1999

SENATE HEALTH CARE COMMITTEE

MINUTES

SENATE HEALTH CARE COMMITTEE

Chairman:		
William R. Purcell	2117 LB	715-0690
Vice Chairs:		
Jeanne H. Lucas	620 LOB	733-4599
William N. Martin	411 LOB	715-3040
Stephen M. Metcalf	621 LOB	733-5748
Jim W. Phillips, Sr.	628 LOB	733-5870
Ranking Minority:		
Robert A. Rucho	1113 LB	733-5650
Members:		
Roy A. Cooper III	2010 LB	733-5664
Charlie S. Dannelly	2106 LB	733-5955
James S. Forrester	1121 LB	733-5708
John Garwood	1118 LB	733-5742
Kay R. Hagan	519 LOB	733-5856
Fletcher L. Hartsell, Jr.	518 LOB	733-7223
Brad Miller	621 LOB	733-9349
Kenneth R. Moore	1419 LB	715-0607
Beverly Eaves Perdue	629 LOB	733-2055
Ed Warren	623 LOB	733-5953
David F. Weinstein	2108 LB	733-5651

Staff:
Linda Attarian
John Young

LB=Legislative Building
LOB=Legislative Office Building
Raleigh, North Carolina 27601

Committee Clerk:
Lorraine R. Blake

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — SENATE: HEALTH CARE — Valid Through 27-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 96	EDWARDS	ADULT CARE HOME/LIC. EXEMPT	R -CH. SL 99-0193	04-26-99	06-07-99
H 190=	CANSLER	STATE HOSPITALS/PEER REVIEW	*R -CH. SL 99-0222	04-01-99	06-09-99
H 678	SHERRILL	ACUPUNCTURIST REIMBURSEMENT	*S -REF TO COM ON HLTHCARE	05-18-99	
H 715	ALEXANDER	UTILIZATION REVIEW/ASAM CRITERIA	*R -CH. SL 99-0116	04-28-99	05-11-99
H 906	ALEXANDER	PHARMACIST PEER REVIEW	R -CH. SL 99-0081	04-19-99	05-11-99
H 944	CANSLER	EXTEND ADULT CARE HOME BED MORATORIU	R -CH. SL 99-0135	04-27-99	05-19-99
H 996=	WRIGHT	REGULATE SPINAL MANIPULATION	*S -REF TO COM ON HLTHCARE	04-29-99	
H1069=	ALEXANDER	SOCIAL WORKER LICENSURE	*R -CH. SL 99-0313	06-10-99	06-23-99
H1188	BOYD-MCINTYRE	RESEARCH STUDIES/WOMEN PARTICIPANTS	S -REF TO COM ON HLTHCARE	04-28-99	
H1193	NESBITT	HEALTH CARE PROFESSIONALS	*R -CH. SL 99-0226	04-29-99	05-20-99
H1193	NESBITT	HEALTH CARE PROFESSIONALS	*R -CH. SL 99-0226	05-26-99	06-09-99
H1258=	EARLE	HEALTH CARE PERSONNEL REGISTRY CHANG	*R -CH. SL 99-0159	04-28-99	05-26-99
H1340	TOLSON	RESPIRATORY CARE PRACTICE ACT	*S -REF TO COM ON HLTHCARE	07-12-99	
H1470	ALLEN	IMPAIRED DENTAL HYGIENISTS/FEE	*H -PRES. TO GOV. 07-19	06-21-99	07-07-99
S 10=	PERDUE	LONG-TERM CARE SAFETY INITIATIVE	*R -CH. SL 99-0334	01-28-99	04-28-99
S 26=	PURCELL	CHIP CLINICS/REPEAL PROHIBITION	R -CH. SL 99-0004	02-04-99	02-11-99
S 60=	**WARREN E**	**HEART DISEASE PREV. FUNDS**	**S -RE-REF COM ON HLTHCARE**	**05-19-99**	
S 65=	PURCELL	MOTOR VEHICLE OCCUPANT RESTRAINTS	*R -CH. SL 99-0183	02-10-99	03-31-99
S 90=	FORRESTER	INSURANCE/COVER CONTRACEPTIVES	*R -CH. SL 99-0231	02-15-99	03-03-99
S 160	PERDUE	NURSE REHABILITATION	R -CH. SL 99-0291	02-22-99	03-24-99
S 194	RAND	NURSE LICENSURE COMPACT	*R -CH. SL 99-0245	03-01-99	03-24-99
S 198=	CARTER	ADULT CARE HOME LICENSURE	*R -CH. SL 99-0113	03-01-99	03-24-99
S 273	ODOM	CANCER CONTROL REPORTING	*R -CH. SL 99-0033	03-08-99	03-24-99
S 344	FORRESTER	MGD CARE/SPECIALIST REFERRAL	R -CH. SL 99-0168	03-15-99	04-07-99
S 345	FORRESTER	URO REVIEWS BY NC PHYSICIANS	S -PRES. TO GOV. 07-15	03-15-99	04-07-99
S 348	FORRESTER	STOP MISUSE OF LASER POINTERS	*S -PRES. TO GOV. 07-20	03-15-99	04-19-99
S 540=	JORDAN	ORTHOPAEDIC PHYSICIAN ASSISTANTS	S -REF TO COM ON HLTHCARE	03-29-99	
S 614	PURCELL	IMMUNIZATION LAW CHANGES	*R -CH. SL 99-0110	03-29-99	04-22-99
S 620	LEE	AMEND PROFESSIONAL CORP ACT	R -CH. SL 99-0136	03-30-99	04-21-99
S 665=	SOLES	DENTISTS/DENTAL HYGIENISTS	*S -RE-REF COM ON RULES &	04-14-99	06-16-99

NOTES- = AFTER BILL NUMBER SHOWS THAT BILL IS IDENTICAL, AS INTRODUCED, TO ANOTHER BILL.
* AFTER NUMBERS INDICATES THAT TEXT OF BILL WAS ALTERED BY ACTION ON THE BILL.
BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — SENATE: HEALTH CARE — Valid Through 27-JUL-1999

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 678=	ODOM	REGULATE SPINAL MANIPULATION	S -REF TO COM ON HLTHCARE	04-01-99	
S 685	LUCAS	HEALTH INSURANCE/PHYS. ASSISTANTS	R -CH. SL 99-0210	04-01-99	04-21-99
S 733=	SOLES	CHIROPRACTIC CLAIMS REVIEW	S -RE-REF COM ON COMMERCE	04-01-99	04-07-99
S 783=	COCHRANE	LONG-TERM CARE FACILITIES/DISCLOSURE	*S -FAILED CONCUR IN COM SUB	04-07-99	04-28-99
S 793	CLODFELTER	PSYCHOLOGY PRACTICE DEFINITIONS	R -CH. SL 99-0292	04-08-99	04-14-99
S 875=	LUCAS	CERTIFIED PROFESSIONAL MIDWIVES	S -REF TO COM ON HLTHCARE	04-13-99	
S 933	KINNAIRD	ADULT CARE HOMES/TRANSFERS	S -RE-REF COM ON HLTHCARE	04-22-99	
S 951	PERDUE	HEALTH CARE WORKERS/ID BADGE	*R -CH. SL 99-0320	04-14-99	04-21-99
S 960	SOLES	REGULATION OF PHARMACIES	H -REF TO COM ON HEALTH	04-15-99	04-28-99
S 961=	SOLES	MANAGED CARE/PATIENT ACCESS	S -REF TO COM ON HLTHCARE	04-15-99	
S1086	CARPENTER R	RESTRAINTS/DEATHS IN FACILITES	*S -RE-REF COM ON RULES &	04-15-99	04-28-99
S1091	PURCELL	HEP B IMMUNIZ. REQUIRED	S -REF TO COM ON HLTHCARE	04-15-99	
S1119	LUCAS	PERFUSIONIST LICENSURE	S -RE-REF COM ON HLTHCARE	05-11-99	
S1122	MOORE K	AREA MENTAL HEALTH/COUNTY APPROP	*R -CH. SL 99-0202	04-15-99	04-28-99
S1165=	PURCELL	CLINICAL PHARMACIST PRACTITIONER	*S -RE-REF COM ON FINANCE	04-15-99	04-27-99

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BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on Health Care will meet at the following time:

DATE: Wednesday, February 10, 1999
TIME: 12:00 Noon
ROOM: 1124, LB

The following bills or resolutions will be considered:

- S.B. 26, CHIP Clinics/Repeal Prohibition — Senator William R. Purcell

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, February 10, 1999 at 12:00 Noon
Room 1027

MINUTES

The Senate Committee on Health Care met on Wednesday, February 10, 1999 at 12:00 Noon in Room 1027 in the Legislative Building. Fifteen of the members attended, including the Chair, Senator William R. Purcell, who presided. He introduced Quashawna Bond, a page from Windsor, who was sponsored by Senator Ballance, and Heather Funk from Asheboro, who was sponsored by Senator Kinniard.

Senator Purcell introduced Ms. Linda Attarian and John Young, both of the Research staff. He thanked the Committee members for their interest and stated that his vision for the Committee was not only to deal with bills that come before it, but also to become sort of a "think tank" on what needs to be done for health care in North Carolina. He believes that the goal of this Committee should be to see that all of the people of North Carolina have the best possible health care.

Senator Purcell asked Senator Lucas to preside at the discussion of this bill, as he was the primary sponsor. Ms. Attarian had provided each member with a written explanation of Senate Bill 26, CHIP Clinics/Repeal Prohibition. She recognized Senator Purcell, sponsor of this bill, to explain the bill further. After some additional discussion Senator Dannelly moved that the bill be given a favorable report. Senator Lucas called for a vote. The motion carried unanimously.

Senator Purcell introduced Dr. H. David Bruton, Secretary of the Department of Health and Human Resources. Secretary Bruton made a statement to the Committee as to what he believes are the three major issues that must be addressed regarding the health of North Carolina citizens (see Attachment 3).

Senator Purcell then introduced Dr. Andrew Dennis McBride, State Health Director, Department of Health and Human Resources (see Attachment 4).

The meeting adjourned at 1:00 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
William R. Purcell, Chairman

Thursday, March 18, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage.

FAVORABLE

S.B. **26** CHIP Clinics/Repeal Prohibition.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 26*

Short Title: CHIP Clinics/Repeal Prohibition. (Public)

Sponsors: Senators Purcell; Albertson, Ballance, Carter, Dannelly, Garwood, Hagan, Kerr, Kinnaird, Lee, Lucas, Martin of Guilford, Metcalf, Perdue, Phillips, Plyler, Robinson, Shaw of Cumberland, Soles, Warren, Weinstein, and Wellons.

Referred to: Health Care.

February 4, 1999

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE PROHIBITION ON REIMBURSEMENT FOR SERVICES PROVIDED BY SCHOOL-BASED HEALTH CLINICS UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Section 8 of S.L. 1998-1, Extra Session 1998, reads as rewritten:

"Section 8. ~~Except for immunization, no State funds, federal funds, or funds from any other source may be used under the Health Insurance Program for Children established under this act to reimburse medical services performed in school-based health clinic settings.~~ The Executive Administrator and Board of Trustees of the Teachers' and State Employees' Comprehensive Major Medical Plan shall conduct a survey of any claims paid by the Plan's self-insured indemnity program during each of the last three plan years. Any results of the survey shall be used by the Plan in conducting a study of the array of medical services delivered in school-based settings and whether or not such services should be eliminated, curtailed, or expanded. No later than March 31, 1999, the Plan shall make its findings and recommendations pursuant to this study known to the Committee on Employee Hospital and Medical Benefits, the Joint Legislative Health Care Oversight Committee, and the 1999 Session of the General Assembly."

Section 2. This act is effective when it becomes law.

ATTACHMENT 1

EXPLANATION OF SENATE BILL 26
CHIP Clinics/Repeal Prohibition

TO: Senate Health Care Committee
FROM: Linda Attarian, Committee Counsel
DATE: February 8, 1999
SPONSOR: Senator Purcell

Explanation of Senate Bill 26

Senate Bill 26 amends Section 8 of S.L. 1998-1, Extra Session, to repeal the prohibition on reimbursement for health care services provided by school-based clinics under the Children's Health Insurance Program. The Children's Health Insurance Program (hereinafter CHIP), called NC Health Choice, was established by the General Assembly during the 1998 Extra Session with the enactment of Senate Bill 2, ratified as Chapter 98-01 of the 1998 Session Laws. Section 8 of that legislation restricted reimbursements for health care services provided at school-based health clinics to immunizations. Senate Bill 26 repeals this restriction and allows all covered services provided to CHIP enrollees at school-based health clinic to be reimbursed with CHIP funds, effective when the bill becomes law.

Senate Bill 26 leaves intact the second part of Section 8 of Senate Bill 2 which directed the Executive Administrator and Board of the Teachers' and State Employees' Comprehensive Major Medical Plan (hereinafter State Health Plan) to conduct a survey of any claims paid by the State Health Plan during each of the previous three years (1995-97). The results of the survey are to be used to study the types of services delivered at school-based health clinics. Their findings and recommendations as to whether any of the services should be expanded, curtailed or eliminated must be reported to the Joint Legislative Health Care Oversight Committee and the Committee on Employee Hospital and Medical Benefits no later than March 31, 1999.

Background Information on the Children's Health Insurance Program

Congress created a new child health program by enacting Title XXI of the Social Security Act as a part of the Balanced Budget Act of 1997. Under Title XXI, the State Children's Health Insurance Program, federal funds ($39.6 billion over a 10-year period) became available to states for expanding health insurance coverage for low-income children. Participating states have either expanded Medicaid or adopted a non-Medicaid "state plan" option (or a combination of both) to provide health insurance to children under age 19 in families with incomes up to 200 percent of the federal poverty guidelines ($2,057 per month for a family of 4). Title XXI, like Medicaid, is funded jointly by the federal and state governments. As of January 1, 1999, all but two states (Washington and Wyoming) are participating in the program.

North Carolina's CHIP program is called NC Health Choice. Its health care benefits are based on the State Employee's Health Plan and are administered through Blue Cross/Blue Shield of North Carolina. The federal government pays 74 percent of the program costs up to a maximum allotment of 79.5 million each year. The State is required to make a 26 percent match. No county match is required.

NC Health Choice began enrolling children October 1, 1998. It has been estimated that 71,000 children in North Carolina are eligible for the program. As of January 5, 1999 there were 18,511 children enrolled. As a result of the NC Health Choice outreach efforts, an additional 12,601 children have been enrolled in Medicaid

Background Information on School-based Health Clinics in North Carolina

A school-based health clinic is a health center located on school grounds and staffed by health professionals. Students can receive physical and mental health care services without leaving school. School-based health clinics improve access to health care for children who do not get the health care they need because they live in an area with few health care providers, lack transportation, or cannot take time off from school or their parents can't take time off from work.

The clinics provide primary care services such as physical exams, sports physicals, health and dental screenings, health education, diagnosis and treatment of health problems, and laboratory testing. Preventive services include immunizations, nutrition counseling and weight management, substance abuse prevention, pregnancy and sexually transmitted disease prevention (however, no contraceptives, including condoms may be distributed on school property), and conflict resolution. They also provide counseling and referrals for school performance and behavior problems, substance abuse, family conflict, and depression. In North Carolina, parental permission is required before students may receive services from school-based health clinics.

The General Assembly began funding school-based health centers in 1992, appropriating funding for four centers. Since then, $950,000 is appropriated annually to the Department of Health and Human Services to fund fourteen centers. According to the NC Center for Health Statistics, there are currently 50 school-based health centers in 29 counties. There are three major sources of funding for these clinics. Each source of funds contributes one-third the total budgets. The three sources include state, local and federal grants (e.g. the Maternal and Child Health Block Grant) local donations and in-kind contributions; and third party reimbursements (e.g. Medicaid) and fee-for-service.

Supplemental Material Available:

Fact Sheets on NC Health Choice
Questions and Answers About School-Based Health Centers
Map of Counties with School-Based Health Centers
List of North Carolina School-Based Health Centers

ATTACHMENT 2

North Carolina School-Based Health Centers

County	Health Center(s)	Medical Sponsor
Ashe	Northwest High School*	Ashe County Health Department
Buncombe	Asheville High School* Asheville Middle School*	Buncombe County Health Department Mission-St. Joseph's Health System
Catawba	Catawba Valley High School*	Catawba County Health Department
Chatham	Horton Middle School*	Chatham County Health Department
Cleveland	Shelby Middle School* Shelby High School Kings Mountain Middle School Kings Mountain High School Burns High School* Crest High School Crest Middle School*	Cleveland County Health Department Cleveland Regional Medical Center
Durham	NC School of Math and Science Hillside High School Wellness Ctr. Southern High School Wellness Ctr. Geo. Watts Elem. Sch. Wellness Ctr.	Lakewood Family Practice Lincoln Community Health Center. Duke University School of Nursing Duke University School of Nursing
Eastern Band of Cherokee Indians	Cherokee Elementary School*	Cherokee Health Delivery
Forsyth	Independence High School*	Bowman-Gray Baptist Medical Center
Gates	Gates County High School*	Gates County Medical Center
Greene	Greene Central High School*	Greene County Health Care
Guilford	Grimsley High School* High Point Central High School*	Guilford County School Health Alliance
Harnett	Wayne Avenue Primary School Harnett Primary School Dunn Middle School	Harnett County Health Department
Henderson	Apple Valley Middle School	Blue Ridge Community Health Services
Hertford	Hertford County Middle School*	Roanoke-Chowan Alliance
Montgomery	East Middle School*	First Health of the Carolinas

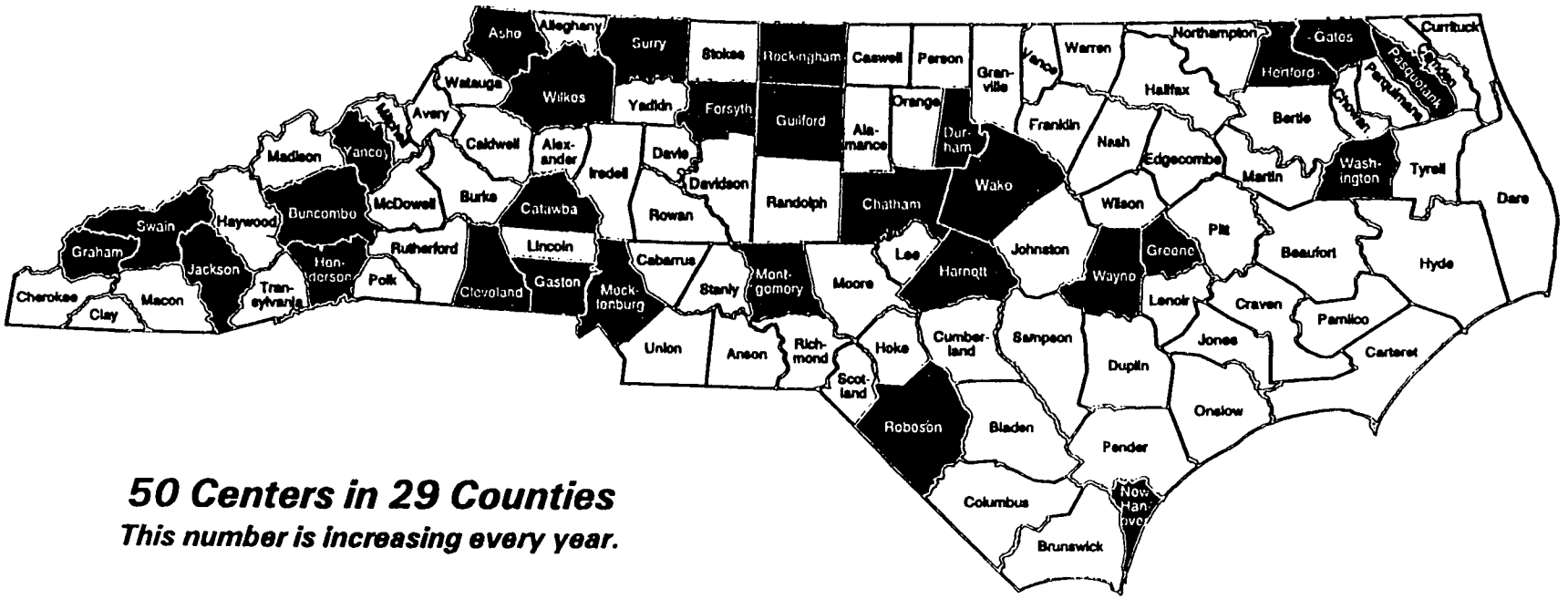
County	Health Center(s)	Medical Sponsor
New Hanover	Lakeside High School	Wilmington Health Access for Teens
Pasquotank	Northeastern High School* Elizabeth City Middle School*	Pasquotank County Health Department
Robeson	Purnell Swett High School*	Robeson County Health Department
Rockingham	McMichael High School Morehad High School Reidsville High School Rockingham County High School	Morehead Memorial Hospital
Surry	Gentry Middle School*	Surry County Health Department
Swain, Jackson & Graham	Robbinsville Middle School* Swain County Middle School* Fairview School*	West Care Health System
Washington	Washington Co. Union Middle Sch.	Washington County Hospital
Wayne	Brogden Middle School* Goldsboro Middle School*	WISH, Inc.
Wilkes	Central Wilkes High School* East Wilkes High School* North Wilkes High School* West Wilkes High School* (Mobile van unit)	Wilkes County Health Department
Yancey	East Yancey Middle School* Cane River Middle School*	Yancey County Health Department

North Carolina School-Linked Health Centers

County	Health Center	Medical Sponsor
Eastern Band of Cherokee Indians	Cherokee Teen Center *	Cherokee Health Delivery
Gaston	Advocates for Healthy Citizens, Inc.	Private Family Physician
Mecklenburg	Teen Health Connection	Carolinas Medical Center
New Hanover	Wilmington Health Access to Teens	Grants: RWJ & Duke Hospitals/Health Department
Wake	Wake Teen Medical Services	Wake Medical Center

*Health Centers using School-Health On-line data system

Making the Grade in North Carolina Is Making a Difference



50 Centers in 29 Counties

This number is increasing every year.

Centers Bring Good Health Care to Young People Who Had Little or None Before

State Center for Health Statistics, October 1998

ATTACHMENT 3

Dr. Bruton's Talk Before the Health Care Committee
12 noon
February 10, 1999

Thank you Senator Purcell for this opportunity to address this first meeting of your new committee on Health. You and your committee have an awesome opportunity to improve the lives of our citizens.

I was asked to talk to you about what I saw as the major issues in health. I have organized my thoughts into three categories that I believe we must accomplish if we are to achieve a healthy North Carolina.

1. Access to quality cost effective medical care; 2. A major shift in our health resources toward prevention with attention to medical ecology; and 3. A system of patient centered delivery of care.

1. **Access**

Access to quality care is becoming a problem that we continue to ignore at our peril. Today, nearly 900,000 North Carolinians don't have health insurance. Despite a strong economy, many people still don't have health coverage. A 1997 study published in the Journal of Health Affairs reported that even when people are employed and can purchase insurance through their employer, many of them aren't doing so. That's because:

1. The 90 percent increase in health insurance premiums between 1987 and 1993 exceeded the rise in wages during that period - making health insurance less affordable for working people.
2. Workers faced higher employee contribution rates, because of the increased use of deductibles and co-pays. And
3. States adopted legislation aimed at enhancing insurance coverage. These mandated benefits led to higher insurance costs.

We have made some good progress in the care of our children. I know many of you personally supported last year's adoption of our NC Health Choice for Children program. Thank you for that support on behalf of North Carolina's uninsured children. Today, more than 38,000 new children are insured because of our Health Choice efforts. Many of them were eligible for Medicaid but not enrolled. We are signing up more than 300 children a day. That's something we can all be proud of. Our integrated Medicaid and Health Choice programs provide a platform to build an excellent care system for the children of low-income families.

Their parents are not so fortunate. Health insurance for day care workers, non-profit staffs, small business employees and many other working families is rapidly becoming non-existent. This year's round of premium increases will enlarge the growing ranks of the uninsured.

When Congress passed the CHIP legislation, it included some little used provisions that would allow use of CHIP funds to insure adults as well as children. There are some strong reasons that we should consider including family coverage.

We talk a lot about families who once received welfare checks, now receiving paychecks. There's good data to show that providing low-income parents with health insurance will keep them working...providing for their families...and moving ahead in the system.

There is published data to show that parents are more likely to enroll their children in a subsidized health insurance program if it serves the whole family rather than just children. Enrollment rates can be as much as 30 percent higher when families can enroll as a unit.

Last year, when I traveled around the state talking up CHIP, I heard repeatedly from moms and dads who realized that even if CHIP became a reality, they—the parents—would still not have health insurance. This is at least an idea worth exploring. The conversation must start sometime on the need for universal coverage in America. If you are 65 years old, or a low income child you are covered. We need to close the gap.

We must protect against lowering quality of care and restrictions in access as our strategy for responding to the current round of health insurance premium increases. My fundamental belief is: that quality care is the most cost effective care, and that clinical care decisions ought to be made by patients and physicians. Brokerage mechanisms designed to match supply and demand with a little left over for profit is not the way to solve our medical cost problem.

Let me tell you a little about what we are doing in the MIC (Mother's Infants and Children) part of our Medicaid operation trying to put into practice this philosophy. Remember, we pay physicians less than 9% of our Medicaid dollars. They direct how 60% or more of our Medicaid dollars are spent. Seeing patients in the office versus being seen in ER, out-patient versus in-patient treatment, what tests, what medicine, what level of long term care, stressing prevention are all behaviors that greatly influence costs.

Our behavior modification program involves both patients and physicians. A good example of changing patient behavior is going on in the Access Care network of pediatricians. A utilization nurse stationed in various practices calls every child who was seen the night before in the emergency room. The nurse finds out how the child is doing, what follow up is needed and helps the mother understand how she could have avoided the ER visit. In Surry County they have reduced ER use by 14% in the first 6 months.

We have structured our MIC delivery system as ACCESS I, II, III. ACCESS I, now in 100 counties, is our primary care case management model. The doctor agrees to provide a medical home for Medicaid patients. The ACCESS doctor guides the patient through the maze of available medical care options, using high tech or expensive care only when it is best for the patient.

We pay a per member per month fee to the doctor for this management service. HCFA lets us do this as long as it saves them money. The ACCESS fees, enhanced utilization cost, disease management protocol and network management cost all come out of the payments for services money. We must show HCFA that not only do we improve quality, we must do it for the same or less money. Frankly they are more interested in the money. We are succeeding in spades. The arithmetic is with us -$30 office visits versus $300 ER visits. Easy to win in that game. We will report to the General Assembly a reduction in growth in the Medicaid program. The average growth in cost per eligible declined from 8.6% in SFY 96-97 to 5.7% in SFY 97-98 and a projected 2.5% in SFY 98-99. This, at a time when we are seeing double-digit premium increases in our private insurance premiums.

ACCESS II takes a group approach to changing behavior. In ACCESS II, we now have 9 sites up and running at various speeds, representing approximately 150,000 Medicaid patients. Here we provide resources for enhanced utilization and clinical care

management. An example of this would be the development of an Internet based collection of outcome data for the pediatric asthma population that would power a rapid cycle improvement project. Physician's commit to share information on their treatment of asthma in children. The clinical outcomes that prove to be most effective; for example: keeping the child out of the ER and not being hospitalized, patient and family education on asthma management, use of preventive therapies, correctly timed redial treatments, all come into play. You build the system for providing the physicians outcome data and disease management information in real time. They will change their management of asthma. You achieve better care and it cost Medicaid less.

Again the concept is: quality care is cost effective. Incidentally the child will miss school less and will probably do better in school if he's not air hungry.

ACCESS III continues the evolution to the formation of Community Care Networks where the physicians, hospitals, public health departments and other providers work together to provide comprehensive care to the Medicaid patients. Where they can provide complete access to quality care at less cost the saving they achieve are put back into the system to provide enhancements in care. We have two ACCESS III sites: Pitt County with the ECU Medical School and Cabarrus County.

The big notion here is to use all of the money available for clinical care, for clinical care. We have none to waste on various economic models and profits. Why circulate your money through some kind of separate payment machine? We deal directly with our providers, and help them change their clinical behavior.

2. Prevention

Clearly the most cost effective medical care activity is prevention of disease and health promotion. I plan to have our new health director; Dr. Dennis McBride present to you an outline of our major Public Health concerns. Let me just list some of them.

In virtually every health statistic, North Carolina's African American population trails the white population---no where is that gap more obvious than in our infant mortality rates. North Carolina's 1997 infant mortality rate was 9.2 infant deaths for every 1,000 live births. Although this rate is the lowest in the state's history, it has held steady at the 9.2 plateau since 1995, while the national trend has continued to decrease. We have reduced some causes of infant morbidity and mortality, but too many of our babies are still being born just to die. This is particularly true in our minority community, where the infant mortality rate is more than twice that of white infants. In fact, the rate for whites actually declined from 7.1 to 6.9 while the rate for minorities rose from 14.3 to 14.8. I'm frustrated by our seeming inability to close this gap.

African Americans often receive less, and poorer quality, health care than white Americans so they tend to become sicker and die earlier than whites.

North Carolina has no coherent integrated plan to provide long term care for our rapidly aging population.

Our School Health Program is virtually non-existent. We have a few wonderful grant and locally supported programs. General School Health coverage is woefully inadequate. We have one school nurse for approximately each 2,400 students. Many schools have no nurse. When you consider the large number of children with special needs cared for by our schools your heart goes out to the children and to the teachers who provide the best nursing care they can. They are trained to be teachers not school nurses.

Mental health care in North Carolina is fragmented, underfunded, often inadequate, or non-existent for major segments of our population.

We are not paying enough attention to medical ecology. People are part of the environment. Some of the things we are doing to our water, soil and air are going to make us sick.

Dr. McBride has some slides to illustrate these and other points.

Strong prevention programs require strong public education programs. Let me give you a personal example---as a pediatrician, I participated in the American Academy of Pediatrics' Back to Sleep public awareness program. It was a simple concept—tell parents to put their babies to sleep on their backs or sides. Well, that simple concept has paid off remarkably. North Carolina's and America's 1997 sudden infant death syndrome rate was the lowest in its history. Public education programs require time, money and smarts. It is an investment that pays off.

Most important prevention efforts take some time to pay off. No entity, other than the state, has the staying power to ensure the success of the core public health functions. Our state's financial commitment to Public Health has not been strong. County government and the Feds provide most of our Public Health funding. Public resources to keep the fragile health services safety net intact are increasingly difficult to secure in a managed care environment.

If our resources are finite and limited, and they are, we must have the political courage to move our money from treatment and crisis intervention into prevention. No better example of this will be seen than in how we use the tobacco settlement money (if any ever materializes). My hope is that our decisions on tobacco money will be evidence based, scientifically valid, and long term. This kind of decision making is most likely to occur in a non-political [501(c)3] Foundation type structure.

While I'm talking about politically courageous prevention, I must talk about AIDS. Our HIV/STD Prevention and Care Section estimates that almost fifty percent of the reported HIV cases are the result drug abuse. There is one real, proven, effective way to address this issue---a needle exchange program. We know these programs work. A 1993 Connecticut study showed a 33 percent reduction in the rate of new HIV infections among needle exchange program participants. The CDC says that this estimate may be low—that even more people may have been saved. Connecticut, Massachusetts and New York have made needle exchange programs legal. We failed on a measure here in 1997, but it is time to try again in 1999. Preventing an AIDS case is a whole lot cheaper than treating it---especially when the patient is likely to be low-income and uninsured. Even though the number of new AIDS cases is down, we have a public health time bomb in the number of seropositive North Carolinians.

3. A System of Patient Centered Medical Care

Our non-system of medical care with its incentives for unrestrained growth led to over capacity, over utilization, expensive technology, some of which had little value, and a general devaluation of the individual patient. We had to control these displacing costs. Medical care expenditures in America have reached a trillion dollars annually, 14% of GNP. These expenditures are not producing health indicators as good as many counties that spend a great deal less. Our lack of a system of care is probably the main reason we are not getting value received.

The way we went about controlling cost, and it worked for a time, was to try to make medical care a commodity that would respond to an enterprise system. HMO's, hospital consolidations, conversions from non-profit to profit entities, corporate medical practices, third party managers and administrators are not good or bad in and of themselves. They are our collective response to trying to get a handle on the high cost of care. These rapid changes in medical care delivery have devalued the individual patient's role in the health care equation. Individual patient's needs and desires have lost power in this new medical economics. The General Assembly should look into a Patient's Bill of Rights Act to help level the playing field for patients as they struggle to obtain quality care from an increasingly rigid delivery system. It's hardly a fair fight – an individual sick patient on one side and a big company or corporation on the other.

The other day I had lunch at the Farmer's Market (I love their biscuits.). On the counter was one of those posters with a collection jar asking help for a cancer victim in Wake County. It is obscene that we have come to that in our medical care delivery system. Any patient in North Carolina needing cancer treatment should have it, and not have to resort to begging from the counter top at the Farmer's Market.

Your committee, this General Assembly and our country have a big job ahead of us in health care.

Thank you.

Table 7
DEMOGRAPHIC, ECONOMIC, AND HEALTH RESOURCES DATA

Resident Data	Resident Population July 1, 1997																Income Levels		Health Care Personnel[1]				Hospital Beds and Use		Medicaid[7]		
			Percent of Total Population in Selected Age-Race-Sex Groups																								
			White Male			White Female				Minority Male			Minority Female														
	Total	Annual % Change Since July 1, 1990	Total	<20	65+	Total	<20	15-44	65+	Total	<20	65+	Total	<20	15-44	65+	Per Capita, 1996	Percent Families Below Poverty, 1989	Persons Per Primary Care Physician[2]	Persons Per Primary Care Physician Plus Extenders[3]	Persons Per Registered Nurse[4]	Persons Per Dentist[4]	Persons Per Hospital Bed[5]	Hospital Use Rate[6]	Percent of Total Population Eligible	Per Capita Expenditure	Percent of Children Using Health Depts. (Visits for Immunization Only Are Not Included.)[8]
North Carolina	7,431,161	1.7	37.2	9.6	4.2	38.7	9.2	16.5	6.3	11.3	4.2	0.8	12.9	4.1	6.0	1.4	22,244	9.9	1,281	1,007	113	2,495	332	109	16.1	$ 523	20.6
Alamance	119,820	1.5	38.2	9.7	5.3	41.3	9.4	16.4	8.2	9.4	3.0	0.8	11.1	3.2	4.9	1.4	22,227	6.0	1,902	1,520	167	2,066	633	116	12.4	452	13.2
Alexander	31,078	1.8	46.9	12.1	4.8	46.7	11.3	20.0	6.9	3.0	1.0	0.2	3.4	1.1	1.3	0.4	19,505	7.3	3,108	2,337	342	5,180	539	119	13.2	427	9.0
Alleghany	9,682	0.1	47.5	10.4	7.9	50.8	10.4	17.5	12.2	0.8	0.2	0.1	0.9	0.2	0.3	0.1	19,568	15.4	1,210	857	198	4,841	209	185	15.4	696	56.5
Anson	23,854	0.3	24.8	5.7	4.0	26.3	5.2	9.8	6.0	22.1	8.1	2.0	26.8	8.2	11.4	4.0	18,292	13.4	1,988	1,629	229	5,964	458	160	27.5	963	37.4
Ashe	23,596	0.9	48.2	10.9	7.8	51.0	10.0	19.2	10.7	0.4	0.1	0.1	0.4	0.1	0.1	0.1	17,852	15.3	1,475	1,223	164	5,899	303	130	18.9	781	53.6
Avery	15,460	0.6	49.2	13.2	6.8	49.5	11.9	20.0	9.1	0.9	0.3	0.1	0.4	0.1	0.2	0.0	20,143	10.2	966	727	100	3,092	183	166	17.8	817	35.7
Beaufort	43,400	0.4	33.1	8.2	4.5	35.7	7.7	13.2	7.0	14.1	5.4	1.5	17.1	5.2	7.3	2.6	18,539	15.9	1,887	1,500	119	3,338	227	119	22.7	774	7.6
Bertie	20,248	-0.1	17.3	4.0	2.9	19.3	4.0	6.6	4.4	28.3	10.8	2.8	35.1	11.1	15.5	4.9	15,944	21.3	2,250	1,418	250	10,124	421	141	32.2	1,023	30.5
Bladen	30,314	0.8	27.8	6.7	3.8	30.5	6.8	11.4	6.1	18.7	6.8	2.0	23.0	6.9	9.5	3.2	19,500	19.4	2,526	1,522	180	6,063	573	124	29.0	971	26.6
Brunswick	65,200	3.8	41.0	9.3	7.0	42.3	8.7	15.7	7.9	7.8	2.7	0.7	8.9	2.7	3.9	1.1	17,305	11.9	3,622	2,650	247	3,835	690	122	18.7	536	24.6
Buncombe	191,122	1.3	43.4	10.9	6.2	47.5	10.4	18.8	9.4	4.2	1.5	0.4	4.8	1.5	2.0	0.7	23,013	8.2	889	657	68	2,012	255	109	15.5	571	21.2
Burke	83,143	1.4	44.9	11.7	5.3	46.4	10.6	18.9	8.0	4.4	1.9	0.3	4.3	1.5	1.8	0.6	19,267	7.7	1,409	1,064	99	3,326	230	111	15.2	571	13.6
Cabarrus	116,502	2.5	42.4	11.3	4.6	44.4	10.8	18.4	7.3	6.3	2.3	0.4	6.9	2.2	3.2	0.8	23,334	6.0	1,189	1,000	101	4,017	247	129	11.4	432	15.8
Caldwell	74,728	0.8	46.3	11.8	5.2	47.8	11.5	19.8	7.5	2.9	1.0	0.2	3.0	0.9	1.3	0.4	19,152	8.2	1,779	1,497	204	4,152	658	118	14.7	541	28.5
Camden	6,308	1.0	40.5	10.4	5.0	37.9	8.8	14.9	6.2	10.6	2.5	1.5	11.0	2.8	4.6	1.6	18,000	12.1	—	—	394	—	—	80	16.4	506	39.9
Carteret	59,057	1.7	45.0	10.4	6.7	45.9	9.9	18.7	8.2	4.3	1.6	0.2	4.8	1.4	2.4	0.5	19,958	9.1	1,969	1,531	151	2,684	492	111	13.8	490	23.8
Caswell	22,059	0.9	29.8	7.5	3.8	31.2	7.2	12.0	6.0	18.8	4.7	2.4	20.2	4.7	8.1	3.6	16,620	14.5	2,757	2,073	380	7,353	—	50	18.3	633	31.7
Catawba	129,540	1.3	43.7	11.2	4.8	45.7	10.8	19.3	7.2	5.0	2.0	0.3	5.5	1.9	2.5	0.5	23,480	4.8	1,364	1,061	103	2,816	307	110	13.5	422	11.7
Chatham	45,130	2.3	38.4	9.4	5.2	40.4	8.6	16.2	7.6	10.0	3.2	1.0	11.3	3.0	4.7	1.7	22,041	7.4	2,149	1,561	258	5,014	631	92	11.5	443	21.0
Cherokee	22,416	1.6	45.8	10.7	8.6	49.7	10.8	17.8	10.9	2.4	0.7	0.2	2.1	0.5	0.7	0.4	15,258	15.3	1,180	949	137	3,736	198	132	23.5	814	33.4
Chowan	14,219	0.7	30.3	7.3	5.7	33.4	7.5	11.3	7.9	16.0	6.1	1.8	20.4	6.7	7.9	3.2	18,459	14.5	1,094	949	118	3,555	275	110	26.0	930	48.5
Clay	8,066	1.8	47.5	10.8	9.5	51.3	10.0	18.8	11.6	0.6	0.1	0.2	0.6	0.1	0.2	0.2	16,964	14.4	2,689	1,867	137	8,066	—	79	17.2	691	53.0
Cleveland	90,650	1.0	37.6	9.7	4.8	40.2	9.2	15.6	7.6	10.5	4.1	0.8	11.7	3.7	5.3	1.2	19,050	8.4	1,395	1,221	141	2,833	227	133	18.9	597	16.2
Columbus	51,942	0.7	31.2	8.2	4.0	34.5	7.7	13.4	6.4	15.5	6.0	1.4	18.7	6.0	8.0	2.6	18,347	19.8	2,078	1,337	121	3,996	309	142	31.1	994	42.4
Craven	88,475	1.2	37.1	9.6	4.3	36.1	9.7	15.5	5.7	12.6	4.8	1.0	14.3	4.7	6.7	1.7	20,573	10.5	1,341	1,064	117	2,269	303	115	17.1	532	24.7
Cumberland	295,255	1.0	32.7	9.8	2.1	29.2	8.7	13.6	3.2	18.3	7.1	0.8	19.8	6.9	9.8	1.4	19,556	12.1	1,273	1,042	143	2,709	490	85	16.5	407	13.5
Currituck	16,571	2.9	45.4	12.0	5.2	44.6	11.5	19.2	6.3	5.0	1.4	0.6	5.0	1.4	2.2	0.9	19,654	8.1	5,524	5,524	460	8,286	—	43	13.6	366	29.1
Dare	27,394	2.7	47.9	11.8	5.4	48.6	11.2	22.0	6.5	1.8	0.6	0.1	1.7	0.5	0.7	0.2	20,611	5.2	2,283	1,527	216	2,283	—	53	9.7	375	26.9
Davidson	140,442	1.5	44.2	11.5	4.9	45.2	10.8	18.8	7.0	5.1	1.8	0.4	5.6	1.7	2.7	0.5	20,061	7.3	2,265	2,047	203	6,106	599	98	13.1	416	13.6
Davie	31,192	1.7	44.7	11.0	5.9	46.4	10.4	18.3	8.3	4.3	1.5	0.4	4.5	1.3	2.0	0.7	25,256	6.1	2,399	1,839	193	3,899	367	112	10.2	415	28.1
Duplin	44,080	1.5	33.1	9.0	4.0	33.8	8.4	12.9	6.1	15.2	5.3	1.5	17.9	5.4	7.5	2.7	22,528	16.2	2,099	1,721	190	4,898	701	131	23.6	717	27.5
Durham	197,710	1.2	29.0	7.3	2.6	30.9	6.9	14.8	4.4	18.3	6.7	1.0	21.8	6.8	11.1	2.0	24,497	8.7	501	361	47	1,765	140	103	15.3	524	9.4
Edgecombe	55,396	-0.3	19.1	4.7	2.6	21.1	4.6	8.0	4.2	26.1	10.7	1.9	33.7	10.8	15.3	3.9	17,510	17.6	2,638	2,162	204	6,155	568	137	32.8	849	57.0
Forsyth	287,160	1.1	35.0	9.0	4.1	38.4	8.6	16.4	6.7	12.3	4.5	0.8	14.3	4.4	6.9	1.4	28,004	7.8	892	633	70	1,762	182	107	13.3	442	9.8
Franklin	43,487	2.7	33.0	8.8	3.4	34.5	8.6	15.2	5.4	15.0	5.2	1.3	17.5	4.9	7.6	2.6	17,546	11.6	3,953	3,188	202	4,349	595	106	18.6	657	44.0
Gaston	180,082	0.4	41.6	11.3	4.4	43.9	10.9	18.3	7.0	6.7	2.7	0.4	7.8	2.7	3.5	0.8	21,598	8.2	1,652	1,343	144	2,814	480	103	16.6	575	23.5
Gates	9,914	0.9	30.4	8.5	4.0	29.5	6.9	12.0	5.3	18.9	5.5	1.9	21.2	6.4	8.8	3.1	16,042	12.7	4,957	3,727	342	9,914	—	61	19.3	699	36.2
Graham	7,504	0.6	45.7	11.1	7.5	46.1	9.5	16.7	9.5	3.7	1.4	0.2	4.5	2.5	1.6	0.2	15,067	22.7	1,501	1,187	278	7,504	—	129	24.1	1,011	75.8
Granville	42,802	1.6	31.7	8.0	3.1	31.8	8.0	13.6	4.8	17.8	5.1	1.7	18.7	5.0	8.0	2.7	18,146	10.0	1,381	1,081	98	2,675	623	97	15.9	536	35.2
Greene	17,651	2.1	30.3	7.4	3.4	29.0	6.2	11.2	5.7	20.6	6.0	1.4	20.2	5.7	9.0	3.0	17,732	14.2	17,651	4,849	333	3,530	—	94	21.3	716	59.4
Guilford	383,186	1.4	33.8	8.3	4.1	36.9	7.9	15.9	6.4	13.5	4.9	0.8	15.8	5.0	7.8	1.5	26,726	7.3	1,228	901	91	1,758	299	111	13.9	488	17.6
Halifax	55,841	0.1	21.5	5.4	3.3	23.4	5.0	8.5	5.4	25.8	9.7	2.2	29.3	9.4	12.8	3.8	16,446	21.0	1,595	1,262	139	5,584	279	147	33.2	895	27.0
Harnett	81,358	2.8	37.4	10.3	3.9	38.9	10.2	17.2	6.0	11.1	4.0	0.7	12.6	4.3	5.7	1.3	16,772	13.8	2,542	2,144	295	5,811	500	105	19.0	560	26.5
Haywood	51,267	1.3	46.6	10.8	8.1	51.5	10.1	17.9	12.1	0.9	0.2	0.1	1.0	0.3	0.4	0.2	19,203	9.5	1,465	1,273	146	2,441	277	139	17.2	602	25.0
Henderson	79,148	2.0	45.7	10.2	9.6	50.1	9.7	16.9	12.9	2.0	0.8	0.2	2.2	0.7	1.0	0.3	23,564	7.5	1,099	888	114	2,139	290	137	14.7	520	22.8
Hertford	21,916	-0.4	18.3	4.5	2.8	20.4	4.1	7.5	5.0	27.4	10.5	2.7	33.9	11.1	14.4	4.8	16,619	19.7	1,044	794	101	2,740	204	124	33.7	1,039	36.8
Hoke	28,882	3.8	22.2	6.2	2.2	20.6	5.6	8.4	3.2	28.1	10.5	1.5	29.1	10.0	13.5	2.8	12,631	17.5	1,699	1,378	321	7,221	—	69	24.1	646	34.2
Hyde	5,280	-0.3	34.0	8.6	5.0	34.3	7.7	13.3	6.6	14.7	5.0	2.0	17.0	4.2	6.8	3.0	17,962	20.1	5,280	2,276	264	—	—	149	27.4	1,025	39.4
Iredell	109,261	2.5	41.1	10.5	4.9	42.8	10.1	17.3	7.3	7.4	2.8	0.5	8.6	2.7	3.9	0.9	21,713	7.0	1,401	1,225	104	2,276	241	136	13.3	430	11.0
Jackson	29,142	1.2	41.7	10.7	5.7	45.9	10.6	20.1	8.3	6.2	2.5	0.4	6.1	2.2	2.8	0.6	17,122	11.7	911	755	105	2,242	335	104	16.7	594	21.9
Johnston	103,181	3.8	40.7	11.0	4.1	42.0	10.0	17.9	6.5	7.9	2.9	0.6	9.4	2.9	4.1	1.2	20,236	11.5	2,580	1,893	274	4,486	596	116	17.0	551	25.6
Jones	8,988	-0.6	30.1	7.9	3.8	32.5	8.5	13.2	5.6	16.8	5.8	2.0	20.6	5.5	8.3	3.5	21,364	16.9	899	794	230	—	—	155	24.8	857	39.0
Lee	48,369	2.4	37.0	9.8	5.0	38.5	9.3	14.9	7.1	11.4	4.2	0.8	13.1	4.8	5.8	1.4	22,376	11.5	1,486	1,110	128	2,546	362	135	18.4	520	13.5
Lenoir	59,038	0.5	28.5	7.0	3.8	30.5	6.7	11.3	6.1	18.0	6.9	1.6	23.0	6.7	10.2	3.2	19,889	15.6	1,904	1,467	108	2,109	225	159	25.3	809	37.9
Lincoln	57,896	2.1	45.3	12.1	4.7	46.3	11.7	19.5	6.8	4.1	1.5	0.3	4.3	1.5	1.9	0.5	19,863	7.3	1,996	1,869	245	4,825	550	109	13.0	430	11.9
McDowell	39,424	1.5	46.3	11.7	6.1	48.5	10.7	19.5	8.8	2.6	0.8	0.2	2.6	0.8	1.0	0.4	17,769	8.4	1,971	1,601	165	3,942	573	119	16.5	523	30.0
Macon	27,664	2.5	46.6	10.4	10.2	51.1	9.6	16.1	13.2	1.2	0.6	0.1	1.1	0.4	0.6	0.1	18,809	12.0	1,257	1,123	151	3,458	317	123	16.4	571	23.7
Madison	18,330	1.1	48.9	12.5	7.6	50.0	11.4	20.1	9.8	0.6	0.2	0.0	0.5	0.1	0.2	0.1	16,601	15.5	1,833	1,450	339	6,110	—	100	20.6	720	34.8
Martin	25,628	0.3	26.3	6.5	3.4	28.7	6.3	10.7	5.8	20.7	7.6	2.1	24.3	7.1	10.3	3.6	16,951	18.6	1,602	1,375	200	5,126	527	138	26.3	834	34.1
Mecklenburg	608,567	2.6	34.8	9.0	3.1	36.3	8.7	17.2	4.7	13.4	5.1	0.6	15.5	5.1	7.8	1.1	30,541	7.2	1,014	836	82	1,739	279	92	12.5	390	14.6
Mitchell	14,729	0.3	47.6	11.4	7.9	52.0	10.8	19.1	11.3	0.2	0.1	0.0	0.2	0.1	0.0	0.0	17,633	12.9	982	867	139	2,946	175	140	16.6	684	33.4
Montgomery	24,473	0.7	36.6	9.7	4.4	35.2	8.8	13.4	6.4	14.8	5.2	0.9	13.4	4.4	6.3	1.7	17,105	10.1	2,719	1,714	220	4,079	644	114	23.0	697	31.2
Moore	69,502	2.5	39.1	8.9	8.9	42.9	8.5	14.0	11.8	8.4	3.2	0.7	9.6	3.0	4.1	1.3	26,239	8.2	1,479	1,142	80	2,397	219	137	14.2	484	23.1
Nash	87,101	1.9	33.1	8.5	3.7	35.3	8.0	14.7	5.9	14.5	5.3	1.1	17.1	5.4	8.1	1.9	20,725	10.7	1,244	1,007	114	2,178	261	88	17.4	554	23.5
New Hanover	146,601	3.1	38.2	9.3	4.5	41.3	9.2	18.2	6.7	9.2	3.4	0.8	11.3	3.6	5.2	1.3	22,886	9.9	940	725	75	1,576	216	104	15.6	534	15.8
Northampton	20,800	0.0	20.7	4.2	4.0	21.1	4.1	6.9	5.3	27.2	8.7	3.2	30.9	8.8	12.4	5.5	16,951	20.5	5,200	2,613	285	5,200	—	140	32.9	985	52.6
Onslow	147,352	-0.3	44.8	13.2	1.9	31.5	10.9	15.5	2.7	13.2	4.6	0.3	10.5	4.1	5.3	0.6	16,184	9.8	1,865	1,610	205	2,679	763	114	12.5	345	12.8
Orange	107,253	2.0	39.0	9.8	3.0	43.1	9.9	24.2	4.5	8.5	2.8	0.6	9.5	2.8	5.0	0.9	27,247	6.4	356	293	53	740	189	76	7.4	297	13.1
Pamlico	11,973	0.7	37.5	8.8	6.4	38.9	7.7	13.9	8.5	10.4	3.4	1.6	13.2	3.4	5.0	2.4	17,821	15.8	1,996	1,636	292	3,991	—	107	18.9	707	33.8
Pasquotank	34,519	1.4	29.0	8.0	3.8	32.2	8.5	12.9	6.0	17.5	7.2	1.6	21.2	6.9	10.2	2.8	18,739	16.6	1,046	872	89	2,877	183	100	22.3	688	50.6
Pender	37,208	4.0	36.1	8.7	5.0	37.1	8.2	14.8	8.2	12.2	4.5	1.2	14.6	4.2	5.6	2.4	18,276	13.8	3,383	2,382	251	4,134	608	102	20.4	638	31.7
Perquimans	10,900	0.6	34.3	8.0	6.5	35.4	7.6	12.5	7.8	13.9	4.9	1.8	16.4	4.5	6.6	3.0	16,034	17.6	5,450	4,098	545	5,450	—	99	24.2	660	61.3
Person	32,920	1.3	33.7	8.6	4.3	36.0	8.2	14.5	6.6	14.3	4.9	1.2	16.1	4.6	6.8	2.4	19,805	9.6	3,292	2,358	230	4,115	643	111	17.1	683	29.3
Pitt	124,395	2.1	32.0	8.9	2.6	33.9	8.6	17.5	4.2	15.5	6.3	1.0	18.6	6.1	9.1	1.9	20,800	15.5	610	501	58	2,539	194	91	19.6	653	14.6
Polk	16,393	1.9	43.2	9.1	10.1	49.8	9.5	15.3	14.2	3.3	1.1	0.3	3.7	0.9	1.5	0.8	25,288	6.9	1,639	1,121	128	2,342	286	84	12.1	538	26.0
Randolph	121,550	2.0	45.7	12.6	4.9	47.4	11.8	20.2	7.1	3.3	1.1	0.2	3.5	1.1	1.6	0.4	20,566	6.5	2,827	2,418	258	3,921	797	100	12.8	420	15.7
Richmond	45,658	0.4	32.6	8.6	4.4	34.7	8.1	13.1	6.6	15.2	6.2	1.2	17.5	6.1	7.6	2.2	16,481	13.0	1,902	1,401	130	3,805	280	199	26.1	909	28.2
Robeson	112,704	1.0	16.4	4.3	2.0	17.7	4.2	6.9	3.3	30.8	12.1	1.9	35.1	12.0	16.0	3.6	15,918	20.7	2,049	1,407	196	4,508	435	145	31.3	970	24.7
Rockingham	89,156	0.5	37.8	9.6	5.0	41.0	9.3	16.1	7.8	9.7	3.2	0.8	11.4	3.2	5.1	1.5	19,215	9.3	1,592	1,326	169	3,566	405	126	16.8	620	23.5
Rowan	122,774	1.5	40.6	10.7	5.4	42.1	10.1	16.7	8.2	8.2	2.9	0.7	9.1	3.2	4.1	1.1	19,834	6.8	1,594	1,332	136	3,410	452	111	14.6	471	13.1
Rutherford	59,396	0.6	42.8	11.4	5.9	45.5	10.9	17.5	8.8	5.6	2.2	0.4	6.1	2.0	2.7	0.7	18,340	9.0	1,800	1,607	175	4,243	458	115	17.4	619	26.1
Sampson	52,650	1.6	31.6	8.3	4.1	33.6	8.2	12.9	6.3	15.8	5.5	1.7	19.1	5.6	8.2	2.7	20,649	17.4	2,289	1,428	165	5,850	436	126	23.6	769	14.1
Scotland	35,004	0.5	26.0	7.2	2.7	28.7	7.2	11.8	4.7	20.3	8.6	1.3	25.1	8.7	11.2	2.6	17,784	15.8	1,591	1,384	151	5,834	328	125	29.4	902	24.5
Stanly	55,131	0.9	42.3	11.4	5.3	44.8	11.2	17.6	8.3	6.1	2.5	0.4	6.9	2.5	3.0	0.7	19,146	7.9	1,723	1,337	183	3,446	554	124	15.5	530	18.5
Stokes	42,848	2.1	46.7	12.4	4.6	48.2	11.4	20.8	6.9	2.5	0.7	0.2	2.6	0.7	1.1	0.4	18,948	7.4	3,895	2,996	306	8,570	642	98	12.7	440	32.2
Surry	66,834	1.2	45.8	11.8	5.8	49.5	11.1	19.5	9.4	2.1	0.7	0.2	2.6	0.9	1.0	0.4	20,064	8.5	1,364	971	123	2,571	317	151	15.2	559	39.4
Swain	11,994	0.9	34.4	8.1	6.1	34.6	6.2	12.5	8.1	16.2	7.3	0.7	14.7	5.3	6.6	1.3	14,278	21.5	1,199	902	128	2,999	241	155	25.7	905	48.6
Transylvania	27,845	1.3	46.0	11.5	9.1	48.7	10.2	17.1	11.7	2.6	1.2	0.2	2.7	1.0	1.2	0.3	20,863	9.7	1,856	1,419	139	2,531	503	112	15.5	515	28.5
Tyrrell	3,672	-0.7	28.9	7.1	5.0	30.5	6.5	12.2	6.5	19.0	7.7	2.4	21.6	5.8	9.3	3.8	16,189	21.1	3,672	2,212	334	—	—	90	29.1	1,008	100.0
Union	106,119	3.6	41.5	12.3	3.5	42.3	11.7	18.6	5.0	7.6	3.1	0.4	8.6	3.1	4.1	0.7	19,706	6.2	2,948	2,530	270	5,896	614	90	11.7	373	14.3
Vance	40,981	0.7	25.4	6.6	3.3	27.9	6.2	11.0	5.2	21.6	8.5	1.6	25.2	8.1	11.7	2.9	18,423	15.3	2,927	1,989	189	4,553	440	125	29.7	873	30.9
Wake	556,853	4.2	37.9	10.1	2.6	39.0	9.8	19.4	3.9	10.9	3.8	0.5	12.2	3.9	6.4	0.9	28,858	5.5	1,101	888	99	1,746	419	87	8.8	276	20.9
Warren	18,140	0.7	19.5	4.2	4.3	20.2	3.8	5.9	5.6	28.5	9.3	3.6	31.8	8.5	12.7	5.9	14,765	23.8	2,016	1,558	378	6,047	—	92	27.1	909	54.5
Washington	13,297	-0.7	24.9	6.0	4.1	27.2	6.0	9.5	6.0	22.2	8.6	1.9	25.7	8.4	11.1	3.0	17,479	17.2	2,216	2,216	237	3,324	281	146	28.9	838	70.1
Watauga	40,862	1.5	47.3	11.9	4.8	49.9	12.5	26.6	6.6	1.5	0.4	0.1	1.4	0.4	1.0	0.1	17,629	10.1	1,572	1,364	124	1,857	275	70	9.1	364	28.7
Wayne	113,182	1.1	35.0	8.7	3.1	31.6	7.9	13.4	4.7	15.6	5.5	1.1	17.9	5.5	8.0	2.1	17,798	11.9	1,594	1,344	126	2,902	432	102	19.1	569	15.9
Wilkes	63,105	0.9	46.6	11.9	5.6	48.2	10.9	19.7	8.1	2.4	0.8	0.3	2.8	0.8	1.2	0.4	19,285	10.7	1,661	1,265	176	4,854	517	136	16.1	630	29.9
Wilson	68,724	0.6	29.1	7.5	3.6	31.6	7.2	12.4	5.9	17.5	6.9	1.3	21.9	6.9	10.1	2.6	21,120	16.1	2,083	1,795	129	3,273	231	112	24.2	717	26.0
Yadkin	35,199	2.2	46.5	11.8	5.9	49.2	11.4	19.3	9.0	2.1	0.6	0.2	2.2	0.6	0.9	0.4	19,162	9.7	3,200	2,078	311	5,028	732	122	12.4	445	28.3
Yancey	16,349	0.8	47.9	11.5	7.4	51.0	10.8	18.9	10.8	0.6	0.2	0.1	0.5	0.2	0.2	0.1	15,719	14.8	1,362	1,024	260	4,087	—	118	19.3	661	31.7

[1]A dash (—) indicates county had no resource of the type stated. Practitioners are by county of practice October 1997. [2]Active federal and nonfederal physicians in general or family practice, internal medicine, pediatrics, and obstetrics/gynecology. Physicians providing very little direct patient care are excluded. [3]Physician extenders are nurse practitioners and physician assistants, each weighted as .66 of a physician and added to the number of primary care physicians. [4]Active federal and nonfederal. [5]Short-stay nonfederal general hospital beds in use in 1995. Estimated military is excluded from the population of Cumberland, Onslow, Craven, and Wayne counties. [6]Based on county of residence. Rates are per 1,000 population, excluding estimated military (see note 5). Numerators are 1997 discharges from nonfederal hospitals located in N.C. Normal newborn babies are excluded. Only N.C. residents served in N.C. hospitals are included. Counties with a large percentage of patients leaving N.C. for hospital care are: Camden, Caswell, Clay, Currituck, Dare, and Gates. [7]State fiscal year 1996-1997 data. [8]Children ages 0-4 using one of the following public health department services in calendar year 1997: child health, child service coordination, or children's special health services. Visits for immunization only are not included.

ATTACHMENT 9

Table 1

Demographic, Social, and Economic Indicators

	United States	North Carolina	Number of States Higher
[redacted] Population, 1996 (millions)	265.3	7.3	10
Annual Percent Increase 1986-1996	1.0	1.6	11
Percent of Total Population, 2000 Projection:			
White	82.1	75.2	41
Black	12.9	22.3	6
Hispanic[1]	11.4	1.6	37
Percent Under 5 Years of Age, 1996	7.3	7.0	18
Percent Ages 65 and Over, 1996	12.8	12.5	27
Pi[redacted] Percent Changes			
[redacted]000	10.4	17.3	13
2000-2010	8.4	10.0	15
Persons per Household, 1996	2.62	2.53	36
Pop. per Square Mile of Land, 1996	75.0	150.3	16
Metropolitan Population, 1994 (millions)[2]	207.7	4.7	12
Percent of Total	79.8	66.6	31
Annual Percent Increase Since 1990	1.2	1.9	13
Nonmetropolitan Pop., 1994 (millions)[2,3]	52.7	2.4	1
Percent of Total	20.2	33.4	18
Annual Percent Increase Since 1990	1.0	1.2	17
Per Capita Personal Income, 1996	$24,231	$22,010	31
Median Household Income, 1995	$34,076	$31,979	32
Percent of Persons below Poverty Level, 1995	13.8	12.6	18
Per Capita Federal Income Tax, 1994	$2,168	$1,849	30
Per Capita Total State Tax Collections, 1996[4]	$1,581	$1,623	15
Per Capita State Government General Revenue, 1995[5]	$2,817	$2,662	28
Per Capita State Government Debt Outstanding, 1995	$1,629	$631	46

[1]Persons of Hispanic origin may be of any race. [2]As defined by U.S. Office of Management and Budget. [3]Excludes New Jersey and District of Columbia. [4]Excludes District of Columbia. Includes sales and receipt taxes; fuel, beverage, and tobacco taxes; individual and corporate inc[redacted] taxes; motor vehicle and operators' licenses; and other state taxes. [5]From int[redacted]mmental (Federal and local government) and other sources, including taxes.

Table 2

Work, Farm, Home, and School Statistics

	United States	North Carolina	Number of States Higher
Civilian Labor Force, 1996 (millions)	133.9	3.8	9
Participation Rate[1]			
Males	74.9	76.1	23
Females	59.3	61.5	22
Percent Unemployed	5.4	4.3	37
Males	5.4	4.3	37
Females	5.4	4.5	36
Employees in Nonagricultural Establishments, 1996 (millions)[2]	119.6	3.6	9
Percent Employed in Manufacturing	15.3	23.8	1
Avg. Hourly Earnings of Manufacturing Production Workers, 1996	$12.78	$10.96	42
Annual Percent Increase Since 1990	3.0	4.1	0
Average Annual Pay, 1995[3]	$27,845	$24,402	29
Full-time Equivalent Employees of State/Local Government, 1995			
State Employees per 10,000 Population[4,5]	151	159	30
Local Gov. Employees per 10,000 Pop.[5]	385	389	18
Mo. payroll per State Employee (in October)[4,6]	$2,854	$2,570	24
Number of Farms, 1996 (thousands)[4]	2,063	58	13
Annual Percent Decrease Since 1990	0.6	1.1	15
Average Acreage per Farm, 1996[4]	469	159	41
Annual Percent Change Since 1990	0.3	0.3	21
Crop Value, 1996 (billions)[4,7]	$106.0	$2.5	15
Number of Households, 1996 (millions)	98.8	2.8	9
Annual Percent Increase Since 1990	1.2	1.8	13
New Privately Owned Single Family Housing Units Started, 1996 (thousands)	1,147.0	54.9	4
Public Elementary and Secondary Schools			
Per Capita Expenditures, 1996[8]	$1,100	$845	47
Average Expenditures per Pupil, 1996[9]	$6,103	$5,147	35
Average Salary of Classroom Teachers, 1996 (thousands)	$37.7	$30.4	41

[1]Persons 16 and older in the civilian labor force as a percent of civilian noninstitutional population. [2]Excludes proprietors, self-employed, farmworkers, unpaid family workers, domestic workers, and Armed Forces. [3]Workers covered by unemployment laws; excludes most agricultural workers on small farms, Armed Forces, elected officials, railroad, domestic, and self-employed individuals. [4]Excludes the District of Columbia. [5]Based on estimated population as of July 1, 1995. [6]Monthly earnings for full-time employees. [7]Excludes Alaska. [8]Based on estimated population, July 1, 1995. [9]In average daily attendance.

Table 3

Social, Welfare, and Health Data

	United States	North Carolina	Number of States Higher
Federal Food Stamp Program, Cost per Participant, 1996	$878	$873	15
National School Lunch Program, Cost per Participant, 1996	$175	$163	20
AFDC[1], Avg. Monthly Payment per Family, 1994	$382	$227	41
Average Weekly Unemployment Insurance Benefits, 1995	$187	$190	18
Average Monthly Social Security Benefit, 1995			
Retired Workers[2]	$720	$682	37
Disabled Workers	$682	$651	43
Widows and Widowers[3]	$680	$606	45
Public Aid (AFDC and SSI) Recipients as a Percent of Resident Population, 1994	7.7	7.2	16
Medicare Benefits, Amount per Enrollee, Calendar Year 1996	$5,117	$4,470	25
Medicaid Benefits, Amount per Recipient, Fiscal Year 1995	$3,405	$2,929	34
Per Capita Federal Aid to State and Local Governments, FY 1996	$858	$714	38
Per Capita State Government Expenditures, FY 1996 (estimated)[4]	$2,813	$2,485	37
Employment (FTE) in Health, 1995			
State Government (thousands)	160	2	26
Local Government (thousands)	209	14	4
Employment (FTE) in Hospitals, 1995			
State Government (thousands)	496	16	9
Local Government (thousands)	551	18	8
Hazardous Waste Sites on the Superfund Priorities List, 1996	1,245	23	16
Crime Rates per 100,000 Population, 1995[5]	5,278	5,640	15
Violent Crime[6]	685	646	19
State Parks and Recreation Areas, 1995 Acres per 1,000 Population	45	19	38

[1]Aid to Families with Dependent Children. [2]Excludes special benefits. [3]Nondisabled only. [4]Excludes Nevada and District of Columbia. [5]Offenses known to the police. [6]Murder (including non-negligent manslaughter), forcible rape, robbery, and aggravated assault.

Table 4

Pregnancy Outcome Statistics

(Data from State and National Reporting Systems)

	United States	North Carolina	Number of States Higher
Legal Induced Abortions 1995 (thousands)[1]	1,210.9	33.4	8
Live Births 1996 (thousands)[2,3]	3,891.5	104.5	10
White	3,093.1	73.8	9
Black	594.8	27.1	6
Hispanic[4]	701.3	5.4	16
Annual Percent Increase Since 1986	0.4	1.6	3
Number per 1,000 Population[2]	14.7	14.3	16
Number per 1,000 Women Ages 15-44[2]	65.3	62.9	22
Percent Minority Births	20.5	29.3	8
Percent Hispanic Births[4]	18.0	5.2	26
Percent 5 Pounds 8 Ounces or less[2]	7.4	8.7	6
White	6.3	6.8	12
Black[4]	13.0	13.9	8
Hispanic[4,5]	6.3	6.2	27
Percent 3 Pounds 4 Ounces or less[2]	1.4	1.8	4
White	1.1	1.2	4
Black[5]	3.0	3.3	3
Hispanic[4,5]	1.1	1.0	23
Percent Mothers Unmarried[2]	32.4	32.0	21
White	25.7	19.1	44
Black[5]	69.8	67.3	27
Hispanic[4,5]	40.7	35.7	31
Percent Late[6]/No Prenatal Care[2]	4.0	3.3	26
White	3.3	2.1	37
Black[5]	7.3	6.7	23
Hispanic[4,5]	6.7	7.4	18
Percent Prenatal Care Before Fourth Month[2]	81.9	83.5	22
W[redacted]	84.0	88.1	9
[redacted]	71.4	71.8	25
H[redacted]nic[4]	72.2	67.8	33
Percent by Cesarean Delivery[2]	20.7	21.1	14
White	20.6	21.1	15
Black[5]	21.7	21.4	20
Hispanic[4,5]	20.0	15.9	42
Teen Birth Rate, 1996[7]	54.4	63.5	10
Neonatal Deaths per 1,000 Live Births, 1996	4.8	6.1	3
Postneonatal Deaths per 1,000 Neonatal Su[redacted], 1996	2.6	3.1	8
Inf[redacted]ths per 1,000 Live Births, 1996	7.3	9.2	4

[1]As collected or estimated by the Centers for Disease Control. [2]Includes races other than White and Black. [3]White, Black, and Hispanic, where used, apply to Race or Hispanic origin of the mother. [4]Persons of Hispanic origin may be of any race. [5]U.S. data excludes certain states (usually 10 or less) with a small minority population. [6]Care beginning in 3rd trimester. [7]Births to mothers ages 15-19 per 1,000 females ages 15-19.

Table 5

Morbidity and Mortality Statistics

(Data from State and National Reporting Systems)

Morbidity Rates 1996[1]	United States	North Carolina	Number of States Higher
Reported Syphilis (all stages)[2]	20.0	36.4	6
Reported Gonorrhea (all sites)[2]	122.8	248.9	3
Verified Tuberculosis	8.0	7.6	16
Hepatitis A	11.7	2.8	42
Hepatitis B	4.0	4.6	14
AIDS	25.2	12.2	26

Age-adjusted Mortality Rates 1996[3]	United States	North Carolina
All Causes	491.6	529.2
Diseases of Heart	134.5	142.3
Cerebrovascular Disease	26.4	33.5
Atherosclerosis	2.2	2.0
Cancer	127.9	131.7
Diabetes Mellitus	13.6	15.0
Pneumonia/Influenza	12.8	14.6
Chronic Obstructive Pulmonary Disease	21.0	22.6
Chronic Liver Disease and Cirrhosis	7.5	7.4
Nephritis/Nephrosis	4.3	4.8
Motor Vehicle Unintentional Injuries	16.2	20.1
All Other Unintentional Injuries	14.2	15.6
Suicide	10.8	11.4
Homicide/Legal Intervention	8.5	9.5

Age-adjusted Mortality Rates 1996[3]	White Male		White Female		Minority Male		Minority Female	
	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.	U.S.	N.C.
All Causes	591.4	619.5	361.9	356.5	811.7	1017.2	481.4	546.8
Diseases of Heart	174.5	181.0	92.9	89.8	205.5	266.4	129.6	141.6
Cerebrovascular Disease	26.3	31.7	22.9	25.7	44.2	66.5	34.8	48.4
Atherosclerosis	2.6	2.2	1.9	1.6	2.2	2.6	1.9	2.5
Cancer	149.2	155.7	107.6	100.3	188.0	234.9	114.6	123.6
Diabetes Mellitus	13.7	13.0	10.7	9.6	23.8	32.2	25.0	31.7
Pneumonia/Influenza	15.2	18.3	10.1	11.0	22.0	27.3	11.6	10.6
Chronic Obstructive Pulmonary Disease	26.3	31.6	18.3	18.4	21.7	28.0	11.4	10.9
Chronic Liver Disease and Cirrhosis	10.5	9.2	4.4	4.1	12.0	15.6	5.3	6.6
Nephritis/Nephrosis	4.7	5.2	3.1	2.6	9.5	12.3	7.3	8.7
Motor Vehicle Unintentional Injuries	22.2	25.6	10.4	12.4	23.1	35.2	9.5	14.3
All Other Unintentional Injuries	20.2	21.4	7.2	7.4	26.2	33.5	9.6	10.4
Suicide	19.1	20.7	4.4	5.4	11.5	11.5	2.5	1.3
Homicide/Legal Intervention	7.3	7.7	2.5	2.6	40.7	37.3	8.2	9.4

[1]Cases per 100,000 population. Cases are from the Centers for Disease Control. [2]Cases updated through June 13, 1997. [3]Deaths per 100,000 population using 10-year age groups and U.S. 1940 population as standard for direct age adjustment.

Table 6

Health Care Resources Data

	United States	North Carolina	Number of States Higher
Health Manpower			
Nonfederal Physicians per 100,000 Civilian Population, 1995	236	214	21
Nurses per 100,000 Civilian Population, 1995	809	820	23
Community Hospitals			
Number of Hospitals, 1995	5,194	119	15
Number of Beds, 1995 (thousands)	872.7	22.7	10
Average Cost to Hospital per Patient per Day, 1995	$968	$832	33
Average Cost to Hospital per Patient per Stay, 1995	$6,216	$5,631	28
Nursing Homes[1]			
Number of Nursing Homes, 1996	17,208	400	16
Number of Beds	1,839,686	39,482	16
Percent of Beds Occupied	82.7	93.8	4
Insurance			
Number of Persons without Health Care Coverage 1996 (thousands)[2]	41,716	1,160	8
Percent of Population, 1996	15.6	16.0	15
Number of Persons Enrolled in HMOs, 1997[3]	66,801	1,070	19
Percent of Population in HMOs, 1997	25.2	14.6	31
Medicare and Medicaid[4]			
Number of Persons Enrolled in Medicare (thousands), 1995	36,789	1,025	9
Benefit Paid per Enrollee, 1995	$4,750	$3,943	34
Number of Medicaid Recipients (thousands), 1996	36,118	1,130	10
Benefit Paid per Recipient	$3,369	$3,255	28
Medicaid Recipients per 100 Persons below Poverty Level, 1995-96	99	126	6

[1]Data are based on a census of certified nursing facilities. [2]Data are based on household interviews of the civilian noninstitutionalized population. [3]Data based on a census of health maintenance organizations. [4]Data are compiled by the Health Care Financing Administration.

Table 8
SELECTED HEALTH INDICATORS – 1997

Resident Data	Pregnancy, Total: Birth Rate[1]	Abortion Rate[2]	Pregnancy Rate[3]	Percent of Live Births: Minority[4]	Low Weight[5]	Late or No Care[6]	Mother Smoked	C-Section[7]	Pregnancy, Females 15-19: Birth Rate[1]	Abortion Rate[2]	Pregnancy Rate[3]	Percent of Live Births: Minority[4]	Low Weight[5]	Late or No Care[6]	Mother Smoked	C-Section[7]	1996 Percent of Births To: Medicaid Mothers[8]	Health Department Mothers[9]	WIC Mothers[10]
North Carolina	63.9	17.1	81.5	29.1	8.8	16.0	15.1	21.4	62.3	22.5	85.5	43.2	10.6	30.3	18.6	14.5	44.4	20.8	42.5
Alamance	67.5	21.0	89.6	23.2	9.3	17.2	16.7	21.5	67.1	32.0	101.3	34.4	12.4	37.8	19.1	14.9	47.5	24.8	39.2
Alexander	65.2	8.0	72.0	6.9	8.6	16.2	20.4	22.9	58.0	6.4	65.5	9.3	14.8	31.5	29.6	14.8	42.5	14.1	40.2
Alleghany	57.9	7.5	66.6	1.0	6.0	12.0	23.0	19.0	49.6	20.7	74.4	0.0	16.7	0.0	50.0	16.7	63.0	29.3	51.1
Anson	66.2	10.3	77.4	62.4	11.9	18.5	18.5	20.3	98.0	17.4	115.4	82.2	12.3	30.1	13.7	12.3	67.8	37.3	59.8
Ashe	57.3	3.9	61.9	0.4	8.8	14.6	23.4	23.8	72.6	6.3	78.9	0.0	13.0	30.4	21.7	17.4	58.4	16.0	57.6
Avery	55.6	7.3	63.9	0.0	9.2	16.7	21.3	25.3	41.7	5.0	46.7	0.0	20.0	32.0	28.0	24.0	58.1	14.2	51.6
Beaufort	62.2	11.0	74.0	35.1	8.9	16.6	18.4	22.6	78.6	18.1	96.7	51.9	8.7	22.1	18.3	12.5	60.1	32.8	53.1
Bertie	60.2	9.0	69.4	77.7	12.3	16.0	6.3	17.8	104.7	11.2	115.9	89.3	17.3	34.7	1.3	8.0	64.5	25.6	67.2
Bladen	72.8	12.5	85.9	45.6	10.0	24.3	19.3	24.7	77.8	17.6	95.4	57.3	9.3	44.0	10.7	10.7	71.0	38.3	62.9
Brunswick	58.6	11.9	70.6	16.0	8.7	18.0	28.3	26.9	78.2	16.8	95.0	22.2	11.1	28.9	34.8	22.2	65.4	36.5	52.1
Buncombe	56.4	18.3	75.2	10.6	8.2	7.5	18.9	17.7	57.5	27.4	85.2	17.9	11.8	15.0	26.8	12.5	51.1	28.9	43.1
Burke	61.5	12.2	74.3	14.6	10.1	21.7	23.7	22.2	91.3	20.7	113.7	22.3	10.0	33.6	29.1	13.2	51.6	40.0	48.1
Cabarrus	66.6	12.8	79.9	16.2	8.6	17.2	14.2	21.6	63.8	16.7	80.5	32.7	8.8	35.8	19.9	10.6	34.2	17.3	31.6
Caldwell	59.8	6.1	66.3	7.6	7.5	11.5	24.6	23.6	79.7	7.5	87.7	11.2	10.7	17.2	31.4	14.8	48.7	27.2	45.9
Camden	25.2	6.5	31.7	25.8	3.2	25.8	12.9	16.1	30.5	6.1	36.6	40.0	0.0	20.0	20.0	40.0	43.6	32.7	45.5
Carteret	50.3	9.8	60.3	10.5	7.8	12.0	20.9	25.6	41.7	13.7	55.4	17.8	15.1	26.0	24.7	16.4	45.1	5.6	42.3
Caswell	56.0	12.4	69.5	29.8	8.9	12.1	23.0	25.0	53.4	22.4	77.6	48.4	16.1	38.7	22.6	25.8	51.5	13.1	45.1
Catawba	63.6	10.4	74.4	15.7	9.0	18.0	18.0	21.5	71.5	14.0	86.0	28.1	8.5	31.7	26.7	8.9	47.1	34.5	41.1
Chatham	62.7	15.0	78.2	17.0	7.8	11.1	11.5	24.6	53.2	44.2	98.3	33.9	10.2	25.4	15.3	11.9	38.3	13.6	31.3
Cherokee	66.8	12.3	79.3	2.9	4.3	11.2	28.4	20.5	100.5	16.5	117.0	1.6	8.2	24.6	41.0	11.5	61.3	9.2	60.8
Chowan	75.2	5.9	81.8	43.4	6.3	22.4	10.7	27.8	90.7	14.3	105.0	76.3	7.9	26.3	2.6	15.8	50.5	40.9	58.2
Clay	50.1	4.6	54.6	0.0	3.9	9.1	24.7	19.5	50.7	9.2	59.9	0.0	9.1	9.1	9.1	27.3	49.1	3.8	54.7
Cleveland	66.4	8.7	75.7	27.0	9.2	21.5	19.3	21.2	81.7	12.5	95.3	39.9	9.6	32.5	21.9	16.2	53.6	45.1	51.0
Columbus	70.5	13.4	84.4	40.2	10.3	27.7	18.6	21.3	87.0	26.7	114.8	49.0	8.5	37.9	11.8	15.0	56.5	47.1	60.1
Craven	82.8	16.5	99.3	28.6	7.9	19.4	11.9	26.0	78.4	25.2	103.7	42.8	9.3	33.9	9.7	20.3	39.0	13.8	54.8
Cumberland	80.3	23.6	104.5	39.3	9.2	14.0	13.2	17.1	71.7	27.0	99.3	52.9	11.9	29.3	13.5	10.2	32.7	9.9	44.3
Currituck	45.2	7.9	53.2	8.1	6.9	21.2	19.4	19.4	55.2	9.9	65.1	14.3	7.1	35.7	42.9	17.9	46.8	11.3	13.4
Dare	48.5	10.6	59.3	4.6	6.0	16.2	15.2	24.2	39.6	5.5	46.4	17.2	10.3	44.8	17.2	17.2	42.2	17.7	23.4
Davidson	57.6	11.8	69.9	13.1	7.9	14.1	22.2	22.4	70.5	24.6	95.7	19.3	6.9	22.9	33.5	13.5	47.0	21.2	45.9
Davie	60.4	11.4	72.5	9.2	7.6	10.7	20.2	22.0	64.7	27.9	93.9	15.7	9.8	21.6	33.3	19.6	37.4	15.1	37.1
Duplin	84.1	12.4	96.6	31.9	8.2	21.7	12.1	24.2	102.0	22.5	124.5	37.5	11.0	30.9	11.0	19.1	68.4	20.5	60.5
Durham	63.0	29.7	93.4	51.1	10.6	13.6	8.4	21.2	52.5	35.7	89.0	69.5	14.0	29.1	6.7	15.4	38.4	13.0	32.2
Edgecombe	63.5	16.6	81.2	61.1	12.0	29.4	13.7	20.9	102.3	18.7	122.1	74.6	14.7	40.1	10.2	11.7	76.0	56.1	65.3
Forsyth	64.1	20.3	84.7	30.3	10.3	11.5	15.5	19.1	56.6	27.7	84.3	43.8	10.9	20.2	19.2	12.8	40.2	4.0	36.9
Franklin	58.2	14.2	73.3	34.7	9.2	18.4	11.3	22.4	45.0	19.5	65.9	49.3	9.0	32.8	7.5	10.4	50.5	33.3	43.5
Gaston	66.3	12.3	79.0	19.2	8.7	13.8	21.3	20.9	82.6	19.4	102.6	26.7	9.4	20.6	25.8	14.8	43.6	34.5	43.1
Gates	58.3	6.8	65.1	44.2	6.7	10.8	10.0	18.3	50.4	14.4	64.7	78.6	14.3	28.6	14.3	14.3	48.2	2.4	30.1
Graham	69.0	4.4	74.1	8.4	7.4	12.6	23.2	17.9	88.4	0.0	88.4	15.8	0.0	10.5	15.8	15.8	69.0	27.4	78.6
Granville	60.7	22.5	83.7	39.0	10.5	17.1	15.1	22.2	63.1	41.5	105.5	53.9	6.6	27.6	14.5	19.7	50.1	24.5	46.0
Greene	65.2	15.7	80.9	49.4	9.0	20.6	11.2	21.9	79.0	32.8	111.8	75.6	2.4	34.1	12.2	14.6	63.0	40.4	58.7
Guilford	58.6	23.5	82.7	38.4	8.7	13.7	12.9	21.7	46.1	28.9	75.7	57.9	10.1	27.1	18.2	13.6	40.1	16.5	34.0
Halifax	64.9	14.1	80.0	66.0	11.4	18.9	13.9	23.3	91.4	19.7	112.7	77.9	12.8	26.2	8.1	14.5	74.7	23.3	65.7
Harnett	73.7	15.5	89.6	26.5	8.2	21.7	17.9	22.6	68.5	19.7	88.5	39.2	12.9	43.1	23.4	15.3	43.3	2.1	45.8
Haywood	59.1	10.5	69.9	2.0	9.2	9.4	26.5	19.6	76.7	17.3	94.9	2.2	6.5	21.5	41.9	9.7	56.9	11.0	52.6
Henderson	65.3	11.2	76.7	6.1	8.1	9.0	22.3	23.7	55.4	18.8	74.2	8.7	10.7	18.4	36.9	26.2	52.3	26.7	45.0
Hertford	50.1	10.8	61.4	75.1	10.8	18.3	4.6	18.3	60.8	20.7	82.7	81.1	15.1	32.1	5.7	9.4	59.4	5.7	62.6
Hoke	83.9	17.7	102.2	47.5	8.5	16.0	12.1	14.5	111.1	11.0	125.1	65.8	11.7	24.3	6.3	7.2	48.8	23.2	57.2
Hyde	40.7	11.4	53.0	41.9	14.0	23.3	7.0	23.3	14.3	14.3	28.6	50.0	0.0	50.0	0.0	50.0	57.9	33.3	47.4
Iredell	67.3	11.6	79.2	17.4	8.4	19.9	17.2	21.8	70.0	15.5	85.5	35.6	9.9	43.2	25.2	10.8	42.6	10.1	37.5
Jackson	46.7	9.0	56.4	18.9	4.2	13.8	21.2	21.2	42.8	8.0	52.1	26.6	3.1	23.4	31.3	10.9	67.6	12.3	60.4
Johnston	75.6	15.8	91.9	19.1	7.4	20.6	12.4	24.0	83.2	25.5	109.3	31.0	9.3	38.7	19.0	17.3	40.7	19.8	35.0
Jones	48.0	11.9	61.9	36.6	12.9	28.0	14.0	39.8	43.2	25.2	71.9	58.3	16.7	41.7	16.7	33.3	67.6	32.4	70.6
Lee	72.9	18.7	92.3	25.9	7.8	22.6	15.4	22.4	82.5	21.8	105.6	33.3	7.0	40.3	14.7	14.7	56.1	17.5	50.6
Lenoir	62.9	20.6	84.3	49.5	11.6	27.9	16.6	25.6	87.8	35.7	124.6	71.3	13.1	36.9	9.4	11.9	61.3	29.9	57.2
Lincoln	62.4	9.7	72.5	7.1	7.0	15.7	18.8	25.0	61.9	13.4	75.9	14.4	11.7	36.0	21.6	18.0	45.1	13.8	39.2
McDowell	60.2	5.2	65.9	7.6	10.9	10.5	28.3	18.1	70.1	5.5	75.6	7.9	14.5	14.5	38.2	9.2	61.0	34.2	53.2
Macon	62.5	10.0	72.7	1.0	8.3	9.0	20.4	18.0	77.5	17.4	96.5	0.0	8.2	14.3	32.7	14.3	62.3	24.9	55.5
Madison	59.3	7.8	67.4	1.4	7.7	5.4	31.2	20.4	57.5	7.8	66.8	0.0	0.0	8.1	37.8	8.1	48.4	31.3	54.4
Martin	62.1	8.0	70.6	53.0	11.7	18.3	13.5	29.0	66.3	15.7	83.1	67.3	3.6	38.2	18.2	16.4	60.9	59.5	62.9
Mecklenburg	63.6	24.5	88.7	35.9	9.0	11.9	9.7	20.3	48.4	27.3	76.2	65.3	12.9	30.7	13.4	13.7	29.2	11.1	28.4
Mitchell	54.4	6.8	62.5	0.0	7.2	10.5	28.1	19.6	71.1	10.5	81.6	0.0	14.8	25.9	33.3	22.2	55.2	19.6	54.5
Montgomery	84.2	13.1	98.3	26.4	9.1	29.3	13.1	28.3	98.8	10.6	110.8	36.0	12.0	42.7	16.0	18.7	67.0	23.5	58.7
Moore	68.5	16.9	85.9	25.2	8.0	23.5	14.8	24.1	76.1	20.4	96.5	41.3	10.1	42.0	13.8	21.7	58.0	25.0	45.3
Nash	58.7	18.0	77.3	40.6	9.4	24.7	14.6	17.5	63.5	32.3	96.5	58.5	8.7	38.8	12.0	11.5	50.3	26.2	43.6
New Hanover	54.6	25.0	79.8	26.0	9.0	16.3	16.4	22.3	42.1	35.4	78.1	51.1	14.2	36.1	21.5	13.7	46.0	28.7	40.3
Northampton	59.9	12.7	74.1	68.5	14.1	16.6	14.9	22.4	85.5	21.0	106.4	82.5	21.1	24.6	10.5	17.5	72.6	35.1	62.9
Onslow	105.1	20.9	126.5	20.7	6.9	9.8	13.4	16.6	95.6	23.7	120.0	26.4	9.4	16.6	15.7	11.5	20.6	19.2	52.5
Orange	36.9	18.1	55.2	23.9	6.7	9.5	10.6	22.5	17.5	18.9	36.6	38.2	5.6	30.3	19.1	19.1	30.2	7.9	26.0
Pamlico	50.9	12.8	63.7	27.0	11.3	24.3	17.4	29.6	57.4	24.2	81.6	52.6	15.8	47.4	5.3	15.8	73.3	10.0	62.5
Pasquotank	54.9	8.8	63.7	45.3	9.4	19.0	15.6	23.8	53.4	17.3	70.8	68.9	14.9	39.2	14.9	17.6	61.4	43.4	57.6
Pender	60.0	11.6	71.8	24.8	9.9	20.7	18.9	21.8	66.5	13.1	79.6	33.3	9.1	39.4	21.2	10.6	59.6	41.7	54.8
Perquimans	50.9	10.1	61.5	36.8	10.4	18.9	17.0	24.5	77.8	2.9	80.7	51.9	14.8	25.9	3.7	18.5	62.6	39.1	55.7
Person	59.5	18.1	78.6	32.8	10.0	15.1	18.4	23.0	72.6	24.2	96.8	38.1	11.6	33.3	17.4	5.8	48.4	24.3	49.8
Pitt	54.2	18.2	72.9	42.9	11.0	16.1	11.2	21.9	48.7	24.1	73.4	68.0	13.1	30.5	7.6	15.3	53.8	32.5	46.2
Polk	53.0	11.3	65.7	6.2	4.1	15.1	20.5	20.5	55.2	13.8	71.8	10.0	5.0	30.0	5.0	15.0	52.9	20.3	45.3
Randolph	65.0	10.9	76.3	6.6	7.3	14.4	19.0	23.8	66.5	17.7	84.2	4.3	9.0	27.0	21.5	16.3	47.2	16.1	41.4
Richmond	68.4	11.2	80.0	36.6	9.4	21.0	21.5	24.7	98.2	20.2	118.4	41.8	10.3	28.1	21.2	17.1	73.5	27.7	67.7
Robeson	77.5	13.3	91.6	70.3	10.5	35.9	23.5	26.7	101.7	12.2	115.0	72.6	7.5	41.0	22.2	23.8	72.3	21.6	64.8
Rockingham	56.9	13.1	70.8	26.4	11.1	15.1	22.1	21.8	59.5	19.0	80.5	35.3	14.0	22.7	22.0	22.7	54.2	1.9	45.8
Rowan	60.5	11.2	72.5	22.3	10.2	20.5	20.6	20.2	59.9	15.6	76.0	38.4	10.3	37.2	22.3	17.4	47.3	33.0	41.7
Rutherford	64.4	10.5	75.1	14.1	10.5	13.5	21.2	20.4	73.8	15.4	89.2	18.7	8.2	22.4	28.4	16.4	53.2	40.3	54.6
Sampson	72.1	15.7	88.8	35.6	9.0	28.2	13.7	28.7	81.6	26.5	108.7	48.0	10.1	42.6	8.8	26.4	62.4	24.5	58.0
Scotland	70.0	9.1	79.7	55.9	13.1	22.9	16.5	22.7	98.3	8.4	108.1	61.7	9.9	34.8	15.6	14.2	68.5	55.9	67.1
Stanly	60.8	8.6	69.7	17.4	10.4	15.4	17.0	26.8	55.8	10.6	86.9	27.0	11.0	24.0	13.0	20.0	51.4	29.9	48.9
Stokes	55.7	8.7	64.9	6.5	9.5	9.2	28.8	18.9	61.9	13.4	75.3	10.8	4.1	18.9	31.1	9.5	36.2	2.1	29.8
Surry	66.6	8.0	75.1	5.5	6.5	13.9	23.4	21.4	69.4	16.1	86.0	7.5	6.0	27.6	35.8	26.1	53.0	1.2	48.7
Swain	68.5	10.9	79.4	46.5	4.5	14.6	23.6	17.8	98.2	14.9	113.1	48.5	12.1	18.2	30.3	12.1	78.4	18.6	73.1
Transylvania	50.7	9.4	60.1	8.5	5.8	13.1	17.4	24.3	48.5	10.9	59.5	12.5	10.0	22.5	12.5	27.5	63.1	8.1	55.3
Tyrrell	51.8	7.6	61.9	34.1	4.9	22.0	19.5	26.8	30.1	7.5	37.6	25.0	0.0	50.0	0.0	25.0	66.7	52.8	72.2
Union	79.4	10.7	90.8	18.3	7.2	14.6	13.2	19.2	55.0	14.1	70.4	32.9	10.6	29.5	21.3	10.6	34.3	16.6	28.2
Vance	69.8	21.0	92.3	53.6	11.4	27.1	15.1	27.9	95.3	36.6	134.1	66.2	11.3	42.1	9.0	12.8	63.9	19.7	60.0
Wake	60.5	21.3	82.1	27.5	7.4	12.7	6.9	20.8	32.4	26.9	59.7	50.9	10.7	34.0	13.7	11.2	27.0	20.8	24.2
Warren	55.2	16.5	72.6	68.4	11.8	15.0	18.2	23.5	70.8	23.6	94.4	69.2	10.3	23.1	5.1	17.9	64.0	27.5	65.2
Washington	69.4	14.2	84.7	54.7	9.5	20.5	12.1	34.7	87.8	20.3	110.4	71.8	7.7	25.6	17.9	23.1	61.5	53.4	70.7
Watauga	30.6	13.2	43.9	2.3	5.5	7.8	11.0	31.0	12.6	14.1	26.7	3.1	3.1	15.6	18.8	15.6	43.9	26.8	41.8
Wayne	68.2	14.6	83.4	34.8	8.8	33.3	14.6	19.3	77.3	20.9	99.0	48.9	10.0	53.0	14.4	10.0	48.6	41.7	55.7
Wilkes	57.7	7.2	65.4	6.1	7.8	9.6	22.7	27.9	79.9	11.4	92.5	8.6	7.9	17.9	26.4	23.6	56.4	12.5	48.5
Wilson	68.0	17.2	86.2	49.0	8.7	19.3	12.0	18.8	84.8	21.7	108.6	68.6	12.6	30.9	9.2	8.2	61.2	20.5	49.9
Yadkin	60.2	12.9	73.7	4.0	9.6	7.9	23.1	17.9	69.0	9.7	88.7	6.3	14.3	20.6	30.2	15.9	44.4	24.8	37.4
Yancey	60.6	8.0	68.9	1.1	6.9	10.1	21.7	15.9	66.8	7.2	74.0	3.6	0.0	14.3	17.9	0.0	63.1	20.5	59.1

Resident Data	Perinatal and Infant Mortality 1993-1997[11]: Fetal Rate[12]	Neonatal Rate[13]	Postneonatal Rate[14]	Infant Rate[15]	Population-based Mortality Rates: Total[16]	Geriatric (ages 65+)[16]	Violent Causes[17]	Cause-Specific Death Rates[18]: Heart Disease	Cancer	Cerebrovascular Disease	Cancer Incidence Rates, 1995[19]: Total	Female Breast	Lung	Communicable Disease Rates[20]: Syphilis	Gonorrhea	AIDS	Hepatitis B	Chlamydia	Tuberculosis
North Carolina	8.3	6.7	3.0	9.6	8.9	50.5	6.2	259.2	203.9	70.2	455.8	142.5	69.2	3.0	22.7	1.1	0.4	23.0	0.6
Alamance	10.1	6.3	2.4	8.7	10.1	48.2	5.4	303.8	231.2	94.3	599.3	160.1	84.1	4.0	23.4	0.5	0.3	21.3	0.4
Alexander	8.7	5.1	3.1	8.2	8.4	47.5	7.4	257.4	177.0	61.1	457.4	99.0	46.4	0.0	2.6	0.0	0.3	6.8	0.0
Alleghany	13.5	0.0	0.0	0.0	11.5	45.1	8.3	289.2	247.9	82.6	748.6	200.7	62.4	0.0	1.0	0.0	0.0	2.1	0.0
Anson	14.3	5.8	3.5	9.3	11.9	51.8	12.2	402.4	268.3	113.2	453.3	189.4	42.0	4.6	44.9	3.8	0.0	49.0	0.0
Ashe	10.1	7.6	2.6	10.2	11.3	50.0	3.4	322.1	271.2	144.1	635.0	210.9	87.0	0.4	0.0	0.0	0.0	3.0	0.4
Avery	11.9	9.9	4.4	14.2	11.1	54.5	11.6	329.9	258.7	51.7	474.1	224.6	39.5	0.0	0.0	0.0	0.0	3.2	0.0
Beaufort	12.4	8.6	3.2	11.8	11.8	56.7	7.8	380.2	269.6	89.9	413.1	126.7	73.9	3.9	27.2	0.2	0.5	21.2	0.7
Bertie	9.9	7.1	2.2	9.3	13.0	64.8	7.4	301.3	355.6	54.3	503.9	143.0	87.2	4.0	29.6	3.5	0.0	31.1	1.5
Bladen	9.8	9.4	2.8	12.2	11.3	52.4	5.9	389.3	184.7	108.9	409.5	144.6	77.2	2.6	36.3	0.7	0.0	37.9	1.0
Brunswick	7.0	6.0	1.9	7.9	9.8	40.5	8.3	326.7	256.1	70.6	492.3	80.4	90.5	1.5	16.4	0.8	0.3	9.8	0.5
Buncombe	7.5	6.0	2.6	8.5	10.7	50.7	5.4	301.4	230.7	82.7	529.3	189.1	83.7	0.4	13.7	2.1	0.5	16.0	0.3
Burke	8.2	7.9	3.4	11.3	9.0	46.6	5.9	289.9	206.9	56.5	507.1	84.5	71.2	1.3	9.4	0.2	0.2	7.7	0.2
Cabarrus	6.7	4.2	1.5	5.7	8.6	49.9	4.5	270.4	207.7	68.7	467.7	151.5	63.4	0.6	14.8	0.5	0.3	13.4	0.5
Caldwell	8.3	5.4	4.4	9.8	9.5	49.1	6.0	314.5	219.5	74.9	488.3	128.0	65.1	0.5	7.8	0.1	0.4	7.9	0.1
Camden	13.7	13.9	3.5	17.4	9.7	48.8	9.5	190.2	317.1	47.6	459.2	96.5	79.2	1.6	17.4	1.6	0.0	3.2	0.0
Carteret	5.7	5.4	2.9	8.3	10.4	50.8	6.3	340.3	262.5	50.8	487.8	164.3	88.5	1.0	9.7	0.2	0.2	6.6	0.2
Caswell	9.9	11.6	1.7	13.3	9.9	43.6	5.0	285.6	281.1	58.9	491.3	209.7	84.2	1.4	10.9	0.0	0.0	16.8	0.0
Catawba	6.3	3.1	3.3	6.4	9.2	51.5	5.9	250.9	221.6	83.4	517.3	132.7	80.0	2.6	12.5	0.5	0.1	20.2	0.0
Chatham	6.4	6.8	3.6	10.4	9.5	45.3	7.3	257.0	212.7	84.2	426.4	144.4	62.9	1.6	18.6	0.2	0.4	15.5	0.2
Cherokee	7.9	3.2	4.8	8.0	11.6	45.2	9.4	330.1	267.7	89.2	504.0	159.1	73.3	0.9	0.9	0.0	0.4	1.8	0.0
Chowan	12.2	5.2	0.0	5.2	12.8	55.6	8.4	400.9	302.4	91.4	641.4	185.6	71.3	0.7	16.2	0.7	0.0	4.9	1.4
Clay	2.9	3.0	0.0	3.0	11.2	45.0	11.2	322.3	272.7	62.0	375.1	99.7	25.9	0.0	0.0	0.0	0.0	0.0	0.0
Cleveland	9.5	7.7	2.4	10.0	10.2	51.4	8.6	333.1	191.9	79.4	500.4	153.2	77.4	1.0	27.6	0.1	0.7	13.8	0.2
Columbus	9.6	9.2	3.8	13.0	11.0	55.7	11.2	410.1	211.8	80.9	409.6	99.0	74.1	3.9	26.0	2.1	0.4	21.4	1.0
Craven	5.6	4.4	3.0	7.4	8.5	50.5	4.7	260.0	203.4	56.5	440.5	150.2	75.7	1.8	25.2	1.0	0.1	17.4	0.3
Cumberland	7.5	7.6	3.1	10.7	6.0	49.8	6.0	163.9	138.9	34.2	274.1	80.4	59.5	6.0	35.1	1.0	0.2	38.5	0.7
Currituck	1.1	11.5	4.6	16.0	9.4	52.4	6.0	265.5	259.5	54.3	354.0	114.7	94.8	1.2	5.4	0.0	0.0	8.4	0.6
Dare	4.7	2.0	2.0	4.1	7.7	47.6	5.1	230.0	208.1	58.4	337.8	92.6	62.1	0.7	1.8	0.0	0.0	6.6	0.4
Davidson	6.8	4.6	3.4	8.0	9.0	51.6	4.6	282.0	211.5	76.9	440.0	136.8	73.9	1.1	10.1	0.4	0.3	12.5	0.4
Davie	10.2	8.0	1.7	9.7	9.8	48.9	6.4	349.4	224.4	60.9	615.4	145.2	80.7	0.0	5.1	0.3	0.0	13.8	0.0
Duplin	8.7	8.8	3.8	12.6	12.3	61.5	10.4	344.8	274.5	131.6	484.0	167.0	93.5	1.1	32.9	3.2	0.0	15.4	1.1
Durham	9.8	6.4	3.8	10.2	8.6	60.3	7.0	233.7	197.8	50.1	424.6	139.5	71.0	2.5	46.6	2.7	0.4	46.7	0.6
Edgecombe	13.2	7.7	3.7	11.4	10.7	59.5	7.0	301.5	250.9	90.3	559.8	125.4	93.3	7.8	80.7	2.9	1.6	42.6	1.8
Forsyth	6.4	9.3	3.8	13.0	9.0	50.8	4.8	250.4	207.5	74.2	566.3	209.7	71.1	6.5	31.4	1.4	0.8	40.7	0.7
Franklin	8.4	8.1	1.1	9.3	9.1	52.1	8.0	243.8	202.4	101.2	408.2	92.3	52.8	0.7	16.6	0.0	0.0	20.7	0.2
Gaston	9.6	6.4	2.5	8.9	9.7	53.6	6.6	296.5	237.1	52.2	474.1	112.5	85.2	2.0	17.3	1.2	0.2	24.4	0.2
Gates	5.5	3.7	1.9	5.6	13.0	70.9	8.1	524.5	292.5	90.8	377.6	100.6	30.6	6.1	10.1	0.0	0.0	8.1	1.0
Graham	4.3	2.2	0.0	2.2	13.6	55.9	9.3	493.1	306.5	80.0	589.3	159.7	80.4	0.0	0.0	0.0	0.0	9.3	1.3
Granville	9.6	6.7	6.0	12.6	8.9	48.4	7.0	271.0	158.9	77.1	452.2	130.0	75.4	0.5	33.6	1.2	0.0	17.3	0.7
Greene	10.6	11.7	5.9	17.6	8.8	47.6	8.5	226.6	232.3	90.6	428.7	180.5	83.4	2.8	23.8	5.7	0.6	46.5	1.7
Guilford	9.0	7.3	2.8	10.0	8.7	50.3	6.3	221.3	210.6	74.4	499.9	151.9	79.0	7.9	34.4	0.7	0.4	40.3	0.5
Halifax	10.9	12.3	3.0	15.2	11.5	56.8	7.9	390.4	266.8	82.4	468.1	125.3	87.0	3.0	38.0	2.9	0.4	35.6	2.1
Harnett	7.8	6.9	2.5	9.4	8.4	47.0	8.8	240.9	202.8	76.2	383.3	118.6	63.7	7.1	17.8	0.4	0.7	13.2	1.5
Haywood	8.8	4.5	3.7	8.2	11.7	44.2	5.9	409.6	259.4	68.3	498.5	198.2	76.1	0.2	2.5	0.4	0.2	8.4	0.4
Henderson	6.6	6.9	1.7	8.6	12.8	45.6	6.7	391.7	289.3	107.4	772.5	218.2	101.0	0.4	5.3	1.6	0.0	9.9	0.1
Hertford	8.1	15.7	0.0	15.7	11.3	52.1	3.2	333.1	264.6	109.5	471.8	123.2	80.1	1.4	11.9	2.3	1.4	10.5	0.0
Hoke	9.5	6.4	5.6	12.0	6.9	45.6	7.6	169.7	148.9	24.2	256.1	58.8	40.2	3.8	22.9	1.4	0.7	25.6	1.7
Hyde	7.1	7.1	3.6	10.7	13.3	60.0	0.0	587.1	246.2	94.7	614.1	187.0	38.4	24.6	3.8	3.8	1.9	11.4	0.0
Iredell	6.2	6.4	3.8	10.1	9.0	46.1	6.8	274.6	193.1	76.0	573.2	157.5	87.0	3.8	11.4	0.5	0.3	16.3	0.1
Jackson	10.2	7.1	1.3	8.4	9.3	46.8	6.2	226.5	247.1	58.3	500.0	93.4	52.1	0.3	1.7	0.3	0.3	7.2	0.0
Johnston	6.7	6.5	2.3	8.7	8.5	48.5	6.7	265.6	195.8	72.7	501.0	152.6	83.9	2.3	15.4	0.9	0.5	13.7	1.2
Jones	18.7	1.9	9.5	11.4	11.0	56.2	5.6	289.3	322.7	122.4	673.5	217.7	168.4	1.1	12.2	0.0	0.0	6.7	2.2
Lee	6.2	8.5	4.3	12.7	9.1	46.7	7.6	262.6	227.4	53.8	489.0	105.1	58.7	4.8	26.9	0.4	0.6	16.1	0.6
Lenoir	10.3	9.0	4.7	13.7	11.7	54.8	7.5	372.6	237.1	110.1	589.0	183.2	111.7	6.3	45.7	3.6	0.0	40.3	1.0
Lincoln	7.7	5.9	3.5	9.4	8.5	49.4	6.4	310.9	171.0	65.6	415.5	131.3	81.0	0.0	7.4	0.3	0.0	10.9	0.3
McDowell	6.0	5.1	4.7	9.8	9.8	47.2	5.1	309.5	215.6	91.3	507.5	162.7	91.3	0.8	8.4	1.5	0.3	6.6	0.0
Macon	4.5	6.8	3.8	10.5	14.1	49.3	8.0	422.9	325.3	75.9	578.3	196.8	79.9	0.7	1.1	0.0	0.0	2.5	0.0
Madison	5.8	8.8	2.0	10.8	11.1	49.2	5.5	349.2	223.7	60.0	506.2	200.2	78.8	0.0	1.6	1.6	0.5	6.5	0.0
Martin	11.6	7.4	2.5	9.9	10.2	50.0	2.3	331.7	214.6	50.7	441.1	124.1	81.3	2.3	32.0	2.3	0.4	35.1	1.2
Mecklenburg	8.3	5.2	2.4	7.6	6.8	49.7	4.8	188.6	153.5	44.4	406.4	158.2	50.4	2.7	28.7	1.2	0.5	24.1	1.4
Mitchell	7.5	5.1	2.5	7.6	14.7	61.0	3.4	516.0	244.4	129.0	444.8	206.4	53.9	0.0	0.0	0.0	0.0	3.4	0.0
Montgomery	11.8	6.0	4.4	10.3	9.4	49.3	6.1	302.4	224.7	85.4	608.5	197.4	104.9	3.7	18.0	0.4	0.8	17.6	0.0
Moore	9.4	7.8	2.5	10.3	11.4	39.2	7.1	341.0	297.8	120.9	670.6	183.0	102.0	1.9	10.1	0.0	0.3	14.7	0.6
Nash	10.3	8.9	3.4	12.3	9.0	50.9	5.3	256.0	205.5	75.8	521.6	138.5	67.9	3.8	34.9	0.9	1.1	31.0	0.6
New Hanover	8.2	4.2	2.7	6.9	8.7	47.5	5.4	257.2	207.4	78.4	440.6	138.7	65.2	0.4	26.7	2.3	0.3	21.4	0.9
Northampton	13.6	13.1	2.3	15.4	13.7	53.2	9.6	370.2	360.6	158.7	530.7	176.5	48.3	2.9	29.3	3.8	0.5	26.0	1.0
Onslow	5.7	6.3	2.2	8.6	4.7	54.2	4.9	123.5	110.6	32.6	236.6	77.3	49.4	0.6	21.6	0.5	0.0	35.5	0.4
Orange	5.8	6.6	1.4	8.0	5.7	45.7	3.8	141.7	144.5	46.6	391.2	150.6	47.3	2.1	9.1	0.3	0.0	18.8	0.3
Pamlico	5.2	8.8	0.0	8.8	12.8	54.9	10.0	359.1	325.7	66.8	556.1	161.6	101.1	2.5	10.9	0.0	0.0	14.2	0.0
Pasquotank	3.7	12.9	2.3	15.2	9.8	52.1	4.6	278.1	231.8	92.7	351.5	129.5	45.1	8.1	15.1	0.9	0.6	20.9	0.3
Pender	8.7	2.8	2.3	5.1	9.6	44.8	7.0	279.5	209.6	104.8	415.3	106.1	69.2	0.8	10.8	0.8	0.0	13.7	0.0
Perquimans	8.6	12.3	3.5	15.6	13.8	52.9	14.7	339.4	293.6	128.4	544.8	180.9	75.1	1.8	12.8	0.9	0.0	10.1	0.9
Person	9.3	9.4	2.8	12.2	10.5	53.3	7.0	328.1	243.0	97.2	494.7	113.4	102.7	0.3	15.2	0.3	0.0	16.1	0.0
Pitt	8.6	10.5	3.2	13.6	8.2	58.2	5.0	216.2	199.4	65.9	327.0	89.1	49.4	2.3	46.9	2.5	0.5	43.7	1.0
Polk	16.2	10.1	2.6	12.7	13.8	46.7	3.7	414.8	347.7	140.3	603.4	201.7	76.2	0.0	1.8	0.6	1.2	5.5	0.0
Randolph	6.8	3.9	2.9	6.7	8.5	48.3	6.6	260.8	210.6	60.9	390.3	105.1	63.2	1.1	15.6	0.1	0.8	9.7	0.2
Richmond	8.9	7.7	3.3	11.0	11.3	56.4	10.5	378.9	214.6	72.3	458.1	80.1	92.5	3.7	39.6	0.9	0.0	25.6	1.8
Robeson	9.9	8.2	4.0	12.1	9.9	57.4	10.5	299.9	187.2	78.1	369.4	83.6	74.8	8.3	39.1	1.2	0.5	37.6	0.8
Rockingham	10.5	7.4	3.0	10.4	10.8	53.1	6.7	279.3	272.6	112.2	532.1	155.3	92.8	1.1	14.2	0.7	0.0	12.0	0.1
Rowan	8.7	6.0	3.4	9.3	11.0	53.6	7.0	352.7	235.4	89.6	358.4	136.1	49.6	0.9	20.6	0.9	0.4	22.1	0.4
Rutherford	8.5	6.1	4.3	10.4	11.7	56.2	8.8	356.9	245.8	101.0	429.9	147.2	77.9	1.9	8.1	1.0	0.7	12.6	0.2
Sampson	12.4	6.1	3.5	9.6	10.9	52.6	10.8	275.4	262.1	115.9	439.4	112.9	77.2	5.3	19.6	1.3	0.2	8.9	1.3
Scotland	10.7	9.7	3.6	13.3	11.1	63.5	8.3	337.1	257.1	102.8	406.1	171.6	63.4	5.4	51.1	0.9	0.3	47.7	0.9
Stanly	6.1	4.9	3.8	8.7	10.5	54.8	7.3	342.8	237.6	108.8	511.3	133.0	61.4	5.1	8.3	0.4	0.4	6.5	0.5
Stokes	5.9	5.6	4.8	10.3	8.7	53.7	7.2	217.0	191.4	105.0	540.5	177.2	85.2	0.0	7.0	0.5	0.7	9.6	0.0
Surry	8.6	5.4	2.1	7.5	10.6	49.5	7.9	336.7	227.4	80.8	613.1	185.5	95.3	0.0	6.1	0.0	0.0	8.8	0.0
Swain	3.6	7.3	2.5	9.7	11.7	51.8	7.5	366.9	291.8	41.7	657.0	192.0	34.6	0.0	5.0	0.8	0.8	15.0	1.7
Transylvania	7.8	8.5	4.3	12.8	11.6	44.3	4.7	387.9	251.4	107.7	692.0	272.3	95.7	0.7	6.5	0.0	0.0	6.1	0.4
Tyrrell	10.3	10.4	0.0	10.4	13.3	58.6	8.2	299.6	354.0	54.5	524.7	201.4	26.2	0.0	0.0	2.7	0.0	5.4	2.7
Union	7.5	5.7	2.7	8.4	7.2	50.7	5.0	224.3	184.7	53.7	305.5	130.0	44.8	1.2	11.6	1.2	0.0	10.8	0.4
Vance	15.6	8.7	4.7	13.4	11.0	60.3	8.3	290.4	224.5	109.8	459.5	98.9	79.9	3.9	45.1	2.2	0.0	22.7	0.5
Wake	7.8	6.2	2.4	8.6	5.5	47.2	4.1	142.2	129.1	43.1	412.5	138.0	50.2	2.4	18.7	1.4	0.3	24.6	0.8
Warren	8.9	8.0	1.0	9.0	12.1	45.2	9.4	292.2	336.3	132.3	463.1	169.5	88.2	3.9	38.6	0.0	0.0	26.5	0.0
Washington	12.1	7.2	5.1	12.3	10.7	49.7	12.0	300.8	210.6	60.2	428.6	96.3	58.1	7.5	16.5	2.3	0.8	27.8	3.0
Watauga	9.4	4.5	4.5	8.9	6.4	42.2	3.4	186.0	168.9	80.8	403.7	141.0	49.8	0.0	1.7	0.0	0.0	7.1	0.0
Wayne	7.0	7.2	2.3	9.5	8.7	51.8	6.6	249.2	194.4	74.2	430.6	168.7	59.5	7.2	21.2	1.3	0.1	19.6	0.5
Wilkes	9.8	4.6	4.1	8.7	9.6	49.4	7.9	283.7	229.8	74.5	427.0	100.9	58.0	0.0	2.7	0.3	0.3	6.7	0.3
Wilson	15.4	9.3	3.2	12.5	10.5	53.3	9.2	273.6	216.8	85.9	443.7	181.8	60.4	12.1	70.4	1.5	0.6	47.6	2.3
Yadkin	5.0	7.3	1.8	9.1	8.9	43.3	7.7	233.0	181.8	79.5	525.7	132.7	86.1	0.9	7.1	0.0	0.9	6.8	0.0
Yancey	1.1	2.2	2.2	4.5	9.7	42.5	6.7	336.4	220.2	79.5	483.2	120.1	68.1	0.0	0.6	0.0	1.2	7.3	0.0

[1]Live births per 1,000 females 15-44 (15-19). [2]Legal induced abortions per 1,000 females 15-44 (15-19). [3]Pregnancies (reported abortions, fetal deaths, and live births) per 1,000 females 15-44 (15-19). [4]Based on race of mother. [5]5 lbs. 8 oz. or less. [6]Late care defined as first visit after third month. Information often based on maternal recall. [7]Includes primary and repeat C-section. [8]Measured by Medicaid payment for hospital stay of the newborn. [9]Percent receiving some prenatal care at a health department; percents for some counties may be low due to patients going to a public clinic not reporting data to the Health Services Information System. [10]Percent on WIC in prenatal period. [11]All rates are average for the 5-year period, 1993-97. [12]Stillbirths of 20+ weeks gestation per 1,000 deliveries (live births plus stillbirths). [13]Deaths under 28 days per 1,000 births. [14]Deaths 28 days to 1 year per 1,000 neonatal survivors (live births less neonatal deaths). [15]Deaths under 1 year per 1,000 live births. [16]Deaths per 1,000 population. [17]Deaths per 10,000 population; consists of homicides, suicides, unintentional injuries, legal interventions. [18]Deaths per 100,000 population. [19]1995 reported cases per 100,000 population. The female breast cancer rate uses the female population. These are unadjusted rates. Counties with an older population will generally have higher cancer incidence rates and higher death rates for chronic conditions. As a guide, refer to the percentages of the population ages 65+ in Table 7. [20]Cases per 10,000 population.

