

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 758

INTRODUCER: Health Policy Committee and Senators Gibson and Torres

SUBJECT: Diabetes Educators

DATE: February 6, 2018 **REVISED:** _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Rossitto-Van Winkle	Stovall	HP	Fav/CS
2.	_____	_____	AHS	_____
3.	_____	_____	AP	_____

Please see Section IX. for Additional Information:
COMMITTEE SUBSTITUTE - Substantial Changes

I. Summary:

CS/SB 758 creates a new health care profession, the diabetes educator. The bill defines a diabetes educator as a health care practitioner registered under this new law who has demonstrated a comprehensive knowledge of and experience in prediabetes, diabetes prevention, diabetes education and who provides diabetes self-management training (DSMT), as defined in the bill. However, a licensed health care practitioner may practice within the scope of his or her license without this voluntary registration. The bill prohibits any person from representing himself or herself as a diabetes educator without first registering with the Department of Health (DOH). The bill provides requirements for registration and authorizes the DOH to develop rules for renewal procedures, fees, and disciplinary action.

The DOH must implement the registration and regulation of the diabetes educator by July 1, 2019.

The effective date of the bill is July 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 5 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 genetics, the environment, or other risk factors. At this time, there is no method to prevent or cure Type 1 diabetes, and treatment requires the lifetime use of insulin by injection or pump.
- **Type 2:** Sometimes known as "adult-onset diabetes," Type 2 accounts for about 95 percent of all 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 two to ten percent of pregnant women. Gestational diabetes can cause health problems during pregnancy for both the mother and child. Children whose mothers have gestational diabetes are at 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 disorders;
- Vascular disease; and
- Amputations.³

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.⁴

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 Jan. 31, 2018).

² U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Report Card*, (2014), p. 4, available at <http://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf>, (last visited Jan. 31, 2018); See also U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *About Diabetes*, available at <https://www.cdc.gov/diabetes/basics/diabetes.html> (last visited Jan. 31, 2018).

³ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Diabetes Complications*, available at <https://www.cdc.gov/diabetestv/diabetes-complications.html> (last visited Jan. 31, 2018).

⁴ *Id.*

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.⁵ Although an estimated 33 percent of adults in the United States have pre-diabetes, less than ten 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.⁶

Risk factors for diabetes include:⁷

- 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 nine pounds or more; and
- Being physically active less than three times per week.

Persons with any of the above risk factors are five to 15 times more likely to develop Type 2 diabetes.⁸ The Centers for Disease Control and Prevention (CDC) estimates that as many as one out of every three American adults has pre-diabetes, and half of all Americans aged 65 years and older have pre-diabetes.⁹

In 2013, the American Diabetes Association (ADA)¹⁰ released a report updating its earlier studies estimating the fiscal impact 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 were 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.¹¹

⁵ See Mayo Clinic, Patient Care and Health information, Diseases and Conditions, *Prediabetes*, <https://www.mayoclinic.org/diseases-conditions/prediabetes/symptoms-causes/syc-20355278>, (last visited Jan. 31, 2018)

⁶ *Supra* note 2.

⁷ *Id.*

⁸ Florida Department of Health, *Prediabetes, What is Prediabetes?*, <http://www.floridahealth.gov/diseases-and-conditions/diabetes/prediabetes.html> (last visited Jan. 31, 2018).

⁹ *Id.*

¹⁰ 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*, <http://www.diabetes.org/about-us/75th-anniversary/> (last visited Jan. 31, 2018).

¹¹ 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 Jan. 31, 2018).

Diabetes in Florida

In Florida, it is estimated that over 2.4 million people have diabetes and over 5.8 million have pre-diabetes.¹² Over the past 20 years, the prevalence of diagnosed diabetes among Florida adults more than doubled, increasing from 5.2 percent in 1995 to 11.2 percent in 2014.¹³ The CDC projects that one out of three adults could have diabetes by 2050 if trends continue, due to an aging population more likely to develop Type 2 diabetes, increases in minority groups that are at high risk for Type 2 diabetes, and people with diabetes living longer.¹⁴ This is of particular concern in Florida which has the largest population of adults ages 65 and older in the nation.¹⁵

In 2014, approximately one out of 10 mothers giving birth in Florida experienced gestational diabetes during their pregnancy. Gestational diabetes puts mothers at an increased risk of developing Type 2 diabetes later in life, increases the risk of birth complications, and increases the risk of the infant being obese and developing Type 2 diabetes in the future. While the data for diabetes in youth are somewhat limited, studies have shown that the number of youth being diagnosed with Type 2 diabetes is increasing. More than 18,000 new cases of Type 1 diabetes and more than 5,000 new cases of Type 2 diabetes are estimated to be diagnosed among US youth younger than age 20 each year.¹⁶

