HB 992

Department of Legislative Services

Maryland General Assembly
2015 Session

FISCAL AND POLICY NOTE

House Bill 992 (Delegate Hixson, *et al.*)
Ways and Means

Public and Nonpublic Schools - Student Diabetes Management Program

This bill requires the Maryland State Department of Education (MSDE) and the Department of Health and Mental Hygiene (DHMH), in consultation with other experts and stakeholders, to establish guidelines for the training of school employees to become trained diabetes care providers. Each local board of education must require each public school within its jurisdiction to establish a Student Diabetes Management Program that includes training for employee volunteers to provide diabetes care services to students. The bill requires a school nurse or trained diabetes care provider to be available during school hours and at school-sponsored activities.

The bill takes effect July 1, 2015.

Fiscal Summary

State Effect: General fund expenditures increase by $26,500 in FY 2016 for DHMH to hire a half-time diabetes control consultant to develop guidelines for the training of school employees to become trained diabetes care providers. MSDE can assist DHMH with developing the guidelines using existing resources.

(in dollars)	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Revenues	$0	$0	$0	$0	$0
GF Expenditure	26,500	0	0	0	0
Net Effect	($26,500)	$0	$0	$0	$0

Note:() = decrease; GF = general funds; FF = federal funds; SF = special funds; - = indeterminate effect

Local Effect: Local school system expenditures may increase to ensure that a school nurse (who must be a registered nurse (RN) as described below) or trained diabetes care provider will be on-site and available to provide diabetes care services to a student with a Diabetes Medical Management Plan during school hours and at school sponsored activities,

including field trips. Local school system expenditures also increase to provide training to volunteers on specified diabetes care tasks. The amount cannot be determined but may be significant for some school systems depending on the number of volunteers who are recruited. **This bill imposes a mandate on a unit of local government.**

Small Business Effect: None.

Analysis

Bill Summary: A "trained diabetes care provider" means an employee trained in the recognition of the symptoms of diabetes and the administration of health care services needed by an individual with diabetes.

A "Diabetes Medical Management Plan" means a plan developed by a student's physician that describes the health care services needed by the student for the treatment of the student's diabetes at school.

A nonpublic school *may* establish a Student Diabetes Management Program and conduct or contract for a course for the training of employees to become trained diabetes care providers.

The guidelines established by MSDE and DHMH must include instruction on the recognition and treatment of hypoglycemia and hyperglycemia; the appropriate actions to take when blood glucose levels are outside target ranges; understanding physician instructions regarding diabetes medication drug dosage, frequency, and manner of administration; performing finger-stick blood glucose checking, ketone checking, and results recordation; understanding the function and protocol for the use of continuous glucose monitors; and administering glucagon and insulin in accordance with a student's Diabetes Medical Management Plan and results recordation. A training course for employees of a nonpublic school that establishes a Student Diabetes Management Program must include instruction on the same items.

The Student Diabetes Management Program established in each school must recruit employees who are interested in becoming trained diabetes care providers; provide training for employee volunteers before the commencement of a school year or when required by the enrollment of a student with a Diabetes Medical Management Plan; designate locations within the school where a student may privately perform diabetes care tasks; require the school nurse or a trained diabetes care provider to be on-site and available to provide diabetes care services during school hours and at school-sponsored activities, including field trips; establish a system of communication between school administrators and the faculty, school nurse, trained diabetes care providers, parents or guardians of students, and

students; facilitate the access of authorized school personnel to student Diabetes Medical Management Plans; and establish procedures for diabetes-related emergencies.

A school may not compel any employee to participate in a Student Diabetes Management Program. A participating trained diabetes care provider must agree to perform diabetes care tasks for which training has been provided, including checking and recording blood glucose levels and ketone levels, or assisting a student with the tasks; administering glucagon and other emergency treatments as prescribed; administering insulin or assisting a student in the administration of insulin through the insulin delivery system the student uses; and providing oral diabetes medications.