Trends in Infant Mortality and Low Birthweight in North Carolina

Infant mortality in North Carolina decreased from 12.4 infant deaths per 1,000 live births in 1987-88 to 9.2 in 1995-96, representing a decline of 26 percent. Large decreases in infant mortality were observed for both whites and minorities, though the minority infant mortality rate remains roughly two times the rate for whites (Figure 1). The decrease in overall infant mortality resulted from large reductions in every birthweight category, with the exception of births less than 500 grams, where the very high rate of death decreased by a only a small amount. The largest reductions in infant mortality, for both whites and minorities, were for deaths caused by respiratory conditions, SIDS, and birth defects.

While infant mortality declined in North Carolina, the risk of low birthweight (births less than 2,500 grams, or 5 lbs. 9 oz.) increased from 8.0 to 8.7 percent. Low-birthweight infants are 25 times more likely to die as babies of normal birthweight. The risk of low birthweight is about twice as high for minorities compared to whites (Figure 2).

Continued declines in infant mortality will be more difficult to achieve without a reduction in low birthweight. In 1988, North Carolina ranked next to last in the nation in infant mortality. As improvements were seen in the early 1990s, North Carolina's rank improved to about forty-third. However, in 1995, 1996, and 1997 the infant mortality rate for North Carolina remained the same (9.2), while the rate for the nation continued to decline. As a result, preliminary national data for 1997 indicate that North Carolina again had the second highest infant mortality rate in the nation. Reducing the disparity in low birthweight between whites and minorities will be a key to improving overall infant survival in the future.

Figure 1
Infant Death Rates by Race
North Carolina, 1987-1996

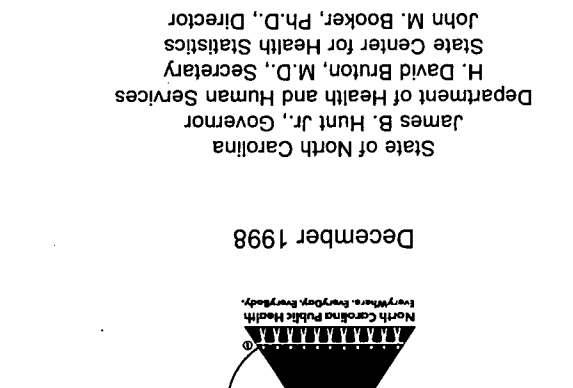
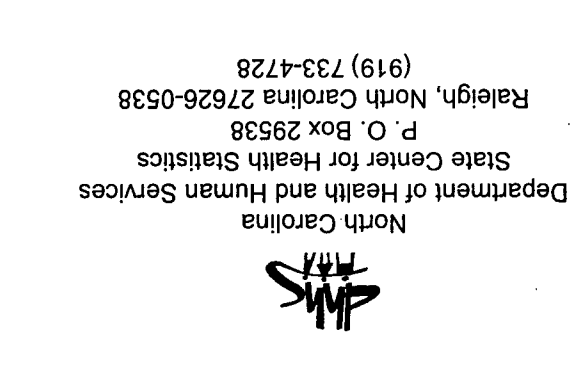


Figure 2
Percentage of Live Births Under 2500 Grams by Race
North Carolina, 1987-1996



Low birthweight is a multi-faceted problem and more than medical interventions are needed to improve it. Increased prenatal care participation and the reduction of teen pregnancies will help, but these are not a complete solution. In 1996, there were 9,128 low birthweight babies born to North Carolina women. Yet, for 78 percent of these low birthweight babies, the mother began prenatal care in the first trimester. The percentage of all mothers beginning prenatal care in the first trimester increased from 75 percent in 1988 to 83 percent in 1996, a period during which the percentage of low-weight births was increasing. Improved prenatal care participation is very important, but it is not the only answer to reducing low birthweight. Also, of the 9,128 low birthweight babies born in 1996, 81 percent were born to mothers age 20 and older. Teenage pregnancy is thus a comparatively small cause of low birthweight in North Carolina. Health interventions will be only part of the solution to this serious and difficult problem. Policies and programs designed to address aspects of the social and economic environment of families may help to reduce low birthweight.

Reductions in infant mortality for respiratory conditions, SIDS, and birth defects contributed significantly to the overall decline from 1987 to 1996. It is important that we build on the successes in these areas as a means of continuing the downward trend in infant mortality. There has been much less success in preventing preterm delivery, which is a major cause of low birthweight. Innovative strategies to reduce preterm delivery are needed if substantial progress is to be made in reducing low birthweight.

This report is excerpted from a special study of the State Center for Health Statistics titled "Infant Mortality and Low Birthweight in North Carolina: The Last 10 Years."

LIST OF TABLES

DATA SOURCES

References for the various data items are too numerous to list here but may be obtained from the State Center for Health Statistics. For the U.S. and N.C., comparisons in Tables 1-6 were largely abstracted or derived from the following: *Statistical Abstract of the United States 1997* (Bureau of the Census); *Health - United States 1998* (National Center for Health Statistics); *Monthly Vital Statistics Reports: Advance Report of Final Natality Statistics 1996* (National Center for Health Statistics); *Morbidity and Mortality Weekly Report*, Vol 45, No. 53, 1996 and Vol. 47, No. SS-2, 1998 (Centers for Disease Control). State and county population was provided by the State Data Center, Office of State Planning.

EXPLANATORY NOTES

In most cases, table headings and footnotes provide definitions for the reported statistics. Additional information needed for data clarification includes the following:

Number of States Higher: This figure is given wherever the statistic or the required numerators and denominators were available for states.

Percent Change: Increases and decreases are generally expressed in terms of average annual percentages computed as the total percentage change divided by the number of intervening years.

Place of Event: Except as otherwise noted, data are by place of residence.

Unadjusted Rates: None of the county-level rates of Table 8 have been adjusted for age. Thus, counties with an older population will generally have higher cancer incidence rates and higher death rates for chronic conditions. Also, the single year measures in Table 8 may be unstable due to small numbers of events.

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State Center for Health Statistics
P. O. Box 29538
Raleigh, North Carolina 27626-0538
(919) 733-4728

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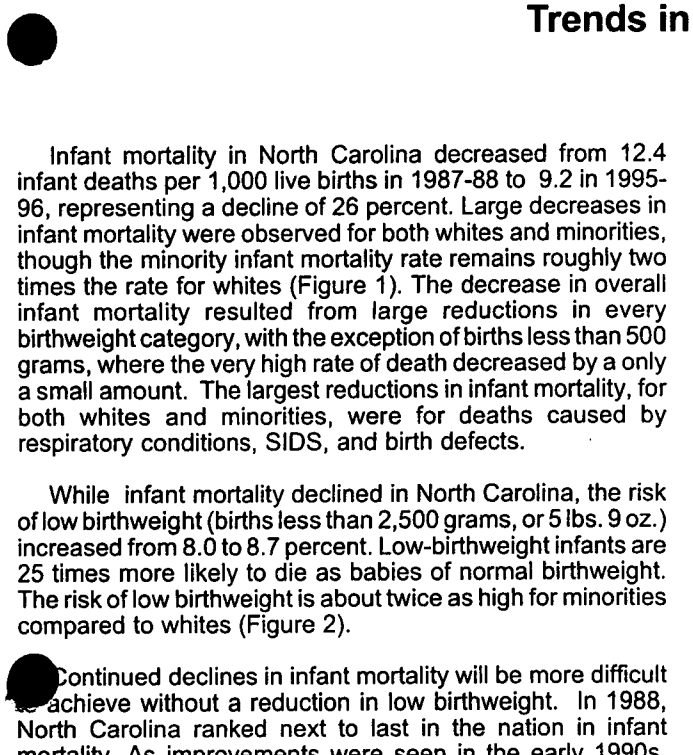

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HEALTH CARE COMMITTEE February 10, 1999

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Casey Berger	National Association of Social Workers NC
Myrna Mills NASW-NC	Nat'l Assoc. of Social Workers - NC Chapter
W H Potter	NCDS & NCPTA PO Box 1471 Raleigh, NC 27602
Steve Edwards	N.C. Red Soc.
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John Rose	NC FAMILY POLICY COUNCIL
Christina Medlin	Covenant w/ NC's Children
Paula A. Wolf	" " "

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HEALTH CARE COMMITTEE February 10, 1999

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Adam Searing	NCHAC
J Cain Stancil	PCMH
Buck Sutton	PCMH
Brenda Simmons	NC Equity
Joann Schaum	NCNA
Sandy Barker	NC Nurses Association
Ronald Penac	NCMA
Margaret Gregory King	N.C. Midwifery Alliance (NCMA)
Phyllis Payne	DCHS, State Hlth Dir's Office
Henry Jones	Attorney - Raleigh

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HEALTH CARE COMMITTEE February 10, 1999

Name of Committee **Date**

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Pam Walpe	nurse of the Day
Charles Boyette M.D.	Day Day
Jan Ramquist	NCSOS
Jane Milby	NCDMA
	AHHC
John Bowdish	Zeb Alley P.A
	DHHS
Jim Bernstein	DHHS
Don Lyons	DHHS
George Reed	NC Council of Churches

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HEALTH CARE COMMITTEE February 10, 1999

Name of Committee **Date**

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[signature]	Health Plans PO BOX 10373 Raleigh
Andrea Lee	North Carolina Family Policy Council Davie St.
Robert Paschal	Young, Moore & Henderson, P.A
[signature]	Granville Co Health Dept Oxford NC
[signature]	NCMS
Hugh Tilson	NCHA
Kathena P Kelly	NC Psychiatric Assoc
Evelyn Hawthorne	UNC-CH
[signature]	NCSBA
Walter Klausmeier	PPCC

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Tom Vitaglione	DWCH/DHHS
Patricia Garcia	APPCNC/SCSL
Barbara Matula	NCMS - Foundation
Becci Garland	Prevent Child Abuse
Paul Lamb	Lamb Consulting
HUGH TILSON	NCHA
Amy Fullbright	Hunton & Williams
Lynn B. Pace	UNC-CH
Mari Watts	GlaxoWellcome
Cat Bebrush	DHHS Communications

2

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SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, February 17, 1999**
TIME: **12:00 Noon**
ROOM: **1124, LB**

The following bills or resolutions will be considered:

- 90, Insurance/Cover Contraceptives

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, February 17, 1999 at 12:00 Noon

MINUTES

The Senate Committee on Health Care met on Wednesday, February 17, 1999 at 12:00 Noon in Room 1124 in the Legislative Building. Fifteen members attended, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Jackie Bennett from Durham, who was sponsored by Senator Basnight.

Senator Purcell announced that S.B. 65, Motor Vehicle Occupant Restraints, had been put off the Committee's calendar for today because a number of questions had been raised about it. He also announced that the Committee would discuss S.B. 90, Insurance/Cover Contraceptives, today, but that a vote would not be taken on it. Ms. Attarian had provided each member of the Committee with an explanation of this bill.

Senator Purcell asked Senator Forrester, sponsor of S.B. 90 to come forward and explain the bill to the Committee. After Senator Forrester's explanation, Senator Purcell called for questions from the Committee and those in attendance.

The following people spoke in favor of this bill:

Marvin Musselwhite, representing the North Carolina OB-GYN Society
Deborah Ross, representing the American Civil Liberties Union, and
Adam Searing, representing the North Carolina Health Access Coalition

The following spoke as having certain reservations or in opposition to this bill:

Perri Morgan, representing the Federation of Independent Business
John Rustin, representing the American Family Policy Council
Harry Kaplan, representing Kaiser Permanente, and
Ken Wright, representing Blue Cross/Blue Shield.

The meeting was adjourned at 12:47 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 90
Health Care Committee Substitute Adopted 3/3/99

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services.**

(a) Every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term care or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services."

Section 2. Effective January 1, 2000, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for ~~mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.~~

~~(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.~~

~~(a2) Notwithstanding G.S. 58-50-123(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage

required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. ~~This section shall be effective after July 10, 1991.~~"

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

EXPLANATION OF SENATE BILL 90
Insurance/Cover Contraception

To: Senate Health Care Committee
From: Linda Attarian, Committee Counsel
Date: February 16, 1999
Sponsor: Senator James Forrester

Brief Explanation:

Senate Bill 90 provides for equitable insurance coverage for prescription contraception. The proposed legislation requires health benefit plans that provide coverage for general prescription drugs, devices and outpatient services to provide coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services. The legislation does not require a health benefit plan to provide coverage for over-the-counter contraceptives.

Section by Section Explanation:

Whereas Clauses:

This section sets out the factual findings that provide a basis for why the legislation is proposed.

Section 1: General Provisions:

Section 1 of the bill amends Article 3 of Chapter 58, (titled "General Regulations of Insurance"), to add a new section (G.S. 58-3-174) to prohibit health benefit plans from excluding or restricting benefits for FDA-approved prescription contraceptive drugs or devices, if the plan provides benefits for other prescription drugs or devices. By including contraceptive devices, this provision ensures that a range of contraceptives will be covered, not just oral contraceptives. These plans must also include coverage for the insertion or removal of the contraceptive and any medically necessary examinations associated with the utilization of the contraceptive.

In addition, health benefit plans may not exclude or restrict benefits for outpatient contraceptive services, if the plan provides benefits for other outpatient services. The same deductibles, copayments, annual limits, and lifetime limits that apply to outpatient services under the policy must also apply to outpatient contraceptive benefits.

Definitions:

"Health benefit plan" and "Insurer": These terms are broadly defined in the bill to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

"Outpatient contraceptive services": Includes services necessary to utilize contraceptive methods to prevent pregnancy.

"Prescribed contraceptive drugs or devices": Includes all FDA-approved prescription contraceptive drugs and devices.

Other Prohibitions:

Section 1 of the bill also prohibits health benefit plans from (1) denying an individual coverage or refusing to renew coverage to an individual to avoid providing contraceptive coverage; (2) providing incentives to encourage individuals to accept less than the minimum protections required under this legislation; (3) penalizing or reducing the reimbursement of healthcare professionals because they prescribe contraceptives or provide contraceptive services; and from (4) providing incentives to health care providers to withhold contraceptive benefits otherwise required under this legislation.

Section 2: Coverage under the "Standard Health Plan". North Carolina law requires insurance companies to offer two types of guaranteed health plans to employers with less than 50 employees. One is a "standard plan" and the other is a "basic plan". Of the two, the standard plan has more benefits. Under this bill, the standard plan must comply with the contraceptive coverage requirement beginning on January 1, 2000.

Section 3: Contains a severability clause.

Section 4: Effective date: The bill is effective when it becomes law and applies to health benefit plans that are delivered, issued, or renewed on or after January 1, 2000.

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HEALTH CARE COMMITTEE — February 17, 1999

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[illegible] Hale	Insurance Department
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HEALTH CARE COMMITTEE — February 17, 1999

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	GPCSSA
Patricia A. Jones	ACLU/APRCNC
Barbara Matula	NCMS-F

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SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, February 24, 1999**
TIME: **12:00 Noon**
ROOM: **1124, LB**

Mr. James Bernstein, Office of Rural Health and Resource Development, Department of Health and Human Resources, will speak on the rural health needs of North Carolina, highlighting the Carolina Access program.

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, February 24, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, February 24, 1999, at 12:00 Noon in Room 1124 in the Legislative Building. Twelve members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Cory Carpenter from Sylva, who was sponsored by Senator Carpenter.

Senator Purcell announced that next week the Committee would discuss S.B. 160, Nurse Rehabilitation, and S.B. 90, Insurance/Cover Contraception. He introduced today's speaker, Mr. Jim Bernstein, founder and director of the Office of Rural Health and Resource Development, Department of Health and Human Resources. Senator Purcell also introduced Mr. Torlon Wade, Assistant Director.

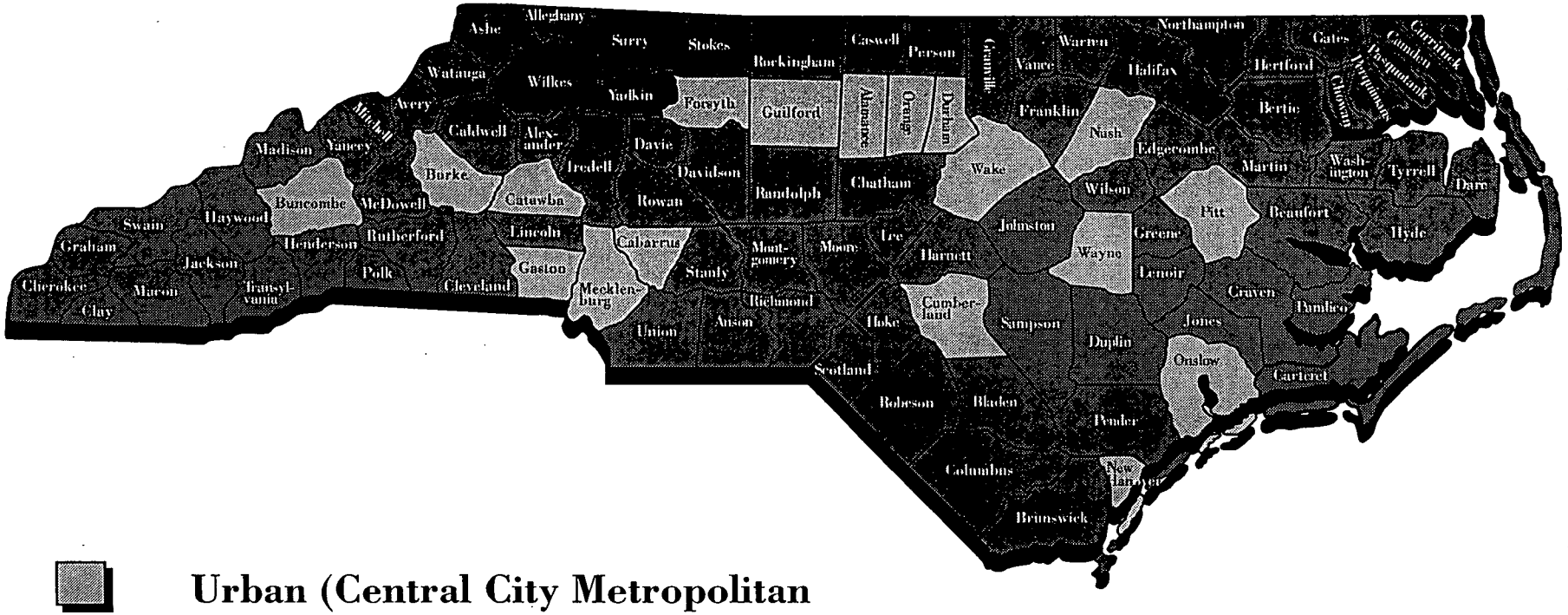
Mr. Bernstein gave Committee members a handout that outlined his slide presentation (Attachment 1). The presentation outlined problems, solutions, and anticipated solutions to rural population health problems. During his talk Mr. Bernstein suggested that some sort of general oversight committee for the state be established; that various health issues could then be addressed before they become problems. Mr. Bernstein provided additional handouts outlining statistics on rural access to health care (Attachments 2, 3, and 4).

Senator thanked Mr. Bernstein for his presentation and adjourned the meeting at 12:47 P.M.

William R. Purcell, Chair

Lorraine R. Blake, Committee Assistant

North Carolina's Rural/Urban County Breakouts



Urban (Central City Metropolitan Statistical Area) Counties 18

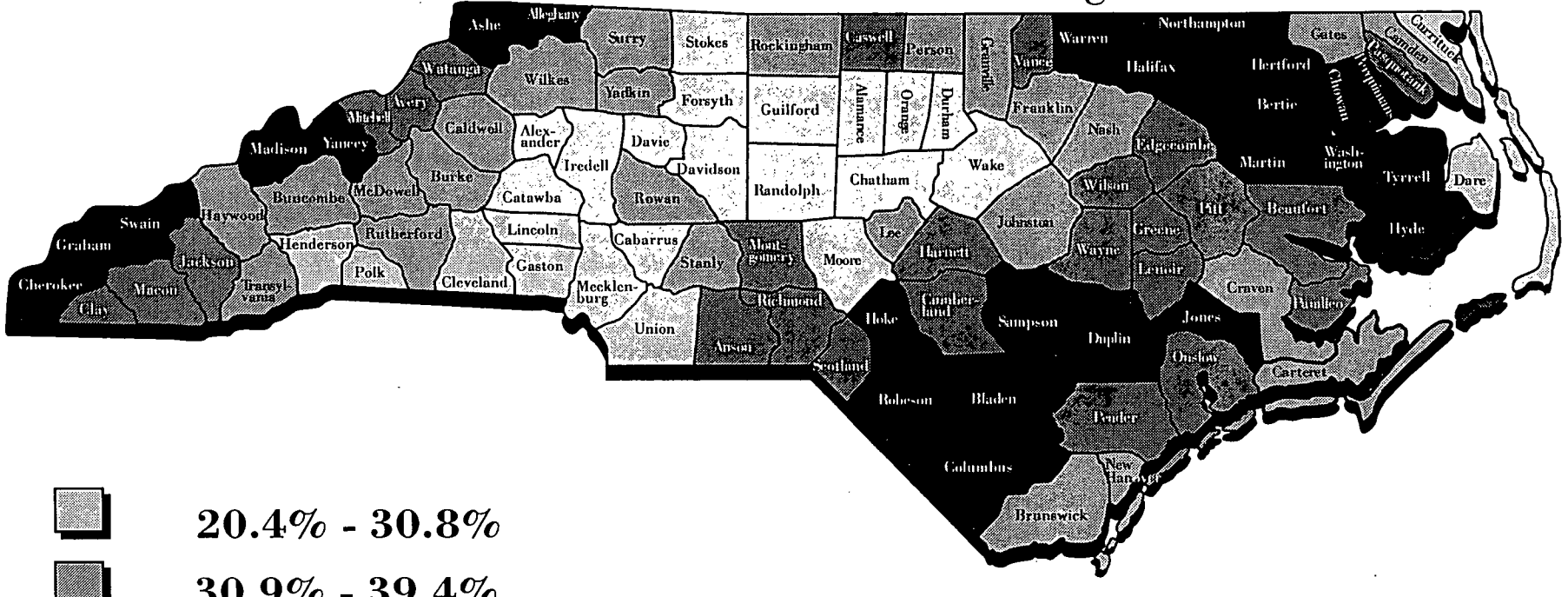
Rural Counties 82

ATTACHMENT 1.

North Carolina Office of Rural Health & Resource Development

Percent Below 200% of Poverty - North Carolina Counties 1990

Overall State Average = 33.3%



20.4% - 30.8%

30.9% - 39.4%

39.5% - 46.5%

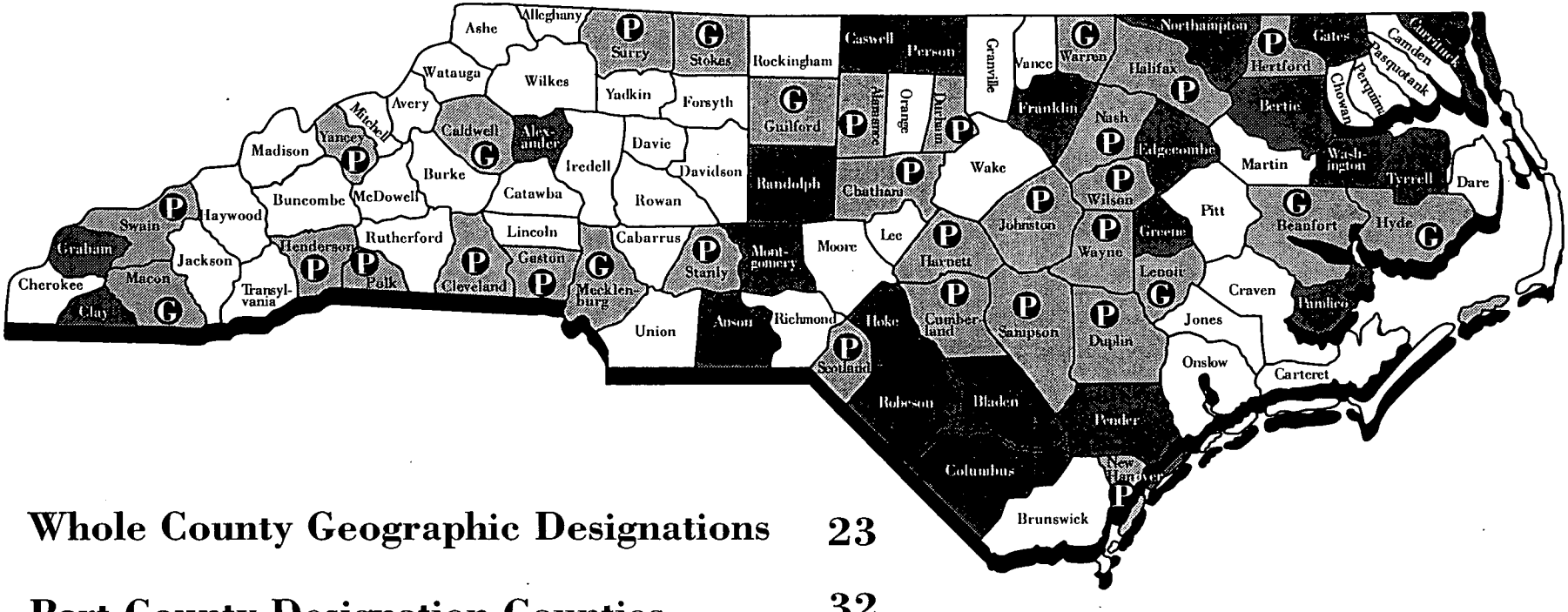
46.6% - 62.0%

North Carolina Office of Rural Health & Resource Development

PU 3 pov 200% 6-96

Health Professional Shortage Area (HPSA) Counties

PRIMARY MEDICAL CARE



Whole County Geographic Designations 23

Part County Designation Counties 32

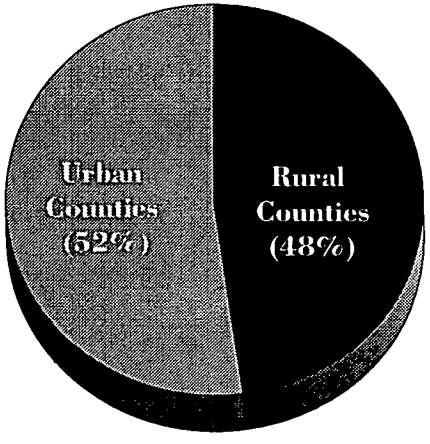
- **G** Part County Geographic Designation 9
- **P** Part County Population Designation 23

Total 55

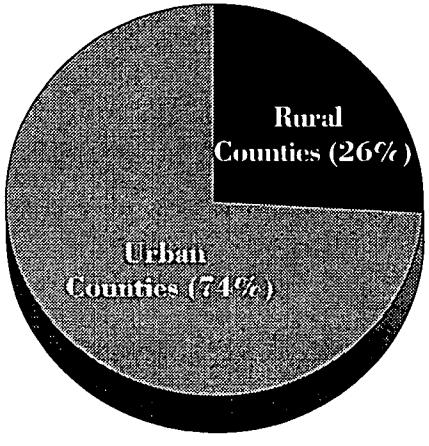
North Carolina Office of Rural Health & Resource Development

PU 3 HPSA gen 7-98

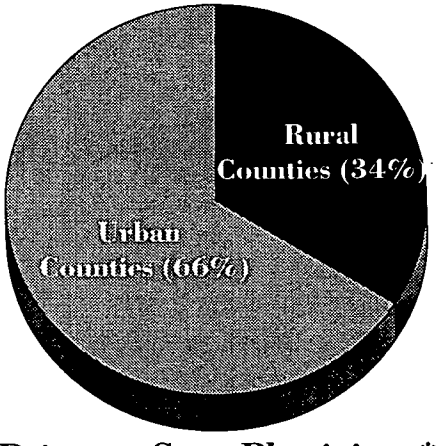
1996 Comparison of Distribution of State's Population and Selected Medical Providers Between 18 Urban Counties & 82 Rural Counties



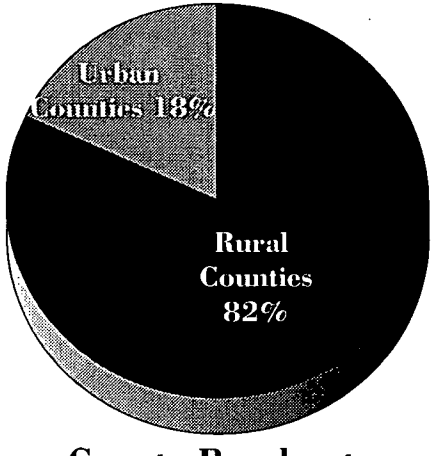
Total Estimated Population 1996



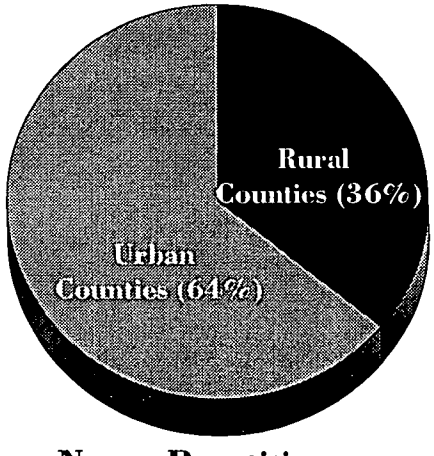
Physicians*



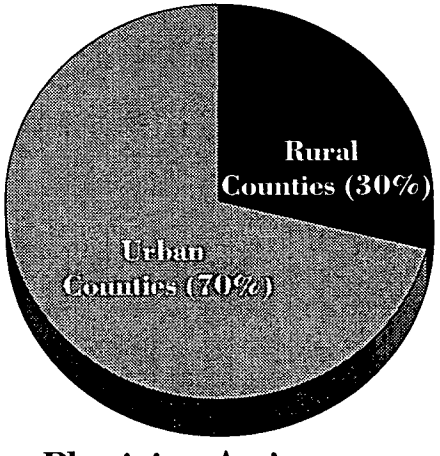
Primary Care Physicians**



County Breakout



Nurse Practitioners



Physician Assistants

Urban (Central City MSA) Counties

Rural (Non-MSA & Non-Central City MSA) Counties

*active, non-federal, non-resident
**FP,GP,IM, PED & OBG

North Carolina Office of Rural Health & Resource Development

PUG3 U/R Comparisons 4-98

The State of Rural North Carolina

Rural people in our state are poorer and more likely to be elderly ....

- **15 percent of rural residents are elderly/older than 65 (vs. 11 percent urban)**
- **16.5 percent of rural residents live in poverty (vs. 11.1 percent urban)**
- **nearly one in four rural children live in poverty, compared to one in seven in urban counties**
- **nearly one in four rural elderly live in poverty, compared to one in six in urban counties**
- **more than twice as many jobs were created in urban areas as in rural counties**

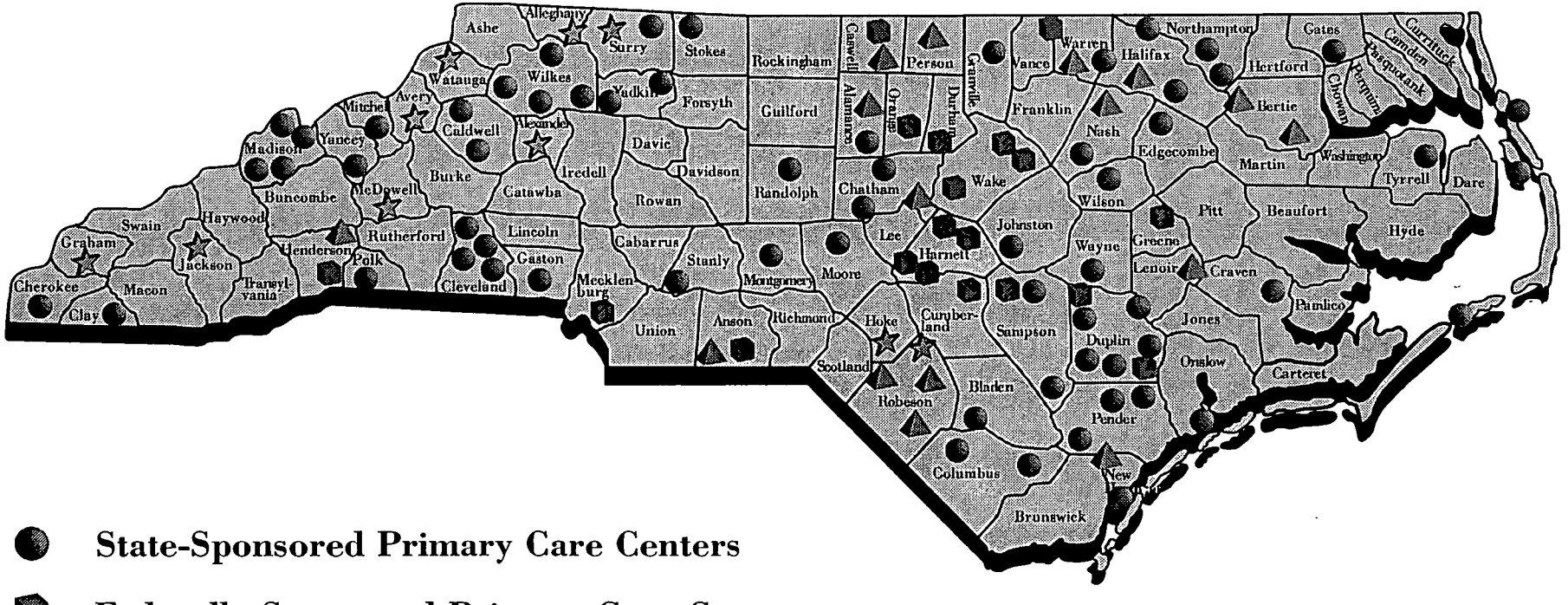
HAVES, HAVE-NOTS

The difference in wealth and school funding can be seen in a comparison of figures from Wake and Vance counties. Although the two school districts are only 40 minutes apart, the disparities between them are great.

	Wake Co.	Vance Co.
Per capita income	$24,841	$16,322
Adjusted property tax base	$36.3 billion	$1.4 billion
Local budget committed to welfare payments	4.9 percent	33 percent
Local spending per student	$1,234	$716
Percent of students at grade level:	79 percent	54 percent

Source: Public School Forum

State-Sponsored and Federally-Sponsored Primary Care Centers

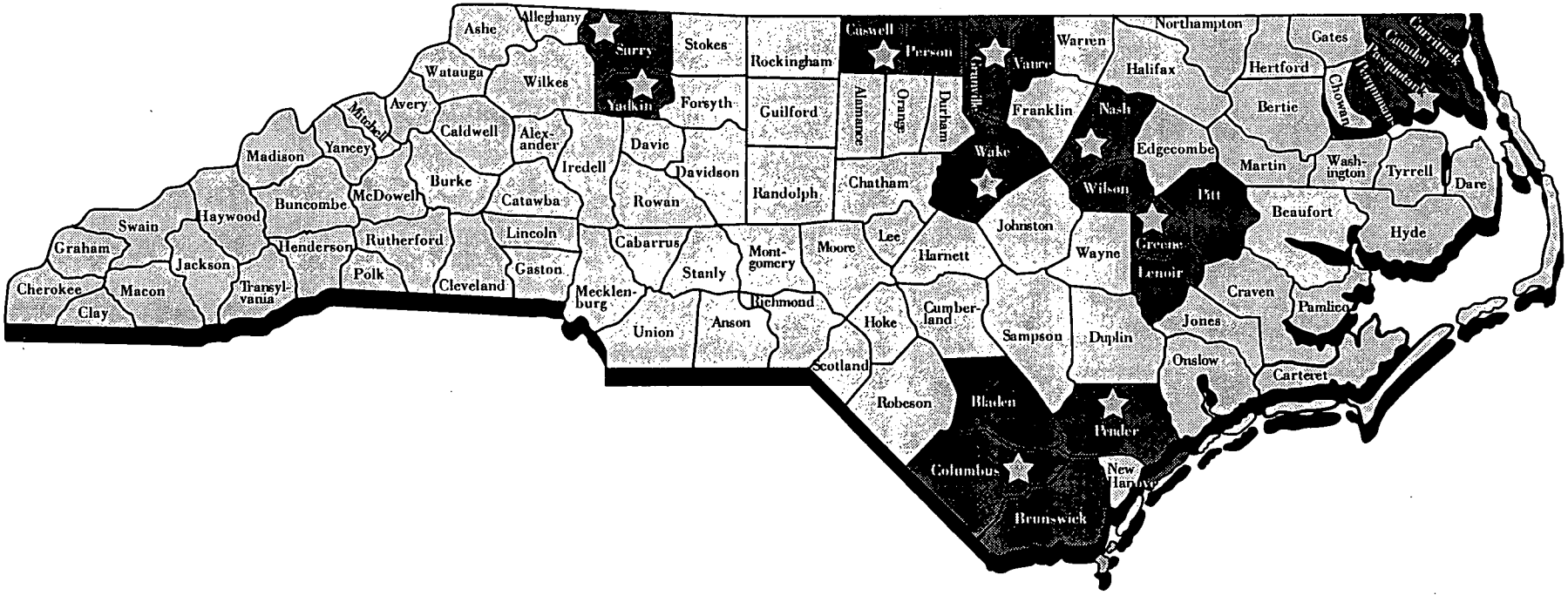


- State-Sponsored Primary Care Centers
- Federally-Sponsored Primary Care Centers
- Joint State/Federal Primary Care Projects
- Special State Primary Care Projects

North Carolina Office of Rural Health & Resource Development

PU 1 S/F Spons 8-98

NC Farmworker Health Program
Service Areas and Sites

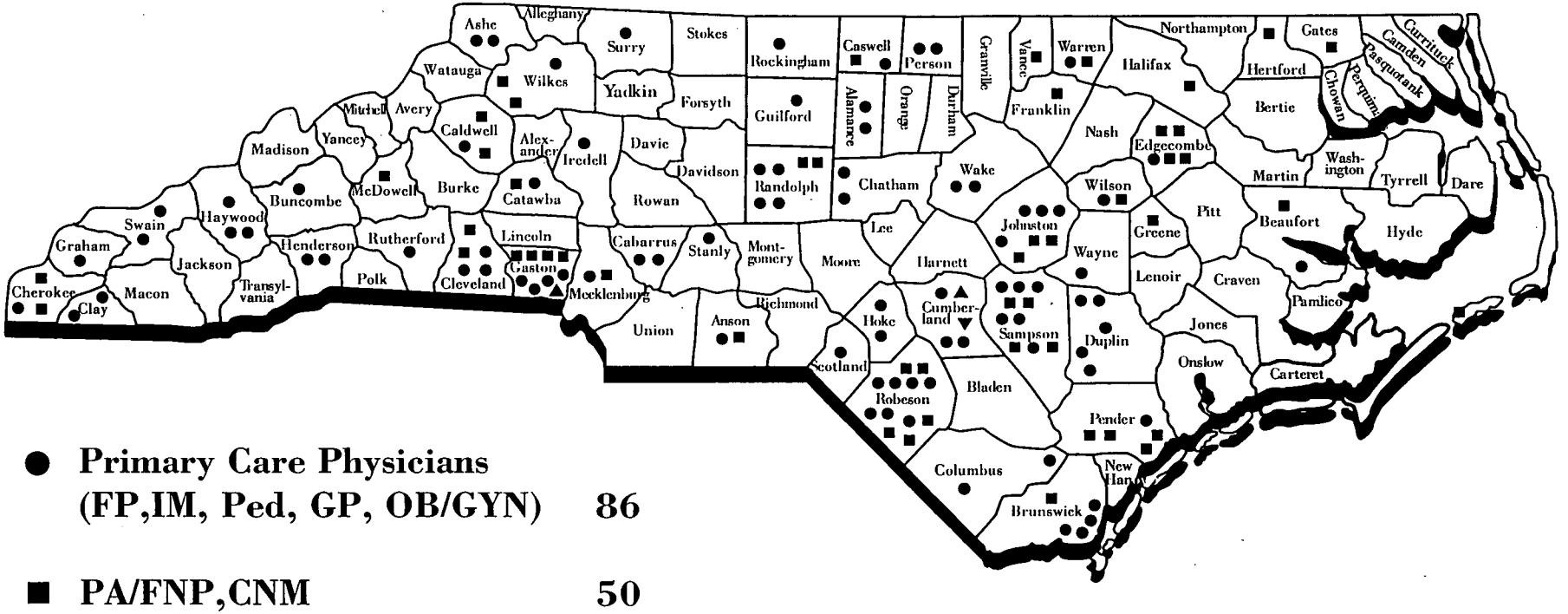


1998 Service Areas and Sites

North Carolina Office of Rural Health & Resource Development

SI 5 Farmworker Health SAs 7-98

Primary Care Provider Placements
FY 1997 - 1998



●	Primary Care Physicians (FP,IM, Ped, GP, OB/GYN)	86
■	PA/FNP,CNM	50
▲	DDS	2
▼	DH	1

North Carolina Office of Rural Health & Resource Development

PU4 PCPP 7-98

Number of North Carolina Counties Within Selected Population/Primary Care Physician Ratio Ranges Tracked Over Five Year Intervals

YEARS	<1500/1	1500-2499/1	2500-4000/1	>4000/1
1976	4	40	33	23
1996	25	56	10	9

Source: Sheps Center for Health Research, UNC-CH and ORHRD from NC Board of Medical Examiners Licensure Data

Evolution of ORHRD

Community-Owned Health Centers

↓

Physician and Provider Placement

↓

Linking Rural Health Centers in Systems

↓

Technical Assistance to Rural Hospitals

↓

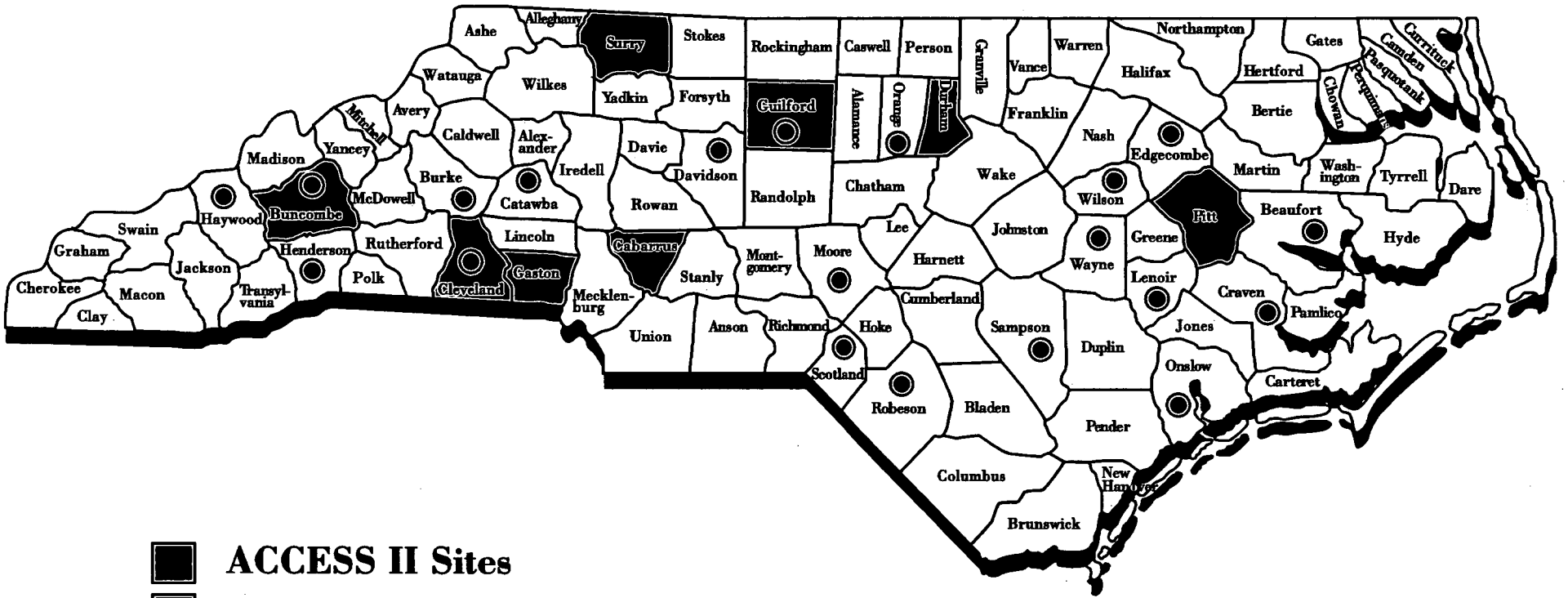
Local Health Department Strategic Planning and Implementation

↓

Integrated Local Health Systems

ACCESS II & III

North Carolina's Community Care Demonstrations



- ACCESS II Sites
- ACCESS III Sites
- Physician Network Sites

February 1999

ACCESS II & III Demonstration Sites Update

	Enrollment 12/1//98	Care Management Staff	Care Management Activities	Other Activities
AccessCare	72,093	• 2 Regional Care Managers • Central Office Health Educator • 23 local care managers	• Web-based communication package for all practices currently receiving data on ER and inpatient hospital utilization • A comprehensive asthma disease management program being implementing in all practices • Established call center services for all practices • LCMs are targeting inappropriate ER utilization by patients	• Collaboration occurring with Health Departments for care management services • Regular monthly Board of Directors meeting • Medical Management; Utilization Review; Health Department; & Pharmacy Committees meeting regularly
ACCESS II Care of Western North Carolina (Buncombe)	2,669	• Project Director being hired • 2 care managers	• 13 question at-risk assessment tool being administered • Pediatric asthma disease management protocols being implemented in Network (CHF & diabetes protocols under development) • Utilize pediatric nurse call center • High risk OB disease management program implemented	• Working with local initiative to apply for Kate B. Reynolds Diabetes Grant • Medical Management & ACCESS II Steering Committee meet monthly • Developed policies & procedures manual for managing high risk clients
CLECO (Cleveland County)	3,313	• 2 Care Managers hired	• Risk assessment being administered on each member • Incentive program being implemented for patient appointment & well child visits • Diabetes disease management protocol is operational	• Medical Management committee meeting monthly • Local initiative is a part of the Medicaid committee that meets quarterly with the Health Department
Durham Network	10,093	• Program director • 3 Community Health Workers • Recruiting 3 social work care managers	• Urgent Care Centers opened as options for patients to access primary care services in evenings and weekends • List of ED triggers and individualized care plans and follow-up developed for network • Duke Health Profile and initial health screening tool is being administered on each new enrollee at DSS & each practice • Asthma Disease Management being used by each practice • Care management database work group has been formed to create a care management database for the network	• Clinical services committee meets bi-weekly • ACCESS II Steering committee meeting monthly • Working with other community groups to apply for Kate B. Reynolds Diabetes Grant • Working with Duke Primary Care QI to develop and implement standards of care for ACCESS II population
Community Health Partners (Gaston County)	6,132	• 2 Care Managers • Member Services Representative	• Developing a care management database that utilizes monthly enrollment data and risk assessment tool • Risk assessment being administered to members • Diabetes disease management protocols being implemented • Developing member brochure and educational and outreach activities • Utilize nurse call center.	• Offering health education classes for ACCESS II members • Medical Management & Steering committees meeting monthly • Working with other community groups to apply for Kate B. Reynolds Diabetes Grant
Guilford ACCESS II Partnership (GAP)	12,446	• Clinical Services Coordinator hired • Project Director being interviewed	• 20 pediatric protocols in place • Pediatric Asthma disease management protocol in place • Risk assessment being administered at each practice	• Limited liability partnership formed • Exploring opportunities to build information infrastructure to support program activities
Surry County Health System	2,593	• 2 Care Managers	• Developed a database to track ED use for members • Conducting home visits to educate members • Central Diabetes protocol implemented in practices • Risk assessment tool being administered to all members	• Steering committee meets monthly • Close collaboration with DSS, local managed care representative, and health department family service coordinators

	Enrollment	Project Resources	Care Management Activities	Budgeting and Other Activities
Cabarrus Managed Care Organization ***ACCESS III***	5,283	• Project Coordinator and staff support from Cabarrus Managed Care Organization • Health Dept and Hospital Case Management Staff • Hospital Financial Staff • CMCO Care Management and Medicaid Advisory Committees	• Conducting home visits and administering risk assessment for all new Medicaid members (high risk OB focus) • CMCO identifying ER visits for follow-up as necessary by case manager and tracking utilization trends • Diabetes disease management protocol rolling out • Medicaid members using after hours nurse advice line	• Steering committee meeting twice monthly • Close collaboration with DSS and local managed care representative • Working with DMA Finance, Pitt and Rural Health on budget development • Working with Rural Health on provider profiling and data management strategy • Participated in identifying budget services. PMPM budget and adjusted Program Expenditure Report in development
University Medical Center Healthcare (Pitt County) ***ACCESS III***	14,482	• Project Coordinator reporting to CCN (UMCH) • Bringing on 4 case managers • P/T Medical Director • UMC Health, hospital, health dept., ECHO working collaboratively	• Conducting risk assessment on new enrollees • Follow-up home visit to targeted new enrollees with focus on high risk OB • High risk OB disease management protocols designed to identify and track high risk mothers • Plans underway to expand pediatric asthma program to cover Medicaid population	• Steering committee meeting every two weeks • Care management committees meeting regularly with new chairs identified in Nov • Working with Cabarrus, DMA Finance and Rural Health on budget development • Working with Rural Health on provider profiling and data management strategy • Participated in identifying budget services. PMPM budget and adjusted Program Expenditure Report in development

ATTACHMENT 2

ACCESS II / ACCESS III
North Carolina's Community Care Plans

Goal

To build a managed health care system for Medicaid and other low-income populations that is organized and operated by community providers and that can achieve access, quality, utilization, and cost objectives. These community plans will build upon the foundation that has been laid by Carolina ACCESS in these communities.

Plans

ACCESS II

- Local Network (Buncombe, Cleveland, Durham, Gaston, Guilford and Surry)

  Limited networks comprised of key Medicaid providers (physicians, hospitals, health departments, and departments of social services) who have agreed to work together to develop the care management systems and supports that are needed to manage enrollee care. Network participants operate under a budget and are paid on a fee for service basis. The size of the local networks range from 2,600 recipients in Surry to 12,000 in Guilford.

- Physician Network (Access Care)

  A statewide network of large Carolina ACCESS practices who have agreed to work together to develop collaborative systems for managing care. This network is comprised of 24 practices in 20 counties with an enrollment of 72,000 recipients.

ACCESS III

- Community Care Networks (Cabarrus and Pitt)

  Countywide plans that are community partnerships involving physician, hospitals, health departments, departments of social services, and other community providers. Networks will assume responsibility for managing the care of eligible Medicaid populations in the county under a budget model. Cabarrus currently has 5,300 recipients enrolled and Pitt has 14,500.

Features

The ACCESS II and ACCESS III plans are distinguished by the following features:

Collaboration.

Where care for these populations has been traditionally fragmented, ACCESS II and III are designed to bring together providers to cooperatively plan for meeting patient needs. The program is also designed to strengthen the provider "safety net" that vulnerable residents rely on for their care.

Population-based

Where providers traditionally respond to patients only when they are sick, ACCESS II and III are designed to have providers take responsibility for an enrolled population and to provide preventive services, and to develop the processes by which at-risk patients can be identified and their care can be managed before high cost interventions are necessary.

Care Management

Where most managed care efforts start (and often end) with managing costs, ACCESS II and III emphasize managing care by encouraging the networks to establish the care management systems and supports to ensure enrollees will receive the care they need. The plans will collaboratively develop disease management programs and care management processes to improve the management of patient care.

Budget

Where traditional payment methods are fee for service or capitation, ACCESS II and III models rely on a budget approach. The plans will be responsible for managing enrollee care under a budget. Plan expenditures will be monitored, compared to the budget, and payments will be periodically adjusted, as necessary, to keep within the budget.

Indigent Care

One of the important objectives of ACCESS II and III is to strengthen the community "safety net" that is in place to serve the growing number of indigent patients. In addition, the ACCESS III plans, which are non-profit community organizations, will use a part of the savings generated under this program for indigent care.

Care Management Initiatives

The heart of the ACCESS II and III plans is collaboratively developing care management initiatives that achieve access, quality, utilization, and cost objectives by improving the management of patient care. Plans are working on short-term and long-term care management initiatives. While short-term initiatives are designed to produce results quickly, the long-term initiatives are aimed at creating fundamental and lasting changes in how patient care is managed.

Specific short-term approaches include:

Managing the Emergency Room Patient

Plans are using their Emergency Room Management Reports to identify inappropriate ER users and then undertake an organized effort to redirect these patients back to their primary care provider by contacting them to understand reasons for ER visit(s) and by providing education and assistance. Plans are also establishing target ER visit rates for their networks and working with practices with poor rates to identify activities for improving performance.

Managing Inpatient Admissions

Plan activities that are designed to better manage admissions include:

- Establishing a data management system that is designed to capture information on all admissions at the time of admission;
- Analyzing inpatient admission data and identifying problem areas;
- Sharing comparative admission data with network providers;
- Setting target admission rates for the network.

Managing Prescriptions

Activities designed to better manage the rapidly increasing cost of prescription drugs include:

- Providing comparative cost data on commonly prescribed drugs;
- Analyzing prescribing practices of network practices and identifying opportunities for improved performance;
- Sharing analysis of prescribing practices and network participants;
- Setting target prescription rates for the network.

Managing the High Risk/High Cost Patient

All sites have developed a screening process and tool to determine those enrollees who, because of their medical and/or social situation, would benefit from an organized program of care management. Several sites are preparing to launch a program that is designed to identify those patients with high annual costs (over $10,000 per year in charges) and, in collaboration with participating practices, review the patient's status and plan of care to determine opportunities for improvements in the quality and cost of effectiveness of care.

Managing Referrals

The newest activity that is aimed at bringing about a new awareness and approach to managing patient care is looking at how patient referrals are managed.

Over the longer-term ACCESS II and III sites are engaged in activities that are designed to bring about fundamental and lasting improvement in how care is managed and delivered. These activities include:

Identifying and Managing the At-Risk Patients

All sites have developed an at-risk assessment process to identify those patients who may require enhanced care management because of their medical and social circumstances. Clients who are identified as at-risk through the screening process are further evaluated to determine the care plan, including medical and social support, that is needed to optimize the care the client needs and receives. Program care managers' (or through referral to other care managers) coordinate and monitor implementation of the care plans.

Developing Collaborative Disease Management Initiatives

The heart of ACCESS II and III will be sites working together to develop common disease and care management initiatives. Toward that end, we have begun a collaborative process, where sites come together to:

- Choose disease management initiatives or care management processes (asthma and ER management are the initial targets);
- Review data and the state of the art in asthma management/ER management;
- Develop expectations and desired objectives;
- Develop measurements and methods of information collection;
- Determine communication/education methods - how to obtain local buy-in;
- Hold "learning sessions" with larger groups to get buy-in;
- Determine implementation plan;
- Determine monitoring/assessment plan

The collaborative process represents a major investment by programs and providers that is essential to bringing about lasting change. The collaborative process can be repeated for other disease and care management processes.

Taking on Community Health Issues

Over the long-term these community-based systems provide a structure for tackling such community health issues as teenage pregnancy and infant mortality. Depending on the health issue to be addressed, community health groups can be added to the core ACCESS II and III coalition to form an ad hoc task force charged with developing and implementing an improvement plan.

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ATTACHMENT 3

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ATTACHMENT 4

FARMWORKER HEALTH PROGRAM
NC OFFICE OF RESEARCH, DEMONSTRATIONS & RURAL HEALTH DEVELOPMENT

The Farmworker Health Program (FHP), a federally-funded program administered by the NC Office of Research, Demonstrations and Rural Health Development, provides funding for community-oriented primary health care services to North Carolina's migrant and seasonal farmworkers.

The majority of the funding is distributed through grants to community health centers, county health departments, and other community-based practices.

serves include

- interpretation/translation services,
- evening and weekend clinic hours,
- outreach,
- case management,
- health education, and
- patient transportation.

PROGRAM HIGHLIGHTS FOR 1998

- $745,864 federal grant
- Funding to *nine* health care agencies: (serving 19 counties)

  Columbus County Community Health Center
  Greene County Health Care
  Harvest Family Health Center
  Pasquotank-Perquimans-Chowan-Camden District Health Department
  Pender County Health Department*
  Piedmont Health Services
  Stovall Medical Center
  Wake County Human Services*
  Surry County Health and Nutrition Center

- Conducted focus groups with a total of *82* farmworkers at eight contract sites to determine farmworkers' impressions of the availability, effectiveness, and appropriateness of health services in North Carolina.

- Provided primary care to more than *(8,000)* migrant and seasonal farmworkers 24,676 (encounters) throughout the agricultural season,
  - 94% were Hispanic/Latino,
  - 2% Black or African American,
  - 1% non-Hispanic White,
  - 1% Asian/Pacific Islander,
  - 2% unreported/unknown.
  -

There are approximately 344,000 migrant and seasonal farmworkers in NC. Our program plus federally funded centers serve approximately 25% of these farmworkers.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE February 17, 1999

Name of Committee **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carmen Hooker Buell	Carolinas HealthCare System
Tommy Worth	" "
Hugh Tilson	NCHA
Casey Herget	NASW - NC
Adam Searing	NCJAC
George Reed	NC Council of Churches
[illegible]	
[illegible]	NCSA
[illegible]	[illegible]
[illegible]	NCMS
Marcy D. Dion	NCMS
S W Wilderne	

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, May 3, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- S.B. 90, Insurance/Cover Contraception — Senator Forrester
- S.B. 160, Nurse Rehabilitation — Senator Perdue

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, March 3, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, March 3, 1999, at 12:00 Noon in Room 1124 in the Legislative Building. Fourteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Ben York, from Albemarle, who was sponsored by Senators Plyler and Purcell.

He told the members that S.B. 160, *Nurse Rehabilitation*, would not be discussed today since its sponsor, Senator Perdue, could not attend this meeting, and that S.B. 90, *Insurance/Cover Contraceptives*, would be taken up as planned. Senator Forrester proposed a Committee Substitute for S.B. 90 (Attachment A). Senator Phillips moved that it be adopted, the motion was voted upon and passed unanimously. Senator Purcell asked Senator Forrester to come forward and explain the Committee Substitute. In doing so, he read a letter from a mother expressing her opinion as to why the bill should be passed (Attachment B). After some discussion Senator Lucas moved that the Committee Substitute receive a favorable report and the original bill receive an unfavorable report. The motion carried unanimously. The meeting was adjourned at 12:16.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
William R. Purcell, Chairman

Wednesday, March 03, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **90** Insurance/Cover Contraceptives

Draft Number:	PCS8541
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

ATTACHMENT A

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 90
Proposed Committee Substitute S90-PCS8541-LN

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors:

Referred to:

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS OR OUTPATIENT SERVICES PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES OR OUTPATIENT CONTRACEPTIVE SERVICES.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services.**

(a) Every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall provide coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. Except as otherwise provided in this subsection, the same deductibles, coinsurance, and other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices. A health benefit plan may require that the total coinsurance, based on the useful life of the drug or device, be paid in advance for those drugs or devices that are inserted or prescribed and do not have to be refilled on a periodic basis.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall provide coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident.
b. Credit.
c. Disability income.
d. Long-term care or nursing home care.
e. Medicare supplement.
f. Specified disease.
g. Dental or vision.
h. Coverage issued as a supplement to liability insurance.
i. Workers' compensation.
j. Medical payments under automobile or homeowners.
k. Hospital income or indemnity.
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 90

Short Title: Insurance/Cover Contraceptives. (Public)

Sponsors: Senators Forrester, Lucas, Purcell; Cochrane, Foxx, Garrou, Hagan, Kinnaird, and Perdue.

Referred to: Health Care.

February 15, 1999

A BILL TO BE ENTITLED

AN ACT TO ENSURE THAT INSURERS THAT PROVIDE HEALTH INSURANCE COVERAGE FOR PRESCRIPTION DRUGS PROVIDE COVERAGE FOR PRESCRIBED CONTRACEPTIVE DRUGS AND DEVICES AND FOR OUTPATIENT CONTRACEPTIVE SERVICES.

Whereas, there are approximately three million unintended pregnancies each year in the United States; and

Whereas, unintended pregnancies lead to higher rates of infant mortality, low birth weight, and maternal morbidity, and threaten the economic stability of families; and

Whereas, two-thirds of women of childbearing age rely on some form of private employment-related insurance to defray their medical expenses; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, Article 3 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-3-174. Coverage for prescription contraceptive drugs or devices and for outpatient contraceptive services.**

(a) Every entity providing a health benefit plan that provides coverage for prescription drugs or devices shall not exclude or restrict coverage for prescription contraceptive drugs or devices. Coverage shall include coverage for the insertion or removal of and any medically necessary examination associated with the use of the prescribed contraceptive drug or device. The same deductibles, coinsurance, and

other limitations as apply to prescription drugs or devices covered under the health benefit plan shall apply to coverage for prescribed contraceptive drugs or devices.

(b) Every entity providing a health benefit plan that provides coverage for outpatient services provided by a health care professional shall not exclude or restrict coverage for outpatient contraceptive services. The same deductibles, coinsurance, and other limitations as apply to outpatient services covered under the health benefit plan shall apply to coverage for outpatient contraceptive services.

(c) As used in this section, the term:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that Act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina Department of Health and Human Services or the United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Accident
b. Credit
c. Disability income
d. Long-term care or nursing home care
e. Medicare supplement
f. Specified disease
g. Dental or vision
h. Coverage issued as a supplement to liability insurance
i. Workers' compensation
j. Medical payments under automobile or homeowners
k. Hospital income or indemnity
l. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

(2) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, and a multiple employer welfare arrangement subject to Article 49 of this Chapter.

(3) 'Outpatient contraceptive services' means consultations, examinations, procedures, and medical services provided on an

outpatient basis and related to the use of contraceptive methods to prevent pregnancy.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State.

(d) A health benefit plan subject to this section shall not:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section;

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section;

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section; or

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services."

Section 2. Effective January 1, 2000, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for ~~mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.~~

~~(a1) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.~~

~~(a2) Notwithstanding G.S. 58-50-123(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.~~ all of the following:

(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices approved by the United States Food and Drug Administration for use as contraceptives, or

outpatient contraceptive services at least equal to the coverage required by G.S. 58-3-174.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. ~~This section shall be effective after July 10, 1991.~~"

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

EXPLANATION OF SENATE BILL 90
Insurance/Cover Contraception

To: Senate Health Care Committee
From: Linda Attarian, Committee Counsel
Date: February 16, 1999
Sponsor: Senator James Forrester

Brief Explanation:

Senate Bill 90 provides for equitable insurance coverage for prescription contraception. The proposed legislation requires health benefit plans that provide coverage for general prescription drugs, devices and outpatient services to provide coverage for FDA-approved prescription contraceptive drugs, devices and outpatient contraceptive services. The legislation does not require a health benefit plan to provide coverage for over-the-counter contraceptives.

Section by Section Explanation:

Whereas Clauses:

This section sets out the factual findings that provide a basis for why the legislation is proposed.

Section 1: General Provisions:

Section 1 of the bill amends Article 3 of Chapter 58, (titled "General Regulations of Insurance"), to add a new section (G.S. 58-3-174) to prohibit health benefit plans from excluding or restricting benefits for FDA-approved prescription contraceptive drugs or devices, if the plan provides benefits for other prescription drugs or devices. By including contraceptive devices, this provision ensures that a range of contraceptives will be covered, not just oral contraceptives. These plans must also include coverage for the insertion or removal of the contraceptive and any medically necessary examinations associated with the utilization of the contraceptive.

In addition, health benefit plans may not exclude or restrict benefits for outpatient contraceptive services, if the plan provides benefits for other outpatient services. The same deductibles, copayments, annual limits, and lifetime limits that apply to outpatient services under the policy must also apply to outpatient contraceptive benefits.

Definitions:

"Health benefit plan" and "Insurer": These terms are broadly defined in the bill to include traditional indemnity plans, managed care plans, HMOs and PPOs. Employer's self-insured health plans would be exempt from these requirements. Many employers, particularly larger employers, self-fund health benefit plans for their employees. These self-funded plans are exempt from State regulation because of a federal law, the Employee Retirement Income Security Act (ERISA), governing employee pension and benefit plans.

"Outpatient contraceptive services": Includes services necessary to utilize contraceptive methods to prevent pregnancy.

"Prescribed contraceptive drugs or devices": Includes all FDA-approved prescription contraceptive drugs and devices.

Other Prohibitions:

Section 1 of the bill also prohibits health benefit plans from (1) denying an individual coverage or refusing to renew coverage to an individual to avoid providing contraceptive coverage; (2) providing incentives to encourage individuals to accept less than the minimum protections required under this legislation; (3) penalizing or reducing the reimbursement of healthcare professionals because they prescribe contraceptives or provide contraceptive services; and from (4) providing incentives to health care providers to withhold contraceptive benefits otherwise required under this legislation.

Section 2: Coverage under the "Standard Health Plan". North Carolina law requires insurance companies to offer two types of guaranteed health plans to employers with less than 50 employees. One is a "standard plan" and the other is a "basic plan". Of the two, the standard plan has more benefits. Under this bill, the standard plan must comply with the contraceptive coverage requirement beginning on January 1, 2000.

Section 3: Contains a severability clause.

Section 4: Effective date: The bill is effective when it becomes law and applies to health benefit plans that are delivered, issued, or renewed on or after January 1, 2000.

(4) 'Prescribed contraceptive drugs or devices' means drugs or devices approved by the United States Food and Drug Administration for use as contraceptives and obtained under a prescription written by a health care provider authorized to prescribe medications under the laws of this State.

(d) A health benefit plan subject to this section shall not do any of the following:

(1) Deny eligibility or continued eligibility to enroll or to renew coverage under the terms of the health benefit plan, solely for the purpose of avoiding the requirements of this section.

(2) Provide monetary payments or rebates to an individual participant or beneficiary to encourage the individual participant or beneficiary to accept less than the minimum protections available under this section.

(3) Penalize or otherwise reduce or limit the reimbursement of an attending provider because the provider prescribed contraceptive drugs or devices, or provided contraceptive services in accordance with this section.

(4) Provide incentives, monetary or otherwise, to an attending provider to induce the provider to withhold from an individual participant or beneficiary contraceptive drugs, devices, or services."

Section 2. Effective January 1, 2000, G.S. 58-50-155 reads as rewritten:

"**§ 58-50-155. Standard and basic health care plan coverages.**

(a) Notwithstanding G.S. 58-50-125(c), the standard health plan developed and approved under G.S. 58-50-125 shall provide coverage for ~~mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.~~

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(1) Mammograms and pap smears at least equal to the coverage required by G.S. 58-51-57.

(2) Prostate-specific antigen (PSA) tests or equivalent tests for the presence of prostate cancer at least equal to the coverage required by G.S. 58-51-58.

(3) Reconstructive breast surgery resulting from a mastectomy at least equal to the coverage required by G.S. 58-51-62.

(4) Prescribed contraceptive drugs or devices approved by the United States Food and Drug Administration for use as contraceptives, or outpatient contraceptive services at least equal to the coverage

required by G.S. 58-3-174, if the plan covers prescription drugs or devices, or outpatient services, as applicable.

(b) Notwithstanding G.S. 58-50-125(c), in developing and approving the plans under G.S. 58-50-125, the Committee and Commissioner shall give due consideration to cost-effective and life-saving health care services and to cost-effective health care providers. ~~This section shall be effective after July 10, 1991.~~"

Section 3. If any section or provision of this act is declared unconstitutional or invalid by the courts, it does not affect the validity of this act as a whole or any part other than the part so declared to be unconstitutional or invalid.

Section 4. This act is effective when it becomes law and applies to health benefit plans that are delivered, issued for delivery, or renewed on and after January 1, 2000. For purposes of this act, renewal of a health benefit policy, contract, or plan is presumed to occur on each anniversary of the date on which coverage was first effective on the person or persons covered by the health benefit plan.

Attachment B

Lorraine Blake (Sen. Purcell)

From: Rita Faye Quick [RFQUICK@ETINTERNET.NET]
Sent: Wednesday, March 03, 1999 12:23 AM
To: Sen. William Purcell
Subject: I support the SB 90 Insurance/Cover Contracptive Bill.

Hello Dr. Purcell,

I hope this letter finds you in good health, since we last talked.

I am writing in support of SB 90, ~~Insurance/Cover Contraceptives Bill~~. I know from personal experiance, had my place of work's, Health Ins., plan covered the high cost of contraceptives and related prescriptions, I would have waited longer before bringing children into the world. I was 25 when my first child was born, I used birth control up until then.

Before I got a job, the cost of my birth control was covered by medicaid. But once I was working, I was expected to pay for my own medical bills, even birth control. However my insurance would not help me with any part of the cost of contraception. So I ask the father of my oldest child to go in halfs on the cost (which would have been $50.00 ea.) but he would not help either. He said birth control was my problem. He now pays $175.00 a mo. child support. That was over 16 years ago, 14 of which I spent on AFDC.

By my health Ins. not covering birth control, we all suffered. The health ins. co. had to pay for the cost of my childs birth, the father had to pay manatory child support, I was forced to choose between weather I was ready to raise a child or an abortion, and our country paid when I chose to be a fulltime mother and went on AFDC.

This could have all been avoided if I could have kept receiving the no cost birth control services I had been using for years while on medicaid and unemployed. The SB 90 bill needs to pass.

Wishing you well,
Rita F. Quick,
Scotland County

VISITOR REGISTRATION SHEET

Health Care — March 99

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
FRED TAYLOR	WRAL-TV
Rals Bickley	N+O
PERRI MORGAN	NFIB
Robert PASCHAL	Young, Moore & Henderson, P.A.
Suzanne Moore RN, BSN	Nurse of the DAY (NCNA)
Barry Smith	Freedom Newspapers
Alicia Gregory	Poyner & Spruill
Parker Poe	Bode & Associates
	JCSL
Brenda Simmons	NC Equity
	NCASW
Joyce Peters	APAssoc/MANST
Jennifer Bubenik	NASW
Jean Williams FNP	Planned Parenthood PPCC
Walter Klausmeier	Planned Parenthood PPCC
Deborah Ross	ACLU
	ACLU
Adam Searing	NCHAC
	NC Council of Churches
William Potter	NCAS - NCPTA
Linda Jo Bain	NCMS
Steve Keen	NCMS
	NCSHA

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
N. Pelligreen	UNC
Tommy Worth	Carolina Healthcare Sys Assn
Patricia Yarn	ACLL/APPCNC
MAFulley	NCHA
Andy Lombardi	NCLM
Alan Skipper	NCMS
Joe Case	NCRMA
Jenny Fullbright	Hunton & Williams
Nancy Manifold	Poyner & Spruill
Lyndon Bone	Bode & Assoc
[illegible]	Moore & VanAllen
Andrea Chinn	John Locke Foundation
John [illegible]	NCFPC
Melody Hunter-Dillion	WTVD News
Gene Guy	MGNS
Joe Johnson	Capital Correspondent
Scott Mooney	AP
Chuck [illegible]	D Business

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, March 10, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

No bills will be discussed at this meeting. We will have speakers from UNC-CH who will discuss organ procurement and organ transplant.

Senator William R. Purcell, M.D., Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, March 10, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, March 10, 1999, at 12:00 Noon in Room 1124 in the Legislative Building. Thirteen members were present, including the Chair, Senator William R. Purcell, who presided.

Senator Purcell called the meeting to order at 12:00 Noon. He introduced Ms. Kim Nicoll, Program Administrator for the organ transplant service at Chapel Hill. Ms. Nicoll introduced Stacy Liekweg, Director of Operations at the University of North Carolina Hospital; Dr. Jeffrey Fair, Director of Abdominal Transplantation at UNC Hospital; and Lloyd Jordan, Executive Director of the Carolina Organ Procurement Agency.

Ms. Liekweg passed out handouts, which outlined her presentation to the Committee (Attachment A). Following her presentation, and in response to a question from a Committee member, Dr. Fair came to the podium and spoke on the matter of using animal organ transplants, which is about ten years in the future; and also about educating the public about the importance of organ donation. Mr. Jordan came to the podium to outline specific steps that are being taken to educate the public about donation. He also outlined the specific criteria that must be met, specifically for a liver transplant.

Senator Purcell thanked Ms. Liekweg, Dr. Fair, and Mr. Jordan for their presentations. The meeting was adjourned at 12:54 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

Update on Issues of Organ Allocation

UNC Comprehensive Transplant
Center and UNC School of Medicine

ATTACHMENT H

Presentation Objectives

- Provide an overview of the impact of organ allocation on patient access to transplantation
- Provide an example of this impact using liver allocation and sharing in North Carolina

Today's overview will include:

- History of United Network for Organ Sharing (UNOS)
- Overview of Organ Procurement Organizations
- History of Statewide Liver Sharing
- Impact of various organ sharing models on patient access

The Evolution of UNOS

- South Eastern Organ Procurement Foundation (SEOPF) was developed in the late 1960's - first organ sharing organization.
- The National Organ Transplant Act (NOTA) of 1984 - provision of a fair and equitable national system to distribute organs.

The Evolution of UNOS (continued)

- The Organ Procurement and Transplantation Network (OPTN), under authority of the U.S. Department of Health and Human Services, was created to operate the system.
- The United Network for Organ Sharing (UNOS), which was modeled after SEOPF, has held the federal contract to operate the OPTN since 1986.

OPOs: Procurement vs. Allocation

- Hospital based OPOs formed geographic boundaries based on local area hospital relationships to foster procurement.
- After the establishment of NOTA geographic boundaries were formalized.

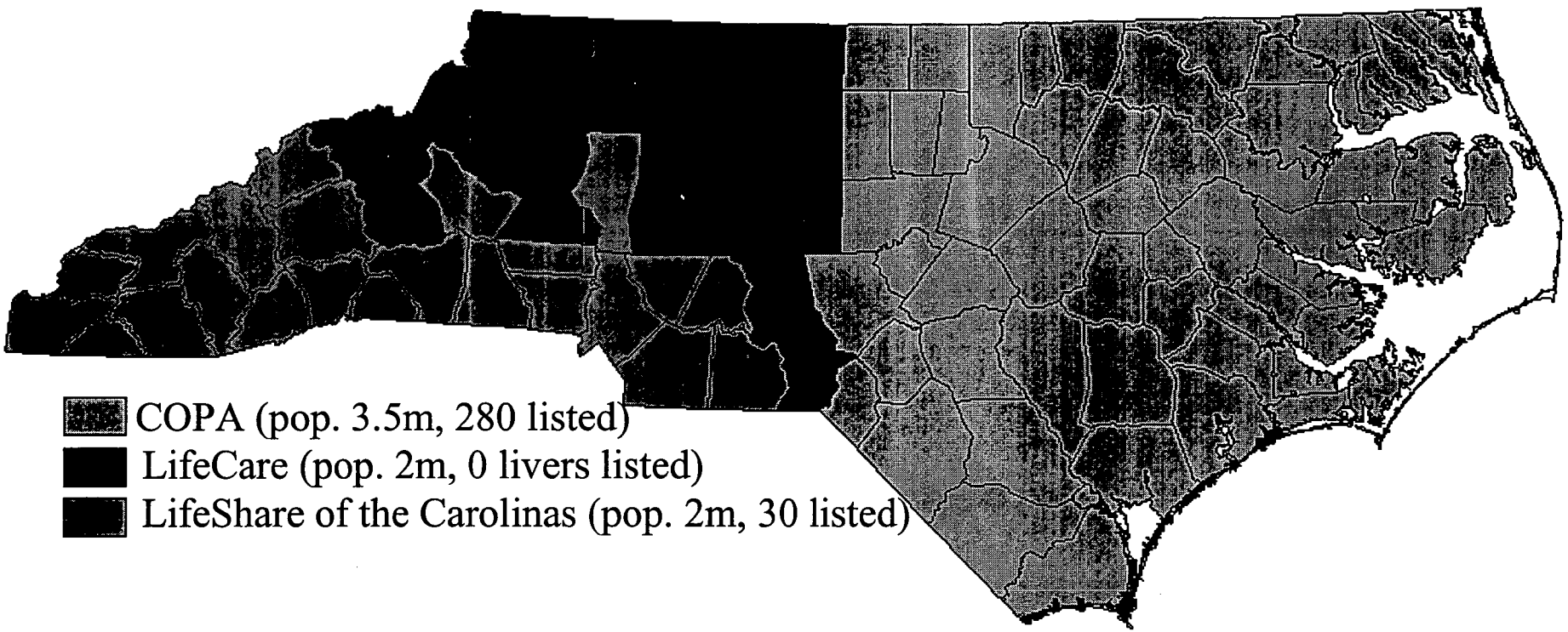
OPOs: Procurement vs. Allocation

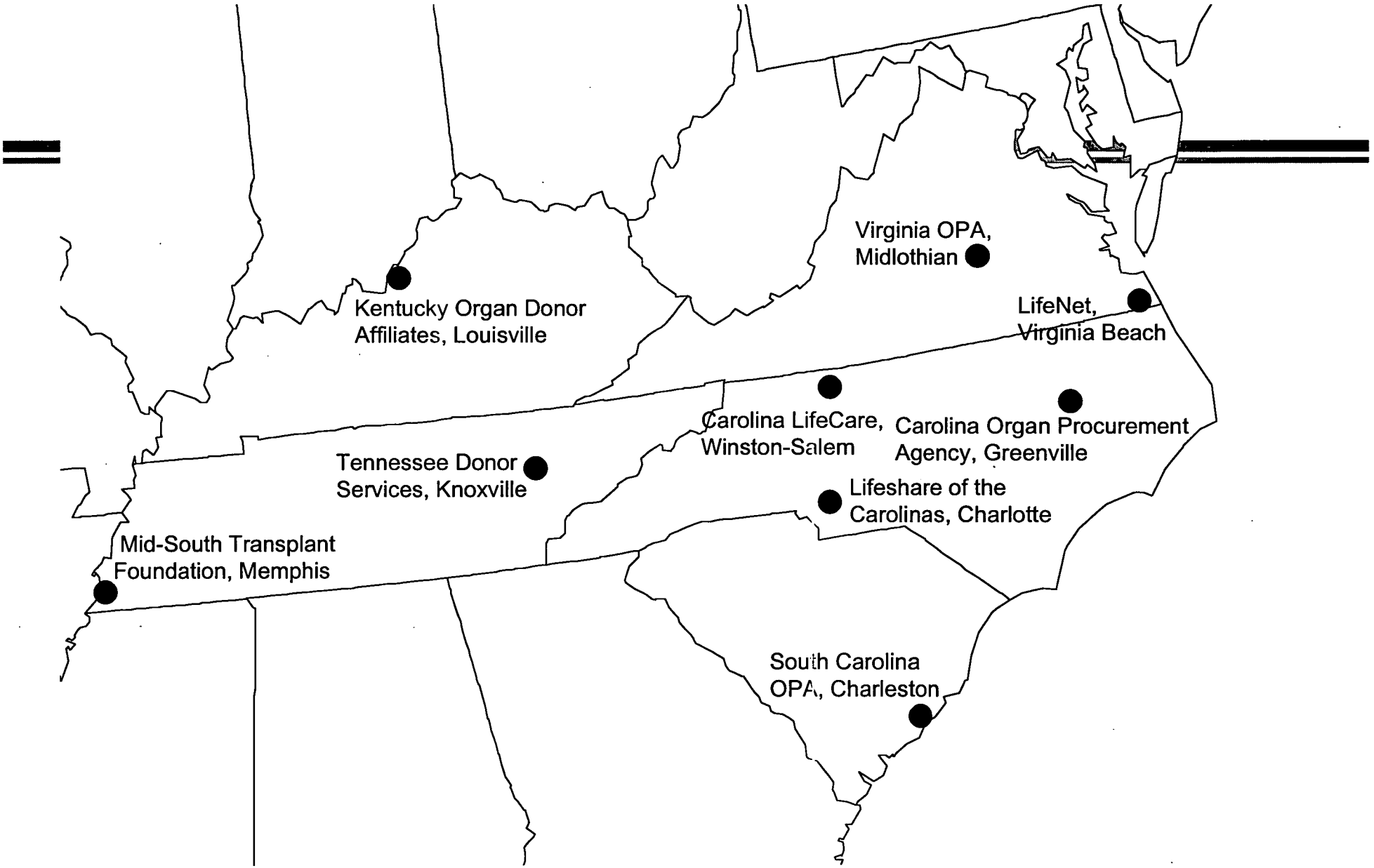
- Organ allocation was linked to the geographic area covered by the designated OPO.
- This created the current arbitrary geographic limitations for organ distribution and creates patient waiting time discrepancies.

How organ allocation currently works for liver transplant

- Waiting list status: 1, 2A, 2B, 3
- Region 11 defined: Virginia,Kentucky, Tennessee, North Carolina, and South Carolina.
- Our state currently has three OPOs: COPA, Charlotte, and Winston-Salem
- Organ allocation (sharing) is first within local OPO, then within the region, and then nationally.

OPO Coverage




Virginia OPA,
Midlothian
Kentucky Organ Donor
Affiliates, Louisville
LifeNet,
Virginia Beach
Carolina LifeCare,
Winston-Salem
Carolina Organ Procurement
Agency, Greenville
Tennessee Donor
Services, Knoxville
Lifeshare of the
Carolinas, Charlotte
Mid-South Transplant
Foundation, Memphis
South Carolina
OPA, Charleston

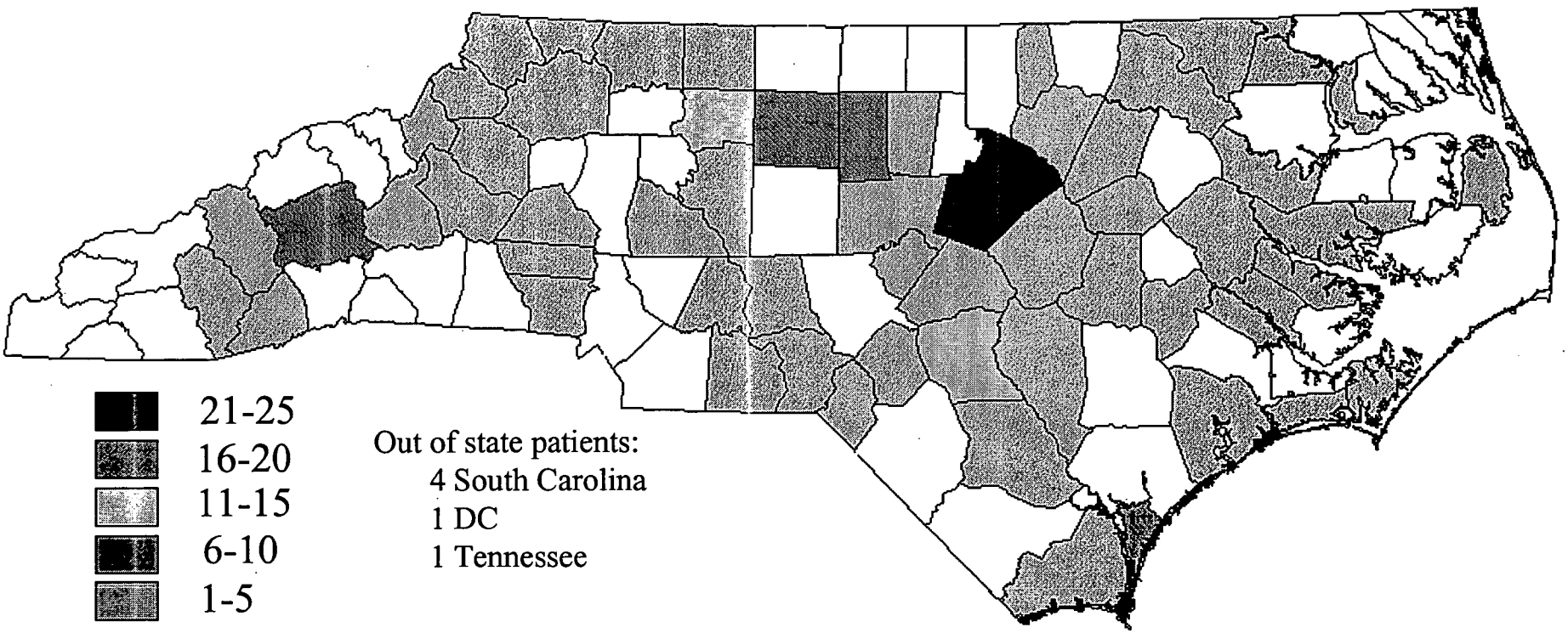
Statewide Sharing in North Carolina

- Statewide liver sharing was initiated as a cooperative effort between the three North Carolina OPOs in 1995 and had been in place as a UNOS approved larger sharing agreement.
- The initiation of statewide sharing allowed the most urgent patients listed for liver transplant in our state to be transplanted first.

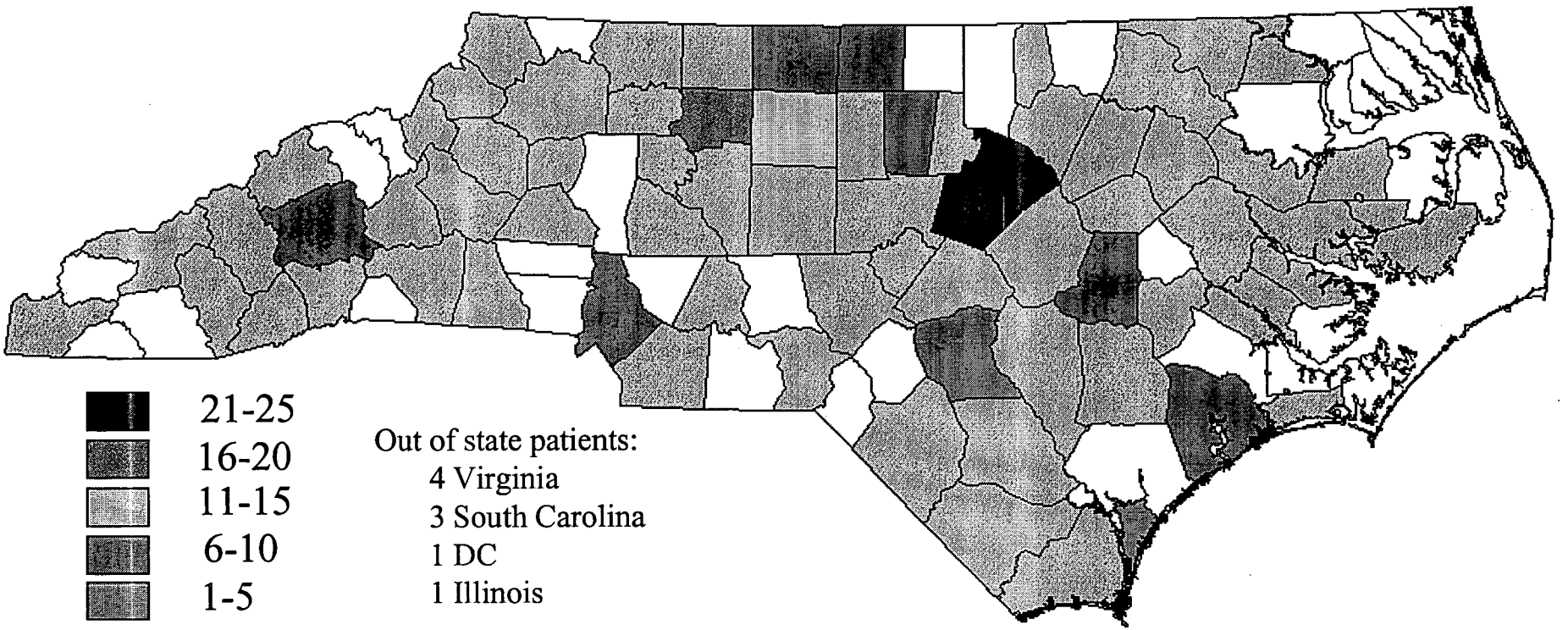
Statewide Sharing in North Carolina (continued)

- This agreement allowed for maximum organ utilization within North Carolina.
- Recently Charlotte's OPO has requested to withdraw from statewide sharing.

Current Listings



Patients Transplanted



What happens when we don't have a statewide sharing agreement?

- Organs that aren't used within the Charlotte OPO will now be offered regionally (instead of staying in state).
- Likewise patients listed in the Charlotte OPO will not benefit by organs that are recovered in the two other OPOs in North Carolina.

National Trends in Organ Allocation

- Increased Medical Utility and Equity of Patient Access through larger organ sharing units
- Equalization of Patient Waiting Time
- Establishment of Federal standards for OPO performance.

105th CONGRESS
2D SESSION

H.R. 4328

CONFERENCE REPORT

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 4328) "making appropriations for the Department of Transportation and related agencies for the fiscal year ending September 30, 1999, and for other purposes", having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate, and agree to the same with an amendment, as follows:

In lieu of the matter stricken and inserted by said amendment, insert:

DIVISION A—OMNIBUS CONSOLIDATED APPROPRIATIONS

That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated, for the several departments, agencies, corporations and other organizational units of the Government for the fiscal year 1999, and for other purposes, namely:

629 of Public Law 101–509 to non-FTE bearing positions including trainees, visiting fellows and volunteers.

SEC. 211. None of the funds appropriated in this Act may be made available to any entity under title X of the Public Health Service Act unless the applicant for the award certifies to the Secretary that it encourages family participation in the decision of minors to seek family planning services and that it provides counseling to minors on how to resist attempts to coerce minors into engaging in sexual activities.

SEC. 212. Subsection (b)(1)(H) of section 401 of the Public Health Service Act (42 U.S.C. 281 (b)(1)(H)) is amended by striking "National Institute of Dental Research" and inserting "National Institute of Dental and Craniofacial Research".

SEC. 213. (a) The final rule entitled "Organ Procurement and Transplantation Network", promulgated by the Secretary of Health and Human Services on April 2, 1998 (63 FR 16295 et seq.) (relating to part 121 of title 42, Code of Federal Regulations), shall not become effective before the expiration of the 1-year period beginning on the date of the enactment of this Act.

(b)(1) The Institute of Medicine under contract with and subject to review by the Comptroller General, in consultation with the Secretary and with the Organ Procure-

ment and Transplantation Network (in this section referred to as the "OPTN"), shall conduct a review of the current polices of the OPTN and the final rule specified in subsection (a) in order to determine the following:

(A) The potential impact on access to transplantation services for low-income populations and for racial and ethnic minority groups. With respect to State policies in carrying out the program under title XIX of the Social Security Act, the determination made under this subparagraph shall include determining the impact of such policies regarding payment for services for patients that are provided to the patients outside of the States in which the patients reside.

(B) With respect to organ procurement organizations (qualified under section 371 of the Public Health Service Act):

(i) The potential impact on the ability of the organizations to facilitate an appropriate rate of organ donation within the service areas of the organizations.

(ii) The reasons underlying the variations in performance among such organizations.

(iii) The potential impact of requiring sharing of organs based on medical criteria instead

of geography on the ability of the organizations to facilitate an appropriate rate of organ donation within the service areas of the organizations.

(C) The potential impact on waiting times for organ transplants, including determinations specific to the various geographic regions of the United States, and if practicable, waiting times for each transplant center by organ and medical status category. The determination made under this subparagraph shall include determining the impact of recent changes made by the OPTN in patient listing criteria and in measures of medical status.

(D) The potential impact on patient survival rates and organ failure rates which lead to retransplantation, including any variance by income status, ethnicity, gender, race, or blood type.

(E) The potential impact on the costs of organ transplantation services.

(F) The potential impact on the liability, under State laws and procedures regarding peer review, of members of the OPTN.

(G) The potential impact on the confidential status of information that relates to the transplantation of organs.

(H) Recommendations, if any, to change existing policies and the final rule.

(2)(A) Not later than May 1, 1999, the Comptroller General of the United States shall submit to the congressional committees specified in subparagraph (B) a report describing the results of the review conducted under paragraph (1).

(B) The congressional committees referred to in subparagraph (A) are the Committee on Commerce of the House of Representatives, the Committee on Appropriations of the House, the Committee on Labor and Human Resources of the Senate, and the Committee on Appropriations of the Senate.

(c)(1) Beginning promptly after the date of the enactment of this Act, the Secretary may conduct a series of discussions with the OPTN in order to resolve issues raised by the final rule referred to in subsection (a).

(2) The Secretary and the OPTN may utilize the services of a mediator in conducting the discussions under paragraph (1). An individual may not be selected to serve as the mediator unless the Secretary and the OPTN both approve the selection of the individual to so serve, and the individual agrees that, not later than June 30, 1999, the individual will submit to the congressional committees specified in subsection (b)(2)(B) a report describing the ex-

tent of progress that has been made through the discussions under paragraph (1).

(d)(1) Beginning on the date of enactment of this Act, the OPTN shall provide to the Secretary, the Institutes of Medicine, and the Comptroller General, upon request, any data necessary to assess the effectiveness of the Nation's organ donation, procurement and organ allocation systems, or to assess the quality of care provided to all transplant patients, and analysis of such data in a scientifically and clinically valid manner. If necessary, the OPTN may provide additional data as they deem appropriate.

(2) The OPTN shall make available to the public timely and accurate program-specific information on the performance of transplant programs. These data shall be updated as frequently as possible, and the OPTN shall work to shorten the time period for data collection and analysis in producing its center-specific outcomes report, including severity adjusted long term survival rates. Such data shall also include such other cost or performance information including but not limited to transplant program-specific information on waiting time within medical status, organ waitings, and refusal of organ offers.

(e) Data provided under subsection (d) shall be specific (if possible) to individual transplant centers and

must be determined in a scientifically and clinically valid manner.

(f) Any disclosure of patient specific medical information under subsection (d) shall be subject to the restrictions contained in the Freedom of Information Act, the Privacy Act, and State laws.

(g) Of the amount appropriated in this title for "OFFICE OF THE SECRETARY-GENERAL DEPARTMENTAL MANAGEMENT", $500,000 shall, not later than 30 days after the date of the enactment of this Act, be transferred to the Comptroller General for purposes of carrying out the studies required and specified in this section.

(h) For purposes of this section:

(1) The term "Comptroller General" means the Comptroller General of the United States.

(2) The term "Organ Procurement and Transplantation Network" means the network operated under section 372 of the Public Health Service Act.

(3) The term "Secretary" means the Secretary of Health and Human Services.

SEC. 214. (a) Section 2003(c) of the Social Security Act (42 U.S.C. 1397b(c)) is amended by striking paragraph (8) and inserting the following:

"(8) $2,299,000,000 for the fiscal year 1998;".

(b) The amendment made by this section takes effect immediately after the amendments made by section 8401 of the Transportation Equity Act for the 21st Century take effect.

SEC. 215. The Consolidated Laboratory Building (Building 50) at the National Institutes of Health is hereby named the Louis Stokes Laboratories.

SEC. 216. None of the funds appropriated by this Act (including funds appropriated to any trust fund) may be used to carry out the Medicare¶Choice program if the Secretary denies participation in such program to an otherwise eligible entity (including a Provider Sponsored Organization) because the entity informs the Secretary that it will not provide, pay for, provide coverage of, or provide referrals for abortions: Provided, That the Secretary shall make appropriate prospective adjustments to the capitation payment to such an entity (based on an actuarially sound estimate of the expected costs of providing the service to such entity's enrollees): Provided further, That nothing in this section shall be construed to change the Medicare program's coverage for such services and a Medicare¶Choice organization described in this section shall be responsible for informing enrollees where to obtain information about all Medicare covered services.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE March 10, 1999

March 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Jackie Brown	DMH DDSAS
Mac Borden	N.C. Pediatric Medical Society
J. Craig Lewis	PCMH
Patricia A Yancy	APPC NC / ACLU
Jim Blackburn	NC Association of County Commissioners
Michelle McPhee	NC Atty Gen's Office
Kyle Armentrout	NC Senate
Phil Hayes	NC Senate
Steve Keene	NC Medical Society
Amy Jo Baggett	NC Medical Society
[illegible]	DHHS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE March 10, 1999

March 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kay Michaels	PPOD
Robert PASchal	Young, Moore & Henderson, P.A.
Ken Schoonhoven	DFS - Facility Planning
Howard KRAMER	N.C. Bd of Nursing
Polly Johnson	NC Bd of Nursing
John Bowdish	Zeb Alley P.A.
Tommy Wentz	CarolinaCare HealthCare System
Alicia Gregory	Poyner & Spruill
Laura Hunsell	NC Bar Association
Mari Smith	NCSA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE March 10, 1999

March 10, 1999

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
W. Rotan Jr	NCDTA - NCDS
[signature]	N. C. A. C. C
HUGH NELSON	NCMA
Victoria Peterson 9 Lewis Ramquist	Durham NCADDA

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
REVISED

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, March 17, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 194, Nurse Licensure Compact** **Senator Rand**

- **S.B. 198, Adult Care Home Licensure** **Senator Carter**

Please Note: S.B. 10 will be heard at a later date; S.B. 194 will be discussed at this meeting.

Senator William R. Purcell, Chair

PLEASE NOTE: THIS MEETING HAS BEEN CANCELLED. We will meet next Wednesday, March 24, 1999.

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, March 17, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING AND BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, March 24, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

• **S.B. 198, Adult Care Home Licensure**	**Senator Carter**
• **S.B. 194 Nurse Licensure Compact**	**Senator Rand**
• **S.B. 273 Cancer Control Reporting**	**Senator Odom**
• **S.B. 160 Nurse Rehabilitation**	**Senator Perdue**

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, March 24, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, March 24, 1999, at 12:05 P.M. in Room 1124 in the Legislative Building. Thirteen members were present, including the Chair, Senator William R. Purcell, who presided.

Senator Purcell called the meeting to order at 12:05 P.M. He introduced Senator Perdue, who explained S.B. 160, Nurse Rehabilitation, which gives the Nursing Board explicit authority to establish programs to aid and monitor nurses experiencing chemical addiction or disability. Senator Lucas moved that the bill be given a favorable report. The motion carried unanimously.

