in opposition
3:24:29 PM Courtney and Debbie Charpiat waives in support
3:24:54 PM Courtney and Debbie Charpiat waives in support
3:24:54 PM Sen Joyner follow up question
3:25:51 PM Gen Armstrong answers
3:25:58 PM Sen Joyner follow up question
3:26:06 PM Gen Armstrong answers
3:26:14 PM Sen Braynon question
3:27:00 PM Gen Armstrong answers
3:28:24 PM Sen Bean calls for question and final confirmation of Dr. John Armstrong
3:29:02 PM Confirmation passes favorably
3:29:15 PM Gaetz and Flores voting favorably
3:29:50 PM Recognition of Health Policy Staff Great Job! Salute!
3:30:06 PM Meeting adjourned