Except for any willful or grossly negligent act, an employee who responds in good faith to provide diabetes-related health care services to a student under provisions of the bill is immune from civil liability for any act or omission in the course of providing care. The provision of diabetes care services by a trained diabetes care provider under provisions of the bill may not be construed as performing acts of practical nursing or registered nursing.

The parent or guardian of a student who needs diabetes care at school must submit a Diabetes Medical Management Plan to the school. Within 30 days after a student's plan is submitted, the plan must be reviewed in a meeting of the parent or guardian, the student, the school nurse, the student's classroom teacher, all trained diabetes care providers who may be required to provide care to the student, and any other necessary individuals. If a student's plan states that the student may perform specified diabetes care tasks independently, the student may perform the authorized tasks wherever the student considers necessary, possess and carry any necessary supplies and equipment, and possess a cellular phone to ask for assistance.

Current Law: With the assistance of the local health department, each local board of education must provide adequate school health services; instruction in health education; and a healthful school environment. MSDE and DHMH must jointly develop public standards and guidelines for school health programs and offer assistance to the local boards of education and local health departments in their implementation.

MSDE and DHMH must jointly establish guidelines for public schools regarding emergency medical care for students with special health needs. The guidelines must include procedures for the emergency administration of medication and the proper follow-up emergency procedures; a description of parental or caregiver responsibilities; a description of school responsibilities; a description of student responsibilities that are age and condition appropriate; and any other issue that is relevant to the emergency medical care of students with special health needs. MSDE and DHMH must provide technical

assistance to schools to implement the guidelines established, train school personnel at the local level, and develop a process to monitor the implementation of the guidelines.

In accordance with the Maryland Nurse Practice Act, and the regulations adopted under the Act, a nurse *may* delegate the responsibility to perform a nursing task to an unlicensed individual, a certified nursing assistant, or a medication technician. However, the delegating nurse retains the accountability for the nursing task. A nursing task delegated by the nurse must be (1) within the area of responsibility of the nurse delegating the act; (2) such that, in the judgment of the nurse, it can be properly and safely performed without jeopardizing the client welfare; and (3) a task that a reasonable and prudent nurse would find is within the scope of sound nursing judgment.

Background: According to the Centers for Disease Control and Prevention, as of 2012, approximately 208,000 individuals under 20 years of age, or 0.25% of the U.S. population in the age group, had diagnosed type 1 or type 2 diabetes. A study of the same age group during 2008-2009, estimated that 18,436 individuals annually were newly diagnosed with type 1 diabetes and 5,089 individuals annually were newly diagnosed with type 2 diabetes. The study found that nonHispanic white children and adolescents had the highest rate of new cases of type 1 diabetes. Conversely, the study found higher rates of new cases of type 2 diabetes among U.S. minority populations.

Type 1 diabetes is an autoimmune disease in which the body's immune system destroys the insulin-producing cells of the pancreas. According to the Centers for Disease Control and Prevention, although disease onset can occur at any age, the peak age for diagnosis is in the mid-teens. People with type 1 diabetes must have insulin delivered by injection or a pump to manage blood glucose levels. However, insulin is not a cure. Although blood glucose control can reduce the risk, type 1 diabetes can still lead to kidney failure, blindness, nerve damage, amputation, heart attack, or stroke. In addition, a potential complication of insulin treatment is hypoglycemia, or low blood glucose, which can result in seizure, unconsciousness, or even death.

Type 2 diabetes is the most common type of diabetes, accounting for 90% to 95% of diagnosed cases of diabetes in adults. Type 2 diabetes usually begins with insulin resistance, a disorder in which cells do not use insulin properly, but also involves varying degrees of dysfunction of the insulin-producing cells. Anyone can develop type 2 diabetes; however, greater risk is associated with older age, obesity, family history of diabetes, women who have had gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity.