Senator Purcell introduced Senator Rand, who spoke on S.B. 194, Nurse Licensure Compact. Senator Garwood moved for a favorable report. The motion carried unanimously.

Senator Odom was recognized to explain S.B. 273, Cancer Control Reporting. In response to a question from a Committee member, Dr. Rebecca Martin, Director of the North Carolina Central Cancer Registry outlined the data requested for this registry and also the limits on releasing this data. Senator Lucas moved for a favorable report and the motion carried unanimously.

Senator Purcell introduced Senator Carter to explain S.B. 198, Adult Care Home Licensure. After speaking on the bill, he introduced an amendment that he said would clarify two points in the bill. Senator Rucho moved that the amendment be approved, and the motion carried. Senator Purcell asked Secretary of Health and Human Services David Bruton to comment on the bill. Secretary Bruton responded that he had discussed the bill with Senator Carter and concurred with it. Senator Phillips commented that "we absolutely need to look at long-term care in this state; what do we expect from nursing care facilities", and a number of Committee members agreed. Senator Metcalf moved for a favorable report on the bill. The motion carried.

The meeting was adjourned at 12:47 P.M.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
William R. Purcell, Chairman

Corrected Report

Wednesday, March 24, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **160** Nurse Rehabilitation.
Sequential Referral: None
Recommended Referral: None

S.B. **194** Nurse Licensure Compact.
Sequential Referral: None
Recommended Referral: None

S.B. **273** Cancer Control Reporting.
Sequential Referral: None
Recommended Referral: None

FAVORABLE, AS AMENDED

S.B. **198** Adult Care Home Licensure.
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 4

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 160

Short Title: Nurse Rehabilitation. (Public)

Sponsors: Senators Perdue; Carpenter, Carter, Clodfelter, Cochrane, Cooper, Dannelly, Forrester, Garrou, Garwood, Hagan, Hoyle, Kerr, Lucas, Martin of Guilford, Metcalf, Miller, Plyler, Purcell, Rand, Reeves, Shaw of Cumberland, Soles, and Warren.

Referred to: Health Care.

February 22, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF NURSING TO ESTABLISH PROGRAMS TO AID THE REHABILITATION AND MONITORING OF NURSES WHO EXPERIENCE CERTAIN ADDICTIONS AND DISABILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-171.23(b) is amended by adding a new subdivision to read:

"(18) Establish programs for aiding in the recovery and rehabilitation of nurses who experience chemical addiction or abuse or mental or physical disabilities and programs for monitoring such nurses for safe practice."

Section 2. This act is effective when it becomes law.

EXPLANATION OF SENATE BILL 160
Nurse Rehabilitation

TO:	**Senator William Purcell, Chair** **Senate Health Care Committee**
FROM:	**John Young, Committee Staff**
DATE:	**February 26, 1999**
SPONSOR:	**Senator Beverly Perdue**

Background

Article 9 of Chapter 90 defines the practice of nursing and establishes the process for licensing of nurses. G.S. 90-171.37 gives the Board of Nursing certain powers to revoke, suspend or deny a license if the Board determines that an applicant or licensee has "a mental or physical disability or uses any drug to a degree that interferes with his or her fitness to practice.

A number of professions in North Carolina including medicine, pharmacy, dentistry and law have programs sanctioned by the various licensing boards that attempt to rehabilitate rather than take traditional disciplinary actions against its drug-dependent licensees. In 1994, the Board of Nursing established a voluntary pilot program to rehabilitate nurses whose competency could be impaired because of use of alcohol and/or drugs called the Alternative Program for Chemical Dependency.

Background Information on the Alternative Program for Chemical Dependency

Criteria for participation in the Alternative Program for Chemical Dependency include:

1. Nurse acknowledges actions which violate the Nursing Practice Act;
2. Nurse acknowledges a chemical dependency problem;
3. Nurse voluntarily requests to participate in the Program;
4. Nurse has no previous history of disciplinary action by the Board.

Once an individual signs the contract with the Program to participate in the Program, the license is held in abeyance a minimum of three months. Following the time interval, the nurse may petition to return to nursing practice.

While the nurse is on the Program, the nurse is monitored in various ways including various required reports and random urine drug screenings. The nurse must notify the Board if the nurse takes medication, including prescription drugs and certain other over-the-counter medications. Monitoring continues for a minimum of three years from the date the nurse returns to licensed nursing practice.

Summary of Senate Bill 160

Although the Board of Nursing may have implicit authority to conduct the Program for Chemical Dependency, SB 160 adds a new power to the Board that gives the Board explicit authority to establish programs to aid and monitor nurses experiencing chemical addiction or disabilities.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 194

Short Title: Nurse Licensure Compact. (Public)

Sponsors: Senators Rand; Ballance, Carrington, Carter, Clodfelter, Cooper, Dalton, East, Forrester, Garrou, Garwood, Gulley, Hagan, Harris, Horton, Hoyle, Kinnaird, Lucas, Metcalf, Odom, Perdue, Phillips, Purcell, Robinson, and Weinstein.

Referred to: Health Care.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO CREATE THE NURSE LICENSURE COMPACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 9G.

"Nurse Licensure Compact.

"**§ 90-171.80. Entering into Compact.**

The Nurse Licensure Compact is hereby enacted into law and entered into by this State with all other states legally joining therein, in the form substantially as set forth in this Article.

"**§ 90-171.81. Findings and declaration of purpose.**

(a) The General Assembly of North Carolina makes the following findings:

(1) The health and safety of the public are affected by the degree of compliance with and the effectiveness of enforcement activities related to states' nurse licensure laws.

(2) Violations of nurse licensure and other laws regulating the practice of nursing may result in injury or harm to the public.

(3) The expanded mobility of nurses and the use of advanced communication technologies as part of our nation's health care

delivery system require greater coordination and cooperation among states in the areas of nurse licensure and regulation.

(4) New practice modalities and technology make compliance with individual states' nurse licensure laws difficult and complex.

(5) The current system of duplicative licensure for nurses practicing in multiple states is cumbersome and redundant to both nurses and states.

(b) The purposes of this Compact are to:

(1) Facilitate the states' responsibility to protect the public's health and safety.

(2) Ensure and encourage the cooperation of party states in the areas of nurse licensure and regulation.

(3) Facilitate the exchange of information between party states in the areas of nurse regulation, investigation, and adverse actions.

(4) Promote compliance with the laws governing the practice of nursing in each jurisdiction.

(5) Through the mutual recognition of party state licenses, grant all party states the authority to hold nurses accountable for meeting all state practice laws in the states in which their patients are located at the time care is rendered.

"**§ 90-171.82. Definitions.**

The following definitions apply in this Article:

(1) Adverse action. -- A home or remote state action.

(2) Alternative program. -- A voluntary, nondisciplinary monitoring program approved by a nurse licensing board.

(3) Compact. -- This Article.

(4) Coordinated licensure information system. -- An integrated process for collecting, storing, and sharing information on nurse licensure and enforcement activities related to nurse licensure laws that is administered by a nonprofit organization composed of and controlled by state nurse licensing boards.

(5) Current significant investigative information. --

a. Investigative information that indicates a licensee has committed more than a minor infraction.

b. Investigative information that indicates a licensee represents an immediate threat to public health and safety.

(6) Home state. -- The party state that is the nurse's primary state of residence.

(7) Home state action. -- Any administrative, civil, equitable, or criminal action permitted by the home state's laws that is imposed on a nurse by the home state's licensing board or another authority. The term includes the revocation, suspension, or probation of a nurse's license or any other action that affects a nurse's authorization to practice.

(8) Licensee. -- A person licensed by the North Carolina Board of Nursing or the nurse licensing board of a party state.

(9) Licensing board. -- A party state's regulatory agency that is responsible for licensing nurses.

(10) Multistate licensure privilege. -- Current official authority from a remote state permitting the practice of nursing as either a registered nurse or a licensed practical or vocational nurse in that state.

(11) Nurse. -- A registered nurse or licensed practical or vocational nurse as those terms are defined by each party state's practice laws.

(12) Party state. -- Any state that has adopted this Compact.

(13) Remote state. -- A party state, other than the home state, where the patient is located at the time nursing care is provided. In the case of the practice of nursing not involving a patient, the term means the party state where the recipient of nursing practice is located.

(14) Remote state action. -- Any administrative, civil, equitable, or criminal action permitted by the laws of a remote state that are imposed on a nurse by the remote state's nurse licensing board or other authority, including actions against a nurse's multistate licensure privilege to practice in the remote state. The term also includes cease and desist and other injunctive or equitable orders issued by remote states or their nurse licensing boards.

(15) State. -- A state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(16) State practice laws. -- The laws and regulations of individual party states that govern the practice of nursing, define the scope of nursing practice, and create the methods and grounds for disciplining nurses. The term does not include the initial qualifications for licensure or the requirements necessary to obtain and retain a license, except for qualifications or requirements of the home state.

"**§ 90-171.83. General provisions and jurisdiction.**

(a) A license to practice registered nursing that is issued by a home state to a resident in that state shall be recognized by each party state as authorizing a multistate licensure privilege to practice as a registered nurse in each party state. A license to practice practical or vocational nursing that is issued by a home state to a resident in that state shall be recognized by each party state as authorizing a multistate licensure privilege to practice as a licensed practical or vocational nurse in each party state. In order to obtain or retain a license, an applicant must meet the home state's qualifications for licensure and license renewal as well as all other applicable state laws.

(b) Party states may, in accordance with each state's due process laws, revoke, suspend, or limit the multistate licensure privilege of any licensee to practice in their state and may take any other actions under their applicable state laws that are

necessary to protect the health and safety of their citizens. If a party state takes an action authorized in this subsection, it shall promptly notify the administrator of the coordinated licensure information system. The administrator shall promptly notify the home state of any actions taken by remote states.

(c) Every licensee practicing in a party state shall comply with the state practice laws of the state in which the patient is located at the time care is rendered. The practice of nursing is not limited to patient care, but shall include all nursing practice as defined by the state practice laws of a party state. The practice of nursing in a party state shall subject a nurse to the jurisdiction of the nurse licensing board and the laws and the courts in that party state.

(d) The Compact does not affect additional requirements imposed by states for advanced-practice registered nursing. A multistate licensure privilege to practice registered nursing granted by a party state shall be recognized by other party states as a license to practice registered nursing if a license to practice registered nursing is required by state law as a precondition for qualifying for advanced-practice registered nurse authorization.

(e) Persons not residing in a party state may continue to apply for nurse licensure in party states as provided for under the laws of each party state. The license granted to such persons shall not be recognized as granting the privilege to practice nursing in any other party state unless explicitly agreed to by that party state.

"§ 90-171.84. Application for licensure in a party state.

(a) Upon receiving an application for a license, the licensing board in a party state shall ascertain through the coordinated licensure information system whether the applicant holds or has ever held a license issued by any other state, whether there are any restrictions on the applicant's multistate licensure privilege, and whether any other adverse action by any state has been taken against the applicant's license.

(b) A licensee in a party state shall hold licensure in only one party state at a time. The license shall be issued by the home state.

(c) A licensee who intends to change his or her primary state of residence may apply for licensure in the new home state in advance of the change. However, a new license shall not be issued by a party state until after the licensee provides evidence of a change in his or her primary state of residence that is satisfactory to the new home state's licensing board.

(d) When a licensee changes his or her primary state of residence by moving between two party states and obtaining a license from the new home state, the license from the former home state is no longer valid.

(e) When a licensee changes his or her primary state of residence by moving from a nonparty state to a party state and obtaining a license from the new home state, the license issued by the nonparty state shall not be affected and shall remain in full force if the laws of the nonparty state so provide.

(f) When a licensee changes his or her primary state of residence by moving from a party state to a nonparty state, the license issued by the former home state converts to an individual state license that is valid only in the former home state. The license does not grant the multistate licensure privilege to practice in other party states.

"**§ 90-171.85. Adverse actions.**

(a) The licensing board of a remote state shall promptly report to the administrator of the coordinated licensure information system any remote state actions, including the factual and legal basis for the actions, if known. The licensing board of a remote state shall also promptly report any current significant investigative information yet to result in a remote state action. The administrator of the coordinated licensure information system shall promptly notify the home state of any such reports.

(b) The licensing board of a party state may complete any pending investigation of a licensee who changes his or her primary state of residence during the course of the investigation. It may also take appropriate action against a licensee and shall promptly report the conclusion of the investigation to the administrator of the coordinated licensure information system. The administrator of the coordinated licensure information system shall promptly notify the new home state of any action taken against a licensee.

(c) A remote state may take adverse action that affects the multistate licensure privilege to practice within that party state. However, only the home state may take adverse action that affects a license that was issued by the home state.

(d) For purposes of taking adverse action, the licensing board of the home state shall give to conduct reported by a remote state the same priority and effect that it would if the conduct had occurred within the home state. The board shall apply its own state laws to determine the appropriate action that should be taken against the licensee.

(e) The home state may take adverse action based upon the factual findings of the remote state if each state follows its own procedures for imposing the adverse action.

(f) This Compact does not prohibit a party state from allowing a licensee to participate in an alternative program instead of taking adverse action against the licensee. If required by the party state's laws, the licensee's participation in an alternative program shall be confidential information. Party states shall require licensees who enter alternative programs to agree not to practice in any other party state during the term of the alternative program without prior authorization from the other party state.

"**§ 90-171.86. Current significant investigative information.**

(a) If a licensing board finds current significant investigative information as defined in G.S. 90-171.82(5)a., the licensing board shall, after giving the licensee notice and an opportunity to respond if required by state law, conduct a hearing and decide what adverse action, if any, should be taken against the licensee.

(b) If a licensing board finds current significant investigative information as defined in G.S. 90-171.82(5)b., the licensing board may take adverse action against the licensee without first providing the licensee notice or an opportunity to respond to the information. A hearing shall be promptly commenced and determined.

"**§ 90-171.87. Additional authority of party state nursing licensing boards.**

Notwithstanding any other powers, party state nurse licensing boards may do any of the following:

(1) If otherwise permitted by state law, recover from licensees the costs of investigating and disposing of cases that result in adverse action.

(2) Issue subpoenas for both hearings and investigations that require the attendance and testimony of witnesses and the production of evidence. Subpoenas issued by a nurse licensing board in a party state for the attendance and testimony of witnesses or the production of evidence from another party state shall be enforced in the other party state by any court of competent jurisdiction according to the practice and procedure of that court. The issuing authority shall pay any witness fees, travel expenses, mileage, and other fees required by the laws of the party state where the witnesses or evidence are located.

(3) Issue cease and desist orders to limit or revoke a licensee's authority to practice in the board's state.

(4) Adopt uniform rules and regulations that are developed by the Compact administrators as provided in G.S. 90-171.89(c).

"**§ 90-171.88. Coordinated licensure information system.**

(a) All party states shall participate in a cooperative effort to create a coordinated data base of all licensed registered nurses and licensed practical or vocational nurses. This system shall include information on the licensure and disciplinary history of each licensee, as contributed by party states, to assist in the coordination of nurse licensure and enforcement efforts.

(b) Notwithstanding any other provision of law, all party states' licensing boards shall promptly report to the coordinated licensure information system any adverse action taken against licensees, actions against multistate licensure privileges, any current significant investigative information yet to result in adverse action, and any denials of applications for licensure and the reasons for the denials.

(c) Current significant investigative information shall be transmitted through the coordinated licensure information system only to party state licensing boards.

(d) Notwithstanding any other provision of law, all party states' licensing boards contributing information to the coordinated licensure information system may designate information that shall not be shared with nonparty states or disclosed to other entities or individuals without the express permission of the contributing party state.

(e) Any personally identifiable information obtained by a party state licensing board from the coordinated licensure information system shall not be shared with nonparty states or disclosed to other entities or individuals except to the extent permitted by the laws of the party state contributing the information.

(f) Any information contributed to the coordinated licensure information system that is subsequently required to be expunged by the laws of the party state contributing the information shall be expunged from the coordinated licensure information system.

(g) The Compact administrators, acting jointly and in consultation with the administrator of the coordinated licensure information system, shall formulate necessary and proper procedures for the identification, collection, and exchange of information under this Compact.

"**§ 90-171.89. Compact administration and interchange of information.**

(a) The executive director of the nurse licensing board of each party state or the executive director's designee shall be the administrator of this Compact for that state.

(b) To facilitate the administration of this Compact, the Compact administrator of each party state shall furnish to the Compact administrators of all other party states information and documents concerning each licensee, including a uniform data set of investigations, identifying information, licensure data, and disclosable alternative program participation.

(c) Compact administrators shall develop uniform rules and regulations to facilitate and coordinate implementation of this Compact. These uniform rules shall be adopted by party states as authorized in G.S. 90-171.87(4).

"**§ 90-171.90. Immunity.**

A party state or the officers, employees, or agents of a party state's nurse licensing board who act in accordance with this Compact shall not be liable for any good faith act or omission committed while they were engaged in the performance of their duties under this Compact.

"**§ 90-171.91. Effective date, withdrawal, and amendment.**

(a) This Compact shall become effective as to any state when it has been enacted into the laws of that state. Any party state may withdraw from this Compact by enacting a statute repealing the Compact, but the withdrawal shall not take effect until six months after the withdrawing state has given notice of the withdrawal to the Compact administrators of all other party states.

(b) No withdrawal shall affect the validity or applicability of any report of adverse action taken by the licensing board of a state that remains a party to the Compact if the adverse action occurred prior to the withdrawal.

(c) This Compact does not invalidate or prevent any nurse licensure agreement or other cooperative arrangement between a party state and a nonparty state that is made in accordance with this Compact.

(d) This Compact may be amended by the party states. No amendment to this Compact shall become effective and binding upon the party states unless and until it is enacted into the laws of all party states.

"**§ 90-171.92. Dispute resolution.**

If there is a dispute that cannot be resolved by the party states involved, the following procedure shall be used:

(1) The party states shall submit the issues in dispute to an arbitration panel that shall consist of an individual appointed by the Compact administrator in the home state, an individual appointed by the Compact administrator in the remote states involved, and an individual appointed by the Compact administrators of all the party states involved in the dispute.

(2) The decision of a majority of the arbitrators shall be final and binding.

"**§ 90-171.93. Construction and severability.**

This Compact shall be liberally construed so as to effectuate the purposes as stated in G.S. 90-171.81(b). The provisions of this Compact shall be severable and if any phrase, clause, sentence, or provision of this Compact is declared to be contrary to the constitution of any party state or of the United States, or if the applicability thereof to any government, agency, person, or circumstance is held invalid, the validity of the remainder of this Compact and the applicability thereof to any government, agency, person, or circumstance shall not be affected. If this Compact shall be held contrary to the constitution of any party state, the Compact shall remain in full force and effect as to the remaining party states and in full force and effect as to the party state affected as to all severable matters."

Section 2. Any nurse whose license has been restricted by the North Carolina Board of Nursing on the date this act becomes effective shall not practice in any other party state as defined in G.S. 90-171.82(12), as enacted in Section 1 of this act, during the time in which the license is restricted unless the nurse receives prior authorization from such other party state.

Section 3. The North Carolina Board of Nursing shall report to the General Assembly on the implementation of the provisions of this Compact no later than March 1, 2005.

Section 4. This act becomes effective July 1, 2000.

EXPLANATION OF SENATE BILL 194
Nurse Licensure Compact

To: Senate Health Care Committee
From: John Young, Committee Staff
Date: March 10, 1999
Sponsor: Senator Tony Rand

Background

Health care is undergoing rapid new developments. The delivery of health care is increasingly occurring across state lines, both electronically and physically. With the increased utilization of telephones, computers, and other telecommunications, health professionals may consult, teach, triage, advise, and provide direct services from long distances. Health care systems are often multistate organizations that require a mobile workforce to meet the specific needs of patients. A key issue for the health regulatory community is the practice of the profession across state lines. The current regulatory model requires state-by-state licensure. Health professionals involved in telehealth practice or employed by healthcare systems that serve patients across state lines must obtain licenses in multiple jurisdictions.

The National Council of State Boards of Nursing has proposed an agreement among states to coordinate certain activities associated with nurse licensure. Under this proposed interstate compact on nurse licensure, a nurse who is licensed in a party state may practice nursing in all other party states, without the necessity of obtaining a license in each state. The nurse only receives one license, from the state in which he/she resides.

The North Carolina Board of Nursing is proposing that North Carolina become a party to this interstate compact developed by the National Council of State Boards of Nursing which would modify the current licensure process and allow the Board to participate in the mutual recognition model for nursing regulation. Following are the characteristics of a mutual recognition model:

- Each state sets its own licensure requirements, which may be similar but differ in details;
- States voluntarily enter into an agreement to legally recognize the licenses issued by other states, regardless of differences in standards; a licensee may practice in any state participating in the agreement under the license issued by his or her state of residence; and
- The nurse has one licensure record. A centralized database of licensure and discipline information is available to assist all nursing boards in licensure and disciplinary actions.

Summary of SB 194

SB 194 contain the following provisions:

1. **G.S. 90-171.80**-Enacts the Nurse Licensure compact.

2. **G.S. 90-171.81**-Findings and declaration of purpose.

3. **G.S. 90-171.82**-Definitions for the new Article.

4. **G.S. 90-171.83**-Provides that a license to practice registered nursing issued by a home state to a resident of that state shall be recognized by each state that is a party to the compact as a multistate licensure privilege to practice as a registered nurse in each party state. This provision addresses issues of discipline, expressly stating that each state's due process laws apply and a nurse must comply with the state practice laws in the state in which they practice. For those states which have not entered the compact, current licensing laws will apply.

5. **C.S. 90-171.84**-Outlines the procedure for application for a nursing license.

6. **G.S. 90-171.85 and 86**-Outline the procedure for handling a complaint received against a nurse.
7. **G.S. 90.171.87**-Outlines additional authorities of nursing boards party to the compact. The new authority given to the N.C. Board is the ability to issue cease and desist orders to limit or revoke a nurse's ability to practice in North Carolina.

8. **G.S. 90-171-88**-Establishes how information will be exchanged across state lines through a database accessible to each of the boards of nursing. The database is currently in place. Only those states who are part of the compact will have full access.

9. **G.S. 90-171-89**-The executive director of the board will represent the Board in the administration of the compact.

10. **G.S. 90-171-90**-Immunity will be granted to officers, employees, or agents involved in the compact who act in good faith.

11. **G.S. 90-171-91**-Method by which states may enter, withdraw from or amend the compact.

12. **G. S. 90-171-92**-Establishes provisions for dispute settlement among party states.
13. **G. S. 90-171-93**-Severability clause.

Section 3 provides that any nurse whose license has been restricted by the Board, as of the effective date, may not practice in any other party state until the restriction has been lifted.

Section 4 directs the Board to report to the General Assembly on implementation of the compact no later than March 1, 2005.

The act is effective July 1, 2000

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 273

Short Title: Cancer Control Reporting. (Public)

Sponsors: Senators Odom; Carpenter, Perdue, and Rucho.

Referred to: Health Care.

March 8, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE ALL FACILITIES AND PROVIDERS THAT DETECT, DIAGNOSE, OR TREAT CANCER PATIENTS TO REPORT CANCER CASES TO THE CANCER CONTROL REGISTRY.

Whereas, cancer control programs and existing statewide population-based cancer registries throughout the country have identified cancer incidence and cancer mortality rates that indicate that the burden of cancer for Americans is substantial and varies widely by geographic location and ethnicity; and

Whereas, statewide cancer incidence and cancer mortality data can be used to identify cancer trends, patterns, and variation for directing cancer control intervention; and

Whereas, since 1947 North Carolina has mandated that physicians report cancer diagnoses in their patients; and

Whereas, changes in communications and medical technology and in the treatment of disease mean that a substantial majority of the data is obtainable from medical facilities such as hospitals, clinics, and laboratories; and

Whereas, current North Carolina law authorizes but does not require facilities that diagnose or treat cancer patients to report clinical, statistical, and other records of cancer; and

Whereas, the current cancer incidence reporting rate in North Carolina is only 87%. This reporting rate is neither compliant with federal standards of 95% nor compliant with Cancer Registry standards of 100%; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-209 reads as rewritten:

"**§ 130A-209. Incidence reporting of ~~cancer.~~ cancer; charge for collection if failure to report.**

(a) ~~A physician~~ All health care facilities and health care providers that detect, diagnose, or treat cancer shall report to the central cancer registry each diagnosis of cancer in any person who is screened, diagnosed, or treated by the facility or provider. ~~for whom the physician is professionally consulted.~~ The reports shall be made within ~~60 days~~ six months of diagnosis. Diagnostic, demographic and other information as prescribed by the rules of the Commission shall be included in the report.

(b) If a health care facility or health care provider fails to report as required under this section, then the central cancer registry may access the information from the facility or provider and report it in the appropriate format. The Commission may adopt rules requiring that the facility or provider reimburse the registry for its cost to access and report the information in an amount not to exceed one hundred dollars ($100.00) per case. Thirty days after the expiration of the six-month period for reporting under subsection (a) of this section, the registry shall send notice to each facility and provider that has not submitted a report as of that date that failure to file a timely report shall result in collection of the data by the registry and liability for reimbursement imposed under this section. Failure to receive or send the notice required under this section shall not be construed as a waiver of the reporting requirement.

(c) As used in this section, the term:

(1) 'Health care facility' or 'facility' means any hospital, clinic, or other facility that is licensed to administer medical treatment or the primary function of which is to provide medical treatment in this State. The term includes health care facility laboratories and independent pathology laboratories;

(2) 'Health care provider' or 'provider' means any person who is licensed or certified to practice a health profession or occupation under Chapter 90 of the General Statutes and who diagnoses or treats cancer."

Section 2. G.S. 130A-210 is repealed.

Section 3. The Health Services Commission may adopt temporary rules in accordance with Chapter 150B of the General Statutes to implement this section.

Section 4. This act is effective when it becomes law.

EXPLANATION OF SENATE BILL 273
Cancer Control Reporting

TO:	**Senator William Purcell, Chair** **Senate Health Care Committee**
FROM:	**John Young, Committee Staff**
DATE:	**March 22, 1999**
SPONSOR:	**Senator Odom**

Background

G.S. 130A-208 establishes a Central Cancer Registry within the Department of Health and Human Services to compile, tabulate and preserve data that relates to the incidence, treatment and cure of cancer. This data is used to identify cancer trends and patterns that help to direct cancer control and intervention. G.S. 130A-209 requires physicians to report to the registry, within 60 days, each diagnosis of cancer for whom the physician is professionally consulted. G.S. 130A-210 authorizes but does not require medical facilities that diagnosis or treat cancer to report to the registry.

Senate Bill 273

SB 273 does the following:

- Repeals G.S. 130A-210 that is permissive language for medical facilities to report cancer data to the registry;

- Amends G.S. 130A-209 to require all health care providers and health care facilities that diagnosis or treat cancer to report to the Central Cancer Registry each diagnosis of cancer in any person who is treated or diagnosed or treated by the facility or provider within 6 months of diagnosis;

- Permits Central Cancer Registry to access information from the facility or provider if the facility or provider does not report as required, and requires the facility or provider to reimburse the Registry in the amount not to exceed $100 per case; and

- Defines "health care facility" and "health care provider".

The act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 198

Short Title: Adult Care Home Licensure. (Public)

Sponsors: Senators Carter; Albertson, Ballance, Clodfelter, Cooper, Dalton, Forrester, Foxx, Gulley, Hagan, Harris, Jordan, Kinnaird, Lee, Martin of Guilford, Metcalf, Perdue, Rand, Reeves, Robinson, Soles, Warren, Weinstein, and Wellons.

Referred to: Health Care.

March 1, 1999

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE ISSUANCE OF A NEW ADULT CARE HOME LICENSE TO AN APPLICANT WHO WAS THE LICENSEE OR ADMINISTRATOR OF AN ADULT CARE HOME THE LICENSE OF WHICH HAD BEEN REVOKED OR DOWNGRADED TO PROVISIONAL STATUS OR AGAINST WHICH A TYPE A PENALTY HAD BEEN ASSESSED.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-2(b)(1) reads as rewritten:

"(b) Licensure; inspections. --

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the Social Services Commission, all adult care homes for persons who are aged or mentally or physically disabled except those exempt in subsection (c) of this section. Licenses issued under the authority of this section shall be valid for one year from the date of issuance unless revoked earlier by the Secretary of Health and Human Services for failure to comply with any part of this section or any rules adopted hereunder. ~~No new license shall be issued for any domiciliary home whose administrator was the administrator for any domiciliary home [adult care home] that had its license revoked until one full year after the date of revocation.~~ Licenses shall be

renewed annually upon filing and the Department's approval of the renewal application. A license shall not be renewed if outstanding fines and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may by rule require. The Department may amend a license by reducing it from a full license to a provisional license whenever the Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

b. There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

c. There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may revoke a license whenever:

a. The Department finds that:

1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

2. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

b. The Department finds that:

1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

2. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The Department finds that the licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the Social Services Commission, for substantial failure to comply with the provisions of this section or rules promulgated pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license."

Section 2. G.S. 131D-2(b) is amended by adding the following subdivision to read:

"(1b) No new license shall be issued for any adult care home to an applicant for licensure who:

a. Was the administrator, licensee, or owner of an adult care home that had its license revoked until one full year after the date of revocation;

b. Is the administrator, licensee, or owner of an adult care home that was assessed a penalty for a Type A or Type B violation until the earlier of one year from the date the penalty was assessed or until the home has substantially complied with the correction plan established pursuant to G.S. 131D-34 and substantial compliance has been certified by the Department; or

c. Is the administrator, licensee, or owner of an adult care home that had its license summarily suspended or downgraded to provisional status until six months from the date of reinstatement of the license, restoration from provisional to full licensure, or termination of the provisional license, as applicable.

An applicant for new licensure may appeal a denial of certification of substantial compliance under subparagraph b. of this subdivision by filing with the Department a request for review by the Secretary within 10 days of the date of denial of the certification. Within 10 days of receipt of the request for review the Secretary shall issue to the applicant a written determination that either denies certification of substantial compliance or certifies substantial compliance. The decision of the Secretary is final."

Section 3. This act is effective when it becomes law and applies to license applications filed on or after that date. The Social Services Commission and the Secretary of Health and Human Services may adopt temporary rules to implement this act.

EXPLANATION OF SENATE BILL 198
Adult Care Home Licensure

To: Senate Health Care Committee
From: John Young, Committee Staff
Date: March 12, 1999
Sponsor: Senator Charles Carter

Background

The Department of Health and Human Services is required by G.S. 131D-2 to inspect and license, under rules of the Social Services Commission, adult care homes. These licenses are valid for one year unless revoked earlier by the Secretary of DHHS for failure to comply with the requirements of statute and rule. A license shall not be renewed if outstanding fines and penalties imposed by the State have not been paid unless the fines and penalties are being appealed.

Besides the applicable criminal penalties, the 1987 General Assembly established an administrative penalty process for violations of adult care home laws in Chapter 131D of the General Statutes. Violations are classified Type A and Type B violations as follows:

- Type A violation means that the violation results in death or serious physical harm, or results in substantial risk that death or physical harm may occur. The penalty may be not less than $500 or more than $10,000.
- Type B violation means that the violation has direct relationship to the health, safety or welfare of any patient, but does not create substantial risk that death or serious physical harm may occur. This penalty does not carry a monetary penalty but requires a plan of correction. If this is not complied with, then the facility may be fined.
- 10NCAC 42C.1901 requires that an administrator be responsible for the total operation of a home and also responsible to the licensing agency and the monitoring agency (local department of social services) for meeting and maintaining the rules. The administrator must apply to the local department of social services to be qualified as an administrator. These forms are completed and forwarded along with references and other appropriate forms to the Division of Facility Services for approval.

Summary of SB 198

SB 198 would prohibit the Division of Facility Services from issuing a ***new*** adult care home license to the applicant if he/she was the administrator, licensee or owner:

1. whose license had been revoked or summarily suspended or downgraded to a provisional license within the past year; or
2. who was assessed a penalty for an A or B penalty within the past year. If a correction plan as established in G.S. 131D-34 is complied with and certified by DHHS that the penalty has been corrected, then a license may be issued sooner than one year.

The act is effective when it becomes law and applies to license applications filed on or after that date.

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 198

AMENDMENT NO. 1
(to be filled in by
Principal Clerk)

S198-ALH-1

Page 1 of __

Date March 24 ,1999

Comm. Sub. [ ]
Amends Title [ ]

moves to amend the bill on page 3, line 25,
by inserting immediately after the word "status" the following:
"as a result of Type A or B violations"; and

on page 3, line 37,
by inserting immediately after the word "rules" the following:
"pursuant to Chapter 150B".

SIGNED _____
Amendment Sponsor

SIGNED _____
Committee Chair if Senate Committee Amendment

ADOPTED ✓ FAILED _____ TABLED _____

VISITOR REGISTRATION SHEET

HEALTH CARE 3-24-99

Name of Committee Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Dennis Patterson	AP
C. Medlin	covenant w/ NCs Children
J Pinsky	
John Cyrus	N.C. State Grange
Tommy Ward	Carolinas HealthCare System
[illegible]	DHHS
MacBowden	N.C. Pediatric Medical Society & Licensed Professional Counselors
Leslie Brown	DMH DD SAS
Ed Regan	N.C.A.C.C.
Kurt Stephenson	AARP
Bill Little	Duke Univ LTC
Fannie Williams	Duke Univ LTC - Senior Leaders
Mary Bethea	NC Div. of Aging - DHHS
Anna Tefft	OSBM
Mary Beene	OSBM
Pat Burnette	GACPD
Kim Floyd	"
Linda McDaniel	DHHS / DFS
Glenn Wells	DHHS / Public Health
Jenny Cooper	N.C. Assisted Living association

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
S. Celeste Toombs	NCWA
Robin Corbett	NCWA
Patricia A. Yaeger	FOR/SCSL/APPCNC
[illegible]	[illegible]
Richard C Hatch	AARP / NC Coalition on Aging
Peggy Mangum	NCALA
Helen Lipman	Mecklenburg Co. DSS
Michael Buckley MD	Capital Area OB/GYN
Margaret Mullinix RN	NCNA
Kyle Armentrout	NC Senate
Lou Wilson	NCALTCF
Stacy Flannery	NC NCFA
Phillip Reese	Asheville Citizen-Times
DAVE BRENDA	DHHS
Charles Carter	Senate
David C Hodgson	Durham Co. Dept. of Social Services
Will Lang	AHHC
Rebecca D. Martin	NC Central Cancer Registry
John M Bookey, PhD	Director State Ctr Health Statistics
KAREN TAM	DHP
Sudey Barker	NC Nurses Association

VISITOR REGISTRATION SHEET

Name of Committee | Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Polly Johnson	NC Board of Nursing, Raleigh
Katherine Davis	Electric Cities

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, March 31, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 65, Motor Vehicle Occupant Restraints** **Senator Purcell**

Senator William R. Purcell, Chair

Senate Healthcare Committee
Wednesday, March 31, 1999
Senate Bill 65: Motor Vehicle Occupant Restraints

Speakers:
Senator William Purcell
Principal Sponsor of SB 65

Sgt. Jeff Winstead — 4 Minutes
NC State Highway Patrol

Joe Parker
Director
Governor's Highway Safety Program — 2 Minutes

Dana Carroll — 5 Minutes
Greensboro

Agency's in support of Occupant Restraint Legislation

- GHSC
- UNC HSRC
- Child Fatality Task Force
- AAA Carolinas
- NC Medical Society
- NCDOT
- NC State Highway Patrol
- American Trauma Society
- AARP-55 Alive
- NC Covenant for Children
- MADD
- NC Department of Insurance
- Wake County Safe Kids Coalition
- NHTSA
- National Safety Council
- Air Bag & Seat Belt Safety Campaign
- American Coalition for Traffic Safety
- Federal Highway Administration
- Insurance Institute for Highway Safety
- Nationwide Insurance Enterprises

SENATE COMMITTEE ON HEALTH CARE

Wednesday, March 31, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, March 31, 1999, at 12:05 P.M. in Room 1124 in the Legislative Building. Fifteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Michelle Cobb, a page from Wake County, who was sponsored by Senator Eric Reeves.

Senator Purcell asked Senator Bill Martin to preside, since S.B. 65, introduced by Senator Purcell was the bill to be considered by the Committee. A Committee Substitute for this bill was given to the Committee members. Senator Lucas moved that the Committee Substitute be adopted, and the motion carried. Senator Purcell explained the bill, then called on Linda Attarian, Staff Research, to explain the changes contained in the Committee Substitute.

After several questions and comments by the members, Senator Martin called on the first speaker, Sergeant Jeff Winstead of the North Carolina Highway Patrol. Bill Hall, of the Highway Research Center at the University of North Carolina followed him. Senator Martin then introduced Joe Parker, Director of the Governor's Highway Safety Program, and following his presentation, Miss Dana Carroll of Greensboro who spoke of her sister's death in an automobile accident.

Senator Dannelly moved for a favorable report on the Committee Substitute, and the motion carried.

The meeting was adjourned at 12:53 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
William R. Purcell, Chairman

Wednesday, March 31, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **65** Motor Vehicle Occupant Restraints.

Draft Number:	PCS7605
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 65*
Proposed Committee Substitute S65-PCS7605-RM

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors:

Referred to:

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

"(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat ~~safety~~ belts ~~in compliance with Federal Motor Vehicle Safety Standard No. 208 must~~ shall have ~~such~~ a ~~safety~~ seat belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. When the vehicle is equipped with sufficient seat belts to accommodate each passenger seated in the rear seat, each rear seat occupant who is 16 years of age or older shall have a seat belt properly fastened about his or her body in compliance with this section. ~~Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

Section 2. G.S. 20-135.2A(e) reads as rewritten:

"(e) ~~Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person violating~~ Any driver or passenger who fails to wear a seat belt as required by this

section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 3. G.S. 20-135.2A(f) reads as rewritten:

"(f) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A driver's failure to wear a seat belt as required by this section while operating a passenger motor vehicle shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 4. G.S. 20-135.2A(h) is repealed.

Section 5. G.S. 20-135.2B(c) reads as rewritten:

"(c) Any person violating this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 6. Section 3 of Chapter 672 of the 1993 Session Laws is repealed.

Section 7. G.S. 20-137.1(a) reads as rewritten:

"(a) Every driver who is transporting ~~a child~~ one or more passengers of less than ~~12~~ 16 years of age shall have ~~the child~~ each such passenger properly secured in a child passenger restraint system ~~(car safety seat)~~ or seat belt which meets federal standards applicable at the time of its manufacture. ~~The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.~~ In vehicles equipped with active passenger-side front air bags, children shall be properly secured in a rear seat unless the child restraint system is designed for use with air bags or the child is in a properly fitted shoulder and seat belt:

(1) A child less than five years of age and less than 40 pounds in weight shall be properly secured in a child passenger restraint system.

(2) A child five years of age or older, or a child weighing 40 or more pounds, shall be properly secured in a child passenger restraint system or seat belt."

Section 8. G.S. 20-137.1(c) reads as rewritten:

"(c) Any person convicted of violating this section may be punished by a fine not to exceed twenty-five dollars ($25.00). No driver charged under this section for failure to have a child under ~~four~~ five years of age properly secured in a restraint system shall be convicted if he produces at the time of his trial proof satisfactory to the court that he has subsequently acquired an approved child passenger restraint system."

Section 9. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.1, 58-36-65, or 58-36-75."

Section 10. This act becomes effective October 1, 1999.

SENATE BILL 65 - PROPOSED COM. SUB.: Motor Vehicle Occupant Restraints

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Sen. William Purcel
Date:	March 26, 1999	**Summary by:**	Linda Attarian
Version:	D		Committee Counsel

SUMMARY: ***The Committee Substitute for SB 65 changes current law governing mandatory use of seat belts and child restraint systems. The Committee Substitute will require every driver and all front and rear passengers in motor vehicles to be properly secured in a seat belt or child passenger restraint system. A driver's failure to wear a seat belt will be considered a moving violation and will result in the assessment of two driver's license points. The Committee Substitute does not amend current law concerning specific statutory exceptions to the mandatory use requirement. The effective date of the act is October 1, 1999.***

Summary of Changes to the original Senate bill by the Committee Substitute:

Sections 1 through 5 of the Senate bill are unchanged by the Committee Substitute.

Section 6 of the Senate bill is deleted from the Committee Substitute.

Section 7 of the Senate bill is unchanged by the Committee Substitute.

Section 8 of the Committee Substitute is not included in the Senate bill, -- a technical error.

Section 8 of the Senate bill is changed as follows by the Committee Substitute (See Section 7 of Committee Substitute):

- *The 60-pound weight threshold for a child is changed to a 40-pound threshold.*
- *Provisions are added to address passenger side front air bags.*
- *The "federal approval" language is deleted and the "properly secured" language is inserted instead.*

Sections 9 and 10 of the Senate bill are unchanged by the Committee Substitute.

CURRENT LAW:

Requirements: Under current law, only drivers, front seat passengers 16 years and older, and any passengers under 12 occupying the front or rear seats of motor vehicles are required to be properly restrained in a seat belt or child safety seat when the vehicle is in forward motion. Children 4 years old or older may be secured by a seat belt instead of a child safety seat.

Enforcement: Violations of the above requirements will result in a fine of $25.00, but no driver's license points will be assessed. Drivers charged with a violation resulting from the driver's failure to properly secure a child less than four years old in a child restraint system will not result in a conviction if the driver subsequently obtains a child safety seat for the child. A driver's failure to wear a seat belt or a front passenger's failure to wear a seat belt may not be used as evidence in a subsequent criminal or civil trail concerning some other cause of action. Further, a violation resulting from the driver's failure to properly secure a child less than 12 years old may not constitute negligence per se or contributory negligence per se or be introduced as evidence of negligence or contributory negligence in any subsequent tort litigation.

Definitions: "Passenger Motor Vehicle" is defined as a motor vehicle designed to carry up to 10 passengers. The definition does not include a trailer, motorcycle or motorized pedacycle.

Exceptions: There are five exceptions to the mandatory seat belt requirements (G.S. 20-135.2A(c)(1-5):

(1) A driver or occupant with a medical or physical condition that prevents appropriate restraint by a safety belt or with a professionally certified mental phobia against the wearing of vehicle restraints;

(2) A motor vehicle operated by a rural letter carrier of the United States Postal Service while performing duties as a rural letter carrier and a motor vehicle operated by a newspaper delivery person while actually engaged in delivery of newspapers along the person's specified route;

(3) A driver or passenger frequently stopping and leaving the vehicle or delivering property from the vehicle if the speed of the vehicle between stops does not exceed 20 miles per hour;

(4) Any vehicle registered and licensed as a property-carrying vehicle in accordance with G.S. 20-88, while being used for agricultural or commercial purposes; or

(5) A motor vehicle not required to be equipped with seat safety belts under federal law.

COMMITTEE SUBSTITUTE ANALYSIS: Section 1 amends G.S. 20-135.2A(a). This subsection currently requires the driver and each front seat occupant 16 years and older to be properly secured with a seat belt. The bill amends this subsection by adding an additional requirement that occupants 16 years and older in the *rear* seat to also be properly secured with a seat belt.

Section 2 amends G.S. 20-135.2A(e), but makes no substantive changes to current law.

Section 3 amends G.S. 20-135.2A(f). This subsection currently provides that NO drivers license points or insurance points will be assessed as a result of a violation of G.S. 20-135.2A. The bill amends this subsection to provide that a violation of the section will be considered a moving violation, and *two points will be assessed against the violator's driver's license for each violation.* NO insurance points will be assessed as a result of a violation of the section.

Section 4 repeals G.S. 20-135.2A(h). This subsection required the Governor's Highway Safety Program to evaluate the provisions of the section (which was originally enacted in 1985) and make a report no later than October 1, 1988.

Section 5 amends G.S. 20-135.2B(c), but makes no substantive changes to current law.

Section 6 repeals Section 3 of Chapter 672 of the 1993 Session Laws. This section of the Session Laws required the Department of Transportation to conduct a study of the effectiveness of the enactment of HB 27, AN ACT TO RESTRICT THE TRANSPORTATION OF CHILDREN UNDER THE AGE OF

TWELVE IN THE OPEN BED OR OPEN CARGO AREA OF A VEHICLE, 1993 General Session. That report was due no later than January 1, 1998.

Section 7 amends G.S. 20-137.1(a). This subsection currently requires every driver to properly secure all passengers under the age of 12 in an appropriate child safety seat or seat belt. The bill amends this subsection to require the driver to properly secure any passenger under the age of *16* in a child safety seat or seat belt, depending on the child's age and weight.

It further amends the subsection by providing that in vehicles equipped with "active" passenger-side front air bags, the driver must secure a child in the rear seat unless the child restraint system is designed for use with air bags or the child is "properly fitted" in a front seat belt and shoulder strap.

The subsection is also amended to specify that if the child is less than 5 years old and weighs less than 40 pounds, the child must be secured in a child safety seat. If the child is older than 5 years OR weighs more than 40 pounds, the child must be properly secured in a child safety seat OR a seat belt.

Section 8 makes a conforming amendment to G.S. 20-137.1(c).

Section 9 amends G.S. 20-137.1(d). This subsection currently provides that NO drivers license points or insurance points will be assessed as a result of a violation of G.S. 20-137. The bill amends this subsection to provide that a violation of the section will be considered a moving violation, and *two points will be assessed against the violator's driver's license for each violation.* NO insurance points will be assessed as a result of a violation of the section.

Section 10 provides that the act will be effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 65*

Short Title: Motor Vehicle Occupant Restraints. (Public)

Sponsors: Senators Purcell, Gulley, Allran; Clodfelter, Dannelly, Forrester, Garrou, Garwood, Hagan, Hartsell, Lee, Lucas, Martin of Guilford, Miller, Phillips, Reeves, and Shaw of Cumberland.

Referred to: Health Care.

February 10, 1999

A BILL TO BE ENTITLED

AN ACT TO ENHANCE MOTOR VEHICLE OCCUPANT RESTRAINT SAFETY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 20-135.2A(a) reads as rewritten:

"(a) Each front seat occupant who is 16 years of age or older and each driver of a passenger motor vehicle manufactured with seat safety belts ~~in compliance with Federal Motor Vehicle Safety Standard No. 208~~ must have such a safety belt properly fastened about his or her body at all times when the vehicle is in forward motion on a street or highway in this State. When the vehicle is equipped with sufficient safety belts to accommodate each passenger seated in the rear seat, each rear seat occupant who is 16 years of age or older must have a seat safety belt properly fastened about his or her body in compliance with this section. ~~Each driver of a passenger motor vehicle manufactured with seat safety belts in compliance with Federal Motor Vehicle Safety Standard No. 208, who is transporting in the front seat a person who is (i) under 16 years of age and (ii) not required to be restrained in accordance with G.S. 20-137.1, must have the person secured by such a safety belt at all times when the vehicle is operated in forward motion on a street or highway in this State. Persons required to be restrained in accordance with G.S 20-11 and G.S. 20-137.1 must be secured as required by those sections.~~"

Section 2. G.S. 20-135.2A(e) reads as rewritten:

"(e) ~~Any person violating this section during the period from October 1, 1985, to December 31, 1986, shall be given a warning of violation only. Thereafter, any person~~

~~violating~~ Any driver or passenger who fails to wear a seat belt as required by this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 3. G.S. 20-135.2A(f) reads as rewritten:

"(f) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A driver's failure to wear a seat belt as required by this section while operating a passenger motor vehicle shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 4. G.S. 20-135.2A(h) is repealed.

Section 5. G.S. 20-135.2B(c) reads as rewritten:

"(c) Any person violating this section shall have committed an infraction and shall pay a ~~fine~~ penalty of twenty-five dollars ($25.00). ~~An infraction is an unlawful act that is not a crime. The procedure for charging and trying an infraction is the same as for a misdemeanor, but conviction of an infraction has no consequence other than payment of a fine.~~ A person ~~convicted of an infraction~~ found responsible for a violation of this section may not be assessed court costs."

Section 6. G.S. 20-135.2B(d) reads as rewritten:

"(d) No ~~drivers license points or~~ insurance points or insurance surcharge shall be assessed on account of violation of this section. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 7. Section 3 of Chapter 672 of the 1993 Session Laws is repealed.

Section 8. G.S. 20-137.1(a) reads as rewritten:

"(a) Every driver who is transporting ~~a child~~ one or more passengers of less than ~~12~~ 16 years of age shall have ~~the child~~ each such passenger properly secured in ~~a child~~ an age-appropriate passenger restraint ~~system (car safety seat) which meets federal standards applicable at the time of its manufacture. The requirements of this section may be met when the child is four years of age or older by securing the child in a seat safety belt.~~ system.

When a child is less than five years of age or less than 60 pounds in weight, the requirements of this section shall be met by securing the child in a child restraint system which meets federal standards applicable at the time of its manufacture. The child restraint system shall be secured in a rear seat of the vehicle if the vehicle has a rear seat that will accommodate a child restraint system.

When a child is five years of age or older or is 60 pounds or more in weight, the requirements of this section may be met by securing the child in a seat safety belt."

Section 9. G.S. 20-137.1(d) reads as rewritten:

"(d) No ~~driver license points or~~ insurance points shall be assessed for a violation of this section; nor shall a violation constitute negligence per se or contributory

negligence per se nor shall it be evidence of negligence or contributory negligence. A violation of this section shall be considered a moving violation for purposes of G.S. 20-16(c), but shall not be considered a moving violation for purposes of G.S. 20-28.21, 58-36-65, or 58-36-75."

Section 10. This act becomes effective July 1, 1999.

Attachment A

FACT SHEET

HOUSE BILL 57 / SENATE BILL 65

"MOTOR VEHICLE OCCUPANT RESTRAINTS"

March 19, 1999

The Need for the Legislation

This legislation is needed to save approximately 90 lives and prevent approximately 800 serious injuries in North Carolina each year. Our existing seat belt laws do not have a sufficient sanction against infraction prone drivers who according to a documented study tend not to hook up themselves or their children. Existing laws on child restraint systems need to be updated to avoid deaths and injuries from air bags and to assure proper restraint until children are big enough to use a seat and shoulder belt. Rear seat belt use by adults would save several lives per year.

Publicity such as the "Click It or Ticket" campaign has been helpful, but in order to be fully effective, must be supplemented by enforcement.

What the Legislation Does

House Bill 57 and Senate Bill 65 would make it clear that children less than five years of age or less than 40 pounds in weight should be in a passenger restraint system, such as a child safety seat or bed. Most importantly, the bill provides that in cars with front seat air bags, children must be secured in a rear seat of the vehicle unless the child is in a restraint system designed for use with air bags or is restrained by a lap and properly fitted shoulder belt. This requirement does not apply if all available passenger restraint systems and seat belts are in use. Existing law only requires children less than four years of age to be in a passenger restraint system. See G.S. 20-137.1.

The bill further addresses the consistent careless driver who is concerned with not accumulating 12 drivers' license points within a three-year period by assigning two drivers' license points to a driver who is not belted or who does not require all children less than 16 years of age to be belted. Studies show that drivers with bad driving records typically have a low seat belt utilization rate and are more prone (1) to have accidents and (2) to leave children unbelted. The bill specifically provides that no insurance points are to be assigned for seat belt violations.

The bill also requires rear seat belt use by adults if sufficient belts are available. Adults in the front seat are already required by existing law to be restrained.

Who Sponsors and Supports the Legislation?

Senate sponsors of Senate Bill 65 are as follows: Senators Purcell, Gulley, and Allran (Primary Sponsors); Clodfelter, Dannelly, Forrester, Garrou, Garwood, Hagan, Hartsell, Lee, Lucas, Martin of Guilford, Miller, Phillips, Reeves, and Shaw of Cumberland

House sponsors of House Bill 57 are as follows: Representatives Alexander and Clary (Primary Sponsors); Boyd-McIntyre, Bridgeman, Cox, Easterling, Goodwin, Hensley, Jarrell, Luebke, Melton, and Mosley

The legislation is supported by AAA of the Carolinas, the American Academy of Pediatrics, the Child Fatality Task Force, the Governor's Highway Safety Program, the North Carolina College of Emergency Physicians, and the North Carolina Department of Transportation, and the North Carolina Medical Society.

For further information, please contact Ann Duncan or Lawrence Davis at 755-2100.

Attachment B

Senate Bill 65 / House Bill 57: Frequently Asked Questions

How many people are being killed now in NC because of not buckling up? How many children? How many back seat adults?

During the three years from July 1995 through June 1998, a total of 3546 occupants of cars, vans and trucks were killed in NC crashes. Of these:

- 165 were children less than age 12 (covered by the child passenger safety law). Of these,
  - 108 (65%) were reported* not to have been buckled up at the time of the crash and
  - 105 (64%) of the children killed were in the front seat.
- 3381 occupants killed were age 12 and older and subject to the seat belt law if in the front seat. Of these,
  - 1940 (57%) were reported not to have been buckled up at the time of the crash
  - 215 (7%) were in the back seat. Of the rear seat occupants killed, 182 (85%) were reported not to have been buckled up at the time of the crash.

* The codes for restraint use contained in the NC crash files cannot be used as an accurate indicator of actual use rates due to over-reporting of seat belt use by drivers and other persons involved in crashes. Restraint use for fatalities is probably more accurate than for other levels of injury due to more thorough investigations for fatalities.

How many people are being seriously injured now in NC because of not buckling up? How many children? How many back seat adults?

During the three years from July 1995 through June 1998, a total of 26,085 occupants of cars, vans and trucks were seriously injured in NC crashes. Of these:

- 1226 were children less than age 12 (covered by the child passenger safety law). Of these,
  - 566 (46%) were reported* not to have been buckled up at the time of the crash and
  - 677 (55%) of the children seriously injured were in the front seat.
- 24,859 occupants killed were age 12 and older and subject to the seat belt law if in the front seat. Of these,
  - 7662 (31%) were reported not to have been buckled up at the time of the crash
  - 1585 (6%) were in the back seat. Of the rear seat occupants seriously injured, 1114 (70%) were reported not to have been buckled up at the time of the crash.

* The codes for restraint use contained in the NC crash files cannot be used as an accurate indicator of actual use rates due to over-reporting of seat belt use by drivers and other persons involved in crashes. Restraint use for fatalities is probably more accurate than for other levels of injury due to more thorough investigations for fatalities.

How many children in North Carolina have been killed by air bags?
There have been 69 children killed due to air bags in the US since 1995. As the table below indicates, none of the deaths have been to children properly restrained at the time of the crash.

Children Killed Due to Air Bags in the US through January 1, 1999	
Total	69
• In rear-facing child safety seats [1]	15
• In forward-facing child safety seats [2]	2
• Unrestrained or improperly restrained children	48
• Wearing lap and shoulder belt [3]	4

[1] Rear-facing child safety seat can never be installed in front of an air bag
[2] Seats in use were improperly installed
[3] Children small enough to have been in child safety seat

Of these 69, four were North Carolina children. These included a five-month-old infant in a rear-facing child safety seat (05/97), a four-year-old unrestrained child (05/96), an eight-year-old unrestrained child (08/97), and a three-year-old child held on the lap of another passenger (11/97).

Don't we already have high utilization rates as compared with other states. What is the correlation between these rates and injuries and deaths prevented?
North Carolina does have high seat belt use in relation to the rest of the country, one of the highest in the nation. This is due to good seat belt and child passenger safety laws, and ongoing active public education and enforcement programs. As a result, the fatal and serious injury rate (the percent of crash-involved drivers and passengers killed or seriously injured) for occupants covered by these laws has been decreasing over the years. Statistical analysis by the UNC Highway Safety Research Center indicates that this decline can be attributed to the education and enforcement programs.

It is quite clear also that we have reached a plateau of 80%- 85% belt use in North Carolina, similar to the experience of other states with high belt use as well as other countries such as Canada. As was shown in Canada, demerit points for violations can push seat belt use even higher.

Why is it necessary to tell an adult to buckle up? Why does it hurt anyone else? What are the extra insurance costs and extra medical costs that must be paid through taxes?
Simply put, history has shown that motorists do not start wearing seat belts in response to educational messages alone. Prior to 1985, public information and education programs in North Carolina were able to increase seat belt use to about 25%. Seat belt use jumped to 45% as soon as the NC seat belt law went into effect in October 1985, even though warning tickets

only could be issued for the first 15 months. When the penalty phase ($25 ticket for a seat belt violation) went into effect in January 1987, seat belt use in NC jumped immediately to 80%. Over the next few years, belt use declined and leveled off at about 60% until the 1993 *Click It Or Ticket* education and enforcement campaign pushed belt use back up to 80+% and belt use in NC has remained relatively steady at this level since.

Research indicates that seat belt nonusers are more often involved in high risk behaviors such as drinking and driving, are less likely to have health care coverage, and are more likely to be involved in crashes. The rate for over involvement in crashes by nonusers has been determined by the UNC Highway Safety Research Center (HSRC) to be as much as 35%.

Unrestrained occupants in crashes do not hurt just themselves. Occupant to occupant contact is a significant cause of injury in crashes. Front seat occupants are especially prone to injury from unbelted rear seat occupants being thrown toward the front seat in a frontal crash.

As taxpayers, we all end up paying for injuries to people without adequate health care coverage and, as noted, seat belt nonusers are less likely to have health care coverage than belt users. HSRC has estimated that implementing stronger sanctions for seat belt violations in the form of driver license points could get at least a large portion of the belt nonusers to buckle up and save NC taxpayers close to $17 million per year in direct medical and emergency costs.

Because of their high-risk lifestyle and higher crash involvement, increases in belt use for the people who currently do not buckle up should result in greater reductions in deaths, injuries and societal costs than did previous increases in belt use.

What if you have more adults or children in the car than available seats or seat belts?
The proposed seat belt law exempts all adults (age 16 and older) if there are more rear seat passengers than available belts and the current child passenger safety (CPS) law already exempts children if all available belted seating positions are occupied.

How many people lose their license each year because of points? How many people could lose their license from a seat belt law violation? How long does it take to get a driver license back?
There are about 6.7 million licensed drivers in North Carolina. As of May 1998, about 5,000 drivers had 10 driver license points and another 3,500 had 11 points. Less than one percent (0.13%) of licensed drivers could lose their license due to points from a single seat belt or child passenger safety law violation.

If a driver accumulates as many as twelve points within a three-year period, his or her license may be suspended. It may be taken for: 60 days for the first suspension; 6 months for the second; and 12 months for the third. When the driving privilege is reinstated, all previous

driver license points are canceled. The accumulation of eight points within three years following the reinstatement of a license can result in a second suspension.

How many seat belt violators are repeat offenders?
There is no way to know. Since no points are assessed, there is no way to track repeat violators.

What is the possibility that drivers license points will later on be reflected in insurance points and higher insurance premiums?
Proposed revisions in Senate Bill 65 / House Bill 57 specifically prohibit the assignment of insurance points or assessment of insurance surcharges for violations of the seat belt or child passenger safety laws.

Who gets the ticket for unbelted adult passengers?
The driver of the vehicle is responsible for passengers subject to the child passenger safety law (currently less than age 12 and proposed to include children less than age 16). Front seat passengers age 16 and older are responsible for themselves and subject to fines for seat belt violations.

How many points for multiple unbelted children?
The wording used for the proposed changes limits the assignment of points to 2 driver license points even if multiple children are unrestrained.

What about an unbelted driver and child?
The driver would be assigned 2 points for his or her own seat belt violation and another 2 points for the child passenger safety law violation for a total of 4.

Didn't the National Transportation Safety Board (NTSB) issue a statement years ago to the effect that using rear seat belts without shoulder harnesses was more dangerous than being unbelted?
This NTSB issued a report, "Performance of Lap Belts in 26 Frontal Crashes," in July 1986 that stopped just short of saying that, in their opinion, no seat belt is better than using a lap belt alone without a shoulder belt. Serious seat belt-induced injuries are possible but these injuries tend to be less frequent and less severe than injuries suffered by unrestrained occupants. Restraint effectiveness estimates issued by the National Highway Traffic Safety Administration indicate that lap-only seat belts are about 25% effective in reducing fatal and serious injuries.

Current recommendations for choosing and using different types of restraints are that all occupants, children and adults, should use some type of upper body restraint such as the harness in a child safety seat or a lap and shoulder belt combination whenever possible but that when no other option exists, the lap belt alone should be used.

Isn't it better to be thrown clear of a car in a crash? What about crashes where a person was saved by being thrown out of the back seat and the ones trapped in were killed?
There may be cases where unrestrained occupants fared better than those belted in, but these are relatively rare and hard to document. Several facts are clear, however, from many years of study by many different people:

- Ejection from a vehicle increases your chance of being killed or seriously injured by about 25%.
  - Vehicles are designed to protect people, but the occupants must stay in the vehicle to take advantage of this.
  - People who are thrown from the vehicle may be lucky and land on soft ground, but they are just as likely to hit the pavement, a tree, a guardrail, or even be run over by their own or some other vehicle.
  - Some people may fear being "trapped" in a burning car, but in fact less than one-half of one percent (0.5%) of crash-involved vehicles catch on fire or go into water. In addition to the low probability of fire or submersion in water happening, properly restrained occupants are more likely to remain conscious and escape the vehicle if it does catch on fire.
- Seat belts and child safety seats are designed to protect people. Child safety seats can save about two-thirds of the children who die unrestrained and seat belts can save about half of the older children and adults who die unrestrained.

How many other states require adults to be belted in the back seat?
Twelve states (Alaska, California, District of Columbia, Kentucky, Maine, Massachusetts, Montana, Nevada, Oregon, Rhode Island, Vermont, Washington) require adults to be buckled up in the rear seat.

How many other states assess drivers license points?
One state (Arkansas) and the District of Columbia assign driver license points for seat belt violations.
Seven states (Alaska, Arkansas, California, Florida, Indiana, New York and Virginia) and the District of Columbia assign points for child restraint violations.

How many other states require child restraints to age 5?
Two states (Arizona and Vermont) require a child passenger restraint system to be used for children less than age 5 (age 4 and younger) with no weight limits.

Four states (South Dakota, Nevada, Wyoming, and Massachusetts) require a child passenger restraint system to be used for children less than age 5 (age 4 and younger) with a 40 pound weight limit as well for use of a seat belt.

Why add another year and a weight limit to the requirement for children to be in a car seat? How are police officers going to be able to enforce weight? Does this mean that they will have to carry scales with them?

The intent of the requirement to keep children in some type of child passenger restraint system until turning age 5 or when they reach 40 pounds is two-fold:

- Child passenger restraint systems (car seats, car beds, harnesses, and booster seats) give children the best protection and should be used until they are really big enough for a seat belt. Under the current NC law, a child can be put into a seat belt at age four even though most four-year-olds are too small to be adequately protected by a seat belt. Many parents assume that if the use of a belt is legal at age 4, then it must be safe.

  Adding another year to the requirement for when children must be in a child passenger restraint system will help to ensure that as many children as possible will receive as much protection as possible in crashes. It should be noted that many parents already comply, and will be able to continue to comply, with this requirement by using booster seats designed to make an available lap and shoulder belt combination fit correctly on a child.

- On the other hand, some three-year-olds are really big and may have outgrown all readily available car seats. (There are "special needs" seats designed for children up to about 100 pounds, but they cost around $500.) The current NC law does not make provision for these large, but still young, children.

In any enforcement stop for possible child passenger safety law violations, the officer must already rely on the word of the parent as to the age of the child and give them the benefit of the doubt. We would expect that officers will do the same for weight. If the child is in a seat belt that fits the child correctly, there would be no reason to issue a citation.

If a child is clearly too small to weigh 40 pounds, and some officers have indicated that they can judge weight more readily than age, the officer would have the option of either educating the parent about the requirements or issue a citation. Parents would have the option of providing proof to the court that the child does indeed weigh at least 40 pounds.

Seventeen states include a weight limit in addition to age for use of a car seat. Enforcement in these states has been accomplished without the need for officers to carry scales.

How many other states require children to be in the back seat?

Three states have some form of requirement for children to be in the rear seat:

- Delaware requires children less than age 12 and less than 65 inches tall to be in the rear seat in passenger-side air bag equipped vehicles where a rear seat is available.
- Louisiana requires children ages 3 through 12 years to be in the rear seat if a rear seat is available.

- Rhode Island requires children 5 years old and younger to be in the rear seat if a rear seat is available.

How do the changes to the child passenger safety law affect day care centers and schools?

Neither the seat belt law nor the child passenger safety law makes reference to who owns or operates the vehicle. Instead they require seat belt or child restraint system use for covered occupants in vehicles required by federal standards to be equipped with seat belts. Thus, day care centers and schools, both public and private, are covered under the child passenger safety law whenever they are transporting children in vehicles required by federal standards to have seat belts.

Any organization is covered under the child passenger safety law if it transports children in passenger cars, vans, or buses required to be equipped with seat belts. Any organization is exempt from the child passenger safety law if it is transporting children in a bus of any type (city bus, charter bus or school bus) not required to be equipped with seat belts.

It should be noted that federal law requires that buses sold to organizations meet Federal standards for school buses (Federal Motor Vehicle Safety Standard 222) if the vehicle will be used for transporting children to or from school or related activities (federal law classifies any vehicle with a seating capacity of 11 or more, including the driver, as a bus). It is not illegal, however, for organizations to use standard vans (those not meeting FMVSS 222) to transport children to and from school if they already have those vehicles.

Large school buses are not required to be equipped with seat belts. Instead, school buses protect children by their larger size, structural integrity and well padded, high back seats placed close together. These "compartmentalized" seats provide very good protection in most crashes. Small school buses, those with a gross vehicle weight rating under 10,000 pounds, must be equipped with lap or lap/shoulder belts at all designated seating positions. Since their sizes and weights are closer to those of passenger cars and trucks, the agency believes seat belts in those vehicles are necessary to provide occupant protection.

Organizations transporting children in vans or other vehicles would be affected by the change in the provision related to when a seat belt is allowable. Under the current law, children can be buckled into a seat belt at age 4, regardless of size. The changes being considered would require that some type of child passenger restraint system be used until the child reaches age 5 or reaches 40 pounds. Many of the 4-year-olds would be large enough to use a seat belt and booster seats could be used for the ones still under 40 pounds.

The National Transportation Safety Board (NTSB) recommends that states pass laws requiring children less than age 12 to be in the back seat of all vehicles when one is available. Proposed revisions to the NC child passenger safety law would require children to be in a rear seat in passenger-side air bag equipped vehicles only and allows children to be in front if secured in a child restraint device designed for use with an air bag or in a properly fitted lap shoulder belt. Why not follow the NTSB recommendations?

In general, the rear seat in general, and the center-rear position in particular, is recommended for maximum protection in most crashes. When possible, the rear seat should be used, especially in passenger side air bag vehicles. Moving a child from the front to the back seat increases the level of protection by about 25% and several dozen children have been killed due to air bags. However, there are several instances where children may be better off in the front seat. There are at least three situations where the use of a safety seat in the front seat would be preferred and recommended over the rear seat:

- A car with five belts (two in front and three in back), driver and passenger air bags, and four children. Among the children, three are required to be in car seats and one is allowed to be in a seat belt. If all car seats were required to be in the rear seat, the older child would be placed in the front seat. If the seat belt does not fit well on this child it would be dangerous and should be avoided. The recommended practice in a case like this would be to have a child in a full-harness car seat in the front position (the harness would keep the child away from the air bag) with the child in the seat belt in the back seat.
- There can also be cases where it may be better to have children with some medical conditions in the front seat if the driver has no one else along to monitor the child.
- A four-year old child weighing 45 pounds would be required to be in a car seat. In an older vehicle with only lap belts in the rear seat, you would not be able to use any of the current convertible or booster seats in the rear seat positions. In general, use of a belt-positioning booster used with the front seat lap and shoulder belt combination could be recommended over a rear seat lap belt only.

As far as the air bag-related deaths and serious injuries to children are concerned, almost all have been cases of rear-facing seats placed in front of an air bag or where the children have been unrestrained or in improperly fitted lap shoulder belts. Placing a rear-facing seat in front of an air bag is extremely dangerous and would be illegal since the car seat and vehicle manufacturers specifically warn that this should not be done. Unrestrained and improperly seat belted children get thrown toward the dashboard during pre-impact braking such that they are right against the air bag when it comes out of the dashboard with an explosive force. Proposed revisions to the law would require that any child in front of an air bag be in a restraint that would keep the child away from the air bag.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — March 31, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Shannon Bullock	GHSP
Kathy Carroll	Visitor
Dana Carroll	" "
Joe Porter	GHSP
Paula A. Wolf.	Covenant w/NC's Children
Crissy Porter	Bone & associates
Alicia Gregory	Poyner & Spruill
Andy Fouts	WCSA
Matt Osborne	AOC
Norma Lobo	NC Nurses Association
Harriet Shapiro	YA/O

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — March 31, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
C Medlin	Coalition of NC's Children
Bill Hall	UNC-HSRC - Chapel Hill
Jeff Winstead	NCSHP
[illegible]	NCMS
[illegible]	DHHS
MT Burnett	GACPD
Ian Rose	UNC
Liz Newlin	WakeMed
John Lyons	N.C. State Grange
Alan Miles	Bailey & Dixon LLP
Michael Bryant	DMV / Driver Services

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — March 31, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Soren Schmidt	NC Justice Center
Pam Seamans	NC Social Services Consortium/ Covenant w/ NC's Children
Robert Moses	NY Parks Council
Adam Searing	NCHAC
Jackie Brown	DMH DDSAS
Steve Keene	NC Medical Society
Susan Valaani	National
[illegible]	Moore & Van Allen
[illegible]	" "
[illegible]	Sen. Ed Warren
Peyton Maynard	9pm inc.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — March 31, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	WCSR

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, April 7, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- S.B. 344, Managed Care/Specialist Referral — Senator Forrester
- S.B. 345, URO Reviews by NC Physicians — Senator Forrester
- S.B. 348, Stop Misuse of Laser Pointers — Senator Forrester

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, April 7, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, April 7, 1999, at 12:04 P.M. in Room 1124 in the Legislative Building. Twelve members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Philip Stewart of the Town of Wade, sponsored by Senator Rand.

Senator Purcell introduced Senator Forrester, who explained S.B. 348, *Stop Misuse of Laser Pointers*. After discussion, Senator Miller moved that this bill be rereferred to Judiciary I Committee. The motion passed and the bill will be rereferred.

Senator Forrester presented a Committee Substitute for S.B. 344, *Mgd. Care/Specialist Referral.* He moved that this Committee Substitute be accepted for discussion. The motion carried, and Senator Forrester explained the changes to the Committee. Senator Lucas made a motion for an unfavorable report for the original bill and a favorable report for the Committee Substitute. The motion was seconded by Senator Warren, and carried.

The third bill presented by Senator Forrester was S.B. 345, *URO Reviews by NC Physicians*. Following discussion, Senator Rucho moved that the bill be rereferred to the Insurance Committee. The motion was seconded by Senator Dannelly and carried.

The meeting adjourned at 12:46 P.M.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, April 07, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **345** URO Reviews by NC Physicians.
Sequential Referral: None
Recommended Referral: Insurance

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **344** Mgd. Care/Specialist Referral.
Draft Number: PCSA605
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 348

Short Title: Stop Misuse of Laser Pointers. (Public)

Sponsors: Senators Forrester and Carpenter.

Referred to: Health Care.

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE MISUSE OF LASER DEVICES.

The General Assembly of North Carolina enacts:

Section 1. Article 8 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-34.8. Criminal use of laser device.**

(a) For purposes of this section, the term 'laser' means light amplification by simulated emission of radiation.

(b) It is unlawful intentionally to point a laser device at another person while the device is emitting a laser beam.

(c) A violation of this section is a Class 1 misdemeanor.

(d) This section does not apply to a law enforcement officer who uses a laser device in discharging or attempting to discharge the officer's official duties. This section does not apply to a person who is licensed or otherwise authorized by law to use a laser device in the person's profession if the laser device is used by the person in discharging or attempting to discharge the person's official duties."

Section 2. This act becomes effective December 1, 1999, and applies to offenses committed on or after that date.

SENATE BILL 348:
Stop Misuse of Laser Pointers

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Senators Forrester, Carpenter
Date:	April 5, 1999		
Version:	1	**Summary by:**	John Young Committee Staff

SUMMARY: This bill would define a laser device and prohibit its misuse. The effective date of the bill would be December 1, 1999

BACKGROUND: Laser pointers are handy devices used by teachers and public speakers but these pointers have the potential to be a dangerous toy that can impair vision if used improperly. The federal Food and Drug Administration has warned that aiming a laser into the eye can cause more damage than staring directly into the sun. Currently there are no statutes in North Carolina that regulate these devices.

BILL ANALYSIS: Senate bill 348 would do the following:

1. Define "laser" as as light amplification by simulated emission of radiation;
2. Make it unlawful to point a laser devicee at another person intentionally while the device is emitting radiation;
3. Exempt the use of a laser device by a law enforcement officer who uses it in attempting to discharge his official duties or by someone who uses it in carring out the person's professional duties.
4. Make the violation of the provisions a Class 1 misdemeanor. (Class1 misdemeanor with no prior record is 1-45 days of community punishment)

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 345

Short Title: URO Reviews by NC Physicians. (Public)

Sponsors: Senators Forrester, Purcell; and Carpenter.

Referred to: Health Care.

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT RECONSIDERATION AND APPEAL OF UTILIZATION REVIEW NONCERTIFICATION BE EVALUATED BY MEDICAL DOCTORS LICENSED TO PRACTICE IN THIS STATE.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"(d) Program Operations. -- In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor licensed to practice medicine in this State shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. G.S. 58-50-61(i) reads as rewritten:

"(i) Requests for Reconsideration. -- An insurer may establish procedures for informal reconsideration of noncertifications. The reconsideration shall be conducted

between the covered person's provider and a medical doctor licensed to practice medicine in this State designated by the insurer. An insurer shall not require a covered person to participate in an informal reconsideration before the covered person may appeal a noncertification under subsection (j) of this section."

Section 3. G.S. 58-50-61(j) reads as rewritten:

"(j) Appeals of Noncertifications. -- Every insurer shall have written procedures for appeals of noncertifications by covered persons or their providers acting on their behalves, including expedited review to address a situation where the time frames for the standard review procedures set forth in this section would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. Each appeal shall be evaluated by a medical doctor licensed to practice medicine in this State who was not involved in the noncertification."

Section 4. G.S. 58-50-61(l) reads as rewritten:

"(l) Expedited Appeals. -- An expedited appeal of a noncertification may be requested by a covered person or his or her provider acting on the covered person's behalf only when a nonexpedited appeal would reasonably appear to seriously jeopardize the life or health of a covered person or jeopardize the covered person's ability to regain maximum function. The insurer may require documentation of the medical justification for the expedited appeal. The insurer shall, in consultation with a medical ~~doctor,~~ doctor licensed to practice medicine in this State, provide expedited review, and the insurer shall communicate its decision in writing to the covered person and his or her provider as soon as possible, but not later than four days after receiving the information justifying expedited review. The written decision shall contain the provisions specified in subsection (k) of this section. If the expedited review is a concurrent review determination, the insurer shall remain liable for the coverage of health care services until the covered person has been notified of the determination. An insurer is not required to provide an expedited review for retrospective noncertifications."

Section 5. This act is effective when it becomes law and applies to utilization reviews conducted on or after January 1, 2000.

SENATE BILL 345:
URO Reviews

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Forrester
Date:	April 3, 1999	**Summary by:**	Linda Attarian
Version:	1		Committee Counsel

SUMMARY: SB 345 changes the current law to requires doctors who evaluate pre-certification denials made by managed care organizations and doctors who investigate appeals from pre-certification denials to be licensed to practice medicine in North Carolina, and thereby under the jurisdiction of the State Medical Board.

CURRENT LAW: Every insurer is required to maintain a utilization review program to monitor the use of health care services and to evaluate the clinical necessity, appropriateness, efficacy or efficiency of health services, providers, or facilities. [G.S. 58-60-61(c)]. Utilization review techniques are used to determine whether a health care service (including an admission or continued stay) meets the insurer's requirements for medical necessity, appropriateness, health care setting, and level of care or effectiveness. This determination is called "pre-certification". [G.S. 58-60-61(a)(17)(c)]. In evaluating whether a particular health care services or supply is medically necessary, insurers employ "clinical review criteria" which include written screening procedures, decision abstracts, clinical protocols, and practice guidelines, in making such determinations. [G.S. 58-60-61(a)(2)].

"Qualified health professionals" under the direction of a "medical doctor" must oversee the insurer's utilization review program. The current law does not define "medical doctor", and thus, a medical doctor could include a person who is not licensed to practice medicine in this state or any other state. [G.S. 58-60-61(d)]. **SB 345 does NOT propose to change the current law with respect to medical doctors who *oversee* the insurer's untilization review program.**

With respect to determinations that a particular health care service does not meet the insurer's requirements for medical necessity, appropriateness, health care setting, level of car or effectiveness, the current law requires a "medical doctor" to review the clinical appropriateness of that determination. Again, "medical doctor" is not defined, and could include a person who is not licensed to practice medicine in this state or any other state. [G.S. 58-60-61(d)]. **SB 345 DOES propose to change current law, by requiring this medical doctor to be licensed to practice in North Carolina.**

Insures are also required to have procedures in place for covered persons to appeal the insurer's certification denial. Under North Carolina law, insurers may provide covered persons with a right to request a "reconsideration" of the denial, but all insurers must provide covered persons with an avenue to formally appeal such denials, including an expedited appeal process when time is of the essence. [G.S. 58060-61(j)].

A reconsideration of a certificafication denial is conducted by the covered person's provider and a "medical doctor" designated by the insurer. [G.s. 58-60-61(I)]. Further, a "medical doctor" must evaluate all appeals of certification denials that was not involved in the certification decision. [G.S. 58-60-61(j)]. In both provisions, the term "medical doctor" is not defined, and thus could include a person who is not

licensed to practice medicine in this state or any other state. **SB 345 proposes to change current law, by requiring this medical doctor to be licensed to practice in North Carolina.**

BILL ANALYSIS: **Section 1:** Amends G.S. 58-50-61(d) to require only medical doctors licensed to practice medicine in North Carolina to evaluate the clinical appropriateness of certification denials under the insurer's utilization review program. Current law does not specify state licensure.

Section 2. Amends G.S. 58-50-61(I) to require insurers to designate only medical doctors licensed to practice medicine in North Carolina to participate in any informal reconsideration of certification denials. Current law does not specify state licensure.

Section 3. Amends G.S. 58-50-61(j) to require insurers to employ only medical doctors licensed to practice medicine in North Carolina to evaluate appeals of certification denials. Current law does not specify state licensure.

Section 4. Amends G.S. 58-50-61(l) to require insurers to consult with only medical doctors licensed to practice in North Carolina to provide an expedited review of a certification denial when such an expedited review is warranted under the statute. Current law does not specify state licensure.

Section 5. Effective date: The act is effective when it becomes law and applies to utilization reviews conducted on or after January 1, 2000.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 7, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
J Ramquist	NCSOS
Michelle McPherson	NCDOJ
Beth Mulcahy	BCBS NC
Joyce Peters	MANCI
Cressy Porter	Bone & Associates
Nancy Pelligreen	UNC
Tommy Worth	Carolinas HealthCare System
Mac Boxley	N.C. Pediatric Medical Society
Mari Smith	NCSCRS
Zeb Alley	ZPA PA
John Bowdish	Zeb Alley P.A.
Amy Jo Bair	NCMS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 7, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Glenn Walker	DHHS / Public Health
Chris Hoke	DHHS
Hugh Tilson	NCHA
Stevie Keene	NCMS
Peyton Maynard	Gpn
W.H. Potter, Jr.	NCDS - NCPTA
Lewis Kirkman	Moore - Van Allen
[illegible]	u
Helen Lipman	Meck. Co.
David Simmons	

REVISED NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, April 14, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 348, Stop Misuse of Laser Pointers**
- **S.B. 793, Psychology Practice Definitions**

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, April 14, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, April 14, 1999, at 12:06 P.M. in Room 1124 in the Legislative Building. Thirteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Rachel Hunt of Goldsboro, who was sponsored by Senator Kerr.

Senator Purcell introduced Senator Clodfelter, who presented his bill, S.B. 793, *Psychology Practice Definitions.* He explained the bill to the Committee members. After some discussion, Senator Rucho moved that the bill receive a favorable report. The motion carried unanimously.

Senator Purcell recognized Senator Forrester who moved that the vote on S.B. 348, *Stop Misuse of Laser Pointers*, to refer the bill to the Insurance Committee be reconsidered. This motion had been made at the April 7, 1999, meeting of the Committee. The motion carried. Dr. Forrester reviewed the bill's intents, then asked Senator Purcell to introduce the speakers. The first speaker was Dr. Raynor Casey, a Raleigh opthamologist. Following his presentation, Senator Purcell introduced Mr. Tim Hitchcock, who is a certified industrial hygienist. Mr. Hitchcock gave the committee three handouts (Attachments A, B, and C). He gave a detailed description of several types of laser pointers outlined in an overhead projector presentation (Attachment D).

Senator Purcell introduced Mike Okun, of the North Carolina AFL-CIO. Mr. Okun spoke briefly as to the importance of passing this bill in regard to the potential effect of having the beam directed at law officers.

Senator Lucas and Senator Moore each presented an amendment. It was agreed that a Committee Substitute would be drawn up which would incorporate these amendments. Senator Dannelly moved that an unfavorable report be given to the bill, and a favorable report be given to the Committee Substitute. The motion carried.

The meeting adjourned at 12:48 P.M.

Senator William R. Purcell, Chair

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

REVISED REPORT

Wednesday, April 14, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **793** Psychology Practice Definitions.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
William R. Purcell, Chairman

Monday, April 19, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **348** Stop Misuse of Laser Pointers.

Draft Number:	PCS4675
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 793

Short Title: Psychology Practice Definitions. (Public)

Sponsors: Senator Clodfelter.

Referred to: Health Care.

April 8, 1999

A BILL TO BE ENTITLED

AN ACT AMENDING THE PSYCHOLOGY PRACTICE ACT TO INCLUDE WITHIN THE SCOPE OF PRACTICE THE DIAGNOSIS AND TREATMENT OF NEUROPSYCHOLOGICAL ASPECTS OF PHYSICAL ILLNESS, ACCIDENT, INJURY, OR DISABILITY AND TO DEFINE THE TERM NEUROPSYCHOLOGICAL.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-270.2 is rewritten to add the following new subsection to read:

"(7a) Neuropsychological. -- Pertaining to the study of brain-behavior relationships, including the diagnosis, including etiology and prognosis, and treatment of the emotional, behavioral, and cognitive effects of cerebral dysfunction through psychological and behavioral techniques and methods."

Section 2. G.S. 90-270.2(8) reads as rewritten:

"(8) Practice of psychology. -- The observation, description, evaluation, interpretation, or modification of human behavior by the application of psychological principles, methods, and procedures for the purpose of preventing or eliminating symptomatic, maladaptive, or undesired behavior or of enhancing interpersonal relationships, work and life adjustment, personal effectiveness, behavioral health, or mental health. The practice of psychology includes, but is not limited to: psychological testing and the evaluation or assessment of personal characteristics such as

SENATE BILL 793:
Psychology Practice Definitions

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Clodfelter
Date:	April 12, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: This bill amends the Psychology Practice Act to include within its scope of practice the diagnosis (including etiology and prognosis) and treatment of neuropsychological aspects of physical illness, accident, injury, or disability and to define the term "neuropsychology".

CURRENT LAW: Article 18A of Chapter regulates the practice of psychology and was first passed by the General Assembly in 1967. This act establishes the North Carolina Psychology Board that consist of seven members appointed by the Governor . The Board is composed of three licensed psychologists, two licensed psychological associates and two members of the public. The act defines the practice of psychology and who must be licensed to practice and who is exempt .

BILL ANALYSIS: Senate Bill 793 amends the "definitions" section of the Psychology Practice Act to:

1. Add a definition of "neuropsychological"; and
2. Clarify that within the scope of practice of psychology is diagnosis, including etiology and prognosis, and treatment of neuropsychological aspects of physical illness, accident, injury, or disability. This would confirm that diagnosis includes determinations of cause and prognosis

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 348
Proposed Committee Substitute S348-PCS4675-RY

Short Title: Stop Misuse of Laser Pointers. (Public)

Sponsors:

Referred to:

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE MISUSE OF LASER DEVICES.

The General Assembly of North Carolina enacts:

Section 1. Article 8 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-34.8. Criminal use of laser device.**

(a) For purposes of this section, the term 'laser' means light amplification by stimulated emission of radiation.

(b) It is unlawful intentionally to point a laser device at another person while the device is emitting a laser beam.

(c) A violation of this section is a Class 1 misdemeanor.

(d) This section does not apply to a law enforcement officer who uses a laser device in discharging or attempting to discharge the officer's official duties. This section does not apply to a person who is licensed or otherwise authorized by law to use a laser device in the person's profession if the laser device is used by the person in discharging or attempting to discharge the person's official duties.

(e) This section does not apply to laser tag and similar games and devices using light emitting diode (LED) technology."

Section 2. This act becomes effective December 1, 1999, and applies to offenses committed on or after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 348

Short Title: Stop Misuse of Laser Pointers. (Public)

Sponsors: Senators Forrester and Carpenter.

Referred to: Health Care.

March 15, 1999

A BILL TO BE ENTITLED

AN ACT TO PROHIBIT THE MISUSE OF LASER DEVICES.

The General Assembly of North Carolina enacts:

Section 1. Article 8 of Chapter 14 of the General Statutes is amended by adding a new section to read:

"**§ 14-34.8. Criminal use of laser device.**

(a) For purposes of this section, the term 'laser' means light amplification by simulated emission of radiation.

(b) It is unlawful intentionally to point a laser device at another person while the device is emitting a laser beam.

(c) A violation of this section is a Class 1 misdemeanor.

(d) This section does not apply to a law enforcement officer who uses a laser device in discharging or attempting to discharge the officer's official duties. This section does not apply to a person who is licensed or otherwise authorized by law to use a laser device in the person's profession if the laser device is used by the person in discharging or attempting to discharge the person's official duties."

Section 2. This act becomes effective December 1, 1999, and applies to offenses committed on or after that date.

SENATE BILL 348:
Stop Misuse of Laser Pointers

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Senators Forrester, Carpenter
Date:	April 5, 1999		
Version:	1	**Summary by:**	John Young Committee Staff

SUMMARY: This bill would define a laser device and prohibit its misuse. The effective date of the bill would be December 1, 1999

BACKGROUND: Laser pointers are handy devices used by teachers and public speakers but these pointers have the potential to be a dangerous toy that can impair vision if used improperly. The federal Food and Drug Administration has warned that aiming a laser into the eye can cause more damage than staring directly into the sun. Currently there are no statutes in North Carolina that regulate these devices.

BILL ANALYSIS: Senate bill 348 would do the following:

1. Define "laser" as as light amplification by simulated emission of radiation;
2. Make it unlawful to point a laser devicee at another person intentionally while the device is emitting radiation;
3. Exempt the use of a laser device by a law enforcement officer who uses it in attempting to discharge his official duties or by someone who uses it in carring out the person's professional duties.
4. Make the violation of the provisions a Class 1 misdemeanor. (Class1 misdemeanor with no prior record is 1-45 days of community punishment)

Attachment A

Compiled By Kelly Anders
National Conference of State Legislatures

Laser Pointer Legislation—February 1999

Total Found: 31

States: Arkansas, California, Connecticut, Illinois, Kansas, Maryland, Massachusetts, Michigan, New York, Rhode Island, Tennessee, Texas, Virginia, and Washington

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Arkansas

1. 1999 Bill Tracking AR H.B. 1343, 82ND REGULAR SESSION, HOUSE BILL 1343, DATE-INTRO: JANUARY 29, 1999, LAST-ACTION: FEBRUARY 19, 1999; From SENATE Committee on PUBLIC HEALTH, WELFARE AND LABOR: Do pass., Prohibits the sale of hand-held laser pointers to minors., ARKANSAS BILL TRACKING STATENET Copyright (c) 1999 by State Net(R), All Rights Reserved.

California

2. 1999 Bill Tracking CA A.B. 293, 1999-00 REGULAR SESSION, ASSEMBLY BILL 293, Related news search, DATE-INTRO: FEBRUARY 8, 1999, LAST-ACTION: FEBRUARY 19, 1999; To ASSEMBLY Committee on PUBLIC SAFETY., Makes it a misdemeanor for any person, corporation, firm, or business entity of any kind to knowingly supply, deliver, sell, or give possession or control of a laser pointer, as defined, to a minor 18 years or younger., CALIFORNIA BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Connecticut

3. 1999 Bill Tracking CT H.B. 5227, 1999 REGULAR SESSION OF THE GENERAL ASSEMBLY HOUSE BILL 5227, DATE-INTRO: JANUARY 13, 1999, LAST-ACTION: JANUARY 13, 1999; To JOINT Committee on PUBLIC SAFETY., Prohibits the sale of laser pointers to people under 18., CONNECTICUT BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

4. 1999 Bill Tracking CT H.B. 5358, 1999 REGULAR SESSION OF THE GENERAL ASSEMBLY HOUSE BILL 5358, DATE-INTRO: JANUARY 14, 1999, LAST-ACTION: JANUARY 14, 1999; To JOINT Committee on JUDICIARY., Protects children from misuse of laser pointers that can result in serious eye damage as well as potential fatal injury if such laser beam is directed at a police officer., CONNECTICUT BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

5. 1999 Bill Tracking CT H.B. 5407, 1999 REGULAR SESSION OF THE GENERAL ASSEMBLY HOUSE BILL 5407, DATE-INTRO: JANUARY 14, 1999, LAST-ACTION: JANUARY 14, 1999; To JOINT Committee on PUBLIC SAFETY., Regulates the sale, possession and use of laser pointers., CONNECTICUT BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Illinois

6. 1999 Bill Tracking IL H.B. 272, 91ST GENERAL ASSEMBLY – 1999-00 GENERAL ASSEMBLY, HOUSE BILL 272, Related news search , DATE-INTRO: JANUARY 27, 1999 LAST-ACTION: FEBRUARY 2, 1999; To HOUSE Committee on JUDICIARY II - CRIMINAL LAW., Creates the offenses of juvenile possession of a laser pointer and transferring a laser pointer to a juvenile; prohibits the possession by a person under 18 years of age

of a laser pointer; prohibits the transfer of a laser pointer to a person under 18 years of age; penalties are Class B misdemeanors; creates the offense of aiming a laser pointer at a peace officer; penalty is a Class A misdemeanor; provides that it is a Class B felony to attach a laser pointer to a firearm or to use in c, ILLINOIS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

7. 1999 Bill Tracking IL H.B. 343, 91ST GENERAL ASSEMBLY -- 1999-00 GENERAL ASSEMBLY, HOUSE BILL 343, Related news search, DATE-INTRO: JANUARY 28, 1999, LAST-ACTION: FEBRUARY 18, 1999; In HOUSE. Read third time. Passed HOUSE. *****To SENATE., Amends the Criminal Code of 1961; creates the offense of aiming a laser pointer at a peace officer; penalty is a Class A misdemeanor; amends the Unified Code of Corrections; provides that the court may impose an extended term sentence if the defendant uses a firearm in the commission of a crime and the firearm has a laser sight attached to it., ILLINOIS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

8. 1999 Bill Tracking IL S.B. 87, 91ST GENERAL ASSEMBLY -- 1999-00 GENERAL ASSEMBLY, SENATE BILL 87, Related news search, DATE-INTRO: JANUARY 28, 1999, LAST-ACTION: FEBRUARY 18, 1999; In SENATE Committee on JUDICIARY: Postponed in committee., Creates the offenses of juvenile possession of a laser pointer and transferring a laser pointer to a juvenile; prohibits the possession by a person under 18 years of age of a laser pointer; prohibits the transfer of a laser pointer to a person under 18 years of age; penalties are Class B misdemeanors; creates the offense of aiming a laser pointer at a Class 3 felony to attach a laser pointer to a firearm or to use a laser pointer in conjunction with a Firearm., ILLINOIS BILL TRACKING STATENET Copyright (c) 1999 by State Net(R). All Rights Reserved.

Kansas

9. 1999 Bill Tracking KS H.B. 2292, 78TH LEGISLATURE -- 1999 REGULAR SESSION, HOUSE BILL 2292, DATE-INTRO: FEBRUARY 5, 1999, LAST-ACTION: FEBRUARY 8, 1999; To HOUSE Committee on JUDICIARY., Pertains to laser pointers; prohibits sale and possession under certain conditions., KANSAS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

10. 1999 Bill Tracking KS H.B. 2378, 78TH LEGISLATURE -- 1999 REGULAR SESSION, HOUSE BILL 2378, DATE-INTRO: FEBRUARY 10, 1999, LAST-ACTION: FEBRUARY 11, 1999; To HOUSE Committee on JUDICIARY., Concerns crimes and punishments; relates to injury or harassment by laser pointer; prescribes penalty therefor., KANSAS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Maryland

11. 1999 Bill Tracking MD S.B. 568; (NEW BILL), 1999 REGULAR SESSION, SENATE BILL 568, DATE-INTRO: FEBRUARY 5, 1999, LAST-ACTION: FEBRUARY 5, 1999; To SENATE Committee on JUDICIAL PROCEEDINGS., Prohibits a person from selling, giving, or offering to sell or give a laser pointer to an minor; prohibits the use of the laser pointers under certain circumstances; provides exceptions to the prohibition on the use of laser pointers; and provides a penalty for violating provisions., MARYLAND BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Massachusetts

12. 1999 Bill Tracking MA H.B. 3805; (NEW BILL), 181ST GENERAL COURT -- 1999 REGULAR SESSION, HOUSE BILL 3805, Related news search, DATE-INTRO: JANUARY 6, 1999, LAST-ACTION: JANUARY 6, 1999; To JOINT Committee on CRIMINAL JUSTICE., Relates to the penalty for the sale of laser pointers to minors., MASSACHUSETTS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

13. 1999 Bill Tracking MA S.B. 220; (NEW BILL), 181ST GENERAL COURT -- 1999 REGULAR SESSION, SENATE BILL 220, Related news search , DATE-INTRO: JANUARY 6, 1999, LAST-ACTION: JANUARY 6, 1999; To JOINT Committee on EDUCATION, ART AND HUMANITIES., Prohibits the possession or sale of

laser pointers in schools. MASSACHUSETTS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

14. 1999 Bill Tracking MA S.D. 467, 181ST GENERAL COURT -- 1999 REGULAR SESSION, SENATE DOCKET 467, Related news search , DATE-INTRO: DECEMBER 7, 1998, LAST-ACTION: JANUARY 19, 1999; Assigned SENATE Bill No. 220., Prohibits laser pointers in schools., MASSACHUSETTS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Michigan

15. 1999 Bill Tracking MI S.B. 33; (NEW BILL), 90TH LEGISLATURE -- 1999 REGULAR SESSION, SENATE BILL 33, Related news search , DATE-INTRO: JANUARY 26, 1999, LAST-ACTION: JANUARY 26, 1999; To SENATE Committee on EDUCATION., Relates to discipline in education; prohibits laser pointers in schools., MICHIGAN BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

16. 1999 Bill Tracking MI S.B. 154; (NEW BILL), 90TH LEGISLATURE -- 1999 REGULAR SESSION, SENATE BILL 154, Related news search , DATE-INTRO: JANUARY 27, 1999, LAST-ACTION: JANUARY 27, 1999; To SENATE Committee on FAMILIES, MENTAL HEALTH AND HUMAN SERVICES., Relates to trade and consumer goods and services; prohibits the sale of laser pointers to minors and possession of laser pointer by a minor., MICHIGAN BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

New York

17. 1999 Bill Tracking NY A.B. 3053; (NEW BILL), 222ND ANNUAL LEGISLATIVE SESSION, ASSEMBLY BILL 3053, DATE-INTRO: JANUARY 28, 1999, LAST-ACTION: JANUARY 28, 1999; To ASSEMBLY Committee on CODES., Crates the crime of criminal sale of laser pointers to minors less than 18 years of age; makes such sale a class A misdemeanor; requires laser pointers displayed for sale to be placed in locked display cases., NEW YORK BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

18. 1999 Bill Tracking NY A.B. 4203, 222ND ANNUAL LEGISLATIVE SESSION, ASSEMBLY BILL 4203, DATE INTRO: FEBRUARY 8, 1999, LAST-ACTION: FEBRUARY 8, 1999; To ASSEMBLY Committee on CODES., Prohibits the sale of laser pointing devices to persons under the age of 18; provides for the storage and display of laser pointers; provides that violations result in a class A misdemeanor., NEW YORK BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

19. 1999 Bill Tracking NY A.B. 4205, 222ND ANNUAL LEGISLATIVE SESSION, ASSEMBLY BILL 4205, Related news search, DATE-INTRO: FEBRUARY 8, 1999, LAST ACTION: FEBRUARY 8, 1999; To ASSEMBLY Committee on CODES., Regulates the sale and use of laser pointers; imposes restrictions on their sale or other transfer to minors and their manner of display in retail establishments; prohibits their possession or use in certain places by minors; prohibits the illumination of certain public servants by lasers by any person; makes provisions for exceptions and affirmative defenses., NEW YORK BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

20. 1999 Bill Tracking NY S.B. 2576; (NEW BILL), 222ND ANNUAL LEGISLATIVE SESSION, SENATE BILL 2576, DATE-INTRO: FEBRUARY 11, 1999, LAST-ACTION: FEBRUARY 11, 1999; To SENATE Committee on CONSUMER PROTECTION., Prohibits the sale of laser pointing devices to persons under the age of 18; provides for the storage and display of laser pointers; provides that violations result in a class A misdemeanor., NEW YORK BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Rhode Island

21. 1999 Bill Tracking RI H.B. 5453, 1999-2000 LEGISLATIVE SESSION, HOUSE BILL 5453, DATE-INTRO: JANUARY 28, 1999, LAST-ACTION: JANUARY 28, 1999; To HOUSE Committee on JUDICIARY., Creates a

new criminal violation for possession as sale of laser pointers to minors., RHODE ISLAND BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

22. 1999 Bill Tracking RI H.B. 5902, 1999-2000 LEGISLATIVE SESSION, HOUSE BILL 5902, DATE-INTRO: FEBRUARY 2, 1999, LAST-ACTION: FEBRUARY 2, 1999; To HOUSE Committee on JUDICIARY., An act relating to criminal offenses; laser pointers., RHODE ISLAND BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

23. 1999 Bill Tracking RI H.B. 6058, 1999-2000 LEGISLATIVE SESSION, HOUSE BILL 6058, DATE-INTRO: FEBRUARY 2, 1999, LAST-ACTION: FEBRUARY 2, 1999; To HOUSE Committee on JUDICIARY., Creates criminal offenses for use of laser pointers., RHODE ISLAND BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Tennessee

24. 1999 Bill Tracking TN H.B. 857, 101ST GENERAL ASSEMBLY, HOUSE BILL 857, DATE-INTRO: FEBRUARY 11, 1999, LAST-ACTION: FEBRUARY 18, 1999; In HOUSE. Read second time., Creates a Class A misdemeanor offense of pointing laser pointer device at law enforcement officer with intent to frighten officer or interfere with performance of officer's official duties., TENNESSEE BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

25. 1999 Bill Tracking TN S.B. 895, 101ST GENERAL ASSEMBLY, SENATE BILL 895, DATE-INTRO: FEBRUARY 11, 1999, LAST-ACTION: FEBRUARY 17, 1999; To SENATE Committee on JUDICIARY., Creates a Class A misdemeanor offense of pointing laser pointer device at law enforcement officer with intent to frighten officer or interfere with performance of officer's official duties., TENNESSEE BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Texas

26. 1999 Bill Tracking TX H.B. 943, 76TH LEGISLATURE, HOUSE BILL 943, Related news search , DATE-INTRO: JANUARY 26, 1999, LAST-ACTION: FEBRUARY 9, 1999; To HOUSE Committee on CRIMINAL JURISPRUDENCE., Relates to the use of laser pointers, regulation of., TEXAS BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Virginia

27. 1998 Bill Tracking VA H.B. 1894, 1999 SESSION, HOUSE BILL 1894, DATE-INTRO: JANUARY 15, 1999, LAST-ACTION: FEBRUARY 16, 1999; Eligible for GOVERNOR'S desk., Authorizes local school boards to regulate the use or possession of laser pointers by students on school property or attending school functions or activities and establish disciplinary procedures for violations., VIRGINIA BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

28. 1998 Bill Tracking VA H.B. 2103, 1999 SESSION, HOUSE BILL 2103, DATE-INTRO: JANUARY 20, 1999, LAST-ACTION: JANUARY 20, 1999; To HOUSE Committee on EDUCATION., Prohibits possession of laser pointers by any person on (i) property of any public, private or parochial elementary, middle or high school, including buildings and grounds, (ii) that portion of any property open to the public used for school-sponsored functions or extracurricular activities while such functions or activities are taking place, or (iii) any school bus owned or operated by any such school., VIRGINIA BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

29. 1998 Bill Tracking VA H.B. 2741, 1999 SESSION, HOUSE BILL 2741, DATE-INTRO: JANUARY 21, 1999, LAST-ACTION: JANUARY 21, 1999; To HOUSE Committee on COURTS OF JUSTICE., Creates a new Class 1 misdemeanor for aiming a laser pointer at a police officer with a mandatory, minimum sentence of six months, 30 days of which shall not be suspended., VIRGINIA BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

Washington

30. 1999 Bill Tracking WA S.B. 5846, 56TH FIRST REGULAR SESSION, SENATE BILL 5846, DATE-INTRO: FEBRUARY 10, 1999, LAST-ACTION: FEBRUARY 11, 1999; To SENATE Committee on JUDICIARY., Regulates laser pointers., WASHINGTON BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

31. 1999 Bill Tracking WA S.B. 5849, 56TH FIRST REGULAR SESSION, SENATE BILL 5849, DATE-INTRO: FEBRUARY 11, 1999, LAST-ACTION: FEBRUARY 11, 1999; To SENATE Committee on JUDICIARY., Makes unlawful use of a laser pointer a misdemeanor., WASHINGTON BILL TRACKING STATENET Copyright (c) 1999 by Information for Public Affairs, Inc.

THE UNIVERSITY OF BIRMINGHAM

Laser Pointers

Recently, there has been much in the local and national press regarding the abuse of laser pointers. Laser pointers have become a 'normal' item of equipment in our lecture theatres. As a result of the reports, we have consulted with the University Safety Unit. In general terms, laser pointers fall into four categories, Class 1, Class 2, Class 3A and Class 3B. Class 1 and Class 2 laser pointers are the recommended choice where a laser pointer is necessary. Class 3B pointers must not be used.

All the pointers supplied by LRAT for use in the lecture theatres are Class 2. Some Class 3B pointers provided by individual Schools for use in the theatres have been withdrawn and replaced. Notices about the use of laser pointers are to be fixed in all lecture theatres which have them over the next few days. It is important that all staff return the pointers to their boxes after use, and where possible lock them away to prevent theft.

If you would like further details on any of the above or have any comments or suggestions to make, please call me on ext 6495. Alternatively you can send email to: a.kelly@bham.ac.uk. General enquires regarding the lecture theatres or equipment hire can be made to Pat Askey, ext 6492, email: p.a.askey@bham.ac.uk

Toni Kelly

Back to Information Services Bulletin

For further information please contact Kevin Knowles

These pages are maintained by Kevin Knowles

Last updated - 21/12/98

Hidden Dangers of Laser Pointers

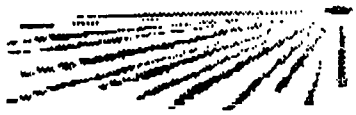
Laser pointers, typically designed to be used as a tool in business and other professional slide shows and presentations, are causing cases of temporary blindness. According to the Food and Drug Administration and the American Academy of Ophthamology (AAO), if someone looks at the red beam for several seconds, damage to the eye's retina can occur and temporary blindness can develop. Two children are known to have been injured by lasers after looking at them for several seconds. Their symptoms included temporary vision loss, decrease vision, and a burning sensation in the eyes. These pointers are sold any number of ways but recently have been marketed towards children as fun and powerful toys. Some cities are banning the sale of lasers to minors without parental consent. The AAO offers the following recommendations for use of laser pointers:

*Laser pointers are not toys and should not be handled or used by children
*Only FDA approved pointers with warning labels should be used.
*Laser pointers should only be used as presentation tools.
*All warnings on the laser pointer should be strictly followed
*Never shine a laser pointer at anyone for any reason

As a physician, I read the information I received from the American Academy of Pediatrics and had more questions. The information states "damage to the retina can occur". It doesn't comment if this damage is permanent or reversible. The symptoms of decreased vision and blindness appear to be temporary. I don't know if one could then assume the retinal damage is also temporary. I e-mailed the American Academy of Ophthamology to get some clarification in March 1999, when I received the information. They are only taking question about eye organ donation this month. Hmm. I feel taking a chance on thinking the retinal damage inflicted by laser pointers is temporary, like the symptoms, is unwise. I usually err for being safe instead of sorry. Because of my cautious nature, I am of the opinion that there is no place for lasers in children's toys. Toys and games containing lasers should not be purchased.

HOME

EYE DOCTORS CONCERNED ABOUT LASER POINTERS:



Growing Number of Eye Injury Cases Reported among Children

The following is an excerpt from American On Line.

October 6, 1998

SAN FRANCISCO, Oct. 6 /PRNewswire/ -- In the wake of two recent reports of eye injuries caused by laser pointers, the American Academy of Ophthalmology upgraded an earlier caution to a warning: ***laser pointers are hazardous and should be kept away from children.***

"We've known that laser pointers had the potential to damage eyes, but we haven't had clear clinical evidence of injuries," said Martin Mainster, M.D., subject expert for the Academy. "We now have reports from Academy members who treated two patients with eye injuries from laser pointers."

Phoenix retina specialist Clive H. Sell, M.D., said he saw an 11-year-old girl who experienced temporary vision loss after staring at the laser beam for several seconds, several times. According to Dr. Sell, the girl and her friends wanted to see if her pupil would constrict. Dr. Sell reported his findings at the Nantucket Retina Society Meeting in July 1998.

Recently, pediatric ophthalmologist, Jane C. Edmond, M.D. of Wilmington, Delaware saw a 13-year-old girl who stared at a laser beam for about 10 seconds. The girl reported an immediate burning sensation and decreased vision. Her vision gradually improved over the next week. "While it is unlikely that anyone would be injured by a brief flash from a laser pointer," Dr. Mainster said, "it is apparent that many children misuse them. It is important that parents and school officials realize laser pointers are not toys. Adults need to take laser pointers very seriously and not allow children to play with them."

Last December, after receiving reports of possible eye injuries, The Food and Drug Administration issued a warning about laser pointers. Laser pointers are identified as class 2 or 3a laser devices by the FDA, with less than five milliwatts of power. They are required to carry appropriate warning labels to be sold in the United States. Exposure to a class 3a laser pointer for 10 seconds or longer may damage the retina. Because laser pointers have been increasingly misused to annoy or harass people, some local governments and school districts have banned their use. Chicago Ridge, Ill., banned their sale to minors. Still, they are increasingly popular, relatively cheap and available at many stores and on the Internet.