Diabetes was the seventh leading cause of death in 2014 in Florida.¹⁷ 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.¹⁸

Florida's Diabetes Advisory Council

The Diabetes Advisory Council (DAC) was created by the Florida Legislature over 40 years ago, as mandated by s. 385.203, F.S., to “guide a statewide comprehensive approach to diabetes prevention, diagnosis, education, care, treatment, impact, and costs thereof.” Members, are appointed by the Governor to represent professional sectors involved in diabetes prevention and care, as well as citizens with diabetes and other citizen advocates. In 2015, the Florida Legislature added a requirement to the DAC to prepare a report describing the public health

¹² American Diabetes Association, (2015, December). Fast Facts - *Data and Statistics-About Diabetes*, available at http://professional.diabetes.org/content/fast-facts-data-and-statistics-about-diabetes/?loc=dorg_statistics (last visited Jan. 31, 2018).

¹³ Florida Department of Health, Florida Diabetes Advisory Council, *2017 Florida Diabetes Report*, p.7., available at: <http://www.floridahealth.gov/provider-and-partner-resources/dac/documents/dac-report-january2017.pdf> (last visited Jan. 31, 2018).

¹⁴ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, *Number of Americans with Diabetes Projected to Double or Triple by 2050*, available at <https://www.cdc.gov/media/pressrel/2010/r101022.html> (last visited Jan. 31, 2018).

¹⁵ *Supra* note 13.

¹⁶ U.S. Department of Health and Human Services, Centers for Disease Control and Prevention *Diabetes Report Card 2014*, available at <http://www.cdc.gov/diabetes/pdfs/library/diabetesreportcard2014.pdf> (Last visited Jan. 31, 2018).

¹⁷ Florida Department of Health, *Florida Vital Statistics Annual Report 2017*, p. 18, <http://www.flpublichealth.com/VSBOOK/pdf/2014/Deaths.pdf>, (last visited Jan. 31, 2018).

¹⁸ Florida Department of Health, *Florida Charts: Diabetes Deaths - Three Year Trends*, <http://www.floridacharts.com/charts/DataViewer/DeathViewer/DeathViewer.aspx?indNumber=0090> (last visited Jan. 31, 2018).

consequences and financial impact on the state of all Types of diabetes and its complications. The legislation instructed the DAC to collaborate with the DOH, Department of Management Services – Division of State Group Insurance (DSGI), and the Agency for Health Care Administration to collect data about diabetes and state programs that address diabetes, as well as develop an action plan to reduce the impact of diabetes.¹⁹ Recommendation number five includes recognizing and reimbursing diabetes educators for providing diabetes self-management education.²⁰

ADA Standards of Medical Care in Diabetes

The ADA’s “Standards of Medical Care in Diabetes,” referred to as the “Standards of Care,” are intended to provide clinicians, patients, researchers, payers, and other interested individuals with the components of the following:

- Diabetes care;
- General treatment goals; and
- Tools to evaluate the quality of care.²¹

The Standards of Care recommendations are not intended to preclude clinical judgment and must be applied in the context of excellent clinical care, with adjustments for individual preferences, comorbidities, and other patient factors. The recommendations include screening, diagnostic, and therapeutic actions that are known or believed to favorably affect health outcomes of patients with diabetes.²²

Diabetes Educators

The ADA defines a “diabetes educator” as, “a health care professional who teaches people who have diabetes how to manage their diabetes.”²³ Diabetes educators are found in hospitals, physician offices, managed care organizations, home health care, and other settings.²⁴

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:

- Allopathic Physician;
- Osteopathic Physician;
- Podiatric Physician;
- Chiropractic Physician;
- Dentist;
- Pharmacist;
- Advanced Registered Nurse Practitioner (ARNP, CNS, CRNA);
- Physician Assistant;

¹⁹ *Supra* note 13.

²⁰ *Id.* at pp. 64 - 65.

²¹ American Diabetes Association, Diabetes Care 2018 Jan; 41(Supplement 1): S1-S2, *Introduction - Standards of Care in Diabetics – 2018*, http://care.diabetesjournals.org/content/41/Supplement_1/S1 (last visited Jan. 31, 2018).