Under guidelines developed by MSDE and DHMH regarding the management of students with diabetes in schools, when an individual with diabetes enters school or a student is diagnosed with diabetes, the school nurse performs an appraisal and assessment and, in

conjunction with the student's family and healthcare providers, develops an individualized care plan for the student. The care plan must address routine and emergency care, including the administration of medication during school hours and school-sponsored activities, and outline what will be done if the school nurse is not available. The school nurse determines whether and to whom any responsibility may be delegated for monitoring blood glucose testing or administering any treatment or medication.

The Maryland State Management of Diabetes at School/Order Form, or other orders addressing all of the same elements, must be completed by an authorized prescriber and submitted to the school by a parent or guardian before a student may receive medication or have an invasive medical procedure, such as blood glucose testing, performed in school.

According to DHMH, diabetes care management protocols exist within school health services programs operating in all of Maryland's 24 jurisdictions. Additional diabetes care is provided in school-based health centers operating in 14 jurisdictions.

In Maryland, school health services programs are mandated and are the responsibility of the local boards of education with assistance from the local health departments. A variety of school health service delivery models have been developed to assure the health needs of children are met in the school setting. These models may include, but are not limited to:

- a RN only;
- both RNs and Licensed Practical Nurses (LPNs);
- both RNs and Certified Nursing Assistant (CNAs); and
- RNs, LPNs, and CNAs.

However, due to a 2004 declaratory ruling of the Maryland Board of Nursing, regardless of the service delivery model, the RN is always the leader of the school health nursing team. The RN, the expert in nursing and health, makes the decisions about how care is provided and who provides the care to the child in the school system. Only the school RN has the authority to use the title school nurse. All other health staff must be referred by their title such as LPN, CNA, or Health Assistant/Health Technician.

State Expenditures: General fund expenditures increase by $26,464 in fiscal 2016, which accounts for a 90-day start up delay after the bill's July 1, 2015 effective date. DHMH has determined that 1.5 contractual positions are needed to implement this bill. However, the Department of Legislative Services advises that only a half-time contractual position is needed. This estimate reflects the cost of hiring one half-time contractual diabetes specialist to develop in consultation with other experts and stakeholders guidelines for the training of school employees to become trained diabetes care providers. It includes salaries, fringe benefits, one-time start-up costs, and operating expenses.

Contractual Position	.5
Salaries and Fringe Benefits	$21,983
Operating Expenses	4,481
Total FY 2016 State Expenditures	**$26,464**

This estimate reflects a July 1, 2016 termination date for the half-time contractual position due to the assumption that the required guidelines for training diabetes care providers can be developed in nine months. However, if additional time is required, DHMH general fund expenditures increase accordingly.

Local Expenditures: Local school system expenditures may increase to ensure that a school nurse (who must be a RN) or trained diabetes care provider will be on-site and available to provide diabetes care services to a student with a Diabetes Medical Management Plan during school hours and at school sponsored activities, including field trips. Due to the different models of school health services a RN, the only nurse that can be officially called a school nurse, may not be on-site during all school hours and at all school sponsored activities. Furthermore, additional personnel may be required to attend school sponsored activities to ensure that a trained diabetes care provider is on-site which may result in additional costs. In addition contingency plans for backup personnel will need to be made, which may require additional personnel to attend events.

Local school system expenditures also increase to provide training to volunteers on specified diabetes care tasks. Local school system expenditures may include hiring substitutes or providing teacher stipends to allow teachers to attend training. Costs for this training cannot be reliably estimated and will vary by school system. For example, Carroll County estimates annual cost of $16,000 and Montgomery County Public Schools reports that costs increase by approximately $200,000 annually to provide the required training program.

Additional Comments: If a nonpublic school chooses to develop a Student Diabetes Management Program, then its expenditures may increase.

Additional Information

Prior Introductions: None.

Cross File: SB 672 (Senators Young and Nathan-Pulliam) - Education, Health, and Environmental Affairs.

Information Source(s): Maryland State Department of Education; Department of Health and Mental Hygiene; Carroll, Harford, Montgomery, and Queen Anne's counties; Department of Legislative Services

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min/rhh

Analysis by: Caroline L. Boice

Direct Inquiries to:
(410) 946-5510
(301) 970-5510