***

MORE ABOUT LASERS

The following is an excerpt from America On Line, November 4, 1998

W A S H I N G T O N, Nov. 4 -- Two American helicopter pilots flying peacekeeping missions over Bosnia have had their eyes burned after lasers were aimed at them from the ground.

In response the United States has ordered all its helicopter pilots flying over Bosnia to wear protective anti-laser goggles.

At first, U.S. military officials believed the incident was caused by nothing more harmful than a laser pointer, like the small, hand-held ones that have become a favorite toy of children.

Pilots in Bosnia have reported numerous incidents where they have spotted a small laser pointed in their direction and never regarded it as more than an irritation. The Pentagon made it clear that the most recent incident was being taken more seriously.

A search of the residential area where the beam that burned the pilots' eyes originated turned up only toy laser pointers.

***

Return to Newsleter

Source

American Academy of Ophthalmology

Forums

Health, Safety, Nutrition and Kids

Related Articles

Check Your Child's Vision Every Two Years

Information and news releases furnished by the members of PR Newswire, who are responsible for their fact and content.

SAN FRANCISCO, Feb. 25, 1998 -- American Academy of Ophthalmology spokesperson Martin Mainster, MD, PhD, advises parents to keep laser pointers away from infants and children in the August 1997 issue of Ophthalmology, the Academy's peer-reviewed journal.

In the Guest Editorial, Dr. Mainster explains that there are different classes of laser devices with varying amounts of power, and that laser pointers are class 3a devices with an output power of less than 5 milliwatts. Class 3b devices, which ophthalmologists use to treat conditions such as detached retinas and other retinal abnormalities, use power settings between 100 and 500 milliwatts, and can pose a serious ocular risk if used improperly. He then asserted, "It is theoretically possible to produce retinal (damage) by staring at a collimated class 3a laser beam for more than 10 seconds, so it is important to keep laser pointers away from infants and children."

In December 1997, the FDA issued a warning to parents and school officials about possible damage to children's eyes from laser pointers. This warning was prompted by reports of two school-based incidences, in which a teacher experienced a 10-day after-image and a cheerleader suffered vision loss from laser pointer exposures. The FDA warning stated: "the light from Class 3a lasers can be as intense, or even more intense, as that from the sun," and it concluded that "injuries associated with these products appear to be related to improper use." FDA Lead Deputy Commissioner Michael A. Friedman, MD, stated that laser pointers "are useful tools for adults that should be used by children only with adequate supervision."

In the Ophthalmology editorial, Dr. Mainster explains that laser pointers do not pose the same risk to adults because "pupil, blink, and aversion response terminate accidental laser pointer exposures in less than 0.25 seconds." He also pointed out that "the label of a class 3a red laser pointer cautions users to avoid shining a laser pointer beam into anyone's eyes," and he concluded: "It makes good sense to follow this advice, just as it is good common sense not to stare into the beam of a 35mm slide projector or the headlight of an approaching locomotive."

CONTACT: magazines, Arthur Stone, 415-561-8539, or broadcast media, Kimberly Westhoff, 415-447-0361, or newspapers, Nancy Roberts, 415-447-0214, all of American Academy of Ophthalmology, or email media@aao.org Web Site: http://www.eyenet.org

Senator Jim Forrester
Room 1121

Attachment B

Dr. Forrester
April 5, 1999

Laser Pointers and Safety or Danger

1
UI - 99129791
TI - Laser pointer-induced macular injury.
AB - PURPOSE: To report a patient with a macular injury caused by a laser pointing device. METHODS: Case report. A healthy 34-year-old man was examined 2 days after he deliberately gazed into the beam of a laser-pointing device with his left eye for an estimated 30 to 60 seconds. His uncorrected visual acuity in each eye was 20/20. He reported a transient central scotoma in the left eye and headache after laser exposure. RESULTS: Both eyes were unremarkable except for a focal retinal pigment epithelial disturbance at the nasal edge of the fovea in the left eye. Fundus fluorescein angiography demonstrated window- defect type hyperfluoresence in the same location. CONCLUSIONS: Laser-pointing devices may cause macular injury when used inappropriately. Conformance with consumer safety recommendations should minimize potential hazards.
SO - Am J Ophthalmol 1999 Jan;127(1):95-6

2
UI - 97358343
TI - Laboratory simulator and field pursuit tracking performance with females and males in the presence of laser glare.
AB - BACKGROUND: The developments in laser technology have increased the precision of many tasks and has made the presence of lasers common-place. In the military the pervasive use of laser devices in uncontrolled environments enhances the potential for human exposure. The visual disruption experienced during these exposures could lead to serious injury or disruption of performance. Characterization of changes in visual-motor performance of military personnel exposed to safe levels of laser glare assists in minimizing mission performance decrements. METHODS: There were 18 female and male military personnel who performed a tracking task in the field and in the laboratory. Two systems were used to assess possible gender differences inherent to the operation of each unit. There were six, 3-s laser trials presented at an irradiance of 400 microW.cm-2 during 15 bright light and 15 simulated dawn/dusk trials with each system. The laser beam on the retina was collinear with the image on the sight. Maximum absolute error (MAE) and total time-off-target (TTOT) scores were determined. RESULTS: Analysis showed that after the flash females tended to lead and males lagged behind the target. No significant differences in MAE or TTOT scores attributable to gender were found. Dawn/dusk flash trials produced greater disruption of pursuit tracking than did bright light trials. Repeated flash exposures showed either an adaptive or a cumulative response. CONCLUSIONS: Significant visual disruption was found following exposure to "safe" levels of laser light and this effect was increased during simulated dawn/dusk

conditions. The degree of performance decrement was not related to gender.
SO - Aviat Space Environ Med 1997 Jul;68(7):580-7

3
UI - 97011342
TI - Lasers, optical systems and safety in ophthalmology: a review.
AB - This is a review of optical methods related to biomicroscopy and laser treatment of the posterior segment of the eye. Contact lenses can be used to observe optical structures and couple laser radiation into the eye for a vast range of conditions and techniques. A small laser spot size is indispensable for photodisruptive work, though this requires a large beam diameter at the pupil and therefore optical systems and techniques such as scleral indentation which maximize the pupillary beam diameter are preferred. For coagulation work the choice of beam focusing optics is crucial for optimum safety. Vitreous replacement can be used to change the refractive power of the eye and permit new combinations of treatment and optical systems. This review covers many aspects of laser irradiation of the eye. It should be clear that, with the multitude of different procedures and optical systems involved, the laser surgeon is faced with a daunting task in assessing and meeting safety limits.
SO - Graefes Arch Clin Exp Ophthalmol 1996 Aug;234(8):473-87
3 **(FOREIGN LANGUAGE)**
UI - 99073426
TI - [The laser pointer: no demonstrated danger to the eyes]
AB - If laser pointers are powerful enough (> 5 mW), they can cause ocular damage. Most laser pointers in use, however, have low power, viz. 1 mW. In the peer-reviewed scientific literature worldwide not a single case of eye damage due to laser pointers is described. A review among Dutch ophthalmologists up to June 1998 revealed no cases of permanent damage caused by laser pointers. In view of the widespread use of laser pointers, the risk of retinal damage must be minimal, even with the types now banned. Laser pointers of 1 mW emitting light red or green light have sufficient visibility on projection screens. It is advisable to prohibit the sale of more powerful pointers to prevent excesses.
SO - Ned Tijdschr Geneeskd. 1998 Sep 5;142(36):1979-82.

4
UI - 99123420
TI - The safety of laser pointers: myths and realities.
SO - Br J Ophthalmol. 1998 Nov;82(11):1335-8.

5
UI - 99003613
TI - Laser pointers and color blindness [letter; comment]
SO - Ophthalmology. 1998 Oct;105(10):1797.

6
UI - 98404787
TI - Safety recommendations for laser pointers.
AB - The use of laser diode pointers that operate in the visible radiation region (400-760 nm) is becoming widespread. These pointers are intended for use by educators while presenting talks in the classroom or at conventions and meetings. They are also useful in any situation where one needs to point out special items during any instructive situation. The pointers can be purchased in novelty stores, mail-order magazines, office supply stores, common electronic stores, and over the internet. The power omitted by these laser pointers ranges from 1 to 5 mW. The potential for hazard with laser pointers is generally considered to be limited to the unprotected eyes of individuals who might be exposed by a direct beam (intrabeam viewing). No skin hazard usually exists. There are, however, even more powerful laser pointers now appearing. The units are imported into the U.S. often without proper manufacturer certification or labeling. The potential for hazards with these devices is not well understood by the general public and workers, and numerous exposure incidents have been recorded by the authors. Users of these products need to be alerted to the potential hazards and be encouraged to follow appropriate safety recommendations. These factors are discussed and safety recommendations for laser pointers are presented.
SO - J Laser Appl. 1998 Aug;10(4):174-80.

7

UK bans powerful laser pointers

Kamran Abbasi, *BMJ*

The British government has banned the most powerful laser pointers because they could cause retinal damage if shone directly into the eye. The pens are used as presentation aids, but they have also been misused to distract goalkeepers, policemen, and drivers at night.

Dr Ajoy Kar, reader in physics at Herriot-Watt University in Edinburgh, used sophisticated calibrated laser power meters to show that the beam from one of the more powerful laser pointers is a hundred times more intense than the brightest sunlight. Following Dr Kar's research, all class 3 laser devices have been banned, although the weaker class 1 and 2 devices are still available.

The classification of these devices differs in the United States and Europe. Under the European classification products up to class 3A are safe. In the United States a 5 mW laser device—the power often used in laser key chains—is a class 3A product, whereas in Europe, according to the International Electrotechnical Commitee's classification, they are class 3B, a more stringent classification. For a 5 mW device to cause permanent retinal damage, the exposure time can be as little as two seconds.

Since their introduction as teaching aids, laser devices have become more readily available. Apart from being used by nightclubbers and concert goers, they have been used to impede the vision of drivers at night. A teenager has become the first person to be convicted of assault with a laser pen for shining the beam into a police officer's eyes. There have also been reports that children have been competing with each other to see who can tolerate staring at the laser beam the longest.

Dr Kar said: "I was asked to carry out tests on these devices by the government. Class 1 and 2 lasers are safe, and the eye is protected by the blink reflex, but 5 mW lasers are potentially dangerous and should not be looked at directly." □

Attachment C

SEN. JIM FORRESTER

Lifelines Health

Don't look now: Laser pointers can damage eyes in a flash

By Darryn Simmons
GANNETT NEWS SERVICE

Most kids who have and play with laser pointers don't think there is anything wrong with this fad.

But optometrists say laser pointers have the potential to be dangerous.

"These things are not toys," says Jim Chernau, optometrist at the Montgomery (Ala.) Optical Clinic.

A report by B. Ralph Chou and Anthony Cullen, optometrists at the University of Waterloo School of Optometry in Waterloo, Ontario, says the laser pointers emit a narrow, intense beam of red laser light with a power output of 5 milliwatts or less.

By comparison, a fluorescent lamp has a power output of 40 watts.

Chernau explains that what makes the light dangerous is the narrowness and high intensity of the beam.

"The light can damage tissue in the retina and burn out the macula — the point of central vision in the retina," he says. "Staring into a laser pointer can have the same intensity as looking directly into the sun."

Frederick Jackson, an optometrist at Primary Eyecare Associates in Montgomery, says damage can occur quickly.

"It takes 100 seconds for the laser pointers to cause damage to the retina," he says. "And for some people, it takes only 50."

The laser pointers can damage more than the retina.

Cindy Peeterse, an optometrist at Vision Associates in Montgomery, says the kind of light that comes from a laser pointer can cause a multitude of problems.

"Any kind of light that gives off some kind of [ultraviolet] radiation, like a laser pointer, can cause thermal burns in the eye," she says. "This causes things like lens changes, a form of cataract, pigment changes, or other decreases or changes in vision."

Chernau compares the laser pointers to some of the lasers used for eye surgery.

"For surgeries, we use an argon laser to refract cataracts and if we used it at high intensity, it would damage the eye," he says. "That is what a laser pointer can do — cause permanent damage and a loss of central vision."

If you have a laser pointer shined in your face, Chernau says you should move out of the way or close your eyes immediately.

Chernau also wants parents to know the damage laser pointers can do.

"We've got to get parents to understand that these things are nothing to play with and that they need to be out of the hands of children." □

R. Timothy Hitchcock, CIH

* IBM Corporation
* UNC-Chapel Hill
* American National Standard Committee Z136
* Laser Institute of America

Attachment D

Topical Outline

I. Laser operation & characteristics

II. Legal requirements: US FDA

III. Effects of exposure to laser pointer beams

IV. Accidents and incidents with laser pointers

L ight

A mplification by

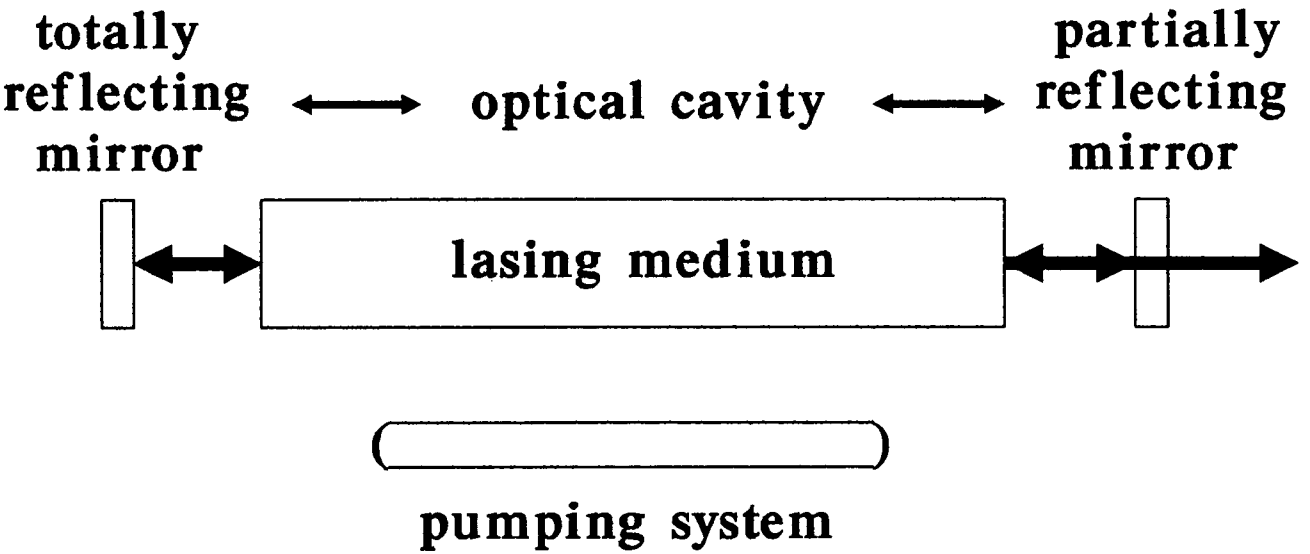
S timulated

E mission of

R adiation

Laser Operation (1):

Basic Laser Components

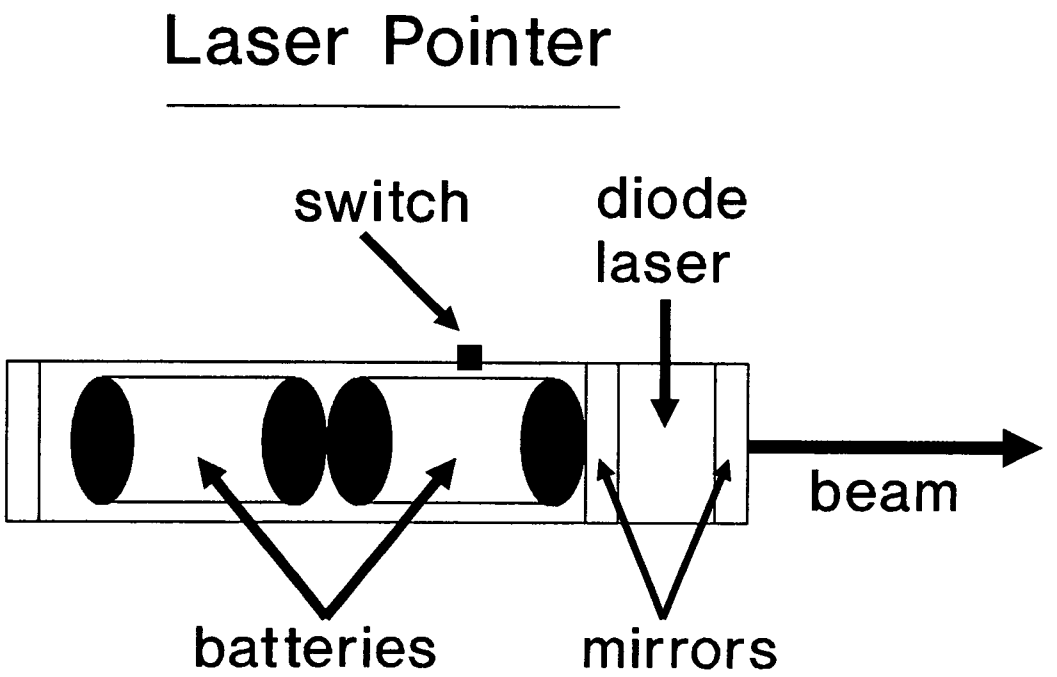


Laser Operation (2):

Laser Pointer

* semiconductor (diode) laser
* very small size
* pumping system: batteries
* 31 colors from infrared to blue

Laser Operation (3):



Legal Requirements (1):

US FDA: 21 CFR Subchapter J

* manufacturer self-certification
* laser/laser product classification
* laser pointers: demonstration laser products

Legal Requirements (2):

Laser Classification

Class	Relative Power	Potential Hazard
1	Extremely low	None known
2a	Very, very low	Very, very low
2	Very low	Very low
3a	Low	Low
3b	Medium	Medium
4	High	High

Legal Requirements (3):

Demonstration Laser Products

* restricted to Class I, II, or IIIa

* Class IIIb or IV are not allowed

Effects of Exposure (1):

Important Factors

* human aversion response
* difficulties of beam aiming
* safety factor in exposure limits
* beam color - sensitivity

Effects of Exposure (2):

Observed Effects

* retinal lesion (very rare)

* transient effects (more common):
  - affect vision-critical activities
  - startle
  - glare
  - afterimage
  - flash blindness

Accidents & Incidents (1):

* two documented cases of retinal damage
* some reports of transient effects
* many reports of nuisance effects ("dotting")

April 15, 1999

Raynor C. Casey, M.D.
2709 Blue Ridge Road
Raleigh, North Carolina 27612

Dear Dr. Casey:

Thank you for taking time from your busy schedule to speak to the Senate Health Care Committee yesterday. Your presentation on the use and/or misuse of laser pointers was both informative and helpful to the Committee.

Again, I appreciate your willingness to participate in discussion of this potential legislation.

Sincerely yours,

William R. Purcell, M.D.

WRP/lrb

April 15, 1999

Mr. Tim Hitchcock
I.B.M. Corporation
Post Office Box 12195
MD-692-002
Research Triangle Park, North Carolina 27709

Dear Mr. Hitchcock:

Thank you for taking time from your busy schedule to speak to the Senate Health Care Committee yesterday. Your presentation on the use and/or misuse of laser pointers was both informative and helpful to the Committee.

Again, I appreciate your willingness to participate in discussion of this potential legislation.

Sincerely yours,

William R. Purcell, M.D.

WRP/lrb

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **April 14, 1999**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sherry Boehme	North Carolina Midwifery Alliance
Wanda Sundermann	Carolina Assoc. for the Advancement of Midwifery
MICHAEL CROWELL	NC PSYCH. ASS'N
Barry Smith	Freedom Newspapers
[signature]	NC PBA.
[signature]	DMH DDSAS
[signature]	NCMS
[signature]	NCMS
[signature]	NCSCPS
Steve Keene	NCMS
[signature]	NCMS

VISITOR REGISTRATION SHEET

(2)

SENATE HEALTH CARE COMMITTEE — **April 14, 1999**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tim Hitchcock	IBM Corporation, RTP, NC
	NCSOS
Flora Dunbar	NCAPP

Principal Clerk ___
Reading Clerk ___

REVISED NOTICE
April 19, 1999

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, April 21, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

• S.B. 614, Immunization Law Changes	Senator Purcell
• S.B. 685, Health Insurance/Phys. Assistants	Senator Lucas
• S.B. 783, Long-Term Care Facilities/Disclosure	Senator Cochrane
• S.B. 951, Health Care Workers/ID Badge	Senator Perdue

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

REVISED NOTICE
April 20, 1999

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, April 21, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

• S.B. 620 Amend Professional Corp. Act	Senator Lee
• S.B. 960, Regulation of Pharmacies	Senator Soles
• S.B. 951, Health Care Workers/ID Badge	Senator Perdue
• S.B. 685, Health Insurance/Phys. Assistants	Senator Lucas
• S.B. 1122 Area Mental Health/County Approp.	Senator K. Moore
• S.B. 614, Immunization Law Changes	Senator Purcell

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

REVISED NOTICE
April 20, 1999

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

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• S.B. 951, Health Care Workers/ID Badge	Senator Perdue
• S.B. 960, Regulation of Pharmacies	Senator Soles
• S.B. 1122, Area Mental Health/County Approp.	Senator K. Moore

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, April 21, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, April 14, 1999, at 12:10 P.M. in Room 1124 in the Legislative Building. Sixteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Chris Livermore of Gastonia who was sponsored by Senator Hoyle, and Senate Page Jason Cheek of Lexington who was sponsored by Senator Cochrane. Both Pages are members of the North Carolina Civil Air Patrol.

Senator Purcell introduced Senator Lee who presented his bill, S.B. 620, *Amend Professional Corp. Act.* Senator Perdue moved for a favorable report and the motion carried unanimously.

Senator Purcell called on Senator Perdue to present her bill, S.B. 951, *Health Care Workers/ID Badge.* She presented a Committee Substitute. Senator Phillips moved for a favorable report for the Committee Substitute for purposes of discussion, and the vote was unanimous. Senator Martin moved for a favorable report for the Committee Substitute and an unfavorable report for the original bill. The motion carried unanimously.

Senator asked Senator Lucas to present her bill, S.B. 685, *Health Insurance/Phys. Assistants.* Senator Dannelly moved for a favorable report and after discussion the motion carried unanimously.

Senator Purcell recognized Senator Moore to present his bill, S.B. 1122. He presented a Committee Substitute for this bill. Senator Perdue moved for approval of the Committee Substitute for purposes of discussion; the motion carried unanimously. After considerable discussion the Chairman displaced the bill from the Committee calendar.

Senator Purcell turned chairmanship of the meeting over to Senator Lucas in order that he could present his bill, S.B. 614, *Immunization Law Changes* to the Committee. He presented a Committee Substitute to this bill and moved that it be adopted for discussion. The motion carried unanimously. Senator Rucho moved for an unfavorable report for the original bill and a favorable report for the Committee Substitute. The motion carried unanimously.

The meeting adjourned at 1:00 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, April 21, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **620** Amend Professional Corp. Act.
Sequential Referral: None
Recommended Referral: None

S.B. **685** Health Insurance/Phys. Assistants.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **951** Health Care Workers/ID Badge.
Draft Number: PCS1715
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Thursday, April 22, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **614** Immunization Law Changes.

Draft Number:	PCS3785
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S

SENATE BILL 620

Short Title: Amend Professional Corp. Act. (Public)

Sponsors: Senator Lee.

Referred to: Health Care.

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO ALLOW PROFESSIONAL CORPORATIONS TO BE FORMED BETWEEN ANY PHYSICIAN AND CERTAIN NURSING SPECIALISTS, SOCIAL WORKERS, AND COUNSELORS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 55B-14(c)(4) reads as rewritten:

"(4) A ~~physician practicing psychiatry;~~ physician, or a licensed psychologist, or both, and a certified clinical specialist in psychiatric and mental health nursing, a certified clinical social worker, a licensed professional counselor, or each of them, to render psychotherapeutic and related services that the respective stockholders are licensed, certified, or otherwise approved to provide."

Section 2. This act is effective when it becomes law.

SENATE BILL 620:
Amend Professional Corp. Act

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Soles
Date:	April 21 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: SB 620 would remove the restriction that a physician practicing psychiatry be part of the group forming a professional corporation along with certain nursing specialists, social workers, and counselors. In its place, the requirement would be that any physician be part of the group forming the professional corportion along with certain nursing specialists, social workers, or counselors. The act is effective when it becomes law.

BACKGROUND: G.S.55B creates the Professional Corporations Act. This act allows a professional corporation to be formed with the following limitations:

1. At least one incorporator shall be a person who is duly licensed by the appropriate licensing board to render the same professional services which may be rendered by the professional corporation (licensee).
2. All of the shares of the stock of the corporation shall be owned by the licensees of the corporation that offer the professional service.
3. At least one director and one officer shall be a licensee.
4. The articles of incorporation shall designate the personal services to be rendered by the corporation and shall be accompanied by a certification of the appropriate licensing board that the stock is in complince with the provisions of the chapter.

The professional corporation may be formed by and between or among eight listed combinations of licensed professionals. One of the combinations listed is a physician practicing psychiatry and certain listed nursing specialists, social workers and counselors.

BILL ANALYSIS: G.S. 55B-14(c)(4) requires that a physician practicing psychiatry be part of a group along with certain nursing specialists, social workers and counselors that forms a professional corporation. SB 620 would remove the requirement that the physician be a physician that practices psychiatry .This bill would not affect any of the other seven other combinations that are allowed to form a professional corporation.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 685

Short Title: Health Insurance/Phys. Assistants. (Public)

Sponsors: Senators Lucas; Dannelly, Kinnaird, Phillips, Rand, and Shaw of Cumberland.

Referred to: Health Care.

April 1, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THAT TREATMENT OR SERVICES RENDERED BY PHYSICIAN ASSISTANTS SHALL BE REIMBURSABLE UNDER THE STATE HEALTH PLAN AND OTHER HEALTH INSURANCE POLICIES UNDER CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

Section 1. Article 50 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-50-26. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a policy governed by Articles 1 through 64 of this Chapter shall be denied the payment or reimbursement on account of the fact that the services were rendered through a physician assistant acting under the authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 2. G.S. 58-50-30 reads as rewritten:

"**§ 58-50-30. Discrimination forbidden; right to choose services of optometrist, podiatrist, certified clinical social worker, dentist, chiropractor, psychologist, pharmacist, certified fee-based practicing pastoral counselor, ~~or advanced practice registered nurse.~~ advanced practice nurse, or physician assistant.**

(a) Discrimination between individuals of the same class in the amount of premiums or rates charged for any policy of insurance covered by Articles 50 through

55 of this Chapter, or in the benefits payable thereon, or in any of the terms or conditions of the policy, or in any other manner whatsoever, is prohibited.

Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for payment of or reimbursement for any service rendered in connection with a condition or complaint which is within the scope of practice of a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the services, whether the services be performed by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly licensed pharmacist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provision contained in the policy. Whenever any policy of insurance governed by Articles 1 through 64 of this Chapter provides for certification of disability that is within the scope of practice of a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, the insured or other persons entitled to benefits under the policy shall be entitled to payment of or reimbursement for the disability whether the disability be certified by a duly licensed physician, a duly licensed physician assistant, a duly licensed optometrist, a duly licensed podiatrist, a duly licensed dentist, a duly licensed chiropractor, a duly certified clinical social worker, a duly licensed psychologist, a duly certified fee-based practicing pastoral counselor, or an advanced practice registered nurse, notwithstanding any provisions contained in the policy. The policyholder, insured, or beneficiary shall have the right to choose the provider of the services notwithstanding any provision to the contrary in any other statute.

Whenever any policy of insurance provides coverage for medically necessary treatment, the insurer shall not impose any limitation on treatment or levels of coverage if performed by a duly licensed chiropractor acting within the scope of the chiropractor's practice as defined in G.S. 90-151 unless a comparable limitation is imposed on the medically necessary treatment if performed or authorized by any other duly licensed physician.

(b) For the purposes of this section, a 'duly licensed psychologist' shall be defined only to include a psychologist who is duly licensed in the State of North Carolina and has a doctorate degree in psychology and at least two years clinical experience in a recognized health setting, or has met the standards of the National Register of Health Service Providers in Psychology. After January 1, 1995, a duly licensed psychologist shall be defined as a licensed psychologist who holds permanent licensure and

certification as a health services provider psychologist issued by the North Carolina Psychology Board.

(c) For the purposes of this section, a 'duly certified clinical social worker' is a 'certified clinical social worker' as defined in G.S. 90B-3(2) and certified by the North Carolina Certification Board for Social Work pursuant to Chapter 90B of the General Statutes.

(c1) For purposes of this section, a 'duly certified fee-based practicing pastoral counselor' shall be defined only to include fee-based practicing pastoral counselors certified by the North Carolina State Board of Examiners of Fee-Based Practicing Pastoral Counselors pursuant to Article 26 of Chapter 90 of the General Statutes.

(d) Payment or reimbursement is required by this section for a service performed by an advanced practice registered nurse only when:

(1) The service performed is within the nurse's lawful scope of practice;

(2) The policy currently provides benefits for identical services performed by other licensed health care providers;

(3) The service is not performed while the nurse is a regular employee in an office of a licensed physician;

(4) The service is not performed while the registered nurse is employed by a nursing facility (including a hospital, skilled nursing facility, intermediate care facility, or home care agency); and

(5) Nothing in this section is intended to authorize payment to more than one provider for the same service.

No lack of signature, referral, or employment by any other health care provider may be asserted to deny benefits under this provision.

For purposes of this section, an 'advanced practice registered nurse' means only a registered nurse who is duly licensed or certified as a nurse practitioner, clinical specialist in psychiatric and mental health nursing, or nurse midwife.

(e) Payment or reimbursement is required by this section for a service performed by a duly licensed pharmacist only when:

(1) The service performed is within the lawful scope of practice of the pharmacist;

(2) The service performed is not initial counseling services required under State or federal law or regulation of the North Carolina Board of Pharmacy;

(3) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(4) The service is identified as a separate service that is performed by other licensed health care providers and is reimbursed by identical payment methods.

Nothing in this subsection authorizes payment to more than one provider for the same service.

(f) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1;
(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and
(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 3. G.S. 58-50-56(j) reads as rewritten:

"(j) A list of the current participating providers in the geographic area in which a substantial portion of health care services will be available shall be provided to insureds and contracting parties. The list shall include participating physician assistants and their supervising physician."

Section 4. Article 65 of Chapter 58 of the General Statutes is amended by adding the following new section to read:

"**§ 58-65-36. Physician services provided by physician assistants.**

No agency, institution, or physician providing a service for which payment or reimbursement is required to be made under a contract governed by this Article or Article 66 of this Chapter shall be denied the payment or reimbursement on account of the fact that the service was rendered through a physician assistant acting under authority of rules adopted by the North Carolina Medical Board pursuant to G.S. 90-18.1."

Section 5. G.S. 58-65-1(a) reads as rewritten:

"(a) Any corporation heretofore or hereafter organized under the general corporation laws of the State of North Carolina for the purpose of maintaining and operating a nonprofit hospital and/or medical and/or dental service plan whereby hospital care and/or medical and/or dental service may be provided in whole or in part by said corporation or by hospitals and/or physicians and/or dentists participating in such plan, or plans, shall be governed by this Article and Article 66 of this Chapter and shall be exempt from all other provisions of the insurance laws of this State, heretofore enacted, unless specifically designated herein, and no laws hereafter enacted shall apply to them unless they be expressly designated therein.

The term 'hospital service plan' as used in this Article and Article 66 of this Chapter includes the contracting for certain fees for, or furnishing of, hospital care, laboratory facilities, X-ray facilities, drugs, appliances, anesthesia, nursing care, operating and obstetrical equipment, accommodations and/or any and all other services authorized or permitted to be furnished by a hospital under the laws of the State of North Carolina and approved by the North Carolina Hospital Association and/or the American Medical Association.

The term 'medical service plan' as used in this Article and Article 66 of this Chapter includes the contracting for the payment of fees toward, or furnishing of, medical, obstetrical, surgical and/or any other professional services authorized or

permitted to be furnished by a duly licensed physician, except that in any plan in any policy of insurance governed by this Article and Article 66 of this Chapter that includes services which are within the scope of practice of a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, and a duly licensed physician, then the insured or beneficiary shall have the right to choose the provider of the care or service, and shall be entitled to payment of or reimbursement for such care or service, whether the provider be a duly licensed optometrist, a duly licensed chiropractor, a duly licensed psychologist, a duly licensed pharmacist, an advanced practice registered nurse, a duly certified clinical social worker, a duly certified fee-based practicing pastoral counselor, a duly licensed physician assistant, or a duly licensed physician notwithstanding any provision to the contrary contained in such policy. The term 'medical services plan' also includes the contracting for the payment of fees toward, or furnishing of, professional medical services authorized or permitted to be furnished by a duly licensed provider of health services licensed under Chapter 90 of the General Statutes."

Section 6. G.S. 58-65-1 is amended by adding the following new subdivision to read:

"(b2) Payment or reimbursement is required by this section for a service performed by a duly licensed physician assistant only when:

(1) The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

(2) The policy currently provides reimbursement for identical services performed by other licensed health care providers; and

(3) The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant.

Nothing in this subsection is intended to authorize payment to more than one provider for the same service. For the purposes of this section a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 7. G.S. 135-40.6 is amended by adding the following new subdivision to read:

"(11) Coverage for Physician Services Provided by Physician Assistants. -- Notwithstanding any other provision of this section or the Plan, benefits shall be payable for physician services performed by a duly licensed physician assistant subject to the following limitations:

a. The service performed is within the lawful scope of practice of the physician assistant in accordance with rules adopted by the North Carolina Medical Board, pursuant to G.S. 90-18.1;

b. The plan currently provides reimbursement for identical services performed by other licensed health care providers;

c. The reimbursement is made to the physician, clinic, agency, or institution employing the physician assistant; and

d. Nothing in this subdivision authorizes payment to more than one provider for the same service.

As used in this subdivision, a 'duly licensed physician assistant' is a physician assistant as defined by G.S. 90-18.1."

Section 8. G.S. 135-40.7B(c) reads as rewritten:

"(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;

(2) Licensed or certified doctors of psychology;

(3) Certified clinical social workers;

(3a) Licensed professional counselors;

(4) Certified clinical specialists in psychiatric and mental health nursing;

(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

(5) Repealed by Session Laws 1997-512, s. 14.

(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology; ~~and~~

(7), (8) Repealed by Session Laws 1997-512, s. 14.

(9) Certified fee-based practicing pastoral ~~counselors.~~ counselors; and

(10) Licensed physician assistants, pursuant to G.S. 90-18.1, under the supervision of a licensed psychiatrist."

Section 9. This act becomes effective January 1, 2000, and applies to treatment or services rendered on or after that date.

SENATE BILL 685:
Health Insurance/Physician Assistants

BILL ANALYSIS

Committee: Senate Health Care
Date: April 14, 1999
Version: 1

Introduced by: Sen. Lucas
Summary by: Linda Attarian
Committee Counsel

SUMMARY: This legislation addresses the right of physician assistants to collect from health insurers for covered health care services provided under the supervision of physicians. Under the proposed legislation, physician assistants will gain the right to bill the State Employees' Comprehensive Major Medical Plan (hereinafter State Employees' Health Plan), Blue Cross/Blue Shield of North Carolina and other insurers for covered services that are within the scope of practice of physician assistants. The reimbursements will not be made directly to the physician assistant, but will be made to the physician, clinic, agency or institution employing the physician assistant. If enacted the bill will become effective on July 1, 2000.

CURRENT LAW: A physician assistant (hereinafter PA) is a graduate of an accredited PA educational program and are licensed by the North Carolina Medical Board. They are authorized by the State of North Carolina to "perform medical acts, tasks, and functions" under the supervision of a physician. A PA is authorized, under specified conditions, to write prescriptions, compound and dispense drugs, order medications, tests and treatments in hospitals, clinics, nursing homes, and other health care facilities in North Carolina. (See G.S. 90-18.1). The North Carolina Medicaid program reimburses physician assistants at 100 percent of what physicians would receive for providing identical services. Other insurers are not required under State law to reimburse for medical services performed by a PA and may employ other discriminatory practices towards an enrollee's access to physician assistants.

BILL ANALYSIS:

Section 1. Adds a new section to Article 50 of Chapter 58 that applies to insurers subject to the provisions of Articles 1-64 of Chapter 58, which includes all insurers not exempt from State regulation, but does not include HMOs, State Employees Health Plan, and Hospital, Medical and Dental Service Corporations. The new section prohibits insurers from denying a payment to a health care provider for a covered service because a PA provided the service. This reimbursement requirement is conditioned on the PA acting under the authority of rules adopted by the NC Medical Board.

Section 2. Amends G.S. 58-50-30, which applies to health plans subject to the provisions of Articles 1-64 of Chapter 58, to provide that such insurers may not deny payments to a PA for a covered service if the service is provided to the insured in connection with a condition or complaint which is within the scope of the PA's practice. Payments must be made to the physician, clinic, agency, or institution employing the PA, and not to the PA directly. This non-discriminatory policy will also apply to when a policy provides for the certification of a disability. Finally, the policyholder shall have the right to choose to receive the covered service from a PA notwithstanding any provision to the contrary in any other statute.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S

SENATE BILL 951

Short Title: Health Care Workers/ID Badge. (Public)

Sponsors: Senator Perdue.

Referred to: Health Care.

April 14, 1999

A BILL TO BE ENTITLED

AN ACT TO PROTECT PATIENTS' RIGHTS BY REQUIRING NAME BADGES OR OTHER IDENTIFICATION FOR HEALTH CARE PRACTITIONERS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 37.

"Health Care Practitioner Identification.

"**§ 90-640. Identification badges required.**

(a) For purposes of this section, 'health care practitioner' means an individual who is licensed, certified, or registered to engage in the practice of medicine, nursing, dentistry, pharmacy, or any related occupation involving the direct provision of health care to patients.

(b) When providing health care to a patient, a health care practitioner shall wear a badge or other form of identification displaying in readily visible type the individual's name and the license, certification, or registration held by the practitioner. If the identity of the individual's license, certification, or registration is commonly expressed by an abbreviation rather than by full title, that abbreviation may be used on the badge or other identification.

(c) The badge or other form of identification is not required to be worn if the patient is being seen in the health care practitioner's office and the name and license of the practitioner can be readily determined by the patient from a posted license, a sign in the office, a brochure provided to patients, or otherwise.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 951
Senate Committee Substitute S951-PCSLT-001
ATTENTION: LINE NUMBERS MAY CHANGE UPON ADOPTION.

Short Title: Health Care Workers/ID Badge. (Public)

Sponsors:

Referred to: Health Care.

April 14, 1999

A BILL TO BE ENTITLED

AN ACT TO PROTECT PATIENTS' RIGHTS BY REQUIRING NAME BADGES OR OTHER IDENTIFICATION FOR HEALTH CARE PRACTITIONERS.

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"Health Care Practitioner Identification.

"§ 90-640. Identification badges required.

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(b) When providing health care to a patient, a health care practitioner shall wear a badge or other form of identification displaying in readily visible type the individual's name and the license, certification, or registration held by the practitioner. If the identity of the individual's license, certification, or registration is commonly expressed by an abbreviation rather than

by full title, that abbreviation may be used on the badge or other identification.

(c) The badge or other form of identification is not required to be worn if the patient is being seen in the health care practitioner's office and the name and license of the practitioner can be readily determined by the patient from a posted license, a sign in the office, a brochure provided to patients, or otherwise.

(d) Each licensing board or other regulatory authority for health care practitioners may adopt rules for exemptions from wearing a badge or other form of identification, or for allowing use of the practitioner's first name only, when necessary for the health care practitioner's safety or for therapeutic concerns.

(e) Violation of this section is a ground for disciplinary action against the health care practitioner by the practitioner's licensing board or other regulatory authority."

Section 2. G.S. 90-171.43 reads as rewritten:

"§ 90-171.43. License required.

~~No person shall practice or offer to practice as or use any card, title or abbreviation to indicate that such person is a registered nurse or licensed practical nurse unless that person is currently licensed as provided by this Article.~~ No person shall practice or offer to practice as a registered nurse or licensed practical nurse, or use the word 'nurse' as a title for herself or himself, or use an abbreviation to indicate that the person is a registered nurse or licensed practical nurse, unless the person is currently licensed as a registered nurse or licensed practical nurse as provided by this Article. If the word 'nurse' is part of a longer title, such as 'nurse's aide', a person who is entitled to use that title shall use the entire title and may not abbreviate the title to 'nurse'. This Article shall not, however, be construed to prohibit or limit the following:

(1) The performance by any person of any act for which that person holds a license issued pursuant to North Carolina law;

(2) The clinical practice by students enrolled in approved nursing programs, continuing education programs, or refresher courses under the supervision of qualified faculty;

(3) The performance of nursing performed by persons who hold a temporary license issued pursuant to G.S. 90-171.33;

(4) The delegation to any person, including a member of the patient's family, by a ~~physician licensed to practice medicine in North Carolina, a licensed dentist or~~ registered nurse of those patient-care services which are routine, repetitive, limited in scope that do not require the professional judgment of a registered nurse or licensed practical nurse;

(5) Assistance by any person in the case of emergency.

Any person permitted to practice nursing without a license as provided in subdivision (2) or (3) of this section shall be held to the same standard of care as any licensed nurse."

Section 3. This act becomes effective October 1, 1999, but from October 1, 1999 to October 1, 2001, all health care practioners are required to wear name badges only. Effective October 1, 2001, all health care practioners shall be in full compliance with this act.

SENATE BILL 951:
Health Care Workers/ID Badges

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Perdue
Date:	April 21, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***Requires (with certain exemptions) that a physician, nurse, dentist or pharmacist shall wear a badge or other form of identification displaying the individuial's name and the license, certification or registration held by the proactitioner. The act regulating the practice of nursing is also amended to specify that no one may use the word "nurse" as a title unless the person is currently licensed. The act is effective october 1, 1999***

CURRENT LAW: Senate Bill would add a new Article 37 to Chapter 90 of the General statutes and amend the Nurse Practice Act to redefine who may use the word "nurse".

BILL ANALYSIS: Senate Bill 951 would do the following:

1. Add a new Article 37 to GS Chapter 90 with the following provisions;
   a. define "health care practitioner" to mean an individual who is licensed, certified, or registered to practice medicine, nursing, dentistry, pharmacy or any related occupation involving the direct provision of health care to patients,
   b. Such health care practitioners, when providing care to patients, must wear a badge in readily visible type, the individual's name and the license, certification, or registration the practitioner holds,
   c. The badge need not be worn if the patient is being seen in the practitioner's office and the name and license can readily be determined by the patient from a posted license, a sign ,etc.
   d. Authorizes licensing boards and other rgulatory authorities for practitioners to adopt rules for exemption from wearing badges when necessary for practitioner's safety or for therapeutic
   e. Violation of this section is a ground for disciplinary action against a proactitioner by the board.

2. Amend G.S. 90-171.43 (requiring license for the practice of nursing) to do the following:
   a. No one may use the word "nurse" as a title unless the person is currently licensed as a registered nurse or licensed practical nurse.
   b. If the word "nurse" is part of a larger title such as "nurse aide", a person who is entitled to use that title is to use the entire title and may not abbreviate it to "nurse".
   C. G.S. 90-171.43 requires the licensure of nurses but exempts certain functions from these licensing provisions. One of these is the delegation to any person, including the members of a person' family, by a physician licensed to practice medicine in North Carolina, a licensed dentist, or a registered nurse , patient care services that do not require the professional judgement of a registered nurse. The bill would remove this delegation from the physician and dentist but leave this with the nurse.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 614

Short Title: Immunization Law Changes. (Public)

Sponsors: Senators Purcell; Albertson, Clodfelter, Forrester, Gulley, Lucas, Miller, and Phillips.

Referred to: Health Care.

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE IMMUNIZATION LAWS PERTAINING TO ADMINISTRATION AND REPORTING OF IMMUNIZATIONS, CERTIFICATES OF IMMUNIZATIONS RECEIVED IN OTHER STATES, SUBMISSION OF IMMUNIZATION CERTIFICATES TO CHILD CARE FACILITIES AND PRESCHOOL AUTHORITIES, AND TO MAKE OTHER TECHNICAL CHANGES TO THE IMMUNIZATION STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-41(b) reads as rewritten:

"(b) A local health director shall have the following powers and duties:

(1) To administer programs as directed by the local board of health;

(2) To enforce the rules of the local board of health;

(3) To investigate the causes of infectious, communicable and other diseases;

(4) To exercise quarantine authority and isolation authority pursuant to G.S. 130A-145;

(5) To disseminate public health information and to promote the benefits of good health;

(6) To advise local officials concerning public health matters;

(7) To enforce the immunization requirements of Part 2 of Article ~~7~~ 6 of this Chapter;

(8) To examine and investigate cases of venereal disease pursuant to Parts 3 and 4 of Article 6 of this Chapter;

(9) To examine and investigate cases of tuberculosis pursuant to Part 5 of Article 6 of this Chapter;
(10) To examine, investigate and control rabies pursuant to Part 6 of Article 6 of this Chapter;
(11) To abate public health nuisances and imminent hazards pursuant to G.S. 130A-19 and G.S. 130A-20;
(12) To employ and dismiss employees of the local health department in accordance with Chapter 126 of the General Statutes;
(13) To enter contracts, in accordance with The Local Government Finance Act, G.S. Chapter 159, on behalf of the local health department. Nothing in this paragraph shall be construed to abrogate the authority of the board of county commissioners."

Section 2. G.S. 130A-153 reads as rewritten:

"**§ 130A-153. Obtaining immunization; reporting by local health departments; access to immunization information in patient records; immunization of minors.**

(a) The required immunization may be obtained from a physician licensed to practice medicine or from a local health department. Local health departments shall administer ~~the~~ required and State-supplied immunizations at no cost to the patient. The Department shall provide the vaccines for use by the local health departments. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall ~~state~~ state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health departments, and the patient's attending physician. In addition, an insurance institution, agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may share immunization information with the Department. The Commission may, for the purpose of assisting the Department in enforcing this Part, provide by rule that other persons may have access to immunization information, in whole or in part.

(d) A physician or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A physician or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to obtain the immunization for the minor."

Section 3. G.S. 130A-154 reads as rewritten:

"**§ 130A-154. Certificate of immunization.**

(a) A physician or local health department administering a required vaccine shall give a certificate of immunization to the person who presented the child for immunization. The certificate shall state the name of the child, the name of the

child's parent, guardian, or person responsible for the child obtaining the required immunization, the address of the child and the parent, guardian or responsible person, the date of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the doses were given, the name and address of the physician or local health department administering the required immunization and other relevant information required by the Commission.

(b) Except as otherwise provided in this subsection, a person who received immunizations in a state other than North Carolina shall present an official certificate or record of immunization to the child care facility, school (K-12), or college or university. This certificate or record shall state the person's name, address, date of birth, and sex; the type and number of doses of administered vaccine; the dates of the first MMR and the last DTP and polio; the name and address of the physician or local health department administering the required immunization; and other relevant information required by the Commission."

Section 4. G.S. 130A-155 reads as rewritten:

"**§ 130A-155. Submission of certificate to child care ~~facility~~ facility, preschool and school authorities; record maintenance; reporting.**

(a) No child shall attend a school (K-12), whether public, private or religious, a preschool educational program not operated by a public school, or a child care facility as defined in G.S. 110-86(3), unless a certificate of immunization indicating that the child has received the immunizations required by G.S. 130A-152 is presented to the school or facility. The parent, guardian, or responsible person must present a certificate of immunization on the child's first day of attendance to the principal of the school or operator of the facility, as defined in G.S. 110-86(7). If a certificate of immunization is not presented on the first day, the principal or operator shall present a notice of deficiency to the parent, guardian or responsible person. The parent, guardian or responsible person shall have 30 calendar days from the first day of attendance to obtain the required immunization for the child. If the administration of vaccine in a series of doses given at medically approved intervals requires a period in excess of 30 calendar days, additional days upon certification by a physician may be allowed to obtain the required immunization. Upon termination of 30 calendar days or the extended period, the principal or operator shall not permit the child to attend the school or facility unless the required immunization has been obtained.

(b) The ~~school~~ school, preschool, or child care facility shall maintain on file immunization records for all children attending the school or facility which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a child transfers to another school or facility, the school or facility which the child previously attended shall, upon request, send a copy of the child's immunization record at no charge to the school or facility to which the child has transferred.

(c) Within 60 calendar days after the commencement of a new school year, the school shall file an immunization report with the Department. The preschool or child care facility shall file an immunization report annually with the Department. The

report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the number of children who received a medical exemption and the number of children who received a religious exemption.

(d) Any adult who attends school (K-12), whether public, private or religious, shall obtain the immunizations required in G.S. 130A-152 and shall present to the school a certificate in accordance with this section. The physician or local health department administering a required vaccine to the adult shall give a certificate of immunization to the person. The certificate shall state the person's name, address, date of birth and sex; the number of doses of the vaccine given; the date the doses were given; the name and addresses of the physician or local health department administering the required immunization; and other relevant information required by the Commission."

Section 5. G.S. 130A-155.1(d) is repealed.

Section 6. G.S. 130A-156 reads as rewritten:

"**§ 130A-156. Medical exemption.**

The Commission for Health Services shall adopt by rule ~~a list of~~ medical contraindications to immunizations required by G.S. 130A-152. If a physician licensed to practice medicine in this State certifies that a required immunization is or may be detrimental to a person's health due to the presence of one of the contraindications ~~listed~~ adopted by the Commission, the person is not required to receive the specified immunization as long as the contraindication persists. The State Health Director may, upon request by a physician licensed to practice medicine in this State, grant a medical exemption to a required immunization for a contraindication not on the list adopted by the Commission."

Section 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 614
PROPOSED COMMITTEE SUBSTITUTE FOR SENATE BILL 614 S614-PCSRY-001
THIS IS A DRAFT: LINE NUMBERS MAY CHANGE AFTER ADOPTION
12-APR-99 11:43:04

Short Title: Immunization Law Changes. (Public)

Sponsors:

Referred to: Health Care.

March 29, 1999

A BILL TO BE ENTITLED

AN ACT TO MAKE CHANGES TO THE IMMUNIZATION LAWS PERTAINING TO ADMINISTRATION AND REPORTING OF IMMUNIZATIONS, CERTIFICATES OF IMMUNIZATIONS RECEIVED IN OTHER STATES, SUBMISSION OF IMMUNIZATION CERTIFICATES TO CHILD CARE FACILITIES AND SCHOOL AUTHORITIES, AND TO MAKE OTHER TECHNICAL CHANGES TO THE IMMUNIZATION STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 130A-41(b) reads as rewritten:

"(b) A local health director shall have the following powers and duties:

(1) To administer programs as directed by the local board of health;

(2) To enforce the rules of the local board of health;

(3) To investigate the causes of infectious, communicable and other diseases;

(4) To exercise quarantine authority and isolation authority pursuant to G.S. 130A-145;

(5) To disseminate public health information and to promote the benefits of good health;

(6) To advise local officials concerning public health matters;

(7) To enforce the immunization requirements of Part 2 of Article ~~7~~ 6 of this Chapter;
(8) To examine and investigate cases of venereal disease pursuant to Parts 3 and 4 of Article 6 of this Chapter;
(9) To examine and investigate cases of tuberculosis pursuant to Part 5 of Article 6 of this Chapter;
(10) To examine, investigate and control rabies pursuant to Part 6 of Article 6 of this Chapter;
(11) To abate public health nuisances and imminent hazards pursuant to G.S. 130A-19 and G.S. 130A-20;
(12) To employ and dismiss employees of the local health department in accordance with Chapter 126 of the General Statutes;
(13) To enter contracts, in accordance with The Local Government Finance Act, G.S. Chapter 159, on behalf of the local health department. Nothing in this paragraph shall be construed to abrogate the authority of the board of county commissioners."

Section 2. G.S. 130A-153 reads as rewritten:

"**§ 130A-153. Obtaining immunization; reporting by local health departments; access to immunization information in patient records; immunization of minors.**

(a) The required immunization may be obtained from a physician licensed to practice medicine or from a local health department. Local health departments shall administer ~~the~~ required and State-supplied immunizations at no cost to the patient. The Department shall provide the vaccines for use by the local health departments. A local health department may redistribute these vaccines only in accordance with the rules of the Commission.

(b) Local health departments shall file monthly immunization reports with the Department. The report shall be filed on forms prepared by the Department and shall ~~state~~ state, at a minimum, each patient's age and the number of doses of each type of vaccine administered.

(c) Immunization certificates and information concerning immunizations contained in medical or other records shall, upon request, be shared with the Department, local health departments, and the patient's attending physician. In addition, an insurance institution, agent, or insurance support organization, as those terms are defined in G.S. 58-39-15, may share immunization information with the Department. The Commission may, for the purpose of assisting the Department in enforcing this Part,

provide by rule that other persons may have access to immunization information, in whole or in part.

(d) A physician or local health department may immunize a minor with the consent of a parent, guardian, or person standing in loco parentis to the minor. A physician or local health department may also immunize a minor who is presented for immunization by an adult who signs a statement that he or she is authorized by a parent, guardian, or person standing in loco parentis to the minor to obtain the immunization for the minor."

Section 3. G.S. 130A-154 reads as rewritten:

"**§ 130A-154. Certificate of immunization.**

(a) A physician or local health department administering a required vaccine shall give a certificate of immunization to the person who presented the child for immunization. The certificate shall state the name of the child, the name of the child's parent, guardian, or person responsible for the child obtaining the required immunization, the address of the child and the parent, guardian or responsible person, the date of birth of the child, the sex of the child, the number of doses of the vaccine given, the date the doses were given, the name and address of the physician or local health department administering the required immunization and other relevant information required by the Commission.

(b) Except as otherwise provided in this subsection, a person who received immunizations in a state other than North Carolina shall present an official certificate or record of immunization to the child care facility, school (K-12), or college or university. This certificate or record shall state the person's name, address, date of birth, and sex; the type and number of doses of administered vaccine; the dates of the first MMR and the last DTP and polio; the name and address of the physician or local health department administering the required immunization; and other relevant information required by the Commission."

Section 4. G.S. 130A-155 reads as rewritten:

"**§ 130A-155. Submission of certificate to child care ~~facility~~ facility, preschool and school authorities; record maintenance; reporting.**

(a) No child shall attend a school ~~(K-12),~~ (pre K-12), whether public, private or religious, a child care facility as defined in G.S. 110-86(3), unless a certificate of immunization indicating that the child has received the immunizations required by G.S. 130A-152 is presented to the school or facility. The parent, guardian, or responsible person must present a certificate of immunization on the child's first day of attendance to the

principal of the school or operator of the facility, as defined in G.S. 110-86(7). If a certificate of immunization is not presented on the first day, the principal or operator shall present a notice of deficiency to the parent, guardian or responsible person. The parent, guardian or responsible person shall have 30 calendar days from the first day of attendance to obtain the required immunization for the child. If the administration of vaccine in a series of doses given at medically approved intervals requires a period in excess of 30 calendar days, additional days upon certification by a physician may be allowed to obtain the required immunization. Upon termination of 30 calendar days or the extended period, the principal or operator shall not permit the child to attend the school or facility unless the required immunization has been obtained.

(b) The school or child care facility shall maintain on file immunization records for all children attending the school or facility which contain the information required for a certificate of immunization as specified in G.S. 130A-154. These certificates shall be open to inspection by the Department and the local health department during normal business hours. When a child transfers to another school or facility, the school or facility which the child previously attended shall, upon request, send a copy of the child's immunization record at no charge to the school or facility to which the child has transferred.

(c) Within 60 calendar days after the commencement of a new school year, the school shall file an immunization report with the Department. The child care facility shall file an immunization report annually with the Department. The report shall be filed on forms prepared by the Department and shall state the number of children attending the school or facility, the number of children who had not obtained the required immunization within 30 days of their first attendance, the number of children who received a medical exemption and the number of children who received a religious exemption.

(d) Any adult who attends school ~~(K-12),~~ (pre K-12), whether public, private or religious, shall obtain the immunizations required in G.S. 130A-152 and shall present to the school a certificate in accordance with this section. The physician or local health department administering a required vaccine to the adult shall give a certificate of immunization to the person. The certificate shall state the person's name, address, date of birth and sex; the number of doses of the vaccine given; the date the doses were given; the name and addresses of the physician or

local health department administering the required immunization; and other relevant information required by the Commission."

Section 5. G.S. 130A-155.1(d) is repealed.

Section 6. G.S. 130A-156 reads as rewritten:

"**§ 130A-156. Medical exemption.**

The Commission for Health Services shall adopt by rule ~~a list of~~ medical contraindications to immunizations required by G.S. 130A-152. If a physician licensed to practice medicine in this State certifies that a required immunization is or may be detrimental to a person's health due to the presence of one of the contraindications ~~listed~~ adopted by the Commission, the person is not required to receive the specified immunization as long as the contraindication persists. The State Health Director may, upon request by a physician licensed to practice medicine in this State, grant a medical exemption to a required immunization for a contraindication not on the list adopted by the Commission."

Section 7. This act is effective when it becomes law.

SENATE BILL 614:
Immunization law Changes

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Clodfelter
Date:	April 12, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: This bill makes technical, clarifying and other changes to the current immunization statutes. The act is effective when it becomes law.

CURRENT LAW: G.S. 130A-152 requires that every child in North Carolina be immunized against diptheria, tetanus, whooping cough, poliomyelitis, red measles (rubeola) and rubella. In addition, the Commission for Health Services may require other immunizations upon determination that the immunization is in the interest of the public health. The Commission for Health Services shall adopt and the Department shall enforce rules concerning implementation of the immunization program. There is a religious reemption to these requiremements.

BILL ANALYSIS: Section 1: G.S. 130A-41(b) is amended to change an incorrect reference.

Section 2: The current statute requires that local health departments administer the required immunizations at no charge. The local health departments are required to file monthly immunization reports giving each patient's age and the number of doses of each type of vaccine administered. The bill would amend G.S. 130A-153 to add the words "and State-supplied" to make clear that local health departments shall not charge (including administration) for the required immunizations. It would also add the words "at a minimum" to permit additional information to be collected.

Section 3: G.S. 130A-154 requires that the local health department or the physician administering a required vaccine give a certificate of immunization to the person who presented the child for immunization. The bill would add a new G.S. 103A154(b) that sets out information that must be included in a certificate or record of immunization administered in another state when a person presents such acertificate to a child care facility, school, or college or university in North Carolina.

Section 4: Currently all school children k-12 must be immunized before attending school. Some school systems have developed pre-k programs and there is some question about whether the current statute requires the same immunization as is required for k-12. This section would require the whole spectrum of prek- 12 to be covered.

Section 5: Currently, all persons attending a college or university must present to the college or university a certificate of immunization. One of the exemptions to this requirement is for persons enrolled in a college or university on or before July 1, 1986, unless after July 1, 1986 the person transfers, interupts study for a period of six months or more or graduates. This exemption would be repealed

Section 6: This section makes a technical correction by changing one word..

VISITOR REGISTRATION SHEET

(2)

Name of Committee

4-21-99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Bob Rowe-West	DHHS / DPH
Ann Wagle	DHHS / DPH
Jan Hoff	DHHS
Ellen Weller	DHHS/Public Health
Mary J Bitter	NCNA
Margaret Mullinix	NCNA
Janet Sherman	NC Council
Marian Darcy	NCNA
Patricia Loeslein	NCPHA
J Baumgartner	NCANA
Joann Scher	NCNA
Polly Johnson	NC Board of Nursing
Bob Cull	Bob Cull & Stamper
Lisa Welch & Crew	UNCTV
Mary Jo Hill	NASW-NC

(1)

VISITOR REGISTRATION SHEET

Health Care — 4 - 21

Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Judy Bryan	B&C
V. McBride	NCDA
John Cyrus	N.C. State Grange
Jeffrey White	Pro Tem
[illegible]	NCBIC
Will Jay	AHHC
Cassie Covac	NCMA
Maggie King	NCMA Raleigh, NC
Helen Lipina	Mecklenburg Co.
Ron Aycock	NC Assoc of Counties
Hilary Allen	Meredith College
Felix Brown	DMHDDSAS
Tommy Worth	Carolina Healthcare System
[illegible]	Pagan & Spaulding
Jim Speed	

VISITOR REGISTRATION SHEET

(3)

Name of Committee

4-21-99
Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
Howard Kramer	N.C. Bd. of Nursing
Jim. Blackburn	Assoc. County Commrs
Ann Case	NCKMA
Jason Check	Civil Air Patrol - Senate Page
Angie McMillan	time

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **April 27, 1999**
TIME: **2:30 to 3:30 P.M.**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 960, Regulation of Pharmacies** **Senator Soles**
- **S.B. 1165, Clinical Pharmacist Practitioner** **Senator Purcell**

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Tuesday, April 27, 1999

MINUTES

The Senate Committee on Health Care met on Tuesday, April 27, 1999, at 2:30 P.M. in Room 1124 in the Legislative Building. Eleven members were present, including the Chair, Senator William R. Purcell, who presided. Senator Purcell introduced Senate Pages Valisha Summerfield of Raleigh, sponsored by Senator Reeves and Matthew Newell of Franklin, sponsored by Senator Carpenter.

Senator Purcell asked Senator Soles to present his bill, S.B. 960, *Regulation of Pharmacies*. A Committee Substitute was presented, and Senator Dannelly moved that the Committee Substitute be adopted for purposes of discussion. The motion carried unanimously. Senator Soles asked Committee Counsel, John Young to explain the Committee Substitute to the members. Senator Cooper moved for an unfavorable report for the bill and a favorable report for the Committee Substitute. The motion carried unanimously.

As Senator Purcell was to explain his bill, S.B. 1165, *Clinical Pharmacist Practitioner*, to the Committee, he asked to Senator Martin to preside in his place. Senator presented a Committee Substitute; Senator Cooper moved for adoption of the Committee Substitute for purposes of discussion and the motion carried unanimously. Senator Purcell moved for an unfavorable report as to the original bill and a favorable report for the Committee Substitute. The motion carried unanimously and was sent to the Finance Committee by way of a sequential referral.

The meeting adjourned at 3:15 P.M.

William R. Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Tuesday, April 27, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1165** Clinical Pharmacist Practitioner.

Draft Number:	PCS6664
Sequential Referral:	Finance
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, April 28, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1068** Restraints/Death in Facilities.

Draft Number:	PCS3807
Sequential Referral:	None
Recommended Referral:	Rules
Long Title Amended:	Yes

S.B. **1122** Area Mental Health/County Appropriations.

Draft Number:	PCS4695
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1165
Proposed Committee Substitute S1165-PCS6664-RM

Short Title: Clinical Pharmacist Practitioner. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA MEDICAL BOARD AND THE BOARD OF PHARMACY TO ADOPT REGULATIONS TO APPROVE CLINICAL PHARMACIST PRACTITIONERS TO PRACTICE DRUG THERAPY MANAGEMENT PURSUANT TO A DRUG THERAPY MANAGEMENT AGREEMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-6 reads as rewritten:

"**§ 90-6. Regulations governing applicants for license, examinations, etc.; appointment of subcommittee.**

(a) The North Carolina Medical Board is empowered to prescribe such regulations as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules and regulations to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective when adopted by both the North Carolina Medical Board and

the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations.

(c) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina Board of Pharmacy to develop rules and regulations to govern the performance of medical acts by clinical pharmacist practitioners, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by clinical pharmacist practitioners and shall become effective when adopted by both the North Carolina Medical Board and the North Carolina Board of Pharmacy. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations."

Section 2. G.S. 90-18(c) is amended by adding a new subdivision to read:

"(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards. Drug therapy management shall be defined as the implementation of predetermined drug therapy which includes: (i) diagnosis and product selection by the patient's physician; (ii) modification of prescribed drug dosages, dosage forms, and dosage schedules; and (iii) ordering tests; all pursuant to an agreement that is physician, pharmacist, patient, and disease specific."

Section 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Limitations on clinical pharmacist practitioners.**

(a) Any pharmacist who is approved under the provisions of G.S. 90-18(c)(3a) to perform medical acts, tasks, and functions may use the title 'clinical pharmacist practitioner'. Any other person who uses the title in any form or holds himself or herself out to be a clinical pharmacist practitioner or to be so licensed shall be deemed to be in violation of this Article.

(b) Clinical pharmacist practitioners are authorized to implement predetermined drug therapy, which includes diagnosis and product selection by the patient's physician, modify prescribed drug dosages, dosage forms, and dosage schedules, and to order laboratory tests pursuant to a drug therapy management agreement that is physician, pharmacist, patient, and disease specific under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations developed by a joint subcommittee governing the approval of individual clinical pharmacist practitioners to practice drug therapy management with

such limitations that the Board determines to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The North Carolina Medical Board has assigned an identification number to the clinical pharmacist practitioner which is shown on written prescriptions written by the clinical pharmacist practitioner.

(4) The drug therapy management agreement prohibits the substitution of a chemically dissimilar drug product by the pharmacist for the product prescribed by the physician without the explicit consent of the physician and includes a policy for periodic review by the physician of the drugs modified pursuant to the agreement or changed with the consent of the physician.

(c) Clinical pharmacist practitioners in hospitals and other health facilities that have an established pharmacy and therapeutics committee or similar group that determines the prescription drug formulary or other list of drugs to be utilized in the facility and determines procedures to be followed when considering a drug for inclusion on the formulary and procedures to acquire a nonformulary drug for a patient may order medications and tests under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations governing the approval of individual clinical pharmacist practitioners to order medications and tests with such limitations as the Boards determine to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The supervising physician has provided to the clinical pharmacist practitioner written instructions for ordering, changing, or substituting drugs, or ordering tests with provision for review of the order by the physician within a reasonable time, as determined by the Boards, after the medication or tests are ordered.

(4) The hospital or health facility has adopted a written policy, approved by the medical staff after consultation with nursing administrators, concerning the ordering of medications and tests, including procedures for verification of the clinical pharmacist practitioner's orders by nurses and other facility employees and such other procedures that are in the best interest of patient health and safety.

(5) Any drug therapy order written by a clinical pharmacist practitioner or order for medications or tests shall be deemed to have been authorized by the physician approved by the Boards as the supervisor of the clinical pharmacist practitioner and the supervising physician shall be responsible for authorizing the prescription order.

(d) Any registered nurse or licensed practical nurse who receives a drug therapy order from a clinical pharmacist practitioner for medications or tests is authorized to perform that order in the same manner as if the order was received from a licensed physician."

Section 4. G.S. 90-85.3 is amended by adding a new subsection to read:

"(b1) 'Clinical Pharmacist Practitioner' means a licensed pharmacist who meets the guidelines and criteria for such title established by the joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and is authorized to enter into drug therapy management agreements with physicians in accordance with the provisions of G.S. 90-18.3."

Section 5. G.S. 90-85.3(r) reads as rewritten:

"(r) 'Practice of pharmacy' means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered. An approved clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.3."

Section 6. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-85.26A. Clinical pharmacist practitioners subcommittee.**

The Board of Pharmacy shall appoint and maintain a subcommittee of the Board consisting of four licensed pharmacists to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the provision of drug therapy management by clinical pharmacist practitioners and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The rules developed by this subcommittee shall govern the performance of acts by clinical pharmacist practitioners and shall become effective when they have been adopted by both Boards."

Section 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1165

Short Title: Clinical Pharmacist Practitioner. (Public)

Sponsors: Senator Purcell.

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF CLINICAL PHARMACIST PRACTITIONERS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-6 reads as rewritten:

"**§ 90-6. Regulations governing applicants for license, examinations, etc.; appointment of subcommittee.**

(a) The North Carolina Medical Board is empowered to prescribe such regulations as it may deem proper, governing applicants for license, admission to examinations, the conduct of applicants during examinations, and the conduct of examinations proper.

(b) The North Carolina Medical Board shall appoint and maintain a subcommittee to work jointly with a subcommittee of the Board of Nursing to develop rules and regulations to govern the performance of medical acts by registered nurses, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by registered nurses and shall become effective when adopted by both the North Carolina Medical Board and the Board of Nursing. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations.

(c) The North Carolina Medical Board shall appoint and maintain a subcommittee of four licensed physicians to work jointly with a subcommittee of the North Carolina

Board of Pharmacy to develop rules and regulations to govern the performance of medical acts by licensed pharmacists, including the determination of reasonable fees to accompany an application for approval not to exceed one hundred dollars ($100.00) and for renewal of approval not to exceed fifty dollars ($50.00). The fee for reactivation of an inactive incomplete application shall be five dollars ($5.00). Rules and regulations developed by this subcommittee from time to time shall govern the performance of medical acts by licensed pharmacists and shall become effective when adopted by both the North Carolina Medical Board and the North Carolina Board of Pharmacy. The North Carolina Medical Board shall have responsibility for securing compliance with these regulations."

Section 2. G.S. 90-18(c) is amended by adding a new subdivision to read:

"(3a) The provision of drug therapy management by a licensed pharmacist engaged in the practice of pharmacy pursuant to an agreement that is physician, pharmacist, patient, and disease specific when performed in accordance with rules and regulations developed by a joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and approved by both Boards."

Section 3. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Limitations on clinical pharmacist practitioners.**

(a) Any person who is licensed under the provisions of G.S. 90-18(c)(3a) to perform medical acts, tasks, and functions may use the title 'clinical pharmacist practitioner'. Any other person who uses the title in any form or holds himself or herself out to be a clinical pharmacist practitioner or to be so licensed shall be deemed to be in violation of this Article.

(b) Clinical pharmacist practitioners are authorized to implement predetermined drug therapy, modify prescribed drug dosages, dosage forms, and dosage schedules, and to order laboratory tests pursuant to a drug therapy management agreement that is physician, pharmacist, patient, and disease specific under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations developed by a joint subcommittee governing the approval of individual clinical pharmacist practitioners to practice drug therapy management with such limitations that the Board determines to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The North Carolina Medical Board has assigned an identification number to the clinical pharmacist practitioner which is shown on written prescriptions written by the clinical pharmacist practitioner.

(4) The drug therapy management agreement prohibits the substitution of a chemically dissimilar drug product by the pharmacist for the product prescribed by the physician without the consent of the

physician and includes a policy for periodic review by the physician of the drugs modified pursuant to the agreement or changed with the consent of the physician.

(c) Clinical pharmacist practitioners in hospitals and other health facilities that have an established pharmacy and therapeutics committee or similar group that determines the prescription drug formulary or other list of drugs to be utilized in the facility and determines procedures to be followed when considering a drug for inclusion on the formulary and procedures to acquire a nonformulary drug for a patient may order medications and tests under the following conditions:

(1) The North Carolina Medical Board and North Carolina Board of Pharmacy have adopted regulations governing the approval of individual clinical pharmacist practitioners to order medications and tests with such limitations as the Boards determine to be in the best interest of patient health and safety.

(2) The clinical pharmacist practitioner has current approval from both Boards.

(3) The supervising physician has provided to the clinical pharmacist practitioner written instructions for ordering, changing, or substituting drugs, or ordering tests with provision for review of the order by the physician within a reasonable time, as determined by the Boards, after the medication or tests are ordered.

(4) The hospital or health facility has adopted a written policy, approved by the medical staff after consultation with nursing administrators, concerning the ordering of medications and tests, including procedures for verification of the clinical pharmacist practitioner's orders by nurses and other facility employees and such other procedures that are in the best interest of patient health and safety.

(d) Any drug therapy order written by a clinical pharmacist practitioner or order for medications or tests shall be deemed to have been authorized by the physician approved by the Boards as the supervisor of the clinical pharmacist practitioner and the supervising physician shall be responsible for authorizing the prescription order.

(e) Any registered nurse or licensed practical nurse who receives a drug therapy order from a clinical pharmacist practitioner for medications or tests is authorized to perform that order in the same manner as if the order was received from a licensed physician."

Section 4. G.S. 90-85.3 is amended by adding a new subsection to read:

"(b1) 'Clinical Pharmacist Practitioner' means a licensed pharmacist who meets the guidelines and criteria for such title established by the joint subcommittee of the North Carolina Medical Board and the North Carolina Board of Pharmacy and is authorized to enter into drug therapy management agreements with physicians in accordance with the provisions of G.S. 90-18.3."

Section 5. G.S. 90-85.3(r) reads as rewritten:

"(r) 'Practice of pharmacy' means the responsibility for: interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services. A pharmacist may advise and educate patients and health care providers concerning therapeutic values, content, uses and significant problems of drugs and devices; assess, record and report adverse drug and device reactions; take and record patient histories relating to drug and device therapy; monitor, record and report drug therapy and device usage; perform drug utilization reviews; and participate in drug and drug source selection and device and device source selection as provided in G.S. 90-85.27 through G.S. 90-85.31. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order in accordance with rules and regulations adopted by each of the Boards of Pharmacy, the Board of Nursing, and the North Carolina Medical Board. Such rules and regulations shall be designed to ensure the safety and health of the patients for whom such drugs are administered. A licensed clinical pharmacist practitioner may collaborate with physicians in determining the appropriate health care for a patient, subject to the provisions of G.S. 90-18.3."

Section 6. Article 4A of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-85.26A. Clinical pharmacist practitioners subcommittee.**

The Board of Pharmacy shall appoint and maintain a subcommittee of the Board consisting of four licensed pharmacists to work jointly with the subcommittee of the North Carolina Medical Board to develop rules and regulations to govern the provision of drug therapy management by clinical pharmacist practitioners and to determine reasonable fees to accompany an application for approval or renewal of such approval as provided in G.S. 90-6. The rules developed by this subcommittee shall govern the performance of acts by licensed pharmacists and shall become effective when they have been adopted by both Boards."

Section 7. This act is effective when it becomes law.

SENATE BILL 1165:
Clinical Pharmacist Practitioner

BILL ANALYSIS

Committee:	Senate Health Committee	**Introduced by:**	Rep. Gorden Allen
Date:	April 18, 1999	**Summary by:**	Linda Attarian
Version:	Proposed Committee Substitute		Committee Counsel

SUMMARY: ***Senate Bill 1165 (PCS) would allow collaborative practice agreements between physicians and pharmacists, and would create a new area of practice for licensed pharmacists approved to practice as "clinical pharmacist practitioners" under rules to be adopted by the NC Medical Board and the Board of Pharmacy. The bill would authorize clinical pharmacist practitioners to enter into drug therapy management agreements with physicians and perform medical tasks in accordance with law. The bill would establish the law for the conditions and limitations of the practice of clinical pharmacist practitioners.***

CURRENT LAW:

Under current law [G.S. 90-85.3(r)] a licensed pharmacist's scope of practice is limited to: "interpreting and evaluating drug orders, including prescription orders; compounding, dispensing and labeling prescription drugs and devices; properly and safely storing drugs and devices; maintaining proper records; and controlling pharmacy goods and services". A pharmacist may also advise and educate patients and health care providers concerning drugs and devices. A pharmacist who has received special training may be authorized and permitted to administer drugs pursuant to a specific prescription order.

If enacted, a "clinical pharmacist practitioner" will be authorized to perform the tasks that fall within a physician's scope of practice, and would otherwise be prohibited from performing. These tasks include: implementation predetermined drug therapy, modification of prescribed drug dosages, dosage forms, and dosage schedules, and ordering laboratory tests. However, even if the bill is enacted, clinical pharmacist practitioner may perform these tasks only when pursuant to a drug therapy management agreement that is physician, pharmacist, patient and disease specific.

BILL ANALYSIS:

Section 1. Requires the NC Medical Board to appoint and maintain a subcommittee to work jointly with a subcommittee of the NC Board of Pharmacy to develop rules governing the performance of the clinical pharmacist practitioner. These Boards will retain the oversight of the collaborative agreements.

Section 2 –3. Conforming amendments to the Medical Practice Act.

Section 4. Outlines the scope of practice limitations of clinical pharmacist practitioners, including the tasks and functions that the clinical pharmacist practitioner will be authorized to perform and the conditions underwhich such tasks and functions may be performed.

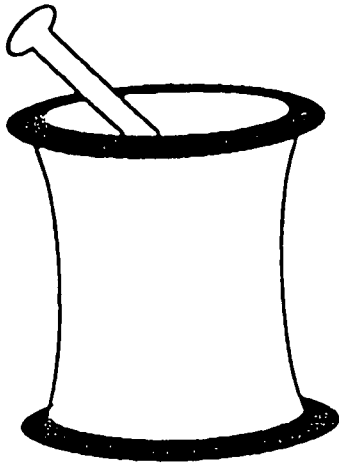
Sections 4 –5: Conforming amendments to the Pharmacy Practice Act.

Section 6: Requires the NC Board of Pharmacy to appoint and maintain a subcommittee to work jointly with a subcommittee of the NC Medical Board to develop rules governing the performance of the clinical pharmacist practitioner.

Section 7. Effective when the bill becomes law.

BACKGROUND: According to the North Carolina Pharmaceutical Association, 24 states allow some form of collaborative agreement between physicians and pharmacists.

Clinical Pharmacist Practitioner SB 1165



Fact Sheet For Collaborative Agreements

What is a collaborative agreement?

It is a voluntary written agreement between physicians and pharmacists that outlines a plan for drug therapy management. These agreements involve care that falls within the scope of practice of the participating physician and pharmacist.

What are the purposes of collaborative agreements?

1. To ensure optimal management of a patient's drug therapy through the voluntary collaboration of physicians and pharmacists.
2. To allow the pharmacist to provide comprehensive drug therapy management and monitoring in a system of health care that emphasizes a team approach, concentrating on positive outcomes with drug therapy.

How many states currently allow collaborative practice agreements?

Currently, 24 states allow some form of collaborative agreement between physicians and pharmacists.

Who provides oversight of these arrangements?

Both the Board of Medicine and the Board of Pharmacy provide oversight.

Remember:

Collaborative agreements do:

- Provide an option for improving and optimizing drug therapy outcomes.
- Provide a framework for physicians to voluntarily enter into protocol arrangements with pharmacists.

Collaborative agreements *do not*:

- Give pharmacists independent perscriptive authority
- Diminsh the authority of the physicians in the care of patients
- Require the participation of pharmacists or physicians -- it a voluntary agreement
- Affect a patient's right to go to the pharmacy of his or her choice

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 960
Proposed Committee Substitute S960-PCSRY-001
THIS IS A DRAFT: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: Regulation of Pharmacies. (Public)

Sponsors:

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE BOARD OF PHARMACY TO ADOPT RULES REGULATING PHARMACIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-85.21 reads as rewritten:

"§ 90-85.21. Pharmacy ~~permit.~~ permit; Board regulation of pharmacies.

(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacist personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacist personnel within 30 days of such change.

(b) Each physician who dispenses prescription drugs, for a fee or other charge, shall annually register with the Board on the form provided by the Board, and with the licensing board having jurisdiction over the physician. Such dispensing shall comply in all respects with the relevant laws and regulations that apply to pharmacists governing the distribution of drugs, including packaging, labeling, and record keeping. Authority and responsibility for disciplining physicians who fail to comply

with the provisions of this subsection are vested in the licensing board having jurisdiction over the physician. The form provided by the Board under this subsection shall be as follows:

Application For Registration
With The Pharmacy Board
As A Dispensing Physician

1. Name and Address of Dispensing Physician

2. Affix Dispensing Label Here

3. Physician's North Carolina License Number .....

4. Are you currently practicing in a professional association registered with the North Carolina Medical Board? .....Yes .....No. If yes, enter the name and registration number of the professional corporation:
.....
.....

5. I certify that the information is correct and complete.
....
Signature Date

(c) To protect the public health and safety, the board may adopt rules regulating pharmacies that are consistent with the laws of this State. In adopting such rules the Board shall consider:

(1) The maintenance of the quality, quantity, integrity, safety and efficacy of drugs or devices distributed, dispensed or administered;

(2) The maintenance of the integrity of, and public confidence in, the profession and the delivery of quality pharmaceutical services to the citizens of North Carolina; and

(3) Any other factors related to public health, safety and welfare."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 960

Short Title: Regulation of Pharmacies. (Public)

Sponsors: Senator Soles.

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE BOARD OF PHARMACY TO ADOPT RULES REGULATING PHARMACIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-85.21 reads as rewritten:

"**§ 90-85.21. Pharmacy ~~permit.~~ permit; Board regulation of pharmacies.**

(a) In accordance with Board regulations, each pharmacy in North Carolina shall annually register with the Board on a form provided by the Board. The application shall identify the pharmacist-manager of the pharmacy and all pharmacist personnel employed in the pharmacy. All pharmacist-managers shall notify the Board of any change in pharmacist personnel within 30 days of such change.

(b) Each physician who dispenses prescription drugs, for a fee or other charge, shall annually register with the Board on the form provided by the Board, and with the licensing board having jurisdiction over the physician. Such dispensing shall comply in all respects with the relevant laws and regulations that apply to pharmacists governing the distribution of drugs, including packaging, labeling, and record keeping. Authority and responsibility for disciplining physicians who fail to comply with the provisions of this subsection are vested in the licensing board having jurisdiction over the physician. The form provided by the Board under this subsection shall be as follows:

Application For Registration
With The Pharmacy Board
As A Dispensing Physician

1. Name and Address of Dispensing Physician

2. Affix Dispensing Label Here

3. Physician's North Carolina License Number .....

4. Are you currently practicing in a professional association registered with the North Carolina Medical Board? .....Yes .....No. If yes, enter the name and registration number of the professional corporation:

.....

.....

5. I certify that the information is correct and complete.

....

Signature Date

(c) To protect public health and safety, the Board may adopt rules regulating pharmacies."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1086
Proposed Senate Committee Substitute - S1086-PCSLN-001
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION.

Short Title: Restraints/Deaths in Facilities. (Public)

Sponsors:

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE MENTAL HEALTH STUDY COMMISSION TO STUDY THE USE OF PHYSICAL AND MECHANICAL RESTRAINTS IN CERTAIN FACILITIES, AND TO STUDY THE REPORTING OF DEATHS IN CERTAIN FACILITIES, AND TO STUDY ACCESS TO INFORMATION ABOUT THESE DEATHS BY THE GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES.

The General Assembly of North Carolina enacts:

Section 1. The Mental Health Study Commission shall study the following:

(1) The use of physical or mechanical restraint or seclusion of persons in the following facilities:
   a. Mental health facilities licensed under Article 2 of Chapter 122C of the General Statutes; and
   b. Child placing and child caring facilities licensed under Article 1A of Chapter 131D of the General Statutes.

(2) The reporting of deaths of persons in facilities licensed under Article 2 of Chapter 122C of the General Statutes, Articles 1A and 3 of Chapter 131D

of the General Statutes to the Secretary of Health and Human Services.

(3) Access to the information contained in reports required under subdivision (2) of this section, by the Governor's Advocacy Council for Persons with Disabilities for the monitoring of deaths occurring in such facilities.

(4) Any other issues the Commission deems appropriate for the study.

In conducting the study, the Commission shall solicit the input of the Governor's Advocacy Council for Persons with Disabilities and the contents of and any proposed revisions to Senate Bill 1086, 1999 General Assembly.

The Commission shall report its findings and recommendations to the 1999 General Assembly, Regular Session 2000, not later than May 1, 2000.

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1122
Proposed House Committee Substitute - S1122-PCSLN-002
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION.

Short Title: Area Mental Health/County Appropriations. (Public)

Sponsors: Senator Moore.

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW TO ALLOW COUNTIES TO REDUCE CERTAIN COUNTY APPROPRIATIONS AND EXPENDITURES FOR AREA MENTAL HEALTH AUTHORITIES FOR FUTURE FISCAL YEARS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-115(d) reads as rewritten:

"(d) Except as otherwise provided in this subsection, ~~Counties~~ counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time special needs of the area authority."

Section 2. This act becomes effective July 1, 1999.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 27, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Bobby Bryan	RRC
Ann Case	NCRMA
Walter Price	Charlotte Chamber
Thomas Vance Bennett	NCCFTF
Ellen DePue	Novartis
Jeff Lipe	Bayer
Amy Jo Bain	NC Medical Society
CP Merlin	COVENANT W/ NC'S CHILDREN
Hugh Tilson	NCHA
Kim Hibbard	NCLM
Kevin Howell	Governor's Office

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 27, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Dan Barrett	NCAP
Caroline Tedder	2308 Danbury Rd. Greensboro, NC 27408
John Boerdish	Zeb Alley P.A.
Glenn Wells	DHHS/ Public Health
Andy Eller	NC RMA
Fran Preston	NCRMA
Mark Gregory	Kerr Drug
David Work	NC Pharmacy Board
M L WEESEL	ALLEN + PINNIX
Mike Drain	- MERCK
Ann Christian	Alley
Alicia Gregory	Poyner & Spruill

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 27, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John McNally	MFHS
Paula A. Wolf	Covenant w/ NC's Children

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE: **April 28, 1999**
TIME: **12:00 to 1:00 P.M.**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 10, Long-Term Care Safety Initiative** **Senator Perdue**
- **S.B. 783, Long-Term Care Facilities/Disclosure** **Senator Cochrane**
- **S.B. 933, Adult Care Homes/Transfers** **Senator Kinnaird**

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, April 28, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, April 28, 1999 at 12:12 P.M. in Room 1125 in the Legislative Building. Seventeen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Zack Crocker from Smithfield, sponsored by Senator Wellons.

Senator Purcell introduced Senator Perdue to explain her bill, S.B. 10, *Long-Term Care Safety Initiative*. Senator Forrester moved that a Committee Substitute be adopted for purposes of discussion, and the motion carried unanimously. Senator moved adoption of her amendment for purposes of discussion and explained it to the Committee. Senator Phillips moved that the amendment be adopted; the motion carried unanimously. After additional discussion Senator Warren moved for an unfavorable report for the bill and a favorable report for the Committee Substitute. The amendment passed in today's Committee meeting will be rolled into a new Committee Substitute.

Senator Purcell asked Senator Kinnaird to present her bill, S.B. 933, *Adult Care Homes/Transfers*. Senator Kinnaird asked to withdraw her bill since its contents were covered in Senator Perdue's bill (above). Senator Purcell thanked her for her work on S.B. 933.

Senator Purcell asked Senator Cochrane to explain her bill, S.B. 783 *Long-Term Care Facilities/Disclosure.* Senator Perdue noted that most of the content of S.B. 783 was covered in S.B. 10 except for one major point; and moved that S.B. 783 be rewritten as a Committee Substitute deleting the points covered in S.B. 10. The motion carried unanimously.

Senator Purcell introduced Senator Phillips to explain his bill, S.B. 1086, *Restraints/Death in Facilities.* Senator Phillips introduced a Committee Substitute. Senator Martin moved that the Committee Substitute be adopted for purposes of discussion. The motion carried unanimously. Senator Martin moved that the Committee Substitute be given a favorable report and that this bill be referred to the Rules Committee for further study. The motion carried unanimously.

Senator Moore was recognized to present his bill, S.B. 1122, *Area Mental Health/County Appropriations*. He gave Committee members a Committee Substitute. Senator Forrester moved to approve the substitute for purposes of discussion. The motion carried and Senator Moore explained his bill. Senator Moore moved for a favorable report for the Committee Substitute. After discussion the motion was voted on and carried uananimously.

The meeting adjourned at 1:15 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, April 28, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **10** Long-Term Care Safety Initiative.

Draft Number:	PCS7674
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **783** Long-Term Care Facilities/Disclosure.

Draft Number:	PCS3808
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

S.B. **960** Regulation of Pharmacies.

Draft Number:	PCS2757
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 3

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, April 28, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1086** Restraints/Death in Facilities.

Draft Number:	PCS3807
Sequential Referral:	None
Recommended Referral:	Rules
Long Title Amended:	Yes

S.B. **1122** Area Mental Health/County Appropriations.

Draft Number:	PCS4695
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

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SENATE BILL 10
Proposed Senate Committee Substitute S10-PCSLN-002C
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION.

Short Title: Long-Term Care Safety Initiative. (Public)

Sponsors:

Referred to:

January 28, 1999

A BILL TO BE ENTITLED

AN ACT TO ENACT REFORMS IN THE LONG-TERM CARE INDUSTRY IN ORDER TO IMPROVE QUALITY OF CARE, INCREASE PROTECTION OF RESIDENTS, AND STRENGTHEN REGULATORY OVERSIGHT OF INDUSTRY PRACTICES.

The General Assembly of North Carolina enacts:

PART I. SUBSTANTIVE PROVISIONS FOR RESIDENT SAFETY

Section 1.1. Article 1 of Chapter 131D of the General Statutes is amended by adding the following new sections to read:

"**§ 131D-4.4. Adult care home minimum safety requirements.**

In addition to other requirements established by this Article or by rules adopted pursuant to this Article or other provisions of law, every adult care home shall provide to each resident the care, safety, and services necessary to enable the resident to attain and maintain the highest practicable level of physical, emotional, and social well-being in accordance with:

(1) The resident's individual assessment and plan of care; and

(2) Rules and standards relating to quality of care and safety adopted under this Chapter.

"**§ 131D-4.5. Rules adopted by Medical Care Commission.**

The Medical Care Commission shall adopt rules as follows:

(1) Establishing minimum medication administration standards for adult care homes. The rules shall include the minimum staffing

and training requirements for medication aides and standards for professional supervision of adult care homes' medication controls. The requirements shall be designed to reduce the medication error rate in adult care homes to an acceptable level. The requirements shall include, but need not be limited to, all of the following:

a. Training for medication aides, including periodic refresher training.

b. Standards for management of complex medication regimens.

c. Oversight by licensed professionals.

d. Measures to ensure proper storage of medication.

(2) Establishing training requirements for adult care home staff in behavioral interventions. The training shall include appropriate responses to behavioral problems posed by adult care residents. The training shall emphasize safety and humane care and shall specifically include alternatives to the use of restraints.

(3) Establishing minimum training and education qualifications for supervisors in adult care homes and specifying the safety responsibilities of supervisors.

(4) Specifying the qualifications of staff who shall be on duty in adult care homes during various portions of the day in order to assure safe and quality care for the residents. The rules shall take into account varied resident needs and population mixes.

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules may provide for procedures comparable to those provided to nursing home residents pursuant to federal law, to Chapter 131E of the General Statutes, and to related rules.

(6) Establishing procedures for determining the compliance history of adult care homes' principals and affiliates. The rules shall include criteria for refusing to license facilities which have a history of, or have principals or affiliates with a history of, noncompliance with State law, or disregard for the health, safety, and welfare of residents.

(7) For the licensure of special care units in accordance with G.S. 131D-4.6, and for disclosures required to be made under G.S. 131D-7.

(8) For time limited provisional licenses and for granting extensions for provisional licenses.

"**§ 131D-4.6. Licensure of special care units.**

(a) As used in this section, the term 'special care unit' means a wing or hallway within an adult care home, or a program provided by an adult care home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities.

(b) An adult care home that holds itself out to the public as providing a special care unit shall be licensed as such and shall, in addition to other licensing requirements for adult care homes, meet the standards established under rules adopted by the Medical Care Commission.

(c) An adult care home that holds itself out to the public as providing a special care unit without being licensed as a special care unit is subject to licensure actions and penalties provided under G.S. 131D-2(b), as well as any other action permitted by law."

"§ 131D-4.7. Adult care home specialist fund.

There is established the adult care home specialist fund. The fund shall be maintained in and by the Department for the purpose of assisting county departments of social services in paying salaries of adult care home specialists."

Section 1.2. G.S. 131D-2(a1) reads as rewritten:

"(a1) Persons not to be cared for in adult care homes. -- Except when a physician certifies that appropriate care can be provided on a temporary basis to meet the resident's needs and prevent unnecessary relocation, adult care homes shall not care for individuals with any of the following conditions or care needs:

(1) Ventilator dependency;
(2) Individuals requiring continuous licensed nursing care;
(3) Individuals whose physician certifies that placement is no longer appropriate;
(4) Individuals whose health needs cannot be met in the specific adult care home as determined by the residence; and
(5) Such other medical and functional care needs as the ~~Social Services~~ Medical Care Commission determines cannot be properly met in an adult care home."

Section 1.3. G.S. 131D-2(a2)(12) reads as rewritten:

"(12) Such other medical and functional care needs as the ~~Social Services~~ Medical Care Commission determines cannot be properly met in multiunit assisted housing with services."

Section 1.4. G.S. 131D-2(c2) reads as rewritten:

(c2) The ~~Social Services~~ Medical Care Commission shall adopt ~~any~~ rules necessary to carry out this section. The Commission has the authority, in adopting rules, to specify the limitation of nursing services provided by assisted living residences. In developing rules, the Commission shall consider the need to ensure comparable quality of services provided to residents, whether these services are provided directly by a licensed assisted living provider, licensed home care agency, or hospice. In adult care homes, living arrangements where residents require supervision due to cognitive impairments, rules shall be promulgated to ensure that supervision is appropriate and adequate to meet the special needs of these residents."

Section 1.5. G.S. 131D-2(b) is amended by adding the following new subdivision to read:

"(6) Prior to issuing a new license or renewing an existing license, the Department shall conduct a compliance history review of the

facility and its principals and affiliates. The Department may refuse to license a facility when the compliance history review shows a pattern of noncompliance with State law by the facility or its principals or affiliates, or otherwise demonstrates disregard for the health, safety, and welfare of residents in current or past facilities. The Department shall require compliance history information and make its determination according to rules adopted by the Medical Care Commission.

Section 1.6. G.S. 131D-21 is amended by adding the following new subdivision to read:

"(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Secretary, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law."

Section 1.7. G.S. 131D-2(b)(1) reads as rewritten:

"(b) Licensure; inspections. --

(1) The Department of Health and Human Services shall inspect and license, under rules adopted by the ~~Social Services~~ Medical Care Commission, all adult care homes for persons who are aged or mentally or physically disabled except those exempt in subsection (c) of this section. Licenses issued under the authority of this section shall be valid for one year from the date of issuance unless revoked earlier by the Secretary ~~of Health and Human Services~~ for failure to comply with any part of this section or any rules adopted hereunder. No new license shall be issued for any ~~domiciliary~~ adult care home whose administrator was the administrator for any ~~domiciliary~~ adult care home that had its license revoked until one full year after the date of revocation. Licenses shall be renewed annually upon filing and the Department's approval of the renewal application. A license shall not be renewed if outstanding fines and penalties imposed by the State against the home have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration. The renewal application shall contain all necessary and reasonable information that the Department may by rule require. Except as otherwise provided in this subdivision, the ~~The~~ Department may amend a license by reducing it from a

full license to a provisional license for a period of not more than 90 days whenever the Department finds that:

a. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles;

b. There is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

c. There is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

The Department may extend a provision license for not more than one additional 90 day period upon finding that the licensee has made substantial progress towards remedying the licensure deficiencies that caused the license to be reduced to provisional status.

The Department may revoke a license whenever:

a. The Department finds that:

1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

2. It is not reasonably probable that the licensee can remedy the licensure deficiencies within a reasonable length of time; or

b. The Department finds that:

1. The licensee has substantially failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles; and

2. Although the licensee may be able to remedy the deficiencies within a reasonable time, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future; or

c. The Department finds that the licensee has failed to comply with the provisions of Articles 1 and 3 of Chapter 131D of the General Statutes and the rules adopted pursuant to these Articles, and the failure to comply endangered the health, safety, or welfare of the patients in the facility.

The Department may also issue a provisional license to a facility, pursuant to rules adopted by the ~~Social Services~~ Medical Care Commission, for substantial failure to comply with the provisions

of this section or rules ~~promulgated~~ adopted pursuant to this section. Any facility wishing to contest the issuance of a provisional license shall be entitled to an administrative hearing as provided in the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails written notice of the issuance of the provisional license."

Section 1.8. G.S. 131D-26 is amended by adding the following new subsection to read:

"(a1) When the department of social services in the county in which a facility is located receives a complaint alleging a violation of the provisions of this Article pertaining to patient care or patient safety, the department of social services shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a resident as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a resident as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory requirements for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes."

Section 1.9. G.S. 131E-124 is amending by adding two new subsections to read:

"(a1) When the Department receives a complaint alleging a violation of the provisions of this Part pertaining to patient care or patient safety, the Department shall initiate an investigation as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a resident as defined by G.S. 131D-20(1)

(3) Within 48 hours if the complaint alleges neglect of a resident as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days. The requirements of this section are in addition to and not in lieu of any investigatory requirements for adult protective services pursuant to Article 6 of Chapter 108A of the General Statutes.

. . .

(d) Pursuant to 42 U.S.C. § 1395 and G.S. 131E-127, a nursing home as defined in G.S. 131E-101(6), is not in violation of any applicable statute, rule, or regulation for any action taken pursuant to a physician's order when the physician has determined that the action is medically necessary."

Section 1.10. G.S. 108A-103 is amended by adding the following new subsection to read:

"(d) The director shall initiate the evaluation described in subsection (a) of this section as follows:

(1) Immediately upon receipt of the complaint if the complaint alleges a life-threatening situation.

(2) Within 24 hours if the complaint alleges abuse of a resident as defined by G.S. 131D-20(1).

(3) Within 48 hours if the complaint alleges neglect of a resident as defined by G.S. 131D-20(8).

(4) Within two weeks in all other situations.

The investigation shall be completed within 30 days."

Section 1.11. G.S. 131E-233 is amended by adding the following new subsection to read:

"(c) (1) Upon petition by the Department for emergency intervention, a court may order the appointment of an emergency temporary manager after finding that there is reasonable cause to believe that:

a. Conditions or a pattern of conditions exist in the long-term care facility that create an immediate substantial risk of death or serious physical harm to residents; or

b. The long-term care facility is closing or intends to close before the time in which a hearing would ordinarily be scheduled, and:

1. Adequate arrangements for relocating residents have not been made, or

2. Quick relocation would not be in the best interest of residents.

(2) The court shall appoint an emergency temporary manager to serve until a hearing is conducted in accordance with ordinary procedures and shall direct the temporary manager to make only such changes in administration as necessary to protect the health or safety of residents until the emergency condition is resolved.

(3) The court shall schedule a hearing on the appointment of an emergency temporary manager within three days after service of notice of the filing of the petition. Notice of the filing of the petition and other relevant information, including the factual basis of the belief that an emergency temporary manager is needed shall be served upon the facility as provided in this Article. The notice shall be given at least 24 hours prior to the hearing of the petition for emergency intervention, except that the court may issue an immediate emergency order ex parte upon a finding as fact that:

a. The conditions specified above exist, and

b. There is likelihood that a resident may suffer irreparable injury or death if the order is delayed.

The order shall contain a show-cause notice to each person upon whom the notice is served directing the person to appear immediately or at any time up to and including the time for the hearing of the petition for emergency services and show cause, if any exists, for the dissolution or modification of the order. Unless dissolved by the court for good cause shown, the emergency order ex parte shall be in effect until the hearing is held on the petition for emergency services. At the hearing, if the court determines that the emergency continues to exist, the court may order the provision of emergency services in accordance with subsections (a) and (b) of this section."

Section 1.12. G.S. 131E-234 reads as rewritten:

"**§ 131E-234. Grounds for appointment of temporary manager.**

Upon a showing by the Department that one or more of the following grounds exist, the court may appoint a temporary manager for an initial period of 30 days or the first review by a superior court judge pursuant to G.S. 131E-243, whichever is longer:

(1) Conditions or a pattern of conditions exist in the long-term care facility that create a substantial risk of death or serious physical harm to residents or that death or serious physical harm has occurred, and it is probable that the facility will not or cannot immediately remedy those conditions or pattern of ~~conditions;~~ conditions, or the facility has shown a pattern of failure to comply with applicable laws and rules and continues to fail to comply;

(2) The long-term care facility is operating without a license;

(3) The license of the long-term care facility has been revoked or the long-term care facility is closing or intends to close and: (i) adequate arrangements for relocating residents have not been made, or (ii) quick relocation would not be in the best interest of the residents; or

(4) A previous court order has been issued requiring the respondent to act or refrain from acting in a manner directly affecting the care of the residents and the respondent has failed to comply with the court order."

Section 1.13. G.S. 131E-242(a) reads as rewritten:

"**§ 131E-242. Contingency fund.**

(a) The Department ~~shall establish~~ may maintain a temporary management contingency ~~fund~~ fund. ~~from the proceeds of penalties collected by the Department under the provisions of G.S. 131D-2 for adult care homes.~~"

Section 1.14. G.S. 131D-2(e) reads as rewritten:

"(e) ~~The Department of Health and Human Services shall provide the method of evaluation of residents in adult care homes in order to determine when any of those residents are in need of the professional medical and nursing care provided in licensed nursing homes.~~ The Department shall ensure that facilities conduct and

complete an assessment of each resident prior to admitting the resident and annually thereafter. In conducting the assessment the facility shall use an assessment instrument approved by the Secretary upon the advice of the Assistant Secretary for Aging. The Department shall provide ongoing training for facility personnel in the use of the approved assessment instrument.

The facility shall use the assessment to develop appropriate and comprehensive service plans and care plans and to determine the level and type of facility staff that is needed to meet the needs of residents. The assessment shall determine a resident's level of functioning and shall include, but not be limited to, cognitive status and physical functioning in activities of daily living. Activities of daily living are personal functions essential for the health and well being of the resident. The assessment shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to the resident's physician or other appropriate licensed health care professional or community resource.

The Department as part of its inspection and licensing of adult care homes shall review assessments and related service plans and care plans for a selected number of residents. In conducting this review, the Department shall determine:

(1) Whether the appropriate assessment instrument was administered and interpreted correctly;

(2) Whether the facility is capable of providing the necessary services;

(3) Whether the service plan or care plan conforms to the results of an appropriately administered and interpreted assessment; and

(4) Whether the service plans or care plans are being implemented fully and in accordance with an appropriately administered and interpreted assessment.

If the Department of finds that the facility is not carrying out its assessment responsibilities in accordance with this section the Department shall notify the facility and require the facility to implement a corrective action plan. The Department shall also notify the resident of the results of its review of the assessment, service plans, and care plans developed for the resident. In addition to administrative penalties, the Secretary may suspend the admission of any new residents to the facility. The suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removing the suspension."

PART II. ADULT CARE HOME DISCLOSURE REQUIREMENTS

Section 2.1. Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-7. Adult care home special care units; disclosure of information required.**

(a) An adult care home licensed under this Part that provides care for person's with Alzheimer's disease or other dementias in a special care unit shall disclose the form of care or treatment provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be in writing and shall be made to all of the following:

(1) The Department as part of its licensing procedures.

(2) Each person seeking placement within an Alzheimer's special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(3) The Office of State Long-Term Care Ombudsman, annually, or more often if requested.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.

(3) The process used for assessment and establishment of the plan of care and its implementation, including how the plan of care is responsive to changes in the resident's condition.

(4) Staffing ratios and how they meet the resident's need for increased care and supervision.

(5) Staff training that is dementia-specific.

(6) Physical environment and design features that specifically address the needs of residents with Alzheimer's disease or other dementias.

(7) Frequency and type of programs and activities for residents of the special care unit.

(8) Involvement of families in resident care, and availability of family support programs.

(9) Additional costs and fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosure of each adult care home subject to this section. Substantial changes to written disclosures shall be reported to the Department at the time the change is made.

(d) Nothing in this section shall be construed as prohibiting an adult care home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required under this section apply only to an adult care home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' has the same meaning as applies under G.S. 131D-4.6.

Section 2.2. G.S. 131D-6 is amended by adding the following new subsection to read:

"(b1) An adult day care program that provides or that advertises, markets, or otherwise promotes itself as providing special care services for person's with Alzheimer's disease or other dementias shall provide the following written disclosures to the Department and to persons seeking adult day care program special care services:

(1) A statement of the overall philosophy and mission of the adult day care program and how it reflects the special needs of participants with dementia.
(2) The process and criteria for providing or discontinuing special care services.
(3) The process used for assessment and establishment of the plan of care and its implementation, including how the plan of care is responsive to changes in the participant's condition.
(4) Staffing ratios and how they meet the participant's need for increased special care and supervision.
(5) Staff training that is dementia-specific.
(6) Physical environment and design features that specifically address the needs of participants with Alzheimer's disease or other dementias.
(7) Frequency and type of participant activities provided.
(8) Involvement of families in special care and availability of family support programs.
(9) Additional costs and fees to the participant for special care.

(c) As part of its certification renewal procedures and inspections, the Department shall examine for accuracy the written disclosure of each adult day care program subject to this section. Substantial changes to written disclosures shall be reported to the Department at the time the change is made.

(d) Nothing in this section shall be construed as prohibiting an adult day care program that does not advertise, market, or otherwise promote itself as providing special care services for person's with Alzheimer's disease or other dementias from providing adult day care services to persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care service' means a program, service, or activity designed especially for participants with Alzheimer's disease, other dementia, or other special needs disease or condition, as determined by the Medical Care Commission."

PART III. MISCELLANEOUS AND CONFORMING PROVISIONS

Section 3.1. Effective July 1, 1999, G.S. 131D-4.2(c) is repealed.

Section 3.2. G.S. 131D-4.2(h) reads as rewritten:

"(h) The report documentation shall be used to adjust the adult care home rate annually, an adjustment that is in addition to the annual standard adjustment for inflation as determined by the Office of State Budget and Management. Rates for family care homes shall be based on market rate data. The ~~Department~~ Secretary of Health and Human Services shall adopt rules for the rate-setting methodology and audited cost reports in accordance with G.S. 143B-10."

Section 3.3. G.S. 131D-2(a) is amended by adding the following new subdivision to read:

"(1f) 'Department' means the Department of Health and Human Services unless some other meaning is clearly indicated from the context."

Section 3.4. G.S. 131D-2(a) is amended by adding the following new subdivision to read:

"(12) 'Secretary' means the Secretary of Health and Human Services unless some other meaning is clearly indicated from the context."

Section 3.5. Effective October 1, 1999, G.S. 143B-153(3) reads as rewritten:

"(3) The Social Services Commission shall have the power and duty to establish and adopt standards:

a. For the inspection and licensing of maternity homes as provided by G.S. 131D-1;

~~b. For the inspection and licensing of adult care homes for aged or disabled persons as provided by G.S. 131D-2(b) and for personnel requirements of staff employed in adult care homes;~~

c. For the inspection and licensing of child-care institutions as provided by G.S. 131D-10.5;

d. For the inspection and operation of jails or local confinement facilities as provided by G.S. 153A-220 and Article 2 of Chapter 131D of the General Statutes of the State of North Carolina;

e. Repealed by Session Laws 1981, c. 562, s. 7.

f. For the regulation and licensing of charitable organizations, professional fund-raising counsel and professional solicitors as provided by Chapter 131D of the General Statutes of the State of North Carolina."

Section 3.6. G.S. 143B-165(10) reads as rewritten:

"(10) The Commission shall have the power and duty to ~~promulgate~~ adopt rules ~~and regulations~~ for the operation of nursing homes, as defined by ~~G.S. 130-9(e).~~ Article 6 of Chapter 131E of the General Statutes."

Section 3.7. Effective October 1, 1999, G.S. 143B-165 is amended by adding the following new subdivision to read:

"(13) The Commission shall have the power and duty to adopt rules for the inspection and licensure of adult care homes and operation of adult care homes, as defined by Article 1 of Chapter 131D of the General Statutes, and for personnel requirements of staff employed in adult care homes, except where rule-making authority is assigned to the Secretary."