²² *Id.*

²³ *Id.*

²⁴ *Id.*

- 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;
- Mental Health Counselor;
- Clinical Psychologist; and
- Clinical Social Worker.²⁵

Kentucky enacted a diabetes educator law in 2013, and Indiana did so in 2016.²⁶ Both are under the respective state's BOM. 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;²⁷ or
- The credentialing program of the American Association of Diabetes Educators (AADE) or the National Certification Board for Diabetes Educators (NCBDE); or
- An equivalent credentialing program as determined by the board.

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

²⁵ See chs. 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 478, 480, 484, 486, 490; and 491, F.S.; and part I, part II, part III, part V, part X, part XIII, and part XIV of ch. 468, F.S.; and part III or part IV of ch. 483, F.S.

²⁶ See American Association of Diabetes Educators, *State Legislation* <https://www.diabeteseducator.org/advocacy/state-legislation> (last visited Jan. 31, 2018).

²⁷ 201 KAR 45:110 (2015), requires the apprentice diabetes educator to accumulate at least 750 hours of supervised work experience in five 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.

- The AADE core concepts course²⁸ 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.²⁹

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;
- Counsel patients 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.³⁰

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.³¹

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.³²

²⁸ 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 Jan. 31, 2018).

²⁹ The American Association of Diabetes Educators, *About AADE*, <https://www.diabeteseducator.org/about-aade> (last visited Jan. 31, 2018).

³⁰ *Id.*

³¹ National Certification Board for Diabetes Educators, *History*, <http://www.ncbde.org/about/history/> (last visited Jan. 31, 2018).

³² *Id.*

The CDC has also established the CDC National Diabetes Recognition Program (NDRP) as part of the National Diabetes Prevention Program (NDPP).³³ 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.³⁴ 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 lifestyle coaches are registered dietitians or registered nurses, but no credentials are required;³⁵ and the CDC has a free lifestyle coach facilitator training guide available on its website.³⁶

The AADE also offers NDPP diabetes lifestyle coach training based on the curriculum of the CDC in a two-day, in person, course for \$750 - \$850 to acquire all necessary skills to deliver a successful CDC NDRP/NDPP Program.³⁷

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;

³³ U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *Diabetes Prevention Recognition Program, Standards and Operating Procedures* (January 1, 2015), <http://www.cdc.gov/diabetes/prevention/pdf/dprp-standards.pdf> (last visited Jan. 31, 2018).

³⁴ U.S. Department of Health and Human Services, Center for Disease Control and Prevention, *What Is the National DPP?* available at <http://www.cdc.gov/diabetes/prevention/about/index.html> (last visited Jan. 31, 2018).

³⁵ *Supra* note 32, at 25.

³⁶ 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 Jan. 31, 2018).

³⁷ 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 Jan. 31, 2018).

- 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 over the regulation and to the legislative committees of reference.³⁸ This required information is traditionally compiled in a “Sunrise Questionnaire.”

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 Senate Sunrise Questionnaire was received March 30, 2017,³⁹ for similar proposed legislation in 2017.⁴⁰

The Senate Sunrise Questionnaire indicates that the AADE is seeking regulation in Florida; and that in 2017 there were approximately 700 individuals who were members of the AADE in Florida, many having earned the CDE certification from the NCBDE or the BC-ADM.

The Questionnaire notes that practitioners typically deal with individuals with or at risk of diabetes and related conditions to achieve behavioral change which will lead to better clinical outcomes and improved health status. The questionnaire notes that a physician typically refers a patient to a nurse who practices in diabetes education, nutritionist, dietician or podiatrist for diabetic education. Registration would bring attention to the benefits of DSMT programs. The questionnaire further notes that marketplace factors will not be as effective as government regulation because places like grocery stores, drug stores, massage establishments, and spas offer diabetes education or wellness programs, and these programs are not recognized by the American Diabetes Association. The legislation would permit health care practitioners to become recognized as Florida Registered Diabetes Educators.

The restrictions on the practice of providing diabetes education may affect the public’s access to these services.

III. Effect of Proposed Changes:

CS/SB 758 creates part XVII of ch. 468, F.S., entitled “Diabetes Educators,” to establish a regulated profession in Florida. Registration is voluntary unless a person holds himself or herself

³⁸ See s. 11.62(4)(a)-(m), F.S.

³⁹ See Florida Senate Sunrise Questionnaire, Diabetes Educators, (March 30, 2017) (on file with the Senate Committee on Health Policy).

⁴⁰ See SB 1578 (2017 Regular Session).

out as a diabetes educator or provides DSMT, as defined in the bill. However, a licensed health practitioner may provide services within the scope of his or her license.

The bill makes legislative findings that the provision of DSMT by unregistered and incompetent practitioners presents a danger to the public health and safety; and that it is the intent of the Legislature to prohibit persons who fall below the minimum competency standards for a diabetes educator from providing DSMT in Florida.