Section 3.8. The Department of Health and Human Services shall establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators, and affiliates of nursing homes and adult care homes.

Section 3.9. The Department of Health and Human Services shall continue its demonstration project testing whether the TEACCH model is a viable method for finding and retaining competent staff for adult care homes and nursing homes.

Section 3.10. The Secretary of Health and Human Services may adopt temporary rules in accordance with Chapter 150B of the General Statutes to implement G.S. 131D-4.5 as enacted by this act. The Secretary's authority to adopt temporary rules to implement G.S. 131D-4.5 as enacted by this act expires on the date that permanent rules adopted by the Medical Care Commission to implement G.S. 131D-4.5 as enacted by this act become effective.

Section 3.11. Part 14E of Article 3 of Chapter 143B is repealed.

Section 3.12. The Department of Health and Human Services shall recommend to the North Carolina Study Commission on Aging a more efficient system of regulatory administration for adult care homes that delineates clear authority and streamlines government functions. The Department shall report its recommendations to the North Carolina Study Commission on Aging on or before February 1, 2000. The North Carolina Study Commission on Aging shall review the Department's recommendations and shall make recommendations to the General Assembly on or before May 1, 2000.

Section 3.13. The North Carolina Study Commission on Aging shall study the following:

(1) Establishment of a licensing fee as a source of revenue for, monitoring, staffing, and temporary management of adult care homes.

(2) The need for licensure of adult care home administrators, separate from the licensure of adult care facilities.

(3) The lack of uniformity, accountability, and central authority in the current regulatory system and how this impacts on care delivery and quality of life for adult care home residents.

The Commission shall report its findings and recommendations to the General Assembly on or before May 1, 2000.

Section 3.14. The Joint Legislative Health Care Oversight Committee shall study whether the Health Care Personnel Registry is working effectively and shall recommend any changes needed to improve its effectiveness. In conducting its study, the Committee shall consider the following:

(1) The extent to which employers of health care personnel subject to listing in the Registry are complying with statutory requirements to report incidents to the Registry.

(2) The extent to which employers of health care personnel subject to listing in the Registry are contacting the Registry before making hiring decisions to ascertain if applicants are listed in the Registry.

(3) Whether the scope of the Registry should be expanded to cover other types of health care personnel or health care facilities.

(4) Other issues relating to the Health Care Personnel Registry and its purpose.

The Health Care Oversight Committee shall report its findings and recommendations to the General Assembly on or before May 1, 2000.

Section 3.15. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 10

Short Title: Long-Term Care Safety Initiative. (Public)

Sponsors: Senators Perdue; Albertson, Ballance, Carter, Cooper, Dalton, Dannelly, Garrou, Gulley, Harris, Hoyle, Jordan, Kerr, Kinnaird, Lucas, Martin of Pitt, Martin of Guilford, Metcalf, Miller, Odom, Phillips, Plyler, Purcell, Rand, Reeves, Robinson, Soles, Warren, Weinstein, and Wellons.

Referred to: Health Care.

January 28, 1999

A BILL TO BE ENTITLED

AN ACT TO ENACT REFORMS IN THE LONG-TERM CARE INDUSTRY IN ORDER TO IMPROVE QUALITY OF CARE, INCREASE PROTECTION OF RESIDENTS, AND STRENGTHEN STATE OVERSIGHT OF INDUSTRY PRACTICES.

Whereas, because of shorter hospital stays, acutely ill elderly and disabled citizens are more often being sent directly from the hospital to a nursing home because of the need for higher levels of care; and

Whereas, the likelihood is increasing that adult care home residents will experience significant problems with activities of daily living and will therefore need heavy-care services; and

Whereas, although many adult care homes and nursing homes are able to provide adequate care and good quality of life for their residents, others of these homes are understaffed and provide inadequate services; and

Whereas, staffing and service problems encompass not only staff-to-resident ratios but also insufficient staff training, staff incompetence, and failure to provide needed services for which the State has already paid; and

Whereas, although recent changes in State law have improved certain conditions in some long-term care facilities, the changes have not significantly improved the lives of many of the State's long-term care residents; and

Whereas, lapses in adequate care have compromised the safety of residents and have lead to unhealthy, unkind, and sometimes tragic results; and

Whereas, when experience shows that certain industry practices jeopardize the health and safety of long-term care residents, then the State should strengthen its oversight of the industry to the extent necessary to protect and preserve the well-being of its elderly and disabled citizens; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. This act is effective when it becomes law.

EXPLANATION OF PROPOSED SENATE COMMITTEE SUBSTITUTE FOR SENATE BILL 10

Long-Term Care Safety Initiative

To: Senate Health Care Committee
From: John Young, Committee Staff
Date: April 26, 1999
Sponsor: Senator Beverly Perdue

The Proposed Senate Committee Substitute for Senate Bill 10 does the following:

- Requires the **Medical Care Commission to adopt rules** for adult care homes to establish minimum medication administration standards, establish training requirements for staff, establish minimum training and education qualifications for supervisors, specify qualifications of staff for each shift based on varied needs and population mix, implement due process and appeals rights for transfer and discharge of residents, establish procedures for determining the compliance history of adult care homes, establish standards for special care units and disclosure of special services offered for Alzheimer's and other dementia, and requirements of granting extensions for provisional licenses. This section is tied to section 3.10 that allows the Secretary of DHHS to adopt temporary rules to implement the above requirements. **(Section 1.1)**

- Requires facilities that publicize a **"special care unit" be licensed** as such. Under current law, adult care homes that advertise as providing a unit for Alzheimer's or dementia patients are not regulated on whether those units provide better or different care than is provided in the nonspecial care part of the facility. **(Section 1.1)**

- Establishes an **Adult Care Home Specialist Fund in DHHS**. DHHS maintains the fund. Funds used to pay salaries of adult care home specialists. No fees are authorized. **(Section 1.1)**

- Amends current licensing law for adult care homes to require DHHS, when issuing a new license or renewing an existing license, to **conduct a compliance history review** of the licensee. DHHS **may** refuse to issue a license when compliance history review shows a **pattern of noncompliance with State law or otherwise demonstrates disregard for health, safety, and welfare of residents.** Noncompliance history review pertains not only to current facility but other facilities owned or operated by the licensee. **(Section 1.5)**

- Provides that **residents have a right not to be transferred or discharged** except for specified reasons and requires 30 days' advance notice. Resident has a right to appeal

a facility's attempt to transfer or discharge. Resident may remain in facility pending appeal resolution. **(Section 1.6)**

- Amends licensing statute **to limit a provisional license to 90 days** or less but with one additional 90 day extension if DHHS finds that the licensee has made substantial progress toward remedying the licensure deficiencies. **(Section 1.7)**

- Establishes **minimum complaint response times.** Investigation must commence immediately if complaint alleges life-threatening situation, 24 hours if it alleges abuse or neglect, and within two weeks in any event. Investigation must be completed within 30 days. Response time requirements apply to adult care homes and nursing homes. **(Sections 1.8, 1.9, and 1.10)**

- Amends the current law pertaining to **temporary management of nursing homes and adult care homes**. Allows Department to file **a petition for emergency intervention**. This would allow the court to appoint an emergency temporary manager to serve until a hearing is conducted. Court must schedule hearing within three days of petition. Amends grounds for temporary management to include a facility's pattern of failure to comply with the law. **(Sections 1.11 and 1.12)**

- Current law provides that the contingency fund is funded from penalties collected under nursing home and adult care home penalty statutes. This language about creating the fund from penalty money is being repealed because it has been judged to be unconstitutional but allows DHHS to maintain this fund without the funding from penalties. **(Section 1.13)**

- Requires that facilities complete an **assessment** on each resident before the resident is admitted and shall be used to develop appropriate and comprehensive service plans and care plans and to determine staff needs. The assessment shall include but not be limited to cognitive status and physical functioning in the activities of daily living and shall not serve as the basis for medical care. The assessment shall indicate if the resident requires referral to a physician or other appropriate licensed health care professional or community resource. DHHS shall ensure that the assessment be completed on an instrument approved by the Secretary. DHHS shall provide ongoing training in the use of the instrument and as part of the licensing and inspection process shall review assessments and related service plans and care plans for a selected number of residents. **(Section 1.14)**

- Requires that adult care homes and adult day care programs offering special care to persons with Alzheimer's disease or related dementia disclose in writing certain information about the distinguishing characteristics of the special program to DHHS, to the person seeking placement, and to the State Long-Term Care Ombudsman. **(Sections 2.1 and 2.2)**

- Repeals (effective July 1, 1999) the requirement that family care homes file with DHHS annual cost reports. **(Section 3.1)**

- Rates for family care homes shall be based on market rate data. **(Section3.2**
- Establishes the new rule-making authority of the Medical Care Commission to make rules for adult care homes. **(Section 3.7)**

- DHHS will apply the TEACCH project being conducted in day care settings to address workforce problems to adult care homes. **(Section 3.9)**

- Gives the Secretary **authority to adopt temporary rules** for the eight safety issues. The authority for the Secretary to adopt rules expires when the Medical Care Commission adopts permanent rules. **(Section 3.10)**

- Requires DHHS to establish and maintain a provider file to record and monitor compliance histories of facilities, owners, operators and affiliates and applies to nursing homes and adult care homes. **(Section 3.8)**

- Repeals a section in the General Statutes pertaining to standards for Alzheimer's units in adult care homes (special care units). Apparently the Department has never adopted these standards. Since the current statute has a definition of "special care unit" that is different from the one in this bill we need to reconcile the two or repeal one. The Department recommends repealing the current one and replacing it with the one in this bill. **(Section 3.11)**

- Requires DHHS to recommend to the Study Commission on Aging a more efficient system of regulating adult care homes that establishes clear authority and streamlines the regulatory process. The Commission shall make recommendations to the General Assembly on or before May 1, 2000. **(Section 3.12)**

- Requires the Study Commission on Aging to study three listed topics and report to the General Assembly by May 1, 2000. **(Section 3.13)**

- Requires the Joint Legislative Health Care Oversight Committee to study whether the Health Care Personnel Registry is working effectively. The Committee is given four factors to consider and shall report its findings by May 1, 2000. **(Section 3.14)**

- Bill is effective upon becoming law. **(Section 3.15)**

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 933
Proposed Committee Substitute S933-PCS3798-LN

Short Title: Adult Care Homes/Transfers. (Public)

Sponsors:

Referred to:

April 14, 1999

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE RIGHTS OF ADULT CARE HOME RESIDENTS WITH RESPECT TO TRANSFER OR DISCHARGE FROM THE FACILITY.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, G.S. 131D-21 is amended by adding the following new subdivision to read:

"Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

(17) To not be transferred or discharged from a facility except as provided under G.S. 131D-21.2."

Section 2. Effective January 1, 2000, Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-21.2. Conditions for transfer or discharge from facility.**

(a) A facility shall not transfer or discharge a resident except under one or more of the following conditions:

(1) The transfer or discharge is necessary, in the opinion of the resident's physician, to meet the resident's welfare and the resident's welfare cannot be met in the facility.

(2) The transfer or discharge is appropriate because, in the opinion of the resident's physician, the resident's health has improved

sufficiently so that the resident no longer needs the services provided by the facility.

(3) The safety of individuals in the facility is endangered.

(4) The health of individuals in the facility would be otherwise endangered. The threat to the health of individuals shall be determined by a licensed physician.

(5) Except as provided in this subdivision, the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility. Reasonable and appropriate notice includes notice by a third-party payor of denial of a claim for payment. A resident may not be transferred for nonpayment if the resident has submitted to a third-party payor all paperwork necessary for payment to be made.

(6) The transfer is otherwise required by State or federal law.

(7) The facility ceases to operate.

If the transfer or discharge is due to a significant change in the resident's condition but is not an emergency requiring immediate transfer or discharge, then prior to transfer or discharge, the facility shall conduct an assessment to determine if a new care plan would allow the facility to meet the resident's needs.

The facility shall include the resident's record documentation of any conditions that result in the transfer or discharge of the resident.

Every facility shall post a notice of the facility's transfer or discharge procedures in a location commonly occupied by facility residents.

(b) Every contract between a facility and resident executed upon admission shall include written disclosure of the transfer or discharge requirements of this section. For resident contracts executed prior to January 1, 2000, compliance with this subsection may be achieved if the facility provides written notice to the resident of the transfer or discharge requirements of this section, including policies and procedures adopted by the facility to comply with the requirements of this section, and files in the resident's record the date notice was provided and written acknowledgement of receipt of the notice signed by the resident.

(c) Before a facility transfers or discharges a resident, the facility shall:

(1) Notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the move in writing and in a language and manner that is understandable to the resident, family member, or legal representative. Notice shall be provided at least 30 days in advance of the transfer or discharge in order to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the facility.

(2) Record the reasons for the transfer or discharge in the resident's record.

(3) Include in the notice all of the following:

a. The effective date of the transfer or discharge.

b. The location to which the resident is transferred or discharged.

c. A statement that the resident has the right to appropriate discharge planning, to appeal the transfer or discharge pursuant to rules adopted by the Social Services Commission, and that the facility must allow the resident to remain in the facility until resolution of the appeal, unless otherwise provided by law.

d. The name, address, and telephone number of the State long-term care ombudsman.

e. The name, address, and telephone number of the Governor's Advocacy Council for Persons with Disabilities.

(4) Provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(d) As used in this section, the term 'transfer or discharge' includes movement of a resident to a bed outside of the facility, whether that bed is in the same physical plan or not. 'Transfer or discharge' does not refer to movement of a resident to a bed within the same facility."

Section 3. The Social Services Commission may adopt temporary rules to implement this act.

Section 4. This act is effective when it becomes law and applies to transfer or discharge of residents occurring on and after January 1, 2000, and to contracts executed on and after January 1, 2000.

SENATE BILL 933:
Adult Care Homes/Transfers.

BILL ANALYSIS

Committee:	Senate Health Committee	**Introduced by:**	Senator Kinnaird
Date:	April 27, 1999	**Summary by:**	O. Walker Reagan, Judiciary 1
Version:	First Edition		

SUMMARY: ***Senate Bill 933 would amend the Adult Care Home Residents Bill of Rights to include a right not to be transferred or discharged from an adult care home except in accordance with the law, and would establish the law for conditions for transfer or discharge from an adult care home.***

CURRENT LAW: Current statutory law does not address the rights of an adult care home or a resident of an adult care home relative to the transfer or discharge of the resident from the home. Most legal rights of the resident in this regard are presently matters of contract law. G.S. 131D-21 sets out residents rights relative to adult care homes, but these rights are silent as to transfer or discharge from an facility.

BILL ANALYSIS: Section 1 of Senate Bill 933 would create a right in residents of adult care homes not to be transfer or discharged from an adult care home except in accordance with G.S. 131D-21.2 as enacted in Section 2 of this bill.

Section 2 adds a new section as G.S. 131D-21.2, effective January 1, 2000 that spells out the resident's rights relative to transfer or discharge. Under this provision, a resident can only be transferred or discharged for the following reasons:

1. Transfer or discharge is necessary for the resident's welfare that can't be meet at the facility as determined by the resident's doctor.
2. The resident's condition, as determined by the resident's doctor, has improved to the extent that the resident no longer needs the services of the facility.
3. The safety of individuals in the facility is endangered.
4. The health of individuals in the facility as determined by a doctor would otherwise be endangered.
5. The resident has failed to pay for staying at the facility after reasonable notice, except where the resident has submitted all necessary paperwork for third party payment and the payment has not been denied.
6. The transfer is required by State or federal law.
7. The facility ceases to operate.

The facility is required to do an assessment to determine if a new plan of care would meet the resident's needs and the resident's record should be documented for the conditions resulting in the transfer or discharge.

Before transfer or discharge, notice shall be given to the resident, the resident's family or legal representative at least 30 days prior to the release, except for emergency or heath and safety reasons. The notice shall include the date of the transfer or discharge, where the resident will be going, a statement explaining the resident's right to appeal to the Social Services Commission, and the name and phone number of the State long-term care ombudsman and Governor's Advocacy Council on Persons with Disabilities.

The terms "transfer or discharge" mean movement to a bed outside the facility, not a transfer within the facility.

EFFECTIVE DATE: The bill is effective when it becomes law but doesn't apply to transfer or discharge of residents until January 1, 2000.

S933-SMRU-001

Senate Bill 933:
Adult Care Homes/Transfers

Purpose: To establish an appeals process and rules regarding Transfer/Discharge of residents living in Adult Care Homes (Formerly Rest Homes).

The State of **North Carolina Eviction Law** provides NC citizens with the right to appeal an eviction. They must receive a written notice, the right to a hearing, and the right to appeal a Magistrate's decision.

Nursing Home residents have similar rights to appeal and can only be discharged for 5 specific reasons. Complaining is not one of these reasons. Nursing Home residents must be provided a 30 day written discharge notice, including the right to appeal this notice.

Currently, **residents in Adult Care Homes have no such rights.** They **may be discharged for any reason, and must only be given a 14-day written notice.** Because residents have **NO RIGHT TO APPEAL** a discharge notice, they are often hesitant to advocate for themselves or lodge grievances concerning their care, for **fear of retaliation and/or discharge from the facility.**

Senate Bill 933 would provide that residents may only be discharged for the following reasons:

1. **The resident's physician deems that the resident's needs cannot be met in the facility.**
2. **The resident's health has improved to the extent the facility's services are no longer needed.**
3. **The resident is a danger to other residents.**
4. **A doctor determines that the resident would endanger the health of other residents in the facility.**
5. **Nonpayment for stay after appropriate notice.**
6. **Transfer is required by federal law.**
7. **The facility closes.**

Before a transfer or discharge occurs, the facility must provide a 30-day written notice to the resident, family member and/or legal responsible party including:

- **the transfer date,**
- **location of transfer,**
- **the resident's right to appeal, and that the resident may remain in the facility until resolution of the appeal,**
- **name/address/phone number of the State Long Term Care Ombudsman and the Governor's Advocacy Council for Person's with Disabilities.**

***Applicable statistics:**

1. A compilation of complaints is kept by the North Carolina Long Term Care Ombudsman Program. These statistics show an increase in the total complaints in NC relating to Adult Care Home transfer/discharge. (A compilation of statewide numbers is process.)

2. At the present time, no other statistics have been found at the state or county level.

3. Because residents are afforded no protection from discharge in Adult Care Homes, they often do not or feel they cannot complain about their quality of care or quality of life.

It is worth noting that these types of complaints are underreported due to the resident's fear of obtaining a label of "chronic complainer" that will influence the new home's attitude, as well.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 933
Proposed Committee Substitute S933-CSLN-1
WARNING: LINE NUMBERS MAY CHANGE AFTER INTRODUCTION.

Short Title: Adult Care Homes/Transfers. (Public)

Sponsors:

Referred to:

April 14, 1999

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE RIGHTS OF ADULT CARE HOME RESIDENTS WITH RESPECT TO TRANSFER OR DISCHARGE FROM THE FACILITY.

The General Assembly of North Carolina enacts:

Section 1. Effective January 1, 2000, G.S. 131D-21 is amended by adding the following new subdivision to read:

"Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

(17) To not be transferred or discharged from a facility except as provided under G.S. 131D-21.2."

Section 2. Effective January 1, 2000, Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-21.2. Conditions for transfer or discharge from facility.**

(a) A facility shall not transfer or discharge a resident except under one or more of the following conditions:

(1) The transfer or discharge is necessary, in the opinion of the resident's physician, to meet the resident's welfare and the resident's welfare cannot be met in the facility.

(2) The transfer or discharge is appropriate because, in the opinion of the resident's physician, the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility.

(3) The safety of individuals in the facility is endangered.

(4) The health of individuals in the facility would be otherwise endangered. The threat to the health of individuals shall be determined by a licensed physician.

(5) Except as provided in this subdivision, the resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility. Reasonable and appropriate notice includes notice by a third-party payor of denial of a claim for payment. A resident may not be transferred for nonpayment if the resident has submitted to a third-party payor all paperwork necessary for payment to be made.

(6) The transfer is otherwise required by State or federal law.

(7) The facility ceases to operate.

If the transfer or discharge is due to a significant change in the resident's condition but is not an emergency requiring immediate transfer or discharge, then prior to transfer or discharge the facility shall conduct an assessment to determine if a new care plan would allow the facility to meet the resident's needs.

The facility shall include the resident's record documentation of any conditions that result in the transfer or discharge of the resident.

Every facility shall post a notice of the facility's transfer or discharge procedures in a location commonly occupied by facility residents.

(b) Every contract between a facility and resident executed upon admission shall include written disclosure of the transfer or discharge requirements of this section. For resident contracts executed prior to January 1, 2000, compliance with this subsection may be achieved if the facility provides written notice to the resident of the transfer or discharge requirements of this section, including policies and procedures adopted by the facility to comply with the requirements of this section, and files in the resident's record the date notice was provided and

written acknowledgement of receipt of the notice signed by the resident.

(c) Before a facility transfers or discharges a resident, the facility shall:

(1) Notify the resident and, if known, a family member or legal representative of the resident, of the transfer or discharge and the reasons for the move in writing and in a language and manner that is understandable to the resident, family member, or legal representative. Notice shall be provided at least 30 days in advance of the transfer or discharge in order to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the facility.

(2) Record the reasons for the transfer or discharge in the resident's record.

(3) Include in the notice all of the following:

a. The effective date of the transfer or discharge.

b. The location to which the resident is transferred or discharged.

c. A statement that the resident has the right to appropriate discharge planning, to appeal the transfer or discharge pursuant to rules adopted by the Social Services Commission, and that the facility must allow the resident to remain in the facility until resolution of the appeal, unless otherwise provided by law.

c. The name, address, and telephone number of the State long-term care ombudsman.

d. The name, address, and telephone number of the Governor's Advocacy Council for Persons with Disabilities.

(4) Provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

(d) As used in this section, the term 'transfer or discharge' includes movement of a resident to a bed outside of the facility, whether that bed is in the same physical plan or not. 'Transfer or discharge' does not refer to movement of a resident to a bed within the same facility."

Section 2. The Social Services Commission may adopt temporary rules to implement this act.

Section 3. This act is effective when it becomes law and applies to transfer or discharge of residents occurring on and after January 1, 2000, and to contracts executed on and after January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 783
Health Care Committee Substitute Adopted 4/28/99

Short Title: Long-Term Care Facilities/Disclosure. (Public)

Sponsors:

Referred to:

April 7, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT NURSING HOMES PROVIDING SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIAS DISCLOSE CERTAIN INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"§ 131E-112. Special care units; disclosure of information required.

(a) A nursing home or combination home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

(1) The Department, as part of its licensing procedures.

(2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.
(3) The process used for assessment and establishment of the plan of care and its implementation, as required under State and federal law.
(4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.
(5) Dementia-specific staff training.
(6) Physical environment features designed specifically for the special care unit.
(7) Alzheimer's disease and other dementia-specific programming.
(8) Opportunities for family involvement.
(9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each licensed facility subject to this section.

(d) Nothing in this section shall be construed as prohibiting a nursing home or combination home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to a nursing home or combination home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' means a wing or hallway within a nursing home, or a program provided by a nursing home, that is designated especially for residents with Alzheimer's disease or other dementias, or other special needs disease or condition, as determined by the Medical Care Commission, which may include mental disabilities."

Section 2. This act becomes effective January 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 783

Short Title: Long-Term Care Facilities/Disclosure. (Public)

Sponsors: Senators Cochrane; Ballantine, Carpenter, Carrington, East, Forrester, Foxx, Garwood, Hartsell, Horton, Martin of Pitt, Martin of Guilford, and Webster.

Referred to: Health Care.

April 7, 1999

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADULT CARE HOMES, NURSING HOMES, AND ADULT DAY CARE PROGRAMS PROVIDING SPECIAL CARE FOR PERSONS WITH ALZHEIMER'S DISEASE OR OTHER DEMENTIAS DISCLOSE CERTAIN INFORMATION.

The General Assembly of North Carolina enacts:

Section 1. G.S. 143B-181.50 reads as rewritten:

"**§ 143B-181.50. Definition of special care unit.**

As used in this Part, the term 'special care unit' means a wing or hallway within a nursing home or ~~rest home~~ adult care home, or a program provided by a nursing home or adult care home, that is ~~separated by closed doors from the rest of the nursing home or rest home and that is designed~~ designated especially for residents with Alzheimer's disease ~~and related dementia.~~ or other dementias."

Section 2. G.S. 143B-181.51 reads as rewritten:

"**§ 143B-181.51. Rules required -- North Carolina Medical Care Commission.**

The North Carolina Medical Care Commission shall develop rules containing State standards for special care units in nursing homes for patients with Alzheimer's disease ~~and related dementia.~~ or other dementias. These standards shall include guidelines concerning the type of care provided in a special care unit, the type of resident who can be served on the unit, the ratio of residents to staff members, and the requirements for the training of staff members. The rules shall also provide for compliance with the disclosure requirements under G.S. 131E-112."

Section 3. G.S. 143B-181.52 reads as rewritten:

"**§ 143B-181.52. Rules required -- Social Services Commission.**

The Social Services Commission shall develop rules containing State standards for special care units in ~~rest~~ adult care homes for patients with Alzheimer's disease ~~and related dementia.~~ or other dementias. These standards shall include guidelines concerning the type of care provided in a special care unit, the type of resident who can be served on the unit, the ratio of residents to staff members, and the requirements for the training of staff members. The rules shall also provide for compliance with the disclosure requirements under G.S. 131D-6(b1) and G.S. 131D-7."

Section 4. Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-112. Special care units; disclosure of information required.**

(a) A nursing home or combination home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

(1) The Department, as part of its licensing procedures.

(2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.

(3) The process used for assessment and establishment of the plan of care and its implementation, as required under State and federal law.

(4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.

(5) Dementia-specific staff training.

(6) Physical environment features designed specifically for the special care unit.

(7) Alzheimer's disease and other dementia-specific programming.

(8) Opportunities for family involvement.

(9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each licensed facility subject to this section.

(d) Nothing in this section shall be construed as prohibiting a nursing home or combination home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to a nursing home or combination home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' has the same meaning as applied under G.S. 143B-181.50."

Section 5. Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-7. Adult care home special care units; disclosure of information required.**

(a) An adult care home licensed under this Part that provides special care for persons with Alzheimer's disease or other dementias in a special care unit shall make the following disclosures pertaining to the special care provided that distinguishes the special care unit as being especially designed for residents with Alzheimer's disease or other dementias. The disclosure shall be made annually, in writing, to all of the following:

(1) The Department, as part of its licensing procedures.

(2) Each person seeking placement within a special care unit, or the person's authorized representative, prior to entering into an agreement with the person to provide special care.

(b) Information that must be disclosed in writing shall include, but is not limited to, all of the following:

(1) A statement of the overall philosophy and mission of the licensed facility and how it reflects the special needs of residents with dementia.

(2) The process and criteria for placement, transfer, or discharge to or from the special care unit.

(3) The process used for assessment and establishment of the plan of care and its implementation, including methods by which the plan of care evolves and is responsive to changes in the resident's condition.

(4) Typical staffing patterns and how the patterns reflect the resident's need for increased care and supervision.

(5) Dementia-specific staff training.

(6) Physical environment features designed specifically for the special care unit.

(7) Alzheimer's disease and other dementia-specific programming.

(8) Opportunities for family involvement.

(9) Additional costs or fees to the resident for special care.

(c) As part of its license renewal procedures and inspections, the Department shall examine for accuracy the written disclosures made by each adult care home subject to this section.

(d) Nothing in this section shall be construed as prohibiting an adult care home that does not offer a special care unit from admitting a person with Alzheimer's disease or other dementias. The disclosures required by this section apply only to an adult care home that advertises, markets, or otherwise promotes itself as providing a special care unit for persons with Alzheimer's disease or other dementias.

(e) As used in this section, the term 'special care unit' has the same meaning as applied under G.S. 143B-181.50."

Section 6. G.S. 131D-6 is amended by adding the following new subsections to read:

"(b1) An adult day care program that provides or that advertises, markets, or otherwise promotes itself as providing special care services to persons with Alzheimer's disease or other dementias shall provide the following written disclosures to the Department and to persons seeking adult day care program special care services:

(1) A statement of the overall philosophy and mission of the adult day care program and how it reflects the special needs of residents with dementia.

(2) The process and criteria for providing or discontinuing special care services.

(3) The process used for assessment and establishment of the plan of special care and its implementation, including methods by which the plan of special care evolves and is responsive to changes in the participant's condition.

(4) Typical staffing patterns and how the patterns meet the participant's need for increased special care and supervision.

(5) Dementia-specific training.

(6) Physical environment features designed specifically for participants with Alzheimer's disease or other dementias.

(7) Frequency and type of participant activities provided to recipients of special care services.

(8) Opportunities for involvement of families in special care and availability of family support programs.

(9) Additional costs or fees to the participant for special care.

(c) As part of its certification renewal procedures and inspections, the Department shall examine for accuracy the written disclosure of each adult day care program subject to this section.

(d) Nothing in this section shall be construed as prohibiting an adult day care program that does not advertise, market, or otherwise promote itself as providing special care services for persons with Alzheimer's disease or other dementias from providing adult day care services to persons with Alzheimer's disease or other dementias."

Section 7. This act becomes effective January 1, 2000.

SENATE BILL 783:
Long-Term Care Facilities Disclosure

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Cochrane
Date:	April 14, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***SB 783 would require that adult care homes, nursing homes, and adult day care programs offering special care to persons with Alzheimer's disease or related dementia disclose in writing certain information about the distinguishing characteristics of the special program to the Department of Health and Human Services and to the person seaking placement or to the person's authorized representative. The act would become effective January 1, 2000***

Background: As of 1998, an estimated 127,000 older persons have some form of dementia, with about 65,600 experiencing a moderate or severe cognitive impairment, such as Alzheimer's disease that affects their memory and ability to reason. Even though only about 5 % of older adults reside in institutions, almost half of all elderly people will live in a nursing home or adult care facility at some point in their lives.

BILL ANALYSIS: The provisions of SB 783 cover the following long-term care facilities:

1. Nursing homes are health care facilities that provide nursing care for patients who need continuing medical supervision for chronic medical conditions or for patients who need remedial or convalescent care, but are not acutely ill on admission and do not need general hospital care.
2. Adult care facilities are assisted living residences in which the housing management provides 24-hour supervision and scheduled and unscheduled personal care services.
3. Adult day care programs provide short-term (less than 24-hour per day) care and supervision for physically or mentally disabled adults in a group setting other than in their homes.

SB 783 does the following:

Section 1: Rewrites the current definition of "special care unit" as found in G.S. 143B-181.50. to include a program as well as a physical location and expands those covered to include "other dementias".

Section 2: Requires that the Medical Care Commission develop rules for compliance with the disclosure requirements as part of the rules governing special care units in nursing homes.

Section 3: Requires that the Social Services Commission deveop rules for compliance with the disclosure requirements as part of the rules governing special care units in nursing homes.

Section 4, 5 and 6: Requires adult care homes. nursing homes. and adult day care programs providing special care for Alzheimer's disease or other dementias to disclose anniually in writing to DHHS as part of the licensing procedure and to each person seeking placement or receiving services the following information:

1. a statement of the overall philosophy and mission and how it reflects the special needs of resident;
2. process and criteria for placement, transfer or discharge;
3. process used for assessment and establishment of the plan of care and its implementation;
4. typical staffing patterns and how these patterns reflect thepatient's need for increased care;
5. dementia-specific staff training;
6. physical environmental features designed specifically for the special care unit;
7. dementia-specific programming;
8. opportunities for family involvement; and
9. additional costs or fees to the resident for special care.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1086
Health Care Committee Substitute Adopted 4/28/99

Short Title: Restraints/Deaths in Facilities. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE THE MENTAL HEALTH STUDY COMMISSION TO STUDY THE USE OF PHYSICAL AND MECHANICAL RESTRAINTS IN CERTAIN FACILITIES, AND TO STUDY THE REPORTING OF DEATHS IN CERTAIN FACILITIES, AND TO STUDY ACCESS TO INFORMATION ABOUT THESE DEATHS BY THE GOVERNOR'S ADVOCACY COUNCIL FOR PERSONS WITH DISABILITIES.

The General Assembly of North Carolina enacts:

Section 1. The Mental Health Study Commission shall study the following:

(1) The use of physical or mechanical restraint or seclusion of persons in the following facilities:
   a. Mental health facilities licensed under Article 2 of Chapter 122C of the General Statutes; and
   b. Child placing and child caring facilities licensed under Article 1A of Chapter 131D of the General Statutes.

(2) The reporting of deaths of persons in facilities licensed under Article 2 of Chapter 122C of the General Statutes, Articles 1A and 3 of Chapter 131D of the General Statutes to the Secretary of Health and Human Services.

(3) Access to the information contained in reports required under subdivision (2) of this section, by the Governor's Advocacy

Council for Persons with Disabilities for the monitoring of deaths occurring in such facilities.

(4) Any other issues the Commission deems appropriate for the study.

In conducting the study, the Commission shall solicit the input of the Governor's Advocacy Council for Persons with Disabilities and the contents of and any proposed revisions to Senate Bill 1086, 1999 General Assembly.

The Commission shall report its findings and recommendations to the 1999 General Assembly, Regular Session 2000, not later than May 1, 2000.

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1122
Health Care Committee Substitute Adopted 4/28/99

Short Title: Area Mental Health/County Appropriations. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAW TO ALLOW COUNTIES TO REDUCE CERTAIN COUNTY APPROPRIATIONS AND EXPENDITURES FOR AREA MENTAL HEALTH AUTHORITIES FOR FUTURE FISCAL YEARS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-115(d) reads as rewritten:

"(d) Except as otherwise provided in this subsection, ~~Counties~~ counties shall not reduce county appropriations and expenditures for current operations and ongoing programs and services of area authorities because of the availability of State-allocated funds, fees, capitation amounts, or fund balance to the area authority. Counties may reduce county appropriations by the amount previously appropriated by the county for one-time special needs of the area authority."

Section 2. This act becomes effective July 1, 1999.

SENATE BILL 1122:
Area Mental Health/County Appropriations.

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Moore
Date:	April 20, 1999	**Summary by:**	Linda Attarian
Version:	1		Committee Counsel

SUMMARY: ***This bill will allow counties to supplant county appropriations and expenditures for area mental health authorities with available State-allocated funds in years other than the year for which the county funds were appropriated. Currently, counties are prohibited from making such reductions in any year.***

CURRENT LAW: Under North Carolina law, the counties are responsible for the delivery of mental health, developmental disabilities, and substance abuse services through a network of local area authorities. In 1995, the General Assembly directed the Department of Health and Human Services to make sure that counties did not reduce county appropriations and expenditures for area mental health, developmental disabilities, and substance abuse authorities because the authorities have received additional State appropriations for these services. (See Chapter 324 of the 1995 Session Laws). In 1996, this mandate was codified as G.S. 122C-115(d) with the enactment of HB 1237. Counties may not adjust their funding allocation to pay for the cost of providing services through the area authorities due to the availability of State-allocated funds, fees, capitation amounts or fund balance to the area authorities.

BILL ANALYSIS:

Section 1. Amends G.S. 122C-115(d) to provide that counties shall not reduce their appropriations to area authorities *during the fiscal year for which the funds were appropriated* because of the availability of State-allocated funds. Under current law, the counties may not reduce their appropriations to area authorities because of the availability of State –allocated funds in any year.

Section 2. If enacted, the bill is effective July 1, 1999

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 28, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Karen Gottovi	Division of Aging
[illegible]	DHHS
Marc College	DHHS
Lynda McDaniel	DHHS/DFS
Joanne Schoen	NC nurses Association
Pam Seamans	NC Social Services Consortium
Sheron Hirsch	NC Social Services Consortium
Gail Holden	Wake Co. Human Services
Marlene Chasson	Friends of Residents in LTC
Pam Barger	Region I Ombudsman
Sharnese Ransome	DSS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 28, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Sue Creighton	DMH/DD/SAS
Lisa Haire	DMH/DD/SAS
David Moser	Triangle J Area Agency on Aging
Wendy Sause	Div. of Aging
Kristie Russ	Ombudsman Program Triangle J Area Agency on Aging
Jill Al-hafez	Ombudsman Program Triangle J Area Agency on Aging
Mark Benton	DHHS
Beth McCleer	NAMI NC
Dave Richard	ARC/NC
Jerry Cooper	NCALA
Stacy Flannery	NCHCFA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 28, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Carol Teal	Friends of Residents in Long Term Care Raleigh, N.C.
Leslie Brown	DMHDDSAS
Polly Williams	AARP / NC Equity
Theresa Stanton	AARP
Janice B. Williams	Senior Fellow - Duke LTC Program
Bill Little	"
John Turner	DHHS
Evelyn Walker	North Carolina Friends of Midwifery
Roger Bone	Bone & Assoc. NCALTCF
Marie Mulady	NCANPHA
Bill Lamb	Division of Aging

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — April 28, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Craig Souza	NC HCFA
Bill Krueger	NTC
Will Jay	AHPC
Kevin Fitzgerald	NC DHHS - DSS
Curtis Venable	
John Cyrus	N.C. State Grange
[illegible]	GHCPD
Jesse Goodman	DFS / DHHS

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, May 5, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- H.B. 906 Pharmacist Peer Review — Representative Alexander
- H.B. 715 Utilization Review/ASAM Criteria — Representative Alexander
- H.B. 96 Adult Care Home/Lic. Exempt — Representative Edwards

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, May 5, 1999

MINUTES

The Senate Committee on Health Care met on Wednesday, May 5, 1999, at 12:05 P.M. in Room 1124 in the Legislative Building. Fourteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Pages, Stephanie Morgan from Caldwell County sponsored by Senator Moore, and Derrick Hinton from Wake County, sponsored by Senator Reeves.

Senator Purcell introduced Representative Martha Alexander to present her bill, H.B. 715, *Utilization Review/ASAM Criteria.* Mrs. Alexander introduced Dr. Philip Hilsman, psychiatrist and president of the North Carolina Chapter of the American Society for Addiction to Medicine. He explained the goals and purposes of the ASAM (see Attachment A). After discussion, Senator Martin offered an amendment which was voted upon and passed. Senator Lucas moved for an unfavorable report as to the bill, but a favorable report for the Committee Substitute, which encompasses Senator Martin's amendment.

Senator Purcell asked Representative Alexander to explain H.B. 906, *Pharmacist Peer Review.* Senator Purcell asked Dave Marley to comment on the bill. Mr. Marley is a pharmacist and Executive Director of the North Carolina Pharmacist Recovery Network. This organization has been funded by the Board of Pharmacy to provide a program for early identification, intervention and referral of impaired pharmacists in North Carolina. After discussion Senator Rucho moved for a favorable report for the bill. The motion passed unanimously.

Senator Purcell introduced Representative Zeno Edwards to present his bill, H.B. 96, *Adult Care Home/Lic. Exempt.* Senator Weinstein moved for a favorable report. After discussion by the Committee members, Senator Martin asked for staff to clarify two points: the health and safety features voided by the exemption, and if liability would be likely to fall back on the State; and asked that if this bill should receive a favorable report, that it not be reported out until these questions are answered. Senator Purcell agreed. The bill was voted upon and passed unanimously.

The meeting was adjourned at 12:55 P.M.

NOTE: Staff will address Senator Martin's concerns by memo with a copy to Chair Purcell (Attachment B).

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Tuesday, May 11, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **906** Pharmacist Peer Review.
Sequential Referral: None
Recommended Referral: None

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1)**715** Utilization Review/ASAM Criteria.
Draft Number: PCS2344
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 715
Committee Substitute Favorable 4/23/99
Proposed Committee Substitute H715-PCS2344-RM

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA FOR SUBSTANCE ABUSE TREATMENT BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) OR SIMILAR CRITERIA.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

"(d) Program Operations. -- In every utilization review program, an insurer or URO shall use documented clinical review criteria that are based on sound clinical evidence and that are periodically evaluated to assure ongoing efficacy. An insurer may develop its own clinical review criteria or purchase or license clinical review criteria. Criteria for determining when a patient needs to be placed in a substance abuse treatment program shall be either (i) the diagnostic criteria contained in the most recent revision of the American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders or (ii) criteria adopted by the insurer or its URO. The Department, in consultation with the Department of Health and Human Services, may require proof of compliance with this subsection by a plan or URO.

Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect

incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 715
Committee Substitute Favorable 4/23/99

Short Title: Utilization Review/ASAM Criteria. (Public)

Sponsors:

Referred to:

March 30, 1999

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT UTILIZATION REVIEW CRITERIA FOR SUBSTANCE ABUSE TREATMENT BE CRITERIA ADOPTED BY THE AMERICAN SOCIETY OF ADDICTION MEDICINE (ASAM) OR SIMILAR CRITERIA.

The General Assembly of North Carolina enacts:

Section 1. G.S. 58-50-61(d) reads as rewritten:

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Qualified health care professionals shall administer the utilization review program and oversee review decisions under the direction of a medical doctor. A medical doctor shall evaluate the clinical appropriateness of noncertifications. Compensation to persons involved in utilization review shall not contain any direct or indirect

incentives for them to make any particular review decisions. Compensation to utilization reviewers shall not be directly or indirectly based on the number or type of noncertifications they render. In issuing a utilization review decision, an insurer shall: obtain all information required to make the decision, including pertinent clinical information; employ a process to ensure that utilization reviewers apply clinical review criteria consistently; and issue the decision in a timely manner pursuant to this section."

Section 2. This act becomes effective October 1, 1999, and applies to utilization reviews conducted on and after that date.

ATTACHMENT A

Thank, Mr. Chairman and members of the committee for your time My name is Philip Hillsman. I am a psychiatrist and addiction specialist. I represent the North Carolina chapter of the American Society of Addiction Medicine, ~~or ASAM~~.

The ASAM Patient Placement Criteria are a set of guidelines for placement of patients in the appropriate level of care, from early intervention and outpatient treatment to hospital services. The Criteria have become a national standard for addiction treatment. [redacted], 18 states require use of the ASAM Criteria in some or all state-funded treatment programs. The Department of Defense official policy on substance abuse treatment uses a system of care based on the ASAM Criteria.

Why should these particular treatment guidelines be used? There are no other similar guidelines available. And research has shown these Criteria to be effective in placing patients in proper treatment. For example, individuals who the Criteria suggest require intensive hospital treatment, but who do not receive this level of care, subsequently require twice the number of hospital days compared with those who received proper treatment.

Some committee members may be concerned about cost. Ladiesand gentlemen, the costs of drug and alcohol addiction lie in the tremendous social and economic ~~costs~~ burden of untreated, or undertreated addiction. Examples include medical problems, accidents, crime and problems in the

workplace, including reduced productivity and injury on the job.

Make no mistake. Addiction is an illness. It only appears that the addict or alcoholic can stop using drugs or drinking if he wants to, and he usually does want to. Part of the brain is determined to use drugs or drink no matter what the cost to the person and everyone around him. However, addiction is a treatable illness. And treatment of addiction effectively reduces costs to society. For example, research has shown that following treatment, criminal activity dropped 23 to 38 percent, and hospital admissions dropped by 50 percent. Treatment is cost-effective; a large study in California showed that for every $1 spent on treatment, California residents saved $7, primarily in reduced criminal justice costs.

The ASAM Criteria emphasize outpatient care. Only two of eight levels are hospital based, for the sickest patients. These Criteria are not gold-plated. They are consistent with modern cost controls on health care expenditures. They are a reasonable response to the need to provide good medical care for a serious, life-threatening illness. The ASAM Criteria allow a statewide standard for addiction treatment. These Criteria will make sure that the level of addiction treatment provided in North Carolina is matched to the level of care needed. Good addiction treatment will reduce the human suffering associated with addiction and save North Carolina money. I urge you to pass House Bill 715. Thank you.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 906

Short Title: Pharmacist Peer Review. (Public)

Sponsors: Representatives Alexander, Gardner; Brown, Cansler, Church, Earle, Hiatt, Sherrill, Wainwright, and G. Wilson.

Referred to: Health.

April 5, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE NORTH CAROLINA BOARD OF PHARMACY TO ENTER INTO AGREEMENTS WITH PHARMACIST PEER REVIEW ORGANIZATIONS FOR IMPAIRED PHARMACISTS.

The General Assembly of North Carolina enacts:

Section 1. Article 4A of Chapter 90 of the General Statutes is amended by adding the following new section:

"**§ 90-85.41. Board agreements with special peer review organizations for impaired pharmacists.**

(a) The North Carolina Board of Pharmacy may, under rules adopted by the Board in compliance with Chapter 150B of the General Statutes, enter into agreements with special impaired pharmacist peer review organizations. Peer review activities to be covered by such agreements shall include investigation, review and evaluation of records, reports, complaints, litigation, and other information about the practices and practice patterns of pharmacists licensed by the Board, as such matters may relate to impaired pharmacists. Special impaired pharmacist peer review organizations may include a statewide supervisory committee and various regional and local components or subgroups.

(b) Agreements authorized under this section shall include provisions for the impaired pharmacist peer review organizations to receive relevant information from the Board and other sources, conduct any investigation, review, and evaluation in an expeditious manner, provide assurance of confidentiality of nonpublic information and of the peer review process, make reports of investigations and evaluations to the

Board, and to do other related activities for operating and promoting a coordinated and effective peer review process. The agreements shall include provisions assuring basic due process for pharmacists that become involved.

(c) The impaired pharmacist peer review organizations that enter into agreements with the Board shall establish and maintain a program for impaired pharmacists licensed by the Board for the purpose of identifying, reviewing, and evaluating the ability of those pharmacists to function as pharmacists, and to provide programs for treatment and rehabilitation. The Board may provide funds for the administration of these impaired pharmacist peer review programs. The Board shall adopt rules to apply to the operation of impaired pharmacist peer review programs, with provisions for: (i) definitions of impairment; (ii) guidelines for program elements; (iii) procedures for receipt and use of information of suspected impairment; (iv) procedures for intervention and referral; (v) arrangements for monitoring treatment, rehabilitation, posttreatment support, and performance; (vi) reports of individual cases to the Board; (vii) periodic reporting of statistical information; and (viii) assurance of confidentiality of nonpublic information and of the peer review process.

(d) Upon investigation and review of a pharmacist licensed by the Board, or upon receipt of a complaint or other information, an impaired pharmacist peer review organization that enters into a peer review agreement with the Board shall report immediately to the Board detailed information about any pharmacist licensed by the Board, if:

(1) The pharmacist constitutes an imminent danger to the public or himself or herself.

(2) The pharmacist refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence.

(3) It reasonably appears that there are other grounds for disciplinary action.

(e) Any confidential patient information and other nonpublic information acquired, created, or used in good faith by an impaired pharmacist peer review organization pursuant to this section shall remain confidential and shall not be subject to discovery or subpoena in a civil case. No person participating in good faith in an impaired pharmacist peer review program developed under this section shall be required in a civil case to disclose any information (including opinions, recommendations, or evaluations) acquired or developed solely in the course of participating in the program.

(f) Impaired pharmacist peer review activities conducted in good faith pursuant to any program developed under this section shall not be grounds for civil action under the laws of this State, and the activities are deemed to be State directed and sanctioned and shall constitute "State action" for the purposes of application of antitrust laws."

Section 2. This act is effective when it becomes law.

HOUSE BILL 906:
Pharmacist Peer Review

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Alexander and Gardner
Date:	May 5, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***This bill authorizes the North Carolina Board of Pharmacy to establish peer review organizations for the purpose of establishing a mechanism to rehabilitate impaired pharmacists.***

CURRENT LAW: A number of professions in North Carolina including medicine, dentistry and law have programs sanctioned by the various boards that attempt to rehabilitate rather than take the traditional disciplinary actions against its drug-dependent and impaired licensees. Since the Board of Pharmacy has no statuatorily sanctioned program, this bill would establish such a mechanism. The provisions of this bill are modeled after the program established by the Board of Medicine in 1987 as contained in Article 1D of G.S. 90.

BILL ANALYSIS: **Section 1** adds a new G.S. 90-85.41 that does the following:

1. Authorizes the Board to enter into areements with special peer review organizations;
2. Allows these organizations to receive relevant information from the Board and other sources, conduct investigations, evaluate the performance of the pharmacists investigated, provide confidentiality, and evaluate the performance of pharmacists investigated, provide confidentiality and make reports and evaluations the the Board, concerning the practices and practice patterns of licensed pharmacists that may be impaired;
3. Authorizes Board to adopt rules under which the peer review organizations may act and provide funds for the peer review organization's operations;
4. Requires peer review organizations are to report to the Board immediately if:
   a. the organization determines that the pharmacists is an imminent danger to the public or himself,
   b. refuses to cooperate with the investigation or submit to treatments and still impaired after treatment and exhibits professional incompetence,
   c. gives other grounds for disciplinary action.
5. Keeps confidential information that comes to the organization as confidential and is not subject to discovery or subpoena in a civil case;
6. Provides that good faith efforts of the peer review organizations are not grounds for civil action.

Section 2 makes the act effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 96

Short Title: Adult Care Home/Lic. Exempt. (Public)

Sponsors: Representative Edwards.

Referred to: Rules, Calendar and Operations of the House.

February 17, 1999

A BILL TO BE ENTITLED

AN ACT TO RESTORE AND APPLY RETROACTIVELY THE EXEMPTION FROM LICENSURE FOR CERTAIN ADULT CARE HOMES MAINTAINED OR OPERATED BY A UNIT OF GOVERNMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-2(c) reads as rewritten:

"(c) The following are excluded from the provisions of this section and are not required to be registered or obtain licensure under this section:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration; ~~and~~

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or ~~indirectly.~~ indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995."

Section 2. This act is effective on and after September 30, 1995.

HOUSE BILL 96:
Adult Care Home/ Licensure Exemption

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Rep. Edwards
Date:	May 5, 1999	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: ***House Bill 96 would restore and apply retroactively the exemption from licensure for certain adult care homes maintained or operated by a unit of government. It is believed from information furnished by the Division of Facility Services that the exemption would apply to only one facility which is in Beaufort county.***

CURRENT LAW: The Department of Health and Human Services is required by G.S. 131D-2 to inspect and license, under rules of the Social Services Commission, adult care homes. These licenses are valid for one year unless revoked earlier by the Secretary of DHHS for failure to comply with the requirements of statute and rule. G.S. 131 D-2(c) lists four current exemptions to the licensure requirement.

BACKGROUND: The adult care home industry partially grew out of county homes that cared for indigents in each county. Usually these were the elderly with no other place to go. Over time, the system began to change, partially because of new attitudes arising out of the 1929 Depression. About 1949 the State began to take some responsibility by helping to fund persons who lived in these "rest homes". As a result, oversight began to be required and these homes were licensed as domiciliary care facilities. In this licensing statute there was, among others, an exemption from the licensure requirement for facilities maintained or operated by a unit of government.

In 1995 the General Assembly rewrote the licensure statutes for domiciliary care facilities (G.S.131D). These facilities were renamed "adult care homes" and the exemption for adult care homes maintained or operated by a unit of government was not included in the rewrite.

BILL ANALYSIS: House Bill 96 would restore and apply rectroactively the exemption from licensure for adult care homes maintained or operated by a unit of government Even though there would be no state oversight for any exempted facility, building code requirements would remain.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 5, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Joy Peters	MANST
J. Craig James	PCMH
Allison Dorn	NCNAP
Katherine Miller	
Maureen Darcy	NCNA
Jane Sechrest	NC Nurses Association
Dave Marley	NCPRN
Tom Melvin	ADONC
Jim King	North Carolina Midwifery Alliance
Damaris Pittman, CPM	NCMA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 5, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Celeste Toombs	N.C. Nurses Assoc
Hugh Tilson	NCHA
Lori Ann Harris	LAHA, Inc
Dave Ames	Smith Ames
Jan Ramquist	NCDHHA

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING

The Senate Committee on **Health Care** will meet at the following time:

DATE:
TIME:
ROOM:

The following bills or resolutions will be considered:

- **THE HEALTH CARE COMMITTEE MEETING FOR THIS WEEK HAS BEEN CANCELLED.**

Senator William R. Purdell, Chair

Principal Clerk
Reading Clerk

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, May 19, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 944** **Extend Adult Care Home Bed Moratorium** **Rep. Cansler**
- **H.B. 1193** **Health Care Professionals** **Rep. Nesbitt**
- **H.B. 96** **Adult Care Home/Lic. Exempt** **Rep. Edwards**

Senator William R. Purcell, M.D., Chair

SENATE COMMITTEE ON HEALTH CARE

Wednesday, May 19, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, May 19, 1999, at 12:08 P.M. in Room 1124 in the Legislative Building. Fourteen members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Page Andi Miller from Wake County, who was sponsored by Senator Virginia Fox.

Senator Purcell asked Representative Cansler to present his bill, H.B. 944, *Extend Adult Care Home Bed Moratorium* to the Committee. Senator Rucho moved for a favorable report. After some discussion the motion was voted upon and carried unanimously.

Senator Purcell called upon Representative Nesbitt to explain his bill, H.B. 1193, *Health Care Professionals.* Senator Forrester presented an amendment to this bill, which excluded midwives, and moved for the adoption of his amendment. The motion carried unanimously. Senator Moore proposed an amendment; however after discussion he withdrew his amendment. Senator Dannelly moved for an unfavorable report on the bill, but favorable as amended. The motion carried unanimously.

Senator Purcell told the Committee that H.B. 96, *Adult Care Home/Lic. Exempt* would have to be postponed until next week since Senator Martin, who was to have presented an amendment could not be at this meeting. He introduced Mr. Don Davenport , County Manager of Beaufort County, who spoke on the history relative to this bill and was able to answer a number of questions for Committee members. Mr. William P. Mayo, Beaufort County Attorney, also spoke to the Committee.

The meeting was adjourned at 12:50 P.M.

William R. Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, May 19, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **944** Extend Adult Care Home Bed Moratorium
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Thursday, May 20, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO SENATE C.S. BILL

H.B. **1193** Health Care Professionals.

Draft Number:	PCS7241
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Monday, June 07, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B. **96** Adult Care Home/Lic. Exempt.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment:

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 944

Short Title: Extend Adult Care Home Bed Moratorium. (Public)

Sponsors: Representatives Cansler; and Morris.

Referred to: Select Committee on Health Care Delivery.

April 8, 1999

A BILL TO BE ENTITLED

AN ACT TO EXTEND THE MORATORIUM ON APPROVAL OF ADDITIONAL ADULT CARE HOME BEDS TO SEPTEMBER 30, 2000.

The General Assembly of North Carolina enacts:

Section 1. Section 11.69(b) of S.L. 1997-443, as amended by Section 12.16C(a) of S.L. 1998-212, reads as rewritten:

"(b) Effective until ~~August 26, 1999,~~ September 30, 2000, the Department of Health and Human Services shall not approve the addition of any adult care home beds for any type home or facility in the State, except as follows:

(1) Plans submitted for approval prior to May 18, 1997, may continue to be processed for approval;

(2) Plans submitted for approval subsequent to May 18, 1997, may be processed for approval if the individual or organization submitting the plan demonstrates to the Department that on or before August 25, 1997, the individual or organization purchased real property, entered into a contract to purchase or obtain an option to purchase real property, entered into a binding real property lease arrangement, or has otherwise made a binding financial commitment for the purpose of establishing or expanding an adult care home facility. An owner of real property who entered into a contract prior to August 25, 1997, for the sale of an existing building together with land zoned for the development of not more than 50 adult care home beds with a proposed purchaser who failed to consummate the transaction may, after August 25, 1997,

sell the property to another purchaser and the Department may process and approve plans submitted by the purchaser for the development of not more than 50 adult care home beds. It shall be the responsibility of the applicant to establish, to the satisfaction of the Department, that any of these conditions have been met;

(3) Adult care home beds in facilities for the developmentally disabled with six beds or less which are or would be licensed under G.S. 131D or G.S. 122C may continue to be approved;

(4) If the Department determines that the vacancy rate of available adult care home beds in a county is fifteen percent (15%) or less of the total number of available beds in the county as of August 26, 1997, and no new beds have been approved or licensed in the county or plans submitted for approval in accordance with subdivision (1) or (2) of this section which would raise the vacancy rate above fifteen percent (15%) in the county, then the Department may accept and approve the addition of beds in that county; or

(5) If a county board of commissioners determines that a substantial need exists for the addition of adult care home beds in that county, the board of commissioners may request that a specified number of additional beds be licensed for development in their county. In making their determination, the board of commissioners shall give consideration to meeting the needs of Special Assistance clients. The Department may approve licensure of the additional beds from the first facility that files for licensure and subsequently meets the licensure requirements."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1193
Second Edition Engrossed 4/28/99

Short Title: Health Care Professionals. (Public)

Sponsors: Representatives Nesbitt and Luebke.

Referred to: Select Committee on Health Care Delivery.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING NURSE PRACTITIONERS, PHYSICIAN ASSISTANTS, AND CERTIFIED NURSE MIDWIVES TO CONDUCT PHYSICAL EXAMINATIONS IN CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 37.

"Health Care Professionals.

"**§ 90-646. Physical examination by qualified health care professionals.**

(a) Whenever a statute or State agency rule enacted before October 1, 1999, requires that a physical examination shall be conducted by a physician, the examination may be conducted by another health care professional qualified to conduct such examination. The term 'health care professional' means a physician, nurse practitioner, physician's assistant, or certified nurse midwife who holds a current valid license or certificate to practice in North Carolina.

(b) This section shall not apply to physical examinations conducted pursuant to G.S. 1A-1, Rule 35; G.S. 15B-12; G.S. 90-14; or any rules adopted by the North Carolina Boxing Commission requiring physical examinations unless those statutes or rules are amended to make the provisions of this section applicable."

Section 2. This act becomes effective October 1, 1999.

HOUSE BILL 1193:
Health Care Professionals

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Reps. Nesbitt and Luebke
Date:	May 19 1999	**Summary by:**	Linda Attarian Committee Counsel
Version:	Second Edition		

SUMMARY: ***House Bill 1193 would amend Chapter 90 to provide that, with a few exceptions, whenever a statute or rule enacted before October 1, 1999 requires that a physical examination be conducted by a physician, the examination may instead be performed by another health care professional as defined in the bill.***

CURRENT LAW: Throughout the North Carolina General Statutes and Administrative Rules there are various provisions requiring a person to receive a physical examination. Many of these provisions require that the exam be conducted a physician or surgeon. For example, G.S. 20-9(g)(2) authorizes the Division of Motor Vehicles to condition the issuance of a driver's license on the applicant's agreement to submit to a physical examination *by a physician or surgeon duly licensed to practice medicine in this State.*

BILL ANALYSIS: **Section 1.** Adds a new Article to Chapter 90 that would apply to any law or rule enacted prior to October 1, 1999 requiring a physician to conduct a physical examination, (with a few exceptions noted below) on someone. The new article would allow a health care professional qualified to conduct a physical examination, other than a physician, to conduct the examination. Health professionals qualified to conduct such an examination are defined in the bill to *mean a physician, a nurse practitioner, a physician assistant, or a certified nurse midwife who holds a current valid license or certificate to practice in North Carolina.*

The section would <u>not</u> apply to:

- G.S. 1A-1, Rule 35, where the physical examination is ordered by the court when someone's physical condition is in controversy in a civil proceeding;
- G.S. 15B-12, where the physical condition of a victim or claimant is material to a claim for an award of compensation;
- G.S. 90-14, where the physical examination is order by the NC Medical Board in a license revocation proceeding;
- Rules adopted by the NC Boxing Commission.

Section 2. If enacted, the act would become effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 1

HOUSE BILL 96

Short Title: Adult Care Home/Lic. Exempt. (Public)

Sponsors: Representative Edwards.

Referred to: Rules, Calendar and Operations of the House.

February 17, 1999

A BILL TO BE ENTITLED

AN ACT TO RESTORE AND APPLY RETROACTIVELY THE EXEMPTION FROM LICENSURE FOR CERTAIN ADULT CARE HOMES MAINTAINED OR OPERATED BY A UNIT OF GOVERNMENT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-2(c) reads as rewritten:

"(c) The following are excluded from the provisions of this section and are not required to be registered or obtain licensure under this section:

(1) Facilities licensed under Chapter 122C or Chapter 131E of the General Statutes;

(2) Persons subject to rules of the Division of Vocational Rehabilitation Services;

(3) Facilities that care for no more than four persons, all of whom are under the supervision of the United States Veterans Administration; ~~and~~

(4) Facilities that make no charges for housing, amenities, or personal care service, either directly or ~~indirectly.~~ indirectly; and

(5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995."

Section 2. This act is effective on and after September 30, 1995.

HOUSE BILL 96:
Adult Care Home/ Licensure Exemption

BILL ANALYSIS

Committee:	Senate Health Care Committee	**Introduced by:**	Rep. Edwards
Date:	May 5, 1999	**Summary by:**	John Young
Version:	2		Committee Staff

SUMMARY: ***House Bill 96 would restore and apply retroactively the exemption from licensure for certain adult care homes maintained or operated by a unit of government. It is believed from information furnished by the Division of Facility Services that the exemption would apply to only one facility which is in Beaufort county.***

CURRENT LAW: The North Carolina Social Services Commission sets licensing standards for adult care facilities. These licensing regulations do the following:

- Establish minimum staff-to-resident ratios.
- Require the facilities meet applicable building and health codes.
- Mandate installation of fire alarms and smoke detectors.
- Establish minimum space requirements for resident's rooms and requirements for recreational, living, dining, kitchen, storage, and bathroom areas.
- Specify the types of personal-care services that must be porovided to residents.
- Establish Nutritional and other standards for food service provided to residents.
- Mandate the homes establish activities programs for residents.
- Establish requirements relating to the provision of medications to residents.

The Division of Facility Services is responsible for determining whether adult care homes meet the licensing requirements and for issuing licenses. County departments of social services, however, are responsible for making unannounced monthly visits to the facility and for monitoring their ongoing compliance with the licensing regulations.

If a facility fails to comply with the licensing requirements, the county department of social services issues a corrective action notice to the facility, requiring it to correct the deficiency/ In the case of serious deficiencies, the county department of social services may recommend further enforcement action by the Division of facility services.

If there is substantial evidence of abuse, neglect, exploitation, or any condition that presents an imminent danger to the health and safety of a resident, the Division of Facility Services has the legal authority to

deny or revoke a facilitiy's license. To issue a provisional license, or summarily suspend the facility's license

Residents of adult care facilities licensed by the State are covered by the Adult Care Home Bill of Rights which confers certain rights, including the rights

- To be treated with respect, consideration dignity, and full recognition of his or her individuality and right to privacy;
- To receive care and services that are adequate, appropriate, and in compliance with relevant laws and rules and regulations;
- To be free from mental and physical abuse, neglect, and exploitation;
- Except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need;
- To manage his or her personal needs funds; and
- To have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedon to refuse such participation.

The law allows the resident, or the resident's guardian to bring civil suit for injunctive relief to enforce the provisions of the Resident's Bill of Rights.

The stautes also establish the long-term care ombudsman program and the local adult care home advisory committee established in each county. These groups may assist in resolving complaints or grievances against a facility. The committee is required to visit each facility at least quarterly.

In 1995 the General Assembly rewrote the licensure statutes for domiciliary care facilities (G.S.131D). These facilities were renamed "adult care homes" and the exemption for adult care homes maintained or operated by a unit of government was not included in the rewrite.

BILL ANALYSIS: House Bill 96 would restore and apply rectroactively the exemption from licensure for adult care homes maintained or operated by a unit of government Even though there would be no state oversight for any exempted facility, building code requirements would remain.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 96
PROPOSED SENATE COMMITTEE SUBSTITUTE - H96-PCSLN-001
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION.

Short Title: Adult Care Home/Lic. Exempt. (Public)

Sponsors:

Referred to: Rules, Calendar and Operations of the House.

February 17, 1999

A BILL TO BE ENTITLED

AN ACT TO EXEMPT CERTAIN ADULT CARE HOMES FROM BUILDING CODE AND PHYSICAL PLANT LICENSURE REQUIREMENTS FOR A LIMITED PERIOD OF TIME.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-2 is amended by adding the following new subsection to read:

"(c5) Institutions that are maintained or operated by a unit of government and that were established, maintained, or operated by a unit of government and exempt from licensure by the Department on September 30, 1995 are exempt from current North Carolina State Building Code requirements and physical plant licensure requirements so long as the institution continues to meet the requirements of the North Carolina State Building Code in effect at the time of construction or remodeling of the institution. These institutions are subject to all other requirements for licensure under this Article."

Section 2. The Department of Health and Human Services, Division of Facility Services, shall inspect facilities exempt from building code and physical plant licensure requirements under G.S. 131D-2(c5) to determine the extent to which the facilities comply with current physical plant licensure rules and applicable building code requirements. On or before April 1, 2000, the Department shall report its findings and recommendations to the North Carolina Study Commission on Aging

and to the House and Senate appropriations committees on health and human services. The North Carolina Study Commission on Aging shall review the findings of the Department of Health and Human Services and make recommendations to the 1999 General Assembly, Regular Session 2000.

Section 3. This act is effective when it becomes law. Section 1 of this act expires July 1, 2000.

North Carolina General Assembly
411 Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27601-2808

telephone: (919) 715-3042
fax: (919) 715-3043
E-mail: billm@ms.ncga.state.nc.us

-----Original Message-----
From: John Young (Research)
Sent: Monday, May 10, 1999 1:56 PM
To: Sen. Bill Martin; Sen. William Purcell
Cc: Rep. Zeno Edwards
Subject: Health and Safety and Liability Questions about HB 96

During the discussion on HB 96 by the Senate Health Committee, questions were raised about certain aspects of the State's responsibility to the facility in Beaufort county in light of the possible exemption from State licensure. Specifically, Sen. Martin asked the staff to investigate two questions and report back before chairman Purcell reported the bill to the Senate floor. Below, are the questions raised by Senator Martin and the answers to those questions.

1. ***If the State does not license the facility, are there any other health or safety safeguards for the facility?*** If the facility is exempted from licensure under 131D, the licensing agency, the Division of Facility Services, would have no authority to enter the facility for any kind of oversight. The Division of Social Services would have authority under Article 6 of Chapter 108A to protect abused, neglected or exploited disabled adults. I can find no other ***State*** agency that would have any other authority. The local health department inspects the kitchen facility since there are 13+ residents and therefore places the facility under residential facility food sanitation requirements. The local fire marshal also has jurisdiction to inspect the facility.

If the State exempted this one facility from adult care home licensure could the State be liable in any way? After discussing the possibility with a number of attorneys, it is their conclusion that they could find no situation or case in which any potential for liability would attach to the State. The primary case is the Stone case arising out of the Hamlet fire. The court found that the State was not liable under the Tort Claims Act even though the State had not inspected the facility in 17 years. The duty is to the public, not to a individual. They seemed to think that the findings in this case and a later safety inspection case arising out of a fair ride safety inspection would be controlling.

If you have any further questions arising from this information, please let me know.

Lorraine Blake (Sen. Purcell)

From: Sen. Bill Martin
Sent: Tuesday, May 11, 1999 10:06 PM
To: Sen. William Purcell
Cc: John Young (Research); Linda Attarian (Research)
Subject: FW: Health and Safety and Liability Questions about HB 96

Bill,

John's response to my inquiry causes me to conclude that HB 96 should not be enacted, and the bill should be reconsidered and held in committee. I think it might be appropriate to have the information John uncovered provided to other members of the committee for their review.

If you decide that you would want to reconsider the motion for a favorable report, let me know and I'll make the motion at the next meeting. I know Rep. Edwards will not like this, but I think we have a responsibility to the residents of the facility. Handling it in this manner would, at least, avoid the bill receiving an ufavorable report. Actually, however, the rest of the committee might not agree with the conclusion I have reached; that's why I might be worthwhile to get their perspectives prior to any further action being taken. I'll be guided by your decision.

Thanks.

Bill

Senator Bill Martin
North Carolina General Assembly
411 Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27601-2808

Phone: (919) 715-3042
Fax: (919) 715-3043
E-Mail: billm@ms.ncga.state.nc.us

-----Original Message-----
From: John Young (Research)
Sent: Tuesday, May 11, 1999 9:24 PM
To: Sen. Bill Martin; Sen. William Purcell
Cc: Linda Attarian (Research); Rep. Zeno Edwards
Subject: RE: Health and Safety and Liability Questions about HB 96

Your clarification of your question on health and safety puts a whole new light on the point that you wished clarified. The exemption from G.S. 131D removes that facility from a great deal of state protection , primarily for the residents. I think it important to keep in mind one of the major differences between a nursing home and an adult care facility. The nursing home must conform to federal regulations. Adult care homes do not have to meet any federal certification standards. Therefore, the State and county are the sole governmental guardians for the health and safety of these residents. HB 96 removes State protection in Beaufort Co. The following paragraphs gives a summary of the health and safety protections afforded by G.S. 131D to all other adult care homes in North Carolina.

The North Carolina Social Services Commission sets licensing standards for adult care facilities. These licensing regulations do the following:

- Establish minimum staff-to-resident ratios.
- Require the facilities meet applicable building and health codes.
- Mandate installation of fire alarms and smoke detectors.
- Establish minimum space requirements for residents' rooms and requirements for recreational, living, dining, kitchen, storage, and bathroom areas.
- Specify the types of personal-care services that must be provided to residents.
- Establish nutritional and other standards for food service provided to residents.
- Mandate the homes establish activities programs for residents.
- Establish requirements relating to the provision of medications to residents.

The Division of Facility Services is responsible for determining whether adult care homes meet the licensing requirements and for issuing licenses. County departments of social services, however, are responsible for making unannounced monthly visits to the facility and for monitoring their ongoing compliance with the licensing regulations.

If a facility fails to comply with the licensing requirements, the county department of social services issues a corrective-action notice to the facility, requiring it to correct the deficiency. In the case of serious or uncorrected deficiencies, the county department may recommend further enforcement action by the Division of Facility Services.

If there is substantial evidence of abuse, neglect, exploitation, or any condition that presents an imminent danger to the

health and safety of a resident, the Division of Facility Services has the legal authority to deny or revoke a facility's license, to issue a provisional license, or summarily to suspend the facility's license.

I believe that H96 would also exempt the facility from the Adult Care Home Bill Of Rights which confers certain rights, including the rights

- to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy;
- to receive care and services that are adequate, appropriate, and in compliance with relevant laws and rules and regulations;
- to be free from mental and physical abuse, neglect, and exploitation;
- except in emergencies, to be free from chemical and physical restraint unless authorized for a specified period of time by a physician according to clear and indicated medical need;
- to manage his or her personal needs funds; and
- to have freedom to participate by choice in accessible community activities and in social, political, medical, and religious resources and to have freedom to refuse such participation.

The law allows the resident, or the resident's guardian to bring civil suit for injunctive relief to enforce the provisions of the Residents' Bill of Rights.

There is also the long-term care ombudsman program and the local adult care home advisory committee established in every county for both nursing homes and adult care facilities. They may assist in resolving complaints or grievances against a facility. The committee is required to visit each facility at least quarterly.

As for the legal issues, I hope Linda or another one of our attorneys can help shed more light on that issue. I talked to Walker Reagan about the Hamlet case.

-----Original Message-----
From: Sen. Bill Martin
Sent: Monday, May 10, 1999 2:40 PM
To: John Young (Research); Sen. William Purcell
Cc: Rep. Zeno Edwards; Linda Attarian (Research)
Subject: RE: Health and Safety and Liability Questions about HB 96

John,

Thanks for your response. I still have some concerns, however.

With regard to legal liability, I believe the current situation can be distinguished from the Hamlet case. Here, if a catastrophe were to ensue, the situation would be one in which: (1) the State had previously assumed the duty to inspect for health and safety violations and decided to decline further assumption of that responsibility, without there having been any changes in factual circumstances. (2) although the duty runs to the public, rather than to individuals, I still believe it could be argued during a full appellate process that the purpose of "duty to the public" in such an instance can only be manifested through third party benefit to individuals. The exception would be something like a public health crises arising from failure to contain a contagious disease. There are public expectations that individuals as members of the public are derivative beneficiaries of public health and safety state actions.

In any event, however, I could be wrong on my legal perceptions on the issue.

With regard to your first point, my concern was not so much with whether there would be any other state agency providing regulatory activity. My concern was whether there were any health and safety regulations of significance that would no longer be provided by any public body, thereby exposing residents and employees of and visitors to the facility to dangers that could otherwise be reasonably avoided. By the totality of State actions, would the general public be in a placed in a position to reasonably expect the State to provide some reasonable level of protection against any such dangers? Why were the regulations instituted in the first place, and what circumstances have changed that dictate those initial reasons are no longer pertinent?

Would you mind re-examining the situation in light of this clarification? If after doing so, you, Linda, and legal counsel still feel confident of the initial conclusions, I will be satisfied. during the course of your inquiries, please check with Linda McDougal, also.

Thanks.

Bill

Senator Bill Martin

Lorraine Blake (Sen. Purcell)

From: Sen. Bill Martin
Sent: Wednesday, May 12, 1999 1:56 PM
To: John Young (Research); Sen. William Purcell
Cc: Linda Attarian (Research)
Subject: RE: HB 96

John, as we discussed earlier today, I like this approach. Please do prepare an amendment to accomplish this limited (in scope and time) exemption

Bill

Senator Bill Martin
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-----Original Message-----
From: John Young (Research)
Sent: Wednesday, May 12, 1999 12:22 PM
To: Sen. Bill Martin; Sen. William Purcell
Cc: Linda Attarian (Research)
Subject: RE: HB 96

I talked with Linda McDaniel this morning about the issue of building codes and physical plant. One option for an amendment is to exempt the Beaufort facility only from the licensure requirements related to physical plant and building code for one year and direct Div. of Facility Services to assess the building code and physical plant situation and report back in the short session. This would bring them under the operational requirements of licensure such as staffing requirements, nutrition requirements, activity requirements, the Residents' Bill of Rights and the Community Advisory Committees and the Ombudsman oversight. It would also allow the GA to assess the nature of the physical facility. Under current licensure requirements, a facility only has to meet code and physical plant requirements at the time of licensure. Therefore, there may be licensed facilities that were licensed in the 60's that may be comparable with the Beaufort facility. On the other hand, without an assessment, a blanket exemption may allow some dangerous violation that is not known.

Please instruct me if you would like us to draw an amendment.

-----Original Message-----
From: Sen. Bill Martin
Sent: Tuesday, May 11, 1999 11:55 PM
To: Sen. William Purcell
Cc: John Young (Research); Linda Attarian (Research)
Subject: HB 96

Bill,

I failed to mention another option. It appears that Rep. Edwards' primary voiced concern related to space configuration requirements. Perhaps his bill could be amended exempting the County Home from some specific space requirements and building code requirements. I suggest that Rep. Edwards would need to find out specifically which exemptions they require, clear them with Facility Services, and have our committee staff prepare an appropriate amendment or committee substitute. It is my opinion that exemptions from the other requirements set out in John's message would not be in the best interests of residents.

Bill

Senator Bill Martin
N C General Assembly
411 Legislative Office Building
300 N. Salisbury Street
Raleigh, NC 27601-2808

(1)

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 19, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Craig Souza	NCHCFA
Stacy Flannery	NCHCFA
Don Davenport	Beaufort County, 121 W 3rd St Washington, NC 27889
William P. Mayo	Beaufort County Attorney - Washington NC 2788
Fannie Williams	Duke University LTC, STNL, SLC & AARP
Fred Aldridge	Visitor
Steve Allen	NCMA
Ray Bell	NCMA
Alicia Gregory	Poyner & Spruill
Lou Wilson	NCAHTCF.
Lynda McDaniel	DHHS/DFS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 19, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Pam Seamans	NC Social Services Consortium
Joanne Schoen	NC Nurses Association
S. Celeste Toomb	NC Nurses Assoc.
Cheryl Beaty	NC Nurses Assoc.
Priscilla Swindell	AARP
Katherine Mill	
Will Ing	AHHC
ANNA TEFFT	OSBM
Jackie Brown	DMHDDSAS
Peggy Murphy	GW
Evelyn Hawthorne	UNC-CH
K Shipley M Nicholson	Duke Pharmaceuticals

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 19, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Erin Culbreth	Intern - Sen. Moore
Scott Moonyham	AP
Scott Jenkins	Medical General
[illegible]	Progress Energy
Dave Anderson	Smith Anderson
Guy Morris	city-county
Patricia Yancey	Hospice / APPC NC

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — May 19, 1999

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, May 26, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **S.B. 60** **Heart Disease Prev. Funds** **Senator Warren**
- **H.B. 1258** **Health Care Personnel Registry** **Representative Earle**

Senator William R. Purcell, Chair

REVISED NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, May 26, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1258 Health Care Personnel Registry** **Representative Earle**

Senator William R. Purcell, Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, May 26, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, May 26, 1999, at 12:10 P.M. in Room 1124 in the Legislative Building. Ten members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Pages David Frye and Leroy Duncan, Jr., both of Laurinburg and both sponsored by Senator Purcell and Senator Plyler.

Senator Purcell called upon Representative Earle to present her bill to the Committee. Senator Moore moved for a favorable report. The motion carried unanimously.

The meeting was adjourned at 12:12 P.M.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chairman

Wednesday, May 26, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS)**1258** Health Care Personnel Registry Changes.
Sequential Referral: None
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

2

HOUSE BILL 1258*
Committee Substitute Favorable 4/27/99

Short Title: Health Care Personnel Registry Changes. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO CLARIFY THE FACILITIES THAT ARE INCLUDED IN THE HEALTH CARE PERSONNEL REGISTRY; AND TO REQUIRE THAT EMPLOYERS AT HEALTH CARE FACILITIES ACCESS THE HEALTH CARE PERSONNEL REGISTRY.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256 reads as rewritten:

"**§ 131E-256. Health Care Personnel Registry.**

(a) The Department shall establish and maintain a health care personnel registry containing the names of all health care personnel working in health care facilities in North Carolina who have:

(1) Been subject to findings by the Department of:

a. Neglect or abuse of a resident in a health care facility or a person to whom home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

b. Misappropriation of the property of a resident in a health care facility, as defined in subsection (b) of this section including places where home care services as defined by G.S. 131E-136 or hospice services as defined by G.S. 131E-201 are being provided.

c. Misappropriation of the property of a health care facility.

d. Diversion of drugs belonging to a health care facility or to a patient or client.

e. Fraud against a health care facility or against a patient or client for whom the employee is providing services.

(2) Been accused of any of the acts listed in subdivision (1) of this subsection, but only after the Department has screened the allegation and determined that an investigation is required.

The ~~health care personnel registry~~ Health Care Personnel Registry shall also contain all findings by the Department of neglect of a resident in a nursing facility or abuse of a resident in a nursing facility or misappropriation of the property of a resident in a nursing facility by a nurse aide that are contained in the nurse aide registry under G.S. 131E-255.

(b) For the purpose of this section, the following are considered to be 'health care facilities':

(1) Adult Care Homes as defined in G.S. 131D-2.

(2) Hospitals as defined in G.S. 131E-76.

(3) Home Care Agencies as defined in G.S. 131E-136.

(4) Nursing Pools as defined by G.S. 131E-154.2.

(5) Hospices as defined by G.S. 131E-201.

(6) Nursing Facilities as defined by G.S. 131E-255.

(7) State-Operated Facilities as ~~set forth in G.S. 122C-22.~~ defined in G.S. 122C-3(14)f.

(8) Residential Facilities ~~and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers licensed pursuant to G.S. 122C-23.~~ as defined in G.S. 122C-3(14)e.

(9) 24-Hour Facilities as defined in G.S. 122C-3(14)g.

(c) For the purpose of this section, the following are considered to be 'health care personnel':

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) An in-home aide or an in-home personal care aide who provides hands-on paraprofessional services.

(4) Unlicensed assistant personnel who provide hands-on care, including, but not limited to, habilitative aides and health care technicians.

(d) Health care personnel who wish to contest findings under subdivision (a)(1) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days of the mailing of the written notice of the

Department's intent to place its findings about the person in the ~~health care personnel registry.~~ Health Care Personnel Registry.

(d1) Health care personnel who wish to contest the placement of information under subdivision (a)(2) of this section are entitled to an administrative hearing as provided by the Administrative Procedure Act, Chapter 150B of the General Statutes. A petition for a contested case hearing shall be filed within 30 days of the mailing of the written notice of the Department's intent to place information about the person in the ~~health care personnel registry~~ Health Care Personnel Registry under subdivision (a)(2) of this section. Health care personnel who have filed a petition contesting the placement of information in the health care personnel registry under subdivision (a)(2) of this section are deemed to have challenged any findings made by the Department at the conclusion of its investigation.

(d2) Before hiring health care personnel into a health care facility or service, every employer at a health care facility shall access the Health Care Personnel Registry and shall note each incident of access in the appropriate business files.

(e) The Department shall provide an employer or potential employer of any person listed on the ~~health care personnel registry of~~ Health Care Personnel Registry of the nature of the finding or allegation and the status of the investigation.

(f) No person shall be liable for providing any information for the health care personnel registry if the information is provided in good faith. Neither an employer, potential employer, nor the Department shall be liable for using any information from the health care personnel registry if the information is used in good faith for the purpose of screening prospective applicants for employment or reviewing the employment status of an employee.

(g) Upon investigation and documentation, health care facilities shall ensure that the Department is notified of all substantiated allegations against health care personnel which appear to a reasonable person to be related to any act listed in subdivision (a)(1) of this section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.

(h) The North Carolina Medical Care Commission shall adopt, amend, and repeal all rules necessary for the implementation of this section."

Section 2. This act becomes effective July 1, 1999.

HOUSE BILL 1258:
Health Care Personnel Registry Changes

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Earle
Date:	May 26, 1999	**Summary by:**	Linda Attarian
Version:	Second Edition		Committee Counsel

SUMMARY: ***Under current law, the Department of Health and Human Services is required to maintain a "Health Care Personnel Registry". The purpose of the Registry is to maintain a listing of "health care personnel" (unlicensed nurse aides, in-home aides, in-home personal care aides, and adult care home personal care aides) working in certain "health care facilities" who are being investigated for or have been found to have abused or neglected residents they cared for or diverted drugs or misappropriated property that didn't belong to them.***

Upon request, the Department is required by law to provide employers or future employers at health care facilities with access to the information contained in the Registry. The bill would amend current law by requiring future employers to access the information contained in the Registry prior to hiring the applicant. The bill also makes clarifying changes as to the types of health care facilities covered under this law.

BILL ANALYSIS:

Section 1.

1. Amends G.S. 131E-256(b) to clarify previous amendments to the subsection made in Section 12.16E, Chap. 212, 1998 Session Laws. The Session Law amendments added residential hospitals, 24-hour facilities and other facilities that are operated by the Department that provide services to the mentally ill, substance abusers, and the developmentally disabled to the list of "health care facilities" subject to the requirements of the statute. This bill amends the citations to clarify which facilities were intended to be added to the list.

2. Adds a new subsection to G.S. 131E-256 to REQUIRE every employer at a health care facility to access the health care personnel registry before hiring health care personnel into a health care facility or service. Further requires employers to document each incident of access to the registry in its business files. These files would be subject to review during licensure surveys by the appropriate State or county monitoring authority.

3. Clarifies that health care facilities must notify the Department of allegations that the facilities have substantiated with supporting evidence.

Section 2. This act becomes effective July 1, 1999.

CURRENT LAW: North Carolina law requires health care facilities (defined in the statute) to investigate and document all allegations of resident abuse or neglect, misappropriation of resident or facility property, diversion of drugs belonging to a resident or facility, and fraud against a resident or facility, within five

working days of the date the facility becomes aware of the alleged incident. The facility must take whatever steps are necessary to prevent further acts of abuse, neglect, misappropriation of property, drug diversion, or fraud while the investigation is in progress. [NCAC 10-3B.1002].

Upon completion of the investigation, the health care facility is further required to ensure that all allegations which appear reasonably related to any act of resident abuse or neglect, misappropriation of resident or facility property, diversion of drugs belonging to a resident or facility, and fraud against a resident or facility are reported immediately to the Division of Facility Services. The report must include all information relevant to the investigation. [G.S. 131E-246(g)].

The Department of Health and Human Resources (Department) further investigates the substantiated allegations and makes its own independent "findings". As a result of theses efforts, the Department maintains a health care personnel registry containing the names of all health care personnel (as defined in the statute) working in health care facilities in North Carolina who have been the subject of such findings relating to any of the above acts.

A **"finding"** is "a determination by the Department that an allegation of one or more of the above acts has been substantiated". [NCAC 10-3B-1001(4)]

Health care personnel who have been accused of any of the acts listed above will also be placed on the Registry, but only after the Department has screened the allegation and determined that an investigation is required. [G.S. 131E-246(a)(2)].

The Registry also contains all findings by the Department that are contained in the nurse aide registry under G.S. 131E-255.

Health care facilities are defined under current law to include the following:

(1) Adult Care Homes

(2) Hospitals

(3) Home Care Agencies

(4) Nursing Pools

(5) Hospices

(6) Nursing Facilities

(7) State-Operated Facilities

(8) Residential Facilities and Hospitals for the Mentally Ill, Developmentally Disabled, or Substance Abusers

[G.S. 131E256(b)].

Health care personnel are defined under current law to include the following:

(1) In an adult care home, an adult care personal aide who is any person who either performs or directly supervises others who perform task functions in activities of daily living which are personal functions essential for the health and well-being of residents such as bathing, dressing, personal hygiene, ambulating or locomotion, transferring, toileting, and eating.

(2) A nurse aide.

(3) Licensed and unlicensed in-home aides or in-home personal care aides who provide hands-on paraprofessional services.

[G.S. 131E-256(c)].

Contesting the "findings": Health care personnel who wish to contest a finding made by the Department or the placement of information contained in the registry are entitled to an administrative hearing as provided by the Administrative Procedure Act. (APA). [See G.S. 131E-246]. Article 3 of the APA provides that anyone who is aggrieved by an agency action may file a petition for a contested case with the Office of Administrative Hearings (OAH) within 60 days of being notified of the agency action. Under the Health Care Personnel Registry statute, the petition must be filed within 30 days. Once filed, OAH will assign an Administrative Law Judge (ALJ) to determine if the agency exceeded its authority; acted erroneously; failed to use proper procedure; acted arbitrarily; or failed to act as required by rule or law. The ALJ will make a recommended decision that is not binding on the agency and the agency will make the final decision. Any grievance of a final agency decision goes to superior court. Therefore, if someone wants to contest information in the registry, they can commence a contested case at OAH. An ALJ will hear evidence from both sides and make a recommended decision to the Department. The Department will then decide whether or not to accept the recommendation of the ALJ.

Use of the registry: The Department must provide an employer or potential employer of any person listed on the health care personnel registry with the nature of the finding or allegation and the status of the investigation, but there is no current requirement that such employers must access the registry prior to hiring the person. [G.S. 131E-246(e)]

Immunity from liability: No person will be liable for providing any information for the health care personnel registry if the information is provided in good faith. [G.S. 131E-246(f)].

Duty to report allegations of "bad acts": health care facilities must notify the Department of all allegations that have been investigated and documented against health care personnel which reasonably relate to any act subject to the registry and any resulting disciplinary action, demotion, or termination. [G.S. 131E-246(g)].

BACKGROUND INFORMATION:

Bonnie Cramer, Division of Facility Services, NC Department of Health and Human Services provided the following background information concerning the Health Care Personnel Registry:

Data Concerning Access to the Registry by Employers:

153,000 calls requesting information on over 197,000 applicants/employees between March of 1998 to March of 1999.

Overview of Current Listings in the Registry:

Currently, the Registry contains 896 substantiated findings involving 669 persons; 271 pending investigations involving 221 persons.

Total Findings (Substantiated Claims) by Category:

Category 01 (Resident Abuse)	696
Category 02 (Resident Neglect)	40

Category 03 (Diversion of Resident Drugs)	6
Category 04 (Diversion of Facility Drugs)	0
Category 05 (Fraud Against Resident)	26
Category 06 (Fraud Against Facility)	50
Category 07 (Misappropriation of Facility Property)	4
Category 08 (Misappropriation of Resident Property)	74

Total Allegations (Pending Claims) by Category:

Category 01 (Resident Abuse)	114
Category 02 (Resident Neglect)	45
Category 03 (Diversion of Resident Drugs)	9
Category 04 (Diversion of Facility Drugs)	0
Category 05 (Fraud Against Resident)	17
Category 06 (Fraud Against Facility)	45
Category 07 (Misappropriation of Facility Property)	2
Category 08 (Misappropriation of Resident Property)	39

Personal Data Contained in the Registry of Health Care Personnel:

Nurse Aide Listing Number
Social Security Number
Date of Birth
Deceased Date

Name
Address
Home Phone
Work Phone

Date Tested
Training Program Attended
Evaluation Program Attended
Expiration Date of Nurse Aide Listing

Last Known Place Worked
Last Known Date Worked

Type of Allegation
Facility Type
Status
Date Entered on Registry

Hearing Date
Hearing Result
Allegation
Evidence Summary
Rebuttal Statement

VISITOR REGISTRATION SHEET

HEALTH CARE — 5-26-99

Name of Committee — Date

VISITORS: Please sign below and return to Committee Clerk.

NAME	FIRM OR STATE AGENCY AND ADDRESS
Andy Romanet	N.C.L.M.
Robert Bowe	Bowe & Assoc
John Cyrus	N.C. State Grange
HUGH TILSON	NCATA
Katherine Miller	
S Oliver	NCMed Soc
AJ Klein	NCMed Soc
Ben Murray	NC Nurses association
Joanne Schoen	NC nurses

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, June 2, 1999**
TIME: **12:00 Noon**
ROOM: **Room 1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1193** **Health Care Professionals** **Representative Nesbitt**
- **H.B. 96** **Adult Care Home Licensure** **Representative Edwards**
- **S.B. 60** **Heart Disease Prev. Funds** **Senator Warren**

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

SENATE
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- **S.B. 60** **Heart Disease Prev. Funds** **Senator Warren**

Senator William R. Purcell, Chair

PLEASE NOTE: THIS MEETING HAS BEEN CANCELLED

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, June 9, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1193 Health Care Professionals** **Representative Nesbitt**
- **S.B. 665 Dental Hygienists** **Senator Soles**

Senator William R. Purcell, Chair

REVISED NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, June 9, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1193** **Health Care Professionals** **Representative Nesbitt**
- **S.B. 665** **Dental Hygienists** **Senator Soles**
- **H.B. 190** **State Hospitals/Peer Review/AB** **Representative Cansler**

Senator William R. Purcell, Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, June 9, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, June 9, 1999, at 12:08 P.M. in Room 1124 in the Legislative Building. Ten members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Pages Courtenay Nixon of Edenton, sponsored by Senator Basnight; and Damon Houghton of Sylva, sponsored by Senator Carpenter.

Senator Purcell announced to the Committee members that S.B. 665 has been removed from today's calendar to be considered at a later date.

He introduced Representative Nesbitt speak on his bill, which had been withdrawn earlier. Senator Forrester offered a committee substitute and moved that the committee substitute be adopted for purposes of discussion. The motion carried unanimously. Senator Forrester explained the content of the amendment; and Senator Purcell asked staff member Linda Attarian to further explain the clarification this committee substitute makes to the bill. Senator Hagan moved for a favorable report on the committee substitute. The motion carried unanimously.

Representative Lanier Cansler was recognized to speak on his bill, H.B. 190. Senator Martin moved that a committee substitute be adopted for purposes of discussion. The motion carried unanimously. Representative Cansler explained the purpose of H.B. 190 and the clarification made by the committee substitute. Senator Martin moved for a favorable report for the committee substitute. The motion carried unanimously.

The meeting was adjourned at 12:22 P.M.

Senator William R. Purcell, Chair

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

REVISED

Wednesday, June 09, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS#1)**190** State Hospitals/Peer Review/AB.

Draft Number:	PCS7249
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

UNFAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL NO. 2

H.B.(SCS#1)**1193** Health Care Professionals.

Draft Number:	PCS8139
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED:2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 190*
Committee Substitute Favorable 3/24/99

Short Title: State Hospitals/Peer Review/AB. (Public)

Sponsors:

Referred to:

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE CERTAIN FACILITIES TO SHARE PEER REVIEW INFORMATION WITH ACCREDITING ORGANIZATIONS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-191(e) reads as rewritten:

"(e) For purposes of peer review functions only:

(1) A member of a duly appointed quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the ~~committee; and~~ committee.

(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, "'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the

committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about his testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.

(3) Peer review information that is confidential and is immune from discovery or use in civil actions under subdivision (2) of this subsection may be released to a professional standards review organization that contracts with an agency of this State or the federal government to perform any accreditation or certification function. Information released under this subdivision shall be limited to that which is reasonably required by the review organization to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and immunity as provided under subdivision (2) of this subsection, and the organization shall keep the information confidential subject to that subdivision."

Section 2. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 190*
Proposed Committee Substitute - H190-PCSRY-003
ATTENTION: LINE NUMBERS MAY CHANGE AFTER ADOPTION

Short Title: State Hospitals/Peer Review/AB. (Public)

Sponsors:

Referred to:

March 1, 1999

A BILL TO BE ENTITLED

AN ACT TO AUTHORIZE CERTAIN FACILITIES TO SHARE PEER REVIEW INFORMATION WITH ACCREDITING ORGANIZATIONS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-191(e) reads as rewritten:

"(e) For purposes of peer review functions only:

(1) A member of a duly appointed quality assurance committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement, or proceeding undertaken, made, or performed within the scope of the functions of the ~~committee; and~~ committee.

(2) The proceedings of a quality assurance committee, the records and materials it produces, and the material it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, "'Public records' defined," and shall not be subject to discovery or introduction into evidence in any civil action against a facility or a provider of professional health services that

results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee, and nothing herein shall prevent a provider of professional health services from using such otherwise available information, documents or records in connection with an administrative hearing or civil suit relating to the medical staff membership, clinical privileges or employment of the provider. A member of the committee or a person who testifies before the committee may be subpoenaed and be required to testify in a civil action as to events of which the person has knowledge independent of the peer review process, but cannot be asked about his testimony before the committee for impeachment or other purposes or about any opinions formed as a result of the committee hearings.

(3) Peer review information that is confidential and is not subject to discovery or use in civil actions under subdivision (2) of this subsection may be released to a professional standards review organization that contracts with an agency of this State or the federal government to perform any accreditation or certification function. Information released under this subdivision shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and is not subject to discovery or use in any civil actions as provided under subdivision (2) of this subsection, and the standards review organization shall keep

the information confidential subject to that subdivision."

Section 2. G.S. 131E-95 reads as rewritten:

"**§ 131E-95. Medical review committee.**

(a) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee.

(b) The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1, '"Public records" defined,' and shall not be subject to discovery or introduction into evidence in any civil action against a hospital or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. No person who was in attendance at a meeting of the committee shall be required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of the committee or as to any findings, recommendations, evaluations, opinions, or other actions of the committee or its members. However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee. A member of the committee or a person who testifies before the committee may testify in a civil action but cannot be asked about his testimony before the committee or any opinions formed as a result of the committee hearings.

(c) Information that is confidential and is not subject to discovery or use in civil actions under subsection (b) of this section may be released to a professional standards review organization that performs any accreditation or certification function. Information released under this subdivision shall be limited to that which is reasonably necessary and relevant to the standards review organization's determination to grant or continue accreditation or certification. Information released under this subdivision retains its confidentiality and is not subject to discovery or use in any civil actions as provided under subsection (b) of this section, and the standards review organization shall keep the information confidential subject to that subsection."

Section 3. This act is effective when it becomes law.

HOUSE BILL 190:
State Hospitals/Peer Review/AB

BILL ANALYSIS

Committee:	Senate Health Committee	**Introduced by:**	Representative Cansler
Date:	June 8, 1999	**Summary by:**	John Young
Version:	2		Committee Staff

SUMMARY: ***The House committee substitute for House Bill 190 would allow the release of information gathered in connection with the peer review of facilities subject to the Mental Health, Developmental Disabilities, and Substance Abuse Act of 1985 (GS Ch. 122C). The release may be made to a professional standards review organization that contracts with a State or federal agency to perform any accreditation or certification function. The information must be reasonably required by the organization to grant or continue accreditation or certification. Information released would retain its status as privileged or confidential information that is exempt from public disclosure and from discovery or use in civil actions. The proposed committee substitute is effective when it becomes law.***

CURRENT LAW: State hospitals and other facilities for the mentally ill, the developmentally disabled, and substance abusers are required to conduct peer reviews. Peer review proceedings, the records and materials produced by the review, and material considered by the review are confidential and are not public records. They are not subject to discovery or introduction in a civil action against the facility or provider of health services. However, when protected information is released to a non-State entity, it may lose its status as confidential information.

BACKGROUND: House Bill 190 is requested by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Recently, the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), which accredits the State psychiatric hospital, began requiring facilities to submit the results of peer review investigations. Refusing to share the information could jeapordize the hospital's accreditation. Sharing this information could remove its protection against public disclosure and could expose the State to civil liability.

This summary was contributed to by the Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DHHS).

H190-SMRY-002

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 1193
Second Edition Engrossed 4/28/99
Senate Health Care Committee Substitute Adopted 5/20/99

Short Title: Health Care Professionals. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO CONDUCT PHYSICAL EXAMINATIONS IN CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Physical examination by nurse practitioners and physician assistants.**

(a) Whenever a statute or State agency rule enacted before October 1, 1999, requires that a physical examination shall be conducted by a physician, the examination may be conducted by a nurse practitioner if the examination is authorized under G.S. 90-18.2 or a physician assistant if the examination is authorized under G.S. 90-18.1.

(b) This section shall not apply to physical examinations conducted pursuant to G.S. 1A-1, Rule 35; G.S. 15B-12; G.S. 90-14; or any rules adopted by the North Carolina Boxing Commission requiring physical examinations unless those statutes or rules are amended to make the provisions of this section applicable."

Section 2. This act becomes effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1193
Second Edition Engrossed 4/28/99
Senate Health Care Committee Substitute Adopted 5/20/99
Proposed Committee Substitute H1193-PCS8139-RM

Short Title: Health Care Professionals. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO CONDUCT PHYSICAL EXAMINATIONS IN CERTAIN CIRCUMSTANCES.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 90 of the General Statutes is amended by adding a new section to read:

"**§ 90-18.3. Physical examination by nurse practitioners and physician assistants.**

(a) Whenever a statute or State agency rule requires that a physical examination shall be conducted by a physician, the examination may be conducted and the form signed by a nurse practitioner or a physician's assistant, and a physician need not be present. Nothing in this section shall otherwise change the scope of practice of a nurse practitioner or a physician's assistant, as defined by G.S. 90-18.1 and G.S. 90-18.2, respectively.

(b) This section shall not apply to physical examinations conducted pursuant to G.S. 1A-1, Rule 35; G.S. 15B-12; G.S. 90-14; or any rules adopted by the North Carolina Boxing Commission requiring physical examinations unless those statutes or rules are amended to make the provisions of this section applicable."

Section 2. This act becomes effective October 1, 1999.

HOUSE BILL 1193:
Health Care Professionals

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Forrester
Date:	June 8, 1999	**Summary by:**	Linda Attarian
Version:	PCS: H1193-PCS8139-RM		Committee Counsel

SUMMARY: The Proposed Committee Substitute (PCS) would amend the Senate Health Care Committee Substitute for House Bill 1193 adopted on May 20, 1999. The PCS would clarify that the proposed legislation adopted by this Committee last month, allowing nurse practitioners or physician assistants to conduct physical examinations that are otherwise required by law to be performed by a physician or surgeon, would not change the scope of practice of a nurse practitioner or physician assistant. It would further clarify that any examination form accompanying the examination may be signed by the nurse practitioner or physician assistant conducting the examination.

CURRENT LAW: Throughout the North Carolina General Statutes and Administrative Rules there are various provisions requiring a person to receive a physical examination. Many of these provisions require that the exam be conducted a physician or surgeon. For example, G.S. 20-9(g)(2) authorizes the Division of Motor Vehicles to condition the issuance of a driver's license on the applicant's agreement to submit to a physical examination *by a physician or surgeon duly licensed to practice medicine in this State.*

BILL ANALYSIS:

Section 1. Adds a new section to Article 1 of Chapter 90 that would apply to any law or rule enacted prior to October 1, 1999 requiring a physician to conduct a physical examination, (with a few exceptions noted below) on someone. The new section would allow a physician assistant or nurse practitioner to conduct the examination.

The section would not apply to:

- G.S. 1A-1, Rule 35, where the physical examination is ordered by the court when someone's physical condition is in controversy in a civil proceeding;
- G.S. 15B-12, where the physical condition of a victim or claimant is material to a claim for an award of compensation;
- G.S. 90-14, where the physical examination is order by the NC Medical Board in a license revocation proceeding;
- Rules adopted by the NC Boxing Commission.

Section 2. If enacted, the act would become effective October 1, 1999.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 665

Short Title: Dental Hygienists. (Public)

Sponsors: Senator Soles.

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING DENTAL HYGIENIST LICENSURE BY CREDENTIAL AND AMENDING THE LICENSURE REQUIREMENTS FOR DENTAL HYGIENISTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

~~(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.~~

~~(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.~~

~~(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.~~

~~(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.~~

~~(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.~~

~~(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control and approval.~~

The following definitions apply in this Article:

(1) Board. -- The North Carolina State Board of Dental Examiners.

(2) Dental hygiene. -- The performance of the following functions:

a. Complete oral prophylaxis.

b. Application of preventive agents to oral structures.

c. Exposure and processing of radiographs.

d. Administration of medicaments prescribed by a licensed dentist.

e. Preparation of diagnostic aids and written records of oral conditions for interpretation by the dentist.

f. Any other functions permitted by rules of the Board consistent with this Article.

(3) Dental hygienist. -- A person who is a graduate of a program accredited by the American Dental Association Commission on Dental Accreditation and a Board-approved school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(4) License. -- A certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(5) Licensee. -- A person who has been issued a license by the Board to practice dental hygiene.

(6) Renewal certificate. -- The annual certificate of renewal of license to continue practice of dental hygiene in the State.

(7) Supervision. -- Acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of the acts and the acts are performed pursuant to the dentist's order, control, and approval."

Section 2. G.S. 90-223(a) reads as rewritten:

"(a) The Board is authorized and empowered to:

(1) Conduct examinations for ~~licensure;~~ licensure.

(2) Issue ~~licenses and provisional licenses;~~ licenses.

(3) Issue annual renewal ~~certificates, and~~ certificates.

(4) Renew expired licenses."

Section 3. G.S. 90-223(b) reads as rewritten:

"(b) The Board shall have the authority to make or amend rules and regulations not inconsistent with this Article governing the practice of dental hygiene and the granting, ~~revocation~~ revocation, and suspension of licenses ~~and provisional licenses~~ of dental hygienists.

(1) Any rule promulgated or amended under this Article shall be filed and distributed in accordance with the provisions of Article 5 of Chapter 150B of the General Statutes of North Carolina. A copy must be distributed to all licensed dentists and all licensed dental hygienists within 30 days of final approval by the Board.

(2) The Board shall issue every two years a compilation or supplement of the Dental Hygiene Act and the Board rules and regulations, and, upon written request therefor, a directory of dental hygienists to each licensed dentist and dental hygienist."

Section 4. G.S. 90-226 reads as rewritten:

"**§ 90-226. ~~Provisional license.~~ License by credential.**

~~(a)~~ The ~~North Carolina State Board of Dental Examiners shall, subject to its rules and regulations,~~ Board shall issue a ~~provisional~~ license to practice dental hygiene to any person who is licensed to practice dental hygiene anywhere in the United States, or in any country, ~~territory~~ territory, or other recognized jurisdiction, if the Board shall determine that ~~said~~ the licensing jurisdiction imposed upon ~~said~~ the person requirements for licensure no less exacting than those imposed by this ~~State.~~ State and the person has graduated from a program accredited by the American Dental Association Commission on Dental Accreditation. ~~A provisional licensee may engage in the practice of dental hygiene only in strict accordance with the terms, conditions and limitations of her license and with the rules and regulations of the Board pertaining to provisional license.~~

~~(b) A provisional license shall be valid until the date of the announcement of the results of the next succeeding Board examination of candidates for licensure to practice dental hygiene in this State, unless the same shall be earlier revoked or suspended by the Board.~~

~~(c) No person who has failed an examination conducted by the North Carolina State Board of Dental Examiners shall be eligible to receive a provisional license.~~

~~(d) Any person desiring to secure a provisional license shall make application therefor in the manner and form prescribed by the rules and regulations of the Board and shall pay the fee prescribed in G.S. 90-232.~~

~~(e) A provisional licensee shall be subject to those various disciplinary measures and penalties set forth in G.S. 90-229 upon a determination of the Board that said provisional licensee has violated any of the terms or provisions of this Article.~~"

Section 5. G.S. 90-227 reads as rewritten:

"**§ 90-227. Renewal certificates.**

(a) The Board shall issue annual renewal certificates to licensed dental ~~hygienists.~~ hygienists who have completed a minimum of six hours of continuing education approved by the Board and have successfully completed a course in cardiopulmonary resuscitation.

(b) The Board shall have the authority to establish in its rules and regulations:

(1) The form of application for renewal ~~certificates;~~ certificates.

(2) The time the application must be ~~submitted;~~ submitted.

(3) The type of certificate to be ~~issued;~~ issued.

(4) How the certificate must be ~~displayed;~~ displayed.
(5) The penalty for late ~~application;~~ application.
(6) The automatic loss of license if applications are not submitted."

Section 6. G.S. 90-229 reads as rewritten:

"**§ 90-229. Disciplinary measures.**

~~(a)~~ The ~~North Carolina State Board of Dental Examiners~~ Board shall have the power and authority to (i) ~~Refuse~~ refuse to issue a license to practice dental hygiene; (ii) ~~Refuse~~ refuse to issue a certificate of renewal to practice dental hygiene; (iii) ~~Revoke~~ revoke or suspend a license to practice dental hygiene; and (iv) ~~Invoke~~ invoke such other disciplinary measures, ~~censure~~ censure, or probative terms against a licensee as it deems ~~proper;~~ proper in any ~~instance or~~ instances in which the Board is satisfied that ~~such~~ the applicant or licensee:

(1) Has engaged in any ~~act or~~ acts of fraud, ~~deceit~~ deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal ~~thereof;~~ thereof.
(2) Has been convicted of any of the criminal provisions of this Article or has entered a plea of guilty or nolo contendere to any ~~charge or~~ charges arising ~~therefrom;~~ therefrom.
(3) Has been convicted of or entered a plea of guilty or nolo contendere to any felony charge or to any misdemeanor charge involving moral ~~turpitude;~~ turpitude.
(4) Is a chronic or persistent user of intoxicants, ~~drugs~~ drugs, or narcotics to the extent that the same impairs his or her ability to practice dental ~~hygiene;~~ hygiene.
(5) Is incompetent in the practice of dental ~~hygiene;~~ hygiene.
(6) Has engaged in any act or practice violative of any of the provisions of this Article or violative of any of the rules and regulations promulgated and adopted by the Board, or has aided, ~~abetted~~ abetted, or assisted any other person or entity in the violation of the ~~same;~~ same.
(7) Has practiced any fraud, ~~deceit~~ deceit, or misrepresentation upon the public or upon any individual in an effort to acquire or retain any ~~patient or patients;~~ patients.
(8) Has made fraudulent or misleading statements pertaining to his or her skill, knowledge, or method of treatment or ~~practice;~~ practice.
(9) Has committed any fraudulent or misleading acts in the practice of dental ~~hygiene;~~ hygiene.
(10) Has, in the practice of dental hygiene, committed ~~an act or~~ acts constituting ~~malpractice;~~ malpractice.
(11) Has employed a person not licensed in this State to do or perform any act or service, or has aided, ~~abetted~~ abetted, or assisted any ~~such~~ unlicensed person to do or perform any act or service ~~which~~ that cannot lawfully be done or performed by ~~such person;~~ the person.

(12) Has engaged in any unprofessional conduct as the same may be from time to time, defined by the rules and regulations of the ~~Board;~~ Board.

(13) Is mentally, emotionally, or physically unfit to practice dental hygiene or is afflicted with such a physical or mental disability as to be deemed dangerous to the health and welfare of patients. An adjudication of mental incompetency in a court of competent jurisdiction or a determination thereof by other lawful means shall be conclusive proof of unfitness to practice dental hygiene unless or until such person shall have been subsequently lawfully declared to be mentally competent.

~~(b) As used in this section the term "licensee" includes licensees and provisional licensees and the term "license" includes licenses and provisional licenses.~~"

Section 7. G.S. 90-231 reads as rewritten:

"**§ 90-231. Opportunity for licensee or applicant to have hearing.**

(a) With the exception of applicants for reinstatement after revocation, every applicant for a license ~~or provisional license~~ to practice dental hygiene or licensee ~~or provisional licensee to practice dental hygiene shall~~ shall, after ~~notice~~ notice, have an opportunity to be heard before the ~~North Carolina State Board of Dental Examiners~~ Board shall take any action the effect of which would be:

(1) To deny permission to take an examination for licensing for which application has been duly ~~made; or~~ made.

(2) To deny a license after examination for any cause other than failure to pass an ~~examination; or~~ examination.

(3) To withhold the renewal of a license for any cause other than failure to pay a statutory renewal ~~fee; or~~ fee.

(4) To suspend a ~~license; or~~ license.

(5) To revoke a ~~license; or~~ license.

~~(6) To revoke or suspend a provisional license; or~~

(7) To invoke any other disciplinary measures, ~~censure~~ censure, or probative terms against a ~~licensee or provisional licensee;~~ licensee.

~~such proceedings to~~ Proceedings under this section shall be conducted in accordance with the provisions of Chapter 150B of the General ~~Statutes of North Carolina.~~ Statutes.

(b) In lieu of or as a part of such hearing and subsequent proceedings the Board is authorized and empowered to enter any consent order relative to the discipline, censure, or probation of a ~~licensee, provisional~~ licensee or an applicant for a license ~~or provisional license,~~ or relative to the revocation or suspension of a ~~license or provisional~~ license.

(c) Following the service of the notice of hearing as required by Chapter 150B of the General Statutes, the Board and the person upon whom such notice is served shall have the right to conduct adverse examinations, take depositions, and engage in such further discovery proceedings as are permitted by the laws of this State in civil matters. The Board is hereby authorized and empowered to issue such orders,

commissions, notices, subpoenas, or other process as might be necessary or proper to effect the purposes of this subsection; provided, however, that no member of the Board shall be subject to examination hereunder."

Section 8. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules and regulations not exceeding the following:

(1)	Each applicant for examination	$125.00
(2)	Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist	60.00
(3)	Each restoration of license	60.00
(4)	Each ~~provisional~~ license by credential	60.00
(5)	Each certificate of license to a resident dental hygienist desiring to change to another state or territory	25.00.

All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

Section 9. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) A dental hygienist may practice only under the supervision of one or more licensed dentists. ~~Provided, however, that this subsection (a)~~ The provisions of this subsection shall be deemed to be complied with in the case of dental hygienists employed by the Department of ~~Environment, Health,~~ Environment and Natural Resources and especially trained by ~~said~~ that Department as public health hygienists while performing their duties in the public schools under the direction of a duly licensed dentist.

(b) A dentist in private practice may not ~~employ~~ utilize more than two dental hygienists at one and the same ~~time~~ time. ~~who are employed in clinical dental hygiene positions.~~

(c) Dental hygiene may be practiced only by the holder of a license ~~or provisional license~~ currently in effect and duly issued by the Board. The following acts, practices, ~~functions~~ functions, or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any ~~act or~~ acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

Section 10. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **June 9, 1999**

Name of Committee — Date

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Stephen Stanish	NCFPC
Amy Jo Bain	NC Medical Society
Steve Keene	NC Medical Society
John Cyrus	N.C. State Grange
Walter Price	Charlotte Chamber

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Tuesday, June 15 1999**
TIME: **Immediately after session**
ROOM: **At Senator Purcell's desk in the Senate Chamber**

The following bills or resolutions will be considered:

- S.B. 665, Dental Hygienists — Senator Soles

Senator William R. Purcell, Chair

SENATE HEALTH CARE COMMITTEE

Tuesday, June 15, 1999

MINUTES

The Senate Health Care Committee met Tuesday, June 15, 1999, at 5:40 P.M. in the Senate Chamber at the desk of Chair Senator William R. Purcell. Thirteen members were present, including the Chair.

Senator Soles presented a Committee Substitute for his bill, S.B. 665, *Dental Hygienists.* Senator Hartsell moved that the Committee Substitute be adopted for purposes of discussion and the motion carried. After brief discussion Senator Hartsell moved for an unfavorable report for the original bill and a favorable report for the Committee Substitute. The motion carried unanimously.

The meeting adjourned at 5:45 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, June 16, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **665** Dental Hygienists

Draft Number:	PCS1746
Sequential Referral:	None
Recommended Referral:	Rules
Long Title Amended:	Yes

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 665
Proposed Committee Substitute S665-PCS1746-RM

Short Title: Dentists/Dental Hygienists. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE STATE BOARD OF DENTAL EXAMINERS TO STUDY, CONSIDER, AND DEVELOP PROCEDURES FOR NORTH CAROLINA LICENSURE-BY-CREDENTIAL FOR ALREADY LICENSED OUT-OF-STATE DENTIST AND DENTAL HYGIENIST APPLICANTS; TO RECOMMEND TO THE 2000 SESSION OF THE GENERAL ASSEMBLY ANY CHANGES NEEDED IN THE DENTAL PRACTICE ACT FOR AUTHORIZING SUCH PROCEDURES; AND TO PREPARE PROPOSED ADMINISTRATIVE REGULATIONS TO IMPLEMENT THE NEW LICENSING PATHWAY.

The General Assembly of North Carolina enacts:

Section 1. The State Board of Dental Examiners shall study, consider, and develop procedures for allowing North Carolina to license-by-credential out-of-state licensed dentist and dental hygienist licensure applicants; it shall develop recommendations for any changes needed in the Dental Practice Act; and it shall prepare to submit proposed rules to implement a sound program for the new licensing pathway.

The Board shall determine how the new procedures should be authorized and developed for the Board to allow less burdensome and more timely entry into the State for qualified out-of-state licensed applicants, while at the same time continuing the same degree of protection of the public as is the case under the current law and procedures.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 665

Short Title: Dental Hygienists. (Public)

Sponsors: Senator Soles.

Referred to: Health Care.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING DENTAL HYGIENIST LICENSURE BY CREDENTIAL AND AMENDING THE LICENSURE REQUIREMENTS FOR DENTAL HYGIENISTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 90-221 reads as rewritten:

"**§ 90-221. Definitions.**

~~(a) "Dental hygiene" as used in this Article shall mean the performance of the following functions: Complete oral prophylaxis, application of preventive agents to oral structures, exposure and processing of radiographs, administration of medicaments prescribed by a licensed dentist, preparation of diagnostic aids, and written records of oral conditions for interpretation by the dentist, together with such other and further functions as may be permitted by rules and regulations of the Board not inconsistent herewith.~~

~~(b) "Dental hygienist" as used in this Article, shall mean any person who is a graduate of a Board-accredited school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.~~

~~(c) "License" shall mean a certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.~~

~~(d) "Renewal certificate" shall mean the annual certificate of renewal of license to continue practice of dental hygiene in the State of North Carolina.~~

~~(e) "Board" shall mean "The North Carolina State Board of Dental Examiners" created by Chapter 139, Public Laws of 1879, and Chapter 178, Public Laws of 1915 as continued in existence by G.S. 90-22.~~

~~(f) "Supervision" as used in this Article shall mean that acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of such acts and such acts are being performed pursuant to the dentist's order, control and approval.~~

The following definitions apply in this Article:

(1) Board. -- The North Carolina State Board of Dental Examiners.

(2) Dental hygiene. -- The performance of the following functions:

a. Complete oral prophylaxis.

b. Application of preventive agents to oral structures.

c. Exposure and processing of radiographs.

d. Administration of medicaments prescribed by a licensed dentist.

e. Preparation of diagnostic aids and written records of oral conditions for interpretation by the dentist.

f. Any other functions permitted by rules of the Board consistent with this Article.

(3) Dental hygienist. -- A person who is a graduate of a program accredited by the American Dental Association Commission on Dental Accreditation and a Board-approved school of dental hygiene, who has been licensed by the Board, and who practices dental hygiene as prescribed by the Board.

(4) License. -- A certificate issued to any applicant upon completion of requirements for admission to practice dental hygiene.

(5) Licensee. -- A person who has been issued a license by the Board to practice dental hygiene.

(6) Renewal certificate. -- The annual certificate of renewal of license to continue practice of dental hygiene in the State.

(7) Supervision. -- Acts are deemed to be under the supervision of a licensed dentist when performed in a locale where a licensed dentist is physically present during the performance of the acts and the acts are performed pursuant to the dentist's order, control, and approval."

Section 2. G.S. 90-223(a) reads as rewritten:

"(a) The Board is authorized and empowered to:

(1) Conduct examinations for ~~licensure,~~ licensure.

(2) Issue ~~licenses and provisional licenses,~~ licenses.

(3) Issue annual renewal ~~certificates, and~~ certificates.

(4) Renew expired licenses."

Section 3. G.S. 90-223(b) reads as rewritten:

"(b) The Board shall have the authority to make or amend rules and regulations not inconsistent with this Article governing the practice of dental hygiene and the granting, ~~revocation~~ revocation, and suspension of licenses ~~and provisional licenses~~ of dental hygienists.

(1) Any rule promulgated or amended under this Article shall be filed and distributed in accordance with the provisions of Article 5 of Chapter 150B of the General Statutes of North Carolina. A copy must be distributed to all licensed dentists and all licensed dental hygienists within 30 days of final approval by the Board.

(2) The Board shall issue every two years a compilation or supplement of the Dental Hygiene Act and the Board rules and regulations, and, upon written request therefor, a directory of dental hygienists to each licensed dentist and dental hygienist."

Section 4. G.S. 90-226 reads as rewritten:

"**§ 90-226. ~~Provisional license.~~ License by credential.**

~~(a)~~ The ~~North Carolina State Board of Dental Examiners shall, subject to its rules and regulations,~~ Board shall issue a ~~provisional~~ license to practice dental hygiene to any person who is licensed to practice dental hygiene anywhere in the United States, or in any country, ~~territory~~ territory, or other recognized jurisdiction, if the Board shall determine that ~~said~~ the licensing jurisdiction imposed upon ~~said~~ the person requirements for licensure no less exacting than those imposed by this ~~State.~~ State and the person has graduated from a program accredited by the American Dental Association Commission on Dental Accreditation. ~~A provisional licensee may engage in the practice of dental hygiene only in strict accordance with the terms, conditions and limitations of her license and with the rules and regulations of the Board pertaining to provisional license.~~

~~(b) A provisional license shall be valid until the date of the announcement of the results of the next succeeding Board examination of candidates for licensure to practice dental hygiene in this State, unless the same shall be earlier revoked or suspended by the Board.~~

~~(c) No person who has failed an examination conducted by the North Carolina State Board of Dental Examiners shall be eligible to receive a provisional license.~~

~~(d) Any person desiring to secure a provisional license shall make application therefor in the manner and form prescribed by the rules and regulations of the Board and shall pay the fee prescribed in G.S. 90-232.~~

~~(e) A provisional licensee shall be subject to those various disciplinary measures and penalties set forth in G.S. 90-229 upon a determination of the Board that said provisional licensee has violated any of the terms or provisions of this Article.~~"

Section 5. G.S. 90-227 reads as rewritten:

"**§ 90-227. Renewal certificates.**

(a) The Board shall issue annual renewal certificates to licensed dental ~~hygienists.~~ hygienists who have completed a minimum of six hours of continuing education approved by the Board and have successfully completed a course in cardiopulmonary resuscitation.

(b) The Board shall have the authority to establish in its rules and regulations:

(1) The form of application for renewal ~~certificates;~~ certificates.

(2) The time the application must be ~~submitted;~~ submitted.

(3) The type of certificate to be ~~issued;~~ issued.

(4) How the certificate must be ~~displayed;~~ displayed.
(5) The penalty for late ~~application;~~ application.
(6) The automatic loss of license if applications are not submitted."

Section 6. G.S. 90-229 reads as rewritten:

"**§ 90-229. Disciplinary measures.**

~~(a)~~ The ~~North Carolina State Board of Dental Examiners~~ Board shall have the power and authority to (i) ~~Refuse~~ refuse to issue a license to practice dental hygiene; (ii) ~~Refuse~~ refuse to issue a certificate of renewal to practice dental hygiene; (iii) ~~Revoke~~ revoke or suspend a license to practice dental hygiene; and (iv) ~~Invoke~~ invoke such other disciplinary measures, ~~censure~~ censure, or probative terms against a licensee as it deems ~~proper;~~ proper in any ~~instance or~~ instances in which the Board is satisfied that ~~such~~ the applicant or licensee:

(1) Has engaged in any ~~act or~~ acts of fraud, ~~deceit~~ deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal ~~thereof;~~ thereof.
(2) Has been convicted of any of the criminal provisions of this Article or has entered a plea of guilty or nolo contendere to any ~~charge or~~ charges arising ~~therefrom;~~ therefrom.
(3) Has been convicted of or entered a plea of guilty or nolo contendere to any felony charge or to any misdemeanor charge involving moral ~~turpitude;~~ turpitude.
(4) Is a chronic or persistent user of intoxicants, ~~drugs~~ drugs, or narcotics to the extent that the same impairs his or her ability to practice dental ~~hygiene;~~ hygiene.
(5) Is incompetent in the practice of dental ~~hygiene;~~ hygiene.
(6) Has engaged in any act or practice violative of any of the provisions of this Article or violative of any of the rules and regulations promulgated and adopted by the Board, or has aided, ~~abetted~~ abetted, or assisted any other person or entity in the violation of the ~~same;~~ same.
(7) Has practiced any fraud, ~~deceit~~ deceit, or misrepresentation upon the public or upon any individual in an effort to acquire or retain any ~~patient or patients;~~ patients.
(8) Has made fraudulent or misleading statements pertaining to his or her skill, knowledge, or method of treatment or ~~practice;~~ practice.
(9) Has committed any fraudulent or misleading acts in the practice of dental ~~hygiene;~~ hygiene.
(10) Has, in the practice of dental hygiene, committed ~~an act or~~ acts constituting ~~malpractice;~~ malpractice.
(11) Has employed a person not licensed in this State to do or perform any act or service, or has aided, ~~abetted~~ abetted, or assisted any ~~such~~ unlicensed person to do or perform any act or service ~~which~~ that cannot lawfully be done or performed by ~~such person;~~ the person.

(12) Has engaged in any unprofessional conduct as the same may be from time to time, defined by the rules and regulations of the ~~Board;~~ Board.

(13) Is mentally, emotionally, or physically unfit to practice dental hygiene or is afflicted with such a physical or mental disability as to be deemed dangerous to the health and welfare of patients. An adjudication of mental incompetency in a court of competent jurisdiction or a determination thereof by other lawful means shall be conclusive proof of unfitness to practice dental hygiene unless or until such person shall have been subsequently lawfully declared to be mentally competent.

~~(b) As used in this section the term "licensee" includes licensees and provisional licensees and the term "license" includes licenses and provisional licenses.~~"

Section 7. G.S. 90-231 reads as rewritten:

"**§ 90-231. Opportunity for licensee or applicant to have hearing.**

(a) With the exception of applicants for reinstatement after revocation, every applicant for a license ~~or provisional license~~ to practice dental hygiene or licensee ~~or provisional licensee to practice dental hygiene shall~~ shall, after ~~notice~~ notice, have an opportunity to be heard before the ~~North Carolina State Board of Dental Examiners~~ Board shall take any action the effect of which would be:

(1) To deny permission to take an examination for licensing for which application has been duly ~~made; or~~ made.

(2) To deny a license after examination for any cause other than failure to pass an ~~examination; or~~ examination.

(3) To withhold the renewal of a license for any cause other than failure to pay a statutory renewal ~~fee; or~~ fee.

(4) To suspend a ~~license; or~~ license.

(5) To revoke a ~~license; or~~ license.

~~(6) To revoke or suspend a provisional license; or~~

(7) To invoke any other disciplinary measures, ~~censure~~ censure, or probative terms against a ~~licensee or provisional licensee;~~ licensee.

~~such proceedings to~~ Proceedings under this section shall be conducted in accordance with the provisions of Chapter 150B of the General ~~Statutes of North Carolina.~~ Statutes.

(b) In lieu of or as a part of such hearing and subsequent proceedings the Board is authorized and empowered to enter any consent order relative to the discipline, censure, or probation of a ~~licensee, provisional~~ licensee or an applicant for a license ~~or provisional license,~~ or relative to the revocation or suspension of a ~~license or provisional~~ license.

(c) Following the service of the notice of hearing as required by Chapter 150B of the General Statutes, the Board and the person upon whom such notice is served shall have the right to conduct adverse examinations, take depositions, and engage in such further discovery proceedings as are permitted by the laws of this State in civil matters. The Board is hereby authorized and empowered to issue such orders,

commissions, notices, subpoenas, or other process as might be necessary or proper to effect the purposes of this subsection; provided, however, that no member of the Board shall be subject to examination hereunder."

Section 8. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules and regulations not exceeding the following:

(1)	Each applicant for examination	$125.00
(2)	Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist	60.00
(3)	Each restoration of license	60.00
(4)	Each ~~provisional~~ license by credential	60.00
(5)	Each certificate of license to a resident dental hygienist desiring to change to another state or territory	25.00.

All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

Section 9. G.S. 90-233 reads as rewritten:

"**§ 90-233. Practice of dental hygiene.**

(a) A dental hygienist may practice only under the supervision of one or more licensed dentists. ~~Provided, however, that this subsection (a)~~ The provisions of this subsection shall be deemed to be complied with in the case of dental hygienists employed by the Department of ~~Environment, Health,~~ Environment and Natural Resources and especially trained by ~~said~~ that Department as public health hygienists while performing their duties in the public schools under the direction of a duly licensed dentist.

(b) A dentist in private practice may not ~~employ~~ utilize more than two dental hygienists at one and the same ~~time~~ time, ~~who are employed in clinical dental hygiene positions.~~

(c) Dental hygiene may be practiced only by the holder of a license ~~or provisional license~~ currently in effect and duly issued by the Board. The following acts, practices, ~~functions~~ functions, or operations, however, shall not constitute the practice of dental hygiene within the meaning of this Article:

(1) The teaching of dental hygiene in a school or college approved by the Board in a board-approved program by an individual licensed as a dental hygienist in any state in the United States.

(2) Activity which would otherwise be considered the practice of dental hygiene performed by students enrolled in a school or college approved by the Board in a board-approved dental hygiene program under the direct supervision of a dental hygienist or a dentist duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3), acting as an instructor.

(3) Any ~~act or~~ acts performed by an assistant to a dentist licensed to practice in this State when said act or acts are authorized and permitted by and performed in accordance with rules and regulations promulgated by the Board.

(4) Dental assisting and related functions as a part of their instructions by students enrolled in a course in dental assisting conducted in this State and approved by the Board, when such functions are performed under the supervision of a dentist acting as a teacher or instructor who is either duly licensed in North Carolina or qualified for the teaching of dentistry pursuant to the provisions of G.S. 90-29(c)(3)."

Section 10. This act is effective when it becomes law.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, June 23, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1069, Social Worker Licensure** **Representative Alexander**

Senator William R. Purcell, Chair

- **REVISED NOTICE**

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
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- **H.B. 1069, Social Worker Licensure** — **Representative Alexander**
- **S.B. 1119, Perfusionist Licensure** — **Senator Lucas**

Senator William R. Purcell, Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, June 23, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, June 23, 1999, at 12:07 P.M. in Room 1124 in the Legislative Building. Twelve members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Pages Steven McLeod of Raleigh, sponsored by Senator Miller; and Jason Scott of Fayetteville, sponsored by Senator Rand.

Senator Purcell told the Committee that two bills would be heard today, H.B. 1069, *Social Worker Licensure*, and S.B. 1119, *Perfusionist Licensure*. S.B. 1119 will be discussed today, but not voted upon at this time.

Senator Purcell introduced Representative Martha Alexander to explain H.B. 1069 to the Committee. After discussion, Senator Martin moved for a favorable report for the bill and that it be referred to the Senate Finance Committee. The motion carried unanimously.

Senator Lucas was called to explain S.B. 1119. She presented an amendment to the Committee and moved adoption of the amendment after it was explained. The motion carried unanimously. After numerous comments and questions from Committee members, voting on the bill was put off until a future meeting.

The meeting adjourned at 12:45 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Clerk

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1069
Committee Substitute Favorable 6/1/99

Short Title: Social Worker Licensure. (Public)

Sponsors:

Referred to:

April 15, 1999

A BILL TO BE ENTITLED

AN ACT RECLASSIFYING CERTIFIED CLINICAL SOCIAL WORKERS AS LICENSED CLINICAL SOCIAL WORKERS AND REVISING THE FEES AND QUALIFICATIONS FOR CERTIFICATION AND LICENSURE OF SOCIAL WORKERS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90B of the General Statutes reads as rewritten:

"Chapter 90B.

"Social Worker Certification and Licensure Act.

"**§ 90B-1. Short title.**

This Chapter shall be known as the "Social Worker Certification and Licensure Act."

"**§ 90B-2. Purpose.**

Since the profession of social work significantly affects the lives of the people of this State, it is the purpose of this Chapter to protect the public by setting standards for qualification, ~~training~~ training, and experience for those who seek to represent themselves to the public as certified social workers or licensed clinical social workers and by promoting high standards of professional performance for those engaged in the practice of social work.

"**§ 90B-3. Definitions.**

The following definitions apply in this Chapter:

(1) Board. -- The North Carolina ~~Certification Board for Social Work.~~ Social Work Certification and Licensure Board.

(2) ~~Certified~~ Licensed Clinical Social Worker. -- A person who is competent to function independently, who holds himself or herself out to the public as a social worker, and who offers or provides clinical social work services or supervises others engaging in clinical social work practice.

(3) Certified Master Social Worker. -- A person who is certified under this Chapter to practice social work as a master social worker and is engaged in the practice of social work.

(4) Certified Social Work Manager. -- A person who is certified under this Chapter to practice social work as a social work manager and is engaged in the practice of social work.

(5) Certified Social Worker. -- A person who is certified under this Chapter to practice social work as a social worker and is engaged in the practice of social work.

(6) Clinical Social Work Practice. -- The professional application of social work theory and methods to the ~~psychosocial~~ biopsychosocial diagnosis, treatment, or prevention, of emotional and mental disorders. Practice ~~includes~~ includes, by whatever means of communications, the treatment of individuals, couples, families, and groups, including the use of psychotherapy and referrals to and collaboration with other health professionals when appropriate. Clinical social work practice shall not include the provision of supportive daily living services to persons with severe and persistent mental illness as defined in G.S. 122C-3(33a).

(7) ~~Public~~ Practice of Social Work. -- To perform or offer to perform ~~services~~ services, by whatever means of communications, for other people that involve the application of social work values, principles, and techniques in areas such as social work services, consultation and administration, and social work planning and research.

(8) Social Worker. -- A person engaging in the ~~public~~ practice of social work who is not certified or licensed under this Chapter as a Certified Social Worker, Certified Master Social Worker, ~~Certified~~ Licensed Clinical Social Worker, or Certified Social Work Manager.

"**§ 90B-4. Prohibitions.**

(a) Except as otherwise provided in this Chapter, it is unlawful for any person who is not certified as a social worker, master social worker, or social work manager under this Chapter to represent himself or herself to be certified under this Chapter or hold himself or herself out to the public by any title or description denoting that he or she is certified under this Chapter.

(b) After January 1, 1992, except as otherwise provided in this Chapter, it is unlawful to engage in or offer to engage in the practice of clinical social work without first being ~~certified~~ licensed under this Chapter as a clinical social worker.

(c) Nothing herein shall prohibit school social workers who are certified by the State Board of Education from practicing school social work under the title "Certified School Social Worker." Except as provided for ~~certified~~ licensed clinical social workers, nothing herein shall be construed as prohibiting social workers who are not certified by the Board from practicing social work. Except as provided herein for ~~certified~~ licensed clinical social workers, no agency, institution, board, commission, bureau, department, division, council, member of the Council of State, or officer of the legislative, executive or judicial branches of State government or counties, cities, towns, villages, other municipal corporations, political subdivisions of the State, public authorities, private corporations created by act of the General Assembly or any firm or corporation receiving State funds shall require the obtaining or holding of any certificate issued under this Chapter or the taking of an examination held pursuant to this Chapter as a requirement for obtaining or continuing in employment.

(d) Nothing herein shall authorize the practice of medicine as defined in Article 1 of this Chapter or the practice of psychology as defined in Article 18A of this Chapter.

"§ 90B-5. North Carolina ~~Certification Board for Social Work;~~ Social Work Certification and Licensure Board; appointments; terms; composition.

(a) For the purpose of carrying out the provisions of this Chapter, there is hereby created the North Carolina ~~Certification Board for~~ Social Work Certification and Licensure Board which shall consist of seven members appointed by the Governor as follows:

(1) At least two members of the Board shall be Certified Social Workers or Certified Master Social Workers, three members shall be ~~Certified~~ Licensed Clinical Social Workers, and two members shall be appointed from the public at large. Composition of the Board as to the race and sex of its members shall reflect the composition of the population of the State of North Carolina.

(2) At all times the Board shall include at least one member primarily engaged in social work education, at least one member primarily engaged in social work in the public sector, and at least one member primarily engaged in social work in the private sector.

(3) All members of the Board shall be residents of the State of North Carolina, and with the exception of the public members, shall be certified or licensed by the Board under the provisions of this Chapter. Professional members of the Board must be actively engaged in the practice of social work or in the education and training of students in social work, and have been for at least three years prior to their appointment to the Board. Such activity during the two years preceding the appointment shall have occurred primarily in this State.

(b) The Governor may only remove a member of the Board for neglect of duty, malfeasance, or conviction of a felony or other crime of moral turpitude.

(c) The term of office of each member of the Board shall be three years. No member shall serve more than two consecutive three-year terms. Each term of service on the Board shall expire on the 30th day of June of the year in which the term expires. As the term of a member expires, the Governor shall make the appointment for a full term, or, if a vacancy occurs for any other reason, for the remainder of the unexpired term.

(d) Members of the Board shall receive compensation for their services and reimbursement for expenses incurred in the performance of duties required by this Chapter, at the rates prescribed in G.S. 93B-5.

(e) The Board may employ, subject to the provisions of Chapter 126 of the General Statutes, the necessary personnel for the performance of its functions, and fix their compensation within the limits of funds available to the Board.

"**§ 90B-6. Functions and duties of the ~~Certification~~ Board.**

(a) The Board shall administer and enforce the provisions of this Chapter.

(b) The Board shall elect from its membership, a chairperson, a vice-chairperson, and secretary-treasurer, and adopt rules to govern its proceedings. A majority of the membership shall constitute a quorum for all Board meetings.

(c) The Board shall examine and pass on the qualifications of all applicants for certificates and licenses under this Chapter, and shall issue a certificate or license to each successful applicant therefor.

(d) The Board may adopt a seal which may be affixed to all certificates and licenses issued by the Board.

(e) The Board may authorize expenditures deemed necessary to carry out the provisions of this Chapter from the fees which it collects, but in no event shall expenditures exceed the revenues of the Board during any fiscal year. No State appropriations shall be subject to the administration of the Board.

~~(f) The Board shall establish and receive fees not to exceed fifty dollars ($50.00) for initial or renewal application. Fees for the national written examination shall be the cost of the examination to the Board plus an additional fee not to exceed fifty dollars ($50.00). The fee for late renewal shall not exceed fifteen dollars ($15.00). The Board shall maintain accounts of all receipts and make expenditures from Board receipts for any purpose which is reasonable and necessary for the proper performance of its duties under this Chapter.~~

(g) The Board shall have the power to establish or approve study or training courses and to establish reasonable standards for ~~certification and certificate renewal,~~ certification, licensure, and renewal of certification and licensure, including ~~but not limited to~~ the power to adopt or use examination materials and accreditation standards of the Council on Social Work Education or other recognized accrediting agency and the power to establish reasonable standards for continuing social work education; provided that for certificate and license renewal no examination shall be required; provided further, that the Board shall not have the power to withhold approval of study or training courses offered by a college or university having a social work program approved by the Council on Social Work Education.

(h) Subject to the provisions of Chapter 150B of the General Statutes, the Board shall have the power to ~~adopt, amend, or rescind~~ adopt rules ~~and regulations~~ to carry out the purposes of this Chapter, including but not limited to the power to adopt ethical and disciplinary standards.

(i) The Board may order that any records concerning the practice of social work and relevant to a complaint received by the Board or an inquiry or investigation conducted by or on behalf of the Board shall be produced by the custodian of the records to the Board or for inspection and copying by representatives of or counsel to the Board.

"§ 90B-6.1. Board general provisions.

The Board shall be subject to the administrative provisions of Chapter 93B of the General Statutes.

"§ 90B-6.2. Fees.

(a) The Board shall establish fees not exceeding the following amounts:

(1)	All initial applications	$200.00
(2)	Examination	Cost plus an amount not to exceed $40.00
(3)	Repeated examination or any additional examination	Cost plus an amount not to exceed $40.00
(4)	Renewal applications	200.00
(5)	Late fees for renewal	50.00
(6)	Reinstatement	200.00
(7)	Duplicate license	25.00
(8)	Temporary certificate or license	25.00.

(b) Notwithstanding subdivision (a)(4) of this section, the Board may establish a graduated fee schedule for renewals that is based upon the applicant's level of certification or licensure. The Board may establish fees for the actual cost of duplication services, materials, and returned bank items. All fees derived from services provided by the Board under the provisions of this Chapter shall be nonrefundable. The Board shall maintain accounts of all receipts to the Board.

"§ 90B-7. Titles and qualifications for ~~certificates.~~ certificates and licenses.

(a) Each person desiring to obtain a certificate or license from the Board shall make application to the Board upon such forms and in such manner as the Board shall prescribe, together with the required application fee established by the Board.

(b) The Board shall issue a certificate as "Certified Social Worker" to an applicant ~~who:~~ who meets the following qualifications:

(1) Has a ~~bachelor's~~ bachelors degree in a social work program from a college or university having a social work program accredited or admitted to candidacy for accreditation by the Council on Social Work Education for undergraduate ~~curricula or has a bachelor's degree in a subject area related to human services and has~~

~~completed a minimum of 18 semester hours of social work training in a social work program accredited or admitted to candidacy for accreditation by the Council on Social Work Education; and~~ curricula.

(2) Has passed the Board examination for the certification of persons in this classification.

(c) The Board shall issue a certificate as "Certified Master Social Worker" to an applicant ~~who:~~ who meets the following qualifications:

(1) Has a ~~master's~~ masters or ~~doctor's~~ doctoral degree in a social work program from a college or university having a social work program approved by the Council on Social Work ~~Education; and~~ Education.

(2) Has passed the Board examination for the certification of persons in this classification.

(d) The Board shall issue a ~~certificate~~ license as a ~~"Certified~~ "Licensed Clinical Social Worker" to an applicant ~~who:~~ who meets the following qualifications:

(1) Holds or qualifies for a current certificate as a Certified Master Social ~~Worker; and~~ Worker.

(2) Shows to the satisfaction of the Board that he or she has had two years of clinical social work experience with appropriate supervision in the field of specialization in which the applicant will ~~practice; and~~ practice.

(3) Has passed the Board examination for the ~~certification~~ licensure of persons in this classification.

(e) The Board shall issue a certificate as a "Certified Social Work Manager" to an applicant ~~who:~~ who meets the following qualifications:

(1) Holds or qualifies for a current certificate as a Certified Social ~~Worker; and~~ Worker.

(2) Shows to the satisfaction of the Board that he or she has had two years of experience in an administrative setting with appropriate supervision and ~~training; and~~ training.

(3) Has passed the Board examination for the certification of persons in this classification.

(f) The Board may issue a provisional ~~certificate~~ license in clinical social work to a person who has a ~~master's~~ masters or ~~doctor's~~ doctoral degree in a social work program from a college or university having a social work program approved by the Council on Social Work Education and desires to be ~~certified~~ licensed as a clinical social worker. The provisional ~~certificate~~ license may not be issued for a period exceeding two years and the person issued the provisional ~~certificate~~ license must practice under the supervision of a ~~certified~~ licensed clinical social worker or a Board-approved alternate.

"**§ 90B-8. Persons from other jurisdictions.**

(a) The Board may grant a certificate or license without examination or by special examination to any person who, at the time of application, is certified, registered or

licensed as a social worker by a similar board of another country, state, or territory whose certification, registration or licensing standards are substantially equivalent to those required by this Chapter. The applicant shall have passed an examination in the country, state, or territory in which he or she is certified, registered, or licensed that is equivalent to the examination required for the level of certification or licensure sought in this State.

(b) The Board may issue a temporary license to a nonresident clinical social worker who is either certified, registered, or licensed in another jurisdiction whose standards, in the opinion of the Board, at the time of the person's certification, registration, or licensure were substantially equivalent to or higher than the requirements of this Chapter. Nothing in this Chapter shall be construed as prohibiting a nonresident clinical social worker certified, registered, or licensed in another state from rendering professional clinical social work services in this State for a period of not more than five days in any calendar year. All persons granted a temporary clinical social worker license shall comply with the supervision requirements established by the Board.

"**§ 90B-9. Renewal of ~~certificates.~~ certificates and licenses.**

(a) All certificates and licenses shall be effective upon date of issuance by the Board, and shall ~~expire~~ be renewed on or before the second June 30 thereafter.

(b) All certificates and licenses issued hereunder shall be renewed at the times and in the manner provided by this section. At least 45 days prior to expiration of each ~~certificate,~~ certificate or license, the Board shall mail a notice and application for ~~certificate~~ renewal to the ~~person certified for the current certification period.~~ certificate holder or licensee. Prior to the expiration date, the ~~applicant must return the notice~~ application shall be returned properly completed, together with a renewal fee established by the Board pursuant to G.S. 90B-6.2(a)(5) and evidence of completion of the continuing education requirements established by the Board ~~under~~ pursuant to G.S. 90B-6(g), upon receipt of which the Board shall ~~issue to the person to be certified the renewed certificate for the period stated on the certificate.~~ renew the certificate or license. If a certificate or license is not renewed on or before the expiration date, an additional fee shall be charged for late renewal as provided in G.S. 90B-6.2(a)(6).

(c) ~~Any person certified who allows his certificate to lapse for failure to apply for renewal within 45 days after notice shall have his or her certificate automatically suspended, and be subject to a late renewal fee as established pursuant to G.S. 90B-6(f), and if he or she fails to apply for renewal of a certificate within one year after date of such suspension, the certificate shall lapse and may be reissued only upon application as for an original certificate.~~ A certificate or license issued under this Chapter shall be automatically suspended for failure to renew for a period of more than 60 days after the renewal date. The Board may reinstate a certificate or license suspended under this subsection upon payment of a reinstatement fee as provided in G.S. 90B-6.2(a)(7) and may require that the applicant file a new application, furnish new supervisory reports or references or otherwise update his or her credentials, or submit to examination for reinstatement. The Board shall have

exclusive jurisdiction to investigate alleged violations of this Chapter by any person whose certificate or license has been suspended under this subsection and, upon proof of any violation of this Chapter, the Board may take disciplinary action as provided in G.S. 90B-11.

(d) Any person certified or licensed and desiring to retire temporarily from the practice of social work shall send written notice thereof to the Board. Upon receipt of such notice, his or her name shall be placed upon the nonpracticing list and he or she shall not be subject to payment ~~or~~ of renewal ~~fees.~~ fees while temporarily retired. In order to ~~renew certification, application for renewal shall be made in ordinary course with a renewal fee for the current period.~~ reinstate certification or licensure, the person shall apply to the Board by making a request for reinstatement and paying the appropriate fee as provided in G.S. 90B-6.2.

"**§ 90B-10. Exemption from certain requirements.**

(a) Applicants who were engaged in the practice of social work before January 1, 1984, shall be exempt from the academic qualifications required by this act for Certified Social Workers and Certified Social Work Managers and shall be certified upon passing the Board examination and meeting the experience requirements, if any, for certification of persons in that classification.

(b) The following may engage in clinical social work practice without meeting the requirements of G.S. 90B-7(d):

(1) A person who has engaged in clinical social work practice for one year prior to the effective date of this act and who properly applies for and pays the required fees for a certificate as a certified clinical social worker prior to January 1, 1993. Notwithstanding the foregoing provision of this subdivision, any applicant who applied for certification pursuant to this subdivision between December 1, 1993, and January 15, 1994, and who is otherwise eligible for certification under this subdivision but for the January 1, 1993, deadline shall be certified.

(2) A student completing a clinical requirement for graduation while pursuing a course of study in social work in an institution accredited by or in candidacy status with the Council on Social Work Education.

(3) An employee engaged in clinical social work practice exclusively for one of the following employers:

a. **(Effective until January 1, 1999)** The State, a political subdivision of the State, or a local government.

b. A hospital or health care facility licensed pursuant to Article 2 of Chapter 122C of the General Statutes or Articles 5 and 6 of Chapter 131E of the General Statutes.

"**§ 90B-11. Disciplinary procedures.**

(a) The Board may, in accordance with the provisions of Chapter 150B of the General Statutes, ~~refuse to grant or to renew, may suspend, or may revoke the certificate of any person certified under this Chapter on the following grounds:~~ deny,

suspend, or revoke an application, certificate, or license on any of the following grounds:

(1) Conviction of a misdemeanor or the entering of a plea of guilty or nolo contendere to a misdemeanor under this ~~Chapter; or~~ Chapter.

(2) Conviction of a felony or the entering of a plea of guilty or nolo contendere to a felony under the laws of the United States or of any state of the United ~~States; or~~ States.

(3) Gross unprofessional conduct, dishonest practice or incompetence in the practice of social ~~work; or~~ work.

(4) Procuring or attempting to procure a certificate or license by fraud, deceit, or ~~misrepresentation; or~~ misrepresentation.

(5) Any fraudulent or dishonest conduct in social ~~work; or~~ work.

(6) Inability of the person to perform the functions for which he or she is ~~certified,~~ certified or licensed, or substantial impairment of abilities by reason of physical or mental ~~disability; or~~ disability.

(7) Violations of any of the provisions of this Chapter or of rules of the Board.

(b) Upon proof that an applicant, certificate holder, or licensee under this Chapter has engaged in any of the prohibited actions specified in subsection (a) of this section, the Board may, in lieu of denial, suspension, or revocation, take one or more of the following actions:

(1) Issue a reprimand or censure.

(2) Order probation with conditions deemed appropriate by the Board.

(3) Require examination, remediation, or rehabilitation, including care, counseling, or treatment by a professional designated or approved by the Board, the cost of which shall be borne by the applicant, certificate holder, or licensee.

(4) Require supervision for the services provided by the applicant, certificate holder, or licensee by a certified or licensed social worker designated and approved by the Board, the cost of which shall be borne by the applicant, certificate holder, or licensee.

(5) Limit or circumscribe the practice of social work provided by the applicant, certificate holder, or licensee with respect to the extent, nature, or location of the services provided.

(c) The Board may impose conditions of probation or restrictions upon continued practice at the conclusion of a period of suspension or as a requirement for the restoration of a revoked or suspended certificate or license. Instead of or in connection with any disciplinary proceeding or investigation, the Board may enter into a consent order with an applicant, certificate holder, or licensee relative to a discipline, supervision, probation, remediation, rehabilitation, or practice limitation.

(d) In considering whether an applicant, certificate holder, or licensee is mentally or physically capable of practicing social work with reasonable skill and safety, the Board may require an applicant, certificate holder, or licensee to submit to a mental

examination by a licensed clinical social worker or other licensed mental health professional designated by the Board and to a physical examination by a physician or other licensed health professional designated by the Board. The examination may be ordered by the Board before or after charges are presented against the applicant, certificate holder, or licensee and the results of the examination shall be reported directly to the Board and shall be admissible in evidence in a hearing before the Board.

(e) The Board shall provide the opportunity for a hearing under Article 3A of Chapter 150B of the General Statutes to: (i) any person whose certification or licensure was denied or granted subject to restrictions, probation, disciplinary action, remediation, or other conditions or limitations; and (ii) any certificate holder or licensee before revoking or suspending his or her certificate or license or restricting his or her practice or imposing any other disciplinary action or remediation. If the applicant, certificate holder, or licensee waives the opportunity for a hearing, the Board's denial, revocation, suspension, or other action shall be final. No applicant, certificate holder, or licensee shall be entitled to a hearing for failure to pass a qualifying examination.

(f) In any proceeding before the Board, complaint or notice of charges against any applicant, certificate holder, or licensee, and any decision rendered by the Board, the Board may withhold from public disclosure the identity of any client who has not consented to the public disclosure of social work services provided to him or her by the applicant, certificate holder, or licensee. If necessary for the protection and rights of a client and the full presentation of relevant evidence, the Board may close a hearing to the public and receive evidence involving or concerning the delivery of social work services.

(g) Records, papers, and other documents containing information collected and compiled by or on behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with certification, licensure, or a disciplinary matter shall not be considered public records within the meaning of Chapter 132 of the General Statutes. Any notice or statement of charges, notice of hearing, or decision rendered in connection with a hearing, shall be a public record. Information that identifies a client who has not consented to the public disclosure of services rendered to him or her by a person certified or licensed under this Chapter shall be deleted from the public record. All other records, papers, and documents containing information collected and compiled by or on behalf of the Board shall be public records, but any information that identifies a client who has not consented to the public disclosure of services rendered to him or her shall be deleted.

"**§ 90B-12. Violation a misdemeanor.**

Any person violating any provision of this Chapter is guilty of a Class 2 misdemeanor.

"**§ 90B-13. Injunction.**

As an additional remedy, the Board may proceed in a superior court to enjoin and restrain any person from violating the prohibitions of this Chapter. The Board shall not be required to post bond in connection with such proceeding.

"**§ 90B-14. Third-party reimbursements.**

Nothing in this Chapter shall be construed to authorize or require direct third-party reimbursement to persons certified under this Chapter."

Section 2. This act becomes effective July 1, 1999.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, June 23, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1069** Social Worker Licensure.
Sequential Referral: Finance
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
AMENDMENT
Senate Bill 1119

AMENDMENT NO. _____
(to be filled in by
Principal Clerk)

S1119-ARY-001 Page 1 of __

Date _____ ,1999

Comm. Sub. []
Amends Title []

Senator Lucas

moves to amend the bill on page 4, line 6,
by rewriting that line to read:

"of the Board. The first perfusionists appointed to the Perfusion Advisory Committee pursuant to this section shall be eligible for licensure under G.S. 90-651 and upon appointment apply for a license.".

SIGNED Jeanne Lucas
Amendment Sponsor

SIGNED William R Purcell
Committee Chair if Senate Committee Amendment

ADOPTED _____ FAILED _____ TABLED _____

HOUSE BILL 1069:
Social Worker Licensure

BILL ANALYSIS

Committee:	Senate Health Committee	**Introduced by:**	Representative Alexander
Date:	June 18, 1999	**Summary by:**	Mary Shuping
Version:	2nd edition		John Young
	(H-Finance Comm. Sub)		

SUMMARY: House Bill 1069 makes the following changes to the Social Worker Certification Act: (1) changes the name of the Board from the "North Carolina Certification Board for Social Work" to the "North Carolina Social Work Certification and Licensure Board"; (2) reclassifies certified clinical social workers to licensed clinical social workers; (3) increases the maximum fee amounts charged by the Board; (4) provides for certification of a social worker from another jurisdiction if the applicant has passed an equivalent exam in that jurisdiction; (5) authorizes the Board to issue a temporary license to a nonresident clinical social worker if the jurisdiction's standards were equivalent or higher than North Carolina's standards; (6) automatically suspends a certificate or license if not renewed for a period of more than 60 days after the renewal date; (7) provides for alternative disciplinary procedures; (8) authorizes the Board to order mental or physical exams to determine whether or not an individual is mentally or physically competent to practice social work without the Board having to petition the court for the exam(s); and, (9) clarifies whether records in a disciplinary proceeding are public documents.

Most of the changes to the law concerning disciplinary proceedings, hearings, and records are based on the Psychology Practice Act.

CURRENT LAW & BILL ANALYSIS:

House Bill 1069 makes the following changes to the fee structure for certified and licensed social workers:

FEE CHANGES

TYPE OF FEE	CURRENT MAXIMUM FEE	PROPOSED MAXIMUM FEE
Initial Application	$50.00	$200.00
Renewal Application	$50.00	$200.00
Note: The Board may establish a graduated fee schedule based upon the applicant's level of certification or licensure.		
Written Exam	Actual cost + $50.00	Actual Cost + $40.00
Late Renewal	$15.00	$50.00
Repeated Exams or any add'l exams	N/A	Actual Cost + $40.00
Reinstatement	N/A	$200.00
Duplicate License	N/A	$25.00
Temporary certificate or license	N/A	$25.00

ANALYSIS OF HB 1069

Definitions. HB 1069 clarifies that the practice of clinical social work and social work includes treatment by whatever means of communication, and clarifies that the practice of social work includes performing services by whatever means of communication.

Production of Records Concerning the Practice of Social Work. The bill adds a new subsection (i) to allow the Board to order the production of records concerning the practice of social work that are relevant to a complaint, inquiry, or investigation.

Fees. This section lists all fees that may be charged by the Board, as outlined above. This section of the bill also:

- Authorizes the Board to establish a graduated fee schedule for renewals that is based upon the applicant's level of certification or licensure. Fees may not exceed the maximum set by statute.
- Authorizes the Board to establish fees for the actual cost of duplication services, materials, and returned bank items.
- Provides that all fees derived from services provided by the Board are nonrefundable and requires the Board to maintain accounts of all receipts.

Qualifications for Certified Social Workers. Current law provides that an applicant is qualified to be a Certified Social Worker if the applicant:

- Has a bachelor's degree in a social work program that is accredited or admitted to candidacy for accreditation by the Council on Social Work Education for undergraduate curricula; ***OR***
- Has a bachelor's degree in a subject area related to human services and has completed a minimum of 18 semester hours of social work training in an accredited social work program.

House Bill 1069 allows only those applicants who have a bachelor's degree in social work from an accredited college or university to become a Certified Social Worker.

Reciprocity. Current law permits the Board to grant a certificate to an applicant who is certified, registered, or licensed as a social worker in another country, state, or territory if the standards under which the person was certified, registered, or licensed are substantially the same as required by NC law.

House Bill 1069 adds the requirement that the applicant must have passed an exam in the country, state, or territory where the applicant is certified, registered, or licensed that is equivalent to the exam required for the level or certification or licensure in NC.

Temporary Licenses. This section of the bill authorizes the Board to issue a temporary license to a nonresident clinical social worker who is certified, registered, or licensed in another jurisdiction provided that the standards for certification, registration, or licensure were substantially the same as or higher than those in NC. However, a nonresident clinical social worker who is certified, registered, or licensed in another state will not be prohibited from rendering professional services in NC for a period of not more than 5 days in a calendar year. Finally, this section ensures that individuals granted a temporary license must comply with the supervision requirements of the Board.

Renewal/Suspension of Certificate or License for Failure to Renew. Current law provides that all certificates and licenses expire on the second June 30 after issuance. This section of the bill automatically suspends a certificate or license for failure to renew for a period of more than 60 days after the renewal date. The Board may reinstate the certificate or license upon payment of the reinstatement fee and may require the applicant to provide further information.

Inactive Status. This section clarifies that an individual who is certified or licensed who temporarily retires from the practice of social work is not required to pay renewal fees while temporarily retired. In order to reinstate a certificate or license, the individual must make a request for reinstatement and pay the reinstatement fee.

Disciplinary Procedures. This section authorizes the Board to deny, suspend, or revoke a certificate or license if an individual enters a plea of guilty or no contest to a misdemeanor or felony. (Currently, the individual must be convicted of the misdemeanor or felony.)

Alternatives to Denying, Suspending, or Revoking a Certificate or License. This section authorizes the Board to take one or more of the following actions if an individual has committed a prohibited act in G.S. 90B-11(a):

1. Issue a reprimand or censure.
2. Order probation with conditions deemed appropriate by the Board.
3. Require examination, remediation, or rehabilitation, including care, counseling, or treatment by a professional with the cost borne by the individual.
4. Require supervision by a certified or licensed social worker with the cost borne by the individual.
5. Limit the practice of social work provided by the individual with respect to the extent, nature, or location of the services provided.

These alternative disciplinary procedures are substantially the same as those in the Psychology Practice Act.

Probation/Restrictions After Suspension. This section authorizes the Board to impose conditions of probation or restrictions on practice after a period of suspension or as a requirement for the restoration of a revoked or suspended certificate or license. It also allows the Board to enter into a consent order with an individual instead of or in connection with a disciplinary proceeding or investigation. The consent order may be relative to a discipline supervision, probation, remediation, rehabilitation, or practice limitation. These provisions are substantially the same as those in the Psychology Practice Act.

Competence to Practice Social Work. This section authorizes the Board to require an applicant, certificate holder, or licensee to submit to a mental or physical examination when the Board is considering whether the individual is mentally or physically capable of practicing social work with reasonable skill or safety. This section does not require the Board to petition the court to order the individual to undergo the examination(s). These provisions are substantially the same as those in the Medical Practice Act.

Opportunity for Hearing. This section requires the Board to provide the opportunity for a hearing to an individual whose certificate or license has been subjected to disciplinary action, or prior to any disciplinary action. It also provides that if an individual waives the opportunity for a hearing, the Board's disciplinary action is final. Finally, there is no entitlement to a hearing for failure to pass an exam. This section is substantially the same as the Psychology Practice Act.

Records. This section allows the Board to withhold the identity of any client who has not consented to public disclosure in Board proceedings against an applicant, certificate holder, or licensee. The Board would also be authorized to close hearings to the public if necessary to protect the rights of a client. Furthermore, documents containing information complied by on or behalf of the Board as a result of an investigation, inquiry, or interview conducted in connection with certification, licensure, or a disciplinary matter are not considered public records. However, notices, statements of charges, notices of hearing, decisions rendered in connection with a hearing, and all other information compiled by or on behalf of the Board, except for information identifying a client who has not consented to public disclosure, are public records. These requirements are substantially the same as those in the Psychology Practice Act.

EFFECTIVE DATE: The act becomes effective July 1, 1999.

Martha Walston, Committee Counsel, Senate Finance Committee, contributed to this summary.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1119

Short Title: Perfusionist Licensure. (Public)

Sponsors: Senators Lucas; and Kinnaird.

Referred to: Judiciary I.

April 15, 1999

A BILL TO BE ENTITLED

AN ACT AUTHORIZING THE LICENSURE OF PERFUSIONISTS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Chapter to read:

"ARTICLE 37.

"Perfusionist Licensure Act.

"**§ 90-646. Legislative findings.**

The General Assembly finds that the practice of perfusion is an area of health care that is continually evolving to include more sophisticated and demanding patient care activities. The General Assembly further finds that the practice of perfusion by unauthorized, unqualified, unprofessional, and incompetent persons is a threat to public health, safety, and welfare, and therefore it is necessary to establish minimum standards of education, training, and competency for persons engaged in the practice of perfusion.

"**§ 90-647. Definitions.**

The following definitions apply in this Article:

(1) Advisory Committee. -- The Perfusion Advisory Committee.

(2) Certificate holder. -- A person who has been issued a certificate to practice perfusion as a clinical certified perfusionist.

(3) Clinical certified perfusionist. -- A person who has been issued a certificate to practice perfusion by the American Board of Cardiovascular Perfusion (ABCP).

(4) Extracorporeal circulation. -- The diversion of a patient's blood through a heart-lung machine or a similar device that assumes the functions of the patient's heart, lungs, kidneys, liver, or other organs.

(5) Licensee. -- A person who has been issued a license to practice perfusion under this Article.

(6) Perfusion. -- The performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, or a combination of those functions, and the ensuring of safe management of physiological function by monitoring and analyzing the parameters of the systems under the supervision of a licensed physician. The term also includes the use of extracorporeal circulation, long-term cardiopulmonary support techniques, including extracorporeal carbon-dioxide removal and extracorporeal membrane oxygenation, and associated therapeutic and diagnostic technologies; counterpulsation, ventricular assistance, autotransfusion, blood conservation techniques, myocardial and organ preservation, extracorporeal life support, and isolated limb perfusion; the use of techniques involving blood management, advanced life support, and other related functions; and, in the performance of the acts described in this subsection, (i) the administration of pharmacological and therapeutic agents, blood products or anesthetic agents through the extracorporeal circuit or through an intravenous line as ordered by a physician; (ii) the performance and use of anti-coagulation monitoring and analysis, physiologic monitoring and analysis, blood gas and chemistry monitoring and analysis, hematological monitoring and analysis, hypothermia, hyperthermia, hemoconcentration and hemodilution, and hemodialysis in conjunction with perfusion service; and (iii) the observation of signs and symptoms related to perfusion services, the determination of whether the signs and symptoms exhibit abnormal characteristics, and the implementation of appropriate reporting, perfusion protocols, or changes in or the initiation of emergency procedures.

(7) Perfusion protocols. -- Perfusion-related policies and protocols developed or approved by a licensed health care facility or a physician through colloboration with administrators, licensed perfusionists, and other health care professionals.

"**§ 90-648. License required; exemptions.**

(a) On or after January 1, 2000, no person shall practice or offer to practice perfusion as defined in this Article, use the title 'licensed perfusionist', 'certified clinical perfusionist', or 'provisional licensed perfusionist', use the letters 'LP', 'CCP', or 'PLP', or otherwise indicate or imply that the person is a licensed perfusionist,

clinical certified perfusionist, or a provisionally licensed perfusionist unless that person is currently licensed or certified as provided in this Article.

(b) The provisions of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State if the person is performing work incidental to the practice of that profession or occupation and the person does not represent himself or herself as a licensed perfusionist, a clinical certified perfusionist, or a provisionally licensed perfusionist.

(2) A student enrolled in an accredited perfusion education program if perfusion services performed by the student are an integral part of the student's course of study and are performed under the direct supervision of a licensed perfusionist.

(3) A perfusionist employed by the United States government when performing duties associated with that employment.

(4) A person performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

"**§ 90-649. Perfusion Advisory Committee.**

(a) Composition and Terms. -- The North Carolina Perfusion Advisory Committee is created. The Committee shall consist of seven members who shall serve staggered terms. The initial Committee members shall be selected on or before October 1, 1999, as follows:

(1) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint two licensed perfusionists and one physician who is licensed under Article 1 of Chapter 90 of the General Statutes, who shall each serve a term of three years.

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint two licensed perfusionists and one physician who is licensed under Article 1 of Chapter 90 of the General Statutes, who shall each serve a term of two years.

(3) The Governor shall appoint one public member who shall serve a term of one year.

Upon the expiration of the terms of the initial Committee members, members shall be appointed for a term of three years and shall serve until a successor is appointed. No member may serve more than two consecutive full terms.

(b) Qualifications. -- Members of the Committee shall be citizens of the United States and residents of this State. The perfusionist members shall hold current licenses from the Committee and shall remain in good standing with the Committee during their terms. Public members of the Committee shall not be: (i) trained or experienced in the practice of perfusion, (ii) an agent or employee of a person engaged in the practice of perfusion, (iii) a health care professional licensed under

this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

(c) Vacancies. -- Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(d) Removal. -- The Committee may remove any of its members for neglect of duty, incompetence, or unprofessional conduct. A member subject to disciplinary proceedings in his or her capacity as a licensed perfusionist shall be disqualified from participating in the official business of the Committee until the charges have been resolved.

(e) Compensation. -- Each member of the Committee shall receive per diem and reimbursement for travel and subsistence as provided in G.S. 93B-5.

(f) Officers. -- The officers of the Committee shall be a chair, a vice-chair, and other officers deemed necessary by the Committee to carry out the purposes of this Article. All officers shall be elected annually by the Committee for two-year terms and shall serve until their successors are elected and qualified. The chair of the Committee shall be a licensed perfusionist.

(g) Meetings. -- The Committee shall hold its first meeting within 30 days after the appointment of its members, and shall hold at least two meetings each year to conduct business and to review the standards and rules previously adopted by the Committee. The Committee shall establish the procedures for calling, holding, and conducting regular and special meetings. A majority of Committee members constitutes a quorum.

"**§ 90-650. Powers of the Committee.**

The Committee shall have the power and duty to:

(1) Administer this Article.

(2) Issue interpretations of this Article.

(3) Adopt, amend, or repeal rules as may be necessary to carry out the provisions of this Article.

(4) Employ and fix the compensation of personnel that the Committee determines is necessary to carry into effect the provisions of this Article and incur other expenses necessary to effectuate this Article.

(5) Examine and determine the qualifications and fitness of applicants for licensure and certification, provisional licensure, licensure and certificate renewal, and reciprocal licensure and certification.

(6) Issue, renew, deny, suspend, or revoke licenses and certificates, order probation, issue reprimands, and carry out any other disciplinary actions authorized by this Article.

(7) Set fees for licensure and certification, provisional licensure, reciprocal licensure and certification, licensure and certificate renewal, and other services deemed necessary to carry out the purposes of this Article.

(8) Establish continuing education requirements for licensees.

(9) Establish a code of ethics for licensees.

(10) Maintain a current list of all persons who have been licensed or certified under this Article.

(11) Conduct investigations for the purpose of determining whether violations of this Article or grounds for disciplining licensees and certificate holders exist.

(12) Maintain a record of all proceedings and make available to all licensees, certificate holders, and other concerned parties an annual report of all Committee action.

(13) Adopt a seal containing the name of the Committee for use on all official documents and reports issued by the Committee.

"**§ 90-651. Qualifications for licensure and certification.**

(a) An applicant shall be licensed to practice perfusion if the applicant meets all of the following qualifications:

(1) Is at least 18 years old.

(2) Completes an application on a form provided by the Committee.

(3) Successfully completes a perfusion education program approved by the Committee.

(4) Passes an examination administered by the Committee.

(5) Pays the required fee under G.S. 90-654.

(b) An applicant shall be certified as a certified clinical perfusionist if the applicant submits proof satisfactory to the Committee that the applicant has been certified as a certified clinical perfusionist by the American Board of Cardiovascular Perfusion or its successor organization and pays the required fee under G.S. 90-654.

"**§ 90-652. Reciprocity.**

The Committee may grant, upon application and payment of proper fees, a license to a person who has been licensed to practice perfusion in another state or territory of the United States whose standards of competency are substantially equivalent to those provided in this Article or holds a current certificate as a certified clinical perfusionist issued by the American Board of Cardiovascular Perfusion or its successor organization.

"**§ 90-653. Provisional license.**

The Committee may grant a provisional license or certificate for a period not exceeding 12 months to any applicant who has successfully completed an approved perfusion education program and pays the required fee under G.S. 90-654. A provisional license or certificate shall allow the individual to practice perfusion under

the supervision and direction of a licensed perfusionist and in accordance with rules adopted pursuant to this Article. A license or certificate granted under this section shall contain an endorsement indicating that the license or certificate is provisional and stating the terms and conditions of its use by the licensee or certificate holder and shall state the date the license or certificate was granted and the date it expires. Provisional licenses and certificates shall be renewed in accordance with the provisions of G.S. 90-655.

"**§ 90-654. Expenses; fees.**

(a) All fees payable to the Committee shall be deposited in the name of the Committee in financial institutions designated by the Committee as official depositories and shall be used to pay all expenses incurred in carrying out the purposes of this Article.

(b) All salaries, compensation, and expenses incurred or allowed to carry out the purposes of this Article shall be paid by the Committee exclusively out of the fees received by the Committee as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligation of the Committee be charged against the State treasury.

(c) The Committee shall establish fees not exceeding the following amounts:

(1)	Initial application	$ 25.00
(2)	Examination or re-examination	$150.00
(3)	Issuance of license or certificate	$100.00
(4)	Renewal of license or certificate	$ 50.00
(5)	Late renewal of license or certificate	$ 50.00
(6)	Provisional license or certificate	$ 35.00
(7)	Copies of rules	Cost

"**§ 90-655. Renewal of licenses and certificates.**

(a) All licenses and certificates to practice perfusion shall expire one year after the date they were issued. The Committee shall send a notice of expiration to each licensee or certificate holder at his or her last known address at least 30 days prior to the expiration of his or her license. All applications for renewal of unexpired licenses and certificates shall be filed with the Committee and accompanied by proof satisfactory to the Committee that the applicant has completed the continuing education requirements established by the Committee and the renewal fee as required by G.S. 90-654.

(b) An application for renewal of a license or certificate that has been expired for less than two years shall be accompanied by proof satisfactory to the Committee that the applicant has satisfied the continuing education requirements established by the Committee and the renewal and late fees required by G.S. 90-654. A license or certificate that has been expired for more than two years shall not be renewed, but the applicant may apply for a new license or certificate by submitting to reexamination and complying with the current requirements for licensure and certification under this Article. The Committee may renew an expired license or certificate without examination if the applicant moved to another state and has been

licensed or certified in that state for two years preceding the application of renewal, and the applicant pays the renewal fee required by G.S. 90-654.

"**§ 90-656. Suspension, revocation, and refusal to renew.**

(a) The Committee may deny, refuse to renew, suspend, or revoke an application, license, or certificate, or order probation or issue a reprimand if the applicant, licensee, or certificate holder:

(1) Gives false information or withholds material information from the Committee in procuring or attempting to procure a license or certificate.

(2) Gives false information or withholds material information from the Committee during the course of an investigation conducted by the Committee.

(3) Has been convicted of or pled guilty or no contest to a crime that indicates the person is unfit or incompetent to practice perfusion as defined in this Article or that indicates the person has deceived, defrauded, or endangered the public.

(4) Has a habitual substance abuse or mental impairment that interferes with his or her ability to provide appropriate care as established by this Article or rules adopted by the Committee.

(5) Has demonstrated gross negligence, incompetency, or misconduct in the practice of perfusion as defined in this Article.

(6) Has had an application for licensure or certification or a license or certificate to practice perfusion in another jurisdiction denied, suspended, or revoked for reasons that would be grounds for similar action in this State.

(7) Has willfully violated any provision of this Article or rules adopted by the Committee.

(b) The taking of any action authorized under subsection (a) of this section may be ordered by the Committee after a hearing is held in accordance with Article 3A of Chapter 150B of the General Statutes. The Committee may reinstate a revoked license or certificate if it finds that the reasons for revocation no longer exist and that the person can reasonably be expected to perform the services authorized under this Article in a safe manner.

"**§ 90-657. Enjoining illegal practices.**

The Committee may apply to the superior court for an order enjoining violations of this Article. Upon a showing by the Committee that any person has violated this Article, the court may grant injunctive relief."

Section 2. Notwithstanding the requirements of this Act, the North Carolina Perfusion Advisory Committee shall issue a license to practice perfusion to any person who has, as his or her primary job function, been operating cardiopulmonary bypass systems during cardiac surgery cases in a licensed health care facility in the five years immediately preceding application to the Committee or within five of the last eight years preceding application to the Committee. A

perfusionist member of the Committee shall apply for and obtain a license from the Committee within 90 days after the Board begins issuing licenses.

Section 3. This act is effective when it becomes law.

SENATE BILL 1119:
Perfusionist Licensure

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senators Lucas and Kinnaird
Date:	June 23, 1999	**Summary by:**	John Young
Version:	One		Senior Analyst

SUMMARY: Requires persons practicing perfusion as defined in the act to be licensed unless exempted for reasons specified in the act. The act also establishes the following: (1) the Perfusion Advisory Committee; (2) composition and powers of the Advisory Committee; (3) qualifications for licensure; (4) licensing fees; and (5) renewal, suspension, and revocation of licenses. There is a "grandfather" provision for professionals who meet specified practice requirements during the five of last eight years preceding application for licensure.

BACKGROUND: Cardiovascular perfusionists are operating room specialists who assist in cardiopulmonary bypass procedures in support of cardiac surgeons. They are also skilled to give auxiliary cardiac support for circulatory failure and pump-oxygenation for prolonged support of lung and heart functions. The American Board of Cardiovascular Perfusionists (ABCP) certifies applicants as competent to practice profusion after sucessful completion of an examination. There are currently 91 perfusionists practicing in 22 open-heart centers in North Carolina. Perfusionists are licensed in four states, and licensure legislation is pending in five other states.

BILL SUMMARY: Senate Bill 1119 would require anyone who practices perfusion or uses the title "perfusionist" to be licensed, effective January 1, 2000. "Perfusion is defined as the performing of functions necessary for the support, treatment, measurement, or supplementation of the cardiovascular, circulatory, and respiratory systems or other organs, and the safe management of physiological functions, all under the supervision of a physician.

Who is exempt from licensure?

- Persons who are licensed, registered, certified, or credentialed in another occupation if the person is practicing within his or her scope of practice and not representing himself or herself as a perfusionists.
- Students enrolled in an accredited perfusionist education program if working under the supervision of a licensed perfusionist.
- Perfusionists employed by the US government when performing duties associated with that employment.
- Persons performing autotransfusion or blood conservation techniques under the direct supervision of a licensed physician.

Qualifications for licensure.

- Be at least 18.
- Complete an approved perfusion education program.
- Pass the examination administered by the Committee.
- Pay the required fee.

To qualify for certification as a certified clinical perfusionist, an applicant must be certified by the American Board of Cardiovascular Perfusionist and pay a required fee.

Perfusionist Advisory Committee.

Membership: The Committee will consist of seven members, as follows:

- 2 licensed perfusionists appointed by the President Pro Tempore of the Senate.
- 1 physician appointed by the President Pro Tempore of the Senate.
- 2 licensed perfusionists appointed by the Speaker of the House.
- 1 physician appointed by the Speaker of the House.
- 1 public member appointed by the Governor.

Powers of the Committee. The Committee's powers and duties include:

- Determine qualifications for licensure and certification.
- Conduct investigations in connection with disciplinary actions.
- Issue, renew, deny, suspend, or revoke licenses or certificates.
- Establish continuing education requirements.
- Establish a code of ethics for licensees.

"Grandfathering"/Reciprocity. The Perfusion Advisory Committee

- Shall issue a license to practice perfusion to any person whose primary job has been operating cardiopulmonary bypass systems in the 5 years immediately preceding application to the Committee or within 5 of the past 8 years immediately preceding application.

- May grant a license to a person who is licensed to practice in another jurisdiction whose standards of competency are substantially the same as in North Carolina.

- May grant a provisional license or certificate to an applicant who has successfully completed an approved education program and paid the required fee. A provisional license or certificate allows the person to practice perfusion under the supervision of a licensed perfusionist.

Fees. Fees established by the Committee may not exceed the following amounts:

• Initial application	$25.00
• Examination or re-examination	$150.00
• Issuance of license or certificate	$100.00
• Renewal of license or certificate (annually)	$50.00
• Late renewal of license or certificate	$50.00
• Provisional license or certificate	$35.00

*Summary assistance provided by Mary Shuping

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — **JUNE 23, 1999**

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Robin Webb Corbett	NCNA? East Carolina University - School of Nursing
Marjorie Howe, CCSW	NC Soc for Clinical Soc Work
Myra M. Miller, MSW, JD	NASW-NC
Jane Black Moorman MSW CCSW BCD	N.C. Certification Board for Social Work
Jeff Welch	Sen. Lee
Beckie Street	PPAB
Jack Cozart	PPAB
Hugh Wilson	NCHA
Amy Jo Bain	NCMS

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **June 30, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1470, Impaired Dental Hygienists/Fee** **Representative Allen**

Senator William R. Purcell, Chair

NOTE: THIS MEETING HAS BEEN CANCELLED!

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

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DATE: **June 30, 1999**
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The following bills or resolutions will be considered:

- **H.B. 1470, Impaired Dental Hygienists/Fee** **Representative Allen**

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **July 7, 1999**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 1470, Impaired Dental Hygienists/Fee** **Representative Allen**

Senator William R. Purcell, Chair

SENATE HEALTH CARE COMMITTEE

Wednesday, July 7, 1999

MINUTES

The Senate Committee on Health Care met Wednesday, July 7, 1999, at 12:03 P.M. in Room 1124 in the Legislative Building. Eight members were present, including the Chair, Senator William R. Purcell, who presided. He introduced Senate Pages Bryce Davenport of Raleigh, sponsored by Senator Reeves; and Harley Sisler of Hattaras, sponsored by Senator Basnight.

In the absence of Representative Allen, who had a scheduling conflict, Senator Purcell introduced Mr. William H. Potter, Jr., lobbyist for the North Carolina Dental Society. Mr. Potter explained H.B. 1470, *Impaired Dental Hygienists/Fee.* After a brief discussion, Senator Rucho moved for a favorable report. The motion carried unanimously. The meeting adjourned at 12:11 P.M.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Clerk

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, July 07, 1999

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1470** Impaired Dental Hygienists/Fee
Sequential Referral: Finance
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1470
Committee Substitute Favorable 6/8/99

Short Title: Impaired Dental Hygienists/Fee. (Public)

Sponsors:

Referred to:

May 13, 1999

A BILL TO BE ENTITLED

AN ACT ALLOWING THE NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS TO ENTER INTO AGREEMENTS WITH SPECIAL IMPAIRED DENTIST PEER REVIEW ORGANIZATIONS TO INCLUDE PROGRAMS FOR IMPAIRED DENTAL HYGIENISTS, TO COLLECT FEES TO FUND SUCH PROGRAMS, AND TO PROVIDE FOR REPRESENTATION FOR DENTAL HYGIENISTS ON THE STATEWIDE SUPERVISORY COMMITTEE.

The General Assembly of North Carolina enacts:

Section 1. Article 2 of Chapter 90 is amended by adding a new section to read:

"**§ 90-48.3. Board authority to include impaired dental hygienists in programs developed for impaired dentists.**

The Board may enter into agreements with special impaired dentist peer review organizations to include programs for impaired dental hygienists, and the provisions of G.S. 90-48.2 shall apply to any such agreements and programs. Special impaired dentist peer review organizations shall have the authority to appoint to the organizations, upon the recommendation of the dental hygienist member of the Board, one additional member who is a licensed dental hygienist and the member shall participate in activities and programs as they relate to impaired dental hygienists. Peer liaisons and volunteers participating in programs for impaired dental hygienists shall be dental hygienists. Dental hygienists who work with special impaired dentist peer review organizations in conducting programs for impaired dental hygienists shall have the same protections and responsibilities as members of

traditional State and local dental society peer review committees under Article 2A of this Chapter and as provided in G.S. 90-48.2. The provisions of G.S. 90-48.2 regarding confidentiality shall also be applicable to all dental hygienist activities authorized under this section."

Section 2. G.S. 90-223 is amended by adding a new subsection to read:

"(e) The Board shall have the authority to provide for programs for impaired dental hygienists as authorized in G.S. 90-48.3."

Section 3. G.S. 90-232 reads as rewritten:

"**§ 90-232. Fees.**

In order to provide the means of carrying out and enforcing the provisions of this Article and the duties devolving upon the North Carolina State Board of Dental Examiners, it is authorized to charge and collect fees established by its rules and regulations not exceeding the following:

(1)	Each applicant for examination	$125.00
(2)	Each renewal certificate, which fee shall be annually fixed by the Board and not later than November 30 of each year it shall give written notice of the amount of the renewal fee to each dental hygienist licensed to practice in this State by mailing such notice to the last address of record with the Board of each such dental hygienist	60.00
(3)	Each restoration of license	60.00
(4)	Each provisional license	60.00
(5)	Each certificate of license to a resident dental hygienist desiring to change to another state or territory	25.00
(6)	Annual fee to be paid upon license renewal to assist in funding programs for impaired dental hygienists	40.00.

In no event may the annual fee imposed on dental hygienists to fund the impaired dental hygienists program exceed the annual fee imposed on dentists to fund the impaired dentist program. All fees shall be payable in advance to the Board and shall be disposed of by the Board in the discharge of its duties under this Article."

Section 4. G.S. 90-48.2(a) reads as rewritten:

"(a) The State Board of Dental Examiners may, under rules adopted by the Board in compliance with Chapter 150B of the General Statutes, enter into agreements with special impaired dentist peer review organizations formed by the North Carolina Dental Society. The organizations shall be made up of Dental Society members designated by the Society, the Board, and the Dental School of the University of North Carolina. Peer review activities to be covered by such agreements shall include investigation, review and evaluation of records, reports, complaints, litigation, and other information about the practices and practice patterns of dentists licensed by the Board, as such matters may relate to impaired dentists. Special impaired dentist peer review organizations may include a statewide supervisory committee and various

regional and local components or subgroups. The statewide supervisory committee shall consist of representatives from the North Carolina Dental Society, the UNC School of Dentistry, and the Board. When the statewide supervisory committee considers activities and programs that relate to impaired dental hygienists pursuant to G.S. 90-48.3, its membership shall be expanded to include two dental hygienists appointed upon the recommendation of the dental hygienist member of the Board."

Section 5. This act is effective when it becomes law.

HOUSE BILL 1470:
Impaired Dental Hygienists/Fee

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Allen
Date:	July 8, 1999	**Summary by:**	Cindy Avrette/Linda Attarian
Version:	Second Edition		

SUMMARY:House Bill 1470 authorizes the State Board of Dental Examiners to include impaired dental hygienists in programs developed for impaired dentists. The bill imposes an additional $40 annual fee on dental hygienists to support the programs for impaired dental hygienists.

CURRENT LAW: The "Caring Dentist Program" is a program established through agreements between the State Board of Dental Examiners and special impaired dentist peer review organizations formed by the North Carolina Dental Society. The purpose of the program is to identify dentists who have a chemical dependency or a mental illness. If an impairment exists, the peer review organization seeks to intervene and treat the dentist. The peer review organization must report information to the State Board of Dental Examiners if it determines that:

- The dentist constitutes an imminent danger to the public or himself.
- The dentist refuses to cooperate with the program, refuses to submit to treatment, or is still impaired after treatment and exhibits professional incompetence.
- It reasonably appears that there are other grounds for disciplinary action.

The agreements, which establish the Caring Dentist Program, must provide for the investigation, review, and evaluation of information about the practice of licensed dentists as the practices may relate to an impairment. They must also provide for the identification, intervention, treatment, referral, and follow-up care of impaired dentists and for the due process rights of the dentist subject to the Program.

The members of the special impaired dentist peer review organization are volunteer Dental Society members selected by the Board of Directors of the Caring Dentist Program. The members may not be held liable in damages to any person for any action taken or recommendation made within the scope of the functions of that committee. As a general rule, the proceedings and records of a committee must be held in confidence and may not be subject to discovery or introduction into evidence in any civil action arising out of the matters which are the subject of an evaluation and review by the committee

The Board of Directors of the Caring Dentist Program is comprised of representatives from the Dental Society, the State Board of Dental Examiners, and the UNC School of Dentistry. Dentists must pay an annual fee of $50, in addition to the annual renewal fee, to help support the special peer review organizations for impaired dentists.

BILL ANALYSIS: House Bill 1470 would allow the State Board of Dental Examiners to enter into agreements with special impaired dentist peer review organizations to include programs for impaired dental hygienists. The provisions required to be in the agreements concerning impaired dentists would also apply to the agreements concerning impaired dental hygienists.

The bill would give the special impaired dentist peer review organizations the authority to appoint to the organizations one additional member who is a licensed dental hygienist. The organization would make the appointment upon the recommendation of the dental hygienist member of the State Board of Dental Examiners. The dental hygienist member of the State Board is elected by all the licensed dental hygienists. The dental hygienist member of the peer review organization would participate in activities and programs as they relate to impaired dental hygienists. Dental hygienists who work with the special peer review organizations would have the same responsibilities and protections that the dental members have. Peer liaisons and volunteers who work with impaired dental hygienists would be dental hygienists.

The bill would add two dental hygienists to the statewide supervisory committee of the Caring Dentist Program. The dental hygienist members would be present whenever the Committee considers activities and programs that relate to impaired dental hygienists. The two dental hygienists would be appointed to the committee upon the recommendation of the dental hygienist member of the Board.

The bill would also impose an additional annual fee on dental hygienists. The fee could not exceed $40, not could it exceed the annual fee amount imposed on dentists for the impaired dentist program. The fee would be payable upon license renewal. Licenses must be renewed on or before January 1 of each year. The fee would be used to help fund programs for impaired dental hygienists.

VISITOR REGISTRATION SHEET

Health Care — July 7. 99
Name of Committee — Date

VISITORS: PLEASE SIGN BELOW AND RETURN TO COMMITTEE CLERK.

NAME	FIRM OR AGENCY AND ADDRESS
J Craig Lewis	PCMH
Jan Ramquist	NCADH

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on **Health Care** will meet at the following time:

DATE: **Wednesday, July 14, 1999**
TIME: **12:00 Noon**
ROOM: **1027, Legislative Building**

The following bills or resolutions will be considered:

- **H.B. 996, Regulate Spinal Manipulation** **Representative Wright**

Senator William R. Purcell, Chair

NOTICE: THIS MEETING HAS BEEN CANCELLED

Principal Clerk ___
Reading Clerk ___

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Senator William R. Purcell, Chair

2000

SENATE HEALTH CARE COMMITTEE

MINUTES

SENATE HEALTH CARE COMMITTEE

Chairman:
William R. Purcell

Vice Chairs:
Jeanne H.Lucas
William N. Martin
Stephen M.Metcalf
Jim W. Phillips, Sr.

Ranking Minority:
Robert A. Rucho

Members:
Roy A. Cooper III
Charlie S. Dannelly
James S.Forrester
John Garwood
Kay R.Hagan
Fletcher L.Hartsell, Jr.
Brad Miller
Kenneth R. Moore
Beverly Eaves Perdue
Ed Warren
David F.Weinstein

Staff:
Linda Attarian
John Young

Committee Clerk:
Lorraine R. Blake

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium — SENATE: HEALTH CARE — Valid Through 27-JUL-2000

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
H 96	EDWARDS	ADULT CARE HOME/LIC. EXEMPT	R -CH. SL 99-0193	04-26-99	06-07-99
H 190=	CANSLER	STATE HOSPITALS/PEER REVIEW	*R -CH. SL 99-0222	04-01-99	06-09-99
H 678	SHERRILL	ACUPUNCTURIST REIMBURSEMENT	*S -REF TO COM ON HLTHCARE	05-18-99	
H 715	ALEXANDER	UTILIZATION REVIEW/ASAM CRITERIA	*R -CH. SL 99-0116	04-28-99	05-11-99
H 906	ALEXANDER	PHARMACIST PEER REVIEW	R -CH. SL 99-0081	04-19-99	05-11-99
H 944	CANSLER	EXTEND ADULT CARE HOME BED MORATORIU	R -CH. SL 99-0135	04-27-99	05-19-99
H 996=	WRIGHT	REGULATE SPINAL MANIPULATION	*S -REF TO COM ON HLTHCARE	04-29-99	
H1069=	ALEXANDER	SOCIAL WORKER LICENSURE	*R -CH. SL 99-0313	06-10-99	06-23-99
H1188	BOYD-MCINTYRE	RESEARCH STUDIES/WOMEN PARTICIPANTS	S -REF TO COM ON HLTHCARE	04-28-99	
H1193	NESBITT	HEALTH CARE PROFESSIONALS	*R -CH. SL 99-0226	04-29-99	05-20-99
H1193	NESBITT	HEALTH CARE PROFESSIONALS	*R -CH. SL 99-0226	05-26-99	06-09-99
H1258=	EARLE	HEALTH CARE PERSONNEL REGISTRY CHANG	*R -CH. SL 99-0159	04-28-99	05-26-99
H1340	TOLSON	RESPIRATORY CARE PRACTICE ACT	*H -PRES. TO GOV. 07-14	07-12-99	00-06-15
H1470	ALLEN	IMPAIRED DENTAL HYGIENISTS/FEE	*R -CH. SL 99-0382	06-21-99	07-07-99
H1514=	MELTON	RESPITE CARE PROGRAM NOT SUNSET	*R -CH. SL 00-0050	00-06-07	00-06-14
H1519=	INSKO	MENTAL HEALTH SYSTEM REFORM	*R -CH. SL 00-0083	00-06-22	00-06-28
H1520=	INSKO	RESTRAINTS IN FACILITIES	R -CH. SL 00-0129	00-06-22	00-06-28
H1838	CULPEPPER	STATE HEALTH PLAN AMENDMENTS	*S -RE-REF COM ON APPROPR	00-06-30	00-07-05
S 10=	PERDUE	LONG-TERM CARE SAFETY INITIATIVE	*R -CH. SL 99-0334	01-28-99	04-28-99
S 26=	PURCELL	CHIP CLINICS/REPEAL PROHIBITION	R -CH. SL 99-0004	02-04-99	02-11-99
S 60=	**WARREN E**	**HEART DISEASE PREV. FUNDS**	**S -RE-REF COM ON HLTHCARE**	**05-19-99**	
S 65=	PURCELL	MOTOR VEHICLE OCCUPANT RESTRAINTS	*R -CH. SL 99-0183	02-10-99	03-31-99
S 90=	FORRESTER	INSURANCE/COVER CONTRACEPTIVES	*R -CH. SL 99-0231	02-15-99	03-03-99
S 160	PERDUE	NURSE REHABILITATION	R -CH. SL 99-0291	02-22-99	03-24-99
S 194	RAND	NURSE LICENSURE COMPACT	*R -CH. SL 99-0245	03-01-99	03-24-99
S 198=	CARTER	ADULT CARE HOME LICENSURE	*R -CH. SL 99-0113	03-01-99	03-24-99
S 273	ODOM	CANCER CONTROL REPORTING	*R -CH. SL 99-0033	03-08-99	03-24-99
S 344	FORRESTER	MGD CARE/SPECIALIST REFERRAL	R -CH. SL 99-0168	03-15-99	04-07-99
S 345	FORRESTER	URO REVIEWS BY NC PHYSICIANS	R -CH. SL 99-0391	03-15-99	04-07-99
S 348	FORRESTER	STOP MISUSE OF LASER POINTERS	*R -CH. SL 99-0401	03-15-99	04-19-99

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BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

NORTH CAROLINA GENERAL ASSEMBLY

COMMITTEE SUMMARY REPORT

1999-2000 Biennium SENATE: HEALTH CARE Valid Through 27-JUL-2000

BILL	INTRODUCER	SHORT TITLE	LATEST ACTION ON BILL	IN DATE	OUT DATE
S 540=	JORDAN	ORTHOPAEDIC PHYSICIAN ASSISTANTS	S -REF TO COM ON HLTHCARE	03-29-99	
S 614	PURCELL	IMMUNIZATION LAW CHANGES	*R -CH. SL 99-0110	03-29-99	04-22-99
S 620	LEE	AMEND PROFESSIONAL CORP ACT	R -CH. SL 99-0136	03-30-99	04-21-99
S 665=	SOLES	DENTISTS/DENTAL HYGIENISTS	*S -RE-REF COM ON RULES &	04-14-99	06-16-99
S 678=	ODOM	REGULATE SPINAL MANIPULATION	S -REF TO COM ON HLTHCARE	04-01-99	
S 685	LUCAS	HEALTH INSURANCE/PHYS. ASSISTANTS	R -CH. SL 99-0210	04-01-99	04-21-99
S 733=	SOLES	CHIROPRACTIC CLAIMS REVIEW	S -RE-REF COM ON COMMERCE	04-01-99	04-07-99
S 783=	COCHRANE	LONG-TERM CARE FACILITIES/DISCLOSURE	*S -FAILED CONCUR IN COM SUB	04-07-99	04-28-99
S 793	CLODFELTER	PSYCHOLOGY PRACTICE DEFINITIONS	R -CH. SL 99-0292	04-08-99	04-14-99
S 875=	LUCAS	CERTIFIED PROFESSIONAL MIDWIVES	S -REF TO COM ON HLTHCARE	04-13-99	
S 933	KINNAIRD	ADULT CARE HOMES/TRANSFERS	S -RE-REF COM ON HLTHCARE	04-22-99	
S 951	PERDUE	HEALTH CARE WORKERS/ID BADGE	*R -CH. SL 99-0320	04-14-99	04-21-99
S 960	SOLES	REGULATION OF PHARMACIES	H -REF TO COM ON HEALTH	04-15-99	04-28-99
S 961=	SOLES	MANAGED CARE/PATIENT ACCESS	S -REF TO COM ON HLTHCARE	04-15-99	
S1086	CARPENTER R	RESTRAINTS/DEATHS IN FACILITES	*S -RE-REF COM ON RULES &	04-15-99	04-28-99
S1091	PURCELL	HEP B IMMUNIZ. REQUIRED	S -REF TO COM ON HLTHCARE	04-15-99	
S1119	LUCAS	PERFUSIONIST LICENSURE	S -RE-REF COM ON HLTHCARE	05-11-99	
S1122	MOORE K	AREA MENTAL HEALTH/COUNTY APPROP	*R -CH. SL 99-0202	04-15-99	04-28-99
S1165=	PURCELL	CLINICAL PHARMACIST PRACTITIONER	*S -RE-REF COM ON FINANCE	04-15-99	04-27-99
S1176=	CARPENTER R	RESPITE CARE PROGRAM NOT SUNSET	S -RE-REF COM ON APPROPR	00-05-09	00-05-24
S1179=	RAND	HEALTH CARE REGISTRY REPORTS	*R -CH. SL 00-0055	00-05-09	00-05-31
S1215=	DANNELLY	MEDICAL CARE COMMN/RULES	*R -CH. SL 00-0111	00-05-11	00-06-07
S1217=	PHILLIPS	MENTAL HEALTH SYSTEM REFORM	S -RE-REF COM ON RULES &	00-05-11	00-06-07
S1221=	CARPENTER R	RESTRAINTS IN FACILITIES	S -REF TO COM ON HLTHCARE	00-05-15	
S1234=	PURCELL	LONG-TERM CARE RESIDENTS/IMMUN	*R -CH. SL 00-0112	00-05-15	00-05-31
S1254=	MARTIN W	MENTAL HEALTH/CHEM. DEP. PARITY	S -REF TO COM ON HLTHCARE	00-05-16	
S1258	**MARTIN W**	**MEDICAID FUNDS/DENTAL CARE**	***S -RE-REF COM ON APPROPR**	**00-05-16**	**00-06-12**
S1384	RAND	STATE HEALTH PLAN CHANGES	S -REF TO COM ON HLTHCARE	00-05-23	
S1431=	**PURCELL**	**HEALTH STANDARDS/SECRETARY HHS**	**S -RE-REF COM ON APPROPR**	**00-05-25**	**00-06-07**
S1437	GULLEY W	HIGH-RISK INTERV. COV/STATE HEALTH P	S -REF TO COM ON HLTHCARE	00-05-25	

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BOLDED LINE INDICATES BILL INDEXED AS AFFECTING APPROPRIATIONS.

SENATE HEALTH CARE COMMITTEE
1999-2000 SESSION

Bill No.	Bill Title	Sponsor	Date in Committee	Disposition	Final Disposition
S.B. 10	Long-Term Care Safety Initiative	Perdue	April 28, 1998	Committee substitute voted fav., reported out.	Signed by Governor 7/22/99
S.B. 26	CHIP Clinics/Repeal Prohibition	Purcell	February 10, 1999	Favorable report.	Signed by Governor 3/18/99
S.B. 60	Heart Disease Prev. Funds	Warren		Held for further consideration.	
S.B. 65	Motor Vehicle Occupant Restraints	Purcell	March 31, 1999	Committee substitute voted fav., reported out.	Signed by Governor 6/17/99
S.B. 90	Insurance/Cover Contraceptives	Forrester	February 17, 1999	Discussed in Committee, no vote. Committee substitute voted fav., reported out.	Signed by Governor 6/30/99
S.B. 160	Nurse Rehabilitation	Perdue	March 24, 1999	Voted favorable, reported out.	Signed by Governor 7/14/99
S.B. 194	Nurse Licensure Compact	Rand	March 24, 1999	Voted favorable, reported out.	Signed by Governor 7/2/99
S.B. 198	Adult Care Home Licensure	Carter	March 24, 1999	Voted favorable as amended, reported out.	Signed by Governor 5/28/99
S.B. 273	Cancer Control Reporting	Odom	March 24, 1999	Voted favorable, reported out.	Signed by Governor 5/7/99
S.B. 344	Mgd. Care/Specialist Referral	Forrester	April 7, 1999	Committee substitute voted fav., reported out.	Signed by Governor 6/8/99
S.B. 345	URO Reviews by NC Physicians	Forrester	April 7, 1999	Voted favorable, reported out.	Signed by Governor 8/4/99
S.B. 348	Stop Misuse of Laser Pointers	Forrester	April 7, 1999 April 14, 1999	Discussed, held for further consideration. Committee substitute reported favorable	Signed by Governor 8/5/99
S.B. 540	Orthopaedic Physicians Assistants	Jordan		Held for further consideration.	
S.B. 614	Immunization Law Changes	Purcell	April 21, 1999	Committee substitute voted fav., reported out.	Signed by Governor 5/28/99
S.B. 620	Amend Professional Corp. Act	Lee	April 21, 1999	Voted favorable, reported out.	Signed by Governor 6/4/99

Bill No.	Bill Title	Sponsor	Date in Committee	Disposition	Final Disposition
S.B. 665	Dental Hygienists	Soles	June 15, 1999	Voted fav. for com. sub., reported out.	Re-ref. to Senate Rules Com. 6/16/99
S.B. 678	Regulate Spinal Manipulation	Odom		Held for further consideration.	
S.B. 685	Health Insurance/Phys. Assistants	Lucas	April 21, 1999	Voted favorable, reported out.	Signed by Governor 6/25/99
S.B. 783	Long-Term Care Facilities/Disclosure	Cochrane	April 28, 1999	Committee substitute voted fav., reported out	Senate failed to concur with Committee Substitute 7/20/99
S.B. 793	Psychology Practice Definitions	Clodfelter	April 14, 1999	Voted favorable, reported out.	Signed by Governor 7/14/99
S.B. 875	Certified Professional Midwives	Lucas		Held for further consideration.	
S.B. 933	Adult Care Homes/Transfers	Kinnaird	April 28, 1999	Withdrawn by sponsor.	
S.B. 951	Health Care Workers/ID Badge	Perdue	April 21, 1999	Committee substitute voted fav., reported out.	Signed by Governor 7/15/99
S.B. 960	Regulation of Pharmacies	Soles	April 28, 1999	Committee substitute voted fav., reported out.	Ref. to House Health Com. 4/29/99
S.B. 961	Managed Care/Patient Access	Soles		See H.B. 736	
S.B. 1086	Restraints/Deaths in Facilities	Carpenter, R.	April 28, 1999	Committee substitute voted fav., reported out.	Re-ref. to Senate Rules Com. 4/28/99
S.B. 1091	Hep B Immuniz. Required	Purcell		Held for further consideration.	
S.B. 1122	Area Mental Health/County Approp	Moore, K.	April 21, 1999 April 28, 1999	Chair displaced bill. Committee substitute voted fav., reported out.	Signed by Governor 6/21/99
S.B. 1165	Clinical Pharmacist Practitioner	Purcell	April 27, 1999	Committee substitute voted fav., reported out.	Re-ref. to Senate Finance Com. 4/27/99
S.B. 1119	Perfusionist Licensure	Lucas	June 23, 1999	Discussed, held for further consideration.	
S.B. 1176	Respite Care Program No Sunset	Carpenter	May 24, 2000	Voted fav., reported out 5/24/00; seq. referral to App., Base Budget.	See H.B. 1514

Bill No.	Bill Title	Sponsor	Date in Committee	Disposition	Final Disposition
S.B. 1179	Health Care Registry Reports	Rand	May 31, 2000	Comm. sub. voted fav., reported out.	Signed by Governor 6/30/00
S.B. 1215	Medical Care Commission/Rules	Dannelly	June 7, 2000	Voted fav., reported out.	Signed by Governor 7/14/00
S.B. 1217	Mental Health System Reform	W. Martin	June 7, 2000	Voted fav., seq. referral to Rules	See H.B. 1519
S.B. 1221	Restraints in Facilities	Carpenter			See H.B. 1520
S.B. 1234	Long-Term Care Residents Immunization	Purcell	May 31, 2000	Comm. sub. voted fav. reported out.	Signed by Governor 7/14/00
S.B. 1254	Mental Health/Chemical Dependency Parity	Martin		Held for further consideration.	
S.B. 1258	Medicaid Funds/Dental Care	Martin	June 7, 2000	Comm. sub. fav. report, referred to App./Base Budget	No further action.
S.B. 1384	State Health Plan Changes	Rand			See H.B. 1855.
S.B. 1431	Health Standards/Secretary HHS	Purcell	June 7, 2000	Voted fav., seq. referral to App./Base Budget	Placed in 2000-2001 budget.
S.B. 1437	High Risk Intervention Coverage/ State Health Plan	Gulley	June 28, 2000	Withdrawn by sponsor.	

Bill No.	Bill Title	Sponsor	Date in Committee	Disposition	Final Disposition
H B. 96	Adult Care Home/Lic. Exempt	Edwards	June 7, 1999	Voted favorable, reported out.	Signed by Governor 6/18/99
H.B. 190	State Hospitals/Peer Review/AB	Cansler		Unfavorable as to House Com. Sub.,fav. as to Senate Com. Sub., reported out.	Signed by Governor 6/25/99
H.B. 678	Acupuncturist Reimbursement	Sherrill, Luebke		Held for further consideration.	
H.B. 715	Utilization Review/ASAM Criteria	Alexander	May 5, 1999	Unfavorable as to House Com. Sub., fav. to Senate Com. Sub., reported out.	Signed by Governor 5/28/99
H.B. 906	Pharmacist Peer Review	Alexander	May 5, 1999	Favorable, reported out.	Signed by Governor 5/21/99
H.B. 944	Extend Adult Care Home Bed Moratorium	Cansler	May 19, 1999	Favorable, reported out.	Signed by Governor 6/4/99
H.B. 996	Regulate Spinal Manipulation	Wright		Held for further consideration.	
H.B. 1069	Social Worker Licensure	Alexander	June 23, 1999	Favorable, reported out.	Signed by Governor 7/15/99
H.B. 1188	Research Studies/Women Participants	Boyd-McIntyre		Held by sponsor	
H.B. 1193	Health Care Professionals	Nesbitt	May 19, 1999	Unfav. as to bill, fav. to Sen. Com. Sub. #1	Signed by Governor 6/25/99
			June 9, 1999	Unfav. as to Sen. Com.Sub. #1. fav. as to Sen. Com. Sub. #2, reported out.	
H.B. 1258	Health Care Personnel Registry	Earle	May 26, 1999	Fav. as to Senate Com. Sub., reported out	Signed by Governor 6/8/99
H.B. 1340	Respiratory Care Practice Act	Tolson	July 12, 1999 May 24, 2000 June 14, 2000	Held for further discussion. Held for further discussion. Fav. as to Com. Sub., sequential referral to Finance.	Signed by Governor 8/2/00
H.B. 1470	Impaired Dental Hygienists/Fee	Allen	July 7, 1999	Fav. as to Com. Sub., sequential	Signed by Governor 8/4/99

Bill No.	Bill Title	Sponsor	Date in Committee	Disposition	Final Disposition
				referral to Senate Finance Com.	
H.B. 1514	Respite Care Program No Sunset	Melton	June 14, 2000	Fav. as to Com. Sub., recommended referral to Appropriations.	Signed by Governor 6/30/00
H.B. 1519	Mental Health System Reform	Insko	June 28, 2000	Fav. as to Sen. Com. Sub., reported out.	Signed by Governor 7/5/00
H.B. 1520	Restraints in Facilities	Insko	June 28, 2000	Fav. as to Sen. Com. Sub., referred to Finance.	Signed by Governor 7/14/00
H.B. 1838	State Health Plan Amend's.	Culpepper	July 5, 2000	Fav. as to House Com. Sub., referred to App. Base Budget.	Inserted in S.B. 432, ratified 7/13/00.

8/10/00
lrb

THIS MEETING HAS BEEN CANCELLED AND WILL BE HELD ON MAY 24, 2000

REVISED COMMITTEE MEETING NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, May 17, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

• S.B.1179, Health Care Registry Reports	Senator Rand
• S.B. 1176, Respite Care Program No Sunset	Senator Carpenter
• H.B. 1340, Respiratory Care Practice Act	Representative Tolson

Senator William R. Purcell, Chair

Please Note: S.B. 1179, Health Care Registry Reports, will not be presented at this meeting.

REVISED COMMITTEE MEETING NOTICE

Principal Clerk ___
Reading Clerk ___

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Senator William R. Purcell, Chair

Revision No. 3

REVISED MEETING NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: Wednesday, May 24, 2000
TIME: 12:00 Noon
ROOM: 414, Legislative Office Building

The following bills will be considered:

• S.B.1179, Health Care Registry Reports	Senator Rand
• S.B. 1176, Respite Care Program No Sunset	Senator Carpenter
• H.B. 1340, Respiratory Care Practice Act	Representative Tolson

Senator William R. Purcell, Chair

Please note: S.B. 1234, *Long-Term Care Residents Immunization*, has been deleted from the agenda.

The room has been changed from Room 1124 to Room 414.

S.B. 1217, Mental Health System Reform, will NOT be heard at this meeting.

REVISED MEETING NOTICE

Principal Clerk ___
Reading Clerk ___

SENATE
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and
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• H.B. 1340, Respiratory Care Practice Act	Representative Tolson
• S.B. 1234, Long-Term Care Residents Immunization	Senator Purcell

Senator William R. Purcell, Chair

Please note: S.B. 1234, Long-Term Care Residents Immunization has been added to the agenda.

S.B. 1217, Mental Health System Reform, will NOT be heard at this meeting.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

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• S.B.1179, Health Care Registry Reports	Senator Rand
• S.B. 1176, Respite Care Program No Sunset	Senator Carpenter
• H.B. 1340, Respiratory Care Practice Act	Representative Tolson

Senator William R. Purcell, Chair

Senate Health Care Committee
Wednesday, May 24, 2000
12:00 Noon
414 Legislative Office Building

MINUTES

The Senate Health Care Committee met at 12:00 noon on Wednesday, May 24, 2000 in Room 414 of the Legislative Office Building. Twelve members of the committee were present. Senator William R. Purcell presided.

Senator Robert Carpenter was introduced to present his bill, S.B. 1176, *Respite Care Program No Sunset.* Senator Carpenter asked Staff John Young to explain the provisions of this bill to the committee. There were no questions from the committee members, and Senator Lucas moved for a favorable report. The motion was seconded by Senator Weinstein and carried unanimously.

Senator Purcell told the committee that there is a committee substitute for H.B. 1340, *Respiratory Care Practice Act.* Senator Lucas moved that the committee consider the proposed committee substitute. The motion carried. Senator Purcell called upon Representative Tolson, who explained the bill. Senator Purcell asked Staff Linda Attarian to explain the committee substitute.

Senator Purcell called upon Dr. Neil McIntyre, Chief of Pulmonary and Critical Care at Duke University to speak on the bill. Following his presentation, Senator Purcell introduced Mr. Rick Leonard, a respiratory care practitioner; then Mr. Ralph Webb, past president of the North Carolina Society for Respiratory Care and Program Director for respiratory care at Edgecomb College.

Senator Purcell called upon committee members for questions and comments. Senator Lucas brought up a series of questions. Answers were provided by Dr. McIntyre, Mr. Leonard, Representative Tolson, and Ms. Attarian; however, Senator Lucas felt that there were three or four amendments required for this bill. They would deal with the level of reciprocity with other states, the licensing board to meet more than twice a year, the possibility of this board needing to request funding from the state, and the reciprocity agreement not being strong enough. Senator Phillips asked if this bill addressed home health care. Mr. Leonard responded that it does. Dr. McIntyre added that it would exclude persons who did not have the level of education that this work requires.

Senator Forrester questioned whether use of defibrillators should be included in this bill. Senator Moore asked for a definition of non-traditional respiratory care. Representative Tolson said that an answer would be provided at a later meeting.

There being no additional questions or comments, the meeting was adjourned at 12:55 P.M.

William R Purcell
Senator William R. Purcell, M.D, Chair

Lorraine R Blake
Lorraine R. Blake, Committee Assistant.

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, May 24, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **1176** Respite Care Program No Sunset
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1340
Committee Substitute Favorable 6/23/99

Short Title: Respiratory Care Practice Act. (Public)

Sponsors:

Referred to:

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 37.

"Respiratory Care Practice Act.

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and

procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.
f. Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"**§ 90-649. North Carolina Respiratory Care Board; creation.**

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of nine members as follows:

(1) Two members shall be respiratory care practitioners.
(2) Three members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.
(3) One member shall represent the NCHA.
(4) One member shall represent the North Carolina Association of Medical Equipment Services.
(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"**§ 90-650. Appointments and removal of Board members; terms and compensation.**

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(6) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings

upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a

respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"§ 90-654. Exemption from certain requirements.

(a) The Board may issue a license to an applicant who, as of October 1, 1999, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2001.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 1999, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2000, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"§ 90-655. Licensure by reciprocity.

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"§ 90-656. Provisional license.

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"**§ 90-657. Notification of applicant following evaluation of application.**

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"**§ 90-658. License as property of the Board; display requirement; renewal; inactive status.**

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"**§ 90-660. Expenses; fees.**

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"**§ 90-661. Requirement of license.**

After October 1, 2000, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"**§ 90-662. Violation a misdemeanor.**

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 1999. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and, until October 1, 2004, must have

passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public member appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1340
Committee Substitute Favorable 6/23/99
Proposed Committee Substitute H1340-PCS7351-RM

Short Title: Respiratory Care Practice Act. (Public)

Sponsors:

Referred to:

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 38.

"Respiratory Care Practice Act.

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician

to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these

services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. Nontraditional respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"**§ 90-649. North Carolina Respiratory Care Board; creation.**

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of nine members as follows:

(1) Two members shall be respiratory care practitioners.

(2) Three members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.

(3) One member shall represent the NCHA.

(4) One member shall represent the North Carolina Association of Medical Equipment Services.

(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member

of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"**§ 90-650. Appointments and removal of Board members; terms and compensation.**

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(6) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of November immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"§ 90-654. Exemption from certain requirements.

(a) The Board may issue a license to an applicant who, as of October 1, 2000, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2002.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 2000, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2002, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"§ 90-655. Licensure by reciprocity.

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"§ 90-656. Provisional license.

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and

conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"§ 90-657. Notification of applicant following evaluation of application.

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"§ 90-658. License as property of the Board; display requirement; renewal; inactive status.

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"§ 90-659. Suspension, revocation, and refusal to renew a license.

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:
   a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.
   b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.
   c. Practiced respiratory care without a license.
   d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"**§ 90-660. Expenses; fees.**

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"**§ 90-661. Requirement of license.**

After October 1, 2002, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"**§ 90-662. Violation a misdemeanor.**

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person who performs only support activities as defined in G.S. 90-648(13).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 2000. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) must have passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory

Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public members appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4. This act is effective when it becomes law.

HOUSE BILL 1340:
Respiratory Care Practice Act

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Tolson
Date:	May 17, 2000	**Summary by:**	Linda Attarian
Version:	Second		Committee Counsel

SUMMARY: House Bill 1340 establishes a new Article 38 in Chapter 90 of the General Statutes to create a new occupational licensure board for the mandatory licensure of persons engaged in the practice of respiratory care as defined in the act. The act becomes effective when it becomes law.

CURRENT LAW: The practice of respiratory care is not currently defined or regulated under the North Carolina General Statutes.

BILL ANALYSIS: Section 1 creates the "Respiratory Care Practice Act". The following is a brief summary of the key provisions:

Practice of respiratory care. The act defines practice of respiratory care as the observing and monitoring of signs and symptoms, general behavior, and general physical response by a patient to respiratory care treatment and diagnostic testing pursuant to a physician's written order. Respiratory care practice also includes the performance of certain diagnostic tests and the application of certain therapeutic procedures prescribed by a physician.

Procedures that do not require formal respiratory care training and do not call for therapeutic evaluation and assessment are defined in the act as "support activities" and persons performing these activities are not required to be licensed under the act.

Board composition. The act creates a nine member NC Respiratory Care Board. Board members will serve three-year terms. Two of the members must be respiratory care practitioners with at least five years of experience. Three members must be physicians with relevant, specialized expertise. One member will represent the NC Hospital Association and one member will represent the NC Association of Medical Equipment Services. Two members will be from the public at large. Two members (a physician and respiratory care therapist) will be appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives and two members (a physician and respiratory care therapist) will be appointed by the General Assembly upon recommendation of the of President Pro Tempore of the Senate. The Governor will appoint two members from the public at large.

Licensure standards. The act sets forth the minimal licensing standards that must be met for Board approval:

1. Completion of a respiratory care education program as approved by the Commission for Accreditation for Accreditation of Allied Health Educational Programs of the American Medical Association.
2. Completion of the American Heart Association's Basic Cardiac Life Support program.
3. Passage of the entry-level examination given by the National Board of Respiratory Care, Inc. Applicants may take the exam up to three times per year.

The act authorizes the Board to grant a North Carolina license to an applicant holding a valid out-of-state license, certificate, or registration as a respiratory care practitioner if the Board determines the out-of-state requirements are substantially the same as the requirements under this Article.

The act authorizes the Board to grant an applicant a *provisional license* for a period of one year if the applicant has completed the minimum educational requirements and has applied to take the national exam. The provisional license allows the applicant to practice under the supervision of a licensed respiratory care practitioner for a time-limited period.

Fees. The Board is authorized to impose a fee of $50.00 to apply for licensure, a fee of $150.00 to take the examination and a fee $100.00 to be issued a license.

Prohibited acts: The act provides that after October 1, 2000, it shall be unlawful for any person who is not licensed under the act to practice respiratory care or use the title of respiratory care practitioner or otherwise hold themselves out as a respiratory care practitioner. A violation constitutes a Class 1 misdemeanor.