The bill defines the following terms for the profession of diabetes educator:

- “Diabetes educator” as a healthcare practitioner registered under part XVII, of ch. 468, F.S., who has demonstrated a comprehensive knowledge of and experience in prediabetes, diabetes prevention, and diabetes education; and who provides DSMT; and
- “Diabetes self-management education and training” is the assessment and development of a plan of care for a person with diabetes through a collaborative process through which the person gains the knowledge and skills necessary to modify behavior and successfully self-manage the disease as provided for in the national standards published by the American Diabetes Association.

The bill requires that the DOH issue a registration to an applicant who submits the following to the DOH:

- Documentation of:
 - Certification as a Certified Diabetes Educator (CDE) by the National Certification Board for Diabetes Educators (NCBDE); or
 - Certification in Board Certified-Advanced Diabetes Management (BC-ADM) by the American Association of Diabetes Educators (AADF); or
 - Completion of 250 practice hours of diabetes education, of which at least 100 hours must be earned in the calendar year preceding application; a passing score on the NCBDE registration examination; and licensure as a health care practitioner as defined in s. 456.001, F.S.

The bill requires the DOH to renew a registration upon receipt of a renewal application and a biennial renewal fee. The DOH is also required to adopt rules establishing procedures for biennial registration renewal.

The bill creates s. 468.934, F.S., to require the DOH to establish, by rule, the following fees:

- A nonrefundable application fee, not to exceed \$100.00;
- An initial registration fee, not to exceed \$100.00;
- A biennial renewal fee, not to exceed \$80.00; and
- A fee for reactivation of an inactive registration, not to exceed \$135.00.

The fees must be adequate to support the registration program.

The bill creates s. 468.935, F.S., which specifies prohibited acts and creates exemptions. A person may not provide DSMT, or represent himself or herself as a diabetes educator unless he or she is registered with the DOH under this part. This part does not prohibit or restrict a health care practitioner as defined in ch. 456, F.S., from practicing within the scope of his or her

profession. However, a licensed health care practitioner desiring to use the credential of diabetes educator must obtain additional training in diabetes education as noted above, pass the NCBDE examination, and register with the DOH.

A person employed by the federal government performing official duties is also exempt from registration.

The DOH is required to implement the provisions of the bill by July 1, 2019.

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

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:

The bill requires the DOH to establish fees as follows:

- A nonrefundable application fee, not to exceed \$100.00;
- An initial registration fee, not to exceed \$100.00;
- A biennial renewal fee, not to exceed \$80.00; and
- A fee for reactivation of an inactive registration, not to exceed \$135.00.

B. Private Sector Impact:

For a licensed healthcare practitioner, the registration is voluntary. For others, one must be registered and pay the applicable fees to use the title of diabetes educator or to engage in DSMT.

C. Government Sector Impact:

The DOH will experience an increase in revenues associated with diabetes educator application and initial and renewal fees; but will incur an increase in workload and costs associated with the registration and regulation of diabetes educators. The fees must be adequate to implement and administer this part.

VI. Technical Deficiencies:

The bill does not amend s. 20.43(3)(g), F.S., to include the newly created profession of diabetes educators in the listing of professions under the responsibility of the Division of Medical Quality Assurance.

VII. Related Issues:

The effective date of the act is July 1, 2018, and providing an effective date prior to the requirement for the DOH to implement registration and regulation may facilitate implementation of the act. However, the prohibited act takes effect ostensibly a year before the registration is available. Section 468.935(1), F.S., could be amended to be effective July 1, 2019.

The bill authorizes an independent practice without any medical oversight. The Dietetics and Nutrition Practice Council is under the BOM and those practitioners operate pursuant to physician's orders and oversight. Similarly, the diabetes educator functions are similar to those of nurses who operate pursuant to physician or other advanced practitioner orders and oversight.

The bill does not distinguish the standards of practice of the diabetes educators from dietitians, nutritionists, or nurses who also follow ADA Standards.

VIII. Statutes Affected:

This bill substantially amends section 456.001 of the Florida Statutes.

This bill creates the following sections of the Florida Statutes: 468.931, 468.932, 468.933, 468.934, and 468.935.

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 6, 2018:

Deletes certification as a clinical exercise physiologist, registered clinical exercise physiologist, or having a master's degree or higher in social work, in conjunction with 250 hours in diabetes education and passage of the NCBDE examination, as a pathway for registration as a diabetes educator.

- B. **Amendments:**

None.