Persons and practices not required to obtain licensure: The act provides that the following persons practicing respiratory care in the following situations are exempt from licensure requirements.

1. Any person who is registered, certified, credentialed, or licensed in any other profession or any person working under the supervision of a person registered, certified, credentialed, or licensed in any other profession and who is performing services incidental to the occupation of that person or the person who is supervising them and not holding themselves out to be a respiratory care practitioner.
2. A student in a respiratory care education program, working under direct supervision of a respiratory care practitioner while fulfilling requirements of the course of study.
3. Persons serving in the armed forces or the Public Health Service of the United States or employed by the Veteran's Administration when performing duties associated with that service or employment.
4. Persons aiding in the practice of respiratory care who perform support activities which do not require formal academic training, if these persons work under the supervision of a respiratory care practitioner or physician.

Third-party reimbursement. The act specifically states that the act does not authorize respiratory care practitioners to bill directly for third-party reimbursement.

Section 2. Amends G.S. 120-123 to prohibit members of the NC General Assembly from being appointed to the Board.

Section 3. Provides that the initial Board members shall be appointed no later than October 1, 1999 and, not withstanding G.S. 90-649, these initial members must obtain licensure under this Article no later than October 1, 2000. Further, until October 1, 2004, the initial board members must have passed the entry-level national exam. Provides also that the initial Board members serve staggered terms.

Section 4. This Act is effective when it becomes law.

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May 24, 2000

TO: Members of the Senate Health Care Committee

FROM: Linda Attarian, Committee Counsel

RE: Explanation of the changes proposed by the Proposed Committee Substitute for **HB 1340, Respiratory Care Practice Act**

The Proposed Committee Substitute (PCS) makes the following changes to HB 1340, 2nd Edition:

Page 1, line 6: "Article 37" is amended to read "Article 38".

This is a technical change to update the bill since a new Article 37 was enacted by Session Law 1999-320, s.3 (An act to require health care practitioner identification badges).

Page 3, line 2:

Current language: "Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations."

Proposed language: "Nontraditional respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations."

This is a substantive change to clarify the scope of practice of respiratory care in relation to the scope of practice of hospital profusionists.

Page 4, line 20: "July" is deleted and replaced with "November".

This is a technical change to make the month that new Board members are to take office (following expired terms of prior office holders) to the month in which the terms are due to expire under the act (October).

Page 6:

Lines 16, 19, 20-21, and 23-24: date changes.

Most of the changes simply update the bill. The date change on lines 23-24 updates the bill and substantively changes the length of time a temporary license is valid under the act from one year to two years.

Page 8, line 33: date change.

This date change updates the bill and substantively extends the length of time in which it would not be unlawful under the act for an unlicensed person to engage in the practice of respiratory care after the date of enactment of the bill from one year to two years.

Page 9, line 14:

Current language: "Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State **who is performing work incidental to the practice of that** profession or occupation and does not represent himself or herself as a respiratory care practitioner."

Proposed language: "Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State **who is performing work incidental to *or within* the practice of that** profession or occupation and does not represent himself or herself as a respiratory care practitioner."

This provision provides an exemption from licensure under the act for health care professionals, (e.g. nurses), who perform respiratory care techniques and therapies as a normal or routine function of their jobs/professions. This amendment is intended enhance the clarity of the intent of the exemption. By adding the new language, it is hoped that the word "incidental" will not be misinterpreted to narrow the exemption to exclude those who perform such functions on a daily or routine basis.

Page 9, lines 26-31:

Current language: "A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12)."

Proposed language: "A person who performs only support activities as defined in G.S. 90-648(13)."

This amendment removes redundant language that may be construed as a limitation to the exemption on lines 10-16 on that page. Also, a technical correction was made to the citation.

Page 9, lines 42-44:

Current language: "Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina **Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and until October 1, 2004, must have** passed the entry-level examination administered by the National Board for Respiratory Care, Inc."

Proposed language: "Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina **Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) must have** passed the entry-level examination administered by the National Board for Respiratory Care, Inc."

This amendment deletes language that provides a lag time within which the Board appointees who are respiratory care practitioners would have to attain licensure. It is assumed that most or all current practitioners will be eligible for immediate licensure as of the date of enactment. In addition the amendment deletes a sunset on the requirement that these respiratory care practitioner board members must have passed the entry-level examination administered by the National Board for Respiratory Care.

Page 10, line 11 corrects a typo.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1176*

Short Title: Respite Care Program No Sunset. (Public)

Sponsors: Senators Carpenter, Purcell, Carter, Dannelly, Forrester, Harris; and Cochrane.

Referred to: Health Care.

May 9, 2000

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON REQUIREMENTS PERTAINING TO THE REIMBURSEMENT RATE FOR THE RESPITE CARE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. Section 3 of S.L. 1998-97 reads as rewritten:

"Section 3. This act is effective when it becomes ~~law and expires July 1, 2000.~~ law."

Section 2. This act is effective when it becomes law.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — MAY 24, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beanie Hollers	DHHS
Katrina Brahane	UNC Preventive Medicine Residency
Daniel Macklin	UNC Preventive Medicine
Valerie King	" " " "
Ruth Petersen	" " " "
Dana Leinenweber	" " " "
Linda Kinsinger	" " " "
Eric Baggstrom	" " " "
Stacey Sheridan	" " " "
Judy D. Greene	Hiland Hall 1173 Highland Hall Rd. Boone NC 28607
Nancy S Hopper	" "
Susan R Gallo	Respiratory Care Association - Raleigh
Tommy G. Williams	" " " "

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — MAY 24, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
David Cristaldi	NC Society of Perfusionists
Andy Ellen	NC Retail Merchants / NC AIMES
Steve Shore	NC Pediatric Society
Deborah Porterfield	UNC Preventive Medicine Residency
Betsey Tilson	UNC Preventive Medicine Residency
Pat Yancey	Hospice for the Carolinas / FOR
Hugh Tilson	NCHA
AH Massenburg	UNC Preventive Medicine Residency
Sharon Broadnax	Dogwood (CCDANS DDA)
Queen Love	Dogwood Forest Rest Home (Alamance
Sonya Cole Griffin	Graham Manor (Alamance)
Joan D. Sharpe RN	Hi-Land Hall - Watauga Co.

SENATE COMMITTEE ON HEALTH CARE
ROOM 1124, LEGISLATIVE BUILDING
MAY 31, 2000
12:00 NOON

CALL TO ORDER

Senator William R. Purcell, Chair

CONSIDERATION OF BILLS

S.B. 1179	**Health Care Registry Reports**	**Senator Rand**
S.B. 1215	**Medical Care Commission/Rules**	**Senator Dannelly**
S.B. 1234	**Long-Term Care Residents Immunization**	**Senator Purcell**

ADJOURNMENT

REVISION NO. 1

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, May 31, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- S.B.1179, Health Care Registry Reports — Senator Rand
- S.B. 1234, Long-Term Care Residents Immunization — Senator Purcell
- S.B. 1215, Medical Care Commn./Rules — Senator Dannelly

Senator William R. Purcell, Chair

Please Note: S.B. 1215 has been added to the agenda.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
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The Senate Committee on Health Care will meet at the following time:

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Senator William R. Purcell, Chair

Senate Health Care Committee
Wednesday, May 31, 2000
12:00 Noon
1124 Legislative Building

MINUTES

The Senate Health Care Committee met at 12:00 noon on Wednesday, May 31, 2000 in Room 1124 of the Legislative Building. Eleven of the members were present. Senator William R. Purcell presided.

Senator Purcell announced that S.B. 1215, *Medical Care Commission/Rules*, would not be heard today. He said there is a proposed committee substitute for S.B. 1179, *Health Care Registry Reports*. Senator Metcalf moved to adopt the committee substitute for purposes of discussion. Senator Purcell introduced Senator Rand to explain the committee substitute. He did so and told the committee that at some future time an amendment to the bill would be proposed to exempt home health and hospice from reporting allegations as outlined in Section 1, but that the details have yet to be worked out. Senator Purcell called for questions from committee members and then from the audience. There being none, Senator Lucas moved for an unfavorable report to the bill, and a favorable report to the committee substitute. Senator Forrester asked where the money from any fines would go. Senator Rand replied that any fine would go toward the school fund and allocated among the counties. The motion was seconded by Senator Martin and carried.

Senator Purcell asked Senator Lucas to chair the committee in order that he could explain S.B. 1234, *Long-Term Care Residents Immunization*, to the committee and presented a committee substitute. Senator Phillips moved that the committee substitute be adopted for purposes of discussion. The motion carried. He explained the bill to the committee and asked Ms. Attarian to explain the provisions of the committee substitute. Senator Lucas asked about the influenza vaccine provision not be effective until next year. Senator Purcell responded that he had been informed that there may not be sufficient time to order influenza vaccine for this year. Senator Rucho asked about potential liability to the individual giving the vaccine. Senator Purcell responded that a physician or member of the Health Department would be giving the vaccine and that should not be a problem. Senator Martin asked about the general practice in hospitals regarding immunization of employees. Senator Purcell replied that in his experience, most hospitals required employees to receive the influenza vaccine and that there was no evidence that giving the pneumoccocal vaccine to employees would make a difference in preventing illness in preventing illness in residents. Senator Forrester asked about penalties. Senator Purcell said that he hoped that this bill would encourage people to give these vaccines without need for penalties. There being no further questions from the committee or the audience, Senator Dannelly moved for an unfavorable report for the original bill, but a favorable report for the committee substitute. The motion carried.

Senator Purcell asked for a motion to approve the previous meeting's minutes. Senator Lucas so moved. The meeting was adjourned at 12:35 P.M.

William R. Purcell
Senator William R. Purcell, Committee Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, May 31, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1179** Health Care Registry Reports

Draft Number:	PCS2830-LN001A
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

S.B. **1234** Long-Term Care Residents/Immuniz.

Draft Number:	PCS3964-LN001A
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1179
Health Care Committee Substitute Adopted 5/31/00

Short Title: Health Care Registry Reports. (Public)

Sponsors:

Referred to:

May 9, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO REPORTING REQUIREMENTS FOR THE HEALTH CARE PERSONNEL REGISTRY; IMPOSING PENALTIES FOR VIOLATIONS OF LICENSING AND OTHER REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES; AND AUTHORIZING THE ADOPTION OF CERTAIN TEMPORARY AND PERMANENT RULES TO IMPLEMENT REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256(g) reads as rewritten:

"(g) ~~Upon investigation and documentation, health~~ Health care facilities shall ensure that the Department is notified of all ~~substantiated~~ allegations against health care ~~personnel~~ personnel, including injuries of unknown source, which appear to ~~a reasonable person to~~ be related to any act listed in subdivision (a)(1) of this ~~section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.~~ section. Facilities must have evidence that all alleged acts are investigated and must make every effort to protect residents from harm while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department."

Section 2. Article 15 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-256.1. Adverse action on a license; appeal procedures.**

(a) The Department may suspend, cancel, or amend a license when a facility subject to this Article has substantially failed to comply with this Article or rules adopted under this Article.

(b) Administrative action taken by the Department under this section shall be in accordance with Chapter 150B of the General Statutes."

Section 3. G.S. 122C-23 is amended by adding the following new subsection to read:

"(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection, and

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee."

Section 4. Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. -- The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than two hundred fifty dollars ($250.00) nor more than five thousand dollars ($5,000) for each Type A Violation in facilities or programs that serve nine or fewer persons. The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A Violation in facilities or programs that serve 10 or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for Failure to Correct Violations Within Time Specified. --

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to five hundred dollars ($500.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to two hundred dollars ($200.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the

same specific provision of a statute or regulation for which it received a citation during the previous 12 months.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. -- In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a client or patient has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The gravity of the violation, including the probability that death or serious physical harm to a client or patient will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(3) The gravity of the violation, including the probability that death or serious physical harm to a client or patient may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;

(5) Efforts by the licensee to correct violations;

(6) The number and type of previous violations committed by the licensee within the past 36 months;

(7) The amount of assessment necessary to ensure immediate and continued compliance; and

(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The licensee involved;

(2) The clients or patients affected; and

(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(h) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(i) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(2) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

(j) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law.

(k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection."

Section 5. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article; ~~and~~

(4) Adopt rules for the waiver of rules adopted under this ~~Article.~~ Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting; and

d. Establishing requirements for patient advocates."

Section 6. Notwithstanding G.S. 150B-21.1(a), the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt temporary rules to implement G.S. 122C-26(5).

Section 7. Sections 1 through 4 of this act become effective October 1, 2000. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1179*

Short Title: Health Care Registry Reports. (Public)

Sponsors: Senators Rand; Forrester, Hagan, Lucas, Phillips, and Purcell.

Referred to: Health Care.

May 9, 2000

A BILL TO BE ENTITLED

AN ACT TO STANDARDIZE REPORTING REQUIREMENTS FOR HEALTH CARE PERSONNEL REGISTRY, AND TO ALLOW ADVERSE ACTION ON A FACILITY LICENSE FOR FAILURE TO COMPLY WITH REPORTING REQUIREMENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131E-256(g) reads as rewritten:

"(g) ~~Upon investigation and documentation, health~~ Health care facilities shall ensure that the Department is notified of all ~~substantiated~~ allegations against health care ~~personnel~~ personnel, including injuries of unknown source, which appear to ~~a reasonable person to~~ be related to any act listed in subdivision (a)(1) of this ~~section, and shall promptly report to the Department any resulting disciplinary action, demotion, or termination of employment of health care personnel.~~ section. Facilities must have evidence that all alleged acts are investigated and must prevent further potential acts while the investigation is in progress. The results of all investigations must be reported to the Department within five working days of the initial notification to the Department."

Section 2. Article 15 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-256.1. Adverse action on a license; appeal procedures.**

(a) The Department may suspend, cancel, or amend a license when a facility subject to this Article has substantially failed to comply with this Article or rules adopted under this Article.

(b) Administrative action taken by the Department under this section shall be in accordance with Chapter 150B of the General Statutes."

Section 3. This act becomes effective October 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1179
Proposed Committee Substitute S1179-PCS2830-LN001A

Short Title: Health Care Registry Reports. (Public)

Sponsors:

Referred to:

May 9, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO REPORTING REQUIREMENTS FOR THE HEALTH CARE PERSONNEL REGISTRY; IMPOSING PENALTIES FOR VIOLATIONS OF LICENSING AND OTHER REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES; AND AUTHORIZING THE ADOPTION OF CERTAIN TEMPORARY AND PERMANENT RULES TO IMPLEMENT REQUIREMENTS FOR CERTAIN MENTAL HEALTH FACILITIES.

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(b) Administrative action taken by the Department under this section shall be in accordance with Chapter 150B of the General Statutes."

Section 3. G.S. 122C-23 is amended by adding the following new subsection to read:

"(g) The Secretary may suspend the admission of any new clients to a facility licensed under this Article where the conditions of the facility are detrimental to the health or safety of the clients. This suspension shall be for the period determined by the Secretary and shall remain in effect until the Secretary is satisfied that conditions or circumstances merit removal of the suspension. In suspending admissions under this subsection, the Secretary shall consider the following factors:

(1) The degree of sanctions necessary to ensure compliance with this section and rules adopted to implement this subsection, and

(2) The character and degree of impact of the conditions at the facility on the health or safety of its clients.

A facility may contest a suspension of admissions under this subsection in accordance with Chapter 150B of the General Statutes. In contesting the suspension of admissions, the facility must file a petition for a contested case within 20 days after the Department mails notice of suspension of admissions to the licensee."

Section 4. Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-24.1. Penalties; remedies.**

(a) Violations Classified. -- The Department of Health and Human Services shall impose an administrative penalty in accordance with provisions of this Article on any facility licensed under this Article which is found to be in violation of Article 2 or 3 of this Chapter or applicable State and federal laws and regulations. Citations issued for violations shall be classified according to the nature of the violation as follows:

(1) "Type A Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which results in death or serious physical harm, or results in substantial risk that death or serious physical harm will occur. Type A Violations shall be abated or eliminated immediately. The Department shall require an immediate plan of correction for each Type A Violation. The person making the findings shall do the following:

a. Orally and immediately inform the administrator of the facility of the specific findings and what must be done to correct them, and set a date by which the violation must be corrected;

b. Within 10 working days of the investigation, confirm in writing to the administrator the information provided orally under sub-subdivision a. of this subdivision; and

c. Provide a copy of the written confirmation required under sub-subdivision b. of this subdivision to the Department.

The Department shall impose a civil penalty in an amount not less than two hundred fifty dollars ($250.00) nor more than five thousand dollars ($5,000) for each Type A Violation in facilities or programs that serve nine or fewer persons. The Department shall impose a civil penalty in an amount not less than five hundred dollars ($500.00) nor more than ten thousand dollars ($10,000) for each Type A Violation in facilities or programs that serve 10 or more persons.

(2) "Type B Violation" means a violation by a facility of the regulations, standards, and requirements set forth in Article 2 or 3 of this Chapter or applicable State or federal laws and regulations governing the licensure or certification of a facility which present a direct relationship to the health, safety, or welfare of any client or patient, but which does not result in substantial risk that death or serious physical harm will occur. The Department shall require a plan of correction for each Type B Violation and may require the facility to establish a specific plan of correction within a specific time period to address the violation.

(b) Penalties for Failure to Correct Violations Within Time Specified. --

(1) Where a facility has failed to correct a Type A Violation, the Department shall assess the facility a civil penalty in the amount of up to five hundred dollars ($500.00) for each day that the deficiency continues beyond the time specified in the plan of correction approved by the Department or its authorized representative. The Department or its authorized representative shall ensure that the violation has been corrected.

(2) Where a facility has failed to correct a Type B Violation within the time specified for correction by the Department or its authorized representative, the Department shall assess the facility a civil penalty in the amount of up to two hundred dollars ($200.00) for each day that the deficiency continues beyond the date specified for correction without just reason for the failure. The Department or its authorized representative shall ensure that the violation has been corrected.

(3) The Department shall impose a civil penalty which is treble the amount assessed under subdivision (1) of subsection (a) of this section when a facility under the same management, ownership, or control has received a citation and paid a penalty for violating the

same specific provision of a statute or regulation for which it received a citation during the previous 12 months.

(c) Factors to Be Considered in Determining Amount of Initial Penalty. -- In determining the amount of the initial penalty to be imposed under this section, the Department shall consider the following factors:

(1) The gravity of the violation, including the fact that death or serious physical harm to a client or patient has resulted; the severity of the actual or potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(2) The gravity of the violation, including the probability that death or serious physical harm to a client or patient will result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(3) The gravity of the violation, including the probability that death or serious physical harm to a client or patient may result; the severity of the potential harm, and the extent to which the provisions of the applicable statutes or regulations were violated;

(4) The reasonable diligence exercised by the licensee to comply with G.S. 131E-256 and other applicable State and federal laws and regulations;

(5) Efforts by the licensee to correct violations;

(6) The number and type of previous violations committed by the licensee within the past 36 months;

(7) The amount of assessment necessary to ensure immediate and continued compliance; and

(8) The number of clients or patients put at risk by the violation.

(d) The facts found to support the factors in subsection (c) of this section shall be the basis in determining the amount of the penalty. The Department shall document the findings in written record and shall make the written record available to all affected parties including:

(1) The licensee involved;

(2) The clients or patients affected; and

(3) The family members or guardians of the clients or patients affected.

(e) The Department shall impose a civil penalty on any facility which refuses to allow an authorized representative of the Department to inspect the premises and records of the facility.

(f) Any facility wishing to contest a penalty shall be entitled to an administrative hearing as provided in Chapter 150B of the General Statutes. A petition for a contested case shall be filed within 30 days after the Department mails a notice of penalty to a licensee. At least the following specific issues shall be addressed at the administrative hearing:

(1) The reasonableness of the amount of any civil penalty assessed, and

(2) The degree to which each factor has been evaluated pursuant to subsection (c) of this section to be considered in determining the amount of an initial penalty.

If a civil penalty is found to be unreasonable or if the evaluation of each factor is found to be incomplete, the hearing officer may recommend that the penalty be adjusted accordingly.

(g) Any penalty imposed by the Department of Health and Human Services under this section shall commence on the day the violation began.

(h) The Secretary may bring a civil action in the superior court of the county wherein the violation occurred to recover the amount of the administrative penalty whenever a facility:

(1) Which has not requested an administrative hearing fails to pay the penalty within 60 days after being notified of the penalty, or

(2) Which has requested an administrative hearing fails to pay the penalty within 60 days after receipt of a written copy of the decision as provided in G.S. 150B-36.

(i) In lieu of assessing an administrative penalty, the Secretary may order a facility to provide staff training if:

(1) The penalty would be for the facility's only violation within a 12-month period preceding the current violation and while the facility is under the same management; and

(2) The training is:

a. Specific to the violation;

b. Approved by the Department of Health and Human Services; and

c. Taught by someone approved by the Department and other than the provider.

(j) The clear proceeds of civil penalties provided for in this section shall be remitted to the State Treasurer for deposit in accordance with State law.

(k) In considering renewal of a license, the Department shall not renew a license if outstanding fines and penalties imposed by the Department against the facility or program have not been paid. Fines and penalties for which an appeal is pending are exempt from consideration for nonrenewal under this subsection."

Section 5. G.S. 122C-26 reads as rewritten:

"**§ 122C-26. Powers of the Commission.**

In addition to other powers and duties, the Commission shall exercise the following powers and duties:

(1) Adopt, amend, and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing appeals of decisions to approve or deny licensure under this Article; ~~and~~

(4) Adopt rules for the waiver of rules adopted under this ~~Article.~~ Article; and

(5) Adopt rules applicable to facilities licensed under this Article:

a. Establishing personnel requirements of staff employed in facilities;

b. Establishing qualifications of facility administrators or directors;

c. Establishing requirements for death reporting including confidentiality provisions related to death reporting; and

d. Establishing requirements for patient advocates."

Section 6. Notwithstanding G.S. 150B-21.1(a), the Commission for Mental Health, Developmental Disabilities, and Substance Abuse Services shall adopt temporary rules to implement G.S. 122C-26(5).

Section 7. Sections 1 through 4 of this act become effective October 1, 2000. The remainder of this act is effective when it becomes law.

SENATE BILL 1179:
Health Care Registry and Certain Mental Health Reporting

BILL ANALYSIS

Committee:	Health Care	**Introduced by:**	Sen. Rand
Date:	May 19, 2000	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY:

Sections 1 and 2 amends the North Carolina Health Care Personnel Registry to standardize reporting requirements such that standards required under State law are the same as those required for nursing homes under federal law.

Sections 3 through 6 impose administrative penalties on licensed MH/DD/SAS facilities (private psychiatric hospitals, group homes and day treatment and outpatient programs, and ICFMR facilities) for certain violations and authorize adoption of rules to implement

Secttions 1 through 4 are effective October 1, 2000. The remaining sections are effective upon becoming law.

CURRENT LAW:

Sections 1 and 2-Nursing homes are required by State law and federal regulation to report to the Department of Health and Human Services (DHHS) ALL allegations of patient neglect or abuse, misappropriation of patient or facility property, diversion of patient or facility drugs, and fraud against a ppatient or facility. **Adult care homes and certain other facilities that provide hands on, paraprofessional personel care to the elderly or disabled** are subject to State law only, which requires that they report to DHHS such incidents only after an internal investigation has substantiated the allegation. Nursing homes and adult care homes are required by State law to report to DHHS any resulting disciplinary action, demotion, or termination of employment. Penalty provisions exist in current law for nursing homes that fail to make the required reports. No such penalties currently exist for adult care homes and other facilities subject to the health care personnel registry law.

Sections 3 through 6_The current statutes does not permit the Secretary of DHHS or the Mental Health Commission to address certain problem facilities licensed under G.S. 122C short of revoking a license. Those types of facilities licensed under G.S. 122C are 10 private psychiatric hospials, 3400 mental health group homes, day treatment, and outpatient programs, and 332 intermediate care facilities for the mentally retarded.

BILL ANALYSIS:

Section 1: Requires health care facilities to notify DHHS of **all allegations (not just substantiated)** against health care personnel which appear to be related to a prohibited act (abuse, neglect, misappropriation of property, fraud, diversion of drugs). **Current law requires the notice only after the facility has conducted an investigation and the allegation has been substantiated.** Requires facilities to have evidence that an investigation of the allegation was conducted nad must make every effort to

protect residents from harm while the investigation is in progress. Requires facilities to reporet the results of all investigations to DHHS within five working days of the initial notification. **Current law requires the facility to report promptly to DHHS resulting disciplinatry action taken by the facility.**

Section 2-Authorizes DHHS to suspend, cancel, or amend a license when a facility substantially fails to comply with the Registry reporting requirements. Facilities may appeal in accordance with Chapter 150B of the General Statutes.

Section 3-Amends G.S. 123-23 to give the Secretary of DHHS the authority to suspend admissions of new clients where conditions are detrimental to the health and safety of the clients. The suspension shall be for the perion determined by the Secretary. Listed are the factors to be considered by the Secretary in suspending admissions.

Section 4-Amends 122C-24.1 to impose civil monetary penalties based upon the size of the facility and the severity of the violation. Type "A" violations are violations which results in death or serious physical harm or results in substantial risk that death or serious physical harm will occur. The penalty may be not less than $250 nor more than $5000 per violation for facilities licensed for 10 beds or more. And up to $10,000 per violation in facilities licensed for 10 or more beds.DHHS may also impose Type "B" violations These are violations of the regulations, standards and requirements governing the licensure or certification of a facility wwhichpresent a direct relationship to the health, safety, or welfore of any client or patient but which does not result in substantial risk of death or serious physical harm. There is no monetary penalty but DHHS shall require a plan of correction.

Section 5-and 6-Amends 122C-26 to give MH/DD/SAS Commission authority to adopt rules including temporary rules to:

1. set personnel staffing requirements for staff employed in licensed facilities;
2. set qualifications of mntal health facility administrators or directors;
3. implement death reporting requirements; and
4. require patient advocates as a condition of licensure.

Section 7-Directs the Secretary to adopt temporary rules for reporting of deaths in State facilities.

BACKGROUND:

Sections 1 and 2 are recommendation from the Joint Legislative Health Care Oversight Committee.

Sections 3 through 7 were requested by the Department of Health and Human Services to address issues within the mental health system to give regulators a broader range of options in dealing with problem facilities.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1234*
Health Care Committee Substitute Adopted 5/31/00

Short Title: Long-Term Care Residents/Immuniz. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADULT CARE HOMES AND NURSING HOMES ENSURE THAT RESIDENTS AND EMPLOYEES ARE IMMUNIZED AGAINST INFLUENZA VIRUS AND THAT RESIDENTS ARE ALSO IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE.

The General Assembly of North Carolina enacts:

Section 1. Effective September 1, 2000, Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-9. Immunization of residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) An adult care home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the adult care home after November 30 but before March 30 of the following year, the adult care home shall

determine the individual's status for the immunization required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 2. Effective September 1, 2001, G.S. 131D-9, as enacted by Section 1 of this act, reads as rewritten:

"**§ 131D-9. Immunization of employees and residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents and employees to be immunized annually against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) An adult care home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against the influenza virus.

(c) An adult care home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking ~~the immunization,~~ one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the adult care home after November 30 but before March 30 of the following year, the adult care home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the adult care home."

Section 3. Effective September 1, 2000, Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-113. Immunization of residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) A nursing home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the nursing home is unable to verify that the individual has received the required immunization, the nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the immunization required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 4. Effective September 1, 2001, G.S. 131E-113, as enacted by Section 3 of this act, reads as rewritten:

"**§ 131E-113. Immunization of employees and residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) A nursing home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(c) A nursing home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, ~~the immunization,~~ or if the nursing home is unable to verify that the individual has received the required immunization, the

nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the nursing home."

Section 5. The Department of Health and Human Services shall make available to nursing homes and adult care homes educational and informational materials pertaining to vaccinations required under this act.

Section 6. G.S. 130A-29(c) is amended by adding the following new subdivision to read:

"(9) Implementing immunization requirements for adult care homes as provided in G.S. 131D-9 and for nursing homes as provided in G.S. 131E-113."

Section 7. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1234*
Proposed Committee Substitute S1234-PCS3964-LN001A

Short Title: Long-Term Care Residents/Immuniz. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO REQUIRE THAT ADULT CARE HOMES AND NURSING HOMES ENSURE THAT RESIDENTS AND EMPLOYEES ARE IMMUNIZED AGAINST INFLUENZA VIRUS AND THAT RESIDENTS ARE ALSO IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE.

The General Assembly of North Carolina enacts:

Section 1. Effective September 1, 2000, Article 1 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-9. Immunization of residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) An adult care home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the adult care home after November 30 but before March 30 of the following year, the adult care home shall

determine the individual's status for the immunization required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 2. Effective September 1, 2001, G.S. 131D-9, as enacted by Section 1 of this act, reads as rewritten:

"**§ 131D-9. Immunization of employees and residents of adult care homes.**

(a) Except as provided in subsection (e) of this section, an adult care home licensed under this Article shall require residents and employees to be immunized annually against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, an adult care home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) An adult care home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against the influenza virus.

(c) An adult care home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking ~~the immunization,~~ one or both of these immunizations or that an employee has not been immunized against influenza virus, or if the adult care home is unable to verify that the individual has received the required immunization, the adult care home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the adult care home after November 30 but before March 30 of the following year, the adult care home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the adult care home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the adult care home."

Section 3. Effective September 1, 2000, Part A of Article 6 of Chapter 131E of the General Statutes is amended by adding the following new section to read:

"**§ 131E-113. Immunization of residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents to be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against pneumococcal disease.

(c) A nursing home shall document the immunization against pneumococcal disease for each resident. Upon finding that a resident is lacking the immunization, or if the nursing home is unable to verify that the individual has received the required immunization, the nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the immunization required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section."

Section 4. Effective September 1, 2001, G.S. 131E-113, as enacted by Section 3 of this act, reads as rewritten:

"**§ 131E-113. Immunization of employees and residents.**

(a) Except as provided in subsection (e) of this section, a nursing home licensed under this Part shall require residents and employees to be immunized against influenza virus and shall require residents to also be immunized against pneumococcal disease.

(b) Upon admission, a nursing home shall notify the resident of the immunization requirements of this section and shall request that the resident agree to be immunized against influenza virus and pneumococcal disease.

(b1) A nursing home shall notify every employee of the immunization requirements of this section and shall request that the employee agree to be immunized against influenza virus.

(c) A nursing home shall document the annual immunization against influenza virus and the immunization against pneumococcal disease for each ~~resident.~~ resident and each employee, as required under this section. Upon finding that a resident is lacking one or both of these immunizations or that an employee has not been immunized against influenza virus, ~~the immunization,~~ or if the nursing home is unable to verify that the individual has received the required immunization, the

nursing home shall provide or arrange for immunization. The immunization and documentation required shall occur not later than November 30 of each year.

(d) For an individual who becomes a resident of or who is newly employed by the nursing home after November 30 but before March 30 of the following year, the nursing home shall determine the individual's status for the ~~immunization~~ immunizations required under this section, and if found to be deficient, the nursing home shall provide the immunization.

(e) No individual shall be required to receive vaccine under this section if the vaccine is medically contraindicated, or if the vaccine is against the individual's religious beliefs, or if the individual refuses the vaccine after being fully informed of the health risks of not being immunized.

(f) Notwithstanding any other provision of law to the contrary, the Health Services Commission shall have the authority to adopt rules to implement the immunization requirements of this section.

(g) As used in this section, 'employee' means an individual who is a part-time or full-time employee of the nursing home."

Section 5. The Department of Health and Human Services shall make available to nursing homes and adult care homes educational and informational materials pertaining to vaccinations required under this act.

Section 6. G.S. 130A-29(c) is amended by adding the following new subdivision to read:

"(9) Implementing immunization requirements for adult care homes as provided in G.S. 131D-9 and for nursing homes as provided in G.S. 131E-113."

Section 7. This act is effective when it becomes law.

SENATE BILL 1234:
Long-Term Care Residents Immunization

BILL ANALYSIS

Committee:	Health Care	**Introduced by:**	Sen. Purcell
Date:	May 31, 2000	**Summary by:**	John Young
Version:	3		Committee Staff

SUMMARY:

SB 1234 would require that adult care homes and nursing homes ensure that residents and employees are immunized against influenza virus and that residents are also immunized against pneumococcal disease. Immunization for pneumoccocal disease will be effective September 1, 2000 and immunization for influenza will be effective September 1, 2001.

CURRENT LAW:

The bill would add a new G.S. 131D-3.9 and G.S. 131E-113. There is no current requirement concerning immunization in long-term care facilities.

BILL ANALYSIS:

Section 1. Effective September 1, 2000 residents of adult care homes will be required to be immunized against pneumoccocal disease.

Section 2. Effective September 1, 2001, residents of adult care homes must be immunized annually against influenza and residents must be immunized against pneumoccocal disease.

Section 3. Effective September 1, 2000 residents of nursing homes will be required to be immunized against pneumoccocal disease.

Section 4. Effective September 1, 2001, residents and employees of nursing homes will be required to be immunized annually against influenza, and residents must also be immunized against pneumococcal disease. Also provides that authority to adopt rules for immunization resides with the Commission for Health Services

NOTE: G.S. 131D-9 and 131E-113 provides that no person may be required to receive either vaccine if it is medically countraindicated, if it is against the person's religious beliefs, or if the person refuses the vaccine after being fully informed of the health risks of not being immunized.

Section 5. Requires DHHS to make available to adult care homes and nursing homes edicational and informational materials pertaining to vaccinations.

Section 6. Amends the Commission for Health Services statute to authorize adoption of rules for immunizations.

BACKGROUND:

This bill was recommended by the North Carolina Study Commission on Aging after learning the following facts about influenza and pneumoccocal disease among the elderly:

- Although preventable by safe and effective immunizations, influenza and pneumonia are major public health problems in North Carolina, especially among senior citizens;
- In 1998, there were 2688 deaths attributable to influenza and pneumonia,of those deaths, 2362 were 65 years of age or older which is 87.9% of the total; and
- A significant difference exists between Caucasian and African-American immunization rates and mortality rates.
-

Pneumonia and influenza are the leading causes of death attributable to infection in patients aged 65 and older an in the long-term care setting, pneumonia accounts for 13 % to 48% of infections with mortality rates as high as 44%.

From the evidence presented to the Commission, residents and employees of adult care homes and nursing homes are a special population and more vulnerable to outbreaks of these diseases with increased chances of morbidity and mortality.

1997 647 deaths from I+P in Nursing Homes in NC
1558 deaths in Hosp (Some may have come from nursing homes)

NORTH CAROLINA GENERAL ASSEMBLY

LEGISLATIVE FISCAL NOTE

BILL NUMBER: SB 1234

SHORT TITLE: Long-Term Care Residents/Immuniz.

SPONSOR(S): Senator Purcell

FISCAL IMPACT

Yes (X) **No ( )** **No Estimate Available (X)**

	FY 2000-01	FY 2001-02	FY 2002-03	FY 2003-04	FY 2004-05
REVENUES	No Estimate Available				
EXPENDITURES	See Assumptions and Methodology Section.				
POSITIONS:					

PRINCIPAL DEPARTMENT(S) & PROGRAM(S) AFFECTED:
Department of Health and Human Services
Division of Medical Assistance
State/County Special Assistance

EFFECTIVE DATE: September 1, 2000

BILL SUMMARY: The proposed legislation adds two new statutes -- GS 131D-3.9 and 131E-113-- which require licensed adult care homes and nursing homes to require residents and employees to be immunized against influenza virus and to require residents also to be immunized against pneumococcal disease. Includes notification and documentation requirements for adult care homes and nursing homes. Provides that no person may be required to receive either vaccine if it is medically contraindicated, if it is against the person's religious beliefs, or if the person refuses the vaccines after being fully informed of the health risks of not being immunized. Requires the Department of Health and Human Services to make available to adult care homes and nursing homes educational and informational materials pertaining to the vaccinations.

ASSUMPTIONS AND METHODOLOGY:

A. **Cost to Provide Immunizations to Residents:** The health care costs of residents of adult care and nursing homes are covered through Medicare, Medicaid or private health insurance. Medicare is the primary coverage for most residents of adult care and nursing homes because they are age 65 and older or they are disabled. In most cases, Medicaid or private health insurance is secondary insurance for residents. The cost of the actual vaccine and the administration of the influenza virus and pneumococcal disease immunizations are covered by Medicare and Medicaid. Since Medicare is the primary health insurance for residents of adult care and nursing homes; the cost of providing immunizations to residents will have minimal fiscal impact on state or local expenditures for the Medicaid program.

B. **Cost to Provide Immunizations to Employees of Adult Care Homes and Nursing Homes:** The cost of providing the influenza virus immunization to employees of adult care and nursing homes will be the responsibility of the adult care and nursing homes. Since the Medicaid and the State/County Special Assistance Programs purchase services from adult care and nursing homes, the cost of providing immunizations to the employees of these facilities may be included in future cost reports for adult care and nursing homes which are used for rate setting. Since the actual cost of providing immunizations to employees of adult care and nursing homes is not known due to data limitations, the fiscal impact on the Medicaid and State/County Special Assistance Programs cannot be estimated.

C. **Notification and Documentation Requirements:** The proposed legislation requires adult care and nursing homes to notify all residents and employees of the immunizations requirements and to document that that immunizations have been received or refused under the requirements allowed under the proposed legislation. These notification and documentation requirements may increase costs for the adult care and nursing homes. Since the Medicaid and the State/County Special Assistance Programs purchase services from adult care and nursing homes, the cost of the notification and documentation requirements may be included in future cost reports for adult care and nursing homes which are used for rate setting. While the actual cost of the notification and documentation requirements is not known due to data limitations, the fiscal impact on the Medicaid and State/County Special Assistance Programs is expected to be minimal because facilities already maintain records for each employee and resident.

D. **Educational and Information Materials:** The Department of Health and Human Services is required to provide adult care and nursing homes with educational and informational materials pertaining to vaccinations against influenza and pneumococcal disease. Since the Division of Public Health in the Department already promotes the importance of receiving these immunizations, it is assumed that educational and informational materials are readily available for distribution. The cost of providing the materials to the facilities is minimal and can be covered within the current budget.

E. **Potential Cost Savings:** Scientific studies indicate that requiring residents of adult care and nursing homes to receive immunizations for the influenza virus and pneumococcal disease will reduce other health care costs by reducing hospitalizations for pneumonia and respiratory illnesses and decreasing the need for increased care of residents who have pneumonia or influenza while living in adult care homes or nursing homes. The direct

medical care cost savings identified in these studies range from $73 to $141 per individual vaccinated.[1,2] Most of these cost savings would accrue to the Medicare Program, but the Medicaid Program would also benefit when it is providing primary insurance coverage.

Scientific studies also indicate that requiring health care workers to receive immunizations for the influenza virus will reduce health care costs by reducing the incidence of influenza among elderly residents of long-term care facilities.[3] In addition, one study indicates that vaccinated health care workers are less like to get sick and miss days from work if they are vaccinated before the influenza season begins.[4]

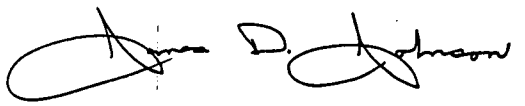
The fiscal impact of the potential cost savings from the immunization of residents and employees of adult care and nursing homes cannot be estimated due to data limitations, but any cost savings will reduce the cost for providing the immunizations.

TECHNICAL CONSIDERATIONS: None.

FISCAL RESEARCH DIVISION 733-4910

PREPARED BY: L. Carol Shaw

APPROVED BY: Jim Johnson



DATE: May 30, 2000

[1] Kristin I. Nichol et. al., "Benefits of Influenza Vaccination for Low-, Intermediate-, and High-Risk Senior Citizens," Archives of Internal Medicine, 1998; 158:1769-1779.
[2] Carol B. Gable et. al., "Pneumococcal Vaccine: Efficacy and Associated Cost Savings," JAMA, 1990; 264:2910-2915.
[3] J. Potter et. al., "Influenza Vaccinations of health Care Workers in Long-Term-Care Hospitals Reduces the Mortality of Elderly Persons." The Journal of Infectious Disease, 1997; 175:1-6.
[4] James A. Wilde et. al., "Effectiveness of Influenza Vaccine in Health Care Workers," JAMA, 1999; 281:908-913.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE — MAY 31, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Austin Bunch	ECU
J. Craig Quick	PCMH / UHS
Whitney Obrig	OSBM
[illegible]	
Patricia A. Yancey	Hospice / FOR
Joseph V Liberty	Home Health / Hospice
MT Burnett	GACPD
Patricia Reeder	NCACC
Howard Kramer	N.C. Bd of Nursing.

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE — MAY 31, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Bowdish	Alley Associates
Cynthia Jonahanka	GPCPD
Joe Donovan	NAMI - NC
Bennett Hollers	DHHS
Stacy Flannery	NCHCFA
Joanne Schoen	NC Nurse Association
Jerry Cooper	DC Assisted Living Association
Jesse Goodman	DHHS - DFS
Lynda McDaniel	DHHS/DFS
[illegible]	DHHS/DFS
[illegible]	Bone & Assoc -
Lou B. Allison	NCALTRF

VISITOR REGISTRATION SHEET

HEALTH CARE COMMITTEE — MAY 31, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kathy Wellman	5277 Fairmead Circle - Raleigh NC
Amy Jo Bain	NC Medical Society
Bill Hottel	Div. of Medical Assistance
Ann Kimbrell, R.N	" " "
Susan Brewer Morgan	Division of Public Health
Barbara Layman	" " " "
Michelle Cotton	DMH/DD/SAS
Jan Ramquist	NCAHA
Stephen W. Keene	NC Medical Society
Suzanne Merrill	NC Division of Social Services
Shannese Ransome	DSS

REVISION NO. 1

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 7, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- S.B. 1215, Medical Care Commission/Rules — Senator Dannelly
- S.B. 1258, Medicaid $/Dental Care — Senator Martin
- S.B. 1431, Health Standards/Secretary HHS — Senator Purcell
- S.B. 1217, Mental Health Reform — Senator Phillips

Senator William R. Purcell, Chair

Please Note: S.B. 1217 has been added to the agenda for this meeting.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 7, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- S.B. 1215, Medical Care Commission/Rules — Senator Dannelly
- S.B. 1258, Medicaid $/Dental Care — Senator Martin
- S.B. 1431, Health Standards/Secretary HHS — Senator Purcell

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE
ROOM 1124, LEGISLATIVE BUILDING
JUNE 7, 2000
12:00 NOON

CALL TO ORDER

Senator William R. Purcell, Chair

APPROVE MINUTES OF PREVIOUS MEETING

CONSIDERATION OF BILLS

S.B. 1215	**Medical Care Commission/Rules**	**Senator Dannelly**
S.B. 1258	**Medicaid$/Dental Care**	**Senator Martin**
S.B. 1431	**Health Standards/Secretary HHS**	**Senator Purcell**
S.B. 1217	**Mental Health Reform**	**Senator Phillips**

ADJOURNMENT

Senate Health Care Committee
Wednesday, June 7, 2000
12:00 Noon
1124 Legislative Building

MINUTES

The Senate Health Care Committee met at 12:00 noon on Wednesday, June 7, 2000, in Room 1124 of the Legislative Building. Seven members of the committee were present. Senator William R. Purcell presided.

Senator Purcell called the meeting to order and introduced Senator Dannelly to present S.B. 1215, *Medical Care Commission/Rules*. A committee substitute was presented by Senator Dannelly. Senator Lucas moved that the substitute be adopted for purposes of discussion and the motion carried. Senator Dannelly explained the reason for removing the bill from last week's meeting and said that a problem with the bill had been resolved; and moved for a favorable report. There being no further discussion, the motion carried.

Senator Purcell asked Senator Phillips to chair the meeting in order that he could explain S.B. 1431, *Health Standards/Secretary HHS*. He said that the purpose of this bill is to provide a "report card" on North Carolina's health care statistics from one year to the next in order that goals can be set to improve health care for the people of North Carolina. He introduced Hugh Tilson, Vice President of Government Relations for the N.C. Hospital Association, who commended the bill on behalf of the Hospital Association. Senator Moore asked if this bill would be sent on to the Appropriations Committee, and the answer was yes. Senator Dannelly moved for a favorable report, and the motion carried.

Senator Purcell introduced Senator Bill Martin to present S.B. 1258, *Medicaid $/Dental Care*. He said that the primary purpose of this bill is to make dental care available to poor children by raising the reimbursement rate to 80 percent of the usual and customary rate. He offered an amendment that would monitor the extent to which the reimbursement would increase the number of Medicaid-eligible children and move the reporting deadline date to May 2002. He moved that the amendment be adopted. Senator Moore offered an amendment that would eliminate a study committee for this bill so that this bill would stay inside the Health Care Committee and the Health Care Oversight Commission. Senator Hagan inquired as to who establishes the usual and customary rates; Senator Rucho was able to provide the answer, the insurance companies. Senator Martin requested that these two amendments be rolled into a committee substitute. Mr. William H. Potter, Jr., representing the Dental Society, and Ms. Janice Rehnquist, representing the Dental Hygienist Association, spoke for the bill. Senator Rucho asked that he be excused from voting and the Chair so noted. Senator Moore moved that the proposed committee substitute, incorporating the two amendments, be given a favorable report. The motion carried.

Senator Purcell introduced Senator Phillips who presented S.B. 1217, *Mental Health Reform* to the committee. Senator Phillips reviewed the work that has gone into this bill and the work and the responsibilities that are inherent in it. Senator Moore moved for a favorable report. Senator Martin rose to commend Senator Phillips for all the work he has put into this legislation. There being no additional comments from the committee or the public the committee voted and the motion carried.

The meeting adjourned at 12:55 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Friday, June 09, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1258** Medicaid $/Dental Care

Draft Number:	PCS6789
Sequential Referral:	Appropriations/Base Budget
Recommended Referral:	None
Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, June 07, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

S.B. **1217** Mental Health System Reform.
Sequential Referral: Rules
Recommended Referral: None

S.B. **1431** Health Standards/Secretary HHS
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

UNFAVORABLE AS TO BILL, BUT FAVORABLE AS TO C.S. BILL

S.B. **1215** Medical Care Commn./Rules.
Draft Number: PCS6786
Sequential Referral: None
Recommended Referral: None
Long Title Amended: No

TOTAL REPORTED: 3

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1215*
Health Care Committee Substitute Adopted 6/7/00

Short Title: Medical Care Commn./Rules. (Public)

Sponsors:

Referred to:

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-4.3(a) reads as rewritten:

"(a) Pursuant to G.S. ~~143B-153, the Social Services~~ 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of the following by adult care homes:

~~(1) Client assessment and independent case management;~~

(2) A minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to State-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:

a. Basic nursing skills;

b. Personal care skills;

c. Cognitive, behavioral, and social care;

d. Basic restorative services; and

e. Residents' rights.

A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;

(3) Monitoring and supervision of residents;

(4) Oversight and quality of care as stated in G.S. 131D-4.1; and

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

In addition to these requirements, the facility shall provide staff to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term 'heavy care resident' means an individual residing in an adult care home who is defined 'heavy care' by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs."

Section 2. G.S. 131D-4.5(5) reads as rewritten:

"**§ 131D-4.5. Rules adopted by Medical Care Commission.**

The Medical Care Commission shall adopt rules as follows:

. . .

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules ~~may provide for procedures comparable to those provided to nursing home residents pursuant to federal law, to Chapter 131E of the General Statutes, and to related rules.~~ shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 3. G.S. 131D-21(17) reads as rewritten:

"**§ 131D-21. Declaration of residents' rights.**

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the ~~Secretary,~~ Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The ~~Secretary~~ Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 4. G.S. 143B-153(2) reads as rewritten:

"(2) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For the programs of public assistance established by federal legislation and by Article 2 of Chapter 108A of the General Statutes of the State of North Carolina with the exception of the program of medical assistance established by G.S. 108A-25(b);

b. To achieve maximum cooperation with other agencies of the State and with agencies of other states and of the federal government in rendering services to strengthen and maintain family life and to help recipients of public assistance obtain self-support and self-care;

c. For the placement and supervision of dependent juveniles and of delinquent juveniles who are placed in the custody of the Office of Juvenile Justice, and payment of necessary costs of foster home care for needy and homeless children as provided by G.S. 108A-48; ~~and~~

d. For the payment of State funds to private child-placing agencies as defined in G.S. 131D-10.2(4) and residential child care facilities as defined in G.S. 131D-10.2(13) for care and services provided to children who are in the custody or

placement responsibility of a county department of social ~~services.~~ services; and

e. For client assessment and independent case management pertaining to the functions of county departments of social services for public assistance programs authorized under paragraph a. of this subdivision."

Section 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1215*
Proposed Committee Substitute S1215-PCS6786-LN100

Short Title: Medical Care Commn./Rules. (Public)

Sponsors:

Referred to:

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-4.3(a) reads as rewritten:

"(a) Pursuant to G.S. ~~143B-153, the Social Services~~ 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of the following by adult care homes:

~~(1) Client assessment and independent case management;~~

(2) A minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to State-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:

a. Basic nursing skills;

b. Personal care skills;

c. Cognitive, behavioral, and social care;

d. Basic restorative services; and

e. Residents' rights.

A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;

(3) Monitoring and supervision of residents;

(4) Oversight and quality of care as stated in G.S. 131D-4.1; and

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

In addition to these requirements, the facility shall provide staff to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term 'heavy care resident' means an individual residing in an adult care home who is defined 'heavy care' by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs."

Section 2. G.S. 131D-4.5(5) reads as rewritten:

"**§ 131D-4.5. Rules adopted by Medical Care Commission.**

The Medical Care Commission shall adopt rules as follows:

. . .

(5) Implementing the due process and appeal rights for discharge and transfer of residents in adult care homes afforded by G.S. 131D-21. The rules ~~may provide for procedures comparable to those provided to nursing home residents pursuant to federal law, to Chapter 131E of the General Statutes, and to related rules.~~ shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 3. G.S. 131D-21(17) reads as rewritten:

"**§ 131D-21. Declaration of residents' rights.**

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the ~~Secretary,~~ Medical Care Commission, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. The ~~Secretary~~ Medical Care Commission shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes."

Section 4. G.S. 143B-153(2) reads as rewritten:

"(2) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For the programs of public assistance established by federal legislation and by Article 2 of Chapter 108A of the General Statutes of the State of North Carolina with the exception of the program of medical assistance established by G.S. 108A-25(b);

b. To achieve maximum cooperation with other agencies of the State and with agencies of other states and of the federal government in rendering services to strengthen and maintain family life and to help recipients of public assistance obtain self-support and self-care;

c. For the placement and supervision of dependent juveniles and of delinquent juveniles who are placed in the custody of the Office of Juvenile Justice, and payment of necessary costs of foster home care for needy and homeless children as provided by G.S. 108A-48; ~~and~~

d. For the payment of State funds to private child-placing agencies as defined in G.S. 131D-10.2(4) and residential child care facilities as defined in G.S. 131D-10.2(13) for care and services provided to children who are in the custody or

placement responsibility of a county department of social ~~services.~~ services; and

e. For client assessment and independent case management pertaining to the functions of county departments of social services for public assistance programs authorized under paragraph a. of this subdivision."

Section 5. This act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1215*

Short Title: Medical Care Commn./Rules. (Public)

Sponsors: Senators Dannelly, Purcell, Carpenter, Carter, Forrester, Harris; Albertson, Ballance, Cochrane, Gulley, Lee, Lucas, Martin of Guilford, Martin of Pitt, Perdue, Phillips, Purcell, and Reeves.

Referred to: Health Care.

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO MAKE CONFORMING CHANGES TO THE GENERAL STATUTES PERTAINING TO MEDICAL CARE COMMISSION AUTHORITY TO ADOPT RULES REGULATING ADULT CARE HOMES AND SOCIAL SERVICES COMMISSION AUTHORITY TO ADOPT RULES PERTAINING TO PUBLIC ASSISTANCE PROGRAMS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 131D-4.3(a) reads as rewritten:

"**§ 131D-4.3. Adult care home rules.**

(a) Pursuant to G.S. ~~143B-153, the Social Services~~ 143B-165, the North Carolina Medical Care Commission shall adopt rules to ensure at a minimum, but shall not be limited to, the provision of the following by adult care homes:

(1) Client assessment and independent case management;

(2) A minimum of 75 hours of training for personal care aides performing heavy care tasks and a minimum of 40 hours of training for all personal care aides. The training for aides providing heavy care tasks shall be comparable to State-approved Certified Nurse Aide I training. For those aides meeting the 40-hour requirement, at least 20 hours shall be classroom training to include at a minimum:

a. Basic nursing skills;

b. Personal care skills;

c. Cognitive, behavioral, and social care;
d. Basic restorative services; and
e. Residents' rights.

A minimum of 20 hours of training shall be provided for aides in family care homes that do not have heavy care residents. Persons who either pass a competency examination developed by the Department of Health and Human Services, have been employed as personal care aides for a period of time as established by the Department, or meet minimum requirements of a combination of training, testing, and experience as established by the Department shall be exempt from the training requirements of this subdivision;

(3) Monitoring and supervision of residents;

(4) Oversight and quality of care as stated in G.S. 131D-4.1; and

(5) Adult care homes shall comply with all of the following staffing requirements:

a. First shift (morning): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents (licensed capacity or resident census) plus 3.0 hours for all other residents, whichever is greater;

b. Second shift (afternoon): 0.4 hours of aide duty for each resident (licensed capacity or resident census), or 8.0 hours of aide duty per each 20 residents plus 3.0 hours for all other residents (licensed capacity or resident census), whichever is greater;

c. Third shift (evening): 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census).

In addition to these requirements, the facility shall provide staff to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this subdivision, the term 'heavy care resident' means an individual residing in an adult care home who is defined 'heavy care' by Medicaid and for which the facility is receiving enhanced Medicaid payments for such needs."

Section 2. G.S. 131D-21(17) reads as rewritten:

"**§ 131D-21. Declaration of residents' rights.**

Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

. . .

"(17) To not be transferred or discharged from a facility except for medical reasons, the residents' own or other residents' welfare, nonpayment for the stay, or when the transfer is mandated under State or federal law. The resident shall be given at least 30 days' advance notice to ensure orderly transfer or discharge, except in

the case of jeopardy to the health or safety of the resident or others in the home. The resident has the right to appeal a facility's attempt to transfer or discharge the resident pursuant to rules adopted by the Secretary, and the resident shall be allowed to remain in the facility until resolution of the appeal unless otherwise provided by law. ~~The Secretary shall adopt rules pertaining to the transfer and discharge of residents that offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes.~~"

Section 3. G.S. 143B-153(2) reads as rewritten:

. . .

"(2) The Social Services Commission shall have the power and duty to establish standards and adopt rules and regulations:

a. For the programs of public assistance established by federal legislation and by Article 2 of Chapter 108A of the General Statutes of the State of North Carolina with the exception of the program of medical assistance established by G.S. 108A-25(b);

b. To achieve maximum cooperation with other agencies of the State and with agencies of other states and of the federal government in rendering services to strengthen and maintain family life and to help recipients of public assistance obtain self-support and self-care;

c. For the placement and supervision of dependent juveniles and of delinquent juveniles who are placed in the custody of the Office of Juvenile Justice, and payment of necessary costs of foster home care for needy and homeless children as provided by G.S. 108A-48; ~~and~~

d. For the payment of State funds to private child-placing agencies as defined in G.S. 131D-10.2(4) and residential child care facilities as defined in G.S. 131D-10.2(13) for care and services provided to children who are in the custody or placement responsibility of a county department of social ~~services.~~ services; and

e. For client assessment and independent case management pertaining to the programs of public assistance authorized under paragraph a. of this subdivision."

Section 4. This act is effective when it becomes law.

SENATE BILL 1215:
Medical Care Commission/Rules

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Sen. Dannelly
Date:	June 6, 2000	**Summary by:**	John Young
Version:	4		Committee Staff

SUMMARY:

Senate Bill 1215 makes conforming changes to the General statutes pertaining to the Medical Care Commission's authority to adopt rules regulating adult care homes and Social Services Commission authority to adopt rules pertaining to public assistance programs. It also makes it clear that Medical Care Commission rules pertaining to transfer and discharge of adult care home residents shall be as stringent as the temporary rules adopted by the Secretary of DHHS

BILL ANALYSIS and BACKGROUND:

The 1999 General Assembly passed Senate Bill 10, which established new safety requirements for adult care homes pertaining to medication administration, staff training, and standards for supervisors and staffing requirements. This bill amended G.S. 143B-153, G.S. 143B-165 and several provisions in G.S. Chapter 131D to transfer from the Social Services Commission to the Medical Care Commission rule making authority with respect to the licensure, inspection, and operation of adult care homes and personnel requirements for adult care home staff.

Although it was the intent of the bill sponsors to transfer rule-making authority for adult care homes to the Medical Care Commission, Senate Bill 10 failed to do that completely. Therefore Senate Bill 1215 makes some changes to delete temporary rule making authority by the Secretary and to complete the transfer of rule making authority to the Medical Care Commission. The following changes are proposed in SB 1215:

- **Sections 1 and 4**-Section 1 deletes one overlooked reference to the Social Services Commission; and deletes the client assessment and independent case management language from the duties of the Medical Care Commission for adult care homes. Adult care homes do not provide and are not reimbursed to provide independent case management for residents. The Social Services Commission needs to have continuing authority to adopt rules for client assessment and case management needed to determine whether State/County Special Assistance applicants and recipients need adult care home level of care. Therefore Section 4 adds it as a duty of the Social Services Commission.
- **Sections 2 and 3**-delete reference to the Secretary of DHHS having temporary rule making authority with respect to transfer and discharge of residents in adult care homes, thereby leaving sole authority for this function with the Medical Care Commission. In the temporary rules, the Secretary "shall offer at least the same protections to residents as State and federal rules and regulations governing the transfer or discharge of residents from nursing homes". This same requirement would be placed on the Medical Care Commission.
- **Section 4**-makes it clear that the Social Services Commission still has the authority to adopt rules for client assessment and independent case management activities administered by county departments of social services concerning programs of public assistance authorized under paragraph a.of this subdivision. The effect is to give both the Social Services Commission and the Medical Care Commission authority to make rules for State/County Special Assistance clients in adult care homes.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 2

SENATE BILL 1258
Health Care Committee Substitute Adopted 6/12/00

Short Title: Medicaid $/Dental Care. (Public)

Sponsors:

Referred to:

May 16, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO INCREASE THE MEDICAID REIMBURSEMENT RATE FOR DENTAL CARE FOR ELIGIBLE CHILDREN, TO APPROPRIATE FUNDS TO ENHANCE EFFORTS TO EXPAND DENTAL CARE FOR LOW-INCOME POPULATIONS IN THE STATE, AND TO ESTABLISH A TASK FORCE TO MAKE RECOMMENDATIONS TO IMPROVE ACCESS TO DENTAL CARE.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of four million six hundred thousand dollars ($4,600,000) for the 2000-2001 fiscal year. These funds shall be used to increase the Medicaid reimbursement rate for dental care for eligible children to eighty percent (80%) of the Usual and Customary Rate charged by North Carolina dentists.

Section 2. There is appropriated from the General Fund to the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development, the sum of five hundred thousand dollars ($500,000) for the 2000-2001 fiscal year. These funds shall be allocated to the Recruitment and Incentives Program for loan repayment for dentists who serve Medicaid and low-income patients in nonprofit dental programs.

Section 3.(a) In consultation with the State Public Health Director, representatives of the School of Dentistry at the University of North Carolina at

Chapel Hill, the North Carolina Dental Society, the Old North State Dental Society, the North Carolina Medical Society, the North Carolina Dental Hygiene Association, The North Carolina Institute of Medicine, and consumer organizations, the Secretary of the Department of Health and Human Services shall monitor and examine the following:

(1) The extent to which the Medicaid reimbursement rate increase is resulting in an increase in:
   a. The number of Medicaid-eligible children seen by dentists participating as Medicaid providers;
   b. The number of dentists participating as Medicaid providers; and
   c. The number of dentists practicing in underserved areas of the State;

(2) Changes in the quality of dental services delivered to Medicaid patients;

(3) The successful creation of a stronger coalition of oral health care providers and physicians, funding agencies, and nonprofit organizations focusing on the oral health care needs of children; and to encourage strengthening of that coalition;

(4) The development of strategies for building upon the recommendations of the North Carolina Institute of Medicine's Task Force on Dental Care Access's 1999 report to the North Carolina General Assembly and to the Secretary of the North Carolina Department of Health and Human Services; and

(5) The identification of additional measures that should be undertaken to improve access to and the quality of oral health care for children.

Section 3.(b) Not later than May 1, 2001, and May 1, 2002, the Secretary shall report any findings and recommendations to the chairpersons of the Senate Appropriations Committee on Human Resources, the House of Representatives Appropriations Subcommittee on Health and Human Services, the Joint Legislative Healthcare Oversight Committee, the Senate and House Health Committees, and to the Fiscal Research Division of the General Assembly.

Section 4. Section 1 of this act becomes effective January 1, 2001. The remainder of this act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1258

Short Title: Medicaid $/Dental Care. (Public)

Sponsors: Senators Martin of Guilford; Albertson, Carpenter, Dannelly, Foxx, Lucas, Phillips, Purcell, Rucho, Warren, Weinstein, and Wellons.

Referred to: Health Care.

May 16, 2000

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO INCREASE THE MEDICAID REIMBURSEMENT RATE FOR DENTAL CARE FOR ELIGIBLE CHILDREN, TO APPROPRIATE FUNDS TO ENHANCE EFFORTS TO EXPAND DENTAL CARE FOR LOW-INCOME POPULATIONS IN THE STATE, AND TO ESTABLISH A TASK FORCE TO MAKE RECOMMENDATIONS TO IMPROVE ACCESS TO DENTAL CARE.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Health and Human Services the sum of four million six hundred thousand dollars ($4,600,000) for the 2000-2001 fiscal year. These funds shall be used to increase the Medicaid reimbursement rate for dental care for eligible children to eighty percent (80%) of the Usual and Customary Rate charged by North Carolina dentists.

Section 2. There is appropriated from the General Fund to the Department of Health and Human Services, Office of Research, Demonstrations, and Rural Health Development, the sum of five hundred thousand dollars ($500,000) for the 2000-2001 fiscal year. These funds shall be allocated to the Recruitment and Incentives Program for loan repayment for dentists who serve Medicaid and low-income patients in nonprofit dental programs.

Section 3.(a) The Secretary of Health and Human Services shall establish a task force to address issues pertaining to availability of dental care in underserved

areas of the State. The Secretary shall appoint members of the task force who shall include the following:

(1) The Dean of the UNC-CH School of Dentistry, or the Dean's designee.
(2) The State Public Health Director, or the Director's designee.
(3) At least one representative from each of the following:
  a. The North Carolina Dental Society.
  b. The North Carolina Medical Society.
  c. The Dental Hygiene Association.
  d. The North Carolina Institute of Medicine.
  e. A consumer organization.

Section 3.(b) The task force shall make recommendations on methods for improving:

(1) The availability of dentists in areas of the State underserved for dental care. The recommendation should include methods for eliminating factors that result in dentists' declining to serve Medicaid patients.
(2) Access to oral health care by North Carolina's children.
(3) Quality of dental services delivered to Medicaid patients.

Section 3.(c) Not later than February 1, 2001, the task force shall report its findings and recommendations to members of the Senate Appropriations Committee on Human Resources and the House of Representatives Appropriations Subcommittee on Health and Human Services.

Section 3.(d) The Department of Health and Human Services shall use funds available to the Department for the 2000-2001 fiscal year to carry out the work of the task force.

Section 4. Section 1 of this act becomes effective January 1, 2001. The remainder of this act becomes effective July 1, 2000.

SENATE BILL 1258:
Medicaid Funds/Dental Care

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Sen. Martin
Date:	June 7, 2000	**Summary by:**	John Young
Version:	1		Committee Staff

SUMMARY: Senate Bill 1258 appropriates $4.6 million for FY 2000-2001 to increase the Medicaid reimbursement rate for dental care for eligible children; appropriates $500,000 for FY2000-2001 to enhance efforts to expand dental care for low-income populations; and establishes an access to dental care task force.

BILL ANALYSIS:

Section 1-Appropriates $4,600,000 for FY 200-2001 to the Department of Health and Human Services to be used to increase the Medicaid reimbursement rate for dental care for eligible children to 80% of the usual and customary rate charged by North Carolina dentists.

Section 2-Makes a $500,000 appropriation for FY 2000-2001 to DHHS, Office of Research, Demonstrations and Rural Health for loan repayment for dentists who serve Medicaid and low-income patients in non-profit dental programs

Section 3-Requires the Secretary of DHHS to establish a task force to include: (1) Dean of UNC-CH School of Dentistry; (2) State Public Health Director; (3) at least one representative from the NC Dental Society, the NC Medical Society, the Dental Hygiene ASS'n, the NC Institute of Medicine, and a consumer organization. The task force shall make recommendations by February 1, 2001 on the availability of dentists in areas undeserved for dental care, access to oral health care for children, and quality of dental services delivered to Medicaid patients. DHHS shall use funds available to carry out the work of the task force.

Section 4-Section 1 becomes effective January 1, 2001. The remainder of the act becomes effective July 1, 2000

BACKGROUND: Over a number of years there has been much concern and debate in the General Assembly about the level of participation of dentists in the Medicaid dental program. The Department of Health and Human Services at the direction of the General Assembly commissioned the Institute of Medicine to establish a Task Force on Dental Care Access to assess possible remedies. The Institute of Medicine found that inadequate access to dental care is commonplace among children of families living in poverty. A lack of dental care for low-income and Medicaid-eligible adults and children often results in severe or persistent pain, inability to eat swollen faces, and increased susceptibility to other medical conditions. A number of factors influence the low use of dental services among Medicaid recipients. One of the primary problems is the low dentist participation rate in the Medicaid program. Only 16% of North Carolina dentists actively participate in the Medicaid program because of the payment rates. On average, North Carolina pays dentists approximately 62% of their usual, customary and reasonable charges for 44 of the most common procedures for children, and 42% of UCR for other procedures. The Institute of Medicine Task Force on Dental Care Access included a number of recommendations in their REPORT. SB 1258 reflects several of these recommendations.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1431*

Short Title: Health Standards/Secretary HHS. (Public)

Sponsors: Senators Purcell, Perdue, Forrester; Albertson, Dannelly, Garwood, Kinnaird, Lucas, and Warren.

Referred to: Health Care.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO DIRECT THE SECRETARY OF HEALTH AND HUMAN SERVICES TO ESTABLISH COMMUNITY HEALTH STANDARDS, AND TO APPROPRIATE FUNDS THEREFOR.

The General Assembly of North Carolina enacts:

Section 1. Article 1 of Chapter 130A of the General Statutes is amended by adding the following new section to read:

"**§ 130A-5.1. State health standards.**

(a) The Secretary shall adopt measurable standards and goals for community health against which the State's actions to improve the health status of its citizens will be measured. The Secretary shall report annually to the General Assembly upon its convening and to the Governor on all of the following:

(1) How the State compares to national health measurements and established State goals for each standard. Comparisons shall be reported using disaggregated data for health standards.

(2) Steps taken by State and non-State entities to meet established goals.

(3) Additional steps proposed or planned to be taken to achieve established goals.

(b) The Secretary may coordinate and contract with other entities to assist in the establishment of standards and preparation of the report. The Secretary may use resources available to implement this section."

Section 2. There is appropriated from the General Fund to the Department of Health and Human Services the sum of fifty thousand dollars ($50,000) for the 2000-2001 fiscal year to implement this act.

Section 3. Section 1 of this act becomes effective October 1, 2000. Section 2 of this act becomes effective July 1, 2000. The remainder of this act is effective when it becomes law.

SENATE BILL 1431:
Health Standards/Secretary DHHS

BILL ANALYSIS

Committee:	Health Care	**Introduced by:**	Senators Purcell, Forrester, Perdue
Date:	June 5, 2000		
Version:	1	**Summary by:**	John Youne Committee Counsel

SUMMARY: Senate Bill 1431 directs the Secretary of the Department of Health and Human Services to make an annual report to the General Assembly based on community health standards and appropriates $50,000 for the 2000-2001 biennium

CURRENT LAW: There is no current requirement for the Secretary of the Department of Health and Human Services to report to the General Assembly concerning the health statutes of the citizens of North Carolina.

BILL ANALYSIS:

Section 1-Adds a new duty of the Secretary of DHHS to require the Secretary to adopt measurable standards and goals to improve the health status of North Carolinians and then report annually to the General Assembly on: (1) how the State compares to national measurements against State goals; (2) steps taken by State and non-state entities to meet the established goals; and (3) additional steps to be taken to achieve goals.

Section 2-Appropriates $50,000 for FY 2000-2001 to implement the act.

Section 3-Section 1 is effective October 1,2000. Section 2 is effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1217*

Short Title: Mental Health System Reform. (Public)

Sponsors: Senators Phillips, Carpenter, Dannelly, Lucas, Martin of Pitt, Martin of Guilford, Purcell; Albertson, Ballance, Carter, Clodfelter, Cooper, Dalton, Forrester, Foxx, Garrou, Garwood, Gulley, Hagan, Harris, Hoyle, Jordan, Kerr, Kinnaird, Lee, Rand, Robinson, Warren, Weinstein, and Wellons.

Referred to: Health Care.

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the

Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.
c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:
a. At least two members of the House of Representatives Committee on Appropriations.
b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.
c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge

of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 3.(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 3.(c) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

Section 3.(d) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, and substance abuse services.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 3.(e) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

SB 1217:
Mental Health System Reform

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Senator Phillips
Date:	June 7, 2000	**Summary by:**	Linda Attarian
Version:	1		Committee Counsel

SUMMARY: ***The bill establishes a new Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. The oversight committee proposed in the legislation would oversee the development of a plan to reform the current system of public mental health, developmental disabilities and substance abuse services and address other issues including structure, governance and financing of services, downsizing of state hospitals, developmental disabilities services, quality of services, and ongoing involvement of consumers and families. The act would become effective July 1, 2000. The oversight committee would be appointed within 30 days of adjournment sine die of the 1999 General Assembly and would convene its first meeting no later than 15 days after all members were appointed.***

CURRENT LAW/BACKGROUND: Currently, pursuant to G.S. 120-204 the Legislative Study Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (Study Commission) exists to "study systemwide issues affecting the development, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered". The Study Commission is composed of 22 members, including 14 members of the General Assembly, representatives of organizations that advocate for individuals in need of mental health, developmental disabilities and substance abuse services, providers and consumers of services, and county commissioners.

The Study Commission is recommending this legislation to establish a new Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (Oversight Committee). The Study Commission recommends that this new Oversight Committee be established for the sole purpose to oversee the development of a plan to reform the current mental health infrastructure and delivery of public mental health, developmental disabilities and substance abuse services. The Oversight Commission is to use, as a blueprint, a comprehensive study of the State's mental health system conducted by the Public Consulting Group, Inc. and coordinated by and under contract with the Office of the State Auditor. The results of the study were published in April 2000 in a report entitled "Study of State Psychiatric Hospitals and Area Mental Health Programs".

BILL ANALYSIS:

Section 1. – This section sets out the findings of the General Assembly with respect to the need for reforming the current public mental health system.

Section 2. – This section establishes a statutory joint legislative oversight committee on mental health, developmental disabilities and substance abuse services. Specifically, the committee:

(1) *Composition*: From each chamber, 8 members to include: Appropriations committee; Chair of DHHS appropriations subcommittee; 2 from minority party

(2) *Terms*: 2 year, beginning on convening of each GA in odd-year. Except, initial term will begin on appointment and end upon convening of 2001 GA. Appointments are to be made within 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee is to convene its first meeting within 15 days after all the members have been appointed.

(3) *Purpose* is to examine systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to governance, accountability, and quality of services.

(4) *Committee organization* (appointment of co-chairs; quorum; powers of joint committee conferred by G.S. 120-19.1 through 19.4).

Section 3(a), (b), (c). – These sections define terms; and direct the Oversight Committee to develop a "Plan for Mental Health System Reform"; and provides the requirements, purposes and content of the Plan.

Section 3(d). – This section requires the Oversight Committee to form subcommittees to consider and develop assigned focus areas of the Plan. The subcommittees will consist of nonvoting representatives from provider groups, consumers, State and local government, business and industry, and advocacy organizations.

Section 3(e). - This section requires the Oversight Committee to meet specified reporting guidelines. The Committee's initial report is due upon the convening of the 2001 General Assembly and its final report is due upon the convening of the 2005 General Assembly. The Committee must also make a progress report concerning the status of its study of the administration, financing, and delivery of developmental disabilities services pursuant to Section 3(c) of the bill upon the convening of the 2001 General Assembly.

Section 4. – This section requires the Speaker of the House of Representatives and the President Pro Tempore of the Senate to make their appointments to the Committee not later than 30 days from the date of adjournment sine die. The section also requires the Committee to convene its first meeting not later than 15 days after the appointments have been made.

Section 5. – This section requires the Department of Health and Human Services to report to both the Joint Legislative Oversight Committee established under Section 2 of the bill and the existing Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services on or before October 1, 2000 and on or before March 1, 2001 on the status of the Department's reorganization efforts.

Section 6. – Effective date: July 1, 2000.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 7, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Kerri Egan	YAID
Martha Lorraine	YAID
Polly Williams	AARP
Helen Lipman	Mech. Co.
Carol Seel	Friends of Residents in Long Term Care
Wendy Sause	NC Division of Aging
John L Crawford	AARP A
Dorothy R Crawford	AARP
Janet Schwegenbach	NC Council
Beth Melcher	NAMI NC
Sharon Hirsch	NC Social Services Consortium
Lyn Wilson	NCALTCF
JoAnn Norris	Public School Forum

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 7, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Cheryl Piet	NC State
Alison Bridges	NC State
Spencer Phillips	State Auditor
Patricia Roeder	NCACC
R. Paul Wilms	NCMBA
Joseph Reynolds	NC Gov's Inst. on Alcohol + SA
David Richard	Arc/in c
Joe Mea	AHHC,
[illegible]	DHHS
[illegible]	[illegible]
Lynda McDaniel	DHHS/DFS
Bernie Heller	DHHS
[illegible]	NCDS

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 7, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Rau	NCFPC
John Bowdish	Alley Associates
Art Rohrer	DMH/DD/SAS
Larry Dix	OJJ
Edwin Stata	General Assembly
Cliff Callaway	Doctor of the Day
Sara Piercy	NC Dental Society
Hugh Wilson	NCHA
Stacy Flannery	NCHCFA
Sara R. Allen	Covenant w/ NC's Children
Amanda Abrams	"

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 7, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Alicia Muenchbaum	YAIO
Shannon Vickery	UNC-TV
Amy Jo Bain	NCMS
MT Burnett	GACPD
Vicky Young	OSA
Lily Farel	DHHS
Glenn Wells	DHHS
Chris Hoke	DHHS
Roc Smith	NCCCC
[illegible]	NCAA/PC comm
Charlotte Davis	DHHS Medicaid
J Kiddle, MD	DMH/DD/SAS

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 14, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- H.B. 1340, Respiratory Care Practice Act — Representative Tolson
- H.B. 1514, Respite Care Program No Sunset — Representative Melton

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE
ROOM 1124, LEGISLATIVE BUILDING
JUNE 14, 2000
12:00 NOON

CALL TO ORDER

Senator William R. Purcell, Chair

APPROVAL OF MINUTES

CONSIDERATION OF BILLS

H.B. 1340	**Respiratory Care Practice Act**	**Representative Tolson**
H.B. 1514	**Respite Care Program No Sunset**	**Representative Melton**

ADJOURNMENT

Senate Health Care Committee
Wednesday, June 14, 2000
12:00 Noon
1124 Legislative Building

MINUTES

The Senate Health Care Committee met at 12:00 noon on Wednesday, June 14, 2000, in Room 1124 of the Legislative Building. Thirteen members of the committee were present. Senator William R. Purcell presided.

Senator Purcell asked Staff Counsel John Young to explain H.B. 1514, *Respite Care Program No Sunset.* There being no questions from the committee members Senator Lucas moved for a favorable report. The motion carried, and at the committee's recommendation, the bill will be sent on to the Appropriations Committee.

Senator Purcell brought H.B. 1340, *Respiratory Care Practice Act* to the committee's attention. Senator Lucas made an amendment to the House committee substitute bill and asked Ms. Attarian, Staff Counsel, to explain the amendment. Representative Tolson, the bill's sponsor, had no objections to the amendment. The amendment was voted on and approved. Representative Tolson presented the bill to the committee and explained its provisions. Mr. William R. Potter, Jr., representing the North Carolina Physical Therapy Association, said that his group was concerned about the definition of respiratory care (non-traditional); and also the definition of training. Representative Tolson asked Dr. Neil McIntyre, Chief of Pulmonary and Critical Care at Duke University, to respond to Mr. Potter's concerns. Dr. McIntyre said that it is his understanding that wording was left vague so that respiratory care practitioners would be allowed to utilize new techniques as they come along; and that it was felt that it was reasonable to give the National Board of Respiratory Care some leeway in educational requirements to allow respiratory care practitioners to perform these new techniques. Senator Martin asked if "new and innovative" could not be substituted for non-traditional; and asked what would be the appropriate licensing associations. Senator Lucas asked what would be the established professional association. Dr. McIntyre responded that that would be the American Association for Respiratory Care. Ms. Jan Tallman, Associate Director of Respiratory Care at Duke, said that the American Association for Respiratory Care is made up of physician bodies such as the North Carolina Thoracic Society, and that the minimum educational requirement for a respiratory care practitioner as stated by the A.A.R.C. is an associate degree, which is a two-year program. Senator Lucas asked if this association does training and develops guidelines. The response was yes. Dr. McIntyre said that the National Board of Respiratory Care exam, which is in the N.C. Statutes, requires at least a high school degree and one at the Associate level in order to be licensed, and that the objections raised by Mr. Potter have already been addressed.

Mr. Tolson asked Mr. Ralph Webb, Director of Respiratory Care at Edgecomb Community College, to comment on licensing requirements. He pointed out that in addition to the educational requirements of the National Board of Respiratory Care, independent hospital administration and the medical staff must approve treatment for respiratory care. Senator Martin proposed an amendment to insert "new and innovative" techniques and for training, insert "The American Association for Respiratory Care". Dr. McIntyre suggested that inserting a phrase to the effect that "meets N.B.R.C. requirements" might encompass all the concerns the committee has about training requirements. Senator Purcell asked the committee if they had any questions about amending the committee substitute. The amendments were voted and carried and will be rolled into a new committee substitute. The question was called and carried. A motion was made to adopt the committee substitute as amended and carried, and the bill will be sent on to the Finance Committee.

The meeting adjourned at 12:45 P.M.

William R Purcell
Senator William R. Purcell, M.D.

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

CORRECTED REPORT

Thursday, June 15, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

**UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL**

H.B.(CS #1)	**1340**	Respiratory Care Practice Act.	
		Draft Number:	PCS4337
		Sequential Referral:	Finance
		Recommended Referral:	None
		Long Title Amended:	No

TOTAL REPORTED: 1

Committee Clerk Comment: None

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Thursday, August 10, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1514** Respite Care Program No Sunset.
Sequential Referral: None
Recommended Referral: Appropriations

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 4

HOUSE BILL 1340
Committee Substitute Favorable 6/23/99
Senate Health Care Committee Substitute Adopted 6/15/00
Senate Finance Committee Substitute No. 2 Adopted 6/29/00

Short Title: Respiratory Care Practice Act. (Public)

Sponsors:

Referred to:

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT, TO PROVIDE FOR THE PROMPT PAYMENT OF CLAIMS UNDER HEALTH BENEFIT PLANS, AND TO MAKE CONFORMING AMENDMENTS TO RELATED CLAIM PAYMENT LAWS.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 38.

"Respiratory Care Practice Act.

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.

f. New and innovative respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the American Association of Respiratory Care.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"**§ 90-649. North Carolina Respiratory Care Board; creation.**

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of 10 members as follows:

(1) Two members shall be respiratory care practitioners.

(2) Four members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.

(3) One member shall represent the NCHA.

(4) One member shall represent the North Carolina Association of Medical Equipment Services.

(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become

a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"§ 90-650. Appointments and removal of Board members; terms and compensation.

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The Old North State Medical Society shall appoint one of the physician members described in G.S. 96-649(a)(2).

(6) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(7) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of November immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"**§ 90-654. Exemption from certain requirements.**

(a) The Board may issue a license to an applicant who, as of October 1, 2000, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2002.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 2000, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2002, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"**§ 90-655. Licensure by reciprocity.**

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"**§ 90-656. Provisional license.**

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S.

90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"§ 90-657. Notification of applicant following evaluation of application.

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"§ 90-658. License as property of the Board; display requirement; renewal; inactive status.

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"§ 90-659. Suspension, revocation, and refusal to renew a license.

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"**§ 90-660. Expenses; fees.**

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"**§ 90-661. Requirement of license.**

After October 1, 2002, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"**§ 90-662. Violation a misdemeanor.**

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"**§ 90-663. Injunctions.**

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"**§ 90-664. Persons and practices not affected.**

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to or within the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person who performs only support activities as defined in G.S. 90-648(13).

"**§ 90-665. Third-party reimbursement.**

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 2000. Notwithstanding the provisions of G.S. 90-

649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) must have passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public members appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; the physician member appointed by the Old North State Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4.(a) Article 3 of Chapter 58 of the General Statutes is amended by adding a new section to read:

"**§ 58-3-225. Prompt claim payments under health benefit plans.**

(a) As used in this section:

(1) 'Health benefit plan' means an accident and health insurance policy or certificate; a nonprofit hospital or medical service corporation contract; a health maintenance organization subscriber contract; a plan provided by a multiple employer welfare arrangement; or a plan provided by another benefit arrangement, to the extent permitted by the Employee Retirement Income Security Act of 1974, as amended, or by any waiver of or other exception to that act provided under federal law or regulation. 'Health benefit plan' does not mean any plan implemented or administered by the North Carolina or United States Department of Health and Human Services, or any successor agency, or its representatives. 'Health benefit plan' also does not mean any of the following kinds of insurance:

a. Credit.

b. Disability income.

c. Coverage issued as a supplement to liability insurance.

d. Hospital income or indemnity.

e. Insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability policy or equivalent self-insurance.

f. Long-term or nursing home care.

g. Medical payments under motor vehicle or homeowners' insurance policies.
h. Medicare supplement.
i. Short-term limited duration health insurance policies as defined in Part 144 of Title 45 of the Code of Federal Regulations.
j. Workers' compensation.

(2) 'Claimant' includes a health care provider or facility that is responsible or permitted under contract with the insurer or by valid assignment of benefits for directly making the claim with an insurer.

(3) 'Health care facility' means a facility that is licensed under Chapter 131E or Chapter 122C of the General Statutes or is owned or operated by the State of North Carolina in which health care services are provided to patients.

(4) 'Health care provider' means an individual who is licensed, certified, or otherwise authorized under Chapter 90 or 90B of the General Statutes to provide health care services in the ordinary course of business or practice of a profession or in an approved education or training program.

(5) 'Insurer' includes an insurance company subject to this Chapter, a service corporation organized under Article 65 of this Chapter, a health maintenance organization organized under Article 67 of this Chapter, or a multiple employer welfare arrangement subject to Article 49 of this Chapter, that writes a health benefit plan.

(b) An insurer shall, within 30 calendar days after receipt of a claim, send by electronic or paper mail to the claimant:

(1) Payment of the claim.
(2) Notice of denial of the claim.
(3) Notice that the proof of loss is inadequate or incomplete.
(4) Notice that the claim is not submitted on the form required by the health benefit plan, by the contract between the insurer and health care provider or health care facility, or by applicable law.
(5) Notice that coordination of benefits information is needed in order to pay the claim.
(6) Notice that the claim is pending based on nonpayment of fees or premiums.

For purposes of this section, an insurer is presumed to have received a written claim five business days after the claim has been placed first-class postage prepaid in the United States mail addressed to the insurer or an electronic claim transmitted to the insurer or a designated clearinghouse on the day the claim is electronically transmitted. The presumption may be rebutted by sufficient evidence that the claim was received on another day or not received at all.

(c) If the claim is denied, the notice shall include all of the specific good faith reason or reasons for the denial, including, without limitation, coordination of benefits, lack of eligibility, or lack of coverage for the services provided. If the claim is contested or cannot be paid because the proof of loss is inadequate or incomplete, or not paid pending receipt of requested coordination of benefits information, the notice shall contain the specific good faith reason or reasons why the claim has not been paid and an itemization or description of all of the information needed by the insurer to complete the processing of the claim. If all or part of the claim is contested or cannot be paid because of the application of a specific utilization management or medical necessity standard is not satisfied, the notice shall contain the specific clinical rationale for that decision or shall refer to specific provisions in documents that are made readily available through the insurer which provide the specific clinical rationale for that decision; however, if a notice of noncertification has already been provided under G.S. 58-50-61(h), then the specific clinical rationale for the decision is not required under this subsection. If the claim is contested or cannot be paid because of nonpayment of premiums, the notice shall contain a statement advising the claimant of the nonpayment of premiums. If a claim is not paid pending receipt of requested coordination of benefits information, the notice shall so specify. If a claim is denied or contested in part, the insurer shall pay the undisputed portion of the claim within 30 calendar days after receipt of the claim and send the notice of the denial or contested status within 30 days after receipt of the claim. If a claim is contested or cannot be paid because the claim was not submitted on the required form, the notice shall contain the required form, if the form is other than a UB or HCFA form, and instructions to complete that form. Upon receipt of additional information requested in its notice to the claimant, the insurer shall continue processing the claim and pay or deny the claim within 30 days after receiving the additional information.

(d) If an insurer requests additional information under subsection (c) of this section and the insurer does not receive the additional information within 90 days after the request was made, the insurer shall deny the claim and send the notice of denial to the claimant in accordance with subsection (c) of this section. The insurer shall include the specific reason or reasons for denial in the notice, including the fact that information that was requested was not provided. The insurer shall inform the claimant in the notice that the claim will be reopened if the information previously requested is submitted to the insurer within one year after the date of the denial notice closing the claim.

(e) Health benefit plan claim payments that are not made in accordance with this section shall bear interest at the annual percentage rate of eighteen percent (18%) beginning on the date following the day on which the claim should have been paid. If additional information was requested by the insurer under subsection (b) of this section, interest on health benefit claim payments shall begin to accrue on the 31st day after the insurer received the additional information. A payment is considered made on the date upon which a check, draft, or other valid negotiable instrument is placed in the United States Postal Service in a properly addressed, postpaid envelope,

or, if not mailed, on the date of the electronic transfer or other delivery of the payment to the claimant. This subsection does not apply to claims for benefits that are not covered by the health benefit plan; nor does this subsection apply to deductibles, co-payments, or other amounts for which the insurer is not liable.

(f) Insurers may require that claims be submitted within 180 days after the date of the provision of care to the patient by the health care provider and, in the case of health care provider facility claims, within 180 days after the date of the patient's discharge from the facility. However, an insurer may not limit the time in which claims may be submitted to fewer than 180 days. Unless otherwise agreed to by the insurer and the claimant, failure to submit a claim within the time required does not invalidate or reduce any claim if it was not reasonably possible for the claimant to file the claim within that time, provided that the claim is submitted as soon as reasonably possible and in no event, except in the absence of legal capacity of the insured, later than one year from the time submittal of the claim is otherwise required.

(g) If a claim for which the claimant is a health care provider or health care facility has not been paid or denied within 60 days after receipt of the initial claim, the insurer shall send a claim status report to the insured. Provided, however, that the claims status report is not required during the time an insurer is awaiting information requested under subsection (c) of this section. The report shall indicate that the claim is under review and the insurer is communicating with the health care provider or health care facility to resolve the matter. While a claim remains unresolved, the insurer shall send a claim status report to the insured with a copy to the provider 30 days after the previous report was sent.

(h) To the extent permitted by the contract between the insurer and the health care provider or health care facility, the insurer may recover overpayments made to the health care provider or health care facility by making demands for refunds and by offsetting future payments. Any such recoveries may also include related interest payments that were made under the requirements of this section. Recoveries by the insurer must be accompanied by the specific reason and adequate information to identify the specific claim. To the extent permitted by the contract between the insurer and the health care provider or health care facility, the health care provider or health care facility may recover underpayments or nonpayments by the insurer by making demands for refunds. Any such recoveries by the health care provider or health care facility of underpayments or nonpayment by the insurer may include applicable interest under this section. The period for which such recoveries may be made may be specified in the contract between the insurer and health care provider or health care facility.

(i) Every insurer shall maintain written or electronic records of its activities under this section, including records of when each claim was received, paid, denied, or pended, and the insurer's review and handling of each claim under this section, sufficient to demonstrate compliance with this section.

(j) A violation of this section by an insurer subjects the insurer to the sanctions in G.S. 58-2-70. The authority of the Commissioner under this subsection does not

impair the right of a claimant to pursue any other action or remedy available under law. With respect to a specific claim, an insurer paying statutory interest in good faith under this section is not subject to sanctions for that claim under this subsection.

(k) An insurer is not in violation of this section nor subject to interest payments under this section if its failure to comply with this section is caused in material part by (i) the person submitting the claim, or (ii) by matters beyond the insurer's reasonable control, including an act of God, insurrection, strike, fire, or power outages. In addition, an insurer is not in violation of this section or subject to interest payments to the claimant under this section if the insurer has a reasonable basis to believe that the claim was submitted fraudulently and notifies the claimant of the alleged fraud.

(l) This section does not apply to claims processed by an insurer on a claims adjudication system that was implemented prior to January 1, 1982, provided that the insurer:

(1) Verifies with the Commissioner that its claims adjudication system qualifies under this subsection; and

(2) Is implementing a new claims adjudication software system and is proceeding in good faith to move all claims to the new system as soon as possible and in any event no later than December 31, 2002.

This subsection expires January 1, 2003.

(m) Nothing in this section limits or impairs the patient's liability under existing law for payment of medical expenses."

Section 4.(b) G.S. 58-3-100(c) reads as rewritten:

"(c) The Commissioner may impose a civil penalty under G.S. 58-2-70 if an HMO, service corporation, MEWA, or insurer fails to acknowledge a claim within 30 days after receiving written or electronic notice of the claim, but only if the notice contains sufficient information for the insurer to identify the specific coverage involved. Acknowledgement of the claim shall be made to the claimant or his legal representative advising that the claim is being investigated; or shall be a payment of the claim; or shall be a bona fide written offer of settlement; or shall be a written denial of the claim. A claimant includes an insured, a health care provider, or a health care facility that is responsible for directly making the claim with an insurer. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 4.(c) G.S. 58-3-172(a) reads as rewritten:

"(a) For all claims denied for health care provider services under health benefit plans, written notification of the denied claim shall be given to the insured and to the health care provider submitting the claim if the health care provider would otherwise be eligible for payment. This subsection does not apply to insurers subject to G.S. 58-3-225."

Section 4.(d) G.S. 58-51-15(a)(7) reads as rewritten:

"(7) A provision in the substance of the following language:

PROOFS OF LOSS: Written proof of loss must be furnished to the insurer at its said office in the case of a claim for loss for which this policy provides any periodic payment contingent upon

continuing loss within ~~90~~ 180 days after the termination of the period for which the insurer is liable and in case of a claim for any other loss within ~~90~~ 180 days after the date of such loss. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event, except in the absence of legal ~~capacity,~~ capacity of the insured, later than one year from the time proof is otherwise required."

Section 5. Section 4 of this act becomes effective July 1, 2001, and applies to claims received on or after that date. The remainder of this act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1340
Committee Substitute Favorable 6/23/99

Short Title: Respiratory Care Practice Act. (Public)

Sponsors:

Referred to:

April 26, 1999

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE RESPIRATORY CARE PRACTICE ACT.

The General Assembly of North Carolina enacts:

Section 1. Chapter 90 of the General Statutes is amended by adding a new Article to read:

"ARTICLE 37.

"Respiratory Care Practice Act.

"**§ 90-646. Short title.**

This Article may be cited as the 'Respiratory Care Practice Act'.

"**§ 90-647. Purpose.**

The General Assembly finds that the practice of respiratory care in the State of North Carolina affects the public health, safety, and welfare and that the mandatory licensure of persons who engage in respiratory care is necessary to ensure a minimum standard of competency. It is the purpose and intent of this Article to protect the public from the unqualified practice of respiratory care and from unprofessional conduct by persons licensed pursuant to this Article.

"**§ 90-648. Definitions.**

The following definitions apply in this Article:

(1) Board. -- The North Carolina Respiratory Care Board.

(2) Diagnostic testing. -- Cardiopulmonary procedures and tests performed on the written order of a physician licensed under Article 1 of this Chapter that provide information to the physician to formulate a diagnosis of the patient's condition. The tests and

procedures may include pulmonary function testing, electrocardiograph testing, cardiac stress testing, and sleep related testing.

(3) Direct supervision. -- The authority and responsibility to direct the performance of activities as established by policies and procedures for safe and appropriate completion of services.

(4) Individual. -- A human being.

(5) License. -- A certificate issued by the Board recognizing the person named therein as having met the requirements to practice respiratory care as defined in this Article.

(6) Licensee. -- A person who has been issued a license under this Article.

(7) Medical director. -- An appointed physician who is licensed under Article 1 of this Chapter and a member of the entity's medical staff, and who is granted the authority and responsibility for assuring and establishing policies and procedures and that the provision of such is provided to the quality, safety, and appropriateness standards as recognized within the defined scope of practice for the entity.

(8) Person. -- An individual, corporation, partnership, association, unit of government, or other legal entity.

(9) Physician. -- A doctor of medicine licensed by the State of North Carolina in accordance with Article 1 of this Chapter.

(10) Practice of respiratory care. -- As defined by the written order of a physician licensed under Article 1 of this Chapter, the observing and monitoring of signs and symptoms, general behavior, and general physical response to respiratory care treatment and diagnostic testing, including the determination of whether such signs, symptoms, reactions, behavior, or general response exhibit abnormal characteristics, and the performance of diagnostic testing and therapeutic application of:

a. Medical gases, humidity, and aerosols including the maintenance of associated apparatus, except for the purpose of anesthesia.

b. Pharmacologic agents related to respiratory care procedures, including those agents necessary to perform hemodynamic monitoring.

c. Mechanical or physiological ventilatory support.

d. Cardiopulmonary resuscitation and maintenance of natural airways, the insertion and maintenance of artificial airways under the direct supervision of a recognized medical director in a health care environment which identifies these services within the scope of practice by the facility's governing board.

e. Hyperbaric oxygen therapy.
f. Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations.

The term also means the interpretation and implementation of a physician's written or verbal order pertaining to the acts described in this subdivision.

(11) Respiratory care. -- As defined by the written order of a physician licensed under Article 1 of Chapter 90, the treatment, management, diagnostic testing, and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system.

(12) Respiratory care practitioner. -- A person who has been licensed by the Board to engage in the practice of respiratory care.

(13) Support activities. -- Procedures that do not require formal academic training, including the delivery, setup, and maintenance of apparatus. The term also includes giving instructions on the use, fitting, and application of apparatus, but does not include therapeutic evaluation and assessment.

"§ 90-649. North Carolina Respiratory Care Board; creation.

(a) The North Carolina Respiratory Care Board is created. The Board shall consist of nine members as follows:

(1) Two members shall be respiratory care practitioners.
(2) Three members shall be physicians licensed to practice in North Carolina, and whose primary practice is Pulmonology, Anesthesiology, Critical Care Medicine, or whose specialty is Cardiothoracic Disorders.
(3) One member shall represent the NCHA.
(4) One member shall represent the North Carolina Association of Medical Equipment Services.
(5) Two members shall represent the public at large.

(b) Members of the Board shall be citizens of the United States and residents of this State. The respiratory care practitioner members shall have practiced respiratory care for at least five years and shall be licensed under this Article. The public members shall not be: (i) a respiratory care practitioner, (ii) an agent or employee of a person engaged in the profession of respiratory care, (iii) a health care professional licensed under this Chapter or a person enrolled in a program to become a licensed health care professional, (iv) an agent or employee of a health care institution, a health care insurer, or a health care professional school, (v) a member of an allied health profession or a person enrolled in a program to become a member of an allied health profession, or (vi) a spouse of an individual who may not serve as a public member of the Board.

"§ 90-650. Appointments and removal of Board members; terms and compensation.

(a) The members of the Board shall be appointed as follows:

(1) The Governor shall appoint the public members described in G.S. 90-649(a)(5).

(2) The General Assembly, upon the recommendation of the Speaker of the House of Representatives, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(3) The General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall appoint one of the respiratory care practitioner members described in G.S. 90-649(a)(1) and one of the physician members described in G.S. 90-649(a)(2) in accordance with G.S. 120-121.

(4) The North Carolina Medical Society shall appoint one of the physician members described in G.S. 90-649(a)(2).

(5) The North Carolina Hospital Association shall appoint the member described in G.S. 90-649(a)(3).

(6) The North Carolina Association of Medical Equipment Services shall appoint the member described in G.S. 90-649(a)(4).

(b) Members of the Board shall take office on the first day of July immediately following the expired term of that office and shall serve for a term of three years and until their successors are appointed and qualified. No member shall serve on the Board for more than two consecutive terms.

(c) The Governor may remove members of the Board, after notice and an opportunity for hearing, for incompetence, neglect of duty, unprofessional conduct, conviction of any felony, failure to meet the qualifications of this Article, or committing any act prohibited by this Article.

(d) Any vacancy shall be filled by the authority originally filling that position, except that any vacancy in appointments by the General Assembly shall be filled in accordance with G.S. 120-122. Appointees to fill vacancies shall serve the remainder of the unexpired term and until their successors have been duly appointed and qualified.

(e) Members of the Board shall receive no compensation for their services but shall be entitled to travel, per diem, and other expenses authorized by G.S. 93B-5.

(f) Individual members shall be immune from civil liability arising from activities performed within the scope of their official duties.

"**§ 90-651. Election of officers; meetings of the Board.**

(a) The Board shall elect a chair and a vice-chair who shall hold office according to rules adopted pursuant to this Article, except that all officers shall be elected annually by the Board for one-year terms and shall serve until their successors are elected and qualified.

(b) The Board shall hold at least two regular meetings each year as provided by rules adopted pursuant to this Article. The Board may hold additional meetings

upon the call of the chair or any two Board members. A majority of the Board membership shall constitute a quorum.

"**§ 90-652. Powers and duties of the Board.**

The Board shall have the power and duty to:

(1) Determine the qualifications and fitness of applicants for licensure, renewal of licensure, and reciprocal licensure.

(2) Establish and adopt rules necessary to conduct its business, carry out its duties, and administer this Article.

(3) Adopt and publish a code of ethics.

(4) Deny, issue, suspend, revoke, and renew licenses in accordance with this Article.

(5) Conduct investigations, subpoena individuals and records, and do all other things necessary and proper to discipline persons licensed under this Article and to enforce this Article.

(6) Employ professional, clerical, investigative, or special personnel necessary to carry out the provisions of this Article and purchase or rent office space, equipment, and supplies.

(7) Adopt a seal by which it shall authenticate its proceedings, official records, and licenses.

(8) Conduct administrative hearings in accordance with Article 3A of Chapter 150B of the General Statutes.

(9) Establish certain reasonable fees as authorized by this Article for applications for examination, licensure, provisional licensure, renewal of licensure, and other services provided by the Board.

(10) Submit an annual report to the North Carolina Medical Board, the North Carolina Hospital Association, the North Carolina Society of Respiratory Care, the Governor, and the General Assembly of all the Board's official actions during the preceding year, together with any recommendations and findings regarding improvements of the practice of respiratory care.

(11) Publish and make available upon request the licensure standards prescribed under this Article and all rules adopted pursuant to this Article.

(12) Request and receive the assistance of State educational institutions or other State agencies.

(13) Establish and approve continuing education requirements for persons seeking licensure under this Article.

"**§ 90-653. Licensure requirements; examination.**

(a) Each applicant for licensure under this Article shall meet the following requirements:

(1) Submit a completed application as required by the Board.

(2) Submit any fees required by the Board.

(3) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements of a

respiratory care education program as approved by the Commission for Accreditation of Allied Health Educational Programs.

(4) Submit to the Board written evidence, verified by oath, that the applicant has successfully completed the minimal requirements for Basic Cardiac Life Support as recognized by the American Heart Association.

(5) Pass the entry-level examination given by the National Board for Respiratory Care, Inc.

(b) At least three times each year, the Board shall cause the examination required in subdivision (5) of subsection (a) of this section to be given to applicants at a time and place to be announced by the Board. Any applicant who fails to pass the first examination may take additional examinations in accordance with rules adopted pursuant to this Article.

"**§ 90-654. Exemption from certain requirements.**

(a) The Board may issue a license to an applicant who, as of October 1, 1999, has passed the entry-level examination given by the National Board for Respiratory Care, Inc. An applicant applying for licensure under this subsection shall submit his or her application to the Board before October 1, 2001.

(b) The Board may grant a temporary license to an applicant who, as of October 1, 1999, does not meet the qualifications of G.S. 90-653 but, through written evidence verified by oath, demonstrates that he or she is performing the duties of a respiratory care practitioner within the State. The temporary license is valid until October 1, 2000, within which time the applicant shall be required to complete the requirements of G.S. 90-653(a)(5). A license granted under this subsection shall contain an endorsement indicating that the license is temporary and shall state the date the license was granted and the date it expires.

"**§ 90-655. Licensure by reciprocity.**

The Board may grant, upon application and the payment of proper fees, a license to a person who, at the time of application holds a valid license, certificate, or registration as a respiratory care practitioner issued by another state or a political territory or jurisdiction acceptable to the Board if, in the Board's determination, the requirements for that license, certificate, or registration are substantially the same as the requirements for licensure under this Article.

"**§ 90-656. Provisional license.**

The Board may grant a provisional license for a period not exceeding 12 months to any applicant who has successfully completed the education requirements under G.S. 90-653(a)(3) and has made application to take the examination required under G.S. 90-653(a)(5). A provisional license allows the individual to practice respiratory care under the supervision of a respiratory care practitioner and in accordance with rules adopted pursuant to this Article. A license granted under this section shall contain an endorsement indicating that the license is provisional and stating the terms and conditions of its use by the licensee and shall state the date the license was granted and the date it expires.

"**§ 90-657. Notification of applicant following evaluation of application.**

After evaluation of the application and of any other evidence required from the applicant by the Board, the Board shall notify each applicant that the application and evidence submitted are satisfactory and accepted or unsatisfactory and rejected. If the application and evidence is rejected, the notice shall state the reasons for the rejection.

"**§ 90-658. License as property of the Board; display requirement; renewal; inactive status.**

(a) A license issued by the Board is the property of the Board and shall be surrendered by the licensee to the Board on demand.

(b) The licensee shall display the license in the manner prescribed by the Board.

(c) The licensee shall inform the Board of any change of the licensee's address.

(d) The license shall be renewed by the Board annually upon the payment of a renewal fee if, at the time of application for renewal, the applicant is not in violation of this Article and has fulfilled the current requirements regarding continuing education as established by rules adopted pursuant to this Article.

(e) The Board shall notify a licensee at least 30 days in advance of the expiration of his or her license. Each licensee is responsible for renewing his or her license before the expiration date. Licenses that are not renewed automatically lapse.

(f) The Board may provide for the late renewal of an automatically lapsed license upon the payment of a late fee. No late fee renewal may be granted more than five years after a license expires.

(g) In accordance with rules adopted pursuant to this Article, a licensee may request that his or her license be declared inactive and may thereafter apply for active status.

"**§ 90-659. Suspension, revocation, and refusal to renew a license.**

(a) The Board shall take the necessary actions to deny or refuse to renew a license, suspend or revoke a license, or to impose probationary conditions on a licensee or applicant if the licensee or applicant:

(1) Has engaged in any of the following conduct:

a. Employed fraud, deceit, or misrepresentation in obtaining or attempting to obtain a license or the renewal of a license.

b. Committed an act of malpractice, gross negligence, or incompetence in the practice of respiratory care.

c. Practiced respiratory care without a license.

d. Engaged in health care practices that are determined to be hazardous to public health, safety, or welfare.

(2) Was convicted of or entered a plea of guilty or nolo contendere to any crime involving moral turpitude.

(3) Was adjudicated insane or incompetent, until proof of recovery from the condition can be established.

(4) Engaged in any act or practice that violates any of the provisions of this Article or any rule adopted pursuant to this Article, or aided, abetted, or assisted any person in such a violation.

(b) Denial, refusal to renew, suspension, or revocation of a license, or imposition of probationary conditions upon a licensee may be ordered by the Board after a hearing held in accordance with Article 3A of Chapter 150B of the General Statutes and rules adopted pursuant to this Article. An application may be made to the Board for reinstatement of a revoked license if the revocation has been in effect for at least one year.

"**§ 90-660. Expenses; fees.**

(a) All salaries, compensation, and expenses incurred or allowed for carrying out the purposes of this Article shall be paid by the Board exclusively out of the fees received by the Board as authorized by this Article or funds received from other sources. In no case shall any salary, expense, or other obligations of the Board be charged against the State.

(b) All monies received by the Board pursuant to this Article shall be deposited in an account for the Board and shall be used for the administration and implementation of this Article. The Board shall establish fees in amounts to cover the cost of services rendered for the following purposes:

(1) For an initial application, a fee not to exceed twenty-five dollars ($25.00).

(2) For examination or reexamination, a fee not to exceed one hundred fifty dollars ($150.00).

(3) For issuance of any license, a fee not to exceed one hundred dollars ($100.00).

(4) For the renewal of any license, a fee not to exceed fifty dollars ($50.00).

(5) For the late renewal of any license, an additional late fee not to exceed fifty dollars ($50.00).

(6) For a license with a provisional or temporary endorsement, a fee not to exceed thirty-five dollars ($35.00).

(7) For copies of rules adopted pursuant to this Article and licensure standards, charges not exceeding the actual cost of printing and mailing.

"**§ 90-661. Requirement of license.**

After October 1, 2000, it shall be unlawful for any person who is not currently licensed under this Article to:

(1) Engage in the practice of respiratory care.

(2) Use the title 'respiratory care practitioner'.

(3) Use the letters 'RCP', 'RTT', 'RT', or any facsimile or combination in any words, letters, abbreviations, or insignia.

(4) Imply orally or in writing or indicate in any way that the person is a respiratory care practitioner or is otherwise licensed under this Article.

(5) Employ or solicit for employment unlicensed persons to practice respiratory care.

"**§ 90-662. Violation a misdemeanor.**

Any person who violates any provision of this Article shall be guilty of a Class 1 misdemeanor.

"§ 90-663. Injunctions.

The Board may apply to the superior court for an order enjoining violations of this Article, and upon a showing by the Board that any person has violated or is about to violate this Article, the court may grant an injunction or restraining order or take other appropriate action.

"§ 90-664. Persons and practices not affected.

The requirements of this Article shall not apply to:

(1) Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State who is performing work incidental to the practice of that profession or occupation and does not represent himself or herself as a respiratory care practitioner.

(2) A student or trainee working under the direct supervision of a respiratory care practitioner while fulfilling an experience requirement or pursuing a course of study to meet requirements for licensure in accordance with rules adopted pursuant to this Article.

(3) A respiratory care practitioner serving in the armed forces or the Public Health Service of the United States or employed by the Veterans Administration when performing duties associated with that service or employment.

(4) A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12).

"§ 90-665. Third-party reimbursement.

Nothing in this Article shall be construed to require direct third-party reimbursements to persons licensed under this Article."

Section 2. G.S. 120-123 is amended by adding a new subdivision to read:

"(70) The North Carolina Respiratory Care Board as created by Article 37 of Chapter 90 of the General Statutes."

Section 3. The initial appointments to the North Carolina Respiratory Care Board, created in G.S. 90-649, as enacted in Section 1 of this act, shall be appointed no later than October 1, 1999. Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and, until October 1, 2004, must have

passed the entry-level examination administered by the National Board for Respiratory Care, Inc. Notwithstanding the provisions of G.S. 90-650(b), as enacted in Section 1 of this act, of the initial appointments to the North Carolina Respiratory Care Board, one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for three-year terms; one of the members appointed by the General Assembly, upon the recommendation of the Speaker of the House of Representatives, and one of the members appointed by the General Assembly, upon the recommendation of the President Pro Tempore of the Senate, shall be appointed for two-year terms; the public member appointed by the Governor shall be appointed for a one-year term; the physician member appointed by the North Carolina Medical Society shall be appointed for a one-year term; and the members appointed by the North Carolina Hospital Association and the North Carolina Association of Medical Equipment Services shall be appointed for one-year terms.

Section 4. This act is effective when it becomes law.

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May 24, 2000

TO: Members of the Senate Health Care Committee

FROM: Linda Attarian, Committee Counsel

RE: Explanation of the changes proposed by the Proposed Committee Substitute for **HB 1340, Respiratory Care Practice Act**

The Proposed Committee Substitute (PCS) makes the following changes to HB 1340, 2nd Edition:

Page 1, line 6: "Article 37" is amended to read "Article 38".

This is a technical change to update the bill since a new Article 37 was enacted by Session Law 1999-320, s.3 (An act to require health care practitioner identification badges).

Page 3, line 2:

Current language: "Nontraditional cardiopulmonary support techniques in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations."

Proposed language: "Nontraditional respiratory care and related support activities in appropriately identified environments and under the training and practice guidelines established by the appropriate professional associations."

This is a substantive change to clarify the scope of practice of respiratory care in relation to the scope of practice of hospital profusionists.

Page 4, line 20: "July" is deleted and replaced with "November".

This is a technical change to make the month that new Board members are to take office (following expired terms of prior office holders) to the month in which the terms are due to expire under the act (October).

Page 6:

Lines 16, 19, 20-21, and 23-24: date changes.

Most of the changes simply update the bill. The date change on lines 23-24 updates the bill and substantively changes the length of time a temporary license is valid under the act from one year to two years.

Page 8, line 33: date change.

This date change updates the bill and substantively extends the length of time in which it would not be unlawful under the act for an unlicensed person to engage in the practice of respiratory care after the date of enactment of the bill from one year to two years.

Page 9, line 14:

Current language: "Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State **who is performing work incidental to the practice of that** profession or occupation and does not represent himself or herself as a respiratory care practitioner."

Proposed language: "Any person registered, certified, credentialed, or licensed to engage in another profession or occupation or any person working under the supervision of a person registered, certified, credentialed, or licensed to engage in another profession or occupation in this State **who is performing work incidental to *or within* the practice of that** profession or occupation and does not represent himself or herself as a respiratory care practitioner."

This provision provides an exemption from licensure under the act for health care professionals, (e.g. nurses), who perform respiratory care techniques and therapies as a normal or routine function of their jobs/professions. This amendment is intended enhance the clarity of the intent of the exemption. By adding the new language, it is hoped that the word "incidental" will not be misinterpreted to narrow the exemption to exclude those who perform such functions on a daily or routine basis.

Page 9, lines 26-31:

Current language: "A person aiding in the practice of respiratory care, in accordance with rules adopted pursuant to this Article, if the person works under the direct supervision of a respiratory care practitioner or on the order of or under the direct supervision of a physician licensed under Article 1 of this Chapter and performs only support activities as defined in G.S. 90-648(12)."

Proposed language: "A person who performs only support activities as defined in G.S. 90-648(13)."

This amendment removes redundant language that may be construed as a limitation to the exemption on lines 10-16 on that page. Also, a technical correction was made to the citation.

Page 9, lines 42-44:

Current language: "Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina **Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) shall be licensed under Article 37 of Chapter 90 of the General Statutes, as enacted in Section 1 of this act, no later than June 30, 2000, and until October 1, 2004, must have** passed the entry-level examination administered by the National Board for Respiratory Care, Inc."

Proposed language: "Notwithstanding the provisions of G.S. 90-649(b), as enacted in Section 1 of this act, the initial members of the North Carolina **Respiratory Care Board who are appointed pursuant to G.S. 90-649(a)(1) must have** passed the entry-level examination administered by the National Board for Respiratory Care, Inc."

This amendment deletes language that provides a lag time within which the Board appointees who are respiratory care practitioners would have to attain licensure. It is assumed that most or all current practitioners will be eligible for immediate licensure as of the date of enactment. In addition the amendment deletes a sunset on the requirement that these respiratory care practitioner board members must have passed the entry-level examination administered by the National Board for Respiratory Care.

Page 10, line 11 corrects a typo.

HOUSE BILL 1340:
Respiratory Care Practice Act

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Tolson
Date:	May 17, 2000	**Summary by:**	Linda Attarian
Version:	Second		Committee Counsel

SUMMARY: House Bill 1340 establishes a new Article 38 in Chapter 90 of the General Statutes to create a new occupational licensure board for the mandatory licensure of persons engaged in the practice of respiratory care as defined in the act. The act becomes effective when it becomes law.

CURRENT LAW: The practice of respiratory care is not currently defined or regulated under the North Carolina General Statutes.

BILL ANALYSIS: Section 1 creates the "Respiratory Care Practice Act". The following is a brief summary of the key provisions:

Practice of respiratory care. The act defines practice of respiratory care as the observing and monitoring of signs and symptoms, general behavior, and general physical response by a patient to respiratory care treatment and diagnostic testing pursuant to a physician's written order. Respiratory care practice also includes the performance of certain diagnostic tests and the application of certain therapeutic procedures prescribed by a physician.

Procedures that do not require formal respiratory care training and do not call for therapeutic evaluation and assessment are defined in the act as "support activities" and persons performing these activities are not required to be licensed under the act.

Board composition. The act creates a nine member NC Respiratory Care Board. Board members will serve three-year terms. Two of the members must be respiratory care practitioners with at least five years of experience. Three members must be physicians with relevant, specialized expertise. One member will represent the NC Hospital Association and one member will represent the NC Association of Medical Equipment Services. Two members will be from the public at large. Two members (a physician and respiratory care therapist) will be appointed by the General Assembly upon recommendation of the Speaker of the House of Representatives and two members (a physician and respiratory care therapist) will be appointed by the General Assembly upon recommendation of the of President Pro Tempore of the Senate. The Governor will appoint two members from the public at large.

Licensure standards. The act sets forth the minimal licensing standards that must be met for Board approval:

1. Completion of a respiratory care education program as approved by the Commission for Accreditation for Accreditation of Allied Health Educational Programs of the American Medical Association.
2. Completion of the American Heart Association's Basic Cardiac Life Support program.
3. Passage of the entry-level examination given by the National Board of Respiratory Care, Inc. Applicants may take the exam up to three times per year.

The act authorizes the Board to grant a North Carolina license to an applicant holding a valid out-of-state license, certificate, or registration as a respiratory care practitioner if the Board determines the out-of-state requirements are substantially the same as the requirements under this Article.

The act authorizes the Board to grant an applicant a *provisional license* for a period of one year if the applicant has completed the minimum educational requirements and has applied to take the national exam. The provisional license allows the applicant to practice under the supervision of a licensed respiratory care practitioner for a time-limited period.

Fees. The Board is authorized to impose a fee of $50.00 to apply for licensure, a fee of $150.00 to take the examination and a fee $100.00 to be issued a license.

Prohibited acts: The act provides that after October 1, 2000, it shall be unlawful for any person who is not licensed under the act to practice respiratory care or use the title of respiratory care practitioner or otherwise hold themselves out as a respiratory care practitioner. A violation constitutes a Class 1 misdemeanor.

Persons and practices not required to obtain licensure: The act provides that the following persons practicing respiratory care in the following situations are exempt from licensure requirements.

1. Any person who is registered, certified, credentialed, or licensed in any other profession or any person working under the supervision of a person registered, certified, credentialed, or licensed in any other profession and who is performing services incidental to the occupation of that person or the person who is supervising them and not holding themselves out to be a respiratory care practitioner.
2. A student in a respiratory care education program, working under direct supervision of a respiratory care practitioner while fulfilling requirements of the course of study.
3. Persons serving in the armed forces or the Public Health Service of the United States or employed by the Veteran's Administration when performing duties associated with that service or employment.
4. Persons aiding in the practice of respiratory care who perform support activities which do not require formal academic training, if these persons work under the supervision of a respiratory care practitioner or physician.

Third-party reimbursement. The act specifically states that the act does not authorize respiratory care practitioners to bill directly for third-party reimbursement.

Section 2. Amends G.S. 120-123 to prohibit members of the NC General Assembly from being appointed to the Board.

Section 3. Provides that the initial Board members shall be appointed no later than October 1, 1999 and, not withstanding G.S. 90-649, these initial members must obtain licensure under this Article no later than October 1, 2000. Further, until October 1, 2004, the initial board members must have passed the entry-level national exam. Provides also that the initial Board members serve staggered terms.

Section 4. This Act is effective when it becomes law.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1514
Committee Substitute Favorable 6/1/00

Short Title: Respite Care Program No Sunset. (Public)

Sponsors:

Referred to:

May 11, 2000

A BILL TO BE ENTITLED

AN ACT TO REPEAL THE SUNSET ON REQUIREMENTS PERTAINING TO THE REIMBURSEMENT RATE FOR THE RESPITE CARE PROGRAM, AND TO AUTHORIZE THE MEDICAL CARE COMMISSION TO ADOPT TEMPORARY RULES PERTAINING TO RESPITE CARE.

The General Assembly of North Carolina enacts:

Section 1. Section 3 of S.L. 1998-97 reads as rewritten:

"Section 3. This act is effective when it becomes ~~law and expires July 1, 2000.~~ law."

Section 2. Notwithstanding G.S. 150B-21.1(a), the Medical Care Commission shall adopt temporary rules for the purpose of defining the circumstances under which adult care homes may admit residents on a short-term basis for the purpose of caregiver respite and the rules that shall apply during the course of their stay. The Commission's authority to adopt temporary rules under this section expires on the date that permanent rules pertaining to the same subject matter adopted by the Commission as authorized under G.S. 143B-165(10) become effective.

Section 3. This act is effective when it becomes law.

HOUSE BILL 1514:
Respite Care Program No Sunset

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Rep. Melton
Date:	June 12, 2000	**Summary by:**	John Young
Version:	2		Committee Staff

SUMMARY:

House Bill 1514: Section 1 repeals the sunset on requirements pertaining to the reimbursement rate for the respite care program. Section 2 directs the Medical Care Commission to make rules for admission of residents for respite care.

CURRENT LAW:

North Carolina's respite care program (G.S. 143B-181.10) provides relief to the unpaid primary caregivers of elderly or disabled adults who cannot be left alone because of mental or physical problems. In appropriate cases, respite care may include temporary out-of-home placement of an elderly or disabled adult in a hospital, nursing facility, adult care home, adult day health center, or an adult day care center in order to provide total respite for the adult's caregiver. Respite care is part of the continuum of care for impaired older adults to enable families to care for members in their homes and to prevent or delay institutionalization. Counties decide the services that they will offer for older adults through the Home and Community Care Block Grant. Out-of-home respite is one of 17 services that may be funded through the Home and Community Care Block Grant but before August 14, 1998 was the only service in which the reimbursement rate was set in statute (The monthly state reimbursement rate for adult care facilities).

BILL ANALYSIS:

Section 1-Before August 14, 1998, state law provided that payments under the state respite care program for the out-of home placement of an elderly or disabled adult could not exceed the reimbursement rate for care in an adult care home. Effective August 14, 1998 until July 1, 2000 S.L. 1998-97 (SB 1149) repealed the statutory limitation on payments for respite care for out-of-home placements. A sunset was placed on the repeal. The Division of Aging was required to analyze the impact of the repeal of the statutory limitation on the reimbursement rate on services and funds and report to the North Carolina Study Commission on Aging. SB 1176, upon recommendation of the Commission, would repeal the sunset and allow the rate to be established as the other 16 Home and Community Care Block Grant services.

Section 2- Adds a provision directing the Medical Care Commission to adopt rules for the purpose of defining the circumstances under which adult care homes may admit residents on a short-term basis for the purpose of defining the circumstances under which adult care homes may admit residents on a short-term basis for the purpose of caregiver respite. Currently all residents must complete the same admission process whether for respite care or for a regular stay.

BACKGROUND:

In response to requests from individuals and agencies that the maximum reimbursement rate for out-of-home respite be lifted, Senate Bill 1149 was introduced and ratified by the 1998 Session in order to encourage this form of respite care to become a more viable service. Limiting the reimbursement rate for out-of-home respite appeared to discourage the utilization of this service. Concern was expressed about the difficulty agencies interested in providing this service had in finding facilities willing to accept the

Maximum reimbursement rate (i.e. the adult care home monthly reimbursement rate). As required by Senate Bill 1149, the Division of Aging analyzed out-of-home respite services and funding provided through the Home and Community Care Block Grant from FY 1997-98 through FY 1999-2000. The Division reported to the Commission that historically few counties have funded out-of-home respite. Since this is the case, it appeared that there was no significant impact on the program created by the legislation. Therefore, the Commission in its report to the 2000 Session recommended that the sunset be lifted.

Section 2 added by the House. Section 1 has already passed as SB 1176 as introduced by Senator Carpenter.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 14, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
R&N Byrd	Aventis Pharm. 1736 Rivergate Terr. Woodbury Daisy, TN. 37379
John Bowdish	Alley Associates
Joanne Schoop	NC nurses Association
Andy Ellen	NCRMA
Fran Preston	NCRMA
Tom Williams	NCSRC
Susan R Gallo	NCSRC
Janice Thalman	NCSRC
Marianne Stevens	Nurses Assn.
Deborah Bryan	AHA/NC
Steve Keen	NCHA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JUNE 14, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
John Cyrus	N.C. State Grange
Amy Jo Bain	NCMS
Joe Lee	NHHC
Hal Miller	NCACCT

PLEASE NOTE: THIS MEETING HAS BEEN CANCELLED

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 21, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- S.B. 1437, High-Risk Intervention Coverage/ State Health Plan — Senator Gulley

Senator William R. Purcell, Chair

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 21, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- S.B. 1437, High-Risk Intervention Coverage/ State Health Plan — Senator Gulley

Senator William R. Purcell, Chair

REVISION NO. 2

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 28, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

• H.B. 1519, Mental Health System Reform	Representative Insko
• H.B. 1520, Restraints in Facilities	Representative Insko
• S.B. 1437, High-Risk Intervention Coverage/State Health Plan	Senator Gulley

Senator William R. Purcell, Chair

Please Note: S.B. 1437 has been added to the agenda.

REVISION NO. 1

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 28, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- H.B. 1519, Mental Health System Reform — Representative Insko
- H.B. 1520, Restraints in Facilities — Representative Insko

Senator William R. Purcell, Chair

Please Note: H.B. 1520 has been added to the agenda.

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, June 28, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- H.B. 1519, Mental Health System Reform — Representative Insko

Senator William R. Purcell, Chair

SENATE COMMITTEE ON HEALTH CARE
ROOM 1124, LEGISLATIVE BUILDING
JUNE 28, 2000
12:00 NOON

CALL TO ORDER

Senator William R. Purcell, Chair

APPROVAL OF MINUTES

CONSIDERATION OF BILLS

H.B.1519	**Mental Health System Reform**	**Representative Insko**
H.B. 1514	**Restraints in Facilities**	**Representative Insko**
S.B.1437	**High-Risk Intervention Coverage/State Health Plan**	**Senator Gulley**

ADJOURNMENT

Senate Health Care Committee
Wednesday, June 28, 2000
12:00 Noon
1124 Legislative Building

MINUTES

The Senate Health Care Committee met at 12:10 P.M. on Wednesday, June 28, 2000, in Room 1124 of the Legislative Building. Twelve members of the committee were present. Senator William R. Purcell presided.

Senator Purcell introduced Representative Verla Insko to explain H.B. 1519, *Mental Health System Reform*. Senator Martin sent forth an amendment; and briefly explained the amendment to the committee. He moved that the amendment be adopted, and the motion carried. Senator Moore moved that the bill receive a favorable report as amended. The motion carried.

Senator Purcell asked that the committee approve minutes of the previous three meetings. Senator Warren moved that they be approved, and the motion carried.

Representative Insko was asked to present H.B. 1520, *Restraints in Facilities*, to the committee. She gave the committee members a proposed committee substitute to consider. Senator Phillips moved for adoption of the proposed committee substitute for discussion. The motion carried, and Representative Insko explained the committee substitute. Senator Phillips sent forth an amendment to the proposed committee substitute. Senator Purcell called on him to explain the amendment. Senator Dannelly questioned that children in seclusion be observed so that they do not injure themselves. Representative Insko asked Charnese Ranson to respond, and she stated that such ruling already exists. The amendment was voted on and accepted. Senator Moore moved that the proposed committee substitute as amended be adopted and rolled into a committee substitute. The motion carried. The bill was subsequently referred to the Senate Finance Committee.

Senator Purcell introduced Senator Gulley to explain S.B. 1437, *High-Risk Intervention Coverage/State Health Plan*, and told the committee that they would not be voting on the bill at this meeting. Senator Gulley presented a committee substitute. Senator Lucas moved that the proposed committee substitute be adopted for purposes of discussion, and the motion carried. Senator Gulley said that intent of this bill is to expand state health coverage to include licensed therapeutic homes for children and adolescents with mental problems, which would incur a cost of 1.6 to 1.7 million dollars to the state health plan. Budget constrictions make this plan not feasible at this time, and he asked the committee to hold the bill for possible consideration next year.

Senator Lucas asked how many licensed therapeutic foster care homes there are in North Carolina. Jack Walker, Director of the State Health Insurance Plan, responded that there are 915. Senator Phillips asked how many children have been served in this setting; the response was 1,445. Senator Martin asked, during the course of a year, how many children there are in each such home, the cost per child per day, and the length of stay. The response was (in order) one to two children in each home at a cost of $125 to $150 per day with an average length of stay of 90 to 120 days. It was pointed out that each child served most likely would need additional community-based services, and that children served on an in-patient basis would receive a number of services rather than just the one type of treatment. Senator Hagan asked if the costs took into consideration that a number of HMOs might pull out of the state health plan. The answer was no, that the cost was based on what is now. There being no further comments or questions, the meeting was adjourned at 12:50 P.M.

William R Purcell
Senator William R. Purcell, Chair

Lorraine R. Blake
Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, June 28, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

UNFAVORABLE AS TO COMMITTEE SUBSTITUTE BILL NO. 1,
BUT FAVORABLE AS TO SENATE COMMITTEE SUBSTITUTE BILL

H.B.(CS #1)**1519** Mental Health System Reform.

Draft Number:	PCS5112
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	No

H.B.(CS #1)**1520** Restraints in Facilities.

Draft Number:	PCS4339
Sequential Referral:	None
Recommended Referral:	None
Long Title Amended:	Yes

TOTAL REPORTED: 2

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

4

HOUSE BILL 1520*
Committee Substitute Favorable 6/21/00
Third Edition Engrossed 6/22/00
Senate Health Care Committee Substitute Adopted 6/28/00

Short Title: Restraints in Facilities. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE USE OF RESTRAINTS AND SECLUSION IN CERTAIN FACILITIES, REQUIRING THE REPORTING OF CERTAIN DEATHS IN CERTAIN FACILITIES, AND IMPOSING A PENALTY FOR FAILURE TO REPORT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-60 reads as rewritten:

"**§ 122C-60. Use of physical restraints or seclusion.**

(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to ~~himself~~ the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. All instances of restraint or seclusion and the detailed reasons for such action shall be documented in the client's record. Each client who is restrained or secluded shall be observed frequently, and a written notation of the observation shall be made in the client's record.

(a1) A facility that employs physical restraint or seclusion of a client shall collect data on the use of the restraints and seclusion. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The

facility shall make the data available to the Secretary upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary under this subsection. In reviewing data requested under this subsection, the Secretary shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection.

(a2) Facilities shall implement policies and practices that emphasize the use of alternatives to physical restraint and seclusion. Physical restraint and seclusion may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) The Commission ~~may~~ shall adopt rules to implement this section. In adopting rules, the Commission shall take into consideration federal regulations and national accreditation standards. Rules adopted by the Commission shall include:

(1) Staff training and competence in:
   a. The use of positive behavioral supports.
   b. Communication strategies for defusing and deescalating potentially dangerous behavior.
   c. Monitoring vital indicators.
   d. Administration of CPR.
   e. Debriefing with client and staff.
   f. Methods for determining staff competence, including qualifications of trainers and training curricula.
   g. Other areas to ensure the safe and appropriate use of restraints and seclusion.

(2) Other matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others.

The Department may investigate complaints and inspect a facility at any time to ensure compliance with this section."

Section 2.(a) G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking licenses; ~~and~~

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article.~~ Article;

(5) Adopt rules on documenting the use of physical restraint in residential child-care facilities; and

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care facilities."

Section 2.(b) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.5A. Collection of data on use of restraints in residential child-care facilities.**

A residential child-care facility that employs physical restraint of a child shall collect data on the use of the restraint. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The facility shall make the data available to the Department upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department under this subsection. In reviewing data requested under this subsection, the Department shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection."

Section 3.(a) Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-31. Report required upon death of client.**

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. The Secretary may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Secretary of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Secretary or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Secretary shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical

Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of physical restraint or seclusion, then the Secretary shall initiate immediately an investigation of the death.

(d) An inpatient psychiatric unit of a hospital licensed under Chapter 131E of the General Statutes shall comply with this section.

(e) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary or the Council. In carrying out the requirements of this section, the Secretary and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(f) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 3.(b) Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

Section 4. G.S. 130A-385 is amended by adding the following new subsection to read:

"(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

Section 5.(a) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.6B. Report of death.**

(a) A facility licensed under this Article shall notify the Department immediately upon the death of any resident of the facility that occurs within seven days of physical restraint of the resident, and shall notify the Department within three days of the death of any resident of the facility resulting from violence, accident, suicide, or homicide. The Department may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Department shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported to the Council pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department, and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the facility occurs within seven days of the use of physical restraint, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 5.(b) G.S. 131D-10.6 is amended by adding the following new subdivision to read:

"(10) Report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable

State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

Section 6.(a) Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-34.1. Report of death of resident.**

(a) An adult care home shall notify the Department of Health and Human Services immediately upon the death of any resident that occurs in the adult care home or that occurs within 24 hours of the resident's transfer to a hospital if the death occurred within seven days of the adult care home's use of physical restraint or physical hold of the resident, and shall notify the Department of Health and Human Services within three days of the death of any resident of the adult care home resulting from violence, accident, suicide, or homicide. The Department may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from an adult care home in accordance with subsection (a) of this section, the Department of Health and Human Services shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the adult care home occurs within seven days of the adult care home's use of physical restraint or physical hold, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 6.(b) Article 5 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

Section 7. This act becomes effective January 1, 2001.

SENATE
COMMITTEE SUBSTITUTE

GENERAL ASSEMBLY OF NORTH CAROLINA JUN 28 2000

SESSION 1999

ADOPTED D

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HOUSE BILL 1520*
Committee Substitute Favorable 6/21/00
Third Edition Engrossed 6/22/00
Proposed Senate Committee Substitute H1520-PCS4339-LN010

Short Title: Restraints in Facilities. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE USE OF RESTRAINTS AND SECLUSION IN CERTAIN FACILITIES, REQUIRING THE REPORTING OF CERTAIN DEATHS IN CERTAIN FACILITIES, AND IMPOSING A PENALTY FOR FAILURE TO REPORT.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-60 reads as rewritten:

"**§ 122C-60. Use of physical restraints or seclusion.**

(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to ~~himself~~ the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. All instances of restraint or seclusion and the detailed reasons for such action shall be documented in the client's record. Each client who is restrained or secluded shall be observed frequently, and a written notation of the observation shall be made in the client's record.

(a1) A facility that employs physical restraint or seclusion of a client shall collect data on the use of the restraints and seclusion. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The

facility shall make the data available to the Secretary upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary under this subsection. In reviewing data requested under this subsection, the Secretary shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection.

(a2) Facilities shall implement policies and practices that emphasize the use of alternatives to physical restraint and seclusion. Physical restraint and seclusion may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) The Commission ~~may~~ shall adopt rules to implement this section. In adopting rules, the Commission shall take into consideration federal regulations and national accreditation standards. Rules adopted by the Commission shall include:

(1) Staff training and competence in:
   a. The use of positive behavioral supports.
   b. Communication strategies for defusing and deescalating potentially dangerous behavior.
   c. Monitoring vital indicators.
   d. Administration of CPR.
   e. Debriefing with client and staff.
   f. Methods for determining staff competence, including qualifications of trainers and training curricula.
   g. Other areas to ensure the safe and appropriate use of restraints and seclusion.

(2) Other matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others.

The Department may investigate complaints and inspect a facility at any time to ensure compliance with this section."

Section 2.(a) G.S. 131D-10.5 reads as rewritten:

"§ 131D-10.5. Powers and duties of the Commission.

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;

(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this Article;

(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking licenses; ~~and~~

(4) Adopt criteria for waiver of licensing rules adopted pursuant to this ~~Article.~~ Article;

(5) Adopt rules on documenting the use of physical restraint in residential child-care facilities; and

(6) Adopt rules establishing personnel and training requirements related to the use of physical restraints and time-out for staff employed in residential child-care facilities."

Section 2.(b) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.5A. Collection of data on use of restraints in residential child-care facilities.**

A residential child-care facility that employs physical restraint of a child shall collect data on the use of the restraint. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The facility shall make the data available to the Department upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department under this subsection. In reviewing data requested under this subsection, the Department shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection."

Section 3.(a) Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-31. Report required upon death of client.**

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide. The Secretary may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Secretary of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Secretary or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Secretary shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical

Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of physical restraint or seclusion, then the Secretary shall initiate immediately an investigation of the death.

(d) An inpatient psychiatric unit of a hospital licensed under Chapter 131E of the General Statutes shall comply with this section.

(e) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary or the Council. In carrying out the requirements of this section, the Secretary and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(f) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 3.(b) Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

Section 4. G.S. 130A-385 is amended by adding the following new subsection to read:

"(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

Section 5.(a) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.6B. Report of death.**

(a) A facility licensed under this Article shall notify the Department immediately upon the death of any resident of the facility that occurs within seven days of physical restraint of the resident, and shall notify the Department within three days of the death of any resident of the facility resulting from violence, accident, suicide, or homicide. The Department may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Department shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported to the Council pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department, and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the facility occurs within seven days of the use of physical restraint, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 5.(b) G.S. 131D-10.6 is amended by adding the following new subdivision to read:

"(10) Report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable

State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

Section 6.(a) Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-34.1. Report of death of resident.**

(a) An adult care home shall notify the Department of Health and Human Services immediately upon the death of any resident that occurs in the adult care home or that occurs within 24 hours of the resident's transfer to a hospital if the death occurred within seven days of the adult care home's use of physical restraint or physical hold of the resident, and shall notify the Department of Health and Human Services within three days of the death of any resident of the adult care home resulting from violence, accident, suicide, or homicide. The Department may assess a civil penalty of not less than five hundred dollars ($500.00) and not more than one thousand dollars ($1,000) against a facility that fails to notify the Department of a death and the circumstances surrounding the death known to the facility. Chapter 150B of the General Statutes governs the assessment of a penalty under this section. A civil penalty owed under this section may be recovered in a civil action brought by the Department or the Attorney General. The clear proceeds of the penalty shall be remitted to the State Treasurer for deposit in accordance with State law.

(b) Upon receipt of notification from an adult care home in accordance with subsection (a) of this section, the Department of Health and Human Services shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the adult care home occurs within seven days of the adult care home's use of physical restraint or physical hold, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 6.(b) Article 5 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

Section 7. This act becomes effective January 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 3

HOUSE BILL 1520*
Committee Substitute Favorable 6/21/00
Third Edition Engrossed 6/22/00

Short Title: Restraints in Facilities. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT PERTAINING TO THE USE OF RESTRAINTS AND SECLUSION IN CERTAIN FACILITIES, AND REQUIRING THE REPORTING OF CERTAIN DEATHS IN CERTAIN FACILITIES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 122C-60 reads as rewritten:

"**§ 122C-60. Use of physical restraints or seclusion.**

(a) Physical restraint or seclusion of a client shall be employed only when there is imminent danger of abuse or injury to ~~himself~~ the client or others, when substantial property damage is occurring, or when the restraint or seclusion is necessary as a measure of therapeutic treatment. All instances of restraint or seclusion and the detailed reasons for such action shall be documented in the client's record. Each client who is restrained or secluded shall be observed frequently, and a written notation of the observation shall be made in the client's record.

(a1) A facility that employs physical restraint or seclusion of a client shall collect data on the use of the restraints and seclusion. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The facility shall make the data available to the Secretary upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the

confidentiality, privilege, or other prohibition against disclosure of information provided to the Secretary under this subsection. In reviewing data requested under this subsection, the Secretary shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection.

(a2) Facilities shall implement policies and practices that emphasize the use of alternatives to physical restraint and seclusion. Physical restraint and seclusion may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually.

(b) The Commission ~~may~~ shall adopt rules to implement this section. In adopting rules, the Commission shall take into consideration federal regulations and national accreditation standards. Rules adopted by the Commission shall include:

(1) Staff training and competence in:
   a. The use of positive behavioral supports.
   b. Communication strategies for defusing and deescalating potentially dangerous behavior.
   c. Monitoring vital indicators.
   d. Administration of CPR.
   e. Debriefing with client and staff.
   f. Methods for determining staff competence, including qualifications of trainers and training curricula.
   g. Other areas to ensure the safe and appropriate use of restraints and seclusion.

(2) Other matters relating to the use of physical restraint or seclusion of clients necessary to ensure the safety of clients and others.

The Department may investigate complaints and inspect a facility at any time to ensure compliance with this section."

Section 2.(a) G.S. 131D-10.5 reads as rewritten:

"**§ 131D-10.5. Powers and duties of the Commission.**

In addition to other powers and duties prescribed by law, the Commission shall exercise the following powers and duties:

(1) Adopt, amend and repeal rules consistent with the laws of this State and the laws and regulations of the federal government to implement the provisions and purposes of this Article;
(2) Issue declaratory rulings as may be needed to implement the provisions and purposes of this Article;
(3) Adopt rules governing procedures to appeal Department decisions pursuant to this Article granting, denying, suspending or revoking licenses; and
(4) Adopt criteria for waiver of licensing rules adopted pursuant to this Article.

(5) Adopt rules on documenting the use of physical restraint in residential child-care facilities.

(6) Adopt rules establishing personnel and training requirements of staff employed in residential child care facilities."

Section 2.(b) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.5A. Collection of data on use of restraints in residential child-care facilities.**

A residential child-care facility that employs physical restraint of a child shall collect data on the use of the restraint. The data shall reflect for each incidence, the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facility shall analyze the data on at least a quarterly basis to monitor effectiveness, determine trends, and take corrective action where necessary. The facility shall make the data available to the Department upon request. Nothing in this subsection abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department under this subsection. In reviewing data requested under this subsection, the Department shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this subsection."

Section 3.(a) Article 2 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-31. Report required upon death of client.**

(a) A facility shall notify the Secretary immediately upon the death of any client of the facility that occurs within seven days of physical restraint or seclusion of the client, and shall notify the Secretary within three days of the death of any client of the facility resulting from violence, accident, suicide, or homicide.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Secretary shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Secretary shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a client of a facility occurs within seven days of the use of physical restraint or seclusion, then the Secretary shall initiate immediately an investigation of the death.

(d) An inpatient psychiatric unit of a hospital licensed under Chapter 131E of the General Statutes shall comply with this section.

(e) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of

information provided to the Secretary or the Council. In carrying out the requirements of this section, the Secretary and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(f) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 3.(b) Article 1 of Chapter 122C of the General Statutes is amended by adding the following new section to read:

"**§ 122C-5. Report on restraint and seclusion.**

The Secretary shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services on the following for the immediately preceding fiscal year:

(1) The level of compliance of each facility with applicable State and federal laws, rules, and regulations governing the use of restraints and seclusion. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of facilities that reported deaths under G.S. 122C-31, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 122C-31, and the number found by the investigation to be related to the use of restraint or seclusion."

Section 4. G.S. 130A-385 is amended by adding the following new subsection to read:

"(f) If a death occurred in a facility licensed subject to Article 2 or Article 3 of Chapter 122C of the General Statutes, or Articles 1 or 1A of Chapter 131D of the General Statutes, and the deceased was a client or resident of the facility or a recipient of facility services at the time of death, then the Chief Medical Examiner shall forward a copy of the medical examiner's report to the Secretary of Health and Human Services within 30 days of receipt of the report from the medical examiner."

Section 5.(a) Article 1A of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-10.6B. Report of death.**

(a) A facility licensed under this Article shall notify the Department immediately upon the death of any resident of the facility that occurs within seven days of physical restraint of the resident, and shall notify the Department within three days of the death of any resident of the facility resulting from violence, accident, suicide, or homicide.

(b) Upon receipt of notification from a facility in accordance with subsection (a) of this section, the Department shall notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department

shall provide the Council access to the information about each death reported to the Council pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department, and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the facility occurs within seven days of the use of physical restraint, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 5.(b) G.S. 131D-10.6 is amended by adding the following new subdivision to read:

"(10) Report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the level of facility compliance with applicable State law governing the use of restraint and time-out in residential child-care facilities. The report shall also include the total number of facilities that reported deaths under this section, the number of deaths reported by each facility, the number of deaths investigated pursuant to this section, and the number found by the investigation to be related to the use of physical restraint or time-out."

Section 6.(a) Article 3 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-34.1. Report of death of resident.**

(a) An adult care home shall notify the Department of Health and Human Services immediately upon the death of any resident that occurs in the adult care home or that occurs within 24 hours of the resident's transfer to a hospital if the death occurred within seven days of the adult care home's use of physical restraint or physical hold of the resident, and shall notify the Department of Health and Human Services within three days of the death of any resident of the adult care home resulting from violence, accident, suicide, or homicide.

(b) Upon receipt of notification from an adult care home in accordance with subsection (a) of this section, the Department of Health and Human Services shall

notify the Governor's Advocacy Council for Persons With Disabilities that a person with a disability has died. The Department shall provide the Council access to the information about each death reported pursuant to subsection (a) of this section, including information resulting from any investigation of the death by the Department and from reports received from the Chief Medical Examiner pursuant to G.S. 130A-385. The Council shall use the information in accordance with its powers and duties under G.S. 143B-403.1 and applicable federal law and regulations.

(c) If the death of a resident of the adult care home occurs within seven days of the adult care home's use of physical restraint or physical hold, the Department shall initiate immediately an investigation of the death.

(d) Nothing in this section abrogates State or federal law or requirements pertaining to the confidentiality, privilege, or other prohibition against disclosure of information provided to the Department or the Council. In carrying out the requirements of this section, the Department and the Council shall adhere to State and federal requirements of confidentiality, privilege, and other prohibitions against disclosure and release applicable to the information received under this section. A facility or provider that makes available confidential information in accordance with this section and with State and federal law is not liable for the release of the information.

(e) The Secretary shall establish a standard reporting format for reporting deaths pursuant to this section and shall provide to facilities subject to this section a form for the facility's use in complying with this section."

Section 6.(b) Article 5 of Chapter 131D of the General Statutes is amended by adding the following new section to read:

"**§ 131D-42. Report on use of restraint.**

The Department shall report annually on October 1 to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services the following for the immediately preceding fiscal year:

(1) The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical hold of residents. The information shall indicate areas of highest and lowest levels of compliance.

(2) The total number of adult care homes that reported deaths under G.S. 131D-34.1, the number of deaths reported by each facility, the number of deaths investigated pursuant to G.S. 131D-34.1, and the number found by the investigation to be related to the adult care home's use of physical restraint or physical hold."

Section 7. This act becomes effective January 1, 2001.

HOUSE BILL 1520:
Restraints in Facilities

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Rep. Verla Insko (Primary Sponsor)
Date:	June 28, 2000		
Version:	2	**Summary by:**	Linda Attarian Committee Counsel

SUMMARY: The proposed legislation:

- *requires data collection and analysis related to the use of physical restraint and seclusion in **mental health facilities and residential child care facilities**;*
- *requires **mental health facilities** to implement policies and practices that emphasize the use of alternatives to physical restraint or seclusion;*
- *requires reporting and investigation of all deaths occurring within seven days of the use of restraints and seclusion in **mental health facilities, residential child care facilities, and adult care homes** ;*
- *requires reporting of all deaths resulting from violence, accident, suicide, or homicide in **mental health facilities, residential child care facilities, and adult care homes** within three days of the death;*
- *limits the employment of restraint or seclusion in **mental health facilities** to only those staff members who have been properly trained;*
- *requires rule-making authorities to adopt rules on staff training and other matters relating to the use of physical restraint and seclusion necessary to ensure the safety of clients and others **in mental health facilities and residential child care facilities**; and*
- *requires DHHS to make annual reports concerning the use of restraints and seclusion and deaths related to the use of restraints and seclusion in **mental health facilities, residential child care facilities and adult care homes** to the Legislative Study Commission on MH/DD/SAS;*
- *does not abrogate State or federal law or requirements pertaining to the confidentiality, privilege or other prohibitions against disclosure of information provided to the Secretary or the Governor's Advocacy Council for Persons with Disabilities.*

The act becomes effective January 1, 2001.

CURRENT LAW: The use of physical restraints, seclusion, and time-out in mental health facilities, child placement facilities, and adult care homes are currently regulated by a combination of State and federal laws, rules and regulations. The proposed legislation adds additional requirements to this body of law.

BILL ANALYSIS:

Section 1. Current law (G.S. 122C-60) requires mental health facilities to document all instances of restraint or seclusion and record detailed reasons for such actions in the clients record. The bill amends this statute by requiring facilities to collect data on each incident of use of restraints and seclusion and analyze data. The data collected must include the type of procedure used; the length of time employed;

the alternatives considered or employed; and the effectiveness of the procedure or alternative employed. The facilities must analyze the data quarterly to monitor effectiveness, trends, and must take corrective action when necessary. The facility must make the data available to the Secretary on request in accordance with existing State and federal laws pertaining to the disclosure of patient records.

In addition, the section further amends G.S. 122C-60 to require:

Mental health facilities to implement policies and practices that emphasize use of alternatives to physical restraint and seclusion.

Only staff who have been trained and have demonstrated competence in proper use of and alternatives to the use of restraints and seclusion may employ restraints and seclusion. Staff must be retrained at least annually.

Mental Health Commission must adopt rules that provide for staff training and competence in several aspects of the use of restraints and seclusion and other matters relating to the use of physical restraints and seclusion necessary to ensure the safety of clients and others. The Commission must take into federal regulations and national accreditation standards in adopting the rules.

Applicability of this section:
- Psychiatric hospitals (10 facilities);
- Mental health group homes, day treatment and outpatient programs (3400 facilities); and
- Intermediate care facilities for the mentally retarded (332 facilities).

Section 2(a). This section adds a new section to Article 1A of Chapter 131D to require residential child care facilities to collect data on the use of restraint. The data must include the type of procedure used, the length of time employed, alternatives considered or employed, and the effectiveness of the procedure or alternative employed. The facilities must analyze the data to monitor the effectiveness, determine trends, and take corrective actions where necessary. Data must be made available to the Secretary on request.

Section 2(b). This section also requires the Social Services Commission to adopt rules regulating the use of physical restraint and to establish personnel and training requirements.

Applicability of this section: A residential child care facility is defined as a "staffed premise with paid or volunteer staff where children receive continuing full-time foster care. They include child-caring institutions, group homes, and children's camps which provide foster care (includes "wilderness camps").

Section 3 (a). Amends Chapter 122C to add a new section to require mental health facilities to immediately report to the Secretary of DHHS all deaths occurring within seven days of the use of physical restraint or seclusion. The Secretary shall initiate an investigation of such deaths immediately and notify the Governor's Advocacy Council for Persons with Disabilities.

This section further requires the Secretary to report annually to the Legislative Study Commission on MH/DD/SAS each October 1. Report must include:
1. The level of compliance among facilities;
2. Total number of faculties reporting any deaths;

3. The number of deaths reported by each facility;
4. The number of deaths investigated by the Secretary;
5. The number of deaths related to the use of seclusion.

Section 4. Requires the Chief Medical Examiner to forward copies of the medical examiner's report to DHHS in deaths of certain clients.

Section 5(a). Adds a new section to Article 1A of Chapter 131D to require residential childcare facilities to immediately notify DHHS of all deaths occurring within seven days of the use of physical restraint. The Secretary shall initiate an investigation of such deaths immediately and notify the Governor's Advocacy Council for Persons with Disabilities.

Section 5(b). Amends G.S. 131D-10.6 to require the Department to report annually on October 1 to the Legislative Study Commission on MH/DD/SAS. Report must include:
1. The level of compliance with applicable State law governing among facilities;
2. Total number of faculties reporting any deaths;
3. The number of deaths reported by each facility;
4. The number of deaths investigated by the Secretary;
5. The number of deaths related to the use of physical restraint or timeout.

Section 6(a). Amends Article 3 of Chapter 131D to require adult care homes to notify DHHS immediately of all deaths occurring in the adult care home or occurring within 24 hours of a transfer to a hospital from an adult care home, within seven days of the use of a physical restraint or physical hold. The Secretary shall initiate an investigation of such deaths immediately and notify the Governor's Advocacy Council for Persons with Disabilities.

Section 6(b).
The Department shall report annually on October 1 to the Legislative Study Commission on MH/DD/SAS. Report must include:
1. The level of compliance of each adult care home with applicable State law and rules governing the use of physical restraint and physical holds;
2. The number of facilities that reported deaths.
3. The number of deaths reported by each facility;
4. The number of deaths investigated by the Secretary;
5. The number of deaths related to the use of physical restraint or physical hold.

Section 7: The bill becomes effective January 1, 2001.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H

HOUSE BILL 1519*
Committee Substitute Favorable 5/31/00
Senate Health Care Committee Substitute Adopted 6/28/00

Short Title: Mental Health System Reform. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 3.(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 3.(c) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended

effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for

basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

(12) Consider whether the State shall implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

Section 3.(d) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, substance abuse, long-term care, and other appropriate providers.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 3.(e) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

SENATE
COMMITTEE SUBSTITUTE
JUN 28 2000
ADOPTED

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H D

HOUSE BILL 1519*
Committee Substitute Favorable 5/31/00
Proposed Senate Committee Substitute H1519-PCS5112-LN

Short Title: Mental Health System Reform. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 3.(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 3.(c) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended

effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for

basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

(12) Consider whether the State shall implement a contested case hearings procedure for applicants and recipients of mental health, developmental disabilities, and substance abuse services.

Section 3.(d) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, substance abuse, long-term care, and other appropriate providers.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 3.(e) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1519*
Committee Substitute Favorable 5/31/00

Short Title: Mental Health System Reform. (Public)

Sponsors:

Referred to:

May 15, 2000

A BILL TO BE ENTITLED

AN ACT TO ESTABLISH THE JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES, AND TO DIRECT THE OVERSIGHT COMMITTEE TO DEVELOP A PLAN TO REFORM THE STATE SYSTEM FOR MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICES.

Whereas, in 1998 and 1999 the General Assembly directed the State Auditor to coordinate and contract for a study of the State Psychiatric Hospitals and Area Mental Health Programs; and

Whereas, the "Study of State Psychiatric Hospitals and Area Mental Health Programs" ("Study"), April 1, 2000, was conducted by the Public Consulting Group, Inc., under the coordination of the State Auditor, and with the cooperation and assistance of the Department of Health and Human Services and other organizations and individuals; and

Whereas, the findings and recommendations of the Study present a comprehensive blueprint for reform of the State's mental health system; and

Whereas, the General Assembly endorses the findings of the Study; and

Whereas, effective implementation of mental health reform requires continuous legislative oversight to review and consider the recommendations of the Study and other matters and to recommend the necessary changes to State law and policy; Now, therefore,

The General Assembly of North Carolina enacts:

Section 1. Findings. -- The General Assembly finds that:

(1) The State and local government entities are not using effectively and efficiently available resources to administer and provide mental health, developmental disabilities, and substance abuse services uniformly across the State.

(2) Effective implementation of State policy to assist individuals with mental illness, developmental disabilities, and substance abuse problems requires that a standard system of services, designed to identify, assess, and meet client needs within available resources, be available in all regions of the State.

(3) The findings of recent comprehensive independent studies, and recent federal court decisions, compel the State to consider significant changes in the operation and utilization of State psychiatric hospital services.

(4) State and local government funds for mental health, developmental disabilities, and substance abuse services must be committed on a continuing, stabilized basis and will need to be increased over time to ensure that the purposes of mental health system reform are achieved.

(5) Reform of the State mental health, developmental disabilities, and substance abuse services system is necessary and should begin immediately. Reform efforts should focus on correcting system inefficiencies, inequities in service availability, and deficiencies in funding and accountability, and on improving and enhancing services to North Carolina's citizens.

Section 2. Oversight Committee Established. -- Chapter 120 of the General Statutes is amended by adding the following new Article to read:

"ARTICLE 27.

"The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

"§ 120-240. Creation and membership of Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(a) Establishment; Definition. -- There is established the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(b) Membership. -- The Committee shall consist of 16 members, as follows:

(1) Eight members of the Senate appointed by the President Pro Tempore of the Senate, as follows:

a. At least two members of the Senate Committee on Appropriations.

b. The chair of the Senate Appropriations Committee on Human Resources.

c. At least two members of the minority party.

(2) Eight members of the House of Representatives appointed by the Speaker of the House of Representatives, as follows:

a. At least two members of the House of Representatives Committee on Appropriations.

b. The cochairs of the House of Representatives Appropriations Subcommittee on Health and Human Services.

c. At least two members of the minority party.

(c) Terms. -- Terms on the Committee are for two years and begin on the convening of the General Assembly in each odd-numbered year, except the terms of the initial members, which begin on appointment and end on the day of the convening of the 2001 General Assembly. Members may complete a term of service on the Committee even if they do not seek reelection or are not reelected to the General Assembly, but resignation or removal from service in the General Assembly constitutes resignation or removal from service on the Committee.

A member continues to serve until the member's successor is appointed. A vacancy shall be filled within 30 days by the officer who made the original appointment.

"**§ 120-241. Purpose of Committee.**

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services shall examine, on a continuing basis, systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered. The Committee shall make ongoing recommendations to the General Assembly on ways to improve the quality and delivery of services and to maintain a high level of effectiveness and efficiency in system administration at the State and local levels. In conducting its examination, the Committee shall study the budget, programs, administrative organization, and policies of the Department of Health and Human Services to determine ways in which the General Assembly may encourage improvement in mental health, developmental disabilities, and substance abuse services provided to North Carolinians.

"**§ 120-242. Organization of Committee.**

(a) The President Pro Tempore of the Senate and the Speaker of the House of Representatives shall each designate a cochair of the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services. The Committee shall meet at least once a quarter and may meet at other times upon the joint call of the cochairs.

(b) A quorum of the Committee is eight members. No action may be taken except by a majority vote at a meeting at which a quorum is present. While in the discharge of its official duties, the Committee has the powers of a joint committee under G.S. 120-19 and G.S. 120-19.1 through G.S. 120-19.4.

(c) Members of the Committee receive subsistence and travel expenses as provided in G.S. 120-3.1. The Committee may contract for consultants or hire

employees in accordance with G.S. 120-32.02. The Legislative Services Commission, through the Legislative Services Officer, shall assign professional staff to assist the Committee in its work. Upon the direction of the Legislative Services Commission, the Supervisors of Clerks of the Senate and of the House of Representatives shall assign clerical staff to the Committee. The expenses for clerical employees shall be borne by the Committee."

Section 3.(a) Plan for Mental Health System Reform. -- Terms Defined. -- As used in this section, unless the context clearly provides otherwise:

(1) "Committee" means the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(2) "Mental Health System Reform" includes the system of services for mental health, developmental disabilities, and substance abuse.

(3) "Plan" means the Plan for Mental Health System Reform developed and recommended by the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services.

(4) "State Auditor/PCG, Inc., Study" means the "Study of State Psychiatric Hospitals and Area Mental Health Programs, April 1, 2000", conducted by the Public Consulting Group, Inc., under coordination by and contract with the State Auditor.

Section 3.(b) Development of Plan for Mental Health System Reform. -- The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under Article 27 of Chapter 120 of the General Statutes shall develop a Plan for Mental Health System Reform. It is the intent of the General Assembly that the Plan shall be fully implemented not later than July 1, 2005.

Section 3.(c) Purpose and Content of the Plan. -- The Plan shall provide for systematic, phased-in implementation of changes to the State's mental health system. In developing the Plan, the Committee shall do the following:

(1) Review and consider the findings and recommendations of the State Auditor/PCG, Inc., Study.

(2) Report to the 2001 General Assembly upon its convening the changes that should be made to the governance, structure, and financing of the State's mental health system at the State and local levels. The report shall include:

a. An explanation of how and the extent to which the proposed changes are in accord with or differ from the recommendations of the State Auditor/PCG, Inc., Study.

b. Proposed time frames for implementing mental health system reform on a phased-in basis, and the recommended effective date for full implementation of all recommended changes.

c. An estimate of the amount of State and federal funds necessary to implement the changes. The estimate should indicate costs of each phase of implementation and the total cost of full implementation.

d. An estimate of the amount of savings in State funds expected to be realized from the changes. The estimate should show savings expected in each phase of implementation, and the total amount of savings expected to be realized from full implementation.

e. The potential financial, economic, and social impact of changes to the current governance, structure, and financing of the mental health system on providers, clients, communities, and institutions at the State and local levels.

f. Proposed legislation making the necessary amendments to the General Statutes to enact the recommended changes to the system of governance, structure, and financing.

(3) Study the administration, financing, and delivery of developmental disabilities services. The study shall be in greater depth and detail than addressed in the State Auditor/PCG, Inc., Study. The Committee shall make a progress report on its study of developmental disabilities services to the 2001 General Assembly upon its convening.

(4) Study the feasibility and impact of and best methods for downsizing of the State's four psychiatric hospitals. In conducting this study, the Committee shall:

a. Take into account the need to enhance and improve community services to meet increased demand resulting from downsizing, and

b. Consider the findings and recommendations of the MGT of America Report of 1998, as well as the State Auditor/PCG, Inc., Study.

(5) Consider the impact of mental health system reform on quality of services and patient care and ensure that the Plan provides for ongoing review and improvements to quality of services and patient care.

(6) Ensure that the Plan provides for the active involvement of consumers and families in mental health system reform and ongoing implementation.

(7) Address the need to enhance and improve substance abuse services, including services for the prevention of substance abuse.

(8) Recommend a mental health, developmental disabilities, and substance abuse services benefits package that will provide for basic benefits for these services as well as specific benefits for targeted populations.

(9) Take into account the State's responsibility to enable institutionalized persons and persons at risk for institutionalization to receive services outside of the institution in community-based settings in accordance with the United States Supreme Court decision in Olmstead vs. L.C., (1999).

(10) Identify and address issues pertaining to the administration and provision of mental health services to children.

(11) Address issues, problems, strengths, and weaknesses in the current mental health system that are not addressed in the State Auditor/PCG, Inc., Study but that warrant consideration in the development of a reformed mental health system.

Section 3.(d) Subcommittees. -- The Committee shall establish one or more subcommittees to consider and develop specific focus areas of the Plan. Each subcommittee shall be the working group for the focus area assigned by the Committee cochairs. The Committee cochairs shall appoint the cochairs and members of each subcommittee from the Committee membership. The Committee cochairs shall invite representatives from the following to participate as nonvoting members of each subcommittee:

(1) Providers of mental health, developmental disabilities, substance abuse, long-term care, and other appropriate providers.

(2) Consumers of mental health, developmental disabilities, and substance abuse services and family members of consumers of these services.

(3) State and local government, including area mental health programs.

(4) Business and industry.

(5) Organizations that advocate for individuals in need of mental health, developmental disabilities, and substance abuse services.

Subcommittees shall meet at the call of the subcommittee cochairs.

The Committee cochairs shall assign the focus area for each subcommittee. Each subcommittee shall carry out its assignment as directed by the Committee cochairs and shall provide its findings and recommendations to the Committee cochairs for final decision by the Committee.

Section 3.(e) Reports. -- In addition to the report required under subsection (b) of this section, the Committee shall submit the following reports:

(1) To the 2001 General Assembly, upon its convening:

a. A progress report on the development of the Plan required by this section; and

b. An outline of an implementation process for downsizing the four State psychiatric hospitals.

(2) To the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Appropriations Committees on Health and Human

Services, by October 1, 2001, and March 1, 2002, progress reports on the development and implementation of the Plan.

(3) Interim reports on the development and implementation of the Plan to:

a. The 2001 General Assembly, by May 1, 2002. The report shall include legislative action necessary to continue the implementation of changes to the governance, structure, and financing of the State mental health system as recommended by the Committee in its January 2001 report to the General Assembly.

b. The 2003 General Assembly, upon its convening.

c. The 2003 General Assembly, by May 1, 2004. The report shall include legislative action necessary to continue phased-in implementation of the Plan.

(4) To the 2005 General Assembly, upon its convening, a final report on the Plan for Mental Health System Reform.

Section 4. Oversight Committee Appointments. -- The Speaker of the House of Representatives and the President Pro Tempore of the Senate shall make appointments to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services established under this act not later than 30 days from the date of adjournment sine die of the 1999 General Assembly. The Committee shall convene its first meeting not later than 15 days after all members have been appointed.

Section 5. Department of Health and Human Services Reports. -- On or before October 1, 2000, and on or before March 1, 2001, the Department of Health and Human Services shall report to the Legislative Study Commission on Mental Health, Developmental Disabilities, and Substance Abuse Services and to the Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities, and Substance Abuse Services, the status of the Department's reorganization efforts pertaining to the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. The report shall also include efforts underway by the Department to better coordinate policy and administration of the Division of Medical Assistance with policy and administration of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services.

Section 6. Effective Date. -- This act becomes effective July 1, 2000.

HB 1519:
Mental Health System Reform

BILL ANALYSIS

Committee:	Senate Health Care	**Introduced by:**	Reps. Insko (Primary Sponsor)
Date:	June 28, 2000	**Summary by:**	Linda Attarian
Version:	2		Committee Counsel

SUMMARY: ***The bill establishes a new Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services. The oversight committee would oversee the development of a plan to reform the current system of public mental health, developmental disabilities and substance abuse services and address other issues including structure, governance and financing of services, downsizing of state hospitals, developmental disabilities services, quality of services, and ongoing involvement of consumers and families. The act would become effective July 1, 2000. The oversight committee must be appointed within 30 days of adjournment sine die of the 1999 General Assembly and would convene its first meeting no later than 15 days after all members were appointed.***

CURRENT LAW/BACKGROUND: Currently, the Legislative Study Committee on Mental Health, Developmental Disabilities and Substance Abuse Services exists pursuant to G.S. 120-204 (Study Commission). The purpose of the Study Commission is to "study systemwide issues affecting the development, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issues relating to the governance, accountability, and quality of services delivered". The Study Commission is composed of 22 members, including 14 members of the General Assembly, representatives of organizations that advocate for individuals in need of mental health, developmental disabilities and substance abuse services, providers and consumers of services, and county commissioners.

The Study Commission has recommended the establishment of a Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (Oversight Committee) to direct the Oversight Committee to oversee the development of a plan to reform the current system of public mental health, developmental disabilities and substance abuse services. The Study Commission further recommends that a recent (April 1, 2000) comprehensive study by the Public Consulting Group, Inc. entitled "Study of State Psychiatric Hospitals and Area Mental Health Programs" and coordinated by and under contract with the Office of the State Auditor, provide the blueprint for the Oversight Committee's planning process

BILL ANALYSIS:

Section 1. – This section sets out findings of the General Assembly with respect to the need for reforming the current public mental health system.

Section 2. – This section establishes a statutory joint legislative oversight committee on mental health, developmental disabilities and substance abuse services. Specifically:

(1) *Composition*: From each chamber, 8 members to include: Appropriations committee; Chair of DHHS appropriations subcommittee; 2 from minority party

(2) *Terms*: 2 year, beginning on convening of each GA in odd-year. Except, initial term will begin on appointment and end upon convening of 2001 GA.

(3) *Purpose* is to examine systemwide issues affecting the development, financing, administration, and delivery of mental health, developmental disabilities, and substance abuse services, including issuses relating to governance, accountability, and quality of services.

(4) *Committee organization* (appointment of co-chairs; quorum; powers of joint committee conferred by G.S. 120-19.1 through 19.4).

Section 3(a), (b), (c). – These sections define terms; direct the Oversight Committee to develop a Plan for Mental Health System Reform; and provides the requirements, purpose and contents of the Plan.

Section 3(d). – This section requires the Oversight Committee to form subcommittees to consider and develop assigned focus areas of the Plan. *This section of the original bill was amended to clarify that long term care and other appropriate providers would be included as participants as members of each subcommittee.*

Section 3(e). - This section requires the Oversight Committee to meet specified reporting guidelines. The Committee's intial report is due at the convening of the 2001 General Assembly and its final report is due upon the convening of the 2005 General Assembly.

Section 4. – This section requires the Speaker of the House of Representatives and the President Pro Tempore of the Senate to make their appointments to the Committee not later than 30 days from the date of adjournment sine die. The section also requires the Committee to convene its first meeting not later than 15 days after the appointments have been made.

Section 5. – This section requires the Department of Health and Human Services to report to both the Joint Legislative Oversight Committee established under Section 2 of the bill and the existing Legislative Study Commission on Mental Health, Developmental Disabilities and Substance Abuse Services on or before October 1, 2000 and on or before March 1, 2001 on the status of the Department's reorganization efforts.

Section 6. – Effective date: July 1, 2000.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S 1

SENATE BILL 1437

Short Title: High-Risk Intervention Coverage/State Health Plan. (Public)

Sponsors: Senator Gulley.

Referred to: Health Care.

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO AMEND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE FOR COVERAGE OF HIGH-RISK INTERVENTION MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES PROVIDED IN RESIDENTIAL FACILITIES AS DEFINED IN G.S. 122C-3(14)e. OF THE GENERAL STATUTES.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, high-risk intervention, and residential care and treatment:

(1) For mental illness treatment:

a. Licensed psychiatric hospitals;

b. Licensed psychiatric beds in licensed general hospitals;

c. Licensed residential treatment facilities;

d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs; ~~and~~
f. Licensed partial hospitalization ~~programs.~~ programs; and
g. Residential facilities as defined in G.S. 122C-3(14)e.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; ~~and~~
g. Medical detoxification facilities or ~~units.~~ units; and
h. Residential facilities as defined in G.S. 122C-3(14)e.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
(5) Repealed by Session Laws 1997-512, s. 14.
(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7), (8) Repealed by Session Laws 1997-512, s. 14.
(9) Certified fee-based practicing pastoral counselors; and
(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:

a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;
f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors; and
k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:

a. Licensed physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
b. Licensed or certified psychologists;
c. Psychiatrists;
d. Certified substance abuse counselors working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and
k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, and intensive outpatient programs, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, "emergency" is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

Section 2. This act is effective when it becomes law.

SB 1437: High-Risk Intervention Coverage/State Health Plan

BILL ANALYSIS

Committee:	Senate Health	**Introduced by:**	Sen. Wib Gulley
Date:	June 28, 2000	**Summary by:**	Linda Attarian
Version:			Committee Counsel

SUMMARY: ***The bill amends the Teachers' and State Employees' Comprehensive Major Medical Plan (State Health Plan) to provide coverage of high-risk intervention mental health and chemical dependency services provided in licensed therapeutic homes for children and adolescents. The bill would become effective when it becomes law, but would apply to services provided on and after January 1, 2000.***

CURRENT LAW: Currently, the scope of coverage for the treatment of chemical dependency and mental illness under the State Health Plan is limited to allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, and residential care and treatment that is provided in specified treatment settings. In addition, the State Health Plan does not cover charges for care in any facility or location for custodial or for rest cures. Thus, the charges for high-risk intervention treatment provided in group or family care settings is not covered under the State Health Plan. High-risk intervention treatment is covered under Medicaid and NC Health Choice clients in group or family care settings.

High-risk intervention treatment, according to NC Health Choice Authorization Criteria, consists of intensive treatment services provided in residential settings which are intended to prepare clients to function successfully at a lower level of care or prevent clients from needing services at a higher level of care. These services are provided to help clients develop skills and competencies in areas such as behavior, mood, thought patterns, community functioning, and the ability to participate successfully in family living.

Licensed therapeutic homes for children and adolescents are licensed by the Division of Facility Services under the authority of Title 10, Subchapter 14V, Section .5300 of the Administrative Procedures Act. They are defined by rule to be a 24-hour residential facility located in a private residence which provides professionally trained parent-substitutes who work intensively with children and adolescents who are emotionally disturbed or have a substance abuse problem, or both. The parent substitute provides for intensive living, social, therapeutic and skill-learning needs, and receives close supervision and support from a qualified professional.

BILL ANALYSIS: Section 1 changes G.S. 135-40.7B to add "high-risk intervention" services for the care and treatment of mental illness and chemical dependency provided in "licensed therapeutic homes for children and adolescents to the list of specified covered services under the State Health Plan and to provide that such services may be provided on a case-managed basis.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

S D

SENATE BILL 1437
Proposed Committee Substitute S1437-PCS3977-RM

Short Title: High-Risk Intervention Coverage/State Health Plan. (Public)

Sponsors:

Referred to:

May 25, 2000

A BILL TO BE ENTITLED

AN ACT TO AMEND THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN TO PROVIDE FOR COVERAGE OF HIGH-RISK INTERVENTION MENTAL HEALTH AND CHEMICAL DEPENDENCY SERVICES PROVIDED IN LICENSED THERAPEUTIC HOMES FOR CHILDREN AND ADOLESCENTS.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.7B reads as rewritten:

"**§ 135-40.7B. Special provisions for chemical dependency and mental health benefits.**

(a) Except as otherwise provided in this section, benefits for the treatment of mental illness and chemical dependency are covered by the Plan and shall be subject to the same deductibles, durational limits, and coinsurance factors as are benefits for physical illness generally.

(b) Notwithstanding any other provision of this Part, the following necessary services for the care and treatment of chemical dependency and mental illness shall be covered under this section: allowable institutional and professional charges for inpatient care, outpatient care, intensive outpatient program services, partial hospitalization treatment, high-risk intervention, and residential care and treatment:

(1) For mental illness treatment:

a. Licensed psychiatric hospitals;

b. Licensed psychiatric beds in licensed general hospitals;

c. Licensed residential treatment facilities;

d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs; ~~and~~
f. Licensed partial hospitalization ~~programs.~~ programs; and
g. Licensed therapeutic homes for children and adolescents.

(2) For chemical dependency treatment:
a. Licensed chemical dependency units in licensed psychiatric hospitals;
b. Licensed chemical dependency hospitals;
c. Licensed chemical dependency treatment facilities;
d. Area Mental Health, Developmental Disabilities, and Substance Abuse Authorities;
e. Licensed intensive outpatient treatment programs;
f. Licensed partial hospitalization programs; ~~and~~
g. Medical detoxification facilities or ~~units.~~ units; and
h. Licensed therapeutic homes for children and adolescents.

(c) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for mental health under this section:

(1) Psychiatrists who have completed a residency in psychiatry approved by the American Council for Graduate Medical Education and who are licensed as medical doctors or doctors of osteopathy in the state in which they perform and services covered by the Plan;
(2) Licensed or certified doctors of psychology;
(3) Certified clinical social workers;
(3a) Licensed professional counselors;
(4) Certified clinical specialists in psychiatric and mental health nursing;
(4a) Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
(5) Repealed by Session Laws 1997-512, s. 14.
(6) Psychological associates with a masters degree in psychology under the direct employment and supervision of a licensed psychiatrist or licensed or certified doctor of psychology;
(7), (8) Repealed by Session Laws 1997-512, s. 14.
(9) Certified fee-based practicing pastoral counselors; and
(10) Licensed physician assistants under the supervision of a licensed psychiatrist and acting pursuant to G.S. 90-18.1 or the applicable laws and rules of the area in which the physician assistant is licensed or certified.

(c1) Notwithstanding any other provisions of this Part, the following providers and no others may provide necessary care and treatment for chemical dependency under this section:

(1) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager, in facilities described in subdivision (b)(2) of this section, in day/night programs or outpatient treatment facilities licensed after July 1, 1984, under Article 2 of Chapter 122C of the General Statutes or in North Carolina area programs in substance abuse services are authorized to provide treatment for chemical dependency under this section:
   a. Licensed physicians including, but not limited to, physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
   b. Licensed or certified psychologists;
   c. Psychiatrists;
   d. Certified substance abuse counselors working under the direct supervision of such physicians, psychologists, or psychiatrists;
   e. Psychological associates with a masters degree in psychology working under the direct supervision of such physicians, psychologists, or psychiatrists;
   f. Nurses working under the direct supervision of such physicians, psychologists, or psychiatrists;
   g. Certified clinical social workers;
   h. Certified clinical specialists in psychiatric and mental health nursing;
   i. Licensed professional counselors;
   j. Certified fee-based practicing pastoral counselors; and
   k. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes.

(2) The following providers with appropriate substance abuse training and experience in the field of alcohol and other drug abuse as determined by the mental health case manager are authorized to provide treatment for chemical dependency in outpatient practice settings:
   a. Licensed physicians who are certified in substance abuse by the American Society of Addiction Medicine (ASAM);
   b. Licensed or certified psychologists;
   c. Psychiatrists;
   d. Certified substance abuse counselors working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
   e. Psychological associates with a masters degree in psychology working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;

f. Nurses working under the employment and direct supervision of such physicians, psychologists, or psychiatrists;
g. Certified clinical social workers;
h. Certified clinical specialists in psychiatric and mental health nursing;
i. Licensed professional counselors;
j. Certified fee-based practicing pastoral counselors;
1. Substance abuse professionals certified under Article 5C of Chapter 90 of the General Statutes; and
k. In the absence of meeting one of the criteria above, the Mental Health Case Manager could consider, on a case-by-case basis, a provider who supplies:
1. Evidence of graduate education in the diagnosis and treatment of chemical dependency, and
2. Supervised work experience in the diagnosis and treatment of chemical dependency (with supervision by an appropriately credentialed provider), and
3. Substantive past and current continuing education in the diagnosis and treatment of chemical dependency commensurate with one's profession.

Provided, however, that nothing in this subsection shall prohibit the Plan from requiring the most cost-effective treatment setting to be utilized by the person undergoing necessary care and treatment for chemical dependency.

(d) Benefits provided under this section shall be subject to a case management program for medical necessity and medical appropriateness consisting of (i) precertification of outpatient visits beyond 26 visits each Plan year, (ii) all electroconvulsive treatment, (iii) inpatient utilization review through preadmission and length-of-stay certification for nonemergency admissions to the following levels of care: inpatient units, partial hospitalization programs, residential treatment centers, chemical dependency detoxification and treatment programs, ~~and~~ intensive outpatient programs, and therapeutic homes for children and adolescents, (iv) length-of-stay certification of emergency inpatient admissions, and (v) a network of qualified, available providers of inpatient and outpatient psychiatric and chemical dependency treatment. Care which is not both medically necessary and medically appropriate will be noncertified, and benefits will be denied. Where qualified preferred providers of inpatient and outpatient care are reasonably available, use of providers outside of the preferred network shall be subject to a twenty percent (20%) coinsurance rate up to five thousand dollars ($5,000) per fiscal year to be assessed against each covered individual in addition to the general coinsurance percentage and maximum fiscal year amount specified by G.S. 135-40.4 and G.S. 135-40.6.

(e) For the purpose of this section, "emergency" is the sudden and unexpected onset of a condition manifesting itself by acute symptoms of sufficient severity that, in the absence of an immediate psychiatric or chemical dependency inpatient admission, could imminently result in injury or danger to self or others."

Section 2. This act is effective when it becomes law and applies to services provided on or after January 1, 2000.

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: SB 1437 Proposed Senate Committee Substitute (PCS3977-RM)

SHORT TITLE: High-Risk Intervention/State Health Plan

SPONSOR(S): Senator Wib Gulley

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: The Proposed Senate Committee Substitute rewrites G.S. 135-40.7B entitled "Special provisions for chemical dependency and mental health benefits" to include the undefined term "high-risk intervention" under G.S. 135-40.7B(b). The proposed legislation also authorizes coverage for "licensed therapeutic homes for children and adolescents" under the Plan's mental health benefits under a new subsection G.S. 135-40.7B(b)(1)(g) and again under the Plan's coverage for chemical dependency treatment under a new subsection G.S. 135-40.7B(b)(2)(h). G.S. 135-40.7B(d) is also modified to require the proposed new benefits to be subject to case management.

EFFECTIVE DATE: The proposed act is effective when it becomes law and applies to services on or after January 1, 2000.

ESTIMATED IMPACT ON STATE: Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, estimates an increase in claims costs to the Plan's indemnity program to be $2,459,000 for 2000-2001 and $2,240,000 for 2001-2002. Based upon claims information and assumptions supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates an increase in claims costs to the Plan's indemnity program to be $946,392 for 2000-2001 and $1,003,228 for 2001-2002. A combined estimate from the two actuaries indicates the increase in claims cost to the Plan's indemnity program is $1,702,696 for 2000-2001 and $1,621,614 for 2001-2002.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity

program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in about 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706
Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0

Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year. Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family contract dependents. Claim cost trends are expected to increase 13% plus annually. Total enrollment in the program is expected to increase about 3-4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for coverage of Licensed Therapeutic Homes for Children and Adolescents under the Indemnity Plan:
The actuarial estimates assume that a licensed therapeutic home for children and adolescents is a 24-hour residential facility located in a private residence which provides professionally trained parent substitutes who work with children and adolescents who are emotionally disturbed or have a substance abuse problem or both. In addition, the following assumptions have been applied to the estimates by the independent actuaries: a 12% claims cost trend, 3% administrative expense, a 7.5% claims fluctuation reserve, and utilization of case management.

The estimate provided by the Plan's consulting actuary assumes a one-tenth percent (.1%) case rate based on the State's Medicaid program experience for similar services. The estimated eligible population enrolled in the self-insured indemnity program is estimated to be approximately 75,000 children and adolescents. Applying the assumed one-tenth percent (.1%) case rate across the estimated eligible enrolled population is expected to produce 75 admissions per plan year. The average cost per day per admission estimated was based on a range of $125 to $150 per day. The average length of stay was estimated to range between 90 to 120 days per admission assuming the utilization of case management. An additional $959,000 in claims cost is projected in the first year to account for the retroactive application of the proposed benefit enhancement to claims on or after January 1, 2000.

The estimate provided by the General Assembly's consulting actuary assumes a seventy-five hundredths percent (.075%) case rate based on data provided by the Plan and the Plan's contractor for case management of mental health and chemical dependency benefits. The estimated eligible population enrolled in the self-insured indemnity program is estimated to be approximately 75,000 children and adolescents. Applying the assumed seventy-five hundredths percent (.075%) case rate across the estimated eligible enrolled population is expected to produce 55 admissions per plan year. The average cost per day estimated per admission was based on an average rate of $125 per day. The average length of stay was estimated to range between 90 to 120 days per admission assuming the utilization of case management. An additional $199,942 in claims cost is projected in the first year to account for the retroactive application of the proposed benefit enhancement to claims on or after January 1, 2000.

SOURCES OF DATA:
-Actuarial Note, Hartman & Associates, Proposed Committee Substitute for Senate Bill 1437, June 26, 2000, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Proposed Committee Substitute for Senate Bill 1437, June 23, 2000, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Mark Trogdon
APPROVED BY: James D. Johnson
DATE: June 27, 2000

HARTMAN & ASSOCIATES, LLC

ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 26, 2000

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Proposed Committee Substitute to Senate Bill 1437: An Act to Provide for High-Risk Intervention in Therapeutic Homes for Children Under the Comprehensive Major Medical Plan

Dear Mr. Trogdon:

This proposed committee substitute amends G.S. 135-40.7B by adding high-risk intervention and licensed therapeutic homes for children and adolescents as covered services for treatment of chemical dependency and mental illness. It also specifies that these services are subject to case management. This act is effective when it becomes law and applies to services provided on or after January 1, 2000.

The actual cost of this act will depend on a number of factors, including incidence rates, lengths of stay, per diem costs, and the impact on utilization resulting from providing coverage for specific benefits within the continuum of care. Cost estimates are based on information obtained from similar services, including Medicaid coverage of therapeutic homes, coverage of therapeutic homes under the state CHIP program, and claims currently covered by the plan in licensed residential treatment facilities. The estimated cost of this act is shown below:

Fiscal Year	Estimated Cost
2000-2001	$ 946,392
2001-2002	$1,003,228

These estimates assume a 12% annual claim cost trend, a 60-day claim payment lag, 3% administrative expense, 7.5% claim fluctuation reserve, and utilization of case management. The value for the fiscal year beginning July 1, 2000 also includes provision for the retroactive effective coverage date.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/mt

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

Senate Bill 1437
Proposed Committee Substitute 1437-PCS3977-RM

Cost To Provide Coverage for High-Risk Intervention For Mental Health and Chemical Dependency Services in Licensed Therapeutic Homes For Children and Adolescents

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

June 2000

Aon Consulting

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to Senate Bill 1437 (proposed Committee Substitute 1437-PCS3977-RM) entitled "An Act to amend the Teachers' and State Employees' Comprehensive Major Medical Plan to provide for coverage of high-risk intervention mental health and chemical dependency services provided in licensed therapeutic homes for children and adolescents".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/23/00
Date

Professional Peer Review by:

D. Michael Jones, A.S.A., M.A.A.A., E.A.
Assistant Vice President

6/23/00
Date

Aon Consulting

HIGH-RISK INTERVENTION RESIDENTAL COVERAGE FOR CHILDREN

PLAN CHANGE

The draft bill proposes that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) be amended to cover the cost of licensed therapeutic homes involved with the treatment of high-risk mental health and chemical dependency cases.

In general, the plan currently provides benefits for the treatment of mental illness and chemical dependency, subject to the same deductibles, duration limits and coinsurance factors, as are benefits for physical illness. Residential care is covered, but must be provided at a licensed residential treatment facility, providing more than custodial care.

It is proposed that the plan be amended to provide coverage for licensed therapeutic homes providing primarily a custodial level of care as opposed to the medically necessary care being provided at currently covered residential treatment centers. The coverage is limited to children and adolescents.

The proposed act is effective January 1, 2000.

PROJECTED COST IMPACT

Cover high-risk intervention residential costs.	0.13%	0.20%	0.27%	$2,459	$2,240	$2,508

Based on projected claims of $1,006,964,998, $1,181,523,674 and $1,323,306,515 for the 2001, 2002 and 2003 fiscal years respectively. First year cost assumes an implementation date of January 1, 2000 and a 3 month claims payment lag.

PRICING APPROACH

- Available in North Carolina, Medicaid statistics show a 0.1% high-risk intervention utilization/ case rate for their eligible group (children and teenagers). The plan currently has approximately 76,000 members under the age of 18, which would produce 75 expected admissions.
- Value Options, the Plan's Mental Health Case Manager, indicated that there was potential for higher than expected utilization. Based on their recommendation, the combination of additional benefits and no case management would increase the overall expected utilization by 300% to 500%. Due to the addition of case management, we have assumed a utilization increase of 150% to 200%.
- The average per day cost in a certified residential treatment facility was approximately $160 per day (per BCBSNC). Aon used an average per day cost range of $125 to $160 and the average length of stay of 90 to 120 days (as suggested by Value Options) to calculate the high and low scenarios. Applying 75 admissions to the above parameters produces a cost range from $1.3 to $2.7 million, with an expected mid-point of $2.0 million.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — JUNE 28, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Beina Holland	DHHS
Dr. Jean Allen	Parents of child who died in restraint
Cynthia Semachenko	GACPD
Stuart Beide	DMH/DD/SAS - DHHS
Amanda Adams	Covenant w/ NC's Children
Christina Medlin	NC Equity
Roz Savitt	NCCCA
[illegible]	NCPAHA
NT Burnett	GACPD
Dave Richard	Arc NC
Stacy Flannery	NCHCFA

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — JUNE 28, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Tara Larson	DMH/DD/SAS
Iverson Riddle	"
Art Robarge	"
Annette Patrick	Wake County
Steve Keene	NC Medical Society
Amy Jo Bunn	NC Medical Society
Robin Huffman	NC Psychiatric Assoc
Lori Ann Adams	LAA/Assoc
Evelyn Hutchins	UNC-CH
Mary Corum	Parent / SD NC Leadership Network

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE — JUNE 28, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
Wanda Mills	SEANC
Hilary Kaplan	NCAHP
Lynn Bonner	NPO
John Bowditch	Kelly Associates
Brenda Dalton	OSA
Sam Boyd	Leg. Fiscal Research
Crissy Porter	Bone & Associates
Sara Singleton	Governor's Office
Jeff Horton	DHHS- DFS
Lynda McDaniel	DHHS / DFS
Wayne Williams	OSBM

Principal Clerk ___
Reading Clerk ___

SENATE
NOTICE OF COMMITTEE MEETING
and
BILL SPONSOR NOTICE

The Senate Committee on Health Care will meet at the following time:

DATE: **Wednesday, July 5, 2000**
TIME: **12:00 Noon**
ROOM: **1124, Legislative Building**

The following bills will be considered:

- H.B.1838, State Health Plan Amend's. Representative Culpepper

Senator William R. Purcell, Chair

Senate Health Care Committee
Wednesday, July 5, 2000
12:00 Noon
1124 Legislative Building

MINUTES

The Senate Health Care Committee met at 12:10 P.M. on Wednesday, July 5, 2000, in Room 1124 of the Legislative Building. Twelve members of the committee were present. Senator William R. Purcell presided.

Minutes of the previous meeting on June 28, 2000 were given to the committee. Senator Lucas moved that they be approved as written; the motion carried.

Senator Purcell introduced Representative Culpepper to present H.B. 1838, *State Health Plan Amend's.* Representative Culpepper explained the two sections of the bill and called on Mark Trogden of Fiscal Research to state the cost of the bill's provisions, about $136,000 for the first year. Senator Purcell called on Dr. Jack Walker, Director of the State Health Insurance Plan to comment on the cost based on recent experience, which was about $1.6 million for pap smears. He estimated that the additional cost would be between $137,000 and $500,000. Senator Phillips asked the difference between a wellness plan and a health plan. Representative Culpepper responded that the wellness plan is an additional benefit at a cost to the State Health Plan of $150 per person per year. Mr. Sam Byrd of Fiscal Research explained that the wellness plan covers treatment when there is no evidence of a disease; the health plan covers treatment for a specific ailment. Senator Forrester pointed out that the pap smear is an excellent diagnostic tool and that he would add, at a future date, that mammograms be done every year on each female in the State Health Plan. Representative Culpepper agreed.

Section 2 of the bill provides that the Plan's Board of Trustees will have the discretion to restore membership in the plan, after a five-year waiting period, to persons who misrepresented medical bills either deliberately or by accident, and were dropped from the Plan. Full restitution must have been made for this to occur.

Senator Rucho moved for a favorable report and Senator Lucas seconded the motion. The motion carried, with a referral to Appropriations/Base Budget. The meeting was adjourned at 12:40 P.M.

William R. Purcell

Senator William R. Purcell, Chair

Lorraine R. Blake

Lorraine R. Blake, Committee Assistant

NORTH CAROLINA GENERAL ASSEMBLY
SENATE

HEALTH CARE COMMITTEE REPORT
Senator William R. Purcell, Chair

Wednesday, July 05, 2000

SENATOR PURCELL,
submits the following with recommendations as to passage:

FAVORABLE

H.B.(CS #1)**1838** State Health Plan Amend's.
Sequential Referral: Appropriations/Base Budget
Recommended Referral: None

TOTAL REPORTED: 1

Committee Clerk Comment: None

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1999

H 2

HOUSE BILL 1838
Committee Substitute Favorable 6/27/00

Short Title: State Health Plan Amend's. (Public)

Sponsors:

Referred to:

May 30, 2000

A BILL TO BE ENTITLED

AN ACT TO PROVIDE THAT THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN SHALL COVER THE COST OF ONE ANNUAL PAP SMEAR FOR ANY COVERED FEMALE UNDER THE PLAN'S WELLNESS BENEFIT AND TO ALLOW INDIVIDUALS EXCLUDED FROM MEMBERSHIP IN THE TEACHERS' AND STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN FOR FILING FRAUDULENT CLAIMS TO BE CONSIDERED FOR REINSTATEMENT IN THE PLAN.

The General Assembly of North Carolina enacts:

Section 1. G.S. 135-40.5(e) reads as rewritten:

"(e) Routine Diagnostic Examinations. -- The Plan will pay one hundred percent (100%) of allowable charges for routine diagnostic examinations and tests, including ~~Pap smears,~~ breast, colon, rectal, and prostate exams, X rays, mammograms, blood and blood pressure checks, urine tests, tuberculosis tests, and general health checkups that are medically necessary for the maintenance and improvement of individual health but no more often than once every three years for covered individuals to age 40 years, once every two years for covered individuals to age 50 years, and once a year for covered individuals age 50 years and older, unless a more frequent occurrence is warranted by a medical condition when such charges are incurred in a medically supervised facility. Routine diagnostic examinations and tests covered under this subsection also include one Pap smear per year for any covered female. Provided, however, that charges for such examinations and tests are not covered by the Plan when they are incurred to obtain or continue employment, to secure

insurance coverage, to comply with legal proceedings, to attend schools or camps, to meet travel requirements, to participate in athletic and related activities, or to comply with governmental licensing requirements. The maximum amount payable under this subsection for a covered individual is one hundred fifty dollars ($150.00) per fiscal year."

Section 2. G.S. 135-40.2(h) reads as rewritten:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subsection when persons subject to this subsection have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subsection shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subsection."

Section 3. G.S. 135-40.11(a)(6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. The Executive Administrator and Board of Trustees may make an exception to the provisions of this subdivision when persons subject to this subdivision have had a cessation of coverage for a period of five years and have made a full and complete restitution to the Plan for all fraudulent claim amounts. Nothing in this subdivision shall be construed to obligate the Executive Administrator and Board of Trustees to make an exception as allowed for under this subdivision."

Section 4. This act becomes effective July 1, 2000.

STATE OF NORTH CAROLINA
THE TEACHERS' AND STATE EMPLOYEES'
COMPREHENSIVE MAJOR MEDICAL PLAN

- MEMORANDUM -

TO: Senator Aaron W. Plyler
Senator Anthony E. Rand
Senator Robert C. Carpenter
Senator William R. Purcell

FROM: Jack W. Walker, Ph.D.
Executive Administrator

DATE: July 12, 2000

SUBJECT: Pap Smears

With respect to Senate Bill 432 and the proposed amendment to G.S. 135-40.5(e) to provide that routine diagnostic examinations and tests not subject to deductible or coinsurance include one pap smear per year for any covered female, the Executive Administrator concurs with this change. This concurrence is limited to only the annual pap smear provision of Senate Bill 432 and does not address the other provisions of that bill. The Executive Administrator renders no opinion on the remainder of the bill.

Annual pap smears are considered standard medical practice based upon the physician's judgment of the needs of the patient and the Executive Administrator believes that it should be covered in those situations.

The Plan's actuary has estimated the cost to be $136,000 for the first year and $203,000 for the second year. The General Assembly's actuary estimates the cost to be $1,189,038 for the first year and $1,470,222 for the second year. Based upon the review of these two estimates and other information, the Executive Administrator's estimate is that it will cost the Plan $452,000 the first year and $583,000 the second year.

Although the State Health Plan will face financial challenges in the next four years, the Plan's current estimates show that there will be $40 million remaining in the Plan at the end of the biennium. In addition, there is a $48 million reserve that was included in the current budget bill to offset possibly higher health care expenditures.

4509 CREEDMOOR ROAD, SUITE102, RALEIGH, N.C. 27612 (919) 881-2300 FACSIMILE: (919) 881-2307

HOUSE BILL 1838 STATE HEALTH PLAN AMENDMENTS:

BILL ANALYSIS

Committee: Senate Care Health
Date: June 27, 2000
Version: 2

Introduced by:
Summary by: Linda Attarian and John Young
Committee Counsel

SUMMARY: Section 1 provides that SEHP shall cover the cost of one annual Pap smear for any covered female under the Plan's wellness benefit. Sections 2 and 3 allows a person to reapply to the Board of Trustees of the SEHP to regain coverage under the Plan after they have been deemed ineligible for coverage for committing fraud against the Plan. Acceptance for coverage would be at the discretion of the Executive Administrator and the Board of Trustees.. The act becomes effective July 1, 2000.

CURRENT LAW: **Section 1**-Currently, under G.S. 135-40.5(e), charges for Pap smears are covered at 100% as part of routine diagnostic examinations. However, the frequency is limited to once every three years for individuals under age 40, once every two years t ages 40-49, and annually at ages 50 and older.

Sections 2 and 3-Currently, under G.S. 135-40.2(h) if at any time a person is found to have knowingly and willfully made a false statement or a false representation of a material fact in a claim for reimbursement under the State Employee's Health Plan, their coverage will be terminated and the person will no longer be eligible for reinstatement of coverage under the Plan. .

BILL ANALYSIS: **Section 1**-Rewrites G.S. 135-40.5(e), "Routine Diagnostic Examinations", to allow coverage for an annual Pap smear for any covered female without regard to age under the Plan's $150 annual wellness benefit. The proposed change affects covered females age 50 and under since the current wellness benefit allows for an annual Pap smear for females age 50 and over. A combined estimate from the two actuaries on the additional cost to the Plan's indemnity program is $526,519 for 2000-2001 and $633,611 for 2001-2002.

Section 2 and 3- Would allow a person to reapply to the Board of Trustees of the State Health Plan to regain coverage under the Plan after they have been deemed ineligible for coverage under the Plan for committing fraud against the Plan. To reapply for reinstatement, the person must have been off the Plan for 5 years, must have made full restitution, and must comply with any relevant factors the Board establishes for restitution. Acceptance for coverage would be at the discretion of the Executive Director and the Board of Trustees.

North Carolina General Assembly
Legislative Services Office

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(919) 733-7044

Elaine W. Robinson, Director
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(919) 733-2578

MEMORANDUM

TO: Representative Bill Culpepper

FROM: Mark Trogdon, Fiscal Research Division

DATE: June 30, 2000

SUBJECT: Actuarial Note HB 1838 (Second Edition)

In accordance with North Carolina General Statute 120-114 and applicable Rules of the North Carolina Senate and House of Representatives, attached is a certified copy of an original actuarial note on the above subject as prepared by the General Assembly's Consulting Actuary. A certified copy of an original actuarial note on the same subject from the Plan Administrator's Consulting Actuary is also attached for your review.

cc: Senator Purcell, Chair
Senate Committee on Health Care
Janet Pruitt Principal Clerk,

Attachment(s):
(1) Actuarial Note Summary, Fiscal Research Division
(2) Actuarial Note, Aon Consulting
(3) Actuarial Note, Hartman and Associates

NORTH CAROLINA GENERAL ASSEMBLY
LEGISLATIVE ACTUARIAL NOTE

BILL NUMBER: HB 1838 (Second Edition)

SHORT TITLE: State Health Plan Amendments

SPONSOR(S): Rep. Culpepper

SYSTEM OR PROGRAM AFFECTED: Teachers' and State Employees' Comprehensive Major Medical Plan.

FUNDS AFFECTED: State General Fund, State Highway Fund, other State employer receipts, premium payments for dependents by active and retired teachers and State employees, and premium payments for coverages selected by eligible former teachers and State employees.

BILL SUMMARY: Rewrites G.S. 135-40.5(e), "Routine Diagnostic Examinations", to allow coverage for an annual Pap smear for any covered female without regard to age under the Plan's $150.00 annual wellness benefit. The proposed change affects covered females age 50 and under since the current wellness benefit allows for an annual Pap smear for females age and over.

The bill also allows the Executive Administrator and the Board of Trustees to permit former Plan members who have been excluded from coverage for filing fraudulent claims to be reinstated in the Plan upon a cessation of coverage for five years and upon full and complete restitution to the Plan for all fraudulent claims amounts.

EFFECTIVE DATE: July 1, 2000

ESTIMATED IMPACT ON STATE:

Annual Pap Smear Benefit -- Based upon information supplied by the Teachers' and State Employees' Comprehensive Major Medical, the consulting actuary for the Plan, Aon Consulting, estimates the additional cost to the Plan's indemnity program to be $136,000 for 2000-2001 and $203,000 for 2001-2002. Based upon claims information supplied by the Plan, the consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, estimates the additional cost to the Plan's indemnity program to be $1,189,038 for 2000-2001 and $1,470,222 for 2001-2002. A combined estimate from the two actuaries on the additional cost to the Plan's indemnity program is $526,519 for 2000-2001 and $633,611 for 2001-2002.

gibility for Benefits Reinstatement Provision -- Based upon information plied by the Teachers' and State Employees' Comprehensive Major Medical Plan, the consulting actuary for the Plan, Aon Consulting, and the consulting actuary for the General Assembly's Fiscal Research Division,

Hartman & Associates, estimate that the bill will not materially increase the cost to the Plan's indemnity program. The only concern expressed by both actuaries was the likelihood of adverse selection against the Plan by fraudulent filers at the time of reinstatement since they would have been out of the Plan for at least five years.

ASSUMPTIONS AND METHODOLOGY: The Comprehensive Major Medical Plan for Teachers and State Employees is divided into two programs. From October, 1982, through June, 1986, the Plan had only a self-funded indemnity type of program which covered all employees, retired employees, eligible dependents of employees and retired employees, and eligible former employees and their eligible dependents authorized to continue coverage past a termination of employment other than for retirement or disability purposes. A prepaid program of coverage by health maintenance organizations (HMOs) was offered in July, 1986, as an alternative to the Plan's self-insured indemnity program. The benefits of the self-insured indemnity type of program are spelled out in Part 3 of Article 3 of Chapter 135 of the North Carolina General Statutes (i.e., $250 annual deductible, 20% coinsurance up to $1,000 annually, etc. paid by the program's members). HMOs are required to offer benefits that are comparable to those provided by the self-insured indemnity program. Employer-paid non-contributory premiums are only authorized for the indemnity program's coverage for employees and retired employees. Whenever employees and office holders first employed or taking office on and after October 1, 1995 become eligible for health benefits as retired employees, the amount of premium paid by the State for individual coverage will be based upon the retiree's amount of retirement service credit at the time of retirement. Only retired employees with 20 or more years of service credit at retirement will be eligible for non-contributory health benefit premiums. Retirees with 10 or more years of service credit at retirement will be eligible for 50% partially contributory health benefit premiums. Retired employees with 5 or more year of service credit at retirement will be eligible to continue their health benefits on a fully contributory basis. All other types of premium in the indemnity program are fully contributory. Premiums paid by employers to HMOs are limited to like amounts paid to the indemnity program with employees and retired employees paying any HMO amounts above the indemnity program's non-contributory rates. Both types of coverage continue to be available in the Plan with nine HMOs currently covering about 25% of the Plan's total population in about 66 of the State's 100 counties. The Plan's employees and retired employees select the type of program that they wish for themselves and their dependents during the months of August and September of each year for coverage beginning in October. The demographics of the Plan as of December 31, 1999, include:

	Self-Insured Indemnity Program	Alternative HMOs	Plan Total
Number of Participants			
Active Employees	203,482	70,681	274,163
Active Employee Dependents	110,453	44,369	154,822
Retired Employees	96,217	5,712	101,929
Retired Employee Dependents	16,374	1,165	17,539
Former Employees & Dependents with Continued Coverage	2,891	323	3,706

Total Enrollments	429,417	122,742	552,159
Number of Contracts			
Employee Only	230,456	54,059	284,515
Employee & Child(ren)	31,626	14,644	46,270
Employee & Family	39,670	8,182	47,852
Total Contracts	301,752	76,885	378,637
Percentage of Enrollment by Age			
29 & Under	26.7%	41.6%	30.0%
30-44	20.1	27.3	21.7
45-54	21.1	19.6	20.8
55-64	14.9	8.7	13.5
65 & Over	17.2	2.7	14.0
Percentage of Enrollment by Sex			
Male	39.4%	37.8%	39.0%
Female	60.6	62.2	61.0

Assumptions for the Self-Insured Indemnity Program: For the fiscal year beginning July 1, 1999, the self-insured program started its operations with a beginning cash balance of $234.1 million. Receipts for the year are estimated to be $763 million from premium collections, $15 million from investment earnings, and $15 million in risk adjustment and administrative fees from HMOs, for a total of $793 million in receipts for the year. Disbursements from the self-insured program are expected to be $820 million in claim payments and $24 million in administration and claims processing expenses for a total of $844 million for the year beginning July 1, 1999. For the fiscal year beginning July 1, 2000, the self-insured indemnity program is expected to have an operating cash balance of over $183 million with a net operating loss of approximately $120 million for the 2000-2001 fiscal year. For the fiscal year beginning July 1, 2001, the self-insured indemnity program is expected to have an operating cash balance of only $63 million. The self-insured indemnity program is consequently assumed to be unable to carry out its operations for the 2001-2003 biennium without increases in its current premium rates or a reduction in existing benefits or both. This assumption is further predicated upon the fact that the program's cost containment strategies (hospital DRG reimbursements, pre-admission hospital testing, pre-admission hospital inpatient certification with length-of-stay approval, hospital bill audits, required second surgical opinions, mental health case management, coordination of benefits with other payers, Medicare benefit "carve-outs", cost reduction contracts with participating physicians and other providers, prescription drug manufacturer rebates from voluntary formularies, and fraud detection) are maintained and improved where possible. Current non-contributory premium rates are $143.10 monthly for employees whose primary payer of health benefits is Medicare and $187.98 per month for employees whose primary payer of health benefits is not Medicare. Fully contributory premium amounts for employee and child(ren) contracts are $89.06 monthly for children whose primary payer of health benefits is Medicare and $117.16 monthly for other covered children, and $213.60 per month for family contracts whose dependents have Medicare as the primary payer of health benefits and $281.04 per month for other family

contract dependents. Claim cost trends are expected to increase 13% plus annually. Total enrollment in the program is expected to increase about 4% annually over the next two years due to enrollment losses from alternative HMOs. The number of enrolled active employees is expected to show a 4-5% increase annually over the next two years, whereas the growth in the number of retired employees is assumed to be 4% per year. The program is expected to increase by 1-2% per year the number of active employee dependents and enrolled retiree dependents. Investment earnings are based upon a 5-6% monthly return on available cash balances. The self-insured indemnity program maintains a claim stabilization reserve for claim cost fluctuations equal to 7.5% of annual claim payments without reserving additional funds for incurred but unreported claims.

Assumptions for Indemnity Plan's Pap Smear Claims:

The estimate by the Plan's consulting actuary assumes an overall utilization rate of 40% by female participants under the proposed enhanced Pap Smear benefit. The Plan's consulting actuary assumes an average amount paid per Pap Smear procedure to be $19.33 based on the historical claims data reviewed and an annual 12% growth trend in claims costs. The consulting actuary for the General Assembly's Fiscal Research Division, Hartman & Associates, based on claims data supplied by the Plan, assumes and overall utilization rate of 90% by affected female participants under the proposed enhanced Pap Smear benefit. Hartman & Associates also assumes an average amount paid per Pap Smear procedure to be $19.77 based on the historical claims data reviewed and an annual 12% growth trend in claims costs.

Assumptions for Eligibility for Reinstatement Provisions:

Based upon information provided by the Plan, only about six Plan members have been excluded from coverage for filing fraudulent claims. A large majority of these claims involved reimbursement to Plan members for outpatient prescription drugs. Since the time that such claims were determined to be fraudulent, the Plan has taken steps to try to prevent the possibility of future occurrences of fraudulent claims involving outptient prescription drugs.

SOURCES OF DATA:

-Actuarial Note (Pap Smears), Hartman & Associates, House Bill 1838, June 19, 1999, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note (Benefits Reinstatement), Hartman & Associates, Proposed Draft Legislation, March 26, 1999, original of which is on file in the General Assembly's Fiscal Research Division.

-Actuarial Note, (Pap Smears), Aon Consulting, House Bill 1838, June 12, 2000, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

-Actuarial Note, Aon Consulting, Proposed Draft Legislation, March 29, 1999, original of which is on file with the Comprehensive Major Medical Plan for Teachers and State Employees and the General Assembly's Fiscal Research Division.

TECHNICAL CONSIDERATIONS: None

FISCAL RESEARCH DIVISION
733-4910
PREPARED BY: Mark Trogdon
APPROVED BY: James D. Johnson
DATE: June 30, 2000

HARTMAN & ASSOCIATES, LLC
ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27295

June 19, 2000

Mr. Mark Trogdon
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: House Bill 1838: An Act to Provide Coverage for the Cost of One Annual Pap Smear for any Female Covered Under the SEHP

Dear Mr. Trogdon:

This bill would rewrite G.S. 135-40.5(e) to provided coverage for one Pap smear per year for any covered female under the Teachers' and State Employees' Comprehensive Major Medical Plan. Coverage is provided under the wellness benefit as part of routine diagnostic examinations and is not subject to the deductible and coinsurance provisions of the plan. This act becomes effective July 1, 2000.

Currently, charges for Pap smears are covered at 100% as part of routine diagnostic examinations. However, the frequency is limited to once every three years for individuals under age 40, once every two years at ages 40 through 49, and annually at ages 50 and older.

The estimated cost of this act is shown below:

Estimated Cost	
Fiscal Year Beginning July 1, 2000	Fiscal Year Beginning July 1, 2001
$1,189,038	$1,470,222

These estimates are based on an analysis of Pap smears covered under the plan's wellness benefit over the past three years. Projections assume a 12% annual claim cost trend, a 60-day claim payment lag, 3% administrative expense, and a 7.5% claim fluctuation reserve. Increased payments have also been limited by the plan's overall wellness benefit limit of $150 per year.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' & STATE EMPLOYEES' COMPREHENSIVE MAJOR MEDICAL PLAN

• • •

House Bill 1838

SEHP Wellness Benefit/Annual Pap

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

June 2000

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to House Bill 1838 entitled "An Act to provide that the Teachers' and State Employees' Comprehensive Major Medical Plan shall cover the cost of one annual PAP Smear for any covered female under the plan's wellness benefit".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and within the confidentiality requirements of General Statute 120-129 through 120-134. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/05
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

6/12/05
Date

ADDITION OF ANNUAL PAP SMEAR TO MEDICAL PLAN WELLNESS BENEFIT

PLAN CHANGE

The draft bill proposes that the North Carolina Teachers' & State Employees' Comprehensive Major Medical Plan (Plan) be amended to cover the cost of one annual PAP Smear for any covered female under the plan's wellness benefit.

Currently the plan pays 100% of allowable charges ($150 fiscal year maximum) for certain routine examinations and tests that are medically necessary for the maintenance and improvement of individual health. These wellness benefits are limited to once every three years for covered individuals under age 40, once every two years for individuals age 40 to 49 and once every year for individuals age 50 and over.

PAP Smear expenses are an allowable charge under the current wellness benefits, subject to the age related utilization limits. **It is proposed that the plan's wellness benefits be amended to cover one PAP Smear per year, regardless of age.**

The proposed act is effective July 1, 2000.

PROJECTED COST IMPACT

	% Increase			Based on Midpoint Increase (in 000's)		
Plan Design Change	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
Include annual PAP Smear as allowable charge under plan's wellness benefit.	<0.01%	<0.01%	<0.01%	$136	$203	$228

First year cost assumes an implementation date of July 1, 2000 and a 3 month claims payment lag. An annual trend of 12% has been assumed.

PRICING APPROACH

- There are currently 212,000 (approx.) female plan participants eligible for the enhanced PAP Smear benefit. Claims data shows that utilization increases from age 20 through age 59, reducing slightly after age 60. The average utilization rate for all age groups was approximately 30% during the past three experience periods reviewed. The average amount paid per procedure was calculated from the historical claims records and assumed to be $19.33.

- Increased benefit utilization would be expected with the enhanced benefit and we have projected that utilization would increase from 30% to 40% in the affected age group. However, the benefit increase will only impact female participants under age 50. Annual PAP Smears are already available for participant age 50+. The age 50+ accounts for 38% of the projected utilization. Factoring in that the proposed change does not impact all female participants, and the rather low cost per service, this change will have minimal cost impact.

HARTMAN & ASSOCIATES, LLC
ACTUARIAL CONSULTING

MARK V. HARTMAN, FSA, MAAA, MCA, EA

Phone: (336) 731-4038
Fax: (336) 731-2583

668 Link Road
Lexington, NC 27292

March 26, 1999

Mr. Sam Byrd
Fiscal Research Division
North Carolina General Assembly
300 N. Salisbury Street
Raleigh, NC 27603-5925

Re: Proposed Legislation to Allow Individuals Excluded from the Teachers' and State Employees' Comprehensive Major Medical Plan for Filing Fraudulent Claims to be Reinstated in the Plan

Dear Mr. Byrd:

This proposal would amend G.S. 135-40.2(h) and G.S. 135-40.11(a)(6) to provide a means of reinstatement for individuals who have knowingly and willfully made fraudulent claims in the Teachers' and State Employees' Comprehensive Major Medical Plan.

Currently, coverage for an employee or retired employee and their dependents will cease if they are found to have made or caused to be made a fraudulent claim. This proposal provides that after a five year period without coverage and upon full and complete restitution to the Plan for all fraudulent claim amounts, these individuals would be reinstated in the plan and again be eligible for benefits. This act would become effective when it becomes law.

The reinstatement provision may allow adverse selection by the fraudulent claim filers at the time of reinstatement. However, data provided by the Plan indicates that only six employees have ben excluded from coverage since enactment of this provision in 1989. Given this low frequency of exclusion, the financial impact of the reinstatement provided by this legislation is expected to be negligible.

If you have any questions, let me know.

Sincerely,

Mark Hartman

Mark V. Hartman, FSA, MAAA, MCA, EA
Consulting Actuary

MVH/jj

NORTH CAROLINA TEACHERS' &
STATE EMPLOYEES' COMPREHENSIVE
MAJOR MEDICAL PLAN

• • •

Draft Bill

Eligibility for Plan Members Filing
Fraudulent Claims

ACTUARIAL NOTE

Prepared by:

Aon Consulting
One Piedmont Center
3565 Piedmont Road, N.E.
Atlanta, Georgia 30363

March 1999

ACTUARIAL STATEMENT

The State of North Carolina Teachers' and State Employees' Comprehensive Major Medical Plan (Plan) has requested that Aon Consulting prepare an Actuarial Note in response to the Draft Bill to be entitled "An Act to allow individuals excluded from membership in the Teachers' and State Employees' Comprehensive Major Medical Plan for filing fraudulent claims to be reinstated in the Plan".

The Actuarial Note was prepared according to generally accepted actuarial principles and practices, in compliance with General Statute 120-114, and applicable Rules of the North Carolina Senate and House of Representatives. As required by statute, the Note includes an explanatory statement of the proposed change(s) and, to the extent possible, an estimate of the financial and actuarial effect of the proposed change(s) on the Plan. The Actuarial Note makes no comment or opinion with regard to the merits of the measure for which the Note is prepared; however, any identified technical or mechanical defects have been noted.

We have reviewed the input and results of our analysis for reasonableness, and relied upon the data and information provided by the Plan and their Claims Processing Contractor.

Kenneth C. Vieira, F.S.A., M.A.A.A., E.A.
Vice President

3/29/99
Date

Professional Peer Review by:

Fred W. Munzenmaier, F.S.A., M.A.A.A., E.A.
Senior Vice President

March 29, 1999
Date

Aon Consulting

PLAN CHANGE

Section 1, General Statutes 135-40.2 (h), will be amended to read:

"(h) No person shall be eligible for coverage as an employee or retired employee or as a dependent of an employee or retired employee upon a finding by the Executive Administrator or Board of Trustees or by a court of competent jurisdiction that the employee or dependent knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subsection shall have a cessation of coverage for a period of five years and are eligible for benefits after the five year period upon a full and complete restitution to the Plan for all fraudulent claim amounts.

Section 2. General Statute 135-40.11(a) (6) reads as rewritten:

"(6) The last day of the month in which a covered individual is found to have knowingly and willfully made or caused to be made a false statement or false representation of a material fact in a claim for reimbursement of medical services under the Plan. Persons subject to this subdivision shall have a cessation of coverage for a period of five years and are eligible for benefits after the five year period upon a full and complete restitution to the Plan for all fraudulent claim amounts."

Section 3. This act is effective when it becomes law.

PROJECTED COST IMPACT

Plan Design Change	% Increase			Based on Midpoint Increase (in 000's)		
	Low	Mid	High	First Year Cost $	Second Year Cost $	Third Year Cost $
New Benefit Eligibility for Plan Members Filing Fraudulent Claims Under the Teachers' and State Employees Comprehensive Major Medical Plan	Negligible					

PRICING APPROACH

- The number of members excluded from the Plan for filing fraudulent claims is expected to be less than 100 members. To be reinstated in the Plan will be like individual insurance, making it highly probable that claims per enrolled member will be substantially higher than those of the current Plan members and that "adverse selection" will exist.

- Due to the possibility of "adverse selection" and a select group of enrollees, a claims factor should be added to the current premium rate to ensure that the Plan will not be providing a subsidy. Claims factors for these types of risk typically range from 150-200% of expected Plan costs, with some instances being as high as 300%.

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 5, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
EVELYN TERRY	STATE HEALTH PLAN
JACK WALKER	STATE HEALTH PLAN
Cam Cree	BPMHL
Audrey Galloway	NCAE
Anne Dixon	NC-NOW
Jim Ramquist	NCATA
Mark Smith	NCSA
John Bordish	Alley Associates
Roger Bone	Bone & Assoc.
George Irving	Johnson & Johnson
Paul G. Sebo	State Health Plan

VISITOR REGISTRATION SHEET

SENATE HEALTH CARE COMMITTEE — JULY 5, 2000

Name of Committee — **Date**

VISITORS: PLEASE SIGN IN BELOW AND RETURN TO COMMITTEE CLERK

NAME	FIRM OR AGENCY AND ADDRESS
[signature]	[signature] inc.
[signature]	NC Med Soc